South Gloucestershire

Children and Young People's Mental Health Needs Assessment

March 2016

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South Gloucestershire Council

Contents

1. Introduction

The South Gloucestershire Children and Young People's Mental Health Needs Assessment (CYPMHNA) is the first of its kind for South Gloucestershire, and is complementary to the recently completed South Gloucestershire Adult Mental Health Needs Assessment.

The CYPMHNA explores the current and projected mental health needs of children and young people in South Gloucestershire aged 0-18 years taking into account risk and protective factors, service provision, and the potential consequences of poor mental health across the life course.

The CYPMHNA collates data and evidence with the experience and views of children and young people, their parents and carers, and health professionals.

1.1 Definition of mental health and wellbeing

The World Health Organization (WHO) defines 'mental health' as: [1]

"*…a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*"

The importance of mental health in determining the holistic health of an individual is clearly stated in the WHO's constitution: [2]

"*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*."

By contrast, 'mental health problems' have been defined as conditions affecting an individual's mood, thinking and behaviour to a degree that impacts significantly on their ability to function within different areas of life. [3]

These definitions stress the importance of treating physical and mental health equally to achieve 'parity of esteem'. To succeed in this requires health professionals to reconsider how they treat individuals, addressing the needs of the whole person rather than separately treating their physical and mental health. This is particularly important when considering the relationship between physical and mental ill health, as illustrated in Figure 1.

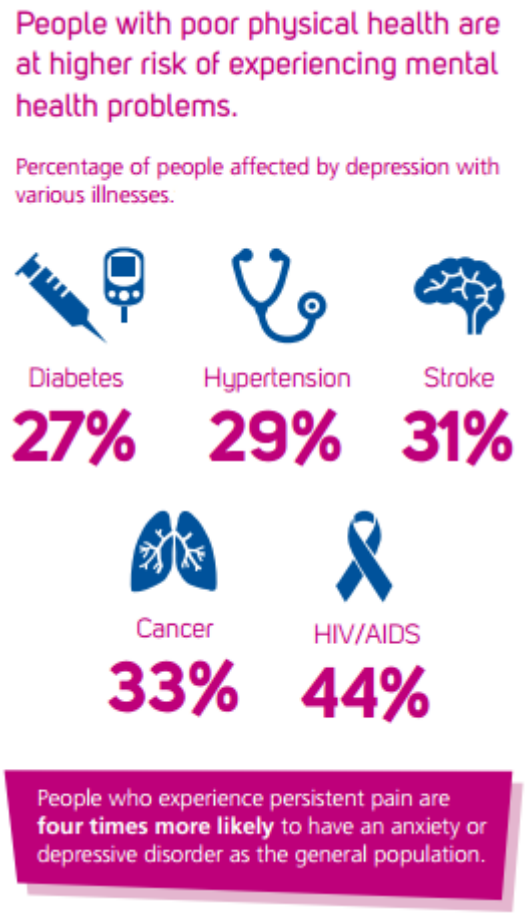


Figure 1 - The percentage of people affected by depression with various illnesses (from NHS England's A Call to Action: Achieving Parity of Esteem; Transformative Ideas for Commissioners) **[4]**

[1] WHO (2014) Mental health: a state of wellbeing. Available at: http://www.who.int/features/factfiles/mental_health/en/ (accessed 30/09/2015).

[2] Ibid.

[3] Law et al. How big an issue is children and young people's mental health? Young Minds doc from Steve

[4] NHS England (2013 – check this) A Call to Action: Achieving Parity of Esteem; Transformative Ideas for Commissioners.

1.2 Child and adolescent mental health

The last survey of the prevalence of mental health problems in children and young people in the UK was conducted in 2004. At that time, nearly 850,000 (9.6%) children and young people aged 5-16 were estimated to have a diagnosable mental health disorder. The study found that the prevalence was greater among 11-16 year olds at 11.5%, or about 510,000 young people, compared to 7.7%, or nearly 340,000 children aged 5-10. [5] Applying the national prevalence to South Gloucestershire it is possible to estimate that around 4,800 children and young people aged 5-19 may have a mental health problem.

It is well documented that a range of risk and protective factors can affect whether a child or young person will develop a mental health problem. These factors can relate to a child's personality, family, socio-economic status and environment, as Table 1 shows. An awareness of these factors can support professionals to develop effective prevention and early intervention services, as well as services for those in need of more intensive support. [6]

Table 1: risk and protective factors, CYP mental health

Child risk factors	Family risk factors	External risk factors	Protective factors
Poverty Family breakdown Single parent family Parental mental ill health Parental criminality, alcoholism, or substance abuse Overt parental conflict Lack of boundaries Frequent family moves/being homeless Over protection Hostile and rejecting relationships Failure to adapt to the child's developmental needs Caring for a disabled parent School non-attendance	Learning disability Abuse Domestic violence Prematurity or low birth weight Shy, anxious or difficult temperament Physical illness Lack of boundaries Looked-after children Lack of attachment to carer Academic failure Low self-esteem Young offenders Chronic illness	Unclear discipline at school Failure to recognise children as individuals at school School exclusion, including school refusal Bullying, including cyber bullying Peer rejection/peer pressure	A good start in life and positive parenting Being loved and feeling secure Living in a stable home environment Parental employment Good parental mental health Activities and interests Positive peer relationships Emotional resilience and positive thinking Sense of humour Full engagement with education

The development of effective services also needs to consider the relationship between mental and physical health, as approximately 12% of young people live with a long-term condition that can increase their risk of poor mental health between two to six times. Conversely, having a mental health problem puts children and young people at greater risk of physical illness, with depression increasing the risk of morbidity by 50%. Furthermore, individuals with mental health problems, such as schizophrenia or bipolar disorder, die 16-25 years sooner than the general population. [7]

The cumulative effects of adverse experiences and environmental circumstances, such as domestic violence, and poverty, all leave their mark. A single risk factor is thought to result in a 1-2% chance of developing a mental health problem; increasing to an 8% chance in the presence of three risk factors, and a 20% chance with four risk factors. [8] Without help and support at the right time and in the right place, risky behaviours and poor psychological resilience can persist into adulthood. [9]

Approximately 10% of the population of South Gloucestershire are living within some of the most deprived neighbourhoods in England (see Figure 2) [10]. Socio-economic disadvantage is a significant risk factor for poor mental health in children and young people, with those growing up in the poorest households at three times greater risk for developing a mental health problem compared to those growing up in less deprived homes. [11][12] Furthermore, deprivation can underpin a range of other risk factors within the family unit, schools, and communities, touching on every aspect of a child's future, including their mental health outcomes. [13]

