NORTH EAST LINCOLNSHIRE COUNCIL
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North East Lincolnshire Council

Child & Adolescent Emotional Wellbeing and Mental Health Needs Assessment

Unique Improvements

Content

Acknowledgements

The Commissioning Support Unit at North East Lincolnshire Council would like to thank all those organisations who contributed their time and insight to developing this report.

This includes:

- North East Lincolnshire Council
- North East Lincolnshire Clinical Commissioning Group
- Lincolnshire Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Navigo
- NHS England
- North East Lincolnshire schools
- North East Lincolnshire Healthwatch
- Humberside Police Force
- North East Lincolnshire voluntary and community sector organisations

A list of those who gave specific feedback via a focus group or interview is included as Appendix 1.

Special thanks to all the children and young people, and their parents and carers, who gave up their time to contribute. In particular, we would like to acknowledge the children and young people from the NSPCC, Youth Action Group and CAMHS User Group, all of whom participated in detailed focus groups.

Thanks are due also to the teaching and non-teaching staff, and school nurses, who supported and participated in school focus groups, at:

- Middlethorpe Primary Academy
- East Ravendale Church of England Primary School
- Havelock Academy Secondary School and Sixth Form
- Oasis Academy Immingham Secondary and Sixth Form

Executive Summary

Introduction

- Unique Improvements were commissioned by North East Lincolnshire Council to undertake a needs assessment of children and young people's emotional and mental health needs, to inform the development of a new emotional wellbeing and mental health pathway, in line with the recommendations from Future In Mind
- Emotional and mental health problems are common amongst children and young people, with the most recent large scale study estimating that 1 in 10 children and young people will suffer from a diagnosable mental health condition at some stage in their childhood. For some young people, their illness will be severe and ongoing; half of all serious mental illness in adults begins during the later teenage years. Some factors (individual, family, social and environmental) place children and young people at greater risk of developing poor mental health
- The majority of children and young people do not access help, and research indicates that there is an 8 year gap between problems first being identified and help being secured
- Mental health, including for children and young people, has been a key governmental priority for some time. In 2015, the Government launched 'Future In Mind', a five-year transformation programme for children and young people's emotional and mental health. Additional funding has been available to local areas, linked to the development of a local transformation plan
- The commissioning arrangements for emotional and mental health services are complex, with a coordinated approach required to ensure that needs are met in the most efficient way. North East Lincolnshire has strong multi-agency arrangements to ensure that this coordinated approach is in place

North East Lincolnshire

- There are approximately 38,000 people aged under 20 in North East Lincolnshire. Population projections suggest that this figure will actually decline slightly over the next 20 years
- North East Lincolnshire is particularly affected by deprivation, and has higher than average rates of children living in low income families, unemployment, statutory homelessness and fuel poverty. This suggests a greater challenge for emotional and mental health than in more affluent areas

- The Public Health Profile for North East Lincolnshire shows that the health and wellbeing of children and young people is generally worse than elsewhere in the country. Of particular concern are the proportion of school leavers attaining 5 or more GCSEs at grades A* to C, the proportion of 16 and 17 year olds not in education, employment or training (NEET), the rate of teenage pregnancy and the rate of children being looked after by the local authority. Again, this suggests a greater challenge for emotional and mental health than in other areas

- We can be clear about the numbers of children and young people known to services from vulnerable groups in North East Lincolnshire. Of particular concern to both the Local Authority and CCG will be the 265 children in care, 550 with learning disabilities, and 441 young people who have offended. Figures from the January 2016 school census show there were 210 North East Lincolnshire pupils with special educational needs with an autistic spectrum condition as their primary need

- The National Child and Maternal Health Intelligence Network (CHIMAT, part of Public Health England) provides estimates of the prevalence of common emotional and mental health conditions in local areas. For North East Lincolnshire, it is estimated that there are 2,320 children and young people aged 5-16 with mental health conditions. Of these, 1,440 will have a conduct disorder, 910 will have an emotional disorder, 385 will have a hyperkinetic disorder (generally ADHD), and 295 will have a range of less common disorders

- The Adolescent Lifestyle Survey which is carried out in North East Lincolnshire provides valuable information about the health and lifestyles of 11-16 year olds. In 2015, 4,266 young people completed a survey. In terms of emotional and mental health, the key messages are that the majority of young people (approximately 85%) generally feel happy about life, although the proportion who report that they worry a lot of the time is increasing. 15% of young people reported that they would hurt themselves if they had a problem – this chimes with what professionals told us about the concerning level of self-harm locally. There has been a significant rise in the proportion of young people reporting cyber-bullying

- The strategic commissioning intentions for North East Lincolnshire's children and young people are set out clearly in a range of plans, including the Future In Mind Local Action Plan, which has been independently evaluated positively by the Education Policy Institute's Mental Health Commission

- North East Lincolnshire is embarking on a major re-commissioning of services for 0-19 year olds, with much more emphasis on prevention and early help. It has been decided to integrate services for emotional and mental health into this approach. We think this is a very positive development and will enable local family hubs to deal with emotional and mental health issues as they arise, as part of an integrated family approach

Literature

- There is now a very strong evidence base which demonstrates that the presence of both risk and protective factors, at individual, family, community and environmental levels, has a very significant impact in determining which children and young people will experience poor mental health. Poor parenting, experiences of abuse and neglect, economic deprivation, bullying and discrimination are key risk factors
- Risk factors tend to accumulate over time and can be interdependent and mutually self-reinforcing. Emotional and mental health problems have a strong association with other poor outcomes including truancy and exclusion, and substance misuse
- There is now a considerable research base into the needs and experiences of particularly vulnerable groups of children and young people. The evidence base is particularly strong for looked after children and young people who have offended
- There is an increasingly sophisticated evidence base for which interventions have been proven to work

Service Review

- The Child and Adolescent Mental Health Service is commissioned by North East Lincolnshire Council via a Section 75 partnership agreement with North East Lincolnshire CCG. The service is provided by Lincolnshire Partnership NHS Foundation Trust and has a contract value of just over £2 million
- The service has been well evaluated by the Care Quality Commission and both users and referrers report a high quality service once a young person has been accepted
- The Service provides a comprehensive range of pathways and treatment modalities, which adhere to clinical guidance/standards developed by the National Institute of Clinical Excellence
- Despite the development of information leaflets and a duty advice line, a significant proportion of referrals are not accepted for assessment/treatment. This suggests that the service's eligibility criteria are not well understood, and causes a lot of waste and frustration in the system. Further work may be required with GPs and other referral agencies to ensure that referral pathways and eligibility criteria are fully understood
- A Crisis Intervention Team, which provides intensive intervention to young people at risk of inpatient admission, has been highly effective at managing young people with complex needs in the community. The use of inpatient facilities is low
- Thresholds to receive a service are very high. Although growing, the range and capacity of services to meet lower level needs at an early stage needs to be further developed

- There is some concern about the eating disorder pathway. The pathway needs to be updated to demonstrate how the new waiting time standard is being achieved. The low numbers of referrals for eating disorders is being monitored locally but we feel this needs some expert input

- The needs of vulnerable groups are generally well catered for, with specific teams for looked after children, CYP with learning disabilities and dedicated workers linked to the YOT and substance misuse service. However, the offer for vulnerable groups is not comprehensive and it would appear that young people from the Youth Offending Team and substance misuse service with more complex needs are not getting the support they need

Consultation

- In excess of 300 people gave their views of Children's and Young people's Emotional and Mental Wellbeing Services. They were a combination of Commissioners, Managers, Providers, Clinical Staff, Children and Young People and their parents and carers

- It is accepted that the number of CYP presenting with emotional and mental wellbeing issues is increasing and the complexity of their conditions is increasing

- There appears to be little support provided for those with low and medium level emotional and mental wellbeing issues. If there is support then it is either over – stretched or unknown to the system. There needs to be a focus on prevention and early intervention

- Pathways for emotional and mental wellbeing are referred to but nobody can produce one. It appears as if they possibly existed in the past and haven't been reviewed

- The CAMH service is acknowledged as a good service if you can access it. The thresholds are too high for the needs of the majority of CYP and service providers

- The workforce acknowledges the issues and has identified training needs to be able to cope better with issues in the community rather than 'handing off' young people

- There is an acknowledgement of the complex lives lived by some CYP and the effect of the wider determinants of health and their families on their ongoing mental health

- Some schools have excellent examples of support for primary school children which falls off as they get older and collapse by year 8. Schools are using exclusion to manage behaviour and exclude automatically for single issues. Last year there were 64 exclusions of which 57 remain excluded. Young people in groups talk about the impact on a class when the teacher is trying to manage behavioural issues. Schools do not explore underlying issues as they don't have the skills, time or capacity to do this. Early intervention is entirely missing in some schools and parents use school as first point of call for advice. There is a perception that the school nursing service is underfunded and sometimes there is only a day or two of provision each month

Conclusion and Recommendations

- Our conclusion is that currently the system does not meet the needs of children and young people with low level emotional and mental health needs well. We think it is probable that this means that a disproportionate number of children and young people tip over into crisis, creating a vicious cycle where specialist mental health resources are focussed on the smallest group of children and young people with the highest needs
- This is acknowledged locally and highlighted in the local transformation plan for emotional wellbeing and mental health. The plan recognises the importance of intervening from the ante-natal period and in the early years, supporting families and those who care for children and building resilience through to adulthood, reducing the demand for specialist services by preventing children growing up and experiencing complex family issues

We recommend that:

- The current system is heavily reliant on a specialist CAMH Service. This means that only those with the most severe presentations are assessed and treated. As an integral part of Future In Mind implementation, a proactive shift to early intervention and easily accessible support in schools and voluntary sector provision is planned. This should be reinforced with a much greater degree of capacity in services for the most vulnerable children and young people (particularly children in need) to understand and engage with emotional and mental health needs. Referral to CAMHS should become the exception rather than the default
- Where specialist CAMHS are required, they need to be available at times which are more convenient to children, young people and families. Commissioners should consider whether early morning, evening or weekend sessions would enable the service to be more accessible and have less negative impact on school attendance
- A key next step will be to engage with schools to identify what they are currently commissioning/providing to support emotional and mental health. A desired outcome would be the commissioning of a consistent, easily accessible schools based service, available to both children and parents on a drop in basis
- Support for parents to manage behaviour well is the most needed and effective intervention for children at the pre-school and primary school phase. NEL should commission evidence based parenting group programmes as part of the core offer in family hubs
- The THRIVE model should be considered as a way to move away from tiers and ensure that services are arranged around the needs of children and young people

- There is a gap in early emotional and psychological support for children and young people with long term health conditions. The current system is set up only to provide a response where needs have escalated to a diagnosable medium/severe condition.
  A psychological support component should be developed for each physical health pathway, which identifies how children and young people will be supported to maintain motivation for managing their conditions effectively, and adjust to the challenges and stigma that accompany many physical health conditions

- The pathway for young people who have offended needs to be reviewed. There are notable innovations in this area (training YOT officers in CBT) but young people with more complex needs are not being addressed

- Continued attention needs to be given to the relatively low numbers of young people presenting with an eating disorder. Whilst it is plausible that this may reflect a specific local response to emotional difficulties, there is not a strong research base to support this. An independent review from a paediatric eating disorder specialist should be commissioned to identify if further action is required

Introduction

Key Points:

- Unique Improvements were commissioned by North East Lincolnshire Council to undertake a needs assessment of children and young people's emotional and mental health needs, to inform the development of a new emotional wellbeing and mental health pathway, in line with the recommendations from Future In Mind
- Emotional and mental health problems are common amongst children and young people, with the most recent large scale study estimating that 1 in 10 children and young people will suffer from a diagnosable mental health condition at some stage in their childhood. For some young people, their illness will be severe and ongoing; half of all serious mental illness in adults begins during the later teenage years. Some factors (individual, family, social and environmental) place children and young people at greater risk of developing poor mental health. The majority of children and young people do not access help, and research indicates that there is an 8 year gap between problems first being identified and help being secured
- Mental health, including for children and young people, has been a key governmental priority for some time. In 2015, the Government launched 'Future In Mind', a five-year transformation programme for children and young people's emotional and mental health. Additional funding has been available to local areas, linked to the development of a local transformation plan
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Purpose and scope of the needs assessment

Unique Improvements were commissioned by North East Lincolnshire Council to undertake this needs assessment. The purpose of the needs assessment is to:

- Understand what CYP require for mental health and emotional wellbeing support and where is most appropriate to access this support i.e. internet, service etc
- Understand how/where commissioners should target future commissioning activity around CYP mental health services
- Provide a model of effective and value for money interventions and services based on the needs of the local population, available evidence base, national best practice and guidance; and
- Build on current knowledge in North East Lincolnshire in order to inform future service need and provision

We have only looked at support for autistic children and young people in terms of their emotional and mental health needs. We do not believe that autism is, in itself, an emotional or mental health problem. However, lack of understanding and discriminatory attitudes lead to a higher rate of emotional and mental health issues in this group. CAMHS clinicians have a role to play in diagnosis and post-diagnostic support, and North East Lincolnshire CCG are currently leading on the development of a holistic, multi-disciplinary pathway for autism diagnosis and support.

We have used the approach described in the Health Development Agency (now National Institute for Clinical Effectiveness) publication, 'Health Needs Assessment: A Practical Guide' (2005).[1] This describes health needs assessment as a 5 stage process, which comprises:

- ✓ Step 1 – Getting started – defining your target population, clarifying your aims, agreeing who needs to be involved, deciding on what resources you need to complete the needs assessment and securing them, and identifying and managing risks
- ✓ Step 2 – Identifying health priorities – profiling your population, gathering data, understanding perceptions of need, and identifying and assessing health conditions and determinant factors

- ✓ Step 3 – Assessing a health priority for action – choosing health conditions and determinant factors with the most significant size and severity impact, and determining effective and acceptable interventions and actions
- ✓ Step 4 – Planning for change – clarifying aims of the intervention, action planning, monitoring and evaluation, and risk management
- ✓ Step 5 – Moving on/review – learning from the review, measuring impact and choosing the next priority

Unique Improvements' work has focussed on Steps 2 and 3

Local commissioners implemented Step 1 in agreeing to commission this piece of work, and will be responsible through Steps 4 and 5 for deliberating on our recommendations and implementing them where this makes sense locally.

There are varying definitions of emotional wellbeing and mental health across different disciplines. The World Health Organization (2005) defines mental health as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[2] As in the WHO's definition of health ("a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"), mental health is not just the absence of illness, but requires an additional positive 'something' to be present in the individual. Thus, the concept of an individual's mental health state is increasingly being uncoupled from mental illness. Mental health and wellbeing consists of emotional wellbeing or happiness, psychological wellbeing and social wellbeing.

The National Institute for Clinical Excellence (NICE) 2013 [3] use the following definitions:

- Emotional wellbeing: being happy and confident and not anxious or depressed
- Psychological wellbeing: the ability to be autonomous, problem solve, manage emotions, experience empathy, be resilient and attentive
- Social wellbeing: Having good relationships with others, not possessing behavioural problems making the person disruptive

In this needs analysis, we are working to this broad concept of emotional health and wellbeing, which pays attention to the needs of all children and young people, rather than focussing on those with diagnosable mental health conditions.

National context

Emotional and mental health is a significant national issue. Experiences of poor mental health are extremely common, and are linked to poor outcomes in terms of physical health and social inclusion. People with serious mental illnesses tend to experience significant health inequalities. Continued social stigma around mental illness prevents many people from accessing help.

Whilst our collective understanding of emotional wellbeing and mental health has deepened considerably in recent years, the systems to support people are sub-optimal and too often only respond to crisis.

Research indicates that there are some factors in a child's life that will make them more likely to experience poor mental health (risk factors), and some that make it less likely (protective factors).

The Australian Primary Schools Mental Health Initiative [4] usefully summarises the key risk and protective factors as follows:

	Protective Factors	Risk Factors
Child	• Easy temperament • Good social and emotional skills • Positive coping style • Optimistic outlook on life • Good attachment to parents or carers	• Complications during birth and early pregnancy • Difficult temperament (overly shy or aggressive) • Low self-esteem • Low intelligence • Poor bonding with parents
Family	• Family harmony and stability • Supportive parenting • Strong family values • Consistency	• Family disharmony, instability or breakup • Harsh or inconsistent discipline style • Parent/s with mental illness or substance misuse • Siblings with a serious illness or disability

School	• Positive school climate • Sense of belonging and connectedness between family and school • Opportunity for participation in a range of activities • Academic achievement	• Peer rejection and/or bullying • Academic failure • Poor attendance • Poor connection between family and school
Life events	• Involvement with a caring adult • Support available at critical times	• Difficult school transition • Death of a family member • Emotional trauma • Experience of physical or sexual abuse
Society	• Participation in community networks • Access to support services • Economic security • Strong cultural identity and pride	• Discrimination • Isolation • Socioeconomic disadvantage • Lack of access to support services

Some definable groups of children and young people tend to experience more risk factors and less protective factors, and therefore are seen as being particularly at risk of poor emotional wellbeing and mental health. Groups seen as particularly at risk include young people not in education, employment or training (NEET), those with special education needs (SEN), those who are looked after by the local authority (LAC), those who self-harm, those who have experienced domestic violence within their families or relationships, teenage parents, those with learning disabilities, those on the autistic spectrum, those who misuse substances, young people who have offended, and those whose parents suffered from post-natal depression – these are the groups that the commissioners of this report have asked us to focus on. We have also included young lesbian, gay bisexual or transgender people, and those with physical disabilities or long–term health conditions.

The British Child and Adolescent Mental Health Surveys [5], carried out in 1999 and 2004, found that 1 in 10 children and young people under the age of 16 had a diagnosable mental health disorder. Among 5 to 10 year olds, 10% of boys and 5% of girls had a diagnosable condition; for 11 to 16 year olds this had risen to 13% for boys and 10% for girls. During childhood and early adolescence, poor mental health tends to present through severe behavioural problems, particularly amongst boys. From the mid-teens, emotional conditions (anxiety, depression and self-harm) tend to become more pronounced, particularly amongst young women. The most common problems are conduct disorders, attention deficit hyperactivity disorder and emotional disorders (anxiety and depression).

Most significant, long term mental illness starts in the teenage years – 50% of mental illness in adulthood has

its first occurrence before the age of 15, rising to 75% by age 18.[6] Spotting the signs of emotional distress as soon as they occur in young people, to enable appropriate support to be accessed, is therefore vital to tackling poor mental health in adulthood.

Despite the prevalence of mental health conditions amongst children and young people, there is a very significant treatment gap. It is estimated that less than a third of children and young people with a mental health condition access support for it. Recent research carried out by the Centre for Mental Health suggests that although 3 in 4 parents of children/ young people with a mental health problem seek help, only 1 in 4 actually receive any support. The average period between children first presenting with symptoms indicating a mental health condition and actually getting help is estimated at 10 years.[7]

National context - current legislation, policy, guidance and best practice

The emotional and mental health of children and young people has been a key government priority for some time. The House of Commons Health Committee undertook an inquiry into CAMHS provision in 2014, publishing a final report in October 2014 which outlined significant problems with the system.[8] At around the same time, NHS England commissioned a review of Tier 4 CAMHS [9], again finding significant challenges and areas for improvement.

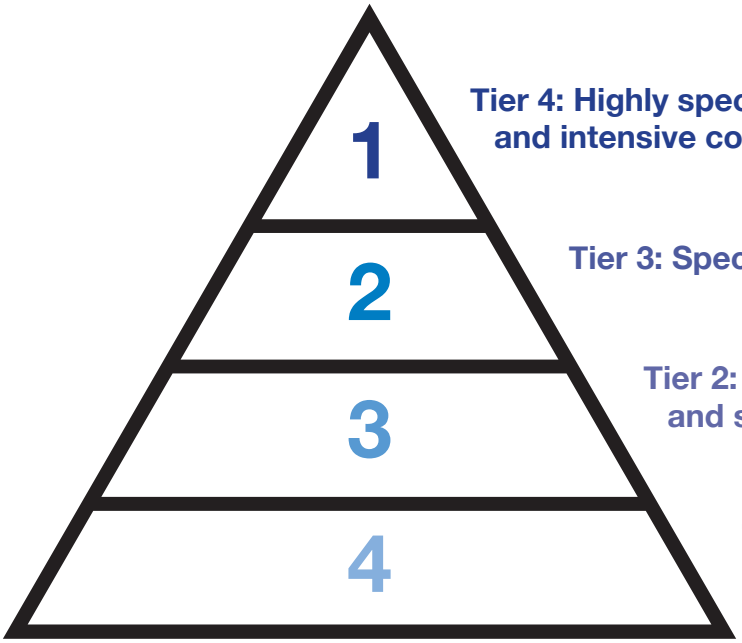
In response, The Children and Young People's Mental Health and Wellbeing Taskforce was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided. The Taskforce published its report, Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing in March 2015.[10]

The report emphasised 5 key themes where action needs to be taken at national, regional and local level to transform the system and secure better outcomes and experiences for children and young people with emotional and mental health needs:

- Promoting resilience, prevention, and early intervention – the Taskforce found that there is much more that can be done to support universal settings for children and young people (particularly schools) to identify emotional needs at an early stage. Taking concerted action to tackle the stigma that still surrounds mental health needs to be a priority. Communities need to be much better informed about emotional and mental health issues, and the Government is keen to explore on a national level how the massive growth in internet usage and smart phone apps can be used to do this safely
- Improving access to effective support – the Taskforce found that the system for meeting the emotional and mental health needs of children and young people is fragmented and difficult to navigate. In the mid – 1990s, a four tier approach to understanding the range of services

involved in an effective CAMHS system was developed, and has come to be the standard framework for children and young people's mental health services. Whilst this has been useful in enabling the development of a range of different approaches, it is now recognised that this can lead to artificial barriers between services, making the system more difficult to navigate. Many areas across the UK are working to move away from 'the tiered structure' around mental health services, exploring the development and design of new models which create a seamless pathway of care and support and that address the diversity of circumstances and issues with which families approach mental health services

The Tiered Model for CAMHS



Tier 4: Highly specialist inpatient CAMHS units and intensive community treatment services

Tier 3: Specialist multidisciplinary CAMH teams

Tier 2: Combination of specialist CAMHS and some community based services

Tier 1: Universal services consisting of primary care agencies, GPs, school nursing

It is also recognised that single points of access where there are multiple services, and open access one stop shops can be very helpful, both to children and families, and to the professionals who are helping them. Allocating specific named individuals to have responsibility for emotional and mental health, particularly in schools, is noted as a key improvement. Transition from children and young people's services to adults' provision is also noted as a concern, with many young people having a poor experience at a time when they are coping with multiple other changes in their lives. The Government will bring in much closer scrutiny and challenge around waiting times, introducing access standards throughout the Future In Mind transformation programme.

- Care for the most vulnerable – the Taskforce recognised that those children and young people who we know to be most vulnerable in general are at higher risk of emotional and mental health difficulties but are often poorly served by existing service structures and systems. Children who have

experienced neglect, abuse or trauma are often poorly served, and better coordination is required for looked after children and young people, young people who have offended and young people with special educational needs

- Accountability and transparency – as previously stated in this report, the commissioning framework for children and young people's mental health services is complex and fragmented. There are multiple commissioners, and investment in children and young people's mental health services is sometimes not given the priority it deserves. The Taskforce found that lack of robust, reliable data on need, service usage, service effectiveness and investment makes it very difficult to hold the system to account, and to benchmark between different areas. Local areas are now expected to work in much more transparent and accountable ways, with clear lead commissioner arrangements working through the joined up governance provided by local Health and Wellbeing Boards. Local areas will be expected to be much more transparent about what they are investing in children and young people's emotional and mental health services, and a new National Dataset and set of access standards will enable benchmarking across the system to determine value for money and effectiveness of local arrangements. The Government is keen to ensure that the growing evidence base is used to full effect, with only those interventions and approaches being used where they are supported by good evidence

- Developing the workforce – the Taskforce recognises that the system will only work effectively if it is made up of the right people, with the right skills, working in the right way. At a national level, the Government will act to ensure that emotional and mental health is given the focus it deserves in relevant professional qualification programmes (e.g. initial teacher training and social work training). There is a key role for Health Education England to work at a regional level to ensure that children and young people's emotional and mental health needs are incorporated into regional workforce development strategies. At a local level, action needs to be taken to ensure that each part of the workforce is clear about its role, can access appropriate advice and support as required, and that there is a strategy to develop skills and expertise where there are gaps

- Local areas are required to publish Local Transformation Plans, setting out the arrangements they have made locally to implement the Future In Mind transformation programme, where they will prioritise their actions, and how they will measure success. Plans are expected to be iterative, reviewed on an annual basis, and incorporated into the annual assurance cycle for Clinical Commissioning Groups

Commissioning Overview

The commissioning landscape for children and young people's emotional and mental health services is complex. It is fundamentally set out in the Health and Social Care Act (2012)[11], which established NHS England, Public Health England and Clinical Commissioning Groups. It also transferred the local responsibility for public health from the NHS to local authorities.

