

# **Public Health Walsall 2015 Children and Young People Emotional Wellbeing and Mental Health Needs Assessment**

This needs assessment is part of the Walsall Joint Strategic Needs Assessment process

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## Executive summary

This needs assessment was requested by Walsall's safeguarding board and completed by Walsall Public health team with close collaboration and support by key colleagues from Walsall Clinical Commissioning Group (CCG), Dudley and Walsall Mental Health Trust and Walsall Childrens Services.

From national understanding we know that;

- The consequences of untreated mental health problems can be long lasting and far reaching, so early intervention is essential
- Many children and young people do not receive timely, accessible and high quality support
- We need to improve how children and young people's mental health services are organised, commissioned and provided

The needs assessment set out to identify patterns and trends in young people's emotional health and wellbeing in order to understand the needs of children and young people in Walsall. It identifies risks and protective factors and the interventions which will help children and young people build strengths and skills, which can help develop coping strategies and help young people manage adversity. It also highlights nationally recognised good practice and assesses unmet need to inform commissioning and service model development.

We learnt that;

- Based on national modelling we estimated that in Walsall, approximately 2,970 preschool children are likely to have a mental health disorder and 4,380 school-age children (5-16 years).
- Boys are more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%) but young men 15-17 years and young people from black and minority ethnic groups were least likely to access mental health support services.
- Between 2006 and 2011 there were 10 suicides in Walsall residents aged 14 to 24 years: roughly about 2 per year.
- Hospital admissions as a result of self harm in Walsall have increased in recent years, especially in young women.
- Higher number of girls were referred to CAMHS for deliberate self harm compared with boys in the last two years (2013/14 – 2014/15).

The groups identified as at particular risk in Walsall were:

- [Children in Need \(Looked After Children\)](#),
- [Children with Special Educational Needs and Learning Disability](#),

- [Youth Offenders](#),
- [Young people at transition to adult services \(age 17/18\)](#),
- [Lesbian, Gay, Bisexual and Transgender Community](#),
- [Travellers and Refugees](#),
- [Teenage Parents and young people who are pregnant](#),
- [Homeless Young People](#),
- [Young people who are Not in Employment Education or Training](#),
- [Young people experiencing domestic abuse or in a home where domestic abuse takes place](#),
- [Young Carers](#).

The particular issues relating to emotional wellbeing and mental health for these groups are highlighted within the needs assessment

## Consultation

Consultation was undertaken with young people and their parents. This showed that;

- Young people are most likely to try “not to panic” if they felt anxious or sad. There was recognition that it is normal to feel sad sometimes and bottling things up is not good.
- Young people would seek support initially from parents, carers and other family members or peers who they trusted
- Phone based services were seen as valued
- There was a good understanding of CAMHS from those who used this service, but delays in diagnosis and long waiting lists for assessments and other appointments were identified
- Those young people asked said they were aware of advice and support services in schools but this is an area that could be developed.
- A relationship with social workers/teachers was seen as fundamental. There was a concern from parents regarding the inevitable stress of testing and exams.
- Outside of statutory services, young people appear to be less well-informed once they leave school
- Parents cope with their children’s health and wellbeing support needs much better if there is a good quality of communication between themselves and the range of professionals delivering services and fellow parents.

We also consulted with stakeholders and discovered;

- No group (apart from DWMPHT) were more than 50% confident in their ability to assess the mental health of children and young people
- CAMHS was the most frequently listed between the groups as a 'used service'. There was a general consensus that CAMHS was difficult to refer into, with long waiting times. However, once the child or young person received help it was considered to be very good.

Most stakeholders felt there was a need for:

- Improved training, particularly around assessment of younger children and to support young people who self harm.
- A clear, up to date directory to help the referral process and identify what is available within each age group and who to contact.
- A service to support young people at transition
- A clearer referral process to all services

## **Recommendations**

Recommendations based on this needs assessment included:

### **Emotional wellbeing and mental health in younger children**

- Increase the provision of age appropriate support services in place for children under age of 11
- Ensure alternative provision for support for young people is available both in and out of office hours to reduce the number of inappropriate referrals to specialist services
- Establish and publicise the provision of talking therapies for young people experiencing mental health issues, particularly in groups with low uptake such as males and ethnic minority groups

### **Services at the point of transition**

- Develop a transition service for young people based upon the expressed needs of young people; exploring the feasibility of developing a 16-25 service.
- Set joint protocols in place so that young people within the transition age group are managed by both CAMHS and AMHS, so they can both provide joint assessment.

### **Services for children in care**

- Assess children who are in care, leaving care and those on the cusp or entering care for what support might be required around their emotional health and wellbeing and offer appropriate emotional wellbeing and mental health support for this group

## Self harm

- Set support for young people who self harm in place to reduce the number of young people who self harm in Walsall
- Establish training for staff to recognise and support young people who self harm.
- Develop out of hours services for young people who self harm

## In Schools and other youth settings

- Offer support to schools and Early Help providers to promote the emotional health and wellbeing of children and young people
- Provide schools and other settings with support;
  - to help children develop social and emotional skills and wellbeing,
  - to help parents develop their parenting skills.
- Work with schools and youth settings to help integrate children's emotional wellbeing and mental health into all aspects of the curriculum, tailored to the developmental needs of children and young people
- Ensure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems and how best to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed.
- Ensure that educational establishments have access to the specialist skills, advice and support they require.