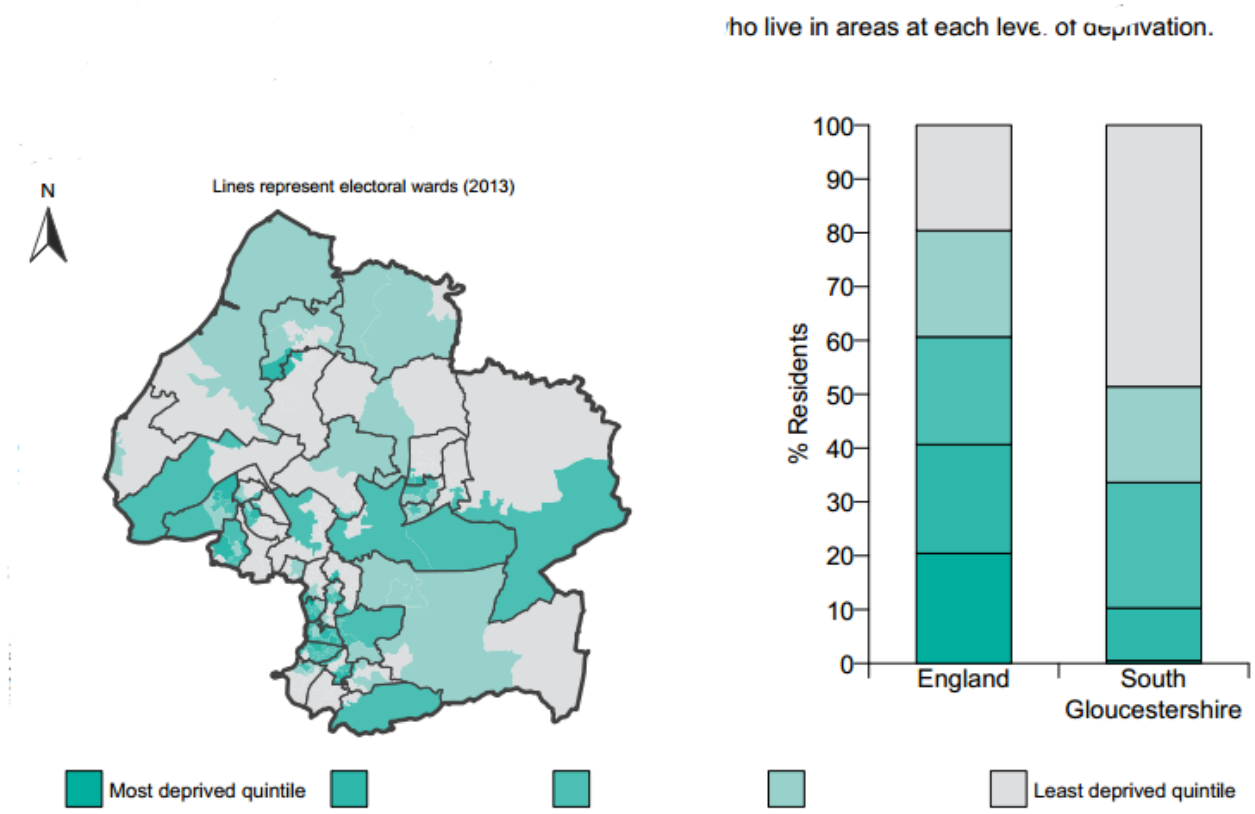


Figure 2 - The map shows differences in deprivation within South Gloucestershire and the chart shows the percentage of the population who live in areas at each level of deprivation (from Public Health England's South Gloucestershire Health Profile)

To put a halt to the accumulation of risk factors in children and young people, early intervention services have proven effective at providing swift action in response to emerging problems from conception to young adulthood. Importantly, early intervention offers the chance to make lasting

improvements to the lives of children and young people, terminating the transmission of persistent social problems from generation to generation. [14]

[5] Green et al. (2005). Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

[6] RCN (2014) Mental health in children and young people. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0003/596451/RCNguidance_CYPmental_health_WEB.pdf

[7] Future in Mind

[8] DfEE (2001) Promoting children's mental health with early years and school settings. Available at: http://www.mentalhealthpromotion.net/resources/promoting-childrens-mental-health-with-early-years-and-school-settings.pdf

[9] Law et al. How big an issue is children and young people's mental health? Young Minds doc from Steve

[10] South Glos health profile PHE

[11] Green H, McGinnity A, Meltzer H, Ford T, Goodman R: Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan, 2005.

[12] CMO 2010 report

[13] Marmot review

[14] Cabinet Office (2011) Early intervention: the next steps. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284086/early-intervention-next-steps2.pdf

1.3 The cost of mental health

The Centre for Mental Health reports that in 2009/2010 the total cost of mental illness was £105.2 billion in England alone (see Figure 3). In children and young people, mental health problems are associated with additional annual costs estimated between £11,030 and £59,130 per child in the UK. These excess costs are shouldered directly by affected families, and a range of agencies, including education, social services and youth justice. By providing effective early intervention services, significant life-long savings can be made in each case. For example, the lifetime costs of a one year cohort of children with conduct disorder (approximately 6% of the UK child population) is estimated at £5.2 billion, with each child affected costing around ten times more than a child

without the disorder.

Effective early intervention services have the potential to reduce the lifetime costs per case of severe conduct disorder by £150,000, and £75,000 for cases of moderate conduct disorders. [15],[16]

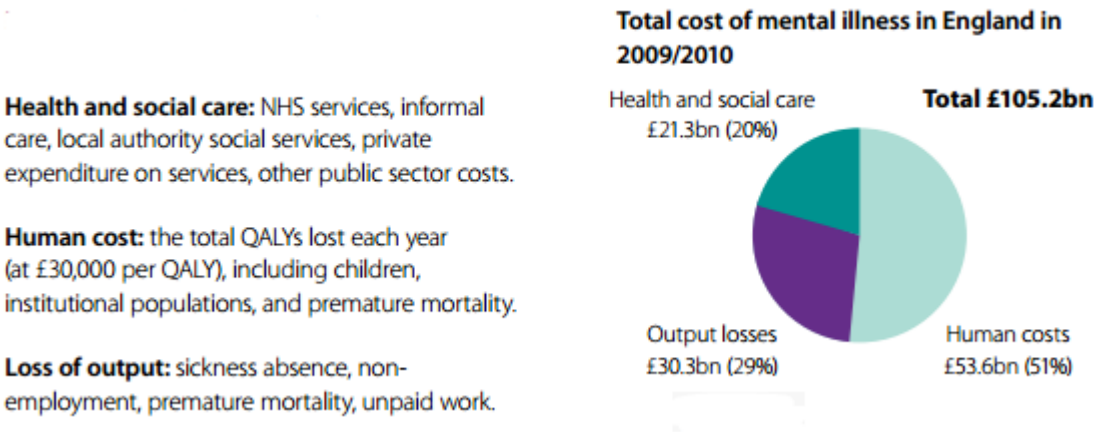


Figure 3 - The cost of mental illness in England 2009/2010 (from the Centre for Mental Health's Economic Burden of Mental Illness Cannot Be Tackled Without Research Investment)

[15] Suhrcke M, Puillas D, Selai C: Economic aspects of mental health in children and adolescents. In Social cohesion for mental wellbeing among adolescents. Copenhagen: WHO Regional Office for Europe, 2008:43-64

[16] CMO report

1.4 National policy context

The mental health of children and young people has gained significant recognition nationally, with a range policy, strategies, and national guidance. The following are key documents that have shaped the current landscape surrounding children and young people, and their mental health needs.

- Every Child Matters (2003): Outlines a vision for every child to have the chance to fulfil their potential of educational attainment, health and economic prosperity, and reducing substance misuse, teenage pregnancy, abuse and neglect, crime and anti-social behaviour.
- Fair Society, Healthy Lives (2010): Acknowledges the significance of the social determinants of health in driving health inequalities, and stresses the importance of reducing inequalities in the early years of physical, emotional, cognitive, linguistic and social development.
- No Health Without Mental Health (2011): Takes a life course approach to improving the mental health and wellbeing of the population and establishing parity of esteem between physical and mental health services, in terms of availability and accessibility.
- Chief Medical Officer's Annual Report 2012: Our Children Deserve Better: Prevention Pays (2013): Recommends that regular surveys of child and adolescent mental health are conducted to aid health service planning, and that these should include the under fives in

light of the focus of intervention during the early years.

- Closing the Gap: Priorities for Essential Change in Mental Health (2014): Challenges the health and social care community to step-up its efforts around mental health promotion and prevention, including a focus on support during maternity, early years and throughout school.
- Future in Mind (2015): A new report by the Department of Health and NHS England emphasising the need to build resilience, promote good mental health, and prevention and early intervention to safeguard the mental health of children and young people. It sets out key proposals to transform the design and delivery of services for children and young people with mental health needs.

1.5 Local policy context

The local landscape will be strengthened by the Children and Young People's Mental Health Strategy, which will respond to the needs identified here. Together with the Adult Mental Health Strategy, South Gloucestershire will work to achieve local parity of esteem between physical and mental health, reduce health inequalities, and respond to vulnerable individuals at the earliest possible moment. Existing policy includes South Gloucestershire's Children and Young People's Plan 2012-2016, the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy 2013-2016, of which all three are currently being refreshed, and findings from this needs assessment will inform their development.

2 Patterns of psychological well-being and mental health in South Gloucestershire children and young people

2.1 Risk and protective factors

As previously described mental health and mental disorders are influenced by the economic, social and physical environments in which children live. Some populations are at higher risk of mental disorders because of their vulnerability to unfavourable circumstances and their gender. Mental health risk factors encompass a wide range of fields from complications during birth, low self-esteem, family disharmony and instability, bullying, difficult life events to societal discrimination and isolation.