A number of agencies are involved in commissioning services, at both a national and local level, as illustrated in the table below:

Organisation	Commissioning Responsibility	Comments
NHS England	• NHS England is responsible for commissioning primary care services (including primary medical care, usually delivered in GP surgeries, and dental care). It is also responsible for specialist services. These are services for people with complex needs, of which there are too small a number for Clinical Commissioning Groups to commission them at a local level. This includes Tier 4 CAMHS • Although there is no legally established definition of a CAMHS Tier 4 service, the focus tends to be on inpatient provision • Additionally, The Health and Justice Team at NHS England is responsible for commissioning healthcare for people in prisons and secure settings, including youth offender institutions and children's secure units	**NHS England has developed a number of specifications, covering:** • General Adolescent Services • Children's Services • Specialist Autistic Spectrum Mental Health Services • Secure forensic mental health service for young people

Public Health England	• Public Health England has a strategic, advisory role, which is semi-independent of the Government, to provide advice to commissioners and policy makers on the needs of the population and how best to meet them	• Public Health England can grant fund or commission services if it so wishes, but is not under a statutory duty to commission health care services
Local authorities	**Since April 2013, all local authorities have been responsible for, "taking such steps as it considers appropriate to improve the health of people in its area." (This applies to top tier and unitary authorities)** Specific services that local authorities are responsible for commissioning are: • Sexual health services • Obesity prevention and physical activity promotion • Substance misuse services • Smoking cessation • Public health programmes for 0-19 year olds (Health Visiting and School Nursing) Local authorities are also responsible for jointly commissioning services that meet the needs of children and young people (aged 0-25) with special educational needs and/or disabilities. These duties stem from the Children and Families Act (2014). This includes those who have social, emotional and behavioural needs	• Health Visiting and School Nursing Services play a key role in terms of emotional and mental health as they are the key health services that should have contact with all children and young people • Local authorities do not have a statutory responsibility to commission services specifically relating to mental health, but can commission services to improve mental health if they determine it is a local need. Many local authorities have identified children and young people's emotional and mental health as a priority need, and often fund school based work

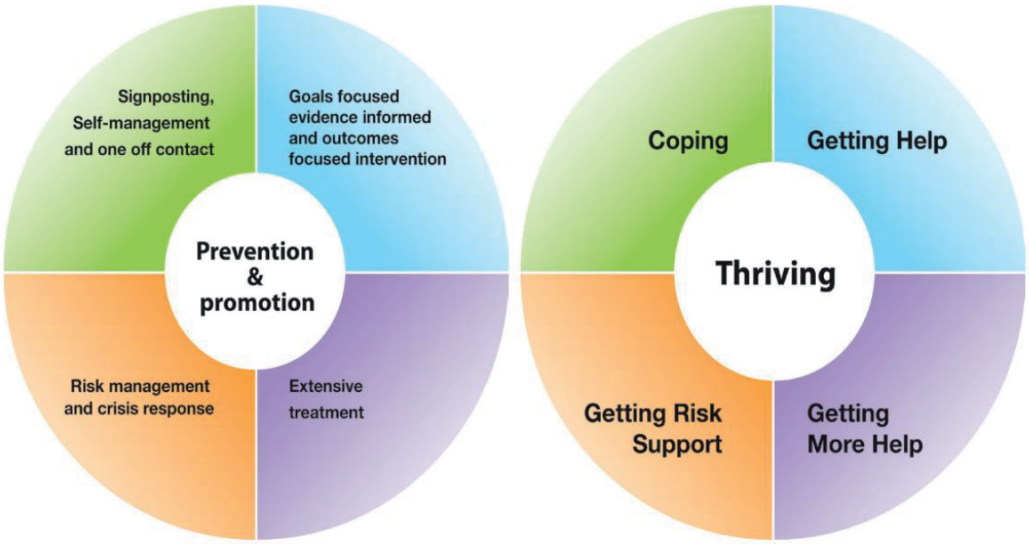
Clinical Commissioning Groups	The fundamental responsibility of Clinical Commissioning Groups is set out in the Health and Social Care Act (2012): a clinical commissioning group may arrange for the provision of such services… as it considers appropriate for the purposes of the health service that relate to securing improvement in the physical and mental health of the persons for whom it has responsibility, or in the prevention, diagnosis and treatment of illness in those persons"	Clinical Commissioning Groups are expected to work towards the aspirations set out in the 'Future In Mind' strategy
Schools	Schools do not have a statutory duty to commission emotional and mental health services. However, guidance issued by the Department for Education makes it clear that schools can commission these services if they see it as beneficial to their pupils [12]	Many schools make an investment in emotional and mental health support, either through employing a school counsellor or commissioning an organisation to provide one to one and group based support

Detailed guidance is available to determine which part of the NHS is the responsible commissioner for clinical health services.[13]

Emerging Issues (model)

The THRIVE Model

The Tavistock and Portman NHS Foundation Trust and The Anna Freud Centre have brought together a consortium who have developed and refined a new model for Child and Adolescent Mental Health Services (CAMHS), called 'THRIVE'.[14] This model offers a radical shift in the way services are conceptualised and could potentially be delivered. It recognises that CAMHS is a smaller part of a bigger system of intervention around mental health and promotes the move away from the 'tiered approach' to services. It recognises the three main domains along the continuum of support and intervention and the tensions between them. Those being promoting wellness (an education model), treating illness (health model) and managing risk (social care model).



The THRIVE Model is partially based on analysis of 38,794 periods of contact with CAMH services in England in 2012/13, and identifies four groups of children and young people who need help with emotional wellbeing and mental health. These are:

- Getting Advice
- Getting Help
- Getting More Help
- Getting Risk Support

The Consortium which developed THRIVE have now secured funding from the Department of Health to work with local pilots to test the implementation of the model, including East London Foundation Trust, Hertfordshire Partnership Foundation Trust, and Pennine Care Foundation Trust. A further document, 'THRIVE Elaborated'[15] sets out the model in more detail and responds to many of the questions that have been raised. The THRIVE model is unique in that it is the only conceptual model to replace tiers that will be rigorously tested at scale. The THRIVE model links to the groupings developed for the CAMHS Payments by Results project (see below), which would mean that if this payment by results system became nationally mandated, the migration to this system would be less disruptive. THRIVE is a significant initiative and commissioners would be sensible to observe the learning from the pilots closely.

CAMHS Payment by Results

In order to bring more transparency to the funding of CAMHS services, the Department of Health and NHS England have been developing a tariff system for paying CAMHS providers based on actual case mix, rather than through locally determined fixed value contracts.[16] This is very similar to the system that is used to pay for acute care and adult mental health care. Cases are allocated to a grouping, which are linked to NICE evidence based pathways, and a tariff is agreed nationally for each group. A draft set of groupings are now being piloted with 20 sites across the country. Commissioners will want to observe this development closely as there is a possibility that this will become a nationally mandated model at some point in the future.

CAMHS Commissioner Modelling Tool

Developed by South, Central and West Commissioning Support Unit, the CAMHS Commissioner Modelling Tool enables commissioners to model what capacity is needed in the local system, based on prevalence and historic activity data, to meet commissioner expectations in terms of waiting times and access to service.[17] The tool is dynamic and allows users to plan for different scenarios, and understand the impact of different approaches. It will provide local commissioners with valuable insight into what resources are required to facilitate genuine transformation, and its use is recommended.

Revised Special Educational Needs Code of Practice

- The most significant change to the system for identifying and addressing special educational needs took place in 2014, with the publication of a comprehensively revised statutory Code of Practice for SEN and Disabilities.[18] Young people now have a statutory right to support up to their 25th birthday, and this includes mental health support where it is necessary for the achievement of educational outcomes. The key impacts here are likely to be emotional and mental health support to young people with conditions on the autistic spectrum and/or with a learning disability

The Children and Families Act (2014)[19] places a new duty on local authorities and the NHS to collaborate locally to commission services for children and young people with special educational needs/disabilities – the intention being to create more seamless, joined up services. As the local offer for this group develops, consideration should be given to whether the needs of this group are best served by a service that is available on a 0-25 basis, and whether there is an opportunity for mental health support to be integrated into a multi-disciplinary pathway approach

Raising the Participation Age

As a result of the new requirement that 16 and 17 year olds are either in full time education, an apprenticeship, or a part time course (if caring/working), there is likely to be an increase in young people accessing local educational provision, whether via schools, colleges or other provision. There is an opportunity here to identify emotional health needs in a group of young people who previously may have been outside of the system. This will mean appropriate training and support for those staff members working with this group, and sufficient provision to meet their needs. Thought will need to be given to this once it is clearer what the local pattern is and where young people from North East Lincolnshire are accessing education.

Places of Safety

The Policing and Crime Bill 2016, currently going through Parliament, legislates to end the practice of children and young people being kept in police cells as a "place of safety" whilst they await mental health assessment or treatment. It is likely that guidance on acceptable arrangements for children and young peoples' places of safety will be published once the Bill has been passed. Commissioners will want to review their local provision to ensure that it is compliant with any national requirements.

Further Development of Future In Mind Local Transformation Plans

All CCG areas in England were required to produce a Future In Mind Local Transformation Plan in 2015. North East Lincolnshire have completed their plan and it has been approved by NHS England. Plans are expected to be updated on an annual basis and it is worthwhile noting that there has been some challenge to the level of ambition contained collectively within the plans. The Education Policy Institute's Mental Health Commission published an analysis of 121 local transformation plans in August 2016 [20], and found that only 15% were 'good', with 37% requiring 'substantial improvement.'

The key challenges identified nationally were:

- Workforce (both in terms of training and key recruitment gaps)
- Funding
- Commissioning
- Data
- Fragmentation
- Not enough focus on early intervention

North East Lincolnshire's Local Transformation Plan was evaluated as follows:

Overall		Requires Improvement
Transparency		Amber
Ambition Amber		Amber
CYP Involvement		Red
Early Intervention		Amber
Governance		Green

The most significant area for improvement identified was in the involvement of children and young people. This was a challenge for many areas due to the timing of the planning phase (the planning guidance was issued in early August 2015, with submission dates in autumn). The involvement of children and young people in this needs assessment should go some way to evidencing more significant engagement with children and young people. There is a really good opportunity to engage children and young people in the ongoing re-shaping of services.

The Commission will publish a report with recommendations in autumn 2016 and these will need to be considered in the ongoing development of NE Lincolnshire's plan.

North East Lincolnshire

Key Points:

- There are approximately 38,000 people aged under 20 in North East Lincolnshire. Population projections suggest that this figure will actually decline slightly over the next 20 years
- North East Lincolnshire is particularly affected by deprivation, and has higher than average rates of children living in low income families, unemployment, statutory homelessness and fuel poverty. This suggests a greater challenge for emotional and mental health than in more affluent areas
- The Public Health Profile for North East Lincolnshire shows that the health and wellbeing of children and young people is generally worse than elsewhere in the country. Of particular concern are the proportion of school leavers attaining 5 or more GCSEs at grades A* to C, the proportion of 16 and 17 year olds not in education, employment or training (NEET), the rate of teenage pregnancy and the rate of children being looked after by the local authority. Again, this suggests a greater challenge for emotional and mental health than in other areas
- We can be clear about the numbers of children and young people known to services from vulnerable groups in North East Lincolnshire. Of particular concern to both the Local Authority and CCG will be the 265 children in care, 550 with learning disabilities and 441 young people who have offended. Figures from the January 2016 school census show there were 210 North East Lincolnshire pupils with special educational needs with an autistic spectrum condition as their primary need
- The National Child and Maternal Health Intelligence Network (CHIMAT, part of Public Health England) provides estimates of the prevalence of common emotional and mental health conditions in local areas. For North East Lincolnshire, it is estimated that there are 2,320 children and young people aged 5-16 with mental health conditions. Of these, 1,440 will have a conduct disorder, 910 will have an emotional disorder, 385 will have a hyperkinetic disorder (generally ADHD), and 295 will have a range of less common disorders
- The Adolescent Lifestyle Survey which is carried out in North East Lincolnshire provides valuable information about the health and lifestyles of 11-16 year olds. In 2015, 4,266 young people completed a survey. In terms of emotional and mental health, the key messages are that the majority of young people (approximately 85%) generally feel happy about life, although the proportion who report that they worry a lot of the time is increasing. 15% of young people reported that they would hurt themselves if they had a problem – this chimes with what professionals told us about the concerning level of self-harm locally. There has been a significant rise in the proportion of young people reporting cyber-bullying
- The strategic commissioning intentions for North East Lincolnshire's children and young people are set out clearly in a range of plans, including the Future In Mind Local Action Plan, which has been independently evaluated positively by the Education Policy Institute's Mental Health Commission

- North East Lincolnshire is embarking on a major re-commissioning of services for 0-19 year olds, with much more emphasis on prevention and early help. It has been decided to integrate services for emotional and mental health into this approach. We think this is a very positive development and will enable local family hubs to deal with emotional and mental health issues as they arise, as part of an integrated family approach

North East Lincolnshire (NEL) is a small unitary authority covering an area of 192km (small 2 = squared). The majority of the resident population live in the towns of Grimsby and Cleethorpes with the remainder living in the smaller town of Immingham, or in surrounding rural villages.

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North East Lincolnshire overview – child demographics etc, deprivation, general health outcomes, vulnerable groups.

NEL has a distinctive economy, built on expertise in manufacturing, engineering, ports and logistics, and food processing. The local area has some significant advantages stemming from its location, labour force, and transport infrastructure that position it for growth in renewables, chemicals, advanced manufacturing and the food and drink sector.

Census figures classify 94.2% of the population of North East Lincolnshire as living in an urban environment, however North East Lincolnshire has a wide variety of parks and open spaces.

The total population of North East Lincolnshire is estimated at 159,570 in the Office for National Statistics 2015 Mid-Year Estimates. The percentage of the local population who are of working age, (16 to 64), is slightly below the England figure of 63.3% at 61.4% (97,980). 19.5% (31,149) of the local population are 65+, which is higher than the England figure of 17.7%. The percentage of children and young people (0 to 15) is in line with the England figure (19.0%) at around 19.1% (30,441) of the population.

The most recent population estimates suggest that there are 37,956 children and young people aged 0-19 in North East Lincolnshire. This breaks down as follows:

Age Group	Girls	Boys	Total
0-4	5,030	5,090	10,120
5-15	9,942	10,371	20,313
16-17	1,962	1,914	3,867
18-19	1,713	1,943	3,656
Total	18,647	19,309	37,956

CYP under the age 20 years make up 23.8% of population in NE Lincs. 6.4% of children are from a minority ethnic group. (CHIMAT).

Population projections for North East Lincolnshire suggest that the under 19 population will reduce slightly over the next 25 years:

	2014	2019	2024	2029	2034	2039
0-4	10,000	9,000	9,000	9,000	9,000	9,000
5-15	10,000	10,000	9,000	9,000	9,000	9,000
16-17	9,000	10,000	10,000	9,000	9,000	9,000
18-19	9,000	8,000	10,000	10,000	9,000	9,000
Total	38,000	37,000	38,000	38,000	36,000	36,000

(Source: ONS Population Projections, based on 2014 data).
Commissioners do not need to factor in any population growth into their plans.

Deprivation

There are real issues of deprivation in North East Lincolnshire, with significant resultant health inequalities within the area. According to the most recent Public Health England profile for North East Lincolnshire, of the factors that influence health and wellbeing, North East Lincolnshire has 'risk' factors that are worse than the national average in several key domains, including:

	NEL	Regional Average	National Average
Children (under 20) in low income families	26.1	19.8	18.0
Children (under 16) in low income families	27.9	20.6	18.6
% of 16-64 year olds in employment	69.0	71.0	72.0
Statutory homelessness – eligible homeless people not in priority need	3.1	1.0	0.9
% of households in fuel poverty	10.8	10.6	10.4

According to the 2015 Indices of Multiple Deprivation, levels of deprivation are actually increasing. In 2010, 27 (or 25.2%) of the lower super output areas in North East Lincolnshire were in the 10% most deprived neighbourhoods in England. By 2015, this had increased to 31 (or 29.2%).

Research indicates that there is a strong link between economic deprivation and poor emotional/ mental health (this is covered in the section on Literature). High levels of deprivation in North East Lincolnshire suggest that there are likely to be higher levels of emotional and mental health needs, particularly in the areas of highest deprivation.

General Health Outcomes

Public Health England's Child Health Profile brings together the 32 most important indicators of child health and wellbeing available at a local level. The North East Lincolnshire Profile demonstrates that the health and wellbeing of children and young people is generally worse than the picture nationally. There are some significant risk factors for poor emotional and mental health present locally. There are high levels of child poverty, and proportionately high numbers of children in care. GCSE results are worrying, and the proportion of young people not in education, employment or training is significantly higher than the national average. Both the rate of teenage conception, and the number of teenage mothers, is of concern. New mothers are much more likely to be smoking at the time their baby is born, and much less likely to breastfeed – two key indicators of the outcomes that children and young people will achieve both in childhood and adult life. All of these indicators suggest that levels of emotional and mental health are also likely to be poorer than in areas which are less deprived and consequently healthier.

Indicator	NEL	Yorkshire & Humber Average	England Average
% of school leavers with 5 or more GCSEs at grades A* to C	52.0	55.3	57.3
% of 16-18 year olds not in education, employment or training	6.8	5.1	4.7
Rate of children in care	7.7	6.4	6.0
Rate of children in poverty	27.9	20.6	18.6
Rate of Under 18 conceptions	40.8	26.4	22.8
Rate of teenage mothers	2.2	1.3	0.9
% who smoke at time of delivery	2.2	15.6	11.4
% breastfeeding initiation	60.9	69.9	74.3

Vulnerable Groups

We can develop a picture of the extent to which a local population contains vulnerable groups of children and young people in two ways; either by using direct data that is readily available (e.g. the number of children who are looked after by the local authority), or by applying national prevalence data to the local population. The table below summarises the situation for North East Lincolnshire:

Vulnerable Group	Number	Rationale/ Evidence	Comments
Looked After Children	265 (Actual)	Nationally validated figure as at 31/03/15 – 2016 figure not yet publicly available	The number has grown significantly since 2011.
CYP with Learning Disabilities	550, of which 225 are estimated to have mental health problems (Estimate)	CHIMAT	20,313
CYP with Special Educational Needs	481 children/ young people with a statement or EHC Plan (Actual)	Nationally validated data for 2016	The number with a statement (or EHC Plan) has decreased significantly since 2007
CYP with ADHD	385 aged 5-16, predominantly boys (Estimate)	CHIMAT	
CYP on the autistic spectrum	200 aged 5-10 (Estimate)	CHIMAT	
Young people not in education, employment or training	230 (Actual)	Nationally validated data for 2015 – 2016 figure not yet publicly available	

CYP with parents in prison	Not possible to estimate		
Young people who've offended	441 (Actual)	Public Health England's CYP Mental Health and Wellbeing Profile	
Young carers	277 (Actual)	Census 2011 – 0.91% of under 15s provide unpaid care	
CYP from Black and Minority Ethnic communities	750 (Actual)	School Census 2014	
Asylum seekers and refugees	Figure suppressed due to low volume	Public Health England's CYP Mental Health and Wellbeing Profile	
Gypsy, Roma and Traveller children	Figure suppressed due to low volume	Public Health England's CYP Mental Health and Wellbeing Profile	
LGBT young people	101 (Estimate)	Census 2011 – nationally, 2.6% of 16-24 year olds self-identified as LGB. We have applied this % to the numbers of 16 and 17 year olds.	
CYP with physical disabilities	2,277 (Estimate)	The DWP and Office for Disability Issues estimates that 6% of children are disabled.[21]	

Further information is available about children and young people with special educational needs. Analysis carried out by the SEN Service in September 2016 found that 15.7% of the pupils in North East Lincolnshire with an EHC Plan or Statement have social, emotional and mental health identified as their primary need – compared to 12.3% nationally. However, at school support stage, this is reversed, with only 8.7% of pupils with social, emotional and mental health as their primary need, compared to 13.7% nationally. This may suggest that the current system is not effective at supporting schools to manage pupils with social, emotional and mental health needs effectively, leading to a reliance on the development of Education, Health and Care Plans, and the specific resources that come with them, to meet needs.

Local strategy, commissioning plans

North East Lincolnshire have developed a range of strategies and plans that set out what has been identified as a priority and how resources are to be used to effect change. Children and young people's emotional and mental health needs are addressed well in overarching local strategies, which provide a strategic driver for prevention and early help. There are a number of local strategies that focus particularly on the emotional and mental health needs of children and young people, and these are well aligned to form a comprehensive approach.

Children and Young People's Plan

Mental Health and Emotional Wellbeing has been identified as a priority by Young People in the NEL Children and Young People's Plan 2014-2016 for the first time and has been based entirely on the views and opinions of children and young people. Within the plan young people have identified mental health and emotional wellbeing as a key area which affects young people in North East Lincolnshire.

NEL Prevention and Early Help Strategy

North East Lincolnshire Council's Prevention and Early Help Strategy sets out the authority's ambition for the development of services aimed at improving outcomes for vulnerable children, young people and families, ensuring that the right support is given at the right times. It acknowledges that children and young people who have an identified mental health problem or whose parents or carers have mental health issues are more likely to experience difficulties in their lives and may need support to help overcome them.

The North East Lincolnshire Health and Wellbeing Strategy 2012-2016

The North East Lincolnshire Health and Wellbeing Strategy 2012-2016 identified the area as having enormous potential and on the brink of major job and business opportunities which will provide opportunities that local communities should benefit from.

The strategy's aspiration was to enable people to play a key part in their own health and wellbeing, which encouraged the community to take a greater role in local health and which underpins a move to high quality, community focussed care. The strategy recognised that people play an active part in society, taking up learning and skills, creating personal confidence and building resilience. It recognised the need to move from cure to prevention, providing support, training, guidance and counselling to people at risk of becoming unwell, with clear targeting of those most in need. The strategy outlined 3 main drivers for change to achieve sustainability in health and wellbeing, namely:

1. Places people inhabit – reducing poverty
2. Services people access – commissioning more joined up services
3. Lifestyles people live – to impact on life expectancy through greater focus on prevention and early detection

The North East Lincolnshire Future in Mind Transformation Plan 2015-2020. This plan was developed in October 2015 and sets out the agreed multi-agency vision for children and young people's emotional and mental health provision. The local plan echoes the themes identified in the national Future In Mind report, with key actions for Year 1 agreed as follows:

Promoting resilience, prevention and early intervention for the mental wellbeing of children and young people	• Create a comprehensive communications and marketing strategy which promotes young people's emotional health and wellbeing in a non-stigmatised way • Develop a range of resources in collaboration with children and young people which encourage young people to be resilient and to look after their own mental health and wellbeing through self-care • Cascade young people's health champions programme to facilitate sign posting peer to peer to promote children and young people's mental health and wellbeing. • Review current peri/postnatal depression pathway to implement joint working arrangements to reduce the incidence of peri/post-natal depression • Prioritise early help and intervention through a structured programme of support for at risk families (0-2 years) through Pioneer Communities programme • Redesign and implement a whole school approach to mental health in partnership with School Nursing, Educational Psychology and Educational settings • Design and develop a programme with CAMHS and school nursing which provides support to educational settings for self-harm through an early intervention programme for young people

Improving access to effective support	• Undertake a participatory health needs assessment for mental health and emotional wellbeing • Identify a suitable place for a single point of access for advice and support which complements existing provision in the community and public sector • Review assessment tools for children and young people's mental health and ensure that they are integrated into other referral models • Review local crisis model and ensure that it is in line with the Crisis Care Concordat and psychiatric liaison service
Care for the most vulnerable	• Review local pathways to ensure that there are processes in place for vulnerable groups to prevent further escalation of problems and considering the holistic needs of the child • Investigate causes of longer waiting times for vulnerable groups and implement appropriate changes to ensure that all vulnerable children and young people are seen within national waiting time standards
Accountability and Transparency	• Use Transformation Plan as the basis for Children and Young People's mental health commissioning priorities until 2020. • Embed the responsibility of overseeing the Transformation Plan as part of the Children's Partnership Board whom report directly to the Health and Wellbeing Board • Ensure the Children and Young People Mental Health and Wellbeing Strategy Group is overseeing the monitoring of the strategy and coordinates local priorities, evidence of need and future direction
Developing the workforce	• Audit all existing training for mental health for the children's workforce and ensure provision is in line with recommendations • Identify any gaps in mental health training for the children's workforce • Roll out Youth Mental 1st Aid across the children's workforce • Define a framework for children's workforce for mental health skills, capabilities and training in line with pre-existing frameworks (SCIF) and local children's safeguarding board

Implementation of the Local Transformation Plan is overseen by a multi-agency group, the Children and Young People's Emotional and Mental Health and Wellbeing Strategy Group. The Group receives quarterly progress updates and the Future In Mind work streams are beginning to deliver change in the system. The Local Transformation Plan was refreshed in October 2016. Key achievements at September 2016 include:

- North East Lincolnshire has successfully applied to become a Children and Young People's Increasing Access to Psychological Therapies area, as part of a new East Midlands partnership. This will upskill staff in a variety of evidence based treatment modalities
- The Access Partnership has been expanded and re-branded as 'Feelings First', providing a range of services including counselling, therapy and family mediation to children and young people who have identified emotional and mental health needs but don't meet the criteria for CAMHS
- Kooth.com has been commissioned to provide an online counselling and support service for children and young people in North East Lincolnshire. This further extends the available capacity in the local system, particularly for children and young people with lower level needs
- A grand total of 932 staff have been trained in supporting children and young people with emotional and mental health needs
- A Task and Finish Group has been established to probe the local situation for eating disorders, where it appears that referrals levels are much lower than might be expected

North East Lincolnshire Social Emotional Mental Health Strategy

The Education Psychology Service has developed a plan, which spans the same planning period as the Local Future In Mind Transformation Plan, and sets out how learning settings will be supported to maximise social, emotional and mental health. The Strategy is linked to the Future In Mind Local Transformation Plan to ensure a coordinated approach and will form the strategic approach for social, emotional and mental health needs in educational settings.