## Early intervention for emotional wellbeing and mental health

- Strengthen early intervention services for children and young people at the tier 1 level and ensure that awareness of services is raised in the community.
- Provide early help support around conduct disorders and antisocial behaviour and support workers in the community and primary care to assess and support individuals and their families

## Specialised services for emotional wellbeing and mental health

- Investigate a single point of access
- Investigate how the delays in reaching assessment stage at tier 3 might be reduced
- Strengthen alternatives to inpatient care on an intensive outreach basis. Work with Tier 4 services on pathways to reduce need for inpatient stay/ reduce length of stay.
- Consider increasing access to consultant support at tier 3.

## Workforce Development

- Support for frontline children's workforce to enable them to understand their role in promotion, prevention and early intervention

- Develop a common understanding of different levels of need and categorisation of thresholds in order to support identification of need and appropriate referrals
- Ensure frontline services have access to information and advice about what services are available. Provide an up-to-date directory of services to support referral; within the proposed directory to provide a clearer referral process
- Ensure referrals processes are clear to reduce children being referred back and forward between different professional groups.

### **Areas for further investigation**

- Identify why the diagnosed prevalence of ASD in children 5-9 years is low in comparison with expected prevalence as set out by ONS
- Identify why referrals to CAMHS are lower than might be expected from the 15 -17 age group and BME communities and reduce barriers to access from these communities
- Further explore the issue of stigma

### **Access to services**

- Ensure that the mental health of women is assessed at every visit during pregnancy and in the postnatal period
- Develop a robust maternal mental health pathway

### **Next Steps**

This needs assessment will be presented to the Health and Wellbeing Board and has been presented to Walsall Children's and Young People Partnership Board. It is being used to inform the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2016-2018 and has formed the basis of the bid for NHSE transformation funding

## Introduction

The Walsall Joint Strategic Needs Assessment in December 2013 identified the emotional health and wellbeing of children and young people as being a priority for the Health and Wellbeing Board. The Walsall Children's Safeguarding Board and Walsall Children and Young People's Board have also identified this as an priority.

The Children and young people Emotional Health and Wellbeing in Walsall Needs Assessment provides a universal population needs based approach to emotional health and wellbeing for all children and young people in Walsall. The data and analysis aims to identify patterns and trends in order to understand the emotional wellbeing and mental health needs of children and young people in Walsall.

The focus in this report is on promoting good mental health: identifying risks, protective factors and interventions which will help children and young people build strengths and skills, especially resilience skills, which can be help to help develop coping strategies and manage adversity.

The overall aim of this health needs assessment is to present a profile of emotional health and wellbeing of children, young people, families and the communities in which they live in Walsall. The needs assessment seeks to inform the Emotional Health and Wellbeing in Walsall Strategy that is currently being developed alongside this report.

Many factors influence the emotional health and wellbeing of children and young people. This needs assessment aims to: -

- Describe the levels of need within the Walsall Population
- Describe the service provision for children and young people with emotional wellbeing and mental health issues
- Review the evidence base of good practice
- Assess unmet need to inform commissioning and service model development
- Make recommendations for system wide development

## Background Information

### Local demographics

The information in this section provides some background information to the children and young people that live in Walsall.

### 0-24 population

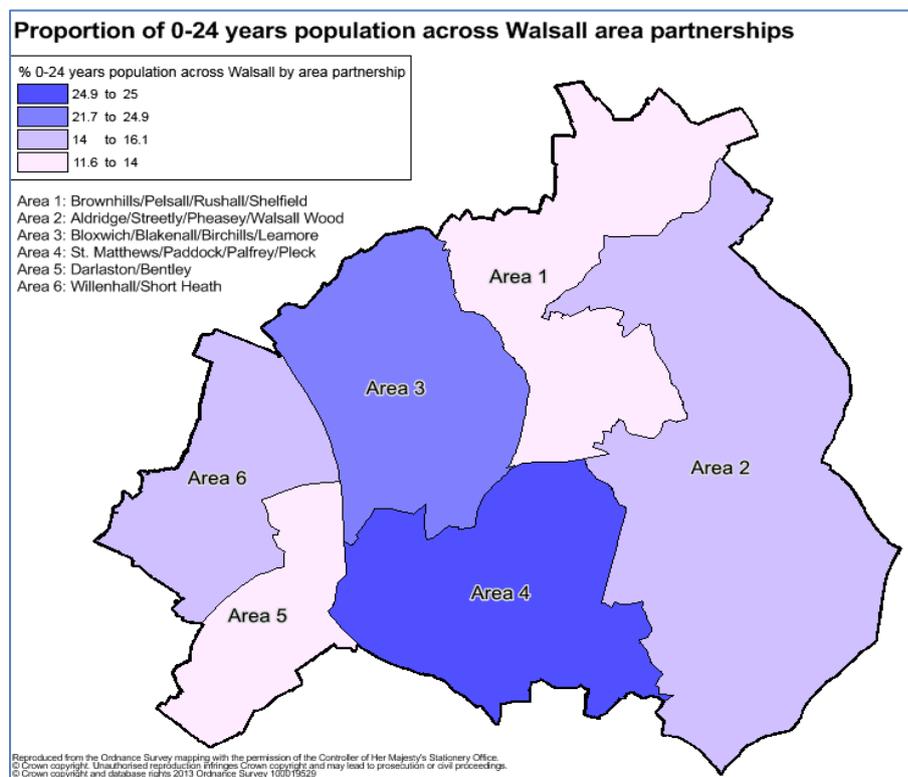
Just under one-third of Walsall's population is under 25 years old (32.3%). Table 1 below shows variation between the six area partnerships (AP) populations, with Darlaston & Bentley (AP5) and Walsall South (AP4) having the highest proportion (36.2%) and Aldridge & Beacon (AP2) the lowest (27%).