As data for South Gloucestershire children in relation to risk and protective factors is documented in other recent reports (such as the South Gloucestershire Child Poverty Strategy) the following data has been provided in Appendix A and should be considered when developing a strategy to improve the emotional health and wellbeing of the children and young people of South Gloucestershire

2.1.1 Maternal and family

- Low birth weight
- Smoking at time of delivery
- Under 18 conception and teenage mothers
- Child poverty
- Parental unemployment
- Looked after children
- Lone parent households
- Long term conditions/ disabilities
- Domestic abuse
- Parental alcohol and drug abuse

2.1.2 Infant and school age

- Learning disabilities
- Children providing care
- Children in need due to abuse or neglect
- School absence
- Obesity

2.1.3 Transition to adulthood

This needs assessment includes children under 18 years and further work is required to review data for this age group.

2.2 Prevalence

Data is available at UK level on the emotional wellbeing or children and the latest release of this dataset is due 20 October 2015. Nationally, it is estimated that about 10% of all children in Great Britain suffer from a mental disorder[17], with boys having a higher prevalence compared to girls, 11.6% vs. 7.5%. Older children (11-15 years old) have a higher prevalence compared to the younger groups (5-10 years old).

There are 80,860 children and young people under 24 in South Gloucestershire. Based on the national prevalence, there are about 4,800 children in South Gloucestershire, aged 5-19 who have a mental health disorder. According to the same survey, the following estimates for mental health disorders were observed

- 1776 children with emotional disorders (3.7%)
- 2784 children with conduct disorders (5.8%)
- 720 children with hyperkinetic disorders (1.5%)

- 624 children with less common disorders (1.3%) out of which 432 are for autism (0.9%)

In the 0-18 population it is predicted South Gloucestershire will experience a 9.4% increase by 2037.

In order to ascertain accurate timely data for South Gloucestershire a survey of school children was administered during 2015. The following analysis was performed using data from the survey with analysis on responses from secondary schools and post 16 groups. For the purpose of this analysis, regularly was defined as doing the activity at least once a month[18].

For Year 8 to Year 10 cumulatively, 17.3% of pupils reported being drunk regularly, while for Year 12 only the percentage more than tripled, with 62.9% of the pupils reporting being drunk on a regular basis. Girls were more likely to drink compared to boys, with 67% vs 60% reporting being drunk in Year 12. Out of those who responded that they drink alcohol regularly, girls were more likely to report being drunk than boys, with 78% compared to 71.3%.

An average of 6.3 % of the secondary school pupils have reported having tried illegal drugs, Year 12 reporting 16.3%.

While nearly 43.7% of secondary school pupils feel stressed about school work, more girls reported feeling this way compared to boys, 47.9% vs 39.4%. Year 12 reported higher percentages of pupils feeling stressed about schoolwork, reaching 60.7%.

Overall, 12.7 % of secondary school pupils considered themselves to often be in trouble at school. Younger pupils (Year 8 and Year 10) were more likely to report being in trouble than older ones (Year 12), 12% vs. 4%. Girls were less likely to be in trouble when compared to boys, 9.4% vs 15.7%.

Overall nearly 8.6% of secondary school children reported being or having someone in their immediate family who experienced domestic abuse. Girls were twice as likely to report this compared to boys (11.2 % vs 6.5%) when Year 8 through Year 12 responses were used.

Year 8 through Year 12 had a 16% overall prevalence of self-harm, with year 10 experiencing the highest prevalence of 18%. Girls were more likely to self-harm compared to boys, 23.6% vs 9.3%. Prevalence was also higher in the pupils eligible for free school meals than those who were not. The difference (22.4% vs 15.5%) could be attributed to the small numbers of pupils eligible for the free school meals which was 8.8%.

Bullying frequency also seems to be linked to self-harm prevalence. Those who reported no bullying have the lowest self-harm prevalence (11.2%) compared to those who experience bullying on a regular basis which present a prevalence of 35%-47%, respectively.

It is noteworthy that 48.5% of those who felt they should join a gang and joined reported self-harming. Of those who reported self-harming, 28% do it quite often or most days.

The numbers of pupils who felt they should join a gang are considerably smaller than those who did not feel so and the observed results could be due to this (8%). The same rationale applies for bullying, especially in the quite often and most days groups.

Older groups experienced a higher prevalence of medical treatment for injuries due to self-harm, though the numbers are small and the pattern might be attributed to this. Year 8 and Year 10 pupils present higher prevalence of still self-harming compared to Year 12.

Serious bullying seems to decrease as pupils get older, ranging from 16.8% in Year 8 to 13% in Year 12. Girls seemed to be more likely to experience serious bullying compared to boys, 15.3% vs 10.9%. The opposite pattern is observed when it comes to inability to sleep due to worrying, older pupils experiencing the highest prevalence (Year 8, Year 10 and Year 12 experiencing 29.7%, 34.6% and 43.1% respectively.

[17] Green et al, 2004

[18] Percentages do not simply match the numerator/denominator formula due to the nature of the survey. There were questions that had various follow-up questions for which a negative answer in the first question would lead to no further questions. In the case of someone denying the second question (first affirmative, quantifying second question by using zero or never) the pupils still answered all subsequent questions. For instance, when asked if they self-harm, when prompted how often they do it, only those who answered yes at the first question were asked the second one.

3. Service activity

3.1 Current national service model

Child and adolescent mental health services (CAMHS) are commonly delivered according to a four-tier strategic framework (see Figure 4), with each of the tiers representing the potential support required for differing levels of need. This model has been widely adopted as the basis for planning, commissioning and delivering services, with localised variations in its application across the country. Most CAMHS services will be provided at Tiers 1 and 2; however, there is a misconception that individuals and services fall neatly within the tiers, with children and young people progressing through them as their condition is found to be more complex. In reality, many practitioners work across tiers, while children and young people may require services from more than one tier at the same time. In theory, this framework should be used conceptually to ensure a comprehensive range of services are commissioned to meet all the needs of children and young people within an area. In practice, the tiers are used to apply rigid service thresholds that can act as a barrier to access for children and young people in need.[19]

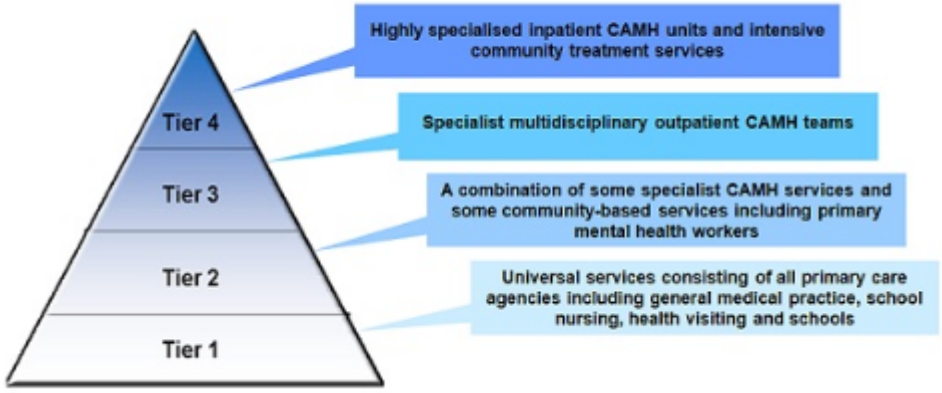


Figure 4 - The CAMHS strategic framework (from the ICP Toolkit, Scotland)

[19] Department for Children, Schools and Families, CAMHS: Four-tier strategic framework. http://webarchive.nationalarchives.gov.uk/20100202100434/http:/dcsf.gov.uk/everychildmatters/healthandwellbeing/mentalhealthissues/camhs/fourtierstrategicframework/fourtierstrategicframework/