0-19 Programme

The Children's Partnership Board has initiated a major transformation of the overall pathways for 0-19 year olds, with a much greater focus on prevention and early intervention.

Analysis of the situation in North East Lincolnshire suggests that of the significant growth in the numbers of looked after children, which is now above the national average, a significant proportion could have been prevented. The core drivers of children being referred to children's social care, and ultimately becoming looked after, are parental mental health, parental substance misuse and domestic violence. The 0-19 Commissioning Programme is looking to focus the whole system on these key issues, and ensure that services can identify and intervene at the earliest possible stage. The emotional and mental health needs of children and young people have been incorporated into this programme, aligned to the work that is taking place to implement the Future In Mind Local Transformation Plan.

Summary of national data sources and tools

CHIMAT

The Child and Maternity Health Intelligence Network (CHIMAT), which is part of Public Health England, provides an excellent summary of expected prevalence of key mental health conditions in children and young people, using local population data available through the Office for National Statistics. The most recent report for North East Lincolnshire [22] states that:

Pre-school children

There are relatively little data about prevalence rates for mental health disorders in pre-school age children. The Report of the Children and Young People's Health Outcomes Forum, "recommends a new survey to support measurement of outcomes for children with mental health problems. In particular, we recommend a survey on a three-yearly basis to look at prevalence of mental health problems in children and young people. This could build on the work of the survey, 'Mental health of children and young people in Great Britain, 2004'." A literature review of four studies [23] looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6%. Applying this average prevalence rate to the estimated population within the area, gives a figure of 1,615 children aged 2 to 5 years inclusive living in North East Lincolnshire who have a mental health disorder.

School-age children

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated through the 2004 British Child and Adolescent Mental Health Survey. Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the table below shows the estimated prevalence of mental health disorder by age group and sex in North East Lincolnshire. Note that the numbers in the age groups 5-10 years and 11-16 years do not add up to those in the 5-16 year age group as the rates are different within each age group.

Estimated number of children with *mental health* disorders by age group and sex

Age Group	All	Boys	Girls
5 - 10	980	655	325
11 - 16	1,340	755	600
5 - 16	2,320	1,395	925

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014), Green, H. et al (2004).

These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders (Green, H. et al, 2004). The following tables show the estimated number of children with conduct, emotional, hyperkinetic and less common disorders in North East Lincolnshire, by applying these prevalence rates (the numbers in this table do not add up to the numbers in the previous table because some children have more than one disorder).

Estimated number of children with *conduct* disorders by age group and sex

Age Group	All	Boys	Girls
5 - 10	635	455	185
11 - 16	805	495	310

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with *emotional* disorders by age group and sex

Age Group	All	Boys	Girls
5 - 10	305	145	165
11 - 16	605	250	355

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with *hyperkinetic* disorders by age group and sex

Age Group	All	Boys	Total
5 - 10	220	195	30
11 - 16	165	145	25

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated number of children with less *common* disorders by age group and sex

Age Group	All	Boys	Total
5 - 10	155	130	30
11 - 16	140	95	50

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

North East Lincs Adolescent Lifestyle Survey

The 2015 North East Lincolnshire Adolescent Lifestyle Survey also provides valuable insight into the needs of young people in the area. It is the most inclusive and comprehensive survey undertaken with young people of secondary school age locally in the last decade. An overall sample size of 4,266 young people represented 51.6% of the 11 to 16-year-old secondary school population. Responses were received from eight of the ten mainstream secondary school academies along with a small representation from young people who were home schooled and those in alternative provision.

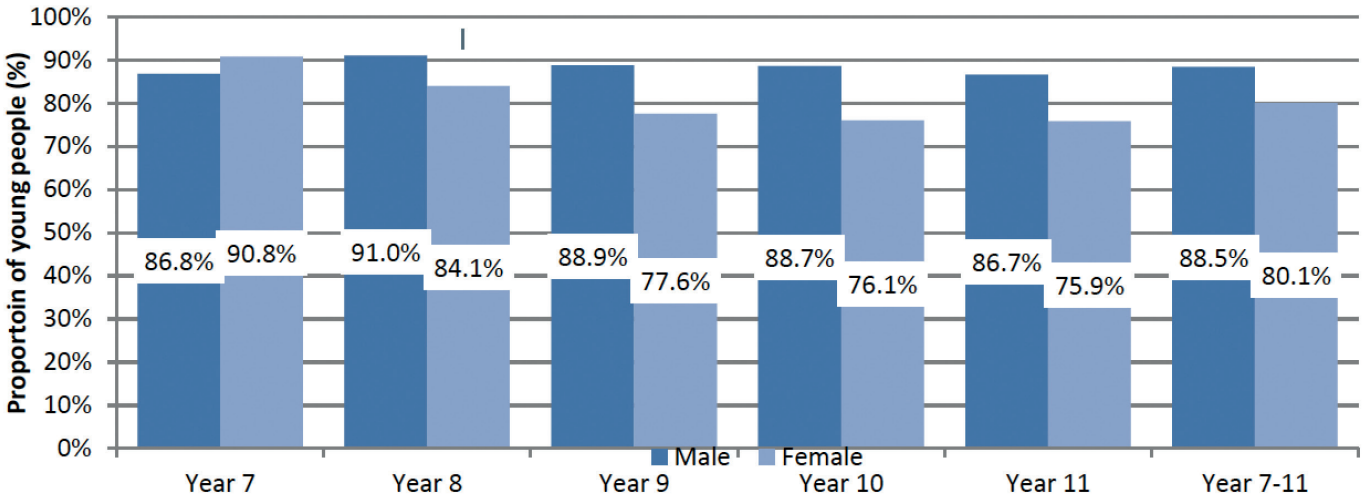
Data is also available from the North East Lincolnshire responses to the Government commissioned What about Youth survey, which was carried out in 2014. Where it is possible to correlate responses to both surveys, we have done so. However, each survey asks different questions so direct comparisons are not always possible.

The key findings in relation to emotional and mental health are analysed below:

- What do young people in North East Lincolnshire feel about their own emotional health and wellbeing?

The majority of young people in NEL said they usually felt happy about life (84.3%) which is similar to the 2011 adolescent lifestyle survey undertaken. This is reported to decline as young person got older to year 11 and males felt happier than females across all years of those surveyed. 96.7% of young people surveyed said they had one or more good friends and over one quarter (27.2%) reported they felt tearful or sad often. In relation to females, this is an increase of 10.9% since the 2011 survey. The proportion of males often feeling bad tempered or angry has reduced since 2011 but the proportion of young people who said they worry a lot of the time has increased from 40.8% to 47% since 2011. This also increases with age and is more prevalent in females than males.

Proportion of young people who feel happy about their life by gender, years 7 to 11



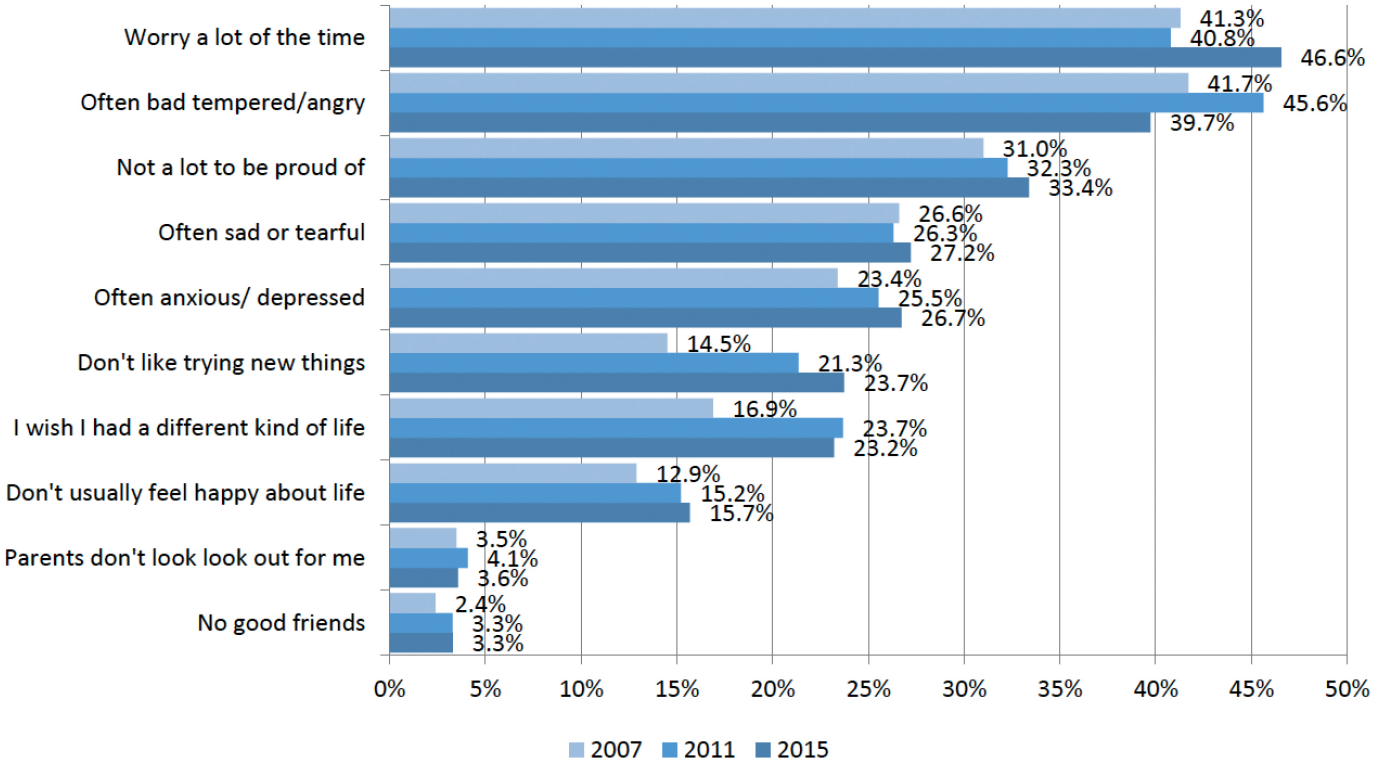
Overall, despite a slight decline in emotional health, there are only small differences in emotional health measured between the 2007 survey and 2015.

Emotional health trend, 2007 to 2015

NEL utilised the short Warwick Edinburgh Mental Wellbeing scale (SWEMWBS) which is a shortened 7 item scale as opposed to the longer 14 item scale. The revised version contains questions which relate more to functioning rather than feeling. The maximum score that can be achieved on the seven item scale is 35 points, with higher score showing better mental wellbeing.

The average for all year groups is 21.8. Males scored a greater average than females. The average score for males tends to stay relatively similar across age groups but it drops and stays lower from year 9 onwards for females.

Emotional health trend, 2007 to 2015



Average SWEMWBS by gender, years 7 to 11

	Male	Female	Total
Year 7	22.9	22.5	22.7
Year 8	23.1	21.5	22.3
Year 9	22.8	20.3	21.6
Year 10	22.5	20.2	21.4
Year 11	22.8	20.1	21.4
Year 7 - 11	22.8	20.8	21.8

How do young people deal with problems?

The majority of young people in NEL (80.6%) said they would talk to someone to help them deal with their problems, 86.5% reported they would think carefully and 81.4% said they would watch TV, with 90.5% listening to music.

Perhaps the most concerning finding in the NEL Adolescent Lifestyle Survey 2015 is that 15% of young people said they would hurt themselves if they had a problem. 2.1% would always cut or harm themselves, 2.8% reported they would usually do this and 9.8% reported they would sometimes cut or hurt themselves.

A higher proportion of young people said they would talk to someone they trust about a school problem (69%) and a problem related to bullying (69.3%) compared to other problems. Problems with body changes and growing up had the highest proportion who said would keep this problem to themselves.

Young people were most likely to worry a lot about school work/ exams, with 30.2% saying they worried a lot and 48% saying they worried a little. Young people were least likely to worry about sexual health, with only 4.1% saying they worried a lot and 9.5% worried a little. It is evident that the proportion of young people who worry a lot about problems increases with age (from year 7 to 11); particularly on issues such as school work, the future, weight and the way they look.

Proportion of young people who worried a lot about problems, years 7 to 11

We know that 32.2% of children and young people surveyed were worried about exams and the level of worry rose as young people moved from year 7 to year 12. Three quarters of all young people reported that it was very important for them to get good marks/ results in school work (74.6%); an increase on the 2011 survey where, overall, 68.7% said that it was very important to for them to get good results. Females were more likely to say that getting good marks/results is very important to them (76.9%) when compared to males (72.2%). This gender difference was found across all year groups apart from year 8's.

The proportion of young people who say that achieving good marks is important also increases with age from 70.2% amongst year 8's to 78.6% in year 11's

The proportion of young people who say achieving good results is very important have increased when compared to the previous 2011 survey; from 68.7% in 2011 to 74.6% in 2015. The proportion of young people reporting that it is very important to get good marks/results in school work has increased across all year groups since the 2011 ALS.

	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 7 - 11
School work/ exams	19.1%	19.6%	27.3%	33.1%	48.3%	30.2%
The way you look	17.1%	28.3%	31.4%	31.3%	28.5%	28.1%
Your weight	15.6%	25.7%	29.3%	28.9%	28.3%	26.2%
Friendships	22.1%	20.6%	22.5%	20.4%	19.6%	21.0%

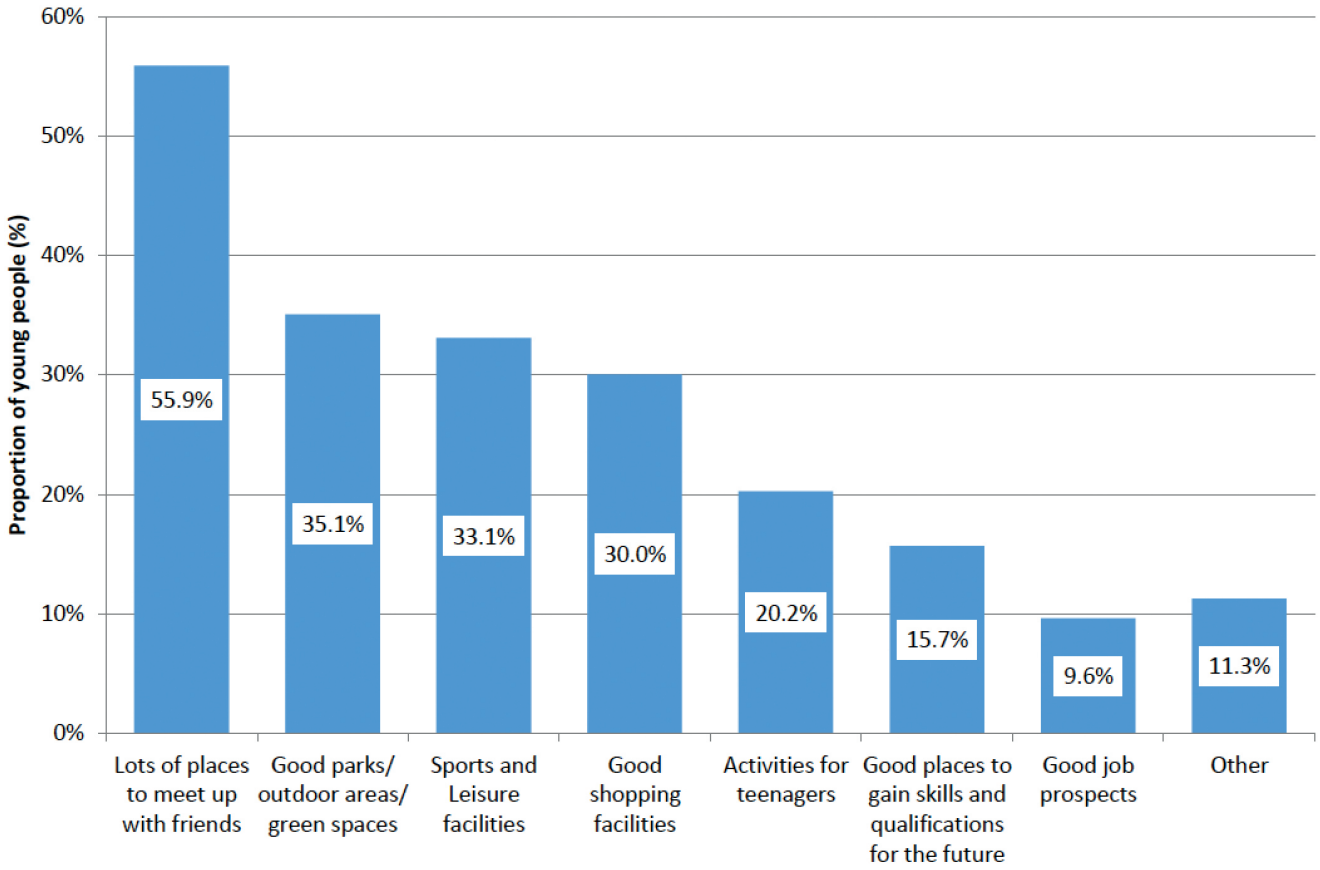
Girlfriends/ boyfriends	12.0%	13.1%	13.4%	17.3%	16.1%	14.6%
Being bullied	14.3%	11.9%	12.5%	8.3%	5.9%	10.3%
Problems at home/ family	11.1%	13.5%	14.4%	14.4%	11.5%	13.2%
Sexual health	2.6%	3.7%	3.7%	5.7%	4.3%	4.1%
Your future/ getting a job	19.4%	21.9%	26.3%	30.2%	42.5%	28.6%

How do young people feel about where they live?

When asked why their local area is a good place to live, the majority of young people reported that there are lots of places to meet up with friends (55.9%) although younger children were more likely to say this than older children (67.2% in year 7 compared to 44.6% in year 11). Less than 10% of young people felt that their local area offered good job prospects (9.6%).

A quarter of young people (24.2%) thought that the parks and play areas in their local area were good or very good; a considerable decrease on the 2011 survey where almost a third (31.5%) of young people thought parks and play areas were good. Half of young people reported that their local area is a good place for young people to live (52.1%), however, the proportion who thought this reduced as age increased (65.4% in year 7's reducing to 42.8% in year 11's).

Reasons why young people think their local area is a good place to live



The Future

The majority of young people (52%) say that they would like to go to college/ university at the end of year 11; the same proportion as in the 2011 ALS. However, a much greater proportion of females (62.9%) than males said they would like to go to college/ university. Whereas, females were more likely to say they want to go to college/ university, males were considerably more likely to want to get a job at 16 (16.3% compared to 8.7%) or do an apprenticeship (18.3% compared to 5.8%). Almost a tenth (9.4%) of young people said that they weren't sure what they wanted to do at the end of year 11. There were no considerable differences in what young people said they would like to do when they leave school when compared with the 2011 survey.

The proportion of young people who would like to go to college/ university increases as children get older from 46.3% in year 7 to 63.2% in year 11. Similarly, the proportion who says they would like to do an apprenticeship increases from 5.2% in year 7 to 17.2% in year 11. On the other hand, a greater proportion of younger children (19%) say they would like to get a job at 16 reducing to 6% in year 11's and the proportion of children who don't know yet what they want to do at the end of year 11 decreases from 10.3% in year 7 to 4.1% in year 11.

What young people would like to do at the end of year 11 by year group

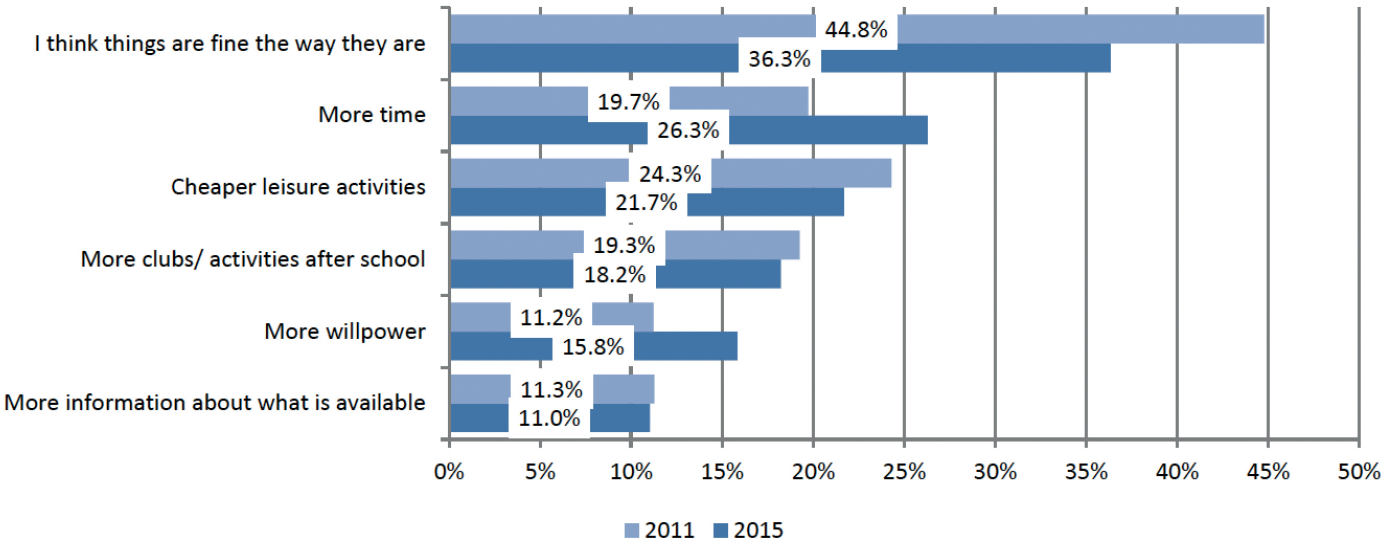
When compared with 2011 a greater proportion of young people thought they would stay in the local area in the future. For those in year 11, just less than a quarter (24.3%) thought they would be living in the local area in 5 years' time when surveyed in 2011, whereas just over a third (33.9%) of year 11's thought they would be living in the area in 5 years' time in the latest survey.