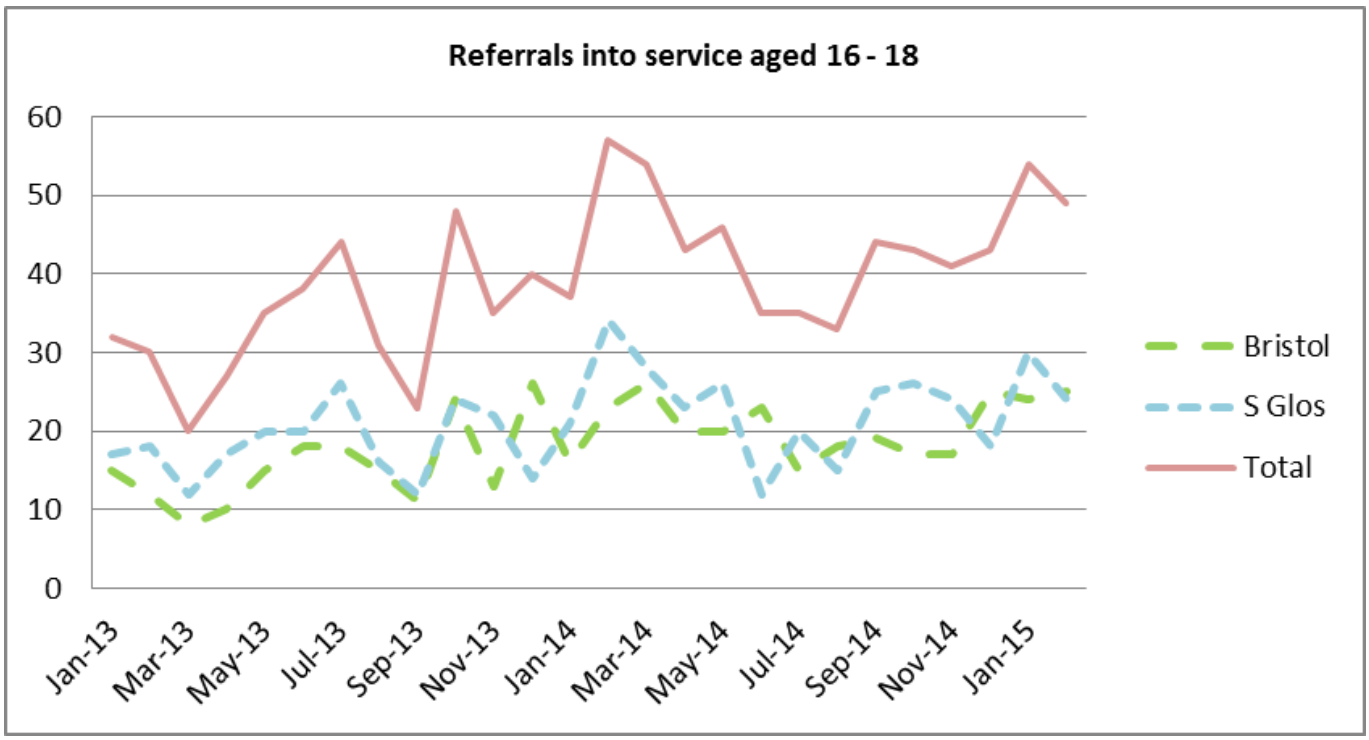
3.2 South Gloucestershire service activity

South Gloucestershire also provide services across the four tiers, although the efficacy of this model is under scrutiny. Themes emerging from a range of local stakeholder events and focus groups highlight a desire for a joined up care pathway that is clearly mapped and comprehensible by both patients and professionals, as well as a greater range of alternative interventions for children and young people who do not meet the existing service thresholds, such as talking therapies, key workers, and peer support. Appendix B provides information on services offered to South Gloucestershire children and young people at the various service tiers.

'Off-The-Record' service activity

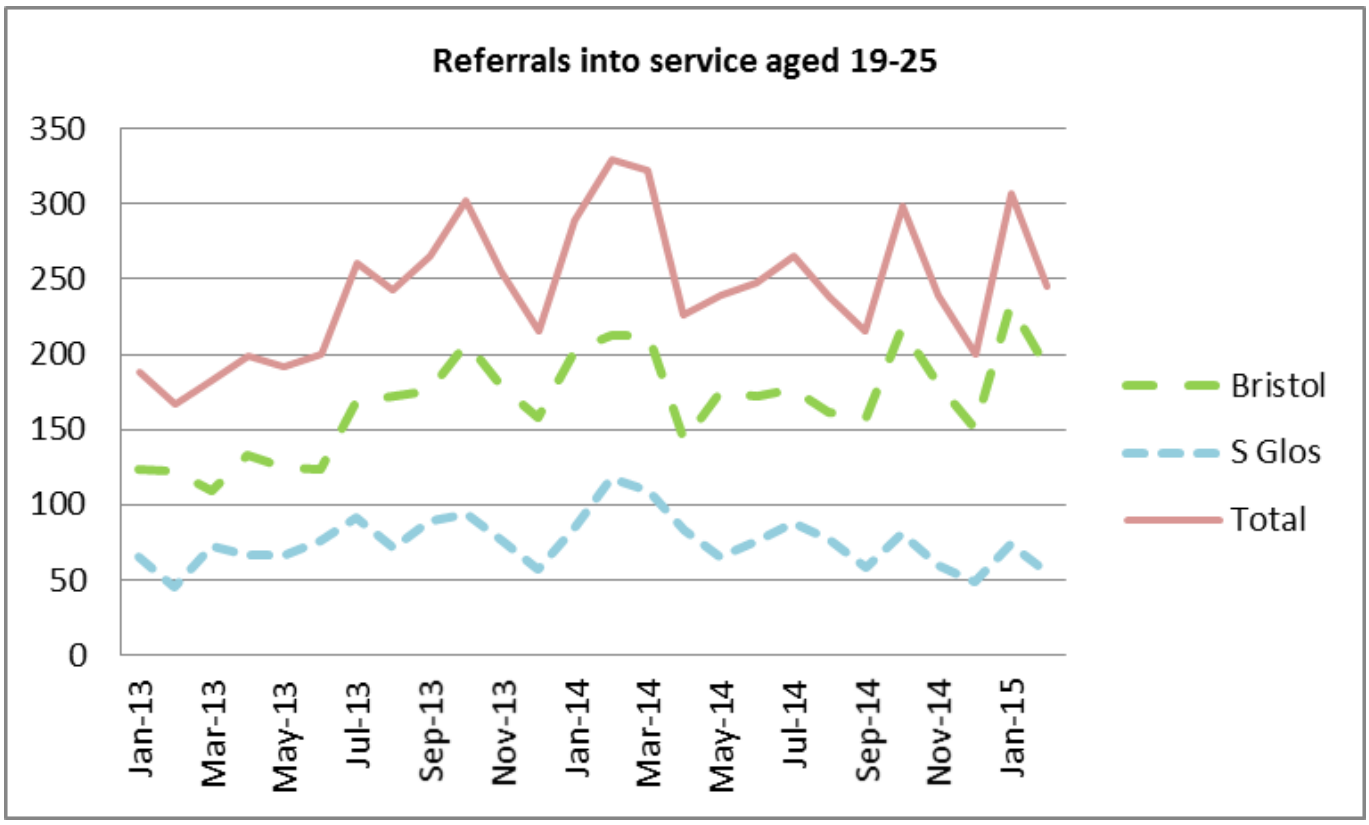
As shown in figures 4 and 5 for both age groups, 16-18 and 19-25 years, the highest referrals are made during January and February. Higher numbers of referrals for 16-18 year olds are being received from South Gloucestershire than Bristol. The pattern then changes for 19-25 with twice as many being referred in Bristol compared to South Gloucestershire.

Figure 4: SG referrals to 'Off-The-Record' (16-18 year olds)



Source: 'Off the Record'

Figure 5: SG referrals to 'Off-The-Record' (19-25 year olds)



Source: 'Off-The-Record'

CAMHS service activity

Referrals to tier three CAMHS have increased in the last five years for South Gloucestershire while the percentage of acceptance has decreased (see table 2).

According to ONS 2014 published statistics, in South Gloucestershire an estimated number of 1,060 children aged 17 and under would require Tier 3 service. This is twice the number of children who have been referred and accepted for these services.

Table 2. South Gloucestershire Tier 3 referrals

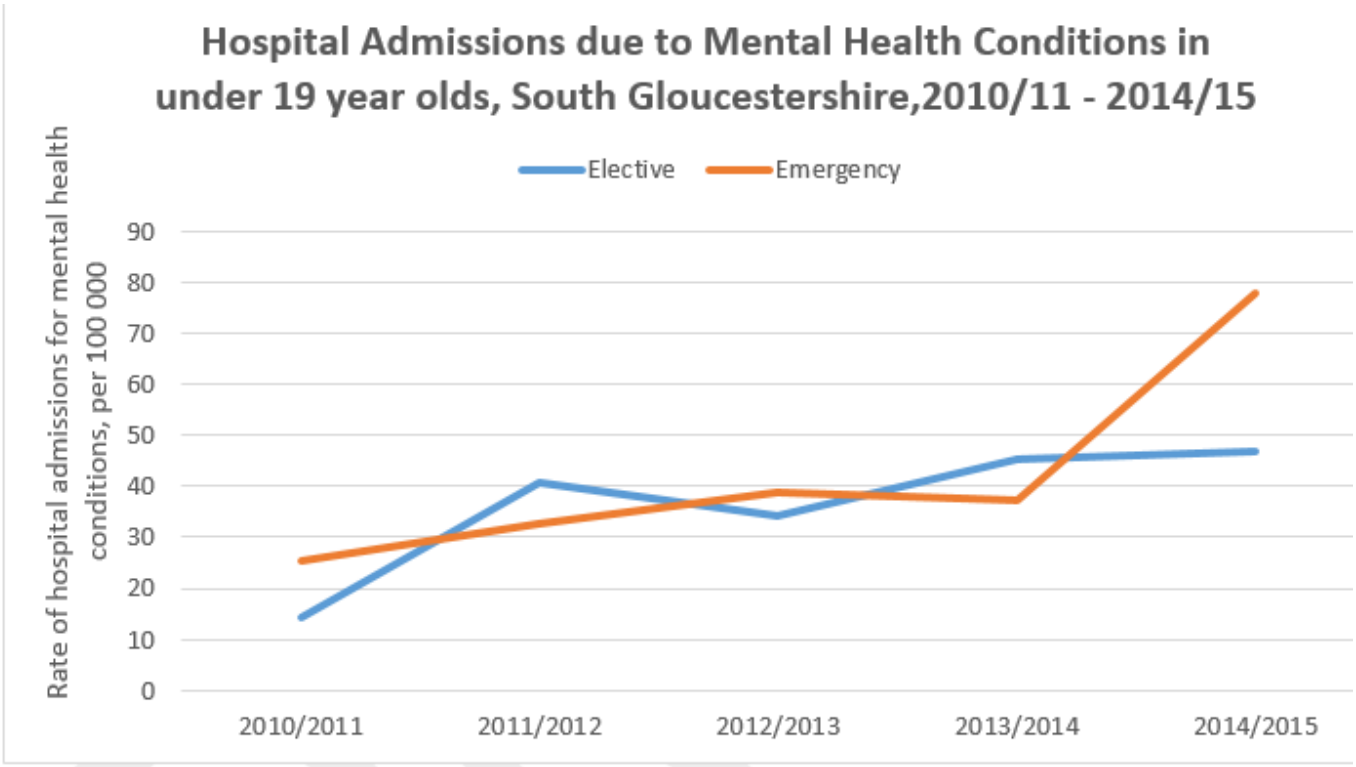
Year	Total referred	Rejected	Accepted	% of accepted given an appt.	% accepted
2010/11	787	203	584	83%	74.2%
2011/12	721	184	537	78%	74.5%
2012/13	874	328	546	82%	62.5%
2013/14	967	328	639	79%	66.1%
2014/15	842	342	500	73%	59.4%
5 yr average	838	277	562	N/A	67.1%

Source: CAMHS

Hospital admissions data

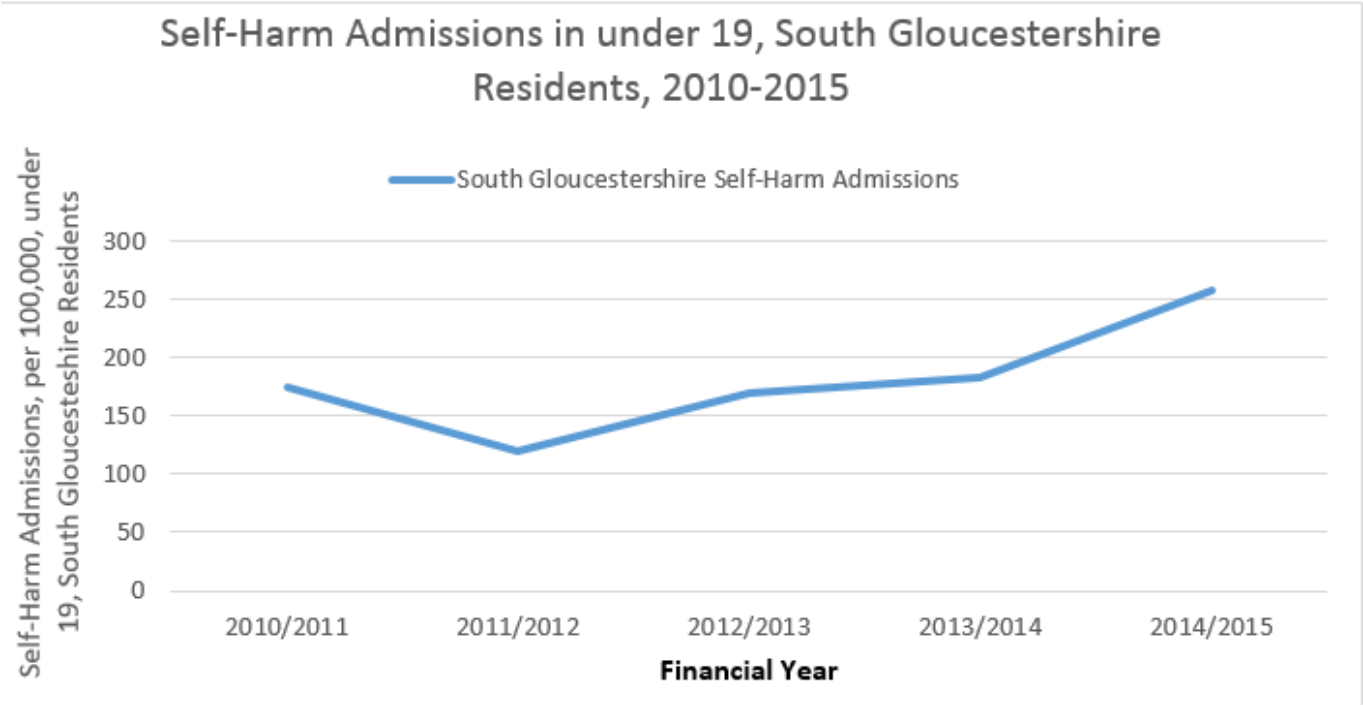
The rates shown in figures 6 to 9 were obtained by extracting all admissions where any of the diagnoses fields had an ICD code that started with F, in under 19 year olds, South Gloucestershire residents. The data was extracted via SQL coding from the database supported by the SWCSU. Hospital admissions due to mental health conditions have increased over the last five years for South Gloucestershire (figure 5) as have admissions for self-harm for those under 19 years of age (figure 7).

Figure 6. Hospital admissions due to mental health conditions, 10-19 year olds, South Gloucestershire residents, 2010/11-2014/15



Source: SUS Statistics accessed via Avon Business Intelligence, South West Clinical Commissioning Unit

Figure 7. Self-harm admissions in under 19, South Gloucestershire Residents, 2010-2015



Source: SUS database. The data was extracted via SQL coding from the database supported by the SWCSU. The above rates were obtained by extracting all admissions where any of the diagnoses fields had an ICD code in X60-X85, in under 19 year olds, South Gloucestershire residents.

4. Stakeholder views

We have run a number of events and focus groups to gather the views of young people, parents and carers, professionals and service providers. The events and focus groups were as follows:

- Bristol and South Gloucestershire children's community health services stakeholder findings 2014 (professionals and parents/carers)
- Healthwatch 'Being Me' event October 2014 (children and young people)
- CYP professionals service mapping event November 2014 (providers and elected members)
- Schools health survey February 2015 (6000 responses from students)
- SEN conference March 2015 (parents and carers)
- South Gloucestershire Youth Board August 2015 (children and young people)

During this process a broad range of views were expressed but a number of priorities were consistently identified by local stakeholders.

Whole population and whole system development (mental health promotion)

- A joined up care pathway that is clearly mapped and understood by professionals and the public alike. What is the local offer?
- Basic mental health awareness training for CYP professionals including strategies for promoting resilience and self-management along with the local knowledge to signpost.
- More information/training for parents about how to promote positive mental health in their children.
- More information/training for CYP about how to manage their own mental health positively.
- Work with schools and parents to address exam and academic pressures.
- Campaigns to address stigma and bullying across a range of risk factors (appearance, sexuality, disability, race).