	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 7 - 11
Study and go to College/University	46.3%	48.5%	46.4%	53.9%	63.2%	52.0%
Get a job at 16	19.0%	15.6%	13.1%	10.8%	6.0%	12.5%
Do an apprenticeship	5.2%	7.5%	14.3%	13.8%	17.2%	12.1%
Study and get a job at 18	12.0%	11.8%	12.2%	10.6%	7.9%	10.8%
Start a family	4.1%	1.4%	1.7%	1.1%	1.1%	1.8%
Training	3.1%	1.6%	1.7%	0.9%	0.5%	1.5%
Don't know yet	10.3%	13.6%	10.6%	8.9%	4.1%	9.4%

Healthy lifestyles

Of the children and young people surveyed in NEL 87.2% reported they had done more than 1 hour of physical activity in the past week, which was a slight increase on 2011. 14.3% reported that they were physically active for at least an hour each day for all seven days of the week – in the What About Youth survey in 2014, the response was broadly similar at 12.9%. Only 18.8% of young people met the government recommendation for physical activity. 36.6% of children and young people felt happy with how active they were but over a quarter, 26.3% thought that more time would help them be more active. This included the provision of more after school clubs, more information about what are available and cheaper leisure activities.

How young people think they could be more active, 2011 and 2015*



Half of young people in NEL report to eat breakfast each day which is a slight increase from the 2011 adolescent survey. Younger children were more likely to eat breakfast. The most common reason for not eating breakfast for young people was not having enough time (31.3%) and it made them feel sick (30.8%).

Only 12.7% of young people reported they eat at least 5 portions of fruit and veg each day. This is similar to the 2011 survey and over half of young people said they would like to eat more healthily than they do.

Nearly half of young people who took part in the adolescent survey said they were happy with their weight. However 45% said they would like to lose weight and 7.5% said they would like to put on weight. Only 2/5th of females (40.7%) said they were happy with their weight.

Sexual Health

Teenage pregnancy is associated with poorer outcomes for both young parents and their children. Overall a 10th of young people in NEL in years 7-11 said they have had sex; there was no significant difference between males and females. However, amongst year 11's a quarter of females (10%) compared to a fifth of males (21%) said they have had sex. The proportion of young people who report they have had sex has decreased across all age groups but has dropped most considerably by approximately half compared to the young people of the same year group in the 2011 survey.

Overall two thirds of young people said that a condom was the method of contraception last time they had sex. 24.6% used the pill and 9.2% used an implant. Almost a quarter (23.5%) said they used no contraception last time they had sex. In comparison to the 2011 survey, contraception and safe sex practices have reduced considerably.

In relation to sexually transmitted infections, overall children and young people's knowledge has dropped considerably since the 2011 survey, most notably for HIV/AIDS and chlamydia and a higher proportion of young people in years 9-11 have never heard of STIs with the exception of HIV/Aids.

Safety

Most young people surveyed said they felt safe in the area they lived (69.9%) with no considerable differences between age groups and gender. Younger children did report they were slightly less likely to say they felt unsafe than older children.

A third of young people (34.1%) said that they had seen images/ pictures online which made them feel uncomfortable, with those in year 11 (45.9%) more than twice as likely to say they had seen images that made them feel uncomfortable than those in year 7 (19.8%). Females were also much more likely to say they had seen images which made them feel uncomfortable than males (39.1% compared to 29.1%).

Over half (55.6%) of children said that they had received messages from someone they don't know while online and just over a quarter (26.1%) said that they believe they have interacted with someone online who was lying about who they are.

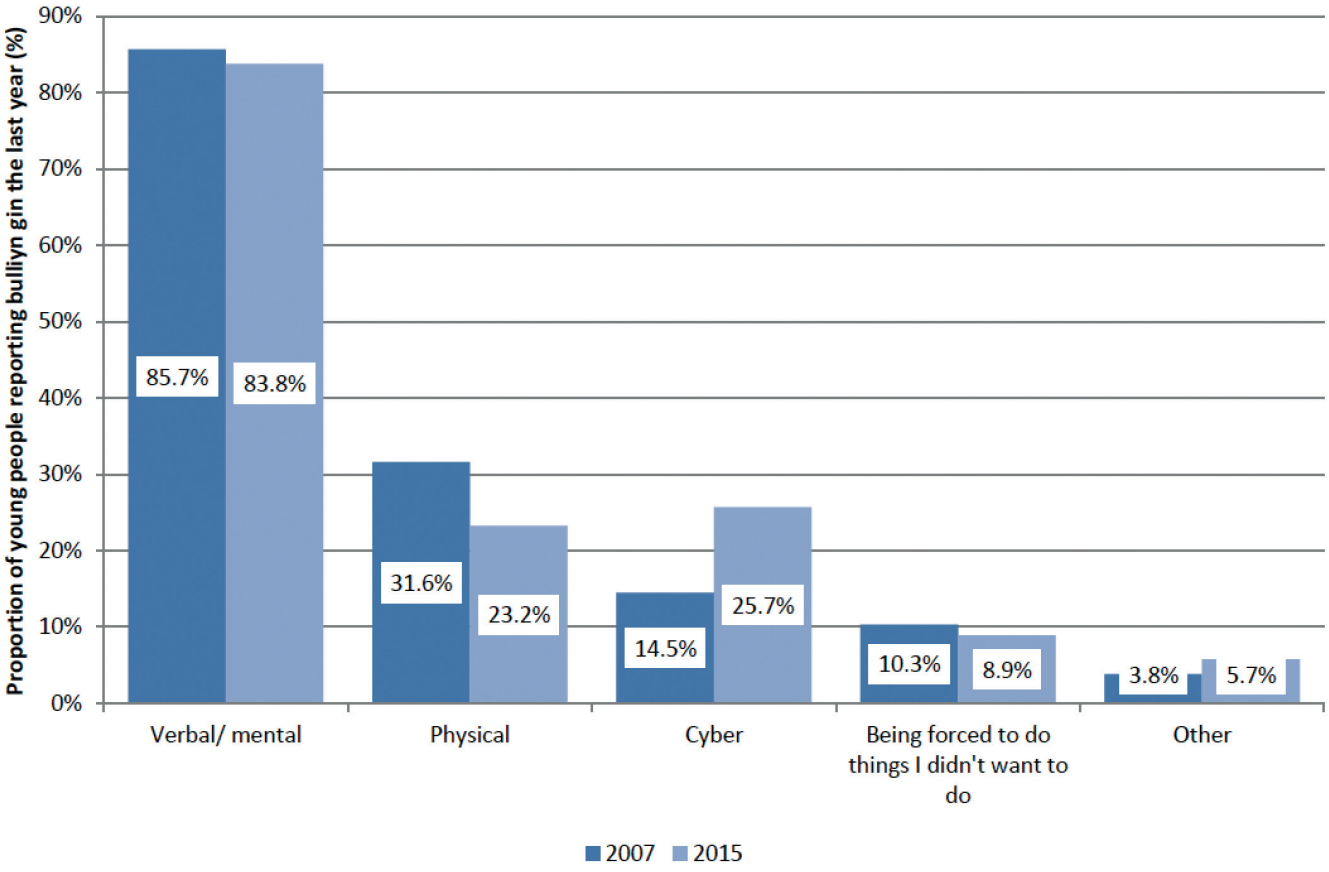
Only a small proportion of young people (6.8%) said that they had been pressured to do something they were not comfortable doing when online and those in year 11 are more likely to say they felt pressured to so something (8.5%) than those in year 7 (3.8%)

Across England, 34-45% of school children have reported bullying in recent surveys (Future in Mind 2015). In NEL, most young people report that they have not been bullied in the last year (62.5%). Over a third of those in years 8 (35.3%) and 9 (35%) stated that they have been bullied at least once in the last year. Year 7's was more likely to say they are bullied most days (8.1%) in comparison to the other year groups. A decreasing proportion of young people say they are bullied most days as age increases.

Of those who have been the victim of bullying in the last year, the majority (83.8%) said that it was verbal/ mental bullying. The second most common type of bullying was cyber (25.7%) followed by physical bullying (23.2%) and being forced to do things (8.9%). Verbal/ mental and cyber bullying were more common amongst older children whereas physical bullying was greater amongst younger children. Males were twice as likely (32.2%) to be physically bullied than females (15.8%) whereas females were twice as likely (34.7%) to be cyber bullied than males (15.1%)

Type of bullying of those who reported bullying the last year, 2007 and 2015*

***Total may exceed 100% as young people were able to give more than one answer.**



Young people who have been bullied are more than twice as likely to feel sad or tearful, feel anxious or depressed and wish they had a different kind of life. Of the young people who said they have never been bullied 90.6% said they usually feel happy about life compared to only 74% of young people who have been bullied in the last year.

Over half of young people (51.5%) who said they had been bullied also said that they felt afraid to go to school because of bullying. Of the young people who had been bullied, 5.2% said they felt afraid to go to school “very often”. Young people in year 11 were less likely to say they felt afraid of going to school because of bullying than in all other year groups. The majority of bullied females (62%) said they felt afraid to go to school whereas just over a third (38.5%) of males said they felt afraid.

The most common reason for bullying was “The way you look/clothes you wear”, with almost half of all bullied females (47.9%) stating this as the reason for bullying and a third of males (31.2%). This was followed by “size or weight” with females again being more likely (40.6%) to give this as a reason for being bullied than males (30%) and approximately a third of young people were unsure as to why they were being bullied.

Domestic Abuse

Tackling domestic violence as a public health issue is vital for ensuring that the most vulnerable people receive support, understanding and treatment. The government's definition of domestic violence, update in 2013, is now inclusive of those aged 16 (Home Office 213) and should therefore be more appropriate to those in adolescence.

Since 2007, the proportion of young people, who were surveyed in NEL, who understood the definition of domestic violence has reduced from 81.5% to 71.7% in 2015 with a marginal 40 rise from 2011 (69.4%). Older children are considerably more likely to understand the definition of domestic violence in 2015 than younger children. In comparison, a much higher proportion of those in year 7 in 2007 (72.3%) understood the domestic violence definition than year 7's in 2015 (47.8%).

Most young people (86.7%) said they had never seen or witnessed domestic violence in their family. There has been a gradual reduction in the proportion of young people who say they have seen or witnessed domestic violence within their family with each successive survey; 25% in 2007, 18% in 2011 and 13.3% in 2015. Most young people (94.6%) said that they feel safe in their own home although females (6.2%) were marginally more likely to say they don't feel safe than males (4.4%); a similar finding in previous surveys.

The table below shows the proportion of males and females by year group who said they would like help and advice about domestic violence. Overall, males (9.2%) were more likely to want advice than females (6.6%) and a higher proportion of males than females said they would like advice except for year 9's. 12.5% of young people in year 7 said they would like advice and this proportion reduces for each year group through to year 11 where 4.6% said they would like advice.

Proportion of young people who say they would like help and advice about domestic violence, by gender and year group

Over half of young people (57.1%) said they would call the police if someone in their family was physically hurting them or another family member, 13.5% said they would not call the police and almost a third (29.4%) said they don't know what they would do. Older children were most likely to say they would call the police.

	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 7 - 11
Male	17.3%	9.9%	7.8%	7.3%	5.5%	9.2%
Female	7.1%	7.8%	9.3%	5.4%	3.9%	6.6%
Total	12.5%	8.8%	8.5%	6.4%	4.6%	7.9%

Substance Misuse

Young people who misuse substances are at greater risk of poorer life outcomes. The increase in use of New Psychoactive substances (NPS) or 'legal highs' particularly amongst young people in the UK is of particular concern. (HSCIC, 2014)

In NEL, only small proportion of young people in years 7-11 are regular smokers (4.8%) over 80% never tried smoking. Smoking prevalence increases with age less than 1% year 7 to 8.6% year 11. The survey showed smoking increases most significantly between year 9 and 10 suggesting majority who take up smoking do so at end of year 9. Overall proportion of young people who have never smoked increased from 68.7% in 2011 to 80.5% in 2015.

The proportion of regular smokers decreased considerably amongst all age groups since the last survey in 2011, from 6.7% to 4.8%, dropping most significantly in year 11's.

For 15 year olds, the findings of the Adolescent Lifestyle Survey (ALS) and What About Youth (WAY) surveys were broadly similar, as below:

MEASURE	WAY	ALS
Percentage who are current smokers	9.9	12.0
Percentage who are regular smokers	7.7	7.6
Percentage who are occasional smokers	2.1	4.4
Percentage who have tried e-cigarettes	20.2	40.0

The only significant difference between the findings of the Adolescent Lifestyle Survey for 15 year olds, and the What About Youth survey, is in the rate of young people who've tried e-cigarettes. One plausible explanation for this is that the WAY survey was carried out in 2014, when e-cigarettes were less well known and available, compared to when the ALS was carried out in 2015.

Regular e-cigarette smoking amongst year 9-11 is currently 4.2% with the proportion of regular users increasing by age. A small proportion said they used e cigarettes then moved onto normal cigarettes (1.2%), however daily use of e-cigarettes was lower in contrast to normal cigarettes. Males are more likely to smoke e-cigarettes regularly (4.7%) than females (3.6%).

The proportion of young people who have consumed a whole alcoholic drink has decreased for each consecutive year since 2004. Less than half young people surveyed (47.7%) said they had ever consumed an alcoholic drink. The latest ALS data shows that the proportion of young people who have never drunk a whole alcoholic drink has decreased most significantly in comparison to the differences in all previous surveys. Just under half (47.7%) of all young people who completed the survey said they had consumed a whole alcoholic drink, a reduction of 22% from 61.1% of young people in the 2011 survey. The 2014 WAY survey found that 70.2% of 15 years old in NE LINCS had consumed an alcoholic drink (Public Health England 2015) whereas the 2015 ALS suggests that this proportion was slightly higher at 76.8%. This is considerably higher than the national percentage of 62.4%.

For 15 year olds, it is possible to compare the findings of the ALS with the nationally led WAY survey. The findings relating to alcohol are as follows:

MEASURE	WAY	ALS
Percentage who have ever tried an alcoholic drink	70.2	76.8
Percentage who are regular drinkers	6.2	8.2
Percentage who have been drunk in the last 4 weeks	17.4	30.6

There is a significant variation in the proportion who report having been drunk in the previous 4 weeks.

Most young people said they had never taken drugs and a lower proportion have taken drugs in 2015 (7.4%) compared to 2011 (8.3%) The number of young people who say they have been offered drugs has slightly increased since 2001 from 15.2% to 16%. There was a lower proportion of young people being offered legal highs (10%). 8% of young people in years 9-11 have tried cannabis and 3.6% have tried legal highs. The proportion who have tried MCAT, ecstasy and cocaine is very low.

A fifth of young people (19.2%) in years 8-11 said they know where to get cannabis and 15.3% said they know where to get MCAT. A relatively high proportion of young people know where to get legal highs (13.3) and cocaine (11.2%). The least accessible drug was ecstasy (8.9%). The proportion of young people who say they have seen others use drugs or know where to get drugs is surprisingly high.

When comparing the data on 15 year olds between the ALS and WAY surveys, both report a similar rate of 15 year olds who have ever tried cannabis – with 9.9% in the WAY survey and 10.4% in the ALS.

Literature

- There is now a very strong evidence base which demonstrates that the presence of both risk and protective factors, at individual, family, community and environmental levels, has a very significant impact in determining which children and young people will experience poor mental health. Poor parenting, experiences of abuse and neglect, economic deprivation, bullying and discrimination are key risk factors
- Risk factors tend to accumulate over time and can be interdependent and mutually self-reinforcing. Emotional and mental health problems have a strong association with other poor outcomes including truancy and exclusion, and substance misuse
- There is now a considerable research base into the needs and experiences of particularly vulnerable groups of children and young people. The evidence base is particularly strong for looked after children and young people who have offended
- There is an increasingly sophisticated evidence base for which interventions have been proven to work

There is now a well-established research base which shows that there are a variety of factors that can impact on mental health and wellbeing. These range from factors which affect the individual themselves, their relationships with immediate family members and the wider community in which they live. Understanding these factors and being able to quantify them allows localities to identify opportunities to improve children and young people's mental wellbeing. It also allows them to evaluate the impact of interventions designed to deliver improvements. Public Health England [24] have conceptualised these influencing factors for children and young people's mental wellbeing under the broad headings of:

- individual: factors which are experienced by an individual rather than as part of a group
- family: influencing factors which relate to a child or young person's family and home environment
- learning environment: factors which influence how a child or young person learns, both within and outside of a formal learning environment
- community; elements of a child's wider social and geographic environment which influence their mental wellbeing

The World Health Organisation[25] summarises these risk and protective factors as follows:

Level	*Adverse factors*		*Protective factors*
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

Wellbeing influencing factors: Individual

- healthy living
- general health
- learning and development
- emotional intelligence
- life events

Key to understanding and influencing mental wellbeing is the experience of an individual themselves. In order to influence the mental wellbeing of a population one must first consider the experience of the individual members of that group. Factors which may affect an individual range from their own health, their lifestyle, significant life events, learning and development and emotional intelligence.

There is a complex relationship between an individual's physical health, their mental wellbeing and mental illness. Positive mental wellbeing has been identified as an influencing factor for children and young people's healthy lifestyle choices (such as physical activity, drug use and sexual health) and may in turn be affected by physical illness and disability.

Significant life events clearly will impact upon the mental health and wellbeing of children and young people and cause both emotional and physical distress. While the occurrence of such events can rarely be controlled there are factors such as learning and emotional intelligence which have been found to mitigate their effects on the mental wellbeing of those experiencing them. Here, the term learning covers the continuous process of learning and development, which generally takes place outside the formal education system. It includes participation in all forms of learning, both taught and non-taught and includes play. There is good evidence to suggest that participating in learning is associated with a range of mental wellbeing benefits (protecting against depression, building resilience to stress and adverse life events, promoting social inclusion and cohesion) and adoption of healthy behaviours.

Emotional intelligence can be described as the ability to recognise and regulate emotions in oneself and others and involves being able to handle difficult and powerful emotions and redirect them in a positive manner, to accurately perceive emotions being felt, and have empathy. A growing body of research is beginning to suggest that emotional intelligence is associated with positive life outcomes, including mental wellbeing.

Mental wellbeing influencing factors: Family

- family relations
- family structure
- parental health
- parental healthy living

For many children the most influential group to which they belong will be their family. The impact which positive or negative experiences can have upon the individual is acknowledged as an important one across this field. Positive feelings about family are highly correlated with feelings of life satisfaction and happiness overall although the degree to which family impacts upon an individual may vary depending upon the age group of interest.

Family relations refers to the quality of interactions with parents and other family members; it includes: parenting styles, attachment, interpersonal relationships and family functioning. It can have either a positive or negative influence upon a child's mental wellbeing. Some important aspects which influence positive mental wellbeing are loving and trusting relationships, support and sense of connection. Aspects which harm mental wellbeing are family discord such as hostility, inter-parental hostility or detachment and family breakup.

In addition to family relationships the health behaviours and wellbeing of family members has been found to have an impact upon the wellbeing of children and young people.

Work by both Nat Cen Social Research and the Department of Health identify maternal mental wellbeing as one of the key determinants of childhood wellbeing particularly in younger age groups.

General parental health behaviours such as smoking drug and alcohol use are important throughout childhood; for example parental alcoholism is associated with higher risk among children of anxiety and abuse.

In addition to the direct consequences which parental behaviour has on the health of children and young people there may be other detrimental effects and hazards which result such as taking on the role of carer to other siblings, emotional abuse or neglect, chaotic family life with poor parent-child bonds, inadequate accommodation, interrupted education and socialisation.

Mental wellbeing influencing factors: Learning Environment

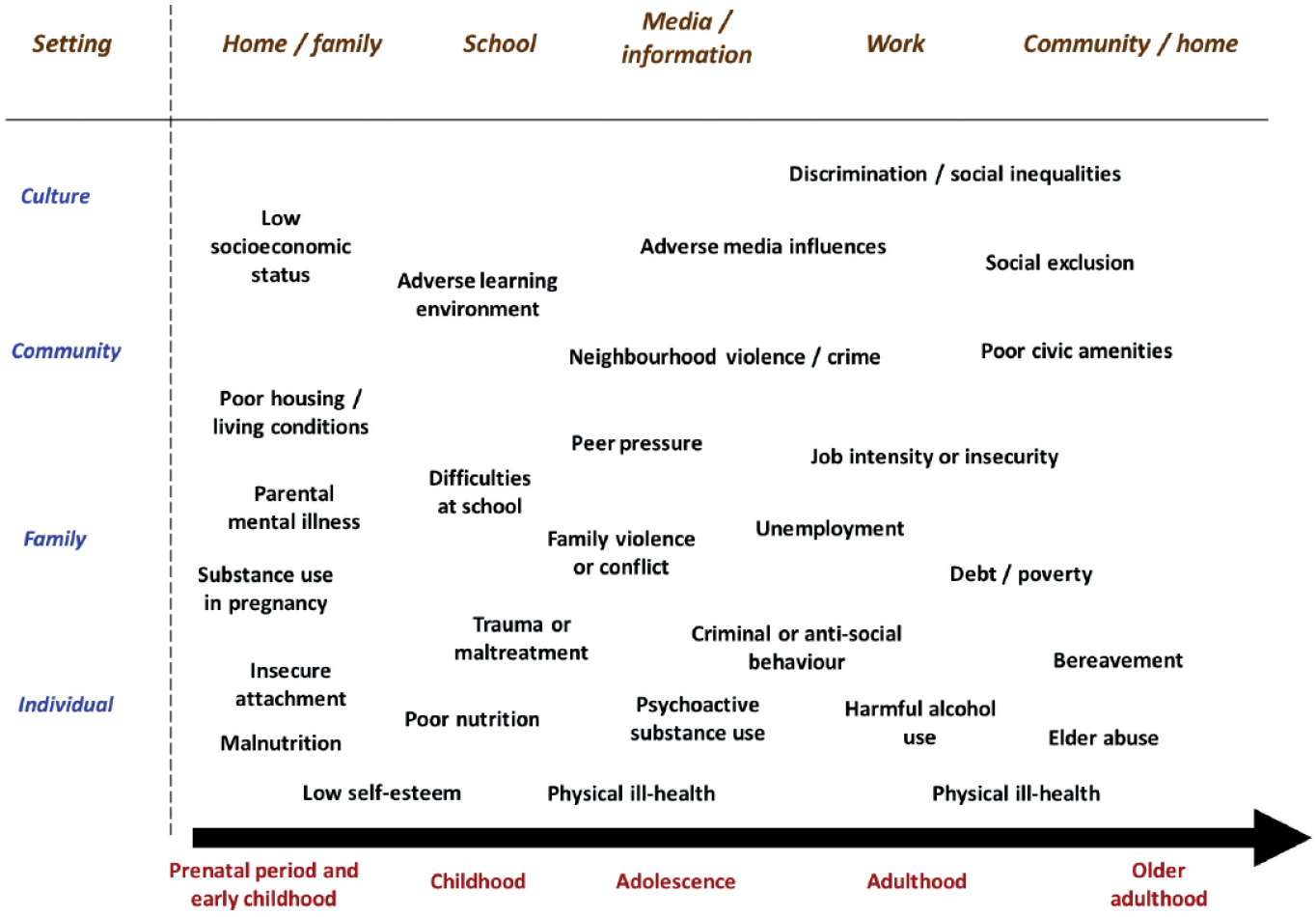
- engagement with learning
- educational environment
- peer relationships
- pressures and expectations

A child's experience of the learning environment has been identified as an important determinant of their mental wellbeing, life satisfaction and happiness. Included within this domain is the learning environment, the opportunity for participation and engagement, organisational culture, relationships with teachers and other adults within the organisation and peer relationships. This includes the relationships which are formed and the expectations and pressures which may be associated with it. Pressure to achieve academically and to 'fit in' with one's peers has a profound impact upon the mental wellbeing of children and young people.