Targeted prevention (mental illness prevention)

- Approaches that support CYP in the context of the whole family situation including parental risk factors and co-ordinating with adult services.
- Proactive support and development of protective factors for CYP most likely to experience mental ill health including children in care, children with disabilities, young offenders, young carers and Gypsies and Travellers.
- More community based support for mums experiencing mild post natal depression (PND).

Strengthening the care pathway for young people with identified mental ill health (treatment and rehabilitation)

- A range of alternatives for young people who do not meet the CAMHS service thresholds including increased capacity for talking therapies, key workers and peer support groups.
- More capacity within CAMHS.
- More support for young people before the transition into adult services.

5. Evidence of good practice

Future in Mind – a new vision for CAMHS

A range of national guidance exists relating the mental and emotional wellbeing of children and young people. In response to calls for change, the report of the Children and Young People's Mental Health Taskforce sets the strategic vision for delivering improvements to the mental and emotional wellbeing of children and young people. In particular, the new vision advocates for an integrated whole-system approach, with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together to create a system built around the needs of children, young people and their families, rather than rigidly defined in terms of the services on offer by an organisation. The future of the current service delivery model in South Gloucestershire is under discussion, and will draw on local service data and the views of patients, families and professionals to ensure that services are patient-centred and accessible. NICE guidance offers recommendations with a focus on key risk factors that can shape a child's mental health and these are summarised in Appendix D.

6. Key findings

One in ten children aged 5-16 are estimated to have a diagnosable mental health problem in the UK. Applying this to South Gloucestershire's population, this translates to approximately 4,800 children and young people.

A single risk factor is thought to result in a 1-2% chance of developing a mental health problem; increasing to an 8% chance in the presence of three risk factors, and a 20% chance with four risk factors. Without help and support at the right time and in the right place, risky behaviours and poor psychological resilience can persist into adulthood. By providing effective early intervention services, significant life-long savings can be made in each case.

A recent survey of school children across South Gloucestershire (secondary school age) highlighted some concerning data regarding levels of drinking 17.3% of pupils (years 8-10) reported being drunk regularly; nearly 43.7% of secondary school pupils reported feeling stressed about school work; nearly 8.6% of secondary school children reported being or having someone in their immediate family who experienced domestic abuse. Year 8 through Year 12 had a 16% overall prevalence of self-harm, with year 10 experiencing the highest prevalence of 18%. Other points of note include 48.5% of those who felt they should join a gang and joined reported self-harming. Of those who reported self-harming, 28% reported doing it 'quite often' or 'most days'.

Referrals from South Gloucestershire to tier three services have increased in the last five years while the percentage of acceptance by the service has decreased. According to ONS 2014 published statistics, in South Gloucestershire an estimated number of 1,060 children aged 17 and under would require Tier 3 service. This is twice the number of children who have been referred and accepted for these services.

Hospital admissions due to mental health conditions have increased over the last five years for South Gloucestershire as have admissions for self-harm for those under 19 years of age.

Views of stakeholders (young people, parents, carers, professionals and service providers) obtained via a number of events and focus groups include the recommendation that information and training is required by all, work with schools should be increased, care pathways should be clarified, risk factors should be targeted (for example via a whole family approach), risk groups such as young carers should be targeted to access services, alternatives should be identified for those not reaching CAMHS service thresholds (such as talking therapies, key workers and peer support) and support should be offered during transition into adult services.

National guidance recommends an integrated whole-system approach, with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together to create a system built around the needs of children, young people and their families, rather than rigidly defined in terms of the services on offer by an organisation.

7. Recommendations to commissioners

1. Offer early intervention and whole system approach

Offer a choice of evidence-based services. Clarify the care pathway in response to the Children and Young People's Mental Health Taskforce strategic vision for delivering improvements to the mental and emotional wellbeing of children and young people. In particular, the new vision advocates for an integrated whole-system approach, with the NHS, public health, voluntary and community, local authority children's services, education and youth justice sectors working together to create a system built around the needs of children, young people and their families, rather than rigidly defined in terms of the services on offer by an organisation.

2. Offer a consistent range of treatments and interventions which are evidence based and informed by practice.

Referrals should be accepted from a wide range of sources such as GPs, schools as well as self-referral.

3. Increase the range and availability of cognitive behavioural therapy, systematic family therapy and parenting courses.

4. Identify gaps in support needs in relation to children with social communication and interaction needs including autistic spectrum conditions whilst accounting for the existence and responsibilities of other services within the wider system and acknowledging that support needs will vary due to ages of children and their location on the spectrum.

5. Workforce development should include a trend towards staff on lower bands with more generalist and community-based roles. Work towards embedding staff with non-clinical teams, e.g. schools, social care and universal services.

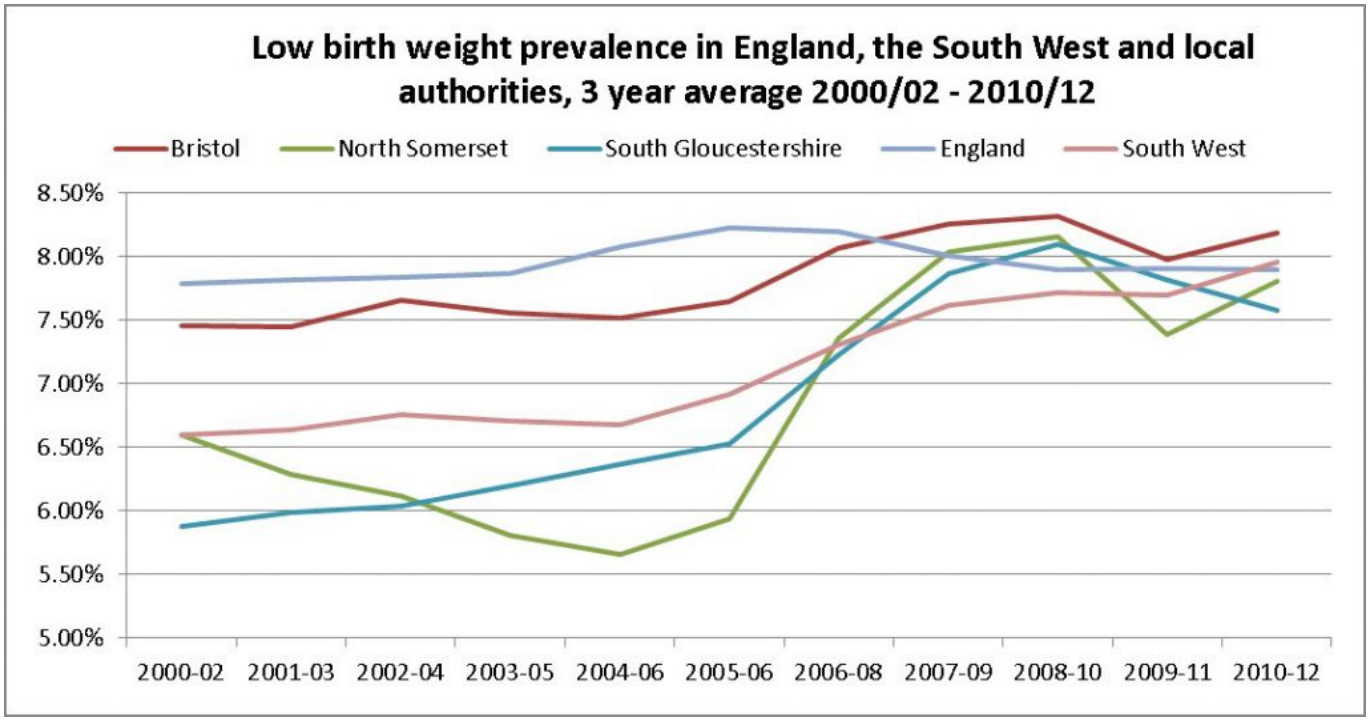
Appendix A

Risk and protective factors

Maternal and family

Low birth weight

Figure 1. Low birthweight prevalence, 3 year average, South Gloucestershire, South West and England, 2000/02-2010/12.