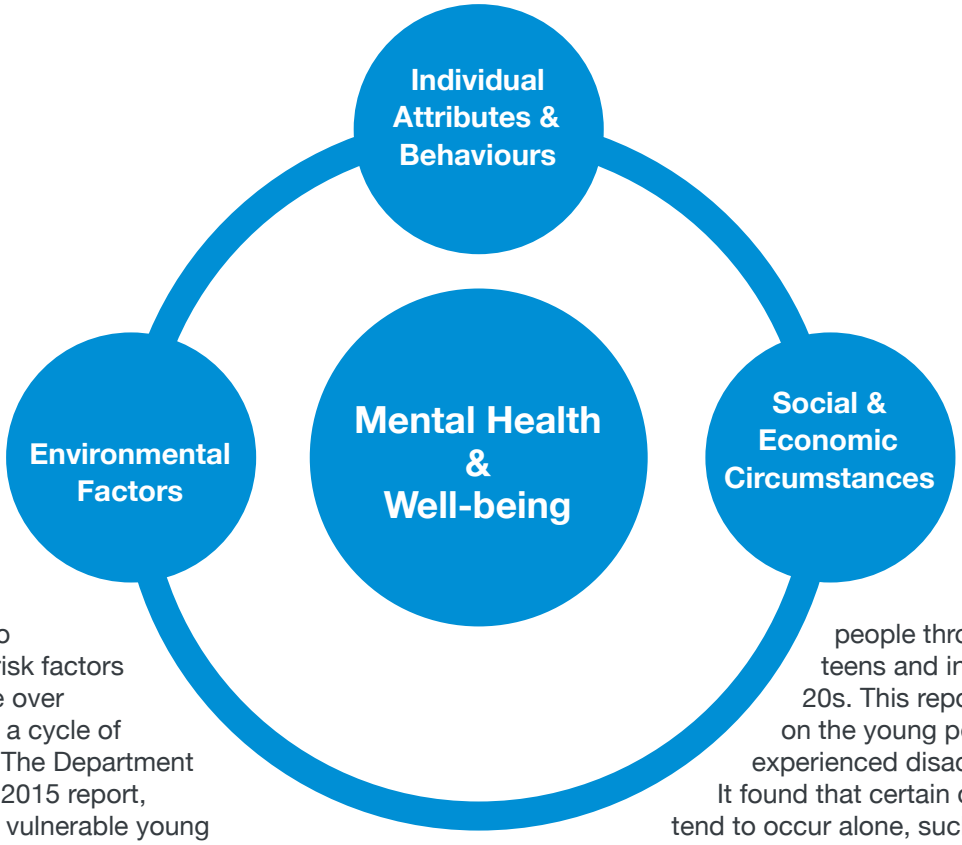
Being bullied has a detrimental effect on mental and physical health and has been seen to have a negative effect on adolescent life satisfaction and mental wellbeing. It is estimated that one in three British school children experience bullying. Being bullied is associated with depression, low self-esteem, poor self-concept, loneliness and anxiety. It has a negative impact on the development of inter-personal relationships and increases the risk of school absenteeism and thus the lowering of academic achievement.

The relevance of risk and protective factors will vary throughout the life course, with factors predominantly located in the family for young children, with the impact of other individual and social factors becoming more important as children and young people get older.

The World Health Organisation usefully summarises this process as follows[26]:



This schematic, also produced by the World Health Organisation[27], demonstrates the interconnected nature of risk and protective factors.



It is important to recognise that risk factors can accumulate over time, leading to a cycle of increasing risk. The Department for Education's 2015 report, 'Understanding vulnerable young people: Analysis from the Longitudinal Study of Young People in England'[28] uses a significant longitudinal study that tracks young people throughout their teens and into their early 20s. This report focusses on the young people who experienced disadvantage. It found that certain disadvantages tend to occur alone, such as emotional health concerns - whereas others occur together. For example, more than two in five young people NEET had two or more other disadvantages.

The study found that certain pairs of disadvantages were more likely to occur together, such as low attainment and NEET, criminal activity and substance misuse, and, low attainment and substance misuse. The study identified six distinct groups of young people:

- A group with no disadvantages, the non-vulnerable group (55 per cent of young people) and five groups of disadvantaged young people:
- Emotional health concerns group (16 per cent), who only had emotional health concerns
- Substance misuse group (8 per cent), who had substance misuse problems and a tendency to have low attainment and emotional health concerns
- Risky behaviours group (8 per cent), who took part in criminal activity and had a tendency for substance misuse, low attainment and emotional health concerns
- Low attainment only group (8 per cent), who tended to only have low attainment
- Socially excluded group (6 per cent), who were NEET and tended to have low attainment, emotional health concerns and substance misuse

Although emotional health concerns do not necessarily lead to other disadvantages for young people, there is evidence that young people displaying risky behaviours, misusing substances or feeling socially isolated are more likely to develop emotional health concerns.

Vulnerable Groups

Some groups of children and young people are particularly vulnerable to poor outcomes, including emotional and mental health difficulties, because their situation tends to mean that they accumulate risk factors and often lack protective factors. Set out below are some of the key research findings relating to each group.

Key research findings

Looked After Children

- Children taken into local authority care are likely to have faced the most severe forms of childhood maltreatment and children who enter care later (having remained for longer in abusive settings) and those who stay in care for longer face the greatest risk of poor outcomes and have more challenging needs (behavioural difficulties, problems with schooling) [29]
- Prevalence studies of looked after children and young people indicate that around 40% meet the threshold for conduct disorder [30]
- Children raised in residential homes have the very highest rates of mental health problems, with approximately three quarters meeting the criteria for a psychiatric diagnosis [31]
- Many children in care have more than one mental health diagnosis [32]

CYP with Learning Disabilities

Research indicates that CYP with learning disabilities are:

- 33 times more likely to have an autistic spectrum condition
- Eight times more likely to have attention deficit and hyperactivity condition
- Six times more likely to have a conduct disorder
- Four times more likely to have a diagnosable emotional mental health problem
- Three times more likely to have psychosis as they move into adolescence/early adult years
- Nearly two times more likely to have a depressive disorder [33]

CYP with Special Educational Needs

- It can be very difficult for school staff to know whether to attribute behaviours to a child's primary diagnosis or identified SEN, or a separate mental health concern. This is often referred to as diagnostic overshadowing
- This confusion was found particularly in teaching staff within some special schools who, for example, found it hard to identify high levels of anxiety as a potential additional mental health concern in children with a diagnosis of ASD
- Typically, mental health concerns in children with complex SEN have been identified by observing behaviours, such as increases in challenging incidents or withdrawal from activities. However, in children who have profound and multiple needs, it may be that we need to be aware of more physical responses to identify distress, such as sweating, eye movements and body posture
- Research has shown that, within some services, there is a lack of specialised knowledge regarding mental health in children with complex SEN. A number of reports have mentioned a difficultly in accessing child and adolescent mental health services (CAMHS) for those children and young people with complex SEN, and that long referral times and a lack of specialised knowledge create serious barriers for schools in securing appropriate support
- Sometimes, a mental health concern has been attributed as part of the child's SEN and, as a consequence, limited support is available for those who need it [34]

CYP with ADHD

Research has shown that mood (e.g., depression) or anxiety disorders are present in 1/4 of all children with ADHD. These other disorders compound the typical issues associated with the symptoms of ADHD.

Many people with ADHD also develop problems regulating their emotions in response to their disorder. Other research has shown that individuals with ADHD, both adults and children, are often impacted by other problems, such as increased risk-taking, substance misuse, and criminal behaviour.

When comorbid conditions are present, it can make the diagnosis of ADHD much more difficult to pinpoint and the symptoms harder to treat. Some comorbid disorders that commonly occur alongside ADHD are:

- Oppositional Defiant Disorder
- Depression
- Anxiety
- Bipolar Disorder
- Conduct Disorder
- Sensory Integration Disorder
- Learning Disorder
- Early Speech/Communication problems [35]

CYP on the autistic spectrum

Anxiety disorders are common among children and adults with ASD. Symptoms are likely affected by age, level of cognitive functioning, degree of social impairment, and ASD-specific difficulties. Many anxiety disorders, such as social anxiety disorder, are not commonly diagnosed in people with ASD because such symptoms are better explained by ASD itself, and it is often difficult to tell whether symptoms such as compulsive checking are part of ASD or a co-occurring anxiety problem. The prevalence of anxiety disorders in children with ASD has been reported to be anywhere between 11% and 84%; the wide range is likely due to differences in the ways the studies were conducted.

Previously, the diagnosis manual DSM-IV did not allow the co-diagnosis of ASD and ADHD. However, following years of clinical research, the most recent publication (DSM-V) in 2013 removed this prohibition of co-morbidity. Thus, individuals with autism spectrum disorder may also have a diagnosis of ADHD, with the modifiers of inattentive, hyperactive, combined-type, or not otherwise specified. Clinically significant symptoms of these two conditions commonly co-occur, and children with both sets of symptoms may respond poorly to standard ADHD treatments. Individuals with autism spectrum disorder may benefit from additional types of medications or from behavioural or other therapies, such as applied behaviour analysis and neuro-feedback.[36]

Young people not in education, employment or training

The most recent Youth Index 2015 [37] highlights that young people not in employment, education and training have poorer wellbeing than other young people in this age band. Young people and young adults are at most risk of developing mental illness at the point when they are most likely to experience multiple gaps and a lack of continuity between youth and adult mental health and social care systems.[38]

Furthermore, a University and College Union study (2014) found that:

- A third of young people not in education, employment or training had suffered from depression
- Young people out of work and training also had higher levels of anxiety than other young people in employment
- Nine out of ten wanted to work or be in education or training but a third felt they had ‘no chance’ of ever getting a job and 40% felt that they had ‘no part in society’
- 37% rarely left their home
- More than 70% said that with the right support they could contribute a lot to the country although they needed advice and support about their options and help to boost their confidence [39]

CYP with parents in prison

There is a strong association between parental imprisonment and adverse outcomes for children of all ages. The emotional and physical reactions to the loss of a parent to prison have been likened to grief felt at bereavement.[40] However, imprisonment does not always elicit the same sympathetic or supportive responses so normal outlets for grieving can be denied.[41] Furthermore, often the remaining parent becomes overwhelmed with survival and can overlook children's hidden needs.[42] Studies suggest that children of prisoners are twice as likely to have mental health problems during their life course.[43] They are also around three times more at risk than their peers of committing antisocial or delinquent behaviour with 65% of boys with a convicted parent going on to offend.[44] Girls with a parent in prison were also particularly noted to have higher risk of gang involvement and multiple vulnerabilities and needs.[45]

Young people who've offended

Children in contact with the youth justice system aged 10-18 are particularly at risk of poor emotional and mental health. Research studies have found that they are:

- More likely to present with symptoms of post-traumatic stress disorder (particularly girls and some young people from BME communities) [46]
- More likely to self-harm and many times more likely to commit suicide [47]
- More likely to have multiple risk factors largely accumulated over time [48]
- More likely to have speech, language and communication difficulties (possibly linking back to poorer early years development) which will have impeded their education and prompted frustration preventing them from processing information [49]
- More likely to have severe attachment difficulties and trauma, sometimes predisposing them to explosive anger [50]
- More likely to have acquired brain injury (ABI) due to historical trauma to the head – ABI is linked to higher risk of violence resulting from neurodevelopmental damage and suicide risk [51]
- At least three times more likely to have a mental health diagnosis compared with children who don't offend [52]
- At least half in both community and custodial settings have been identified with a diagnosable conduct disorder [53]

Young carers

Surveys of young carers have found substantial numbers reporting stress, anxiety, low self-esteem and depression.[54] Some research studies have found that they often feel concerned and anxious about their parent's welfare when they are not there to help look after them[55] especially if a parent has mental health problems and is at risk of self-harming.[56] Other studies also found that substantial numbers reported mental health and related problems, such as eating problems, difficulty in sleeping, and self-harm[57]. Around 5% identified missing school because of their caring responsibilities with one in three of those missing school doing so at least once or twice a month.[58]

Other key facts include:

- Young carers live in households which have an average income £5,000 less than families without a young carer
- Young carers are more likely to live in a household where no adults are in work
- Young carers between the ages of 16 and 18 had a much greater chance of being not in education, employment or training (NEET). Of these, 75% had been NEET at least once (compared with 25% of all young people) and 42% had been NEET for six months or more (compared with 10% of all young people) [59]

CYP from Black and Minority Ethnic communities

There is longstanding evidence of persistent mental health inequalities affecting young adults and adults from some BME communities[60] – particularly young African Caribbean men. This is despite cross cultural prevalence studies suggesting that rates and patterns of diagnosable mental health problems are broadly comparable and stable across different ethnic groups and evidence that children largely start on a level playing field in terms of their mental health. In the past, poor quality prevalence data on BME children and adolescents has hindered understanding of mental health trends among these populations over time – sample sizes for national prevalence studies have been too small to draw reliable conclusions.[61] A recent analysis of eleven year old children in the Millennium Cohort (which oversampled those from BME communities) sheds some light on patterns of mental health over time indicating that at this age, white boys and mixed heritage young people are most likely to present with diagnosable difficulties closely followed by boys classified as black. For girls, those classified as being of mixed heritage were most likely to present with a diagnosable difficulty. Indian boys and girls were least likely to have diagnosable difficulties.[62]

Asylum seekers, refugees and immigrants

Although good quality data remain elusive, there is general consensus that the prevalence of post-traumatic stress disorder and other mental health problems is higher in refugee children than in host country populations.[63] This remains the case even when studies control for other factors such as socio-economic status.[64] There is also evidence that these children and young people are more likely to have more than one mental health difficulty[65] The most commonly reported diagnosable difficulty affecting refugees is PTSD, affecting around 10% of children and young people with refugee histories and which studies cite as being at least twice as high as among non-refugee children. There is also evidence of the enduring nature of experiences of PTSD among these children. A range of longitudinal studies highlighted that PTSD symptoms were still present some 12 years after resettlement.[66]

Studies note evidence of higher levels of depression (although not anxiety) among refugee children, young people and young adults – again with evidence of very longstanding persistence of problems and a higher prevalence of psychosis, grief reactions, conduct disorder, aggression and hyperactivity.[67]

Refugee children also reported higher numbers of sub-threshold symptoms such as:

- Somatic complaints
- Irritability
- Withdrawal
- Sadness and grief
- Suicidal ideation
- Self-harm
- Problems with peers
- Problems with attention, sleeping and eating [68]

Gypsy, Roma and Traveller children

Relatively little is known about the mental health of Gypsies and travellers, although the limited number of studies that have been carried out suggest high levels of mental health problems, including functional disorders, depression, neurotic difficulties and suicidal ideation. In a health status study conducted in 2001 a significantly greater proportion of Gypsies and travellers reported problems with anxiety and depression than the general UK population.[69]

LGBT young people

In 2012, Stonewall, in partnership with the University of Cambridge, surveyed 1,600 LGBT young people in British schools (a survey repeated every four years). This study found that:

- 55% of LGBT children and young people reported being subjected to homophobic bullying
- One in six reported being subjected to physical abuse
- 6% reported being subjected to death threats
- Just under half who experience homophobic bullying skipped school because of it; one in seven had skipped school more than six times
- More than half of LGBT children and young people don't feel there is an adult at school who they can talk to about being gay
- A quarter don't have an adult to talk to at school, home or elsewhere
- Seven out of ten LGBT girls and six out of ten LGBT boys had experienced suicidal thoughts; boys from BME communities had the highest rate of suicidal thoughts affecting nearly eight out of ten
- These children were around three times as likely as other children to have tried to take their own life at some point
- More than half deliberately harmed themselves, which can include cutting or burning themselves [70]
-

A number of international studies have also found that school-aged LGBT young people experience higher levels of emotional distress than other children, including being twice as likely to have depressive symptoms, suicidal thoughts and to attempt suicide.[71]

In a study of transgender youth aged 15-21 a quarter reported a prior suicide attempt[72] – although rates are likely to be lower in younger age groups. Young people from some BME communities were noted to disclose to fewer people, have less involvement in LGBT social activities and to face additional harassment.[73]

CYP with physical disabilities

Children with physical disabilities also appear more likely to experience victimisation.[74] Children with chronic physical health problems and disabilities are also noted to be twice as likely to have diagnosable mental health difficulties as other children.[75]

Summary of the Evidence Base

There is a growing volume of evidence from research studies into the effectiveness of interventions to support children and young people of different ages and in different situations. Recent research has been collated by the Centre for Mental Health in the volume "Missed opportunities: A review of recent evidence into children and young people's mental health"[76], which also identifies some significant areas where further research is required and where there is limited evidence on the effectiveness of some interventions, or how to support young people in some circumstances. This chapter summarises this work.

What is clear from the evidence is that children and young people's mental health and wellbeing must be a bigger priority.

There is good evidence on:

- the real difference that can be made to children's life chances by intervening early at the first sign of deterioration in children's mental health
- what has the best chance of improving outcomes for the one in ten children who develop a diagnosable mental health problem
- what gives children and young people the best start in life in terms of their mental health and emotional wellbeing
- the risk factors which compromise healthy emotional and behavioural development
- the children at greater risk due to an accumulation over time of these risk factors

From pregnancy to age five a range of interventions can help to protect mental health. This must begin with focus a on the mental health of pregnant women, and new mothers, including routine health checks during pregnancy and for the year after birth. These should focus equally on mental and physical health.

There are a range of NICE recommended interventions which have the best chance of improving maternal mental health (National Institute Clinical Evidence, 2014).

These should be engaging and easily accessible for families:

> In the case of mild to moderate mental illness, primarily fast track access to recommended psychological therapies

> for those with more severe mental illnesses it is likely to involve use of medication supported by specialist perinatal mental health services with an expert understanding of both child, maternal and family needs

> mothers in extreme mental health crises should have access to mother and baby units where they can be supported in an appropriate environment designed to minimise stress, with support delivered by specialists in mother, baby and family mental health and in attachment for mother and child

The Maternal Mental Health Alliance report that there should be psychological therapies for mothers with common conditions, specialist perinatal mental health services and mother and baby units for those in crisis but these are not always available.

Signs of diagnosable mental health needs are currently more proven than programmes targeting families or children on the basis of suspected risk factors. Most need to be targeted towards families who have the highest risks or children who are showing early signs of distress including home visiting programmes for parents facing high risks, e.g. Family Nurse Partnerships (which has been decommissioned in North East Lincolnshire) and group parenting programmes for children with behavioural problems (such as Triple P).

Universal programmes (e.g. population-level preventative programmes such as newsletter awareness raising campaigns about optimal parenting or making available parenting groups to everyone) do not appear as effective as targeted strategies. However the 'Triple P' Positive Parenting approach - a programme of parenting support ranging from a media campaign reaching the whole population to specialist group work for those with higher chances of poorer attachment – shows some impact. A similar approach was tested in Ireland targeting three to seven year olds in Galway. It tracked child and family mental health and wellbeing, noting lower levels of mental health difficulties (e.g. conduct problems, emotional problems, ADHD) and improved parental mental health after intervention compared to other areas.

These improvements were mostly sustained after twelve months.

The importance of outreach work in developing strong relationships with parents deemed at high risk has been demonstrated through Sure Starts / Children's Centres. Research indicates more consistent improvements from interventions for children's mental health which target parents with known risk factors affecting children's development. However their impact on later child mental health problems is unproven.

Well implemented group programmes (such as Incredible Years and Triple P level 4 and 5) are effective in promoting positive parenting techniques and in improving children's behavioural problems between the ages of three and 11. Improvements appear greatest for children with more severe needs. These programmes involve praise, encouragement and affection and minimise negative communications or harsh responses. They can also reduce parental stress and improve parental mental health.

One-to-one positive parenting support programmes such as 'Helping the Non-Compliant Child' (a therapist observes a parent and child through a two-way mirror and coaches the parent) are also effective, although they are best reserved for the small percentage of children and families who have complex and multiple needs and are least likely to engage with group programmes.

While programmes targeted at all children are less effective than those targeted at children in higher risk groups or presenting with early symptoms, schools, especially primary schools, have been seen to achieve improvements through universal programmes, especially for higher risk children. Programmes such as PATHS and the Good Behaviour Game appear so far to have greater proven effectiveness during primary school years.

Programmes must be part of a Whole School Approach to promoting mental health and wellbeing and should be delivered exactly as developed (not adapted or partially applied). The World Health Organisation's Whole School Approach sets out a suitable framework. Staff should be well trained and supervised as programmes often fail because of poor quality implementation or ineffective delivery. They also work best alongside access to targeted programmes for those with higher needs. Well supported Whole School and Social and Emotional Learning approaches, plus efforts to reduce bullying help children develop good mental health and facilitate early identification and access to help.

There is good evidence that intervening early in the course of many mental illnesses can significantly reduce later problems –for serious illnesses such as psychosis. Yet many people with mental illnesses fail to receive help for around a decade after first symptoms emerge. Early intervention can reduce symptoms, the impact of poor mental health on development and the likelihood of young people developing cycles of distressing and crises. By increasing a person's chances of recovery, early intervention can also lead to considerable savings.

Various forms of Cognitive Behavioural Therapy (CBT) are effective in reducing anxiety in children and young people aged 7-12 years. E.g. Coping Cat and the Australian version Coping Koala.

Evidence suggests that:

- a number of interventions may reduce stigmatising attitudes or have a promising impact on children and young people e.g. videos and slides to address stigmatising attitude and interactive discussion to help reinforce messages
- greater contact with people with mental health difficulties can help normalise mental health issues and break down stigmatising attitudes. It must include specific conditions to ensure that it does not make things worse. i.e. it presents a realistic view of recovery with the person being someone other participants can relate to and seen as being of equal status. They should also not conform to standard stereotypes
- schools are seen by young people as especially important in helping them seek help. Participants felt that teachers should be more aware of mental health, its effects on school performance and how to help students who may have mental health concerns Teachers also reported being unprepared to deal with or identify mental health problems

The weight of evidence on what works also clearly suggests that it is never too late to intervene during teenage and young adult years. There is evidence that if teenagers experiencing poor mental health receive prompt, high quality support, then episodes will be shorter and less likely to recur and their adult mental health can be significantly improved.

Young people are typically early adopters of new technologies and are more likely to use the internet for sources about mental health concerns. However, online sources and applications are highly variable in quality, effectiveness, reliability and safety of advice offered. Some have worsened mental health difficulties. The National CAMHS Taskforce recommended more commissioning of organisations providing high quality and well supervised digital support, acting as a guide and link for young people to local services such as kooth.com, which has been commissioned in North East Lincolnshire and will be operational from December 2016.

Young people also favour more familiar and less formal sources of professional help such as teachers or 'counsellors' rather than more formal mental health services (and particularly clinic-based help).[77]

Overall, bullying interventions produce inconsistent results with many bullying programmes struggling consistently to achieve positive results. Some have resulted in at least a 30% reduction in bullying in schools, while others have no effect or even seem to increase the amount of bullying.

Key features increasing the likelihood of reductions in bullying include that programmes:

- should include clear and explicit guidance on how to implement and reproduce them successfully
- should not just be standalone classroom level activities
- but should address the systemic and environmental risks related to bullying - through a whole school cultural commitment (including teachers, students, support staff and parents) to policies, promotion, monitoring, addressing and reducing bullying

Effective action to prevent and reduce exclusions should start early in primary school with a focus on preventing the development of behavioural problems through early intervention with first signs of unhealthy behaviour and to reduce the multiplication of risk factors. It also relies on strategies combining educational and mental health approaches.

Schools provide an ideal setting to identify risk of school exclusion early and to link up with good quality SEL and parenting interventions. Well implemented mentoring programmes targeted towards supporting vulnerable children improve school engagement and behaviour. Whole school approaches promoting good behaviour and mental health in primary school and secondary school are vital factors in helping reduce poor pupil mental health and poor behaviour. Positive relationships with a key adult are also considered an important protective factor in terms of healthy behaviour, mental health and child/youth development.

Good relationships between teachers and pupils are important as well as access to good quality counselling and mentoring in schools. As children get older then more intensive interventions such as Multi Systemic Therapy and Functional Family Therapy may also have a role to play in reducing teenage behaviour problems.

Whole school approaches are equally important in secondary schools, creating a positive environment with commitment from the whole school workforce to support children's mental health with social and emotional learning throughout the curriculum. Some universal SEL programmes are developing good evidence for promoting better mental health outcomes, coping skills and reducing risk taking. For example, 'Positive Action' is a school-based programme aimed at improving both social and emotional learning and the school climate. Positive Action consists of a detailed curriculum of approximately 140 short lessons throughout the school year from ages 11 to 14 years.

The 'Whole School Climate' approach is reinforced in the classroom and curriculum and includes training and professional development, coordination of resources, programme promotion and incentives for positive behaviour. It has demonstrated an array of positive effects over time, mostly in relation to substance misuse, reducing early sexual activity, improving school attendance and test scores, reducing exclusions, and in the short term reducing major depressive and anxious symptoms (however, gains in mental health were not sustained at the follow-up stage of the research).

UK-developed programmes, such as the UK Resilience Programme, have shown some early promising results in reducing emotional problems (although not behavioural difficulties). Mindfulness, which involves learning therapeutic and meditative approaches to dealing with stress, has also been tested as a universal approach in schools with very early promise.

There has been mixed evidence on the effectiveness of mentoring, with modest improvements and huge variations across different programmes. Greatest effectiveness (in reducing aggressive behaviour) is noted when targeted at children and young people facing the greatest adversity and disadvantage – but even then results have varied. Some positive outcomes continue a year or more beyond the end of the programme. The most effective mentoring programmes recruit adult volunteers, school staff, or well supported secondary school students. Community-based organisations liaise closely and coordinate with school staff and provide mentors with training and oversight.

Aggression Replacement Therapy (ART) is a group cognitive behavioural-based programme helping aggressive adolescents (aged 12-18) self-regulate and adopt more positive behaviour. It is rarely available in the UK despite proven effectiveness. It is facilitated by trained practitioners and can take place in a range of environments, from schools to youth justice settings. Functional Family Therapy (FFT) is a family programme targeting young people aged 11- 18 who are at risk of entering or already in youth justice settings. FFT works with family behaviours seen to maintain problematic behaviour, supports more effective family communication, trains family members to negotiate effectively and helps establish clear rules about privileges and responsibilities. Multi-systemic therapy (MST) is an intensive home based programme aimed at families with children aged 12-17 who are at risk of or who have a history of arrest. It is also effective in supporting children who are misusing substances with their recovery. It is practical in focus and empowers parents with skills and resources needed to address difficulties that arise in raising teenagers. It empowers young people to cope with family, peer, school and neighbourhood problems. MST involves approximately 60 hours of contact over four to six months.

Common mental health conditions such as depression and anxiety should be managed through a process of good quality initial assessment to determine risks, and through stepped care. Evidence suggests that less complex conditions, where risk of harm is low, can be supported through evidence-based psychological therapies provided through Improving Access to Psychological Therapies (IAPT) services (now available from 16 years onwards), self-help CBT support, physical activity groups (in the case of depression) or group and individual CBT. Young people in this age range are often less happy to approach highly 'clinical feeling services'. They may favour psychological support and counselling from Youth Information Advocacy and Counselling services (YIACs).

There is now good evidence that preventative intervention through Early Detection Services with those at enhanced risk at this very early stage using CBT can prevent the onset of illness or change the course and severity of the illness and its impact on a young person's life.

For young people with more persistent or severe problems, more intensive CBT and/or medication should be available. Referral to specialist mental health services would normally be for young people with depression who are at significant risk of self-harm, have psychotic symptoms, require complex multi-professional care, or where an expert opinion on treatment and management is needed. As for under-16 year olds, Eye Movement Desensitisation Therapy and trauma focused CBT is effective for teenagers and young adults.

Some innovative models of holistic support are now developing to improve access for vulnerable groups. These include:

- The Anna Freud Centre's Adolescent Mentalisation Based Integrative Treatment approach
- Safer London's work with vulnerable young women – but also more generally with young people involved in gangs and offending in London
- Initiatives such as The Integrate Movement (TIM) working with under-served young people such as gang members, young people who offend and some BME young men. Approaches are highly engaging, co-produced, focused on holistic recovery and involve an approach called 'Street Therapy'

Early identification followed by prompt, compassionate and effective treatment of depression is particularly important and has a major role to play in preventing suicide. Reducing reliance on substances is also critical. Good crisis management plans should involve families and should facilitate swift access to crisis care in the event of any escalation of poor mental health. Multi agency post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, and health and care settings.

In cases of psychoses, effective early intervention approaches involve medication but also holistic care from multi-disciplinary teams supporting broader psychosocial recovery. For those recovering from psychosis, placement in employment backed up by specialist mental health support during this transitional adjustment (Individual Placement and Support schemes) has also proved to have a positive effect on people's mental health as well as representing good value for money.

A number of treatment interventions show early stage promise for people with Borderline Personality Disorders including Dialectical Behaviour Therapy (DBT); Mentalisation-based treatment and related approaches; Adolescent Mentalisation-Based Integrative Treatment (AMBIT); Structured Clinical Management (SCM); Multi Systemic Therapy and Functional Family Therapy (MST and FFT).

Many children, young people, families and non-specialist workers do not effectively recognise mental health difficulties. Those with common emotional illnesses took on average just over eight years to get help. For seven of these years, they were unaware of the significance of their symptoms. If young people, families, teachers and other non-specialist professionals recognise mental health problems and have relevant knowledge about risks, causes and effects of treatment, young people are more likely to seek early appropriate help.

People with mental health problems experience more stigma than those with other health problems. Stigma deters people from getting help. Children and young people face higher levels of stigma than adults.

Most parents of children and young people aged 5-15 with a mental health diagnosis seek professional help. Only around a quarter of children and young people and young adults get the help they need. Many seeking help also end up in 'dead ends' despite recognition of a need for assistance.

Good mental health and wellbeing in under five year olds is shaped very early on, right at the very first spark of life and is determined by a complex interplay between genetic make-up and exposure to risks and protective factors in the environment. During pregnancy, poor maternal mental health, over exposure to stress hormones and also to some substances (e.g. tobacco and alcohol) have a toxic effect on a child's brain development and later mental health.

After birth, a healthy attachment to a caregiver helps to protect babies from adversity and stress: acting as a 'buffer' with the world outside and slowly helping infants to self-regulate in the face of frustration. Infants and toddlers facing the highest risks for poor mental health include those whose mothers have untreated mental health problems, whose parents misuse substances, who are subject to maltreatment and neglect, and who live in prolonged poverty. For toddlers, positive proactive parenting (e.g. involving praise, encouragement and warmth) and the absence of harsh, rejecting and coercive parenting are associated with higher child self-esteem and social and academic competences.

Children, young people and families need multiple access points to get the help they need. Most young people prefer non-clinical sources of support including family members and friends; however, in some instances this preference can mean missing out on early effective help that can make a difference. Schools and colleges are seen by children and young people as particularly important places to help pick up and bridge to required support, but many teachers feel ill equipped to help children and young people in this way. Young people also say they often use online sources but worry about the reliability of some of the information they access.

There is a range of interventions that can help to protect mental health from pregnancy to age five. Most need to be targeted towards families who have the highest risks or children who are showing early signs of distress. They include group parenting programmes for children with behavioural problems (e.g. Triple P); home visiting programmes for parents facing high risks (such as Family Nurse Partnerships – the local programme in North East Lincolnshire has been decommissioned); and effective treatment for maternal mental ill health.

School is a unique and critical environment touching the lives of almost all children which has the ability either to build on or redress early life experiences. If schools are mental health-promoting environments (adopting a whole school approach, proactively monitoring mental health and wellbeing, addressing bullying effectively, encouraging healthy relationships and school connectedness, having good links with effective local specialist support and parenting programmes, commissioning good quality counselling services and social and emotional learning programmes), they can help mobilise critical protective factors which can counter earlier experiences, reduce toxic cumulative risk and build children's resilience.

School is one of the few settings where there are proven effective interventions targeting the entire school population which are effective in reducing children's chances of developing future mental health difficulties. Whole school approaches that create a health-promoting environment and secure the commitment of the entire school workforce have been found to promote the best outcomes, to improve coping skills and to reduce risk-taking. Where schools are not psychologically informed environments (with poor management of bullying, dismissive of poorly connected/attached children, insufficient focus on children's wellbeing, poor linkage to support), children's mental health not only suffers but so does their attainment.

Because of the length of time children spend in schools and the number of parents approaching teachers for help, these settings have considerable potential to pick up children's poor mental health early. If approaching a professional, just under half would approach a teacher or member of school staff. Generic counselling services tended to be preferred to more formal mental health, clinical services or cognitive behavioural approaches. Young people generally value help that is genuine, warm, confidential, and non-patronising, that co-produces solutions and builds on strong relationships.

During secondary school, one child in eight will have one or more mental health conditions at any time. The number of children (mainly boys) with severe behavioural problems is higher among this age group. Self-harm is also relatively common, especially among girls, LGBT young people and children with a diagnosable mental health condition.

Some studies have found rising levels of emotional problems among girls in the 11-15 age group. Media-driven pressures to be thin, sexual harassment and harmful content online, and school pressures generate anxiety for girls, and many report being very worried about their mental health or that of their friends.

Misuse of alcohol, smoking and drug taking are all associated with poorer mental health in the 11-15 age group. There are very positive signs that alcohol and substance misuse have been decreasing over the last decade; however, for those who continue, reliance and binge drinking may be getting worse creating greater inequalities between high and low risk children and young people.

Young people in this age group largely don't know where to get help for emotional problems. They also feel stigma strongly. This can lead them to be more secretive about difficulties, which prevents essential early help. Many favour informal sources of support such as friends and family. Seeking support online is also a popular tool for many young people – but

again with concerns from them and in the literature about the variability, unreliability and sometimes harm experienced while seeking help in this way.

In young adulthood, there is a significant increase in self-harm, depression, anxiety and eating disorders, all of which for the first time begin to affect young women more than young men. It is also at this time that we first begin to see more severe mental health diagnoses emerge such as psychosis and personality disorders.

Teenage and young adult years continue to provide vital opportunities for intervention among those facing or living with poor mental health. Intervening early in the course of many mental illnesses can significantly reduce life course impairment.
Yet very few young adults get early help that has the best chance of making a difference and they are the least likely to seek help – particularly males.

For young adults with common mental health problems (depression and anxiety), cognitive behavioural programmes have the best evidence of supporting recovery. CBT is also effective for young adults who have suffered trauma. For young people with emergent psychoses, early identification and holistic intervention supporting recovery is highly effective.

Young adults as a whole are the most likely age group to develop mental health problems but the least likely to recognise that they have a problem that might benefit from treatment. Their difficulties are less likely to be spotted by parents or teachers. Where young adults do seek help, it is often from peers, parents or online information rather than from formal services. Young men are particularly unlikely to seek help, sometimes with tragic results.

Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24. Poor mental health represents a major disease burden for this age group and should be a health improvement priority. There is good evidence that the impact and burden of poor mental health during adult years can be reduced if, during adolescence, you intervene to reduce the duration of episodes of mental illness and to prevent its re-occurrence during these vital years.

Service review – existing services

- The Child and Adolescent Mental Health Service is commissioned by North East Lincolnshire Council via a Section 75 partnership agreement with North East Lincolnshire CCG. The service is provided by Lincolnshire Partnership NHS Foundation Trust and has a contract value of just over £2 million
- The service has been well evaluated by the Care Quality Commission and both users and referrers report a high quality service once a young person has been accepted
- The Service provides a comprehensive range of pathways and treatment modalities, which adhere to clinical guidance/standards developed by the National Institute for Clinical Excellence
- Despite the development of information leaflets and a duty advice line, a significant proportion of referrals are not accepted for assessment/treatment. This suggests that the service's eligibility criteria are not well understood, and causes a lot of waste and frustration in the system
- A Crisis Intervention Team, which provides intensive intervention to young people at risk of inpatient admission, has been highly effective at managing young people with complex needs in the community. The use of inpatient facilities is low
- Thresholds to receive a service are very high. Although growing, the range and capacity of services to meet lower level needs at an early stage needs to be further developed
- There is some concern about the eating disorder pathway. The pathway needs to be updated to demonstrate how the new waiting time standard is being achieved. The low numbers of referrals for eating disorders is being monitored locally but we feel this needs some expert input
- The needs of vulnerable groups are generally well catered for, with specific teams for looked after children, CYP with learning disabilities and dedicated workers linked to the YOT and substance misuse service. However, the offer for vulnerable groups is not comprehensive and it would appear that young people from the Youth Offending Team and substance misuse service with more complex needs are not getting the support they need

Who is commissioning what

Commissioner	Services Commissioned	14/15 Value
NHS England	NHS England commissions CAMHS inpatient beds for children nationally. Some of these beds are used by children from North East Lincolnshire. NHS England has contracts with a number of providers. NHS England is also currently providing funding to the YOT, to run a 'Diversion and Liaison' service, in partnership with Navigo. This is a pilot.	Given the very small number of CYP involved, we do not think it is appropriate to include a financial value. The value of the Navigo contract is not known.
North East Lincolnshire Council	The Council commissions what is described as a 'Tiers 2, 3 and 3+' CAMH Service, for 0 to 18 year olds. This is commissioned jointly with North East Lincolnshire CCG, with the Council acting as lead commissioner following an agreement under section 75 of the NHS Act (2006).	

North East Lincolnshire Clinical Commissioning Group	**Some of the services that the CCG commissions for adults accept referrals for young people aged 16 and over. These are:** • Early Intervention in Psychosis • Eating Disorders **The CCG is also responsible for commissioning acute medical care (e.g. the Emergency Department, acute inpatient beds) and sometimes this is required due to mental rather than physical health issues.**	**Services are commissioned on a '16 years and over' basis and it is not possible to disaggregate the value of the investments based on age.** **It would be extremely difficult to unbundle this expenditure from the overall value of the contract for acute medical care.**
Schools	**Some schools are funding emotional and mental health support services.**	**Not known.**

In addition to services which are commissioned specifically to meet emotional and mental health needs, there are a number of services that contribute to good emotional wellbeing and mental health, particularly at a universal, preventative level. These include:

Who is providing what

Specialist mental health services are provided by:
Lincolnshire Partnership NHS Foundation Trust – CAMHS service for 0-18 year olds.
Navigo – Early Intervention in Psychosis Service (14+), Eating Disorder Service (17.5+) and Liaison and Diversion (14+).

Comprehensive review of all local CAMHS services

Scope and description of service

There is a published service specification for a 'Tier 2, 3 and 3.5 CAMH service'. However, this was developed for 2013/14 and there have been significant national and local changes since then. The specification, and all associated pathways, are being reviewed prior to the service being re-procured in 2017/18.

The specification includes a number of key elements:

1. The service should provide treatment to children and young people with the following conditions:

   - Depressive disorders
   - Anxiety disorders
   - Hyperkinetic disorders
   - Developmental disorders
   - Psychotic disorders
   - Eating disorders
   - Conduct disorders
   - Obsessive compulsive disorders
   - Post traumatic syndromes
   - Somatic syndromes
   - Severe behavioural problems
   - ADHD

2. The service should be able to provide a wide variety of interventions and treatment options, including cognitive behavioural therapy, short and long-term therapy, family therapy and medication. The specification does not include evidence based parenting support, as this is provided by other parts of the system, most notably the Family Hubs and Family Resource Service.

3. The service should provide a dedicated amount of worker time to the LAC, YOT, |North East Substance Misuse Team (NEST) and Pupil Referral Units.

4. The service should provide a 365 day, 24 hour crisis response service, supported by consultant psychiatrists. Following referral, assessments should commence within 2 hours (on a face to face basis) and should be complete within 24 hours. Most assessments will be for young people who present at the Diana, Princess of Wales Hospital in Grimsby.

The service is registered with the Care Quality Commission and underwent a very positive inspection in December 2015, with an overall rating of outstanding. The Commission's inspection team found a number of areas of notable good practice, including:

- Staff within the trust had developed "outcomes oriented CAMHS". This evidence based model focussed on the outcomes for young people and had been recognised in NHS innovation awards
- In North East Lincolnshire the service regularly invited other professionals to their team meetings to provide training on how their services worked and how they could improve links with CAMHS. This included the police, NSPCC, school nurses, child protection social workers and others
- In North East Lincolnshire a practitioner in the team supported young people in sessions in the local gym in line with research which showed physical exercise had positive outcomes on mental health. This was having a positive effect on young people

The service is organised into the following components:

- A Core Team, which deals with all generic tier 2 and tier 3 work
- A tier 3.5 Team, which is commissioned to provide more intensive support to young people who are at risk of inpatient admission
- Specialist teams for LAC, ADHD and Learning Disabilities, with workers also integrated into YOT provision and the PRU
- An emergency response, accessible within 2 hours

The Tier 3.5 Team is a relatively recent innovation, and consequently has been subject to two internal evaluations, one of which has focussed on the types of young people worked with and the prevention of inpatient admissions, and the other on the effectiveness of the intervention, as evidenced by clinical outcome measures. Both evaluations demonstrate that the team is having an extremely positive impact, with a very significant reduction in referrals to Tier 4 inpatient units and statistically significant improvements in functioning for the young people who received a service.

Commissioners are clear that they want to commission a service that intervenes as early as possible, and the specification states that one of the key desired outcomes is that, "there is a reduction in the number of children and young people who require intervention at Tier 3, Tier 3 plus and Tier 4 CAMHS." However, it is very difficult to evidence this from the activity data that is provided, and in fact there has been a significant growth in tier 3.5 referrals, from 205 in 2014/15 to 249 in 2015/16. Over the same period, there has been a decrease in the number of referrals to the Core Team, from 426 in 2014/15 to 348 in 2015/16.

Capacity

There are 29.2 WTE clinical posts in the service, supported by 5 WTE business support staff. There is no accepted methodology to assess the capacity of a CAMH service. However, there are three approaches which might be of use in coming to an informed view about capacity.

Firstly, the National Service Framework for Children, Young People and Maternity Services (2004) [78] recommended a minimum ratio of 15 WTE staff for every 100,000 population. On this basis, North East Lincolnshire CAMHS would require 25 WTE staff.

Secondly, the Royal College of Psychiatrists recommended in 2006[79] that 20 WTE staff were required to meet the needs of children and young people aged 15 and under, per 100,000 population. In addition, the College recommended 5 WTE primary mental health workers per 100,000 population. This would equate to 25 WTE staff in the main CAMHS service, and 10 WTE primary mental health workers. It should be noted that the CAMH service is not currently commissioned to provide a primary mental health service – although there are plans to include this in the specification for a new service from 2018/19 onwards.

The Choice and Partnership Approach (CAPA)[80], which is the required service model in the current specification, contains some important assumptions for workload planning. It assumes that a WTE clinical post with no management responsibilities should be able to provide 16 hours of direct clinical time per week, over 45 weeks of the year. Given a WTE establishment of 29.2 clinical posts, this would equate to 467 clinical hours per week, or 21,015 hours per year. Assuming that not all staff can be entirely clinically focussed, this could be reduced by 25% to achieve a more realistic calculation. So, there should be capacity within the current service to deliver 15,761 clinical hours. Data suggests that for 2014/15, the service carried out 6,647 face to face appointments – an average of 228 appointments annually per WTE staff member, or 5 per week. Remaining capacity will be taken up with provision of advice/consultation, and provision of training. As part of the development of a revised specification, commissioners may want to think about what is the most appropriate balance of direct and non-direct work, how non-direct work can be counted/monitored, and what level of each constitutes a productive service.

It is also important to be aware that there are some nationally recognised pressures on capacity, which include:

- Backfill arrangements for CYP IAPT training opportunities, where this a shortfall between the backfill offered and what is needed
- Difficulty in recruiting to CAMHS vacancies across the whole system
- The impact of maternity leave in health services, which tend to employ more female staff

Location

The CAMH Service is provided from the Freshney Green Primary Care Centre on Sorrel Road in Grimsby.

The Centre is accessible on a bus route from Grimsby town centre, which stops on Yarborough Road, and is a short walk away.

The Centre is a modern health centre, and hosts a wide range of health and social care services, so should be fairly anonymous to access.

Access – hours, referral, thresholds

Hours of service operation are as follows:

Core CAMHS Service	**Open 9 am– 5 pm, Monday, Tuesday, Thursday and Friday, and 9 am – 8 pm on Wednesdays.**
Tier 3 + Team	**Available Monday to Sunday, 8.45 am – 7 pm**
Crisis Service	**Available on a 24/7 basis throughout the year, including on bank holidays. Commissioned to respond within 2 hours.**

Given that most children and young people will be at school or college between 9.00 a.m. and 3.30 p.m. during the week, the opening hours for the Core CAMHS Team will mean that the bulk of children and young people will need to miss school/college to attend an appointment. The viability of early morning, later afternoon/evening and some weekend appointments could be considered.

Although there is no research or publicly available comparator data on appointments which weren't attended (DNAs) (this may be available shortly via the mandatory National Mental Health Services Dataset[81]), the DNA rate for the CAMHS service in North East Lincolnshire seems to be in line with our experience elsewhere. In 2014/15, this was 10.9% of appointments offered, and in 2015/16 had fallen slightly to 10.3%. Although this may seem high, traditionally CAMH services tend to have high DNA rates as children, young people, and families can often struggle to face the issues that are raised in the course of treatment. The DNA rate does not lead us to conclude that there are any particular access issues once children and young people have been accepted by the service.

Referrals

Referrals can be made by professionals, on paper. There is published referral guidance, which is clearly intended to make it easier for professionals making referrals to understand when it would be appropriate to do so, and the service also provides an advice line for potential referrers to discuss their concerns and identify if a referral is appropriate. Despite this, there is a very significant volume of referrals which are not accepted by the service. Data provided by the service suggests that the figures are as follows:

2013/14	**503**	**2015/16**	**509**
2013/14	**378**	**Total**	**1,390**

If we assume that each referral takes 2 hours to make by the referrer, and 1 hour to review by the CAMH service, this equates to 4,170 hours, or 115 working weeks. Over a three year period, the equivalent of a whole time post for two years has been lost to the system. There is also significant evidence of a very high rate of repeat referrals – when the number of referrals received annually is contrasted with the number of unique children and young people seen, the ratio is almost 2:1.

	Referrals	No of CYP referred
2014/15	1,962	1,015
2015/16	1,993	1,021
Total	**3,995**	**2,036**

This means either that:

- Young people have to be referred more than once before they are accepted and provided with an assessment/treatment, or

It is reasonable to expect that both situations would arise to some extent in the most well-functioning system. However, at this volume, it suggests that the system is not working.

- There is a significant volume of re-referrals once young people have been discharged from the service

When referrals are rejected, the identified process is to refer to either children's services or paediatrics, neither of which are set up to respond to emotional and mental health needs.

Thresholds

Good quality, validated assessment tools are used to help determine the extent of a young person's need and what type of treatment might be most appropriate. In some senses these tools also give us a much more granular understanding of the service's eligibility criteria. For example, the Moods and Feelings questionnaire is used to assess for depression. The questionnaire looks at self-reported feelings over the previous two weeks, asking young people to respond to 33 statements with either 'true', 'not true' or 'sometimes'. A score of 0 is awarded if the young person identifies the statement as 'not true', 1 if it 'sometimes true' and 2 if it is 'true'. In order to qualify for a more detailed assessment, young people need to score more than [27].

However, a score of only 20 would be possible if a young person stated that in the last two weeks they had regularly:

- Felt miserable or unhappy, and
- Felt so tired they just sat around and did nothing, and
- Cried a lot, and
- Thought there was nothing good for me in the future, and
- Felt they were a bad person, and
- Thought they could never be as good as other kids, and
- Hated themselves, and
- Thought life wasn't worth living, and
- Thought nobody really lived them, and
- Thought about death or dying.

Parents, family members and other professionals working with the young person would understandably be extremely concerned if a young person was reporting feeling like this, but this young person would not qualify for a more detailed assessment under the current depression pathway.

Activity

Activity data is available on referrals, which teams referrals are allocated to, and appointments attended/ not attended. The service tends to receive just under 2,000 referrals annually, relating to just over 1,000 young people. In 2015/16, 776 referrals were allocated across the Core Team, Core Team (group work), LAC Team, ADHD Team, Learning Disability Team, and Tier 3+ Team. Referral levels seem to be stable, and there should not be a problem in managing this level of referral given the size of the service.

Data suggests that for 2014/15, the service carried out 6,647 face to face appointments – an average of 228 appointments annually per WTE staff member, or 5 per week.

It is worthwhile noting that understanding referral numbers was difficult because of the way that data is reported.

This should be simplified that commissioners are able to understand:

- How many referrals were made in a given period to all CAMHS teams
- How many were accepted
- Of the referrals accepted, which teams they were allocated to

The role of the 'intake team' is purely screening referrals, and it is not useful to commissioners to understand referrals to and from this team.

The more fundamental point with activity is that there is a huge treatment gap – the numbers who are accessing support with their emotional and mental health is much smaller than the numbers who the evidence base suggests will need help.

CHIMAT use a tool developed by Kurtz to estimate how many children and young people would need support at a Tier 1, 2, 3 and 4 level.

Tier	Expected prevalence	CYP supported in NE Lincs – 2015/16	Difference
1	5,150	Not Known	
2	2,405	1021	-2,019
3	635		
4	30	*	

The 'treatment gap' is currently around 2,000 children and young people with needs that would benefit from an intervention delivered by someone with specific mental health training. This is about twice the number of referrals to CAMHS in 2015/16 – so roughly a third of children and young people are getting the support they need. This is not an usual situation and in fact mirrors national trends.