Source: Children and Young People Mental Health and Wellbeing Tool, Public Health England, Fingertips

Low birth weight prevalence has fluctuated in the last 15 years between 6% to 8% which is relatively similar to that of England (7.5%-8%)

Appendix B

Tier 1 – Current services

- Sure Start
- SBCP SAY Project

- Dreamscheme projects
- SARI – 1:1 empowerment sessions for young victims of hate crime bullying
- Pastoral care in schools
- GPs
- Schools
- Acceptance counselling and training (ex Indigo project)
- Counselling and training (self harm, emotional resilience, mindfulness)
- Youth centres in each of the PN areas
- See resources list on CAF toolkit also
- Parent voice
- Supportive parents
- Resound – Blackhorse – parenting groups, befriending scheme
- CAN parent initiative – offering a range of universal support for parents, looking at emotional wellbeing, key transitional stages and positive parenting techniques.
    - Online courses available
    - Discussion groups/seminar (sleeping patterns and routines)
    - Universal training available for professionals
- Southern Brooks run groups such as 'WOW' for support as regards emotional wellbeing in its widest sense. Covers Filton, Patchway but also starting to work wider. Parenting.
- Kingsmeadow Community Flat, Kingswood – sessions to support individuals to improve confidence, counselling prior to young people beginning to get into work/training. Support children through Dreamscheme.
- Our Place Community Flat, Staple Hill – supporting young people – cooking/healthy eating sessions
- St Nicholas Family Centre, Yate – young people's activities
- JUICE Community Project, Cadbury Heath – toddlers groups, homework club
- Bourne Family project, Kingswood
- South Glos Community Sports – active in the PNs supporting young people in exercise e.g. street games
- South Glos Community Learning Service – family courses
- Mind Out – 1 day children and young people mental health awareness course, free to all practitioners/professionals
- Family lives – individual support – parents can receive 1:1 emotional and practical support in home or public space. Can be delivered by family support co-ordinators or volunteer befrienders. Parent training courses, groups and workshops – can be delivered on a range of topics. Free 24/7 national helpline and online support services
- Education other than at School (EOTAS) – Behavioural unit, Severnside, Mental Health, Mangotsfield – The Junction
- Parent support group run by parent link worker
- KTS YISS – Youth Intervention Support Service
- School Nurses
- In house Ignite course – ESF funded Anger & Anxiety course. Ignite is a transition course for young people to re-engage back into education after anxiety issues.
- IAG for students who need support to access positive futures
- First Response
- Southern Brooks youth provision, Patchway

- Health Champions
- Support groups- NAS
- Youth champions?
- Southern Brooks courses – parenting, child development, healthy living, anger management, healthy eating for under 5s and families
- Health visitors
- Toddler groups – 'Bouncing Babies' Bradley Stoke for carers and under 1s specifically set up to support bonding and PND prevention.

Tier 2 – Current services

- Educational psychologists support in school
- Southern Brooks family services team (covering north locality)
- FISS, YISS, FIF (More opportunities for these teams to work alongside community paediatricians and school nurse)
- Hospital education
- Youth clubs
- Social workers
- YOT
- PMHS (LAC) – vacant
- PMHS – School age
- PMHS – Antenatal-4 yrs
- Off the record counselling
- SBCP DV Group
- Survive and Survive groups for children – 'Back on Track'
- School health nurses
- Health Visitors
- Sure Start
- Use of SAF process to co-ordinate services
- YP mentoring services
- Psychologist for 'Looked After' children
- HELP counselling
- The Greenhouse Project
- Evidence based parenting courses
- Paediatricians
- Schools offer 'pyramid' parenting where they have trained staff
- Multi-agency school cluster meetings in 5 areas of South Glos (covering it all) that meet 3-4 times a year to problem solve difficult and stuck cases/SAFeh's contact Heather Churchill x4680 for more details (and for Tier 3)
- Young people's drug and alcohol service – 1:1 ongoing psychosocial and harm reduction interventions – also works at Tier 3
- Family lives – family support co-ordinators can offer intensive support to families to identify key issues/difficulties and equip them with tools to self-manage
- Acceptance, counselling and training (was INDIGO project)
- Self-harm support – counselling – group work

- Abuse counselling
- Self-harm awareness training
- YOT Primary Health Specialist
- Hospital CAMHS/Deliberate Self-Harm Service (covers S.Glos) – Emergency only
- School health nurses/targeted following assessment of need
- Enuresis service – school health nurse led
- Brook in 4 schools currently
- Brook counselling service in Bristol (waiting list)
- REACH – child weight management – all of South Glos (group course and 1:1 service)
- HENRY courses
- Mentoring Programmes (Breakthrough, MiM, FACE etc)

Tier 3 – Current services

- Southern Brooks family services team (covering North locality)
- Social workers
- Primary Mental Health Worker for Looked After children (vacant)
- South Glos – early intervention in psychosis aged 14-35 experiencing a first episode of psychosis
- Be safe – harmful sexual behaviour service for CYP
- Primary infant mental health specialist (S.Glos CAMHS)
- Primary mental health worker – school age (CAMHS)
- Young people substance misuse treatment service (NBT) S.Glos commissions 6 places a year for most complex YPS

Tier 4 – Current services

- Riverside adolescent in-patient unit (Blackberry Hill)
- 'New Horizons' mother and baby centre – Southmead Hospital. Psychiatric in-patients (AWP)

Appendix C

Year 8-Year 12 pupil responses to the School Survey, South Gloucestershire

Question	Secondary School	Numerator	Denominator
Reported being drunk	17.39%	98	249
Tried illegal drugs	6.3%	118	1871
Feel stressed about school work	43.7%	748	1711

Question	Secondary School	Numerator	Denominator
Worry about going to school	15.6%	268	1719
Is often in trouble at school	12.7%	219	1731
Pupil or anyone in their immediate family has been a victim of abuse?	8.6%	147	1705
Ever self-harmed?	12.6%	279	1736
Most common method of self-harm	Cutting		
Those who self-harm regularly	6.1%	65	250
Told someone about your self-harming	51.7%	134	259
Received medical treatment for the injury	8.2%	21	257
Still self-harming	35.3%	91	258
Been seriously bullied in the last year	15.3%	132	1617
Most common causes for bullying	1. Appearance 2. Rumours about themselves 3. Personality 4. Friendship Group 5. Size	N/A	416
Most common methods of bullying	1. Verbal 79% 2. Cyber 27% 3. Isolation 25% 4. Physical 22%	N/A	378
Most common locations where bullying takes place	1. Classroom 33% 2. Other 21% 3. School bus/train16% 4. Outside 13%	N/A	426

Question	Secondary School	Numerator	Denominator
People who have helped with the bullying	1. Family 53% 2. Friends 43% 3. Professional 30% 4. No-one 22.4%	N/A	441
Worried that have difficulty sleeping at night	31.8%	479	1509
Unsatisfied with their life	11.9%	158	1327
Top areas where more support would be needed	1. Cooking skills 40% 2. Money management 31% 3. Getting fit 31% 4. Losing weight 31% 5. Relationships 30%	N/A	1311
Feel confident about their future	87.5%	883	1412
Proud of things they've achieved	87.3%	1247	1429
Felt unhappy in the last week	16.1%	245	1520
Felt unhappy in the last week, at school	20.4%	306	1502

Question	Year 12	Numerator	Denominator
Been drunk	62.9%	180	262
Tried illegal drugs	16.3%	76	467
Feel stressed about school work	60.7%	267	440
Worry about going to school	16.7%	71	424
Is often in trouble at school	4.4%	20	450

Question	Year 12	Numerator	Denominator
Pupil or anyone in their immediate family has been a victim of abuse?	9.8%	44	449
Ever self-harmed?	17%	78	381
Most common method of self-harm	Cutting	N/A	78
Regularly Self-harm	5.9%	24	69
Told someone about your self-harming	48.1%	37	77
Received medical treatment for the injury	15.6%	12	77
Still self-harming	23.7%	18	76
Been seriously bullied in the last year	5.3%	23	436
Most common causes for bullying	1. Rumours about themselves 46% 2. Appearance 44% 3. Personality 42% 4. Friendship group 40%	N/A	50*
Most common methods of bullying	1. Verbal 88% 2. Isolation/exclusion 42% 3. Physical 30%	N/A	50*
Most common locations where bullying takes place	1. Classroom 22.6% 2. School bus/train 18.9% 3. At school 17%		53*
People who have helped with the bullying	1. No-one 39.3% 2. Family 37.5% 3. Friend 32%	N/A	56*
Worried that have difficulty sleeping at night	43%	176	409

Question	Year 12	Numerator	Denominator
Unsatisfied with their life	12.7%	48	377
Top areas where more support would be needed	1. Independent living 46% 2. Money management 45.3% 3. Stress management 42.5% 4. Cooking Skills 41.7% 5. Getting fit 32.8%		
Feel confident about their future	74.8%	306	409
Proud of things they've achieve	80.3%	334	416
Felt unhappy in the last week	18.3%	75	411
Felt unhappy in the last week, at school	23.3%	95	408

*Small dataset careful in interpretation

There is a gradient linking the breakfast intake and the prevalence of self-harm as presented in table 2 below. The highest levels of self-harm are observed in those who never have breakfast, followed by those who do not have breakfast often. Those who have breakfast sometimes and usually have lower levels than those who never or not often have breakfast. The lowest self-harm prevalence is observed in those who have breakfast every morning, and the value is 4.5 lower than those who never have breakfast. This in accordance with previous studies that discuss the frequency of breakfast intake to an alternative measure of deprivation.