Performance

The service has a small number of performance indicators to meet. These are:

- Waiting times – seeing service users within 12 weeks of referral
- Referrals – urgent referrals are seen within 5 days and emergency referrals seen within 24 hours
- DNA rates
- User satisfaction
- Referral to Tier 4 Services

The service is performing very well against these indicators. There is some challenge noted around the DNA rate (this is currently in excess of the target of 8.3% for 14/15) but at 10% this is seen is good anecdotally compared with the national picture.

The service has been highly effective and is performing well in excess of target in terms of reducing Tier 4 admissions. In fact, where Tier 4 admissions are made, they are often requested via the Early Intervention in Psychosis Team, rather than by CAMHS.

Beyond the key performance indicators included in the service specification, the service also provides performance intelligence on:

- Patient Experience and Participation
- Training provided
- Uptake of the Eating Disorders pathway
- Referrals/activity on the Autism pathway
- Progress on Future In Mind projects

Trends of increased need/ demands on services

Referral rates have stayed broadly the same from 2014/15. However, there is a change in the numbers of young people being discharged, which suggests that young people are spending longer in the service.

This may be indicative of greater complexity, although without the use of a standardised tool to assess complexity at initial assessment, this is very difficult to evidence. Discharge rates are as follows:

Year	No of discharges
2013/14	693
2014/15	608
2015/16	587

Mapping of local pathways

The service provides 14 specific pathways, 8 of which are specified by the commissioner. These are: (the specified pathways are in italics)

- *Depression*
- *Anxiety (including generalised anxiety and OCD/BDD)*
- PTSD
- Self-Harm
- *Eating Disorders*
- Mental Health Impact on Physical Health
- Attachment Difficulties
- Harmful sexualised behaviour
- *Attention Behaviour*
- *Autistic Spectrum Disorders*
- *Looked After Children*
- *Youth Offending Service*
- Dual Diagnosis (mental health and substance misuse)
- *Learning Disabilities*

The existence of agreed and published pathways is a good thing and is a strength in the local system. Where there is NICE guidance, this has been incorporated appropriately into the pathways. However, there are some issues with the pathways that require some further reflection.

Self-harm

The self-harm pathway is appropriate and in line with NICE recommendations. However, the overall impact of the system appears to be that most children are getting support at an intensive level after a crisis presentation, rather than the system intervening early to prevent escalation to crisis.

Self-harm among young people, particularly those aged 10 to 24 years, is higher than in any other age group. Figures from Public Health England show the rate at a national level for self-harm finished consultant episodes amongst young people (10-24 years) is 352.3 per 100,000 compared to a regional rate of 368.2 per 100,000. The local rate in North East Lincolnshire of 432.8 per 100,000 is ranked the fifth highest in the Yorkshire and Humber region and is significantly higher than both the national and regional rates. The trend of self-harm hospital admissions among young people (10-24 years) has risen both nationally and regionally in recent years. North East Lincolnshire has shown a significant increase in self-harm admissions; 253 per 100,000 in 2007/08 to 2009/10 to 432.8 per 100,000 in 2010/11 to 2012/13. This was an overall increase of 42% in North East Lincolnshire which now identified that young people locally are significantly more likely to be admitted to hospital for self-harm.

Data provided by Northern and Yorkshire Knowledge and Intelligence Team for self-harm emergency hospital admissions for young people aged 15 to 24 years old shows at a Yorkshire and Humberside regional level, females are over twice as likely to have an emergency self-harm hospital admission than males with a crude rate of 621.2 per 100,000, compared to 269.6 per 100,000. North East Lincolnshire ranks the 7th worst local authority (out of 15) for combined emergency self-harm admissions in the Yorkshire and Humber region. The female admission rate in North East Lincolnshire is 683.6 per 100,000, which although higher than the female rate for the Yorkshire and Humber region (621.2 per 100,000) is not significantly different. Similarly, the rate for males

in North East Lincolnshire (334.9 per 100,000) is also higher than the regional rate (269.6 per 100,000) but again this difference is not statistically significant.

In total, figures provided by NEL CCG show that between 2013/14 and 2015/16 there were 365 deliberate self-harm emergency admissions to the Diana, Princess of Wales Hospital for residents of North East Lincolnshire aged under 18 years. Ward analysis shows that East Marsh, with a rate of 2012.2 per 100,000, is the only ward with a rate significantly greater than the North East Lincolnshire average. The Waltham and Haverstoe wards are significantly lower, with rates of 259.7 and 187.1 per 100,000 respectively. There is a clear correlation between the rate of admissions per ward and their respective deprivation score i.e. wards with higher levels of deprivation typically have higher self-harm emergency admission rates.

Referrals to CAMHS for self-harm are predominantly to the Tier 3.5 team, with 128 referrals in 2015/16, compared to 34 referrals to the Core Team, with a further 34 young people referred to a group based self-harm intervention. If the system was operating optimally, the referral pattern would be reversed – there would be much more activity at Tiers 2 and 3, with less crisis intervention at Tier 3.5.

This is acknowledged within the Future In Mind Local Transformation Plan, with work funded around developing a self-harm curriculum and advice/support for schools on self-harm. Funding was made available in January 2016, so could be expected to have an impact from quarter 4 of 2016/17, with an increase in tier 2 referrals and less crisis presentations to the Tier 3.5 team.

Eating Disorders

A new commissioning standard for community eating disorder services was published in August 2015. This sets out the need for a specialist community eating disorder service for children and young people to be in place for a minimum population size of 500,000, and to accept 50 referrals a year. North East Lincolnshire has entered into partnership agreements with other commissioners to ensure that a service with population coverage in excess of 500,000 and with a demand for more than 50 referrals a year is in place. However, the pathway has not been updated to reflect this requirement. The adult eating disorder service is also commissioned to take referrals for young people aged 17 and over. Young people aged 17 years and above can also access Rharian Fields Specialist Eating Disorder Service designed to deliver a range of individualised services for both male and female clients based on NICE guidelines and the MARSIPAN Report. This is a confusing picture and with this level of possible fragmentation, it is difficult to see how the Access and Waiting Time Standard can be achieved. Children and young people are more likely to receive the most specialist, highly skilled care in a dedicated children's service. The Eating Disorder Pathway needs to be updated to ensure that there is clarity about what services are commissioned, what the eligibility criteria are for services, and how they comply with NHS England commissioning guidance and access standards.

There is also some concern about the low level of referrals to CAMHS for eating disorders. The most recent UK prevalence study[82] would suggest an incidence of 120 per 100,000 10-19 year old females, and 31 per 100,000 10-19 year old males.

For North East Lincolnshire, this would mean an incidence of 3 males and 11 females. Referrals to the service are lower than this, with 5 referrals to the Tier 3+ Team and 5 to the Core Team for eating disorders in 2015/16 – and these may be the same young people stepped down from crisis to more on-going treatment. Referrals for eating disorders have historically been low, with 6 in 2013/14 and 4 in 2014/15. The local interpretation of this is that emotional distress manifests differently in some communities, and the culture in North East Lincolnshire is more orientated towards self-harm, particularly through 'cutting'. This could be a valid interpretation, and there is no evidence that eating disorders are going unnoticed and leading to a high number of acute presentations or morbidity. Having said that, we have found nothing in the research base that supports this very localised presentation of emotional distress, and given the morbidity associated with eating disorders, feel that this requires further, expert investigation.

Data received from NEL CAMHS states there were a total of 23 new cases recorded on the eating disorder register between 2013/14 and 2015/16 of young people aged 10 to 17 years in North East Lincolnshire, or the equivalent of 8 new individual cases per year in North East Lincolnshire.

The low level of referral for eating disorders has meant that North East Lincolnshire agreed with NHS England that the funding allocated nationally to development of a Community Eating Disorder Service for Children and Young People would be used to fund self-harm work instead.

Mental Health Impact on Physical Health

This pathway very simply states that children and young people with physical health issues, where there are concerns about emotional and mental health, can be referred to CAMHS and will be allocated to a generic pathway based on severity of presentation. This doesn't consider the quite specific concerns that children and young people may have about their physical health, and how their psychological state can impact on their ability to look after themselves well. Looking at this from a system, rather than service level, it also means that emotional health needs are not addressed until they have escalated to a diagnosable level, and families who will already be attending a significant number of GP/outpatient/community health appointments will be expected to manage another set of appointments at a different clinic. Good psychological support, which helps children and young people make sense of their condition and the impact it may have on their lives, develop self-esteem and a positive identity that encapsulates their condition, identify role models etc., could be incorporated into their physical health provision, and there is an opportunity to capacity build within these services so that staff can offer more holistic care.

Attention Behaviour

There is an agreed, multi-agency Attention Behaviour Pathway, which focuses on those children and young people who have more entrenched and severe presentations. NICE guidelines for the diagnosis and management of both Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorder recommend evidence based parenting groups, and these are available in North East Lincolnshire via the Family Hubs. Healthwatch perceive that not all parents may be fully aware of this service.

NICE guidance also recommends a period of 'watchful waiting', to determine whether problematic behaviour is a short-term phase as part of normal child development. Once universally available parenting approaches have been tried, and there is no improvement in a child's behaviour, a single assessment is undertaken to understand the child and family's circumstances and needs in more detail. This is presented to a multi-agency Family Hub meeting, and a plan is agreed. Plans are reviewed at 12 weekly intervals, and cases are referred to CAMHS where the multi-agency plan hasn't improved behaviour and specialist assessment – including a possible ADHD diagnosis, is required. This enables the resources of the CAMH services to be targeted at those children and young people most in need of specialist diagnosis and intervention.

Training and capacity building support (IAPT)

There are two key initiatives locally which have been implemented to develop the skill base and capacity to meet emotional and mental health needs within the local workforce. These are the development of a professional capabilities framework for the children's workforce in North East Lincolnshire, and the local area's involvement in the CYP Improving Access to Psychological Therapies [83] programme.

- **Professional Capabilities Framework**

The competencies that relate to emotional and mental health are as follows:

Level	Mental Health Competencies
New Worker	• With guidance, recognises basic signs and symptoms of emotional health problems/disorders • Understands that child and adolescent development involves emotional, physical, sexual, social, moral and character growth and the impact these have on each other • Promotes positive wellbeing of children
Universal	• Recognises the importance of emotional health and own role in promoting this • Understands the CAMHS tiers of intervention, referral routes and how to access support • Understands the importance of building positive emotional health, self-esteem and demonstrates the ability to incorporate this into own work • Is able to respond helpfully to a child or young person who is troubled, by listening appropriately
Universal Plus	**All above, plus:** • Is able to assess for signs of emotional ill health and know when to ask for advice from specialist services
Vulnerable	**All above, plus:** • Communicates with individuals about promoting their health and wellbeing

Complex	**All above, plus:** • Recognises signs of mental health e.g. self-harm, eating disorder, anxiety, depression etc. and can respond to these with the support of CAMHS and adult mental health services
Acute/Specialist	• Recognises signs of mental ill health e.g. self-harm, eating disorder • Recognises the importance of emotional health and provides clarity on their role and the role of their team in promoting this • Has a good understanding of CAMHS and adult emotional health services tiers of intervention, referral routes and how to access support where necessary

A workforce competency audit is currently underway, and this will ensure that there are a range of identified training opportunities to ensure that staff at each level can meet the competency. This attempt to be systematic about who in the workforce needs to do what around emotional and mental health is a positive step forwards. However, if the system is really going to be transformed to meet the emotional health needs of all young people, the required competencies need to be much more ambitious and focussed on staff being up-skilled to take action and deliver straightforward interventions. This is already happening with school nurses and YOT officers being trained in cognitive behavioural therapy. As workforce planning develops, attempts should be made to support staff in different sectors to develop the skills and confidence to actually deliver straightforward, evidence based interventions.

- **CYP IAPT**

The CAMH Service joined the national IAPT initiative in September 2016. CYP IAPT is a national sponsored service improvement initiative. One of its key aims is to spread the use of evidence based interventions, and funded training places are available to services who participate in a range of evidence based modalities. This then provides an excellent opportunity to embed a more evidence based approach. It is a positive step in the right direction that the service has joined a CYP IAPT partnership. In the first year, 4 members of staff (2 from CAMHS, 2 from LA/Navigo) will be trained in evidence based approaches. Subject to the constraints of back-fill arrangements, the CYP IAPT programme provides a valuable opportunity to increase capacity in the whole system to deliver evidence based approaches, and as much use should be made of it as possible.

Vulnerable groups

- NEETs – it is difficult to come to a conclusion about whether young people not in education, employment or training are served well by the current arrangements in terms of their emotional and mental health. There are no specifically commissioned approaches for this group of children and young people, and numbers are disproportionately high in North East Lincolnshire. Given the pattern of intervention, it is probable that these young people are unlikely to receive a service unless they present in crisis

- CYP with SEN – There is a specific team, working to specific pathways, for children and young people with learning disabilities. This is a strength of the current arrangements. A high degree of children and young people with SEN are likely to have a conduct disorder, ADHD, or both, and they benefit from a clear, multi-agency Attention Behaviour pathway. The assessment and planning process for children and young people with special educational needs does appear to be recognising emotional and mental health needs appropriately, with a higher rate than the national average of children with social, emotional and mental health identified as a priority need

- LAC – looked after children and young people benefit from a dedicated service, and this is a key strength locally. Most of North East Lincolnshire's looked after children are placed in or very near (within 20 miles) to the local authority area, so there should not be access issues. One off packages are commissioned for children and young people who are placed too far away from the Grimsby based clinic to access it. However, the service's focus is on children and young people with 'severe attachment difficulties', and this is problematic in two ways. Firstly, there is an assumption that the emotional and mental health needs of looked after children are related to attachment, which may not be the case. Anecdotal evidence nationally suggests that the focus on attachment issues in this group can lead to other issues (particularly autistic spectrum conditions) being undiagnosed. Secondly, it is a high threshold and this probably explains why the LAC team received only 54 referrals in 2015/16. There is a clear need for service provision that addresses less complex presentations

- Self-harm – as above, young people who self-harm would appear to get a good service when their needs are such that a crisis intervention is required. An early intervention approach is being developed for children and young people who self-harm, including evidence based interventions provided by school nurses, and there is emerging anecdotal evidence that this is effective. It is likely that this will begin to have a significant impact on the system in 2016/17

- Domestic Violence – for those children and young people who have been exposed to domestic violence and this is the underlying cause of more complex mental health presentations, CAMHS is providing a good service. The 0-19 programme is focussing on domestic violence as one of the 'toxic trio' of social issues that drive demand for statutory social care services. This should identify children and young people affected by domestic violence at an early stage, and ensure that practitioners are mindful of their psychological needs

- Teen parents – there is no specific pathway or service for teenage parents. We have not seen data about take up rates or outcomes for teenage parents of the CAMH service, so it is difficult to quantify how well their needs are being met
- Learning Disability or Autism and MH problem who display risky or challenging behaviour – children and young people with learning disabilities are served well by the CAMH service. There is a significant gap for children and young people with autistic spectrum conditions at the moment, but this is being addressed by the North East Lincolnshire CCG project to review the diagnostic/support pathway for people with autism
- Substance misuse – young people with substance misuse difficulties benefit from a CAMHS worker being attached to the NEST team. This means that basic interventions can be delivered 'in house', and this should be commended. However, there is a very low referral rate from the NEST team into generic CAMHS, and this suggests that very few young people with substance misuse issues, who will be some of the more challenging and complex presentations, are not getting a Tier 3, complex service. This is a significant gap
- Young people who have offended – young people who have offended and are being supervised by the Youth Offending Team benefit from a CAMHS worker who is attached to the YOT, and also works with the NEST service, where there is a high degree of crossover. The NHS England funded liaison and diversion service, where young people's mental health needs are assessed in the custody suite, is a promising area of good practice. YOT officers have been trained in delivering cognitive behavioural therapy, and this is a significant area of innovation. YOT staff also benefit from clinical supervision and ready availability of advice and support from the CAMHS worker. However, again, the level of referral to the generic CAMH service is problematic. It is likely that young people who have offended will have some of the most complex needs in the area, but it appears they are not able to access a service that meets those needs. This is a significant gap

Consultation

- In excess of 300 people gave their views of Children's and Young People's Emotional and Mental Wellbeing Services. They were a combination of Commissioners, Managers, Providers, Clinical Staff, Children and Young People and their parents and carers
- It is accepted that the number of CYP presenting with emotional and mental wellbeing issues is increasing and the complexity of their conditions is increasing
- There appears to be little support provided for those with low and medium level emotional and mental wellbeing issues. If there is support then it is either over – stretched or unknown to the system. There needs to be a focus on prevention and early intervention
- Pathways for emotional and mental wellbeing are referred to but nobody can produce one. It appears as if they possibly existed in the past and haven't been reviewed
- The CAMH service is acknowledged as a good service if you can access it. The thresholds are too high for the needs of the majority of CYP and service providers
- The workforce acknowledges the issues and has identified training needs to be able to cope better with issues in the community rather than 'handing off' young people
- There is an acknowledgement of the complex lives lived by some CYP and the effect of the wider determinants of health and their families on their ongoing mental health
- Some schools have excellent examples of support for primary school children which falls off as they get older and collapse by year 8. Schools are using exclusion to manage behaviour and exclude automatically for single issues. Last year there were 64 exclusions of which 57 remain excluded. Young people in groups talk about the impact on a class when the teacher is trying to manage behavioural issues. Schools do not explore underlying issues as they don't have the skills, time or capacity to do this. Early intervention is entirely missing in some schools and parents use school as first point of call for advice. There is a perception that the school nursing service is underfunded and sometimes there is only a day or two of provision each month

Targeted contact with schools (primary and secondary) for interviews, focus groups and to encourage the staff to participate in the online surveys.

All schools, academies and the Pupil Referral Unit were contacted to try and engage staff and pupils in the process.

Four school focus groups were held:

- Middlethorpe – Primary Academy
- East Ravendale Church of England- Primary
- Havelock Academy – Secondary and Sixth Form
- Oasis Academy Immingham – Secondary and Sixth Form

Attendance was as follows:

	Yr3	Yr4	Yr5	Yr6	Yr7	Yr8	Yr9	Yr10
Middlethorpe Primary Academy		10						
East Ravendale Church of England Primary	10							
Havelock Academy					12	8	9	9
Oasis Academy Immingham					11	9	8	14

Later the Deputy Chair of the Youth Parliament contacted the schools again to see if contributions could be increased. Roz Danks, Head of Education Services at NEL Council also emailed out to schools to encourage participation.

The main themes arising from the focus groups were:

- Children of all ages prefer to talk about problems face to face with someone they feel they can trust. They are much less likely to feel comfortable speaking to people over the phone/ video calling. This is due in part to concerns that other people could be in a background and overhear conversations
- The environment where children feel comfortable talking about problems needs to be somewhere private where they are confident that nobody else can overhear their conversations
- Younger children of primary school age and up to Year 8 are more likely to feel comfortable approaching teachers with problems. It varies quite a lot amongst children whether they feel comfortable speaking to teachers - this may be due to the overall culture within the school and also how well teachers commit to building trust with the children. And just because schools have dedicated staff to help children with problems, this does not mean children will be aware of this help being available or be comfortable accessing this support - however if relevant to the study, this would require further investigation to substantiate these points
- There is good awareness of among children of all ages of Childline and how to access this support, however few seemed to think this is a service they would choose to access. Awareness of other services varied, although a few children did have some knowledge/ experience of CAMHS. None of these children were very positive about their experiences, with the issues seeming to be not getting a response
- In choosing when to ask for help with problems, the most important factor for most of the CYP I spoke to is having someone available that they can trust as opposed to being able to simply access help straight away - whether this is a family member, friend or a professional. Building trust is important for children if they are to feel comfortable speaking about issues that are causing stress or anxiety, as is consistency in being able to speak to a person they feel they can trust
- Hardly any children understood what the term 'emotional wellbeing' means - and none of the children in any of the groups thought it was a good term to use in communicating with people their age
- There is a wide concern among children about written communication about problems - mainly that what they write could be shared and shown to other people - as well as posted/sent by social media. There was also a similar concern among some children about speaking to people over the phone - that calls could be recorded and information that is taken down could be shared, therefore it is hard for some children to trust speaking to professionals over the phone
- Although a lot of children of all age groups communicate by text message/ Messenger etc., most thought this was not a good way to talk about problems - mainly because messages could be shown to other people but also because what they say might not be understood or because they may have to wait for a reply
- There was a surprisingly low use of email by the children I spoke to - even the older children, and none of them thought email was a good way to talk about problems - partly due to the issue of what they write being shared, but also there was some lack of trust that the email may not get to the right person

- Linked to the above, it does seem that children, especially as they get older, are suspicious about the use of IT, in terms of safety, information being shared and being overhead/listened in on. This was especially the case at Oasis, and when I mentioned it to the Assistant Principal he suggested this may be because they do warn a lot about these sorts of problems, including dangers around social media. This issue suggests that while children of all ages are using texts/Skype/Facetime, internet etc. a lot for finding information and communicating with other people, they are suspicious - partly due to warnings from adults. Therefore, this should be a consideration in designing services for children to access - although it seems an obvious thing to introduce more technology, there may be issues about how comfortable children feel accessing them due to trust relating to security and how information is used

- There are children not accessing any form of support to talk about family related problems as they are worried about in speaking to someone this would lead them to being 'taken into care'. There were two children from Year 8 at Havelock who talked very openly about problems at home and neither wanted to get any help because they were worried that this would lead to them being taken out of their homes - even though clearly there were problems at home that were causing them stress. To me this raised questions about where such children can access help in situations like this, and how can information about services that may be available to help be accessible to them. This was dealt with by a teacher

CAMHS Young People's Participation Group
(4 young people, 2 staff. Young people mix of school, college and one at university).

How easy was it to access the CAMHS Service

Were referred via school nurse or GP. Found it easy; one talked to school nurse then found someone coming into school to see them; with one commenting that there was a wait from referral to first appointment. Some stressed that they had been at crisis point when they first sought or were taken for help. Some commented that they wished they had sought help/ known about CAMHS earlier. Despite the ease of referral they found the experience "pretty scary at the time". The young people had formed positive friendships with people as result of CAMHS service, including with other YP using the service - they valued the shared experiences and understanding that other young people were going through same issues/ problems/feelings.

Everyone commented on how good the service was once they were accepted in to it and that it had tried a range of interventions and therapies to help them understand and work with their illnesses. They felt that the service was very targeted on them as an individual, with a mix of individual and group interventions: "We can be difficult - we are challenged and always find a way to sort it (our problem / illness) out" "I achieved little milestones that were massive for me. Now I do things I could not have imagined three years ago, like drive, go to Uni, have a relationship".

What other support was available to them, or where did they feel that there were gaps?

They had not known about CAMHS before they were referred; subsequently one had used Open Minds and Navigo. Nobody commented on other services available.

There was unanimous agreement that more support needed for their parents. They welcomed the parents' group set up by CAMHS but felt it needed more promotion. Developing this was seen as the biggest need to improve the service. Worker indicated that this had been incorporated into pathway.

They were pleased that CAMHS was setting up a new website, and some had been involved in its development. The next group session is to focus on whether the website meets their needs, plus a review of self-help materials.

New "passport" being introduced (and co-produced from NHS model) which the YP thought was very helpful in making it easy for them to tell their story in new settings without having to go back over everything. The passport was described as "genius" and "perfect".

One YP had benefitted from, and valued, family therapy sessions, but these are no longer commissioned.

What are main problems that young people encountered?

Three reported stigma as a problem, or that they hid attendance at CAMHS as a result of negative attitudes or reactions from other students. One reported very positive support by school, but only after a teacher had told the class about problems and brought issue into public in first place.

Bullying was identified as a major issue by all the young people - physical, on line and psychological, with this latter being the worst. They felt that schools struggled to deal with it and gave example of teacher joining in (and subsequently dismissed by school).

The young people agreed with the other young people that we spoke to, that exclusion is used to manage behaviour.

The young people said that they knew most of what little they had found out about young people's mental wellbeing at school and felt this should be part of the curriculum. They gave examples of schools not knowing how to respond; of inappropriate language ("freak", "nutter") used in school by other students. They felt that mental health should feature in the curriculum and discussions at school, citizenship etc. from a young age so that stigmas were broken down and prejudices were challenged. (The Youth Action Group also told us this). However, they did feel that it was changing as younger children were exposed to storylines on tv etc.

Transition

Both the process of transition and the different culture of Adult Mental Health Services were raised by the young people.

One to one conversations with people on the stakeholder list and others as identified during the course of face to face meetings.

Key themes:

- Number of children needing a service is increasing. This comment was made consistently by all service providers
- Number of presenting factors has increased. CYP are presenting with more complex needs and with three or more conditions
- Access to CAMHS is difficult as you need a clinical mental health diagnosis to trigger an assessment: "You have to say you are going to commit suicide to get in. "(Young Person in focus group). Young people know how to play the system
- CAMHS is good when you get into it – but you cannot access it easily. This was a repeated theme
- There is nothing available in the community for low level early intervention: "There used to be Asgard but it's not available now" (Experienced Service Provider)
- There is a lack of early help provision. – Many respondent described frustration in not being able to get CYP into CAMHS and not having anywhere else to send them to. Frustration coming from awareness that early intervention will reduce the pressure on CAMH services later on as well as improving the life chances for Young People
- Children shouldn't be handed off to other services. Services should be brought to the child and co-ordinated by the key worker who has the best relationship with the child and family. Schools and service providers would like to do more themselves but they lack the confidence in tackling issues
- Vulnerable children of substance misusers are often not getting help and the evidence is that they are of increased risk of developing mental ill health
- Lots of parents have depression and unresolved issues relating to their own childhoods. (Both NSPCC and FAST raised this). This means they struggle to support their children in a positive way
- Priority is building resilience in young people
- There are a lot of problems in society that contribute e.g. social media makes it easier to bully online or groom a young person
- Services report seeing increasing numbers of young people who self – harm
- Sometimes the referrals to CAMHS can be inappropriate and poor quality could come from lack of understanding of what CAMHS can do. Also, lack of awareness of what other services are available creates assumption that CAMHS is the only option
- CAMH service is well defined but not always understood
- 72% of LAC cases could have been avoided if intervention was earlier
- "In other areas authorities have worked at different levels; i.e. sub clinical – with children who are reluctant school attendees"
- Anxiety increases around the time of exams – CYP cannot have a nurturing caring environment when whole focus is on exams

- Schools support to CYP for emotional wellbeing is variable with some doing it really well
- The Home Office is concerned about children with multiple vulnerabilities who are not connected to any service
- The Professional advice line is good
- Parents get mixed messages from services that all have a different approach. Health visitor may say one thing and a community development worker something different
- No evidence of multi – agency working there are multi – agency planning groups and these were described as 'meetings' with little evidence of 'doing'
- Mental Health Care Pathways were articulated by a number of interviewees but they could not be produced – do they exist – do people understand them?
- Greater training is needed for all staff as many only had EMWB training in their professional qualification course which could have been 10 years ago
- There is a need to consider the role of schools and what they can provide
- Very few (5%) of Youth Offenders are able to access CAMHS due to a high level assessment criteria. 80 – 90 % of young offenders have mental health issues often multiple issues but few progresses to receive help
- There is a large gap in the middle – top 5% are seen by CAMHS (which they do very well); there is support for the mild issues but not for the ones who fall in the middle who have multiple or more complex needs and no mental health diagnosis. Needs can arise from attachment issues, abuse, which doesn't fall into CAMHS criteria
- CAMH service works for Looked after children as they get a priority route through a LAC pathway, (the pathway was not seen during the meeting)
- Parents of CYP with special educational needs find the system frustrating because there are long waiting times, the service criteria is very tight and there is little room for manoeuvre
- Parents don't feel supported rather that there is a gate keeper keeping them out and offering nothing
- Schools decided to buy own services but many do not and prefer to exclude instead
- GPs don't seem to know what to do and give wrong advice re services. They don't know the pathways or what services are available from 3rd sector such as Barnardo's Outreach Service. One parent told could not access autism /behavioural pathway unless attended the parenting skills course (which was full); while they also refer to behavioural course instead, even though the course had stopped due to there being no funding
- Lack of victims support for young people who have been victims of harmful sexual behaviour. Need to provide a therapeutic intervention support to minimise future mental health issues

Third Sector organisations:

- Sometimes asked to provide support where there are group behavioural issues or individual exclusions
- Working with Academies is challenging and difficult. Some are better than others; it is fragmented
- They are often asked to contribute to surveys and consultations and then receive no feedback
- Children's services have put very little work out to the VCS and had no discussions regarding CAMHS provision
- Family Hubs still only offer services to very young children with little to offer teenagers
- At a recent engagement exercise the community group got 80 people to contribute. Results went into the council and no further action was taken
- There is a query raised as to whether wider understanding is there
- GPs and other services are not knitted together and GPs don't understand housing issues and sofa surfing etc

Schools:

An online survey to gather schools' views on how to meet children and young people's emotional and mental health needs was carried out in early 2016. 81 responses were received, from at least 18 schools (it was not possible to identify all the schools as this information was omitted by some respondents). 26 (32%) respondents stated that staff in their school had accessed training in emotional and mental health needs. The most common responses were: self-harm, understanding bereavement and loss, attachment, CAMHS pathways and referrals, and youth mental health first aid. Most schools stated that only a small percentage of the school workforce had accessed training. The vast majority of schools were accessing training from North East Lincolnshire Council, rather than sourcing their training from other providers. This is a positive factor as it enables both confidence in the quality of training that schools are accessing, and the opportunity to tailor it to ensure that local pathways and processes are understood.

43 schools (53%) were aware of a range of external services to support children and young people with emotional and mental health. Barnardos, Fortis, the NSPCC and North East Lincolnshire Council were the most commonly cited. Most schools identified that they would like to access more support, although a significant number were not sure what this might look like. A number of schools identified that the support which is available from CAMHS is difficult to access, and they would like it to be available to a wider group of children and young people. Many schools stated their willingness to work with partners to meet the emotional and mental health needs of children and young people, and were keen to access advice/support on how best to do this.

Community focus groups

There were two community focus groups held:

NSPCC

A group of 9 children aged 10 – 16 years, boys and girls. All have parents with mental illness problems. Key themes:

- If they felt worried or stressed they would speak to someone
- Some would speak to a teacher and some definitely would not (back to trust and relationship issues)
- Face to Face preferred as the communication route
- They would like to be seen as soon as possible
- Only three had any idea that Emotional Wellbeing was about 'feelings' the rest had no idea and hey unanimously wouldn't use the term in promotional materials

Youth Action Group (YAG) of the Youth Parliament

A group of eight young people and two staff aged from 15 to 18.and from a mix of different schools. This group are an 'engaged group' with 'engaged' parents and their responses mirror the ones of others in similar circumstances.

Key themes:

- If they felt under pressure they would talk to their parents or take positive action such as go for a walk
- Stress, exams, bullying, getting grades and an emphasis on 'grades not people' in the schools were cited as negative factors. 6 of the 8 had at one point been bullied with one moving school and another describing this as an option under consideration. They described strategies for removing themselves from bullying situations such as 'throwing a sickie' and getting sent home to hiding in the toilets to avoid lessons with bullies in them. All felt schools underestimated the problem. One reported homophobic bullying which was not nipped in the bud. Schools often deal with it by putting the victim in isolation which makes them suffer more
- There was some awareness of what was available if they needed help or support with emotional wellbeing. They learnt about what was available at the YAG not at school. They felt that MH should feature on the school curriculum

- Schools were seen as a real problem as bullying for people identifying mental health issues was a problem. There are also perceived blockages to referral for help in schools as you have to go through a lengthy internal process before you get help
- Different arrangements at different schools causing issues
- Where there is a counsellor it is difficult to get to see them and you don't want to be brought out of class as everyone would know
- Perceptions that the service was poor and the person giving support was unqualified and dragged out from behind the reception desk to give support
- School nursing service varied with some offering a daily service and others a monthly service. Drop in 1 Wednesday a month and not always the same nurse so no continuity
- Behaviour was described as a 'massive issue' which affects everyone while the teacher is dealing with the naughty child the others lose out on teaching time. 'Those that behaved badly got the focus'. Several YP described regular fights but others said it was rare. It was managed through temporary exclusions which didn't work. 'It depends on the parents and their attitudes'
- Views on the CAMHS service – 'it is choc a bloc 'and for the very hard core cases with many issues. People play the system as they know what to say to get in. You have to be on the verge of suicide to get in. Rejection letters from CAMHS don't offer any suggestions for other support – just that you aren't serious enough to be seen – promotes an incentive to pretend to be sicker
- What would improve things? More money for services, more compassion, more and better publicity and information. Mental health should be in citizenship lessons! Teachers need more knowledge and training as well and we need more 'Are you okay?' cards

Online survey for professionals

104 people answered the survey but not everyone answered every question. Responses received were from teachers and other school staff; GPs; Community health staff; Acute staff; CAMHS staff; Youth Offending Team; Children's Social Care; Family Support/Troubled families; Youth Service; Voluntary and community sector and Housing.

- 63% strongly agree and 33% agree that the numbers of children with emotional and mental wellbeing issues is growing
- 51% strongly agree and 44% agree that the complexity is increasing
- The three most common problems presented are;
  - > Attachment difficulties, Anxiety (including phobias, social phobias, panic disorders, generalised anxiety disorder)
  - > Drug and alcohol issues and depression/feeling low
- 57% said children present with 3 or more issues and 37.5% say two or more issues
- The most common social challenges causing emotional responses are;
  - > Abuse and neglect
  - > Family difficulties
  - > Exposure to domestic violence
- When asked about their own role – on a scale of 1 to 10 with 1 being low and 10 being high, nobody scored themselves above 3 for confidence in undertaking activities with CYP. The highest score was for running group sessions but supporting individual YP scored 1.5
- When asked about training they have received for Emotional and Mental Health 32% (the highest group) last received training when they qualified, 17% had never had training
- When asked what would be the most effective in making staff feel confident and supported around CYP EMWB everyone echoed the same message;
  - > Training
  - > Time
  - > Support
- 72% of respondents felt they knew what services are available to support CYP
- 35% felt it was easy to make a referral to CAMHS, 36% were ambivalent and 28% disagreed it was easy to make a referral
- 18% agreed CAMHS could see children quickly with 45% disagreeing and the rest neither agreeing nor disagreeing
- 31% agreed that CAMHS provided good feedback on referrals, 22 % didn't and 46% neither agreed nor disagreed
- 39% felt that joint working with CAMHS makes it easier to incorporate an YP needs into a care plan, 16% didn't agree and 45% neither agreed nor disagreed

When asked what is good about the current system the responses included:

- Direct work with children and parents
- The referral system is quick and efficient
- School Nurses been trained to deliver CBT
- When CAMHS accept and work directly with a child
- That we are paying attention to the need for support
- Think it is really positive that CAMHS is out there for families to access
- That we do have a service
- I feel the system is good but the level of need outweighs the capacity available to provide a consistent and effective offer
- Quick access to high quality CAMHS

When asked what needs to be improved responses included:

- Not enough capacity (more than once)
- Lack of funding
- More services to be available
- More acceptance
- Funding for services, clear pathways and support
- Shorter waiting lists and quicker response times
- Training and support with behavioural problems
- Another tier of mental health services for young people that do not fit CAMHS criteria
- Access to lower level support/ IAG for practitioners
- More counselling

When asked to identify gaps:

- Lack of staff and support
- Not meeting CAHMS criteria
- Behavioural problems
- Diagnosis and broad support
- Lower level support services

An online survey for service users.

- 16 People completed the survey
- When asked what does emotional wellbeing mean? 15 people responded with a range of responses. 14 of them were positive and had some understanding of the term and one felt it was healthy eating
- When asked what they do if they have a problem or worry 13 would talk to someone and only 3 would keep it to themselves or internalise it. No one volunteered any negative actions
- When asked who would you talk to? 15 would talk to a partner, parent, friend or a family member and only one spoke about a clinical person at a refuge

Paper questionnaire to be delivered directly to young people, parents and carers in the community.

102 people completed the survey – broken down by ward as follows:

Under 15s

- 8 – No address
- 6 – Humberston & New Waltham
- 4 - Park
- 4 - Scartho
- 3 – East Marsh
- 3 - Haverstoe
- 3 – Waltham
- 2 – Sidney Sussex
- 2 - South
- 2 - Yarborough
- 1 – Croft Baker
- 1 - Freshney
- 1 - Immingham

16 – 24

- 5 - Immingham
- 3 - Heneage
- 3 - Park
- 3 - Blanks
- 2 – East Marsh
- 1 - Freshney
- 1 - Yarborough

25 +

- 1 - Park

- **When asked 'do you know what emotional wellbeing means?' Only 7 didn't know and the rest gave acceptable answers.**

- **When asked what you do when you have a problem or you are feeling stressed.**

  - 70% would talk to parents/ teachers/family members
  - The rest would keep it to themselves or do nothing

- **The preferred confidantes would be:**

  - Close family/friend
  - Mum, Dad or teacher
  - Boyfriend or girlfriend

- **When asked to list known routes to support the most commonly cited were:**

  - Psychologist / counselling
  - Family/teachers
  - Doctor
  - 10% did not know of where to go

- **When asked how they would access this support the top three were:**

  - Internet /phone
  - Speak to school/parents
  - The Doctor

- **When asked if they or their friends wanted support or advice on emotional issues 62/99 said no. (62%)**

- **Responses to 'what would this support be?' were mixed including someone to talk to, come into school, counselling, and less pressure for exams**

- **This support should be provided at home, visits and school**

- **Respondents would like to be seen as quickly as possible and some are prepared to wait 'a couple of weeks'**

Engagement Conclusions

- In excess of 300 people gave their views of Children's and Young people's Emotional and Mental Wellbeing Services. They were a combination of Commissioners, Managers, Providers, Clinical Staff, Children and Young People and their parents and carers
- It is accepted that the number of CYP presenting with emotional and mental wellbeing issues is increasing and the complexity of their conditions is increasing
- There appears to be little support provided for those with low and medium level emotional and mental wellbeing issues. If there is support then it is either over – stretched or unknown to the system. There needs to be a focus on prevention and early intervention
- Pathways for emotional and mental wellbeing are referred to but nobody can produce one. It appears as if they possibly existed in the past and haven't been reviewed
- The CAMH service is acknowledged as a good service if you can access it. The thresholds are too high for the needs of the majority of CYP and service providers
- The workforce acknowledges the issues and has identified training needs to be able to cope better with issues in the community rather than 'handing off' young people
- There is an acknowledgement of the complex lives lived by some CYP and the effect of the wider determinants of health and their families on their ongoing mental health
- Some schools have excellent examples of support for primary school children which falls off as they get older and collapse by year 8. Schools are using exclusion to manage behaviour and exclude automatically for single issues. Last year there were 64 exclusions of which 57 remain excluded. Young people in groups talk about the impact on a class when the teacher is trying to manage behavioural issues. Schools do not explore underlying issues as they don't have the skills, time or capacity to do this. Early intervention is entirely missing in some schools and parents use school as first point of call for advice. There is a perception that the school nursing service is underfunded and sometimes there is only a day or two of provision each month

Findings

Promoting resilience, prevention and early intervention

The current model for meeting emotional and mental health needs is currently based on a high quality, specialist service, responding predominantly to crisis and complex presentations. By this, we mean that on the whole, children and young people do not receive a service until their difficulties have become so significant and entrenched that a formal diagnosis can be made. Furthermore, most children and young people who enter the system do so at a point of crisis, where their presentation requires an urgent or emergency response and their difficulties are both having a significant adverse impact on day to day functioning, and pose a long-term risk to their health and well-being. To make an analogy, this is akin to a model of diabetic care that is only accessible following diagnosis with type II diabetes, and where most diabetics do not access support until their condition is so poorly managed that they present with an episode of ketoacidosis.

The service is highly effective in supporting those young people with the most complex needs to be cared for at home, rather than to be admitted to a CAMHS inpatient unit. There is very little evidence of preventative or early intervention approaches. This view was echoed by every professional we spoke to, and the young people themselves. One young person told us that CAMHS is only for young people who have attempted suicide.

North East Lincolnshire is embracing a preventative, early help strategy, based on a network of family hubs. A programme to redesign early help services across the 0-19 pathway has been initiated. This is an excellent opportunity to embed support for emotional and mental health into the overall offer for children and young people, and bridge the treatment gap which means that only around 1,000 of the 3,000 children and young people with emotional and mental health needs are getting a service.

Improving access to effective support – a system without tiers

North East Lincolnshire are at an early stage in their conversation about what system could replace the tiered model. The THRIVE model developed by the Anna Freud Centre and the Tavistock Clinic would sit well with the overall direction of children's services locally and should be explored in more detail.

Care for the most vulnerable

There is a good understanding of the needs of vulnerable groups in North East Lincolnshire and the commissioning of specific dedicated provision for looked after children and young people, young people who have offended, young people with substance misuse problems and young people with learning disabilities is to be commended. This builds a very strong foundation for addressing the needs of these groups more fully in the future, but there is some way to go. There are still some significant gaps – for looked after children, these are for those with less complex needs; conversely, for young people who have offended or have substance misuse issues, the gap is in being able to access a more specialist intervention from CAMHS before a crisis occurs.

Accountability and transparency

North East Lincolnshire benefits from a clear, strong integrated commissioning approach, with the Council acting as lead commissioner via a Section 75 agreement.

The CAMH Service will be re-commissioned in 2017/18, and the National Mental Health Services Dataset will be incorporated into the 'information' element of a new specification.

Developing the workforce

Through joining the IAPT initiative and a set of competencies for the children's workforce, North East Lincolnshire is moving in the right direction in terms of a capable and effective workforce. However, the level of ambition needs to be significantly increased.

The current strategy to up-skill key staff groups could be extended over time so that across the workforce, particularly in the voluntary and community sector, staff can deliver counselling and more straightforward evidence based interventions, rather than needing to make a referral into CAMHS.

Conclusion

The major and over-riding conclusion of this needs assessment is that the system does not meet the needs of children and young people with low level emotional and mental health needs well. We think it is probable that this means that a disproportionate number of children and young people tip over into crisis, creating a vicious cycle where specialist mental health resources are focussed on the smallest group of children and young people with the highest needs.

This is acknowledged locally and highlighted in the local transformation plan for emotional wellbeing and mental health. The plan recognises the importance of intervening from the ante-natal period and in the early years, supporting families and those who care for children and building resilience through to adulthood, reducing the demand for specialist services by preventing children growing up and experiencing complex family issues.

Recommendations for future commissioning

- The current system is heavily reliant on a specialist CAMH Service. This means that only those with the most severe presentations are assessed and treated. As an integral part of Future In Mind implementation, a proactive shift to early intervention and easily accessible support in schools and voluntary sector provision is planned. This should be reinforced with a much greater degree of capacity in services for the most vulnerable children and young people (particularly children in need) to understand and engage with emotional and mental health needs. Referral to CAMHS should become the exception rather than the default
- Where specialist CAMHS are required, they need to be available at times which are more convenient to children, young people and families. Commissioners should consider whether early morning, evening or weekend sessions would enable the service to be more accessible and have less negative impact on school attendance
- A key next step will be to engage with schools to identify what they are currently commissioning/providing to support emotional and mental health. A desired outcome would be the commissioning of a consistent, easily accessible schools based service, available to both children and parents on a drop in basis

- Support for parents to manage behaviour well is the most needed and effective intervention for children at the pre-school and primary school phase. NEL should commission evidence based parenting group programmes as part of the core offer in family hubs
- The THRIVE model should be considered as a way to move away from tiers and ensure that services are arranged around the needs of children and young people
- There is a gap in early emotional and psychological support for children and young people with long term health conditions. The current system is set up only to provide a response where needs have escalated to a diagnosable medium/severe condition. A psychological support component should be developed for each physical health pathway, which identifies how children and young people will be supported to maintain motivation for managing their conditions effectively, and adjust to the challenges and stigma that accompany many physical health conditions
- The pathway for young people who have offended needs to be reviewed. There are notable innovations in this area (training YOT officers in CBT) but young people with more complex needs are not being addressed
- Continued attention needs to be given to the relatively low numbers of young people presenting with an eating disorder. Whilst it is plausible that this may reflect a specific local response to emotional difficulties, there is not a strong research base to support this. An independent review from a paediatric eating disorder specialist should be commissioned to identify if further action is required

Appendix 1

Stakeholders Involved in the Development of this Report

- Jane Fell, NLAG lead LAC Nurse, Northern Lincolnshire and Goole NHS Foundation Trust
- Steve Kay, Director Prevention and Early Intervention, North East Lincolnshire Council
- Bill Geer, Commissioner drugs and alcohol services, North East Lincolnshire Council
- Diane O'Keefe, FAST, Service Manager
- Claire Parfrement, Participation Officer, North East Lincolnshire Council
- Jenny King, Cluster Coordinator (teenage pregnancy), North East Lincolnshire Council
- Donna Benefer, Family Hub Advisor, North East Lincolnshire Council
- Karen Tees, Family Hub Advisor, North East Lincolnshire Council
- Liz Cullum, Family Hub Advisor, North East Lincolnshire Council
- Rachel Grayson, Family Hub Advisor, North East Lincolnshire Council
- Dawn Trigg, Macmillan Specialist Nurse, Hospice
- Alfie Hallett, YPSS, North East Lincolnshire Council
- Paul Caswell, Youth Service, North East Lincolnshire Council
- Scott Jacques, REP from Wells Springs Alternative Education
- Vans Braddock – Mead – Practice Lead – Foundations
- Sue Proudlove, NSPCC
- Stef Fox – Chair of Sexual Harmful Behaviour Panel - NSPCC
- Sue Sheriden, NEL Local Children's Safeguarding Board, North East Lincolnshire Council
- Judith Kilvington, Barnardos
- Paul Glazebrook, Partnership Co-ordinator, North East Lincolnshire Healthwatch
- Sarah Wise, Consultant Midwife, Teenage Pregnancy and Sexual Health / Supervisor of Midwives, Northern Lincolnshire and Goole NHS Foundation Trust
- Sharon Ainslie, Sexual Health Facilitator for Yorkshire, Humber and North East, Public Health England
- John Noton – Practice Manager Forum – Dr Hopper & Partners
- Debbie Woodward, Empower

- Linda Dellow, Chief Officer, Centre4
- Stephen Pintus, Director of Public Health, North East Lincolnshire Council
- Matt Clayton, Youth Offending Service, North East Lincolnshire Council
- Carolyn Beck – Health Promotion Programme coordinator – Lifestyle Services NELC
- Jim Hudson, YMCA
- John Manton, YMCA, Contracts Manager
- Joanne Hewson, Deputy Chief Executive, North East Lincolnshire Council
- Paul Cordy, Director Children's Social Care, North East Lincolnshire Council
- Nathaniel Heath, Behaviour Collaborative
- Claire Thompson, Communications and Marketing, North East Lincolnshire Council
- Debbie Haines, Learning & Development Team Manager, North East Lincolnshire Council
- Tracey Urquhart, Consultant Lead Psychologist/ Service Manager, CAMHS North East Lincolnshire
- Mark Fenty - MD - GHoPA
- Sean Snelson – GhoPA, Admin & Finance Director
- Suzanne Bradbury, Principal Educational Psychologist, North East Lincolnshire Council
- Bright Minds Group
- Clare Ward, SEN Services Manager, North East Lincolnshire Council
- Maggie Atkinson, assigned lead/ Director with IMPOWER
- Wendy Shelbourn, Head of Integrated Family Support Service, North East Lincolnshire Council
- Ashley Wyatt NHS, CAMHS lead
- Annie Darby, Adult and Children's Safeguarding, NaviGo
- Caroline Lee, Navigo, PNMHS (Perinatal Mental Health)
- Amanda Simpson. Eating Disorders, NaviGo
- Mike Reeve, Navigo, Eating Disorders
- Marie Fitzgerald - Chair North East Lincolnshire – Parent Participation Forum
- Angie Dyson, Service Lead, North East Lincolnshire Clinical Commissioning Group
- Megan Dennison, Group Manager Children's Social Care, North East Lincolnshire Council
- Bob Ross, Head of Children's Health Provision, North East Lincolnshire Council
- Michelle Barnard, Assistant Director, North East Lincolnshire Clinical Commissioning Group
- Pip Harrison, Advanced Practitioner, CSSU, North East Lincolnshire Council
- The participants of the Attachment Workshop Focus Groups

Focus Groups

Thanks to the Staff and Young people who took part in Focus groups

- NSPCC
- Youth Action Group
- CAMHS Patient Participation Group

Thanks to the Teachers, Staff and School Nurses who took part in the consultation and the young people from the four schools involved in School focus groups.

- Middlethorpe Primary Academy
- East Ravendale Primary School
- Havelock Academy
- Oasis Academy Immingham

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