Table 2: SG school survey analysis

Response to question 'do you self-harm'	Breakfast = Never	%	Breakfast = Not often	%	Breakfast = Sometimes	%	Breakfast = Usually	%	Breakfast = Every morning	%	Total	%
Yes	76	39.6	94	26.1	30	15.5	52	14.1	86	8.7	338	16.1
No	116	60.4	266	73.9	164	84.5	317	85.9	901	91.3	1764	83.9
Total	192	100.0	360	100.0	194	100.0	369	100.0	987	100.0	2102	100.0
Not answered	27	14.1	27	7.5	12	6.2	37	10.0	87	8.8	190	9.0
Total selected:	219		387		206		406		1074		2292	

Appendix D

Summary of relevant NICE guidance recommendations.

Risk factors	Recommendations
Antenatal and postnatal mental health	*Antenatal and postnatal mental health: clinical management and service guidance, CG192 (2014)* • Develop an integrated care plan for women with a mental health problem in pregnancy and the postnatal period, which is co-ordinated by a health professional • Provide culturally relevant information on mental health problems in pregnancy • During the early postnatal period, ask depression identification questions as part of a general discussion about a woman's mental health and wellbeing in primary care setting • Health professionals should understand the variations in the presentation and course of mental health problems during and after pregnancy, and how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services) • Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of 1 or more of the following: seeing or holding the baby, having mementos of the baby, seeing a photograph of the baby • Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers.

Risk factors	Recommendations
Social and emotional wellbeing in the early years	*Social and emotional wellbeing: early years, PH40 (2012)* • Health and wellbeing boards should ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5 • All health and early years professionals should develop trusting relationships with vulnerable families and adopt a non-judgmental approach, while focusing on the child's needs. • Health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing. • Health visitors, school nurses and early years practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of their development. • Family welfare, housing, voluntary services, the police and others who are in contact with a vulnerable child and their family should be aware of factors that pose a risk to the child's social and emotional wellbeing. • Health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support • Health visitors or midwives should try to ensure both parents can fully participate in home visits, by taking into account their domestic and working priorities and commitments. • Health visitors and midwives should consider evidence-based interventions, such as baby massage and video interaction guidance**,** to improve maternal sensitivity and mother–infant attachment. For example, this approach might be effective when the mother has depression or the infant shows signs of behavioural difficulties. • Local authority children's services should ensure all vulnerable children can benefit from high quality childcare outside the home on a part- or full-time basis and can take up their entitlement to early childhood education, where appropriate. • Managers and providers of early education and childcare services should ensure all vulnerable children can benefit from high quality services which aim to enhance their social and emotional wellbeing and build their capacity to learn.

Risk factors	Recommendations
Social and emotional wellbeing in primary education	*Social and emotional wellbeing in primary education, PH12 (2008)* • Local authorities should ensure primary schools provide an emotionally secure environment that prevents bullying and provides help and support for children (and their families) who may have problems. • Schools should have a programme to help develop all children's emotional and social wellbeing. It should be integrated it into all aspects of the curriculum and staff should be trained to deliver it effectively. • Schools should also plan activities to help children develop social and emotional skills and wellbeing, and to help parents develop their parenting skills. • Schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed. Those at higher risk of these problems include looked after children, those in families where there is instability or conflict and those who have had a bereavement
Social and emotional wellbeing in secondary education	*Social and emotional wellbeing in secondary education, PH20 (2009)* • Secondary education establishments should have access to the specialist skills, advice and support they require. • Practitioners should have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing. • Secondary education establishments should provide a safe environment which nurtures and encourages young people's sense of self-worth, reduces the threat of bullying and violence and promotes positive behaviour. • Social and emotional skills education should be tailored to the developmental needs of young people.
Looked-after children and young people	PH28

Risk factors	Recommendations
Domestic violence and abuse	*Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively, PH50 (2014)* • Ensure staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people. • Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly. The violence and abuse may be happening in their own intimate relationships or among adults they know or live with. • Put clear information-sharing protocols in place to ensure staff gather and share information and have a clear picture of the child or young person's circumstances, risks and needs. • Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse. • Ensure staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether or not a referral would be appropriate. • Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse. • Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse. • Monitor these policies and services with regard to children's and young people's needs. • Address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety. This includes the wider educational, behavioural and social effects. • Provide a coordinated package of care and support that takes individual preferences and needs into account. • Ensure the support matches the child's developmental stage (for example, infant, preadolescent or adolescent). Interventions should be timely and should continue over a long enough period to achieve lasting effects. Recognise that long-term interventions are more effective. • Provide interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer. This may involve individual or group sessions, or both. The sessions should include advocacy, therapy and other support that addresses the impact of domestic violence and abuse on parenting. Sessions should be delivered to children and their non-abusive parent or carer in parallel, or together. • Provide support and services for children and young people experiencing domestic violence and abuse in their own intimate relationships.
Self-harm	CG16 and CG133
ADHD	CG72
Depression	CG28

Risk factors	Recommendations
Post-traumatic stress disorder	CG26
Personality disorders	CG77 and CG78
Substance abuse	PH4
Anti-social behaviour and conduct disorders	*Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management, CG158 (2013)* • During initial assessment for a possible conduct disorder, assess for the presence of the following significant complicating factors: - a coexisting mental health problem (for example, depression, post-traumatic stress disorder) - a neurodevelopmental condition (in particular ADHD and autism) - a learning disability or difficulty - substance misuse in young people • Health professionals working with children and young people should take into account that stigma and discrimination are often associated with using mental health services, and that there may be possible variations in the presentation of mental health problems in children and young people of different genders, ages, cultural, ethnic, religious or other diverse backgrounds • Conduct a comprehensive assessment of the child or young person's parents or carers, including parental wellbeing, encompassing mental health, substance misuse (including whether alcohol or drugs were used during pregnancy) and criminal behaviour.
Eating disorders	CG9

Risk factors	Recommendations
Psychosis and schizophrenia	*Psychosis and schizophrenia in children and young people: Recognition and management, CG155 (2013)* • When a child or young person experiences psychotic symptoms, refer for assessment without delay to a specialist mental health service such as CAMHS or an early intervention in psychosis service (14 years or over). • When a diagnosis of psychosis or schizophrenia is not appropriate: - consider individual cognitive behavioural therapy (CBT) with or without family intervention, and - offer treatments recommended in NICE guidance for children and young people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. • Do not offer antipsychotic medication if there is not a diagnosis of psychosis or schizophrenia, or to reduce the risk of psychosis • If the child or young person and their parents or carers wish to try psychological interventions (family intervention with individual CBT) alone without antipsychotic medication, advise that psychological interventions are more effective when delivered in conjunction with antipsychotic medication. If the child or young person and their parents or carers still wish to try psychological interventions alone, then offer family intervention with individual CBT. Agree a time limit (1 month or less) for reviewing treatment options, including introducing antipsychotic medication. Continue to monitor symptoms, level of distress, impairment and level of functioning, including educational engagement and achievement, regularly. • For subsequent acute episodes: - Offer family intervention to all families of children and young people with psychosis or schizophrenia, particularly for preventing and reducing relapse. This can be started either during the acute phase or later, including in inpatient settings - Before referral for hospital care, think about the impact on the child or young person and their parents, carers and other family members, especially when the inpatient unit is a long way from where they live. Consider alternative care within the community wherever possible. If hospital admission is unavoidable, provide support for parents or carers when the child or young person is admitted
Autism	CG128