**Table 1: Population aged 0-24 years in Walsall by area partnership.**

Area	0-4	5-9	10-14	15-19	20-24	0-19	0-24	0-24 age group as % of all ages
Brownhills, Pelsall, Rushall & Shelfield	2,099	2,053	2,054	2,137	1,873	8,343	10,216	28.2%
Aldridge & Beacon	2,551	2,724	2,955	3,181	2,738	11,411	14,149	27.0%
North Walsall	4,441	3,884	3,595	3,594	3,623	15,514	19,137	34.9%
Walsall South	4,590	4,506	4,196	4,199	4,454	17,491	21,945	36.2%
Darlaston & Bentley	2,426	2,063	1,857	1,897	1,969	8,243	10,212	36.2%
Willenhall & Short Heath	2,615	2,466	2,218	2,352	2,685	9,651	12,336	30.9%
<b>Walsall</b>	<b>18,722</b>	<b>17,696</b>	<b>16,875</b>	<b>17,360</b>	<b>17,342</b>	<b>70,653</b>	<b>87,995</b>	<b>32.3%</b>

Source: (ONS), 2013 Mid-year population estimates – Rounded to nearest 100.

**Figure 1: Distribution of 0-24 year's population across Walsall by area partnership.**

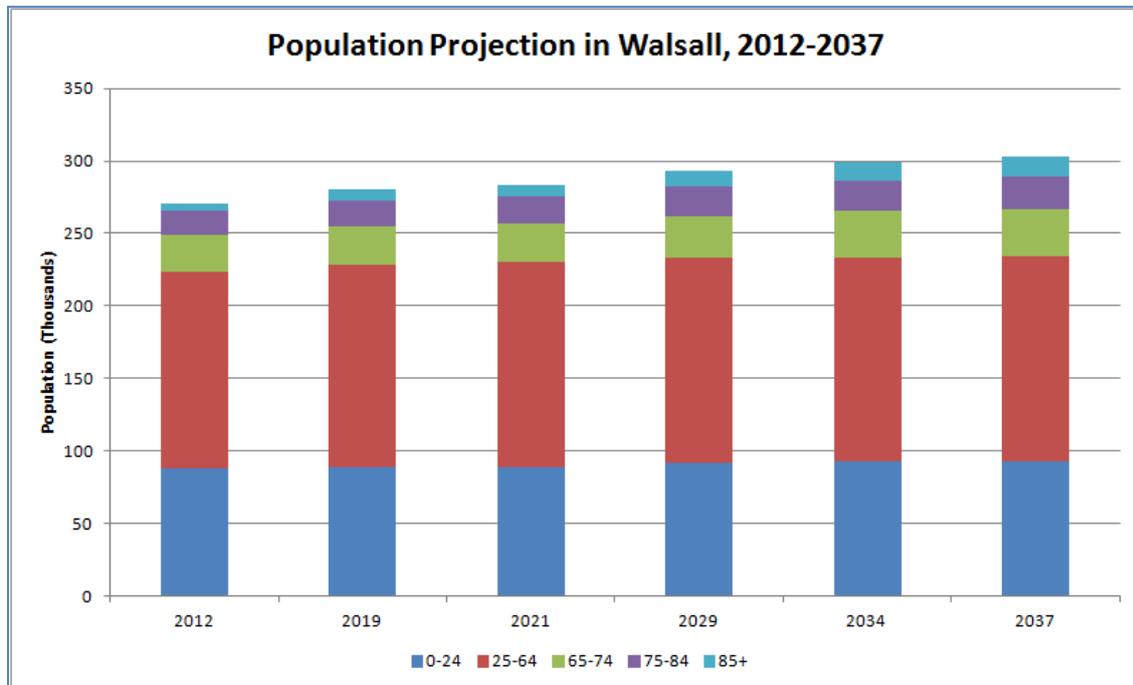


Source: ONS, 2013 mid-year population estimates.

## Population projections

Nationally by 2022 there will be a projected 3% increase in the 0-24 year's age group, with a lower increase projected for Walsall (1.6%).

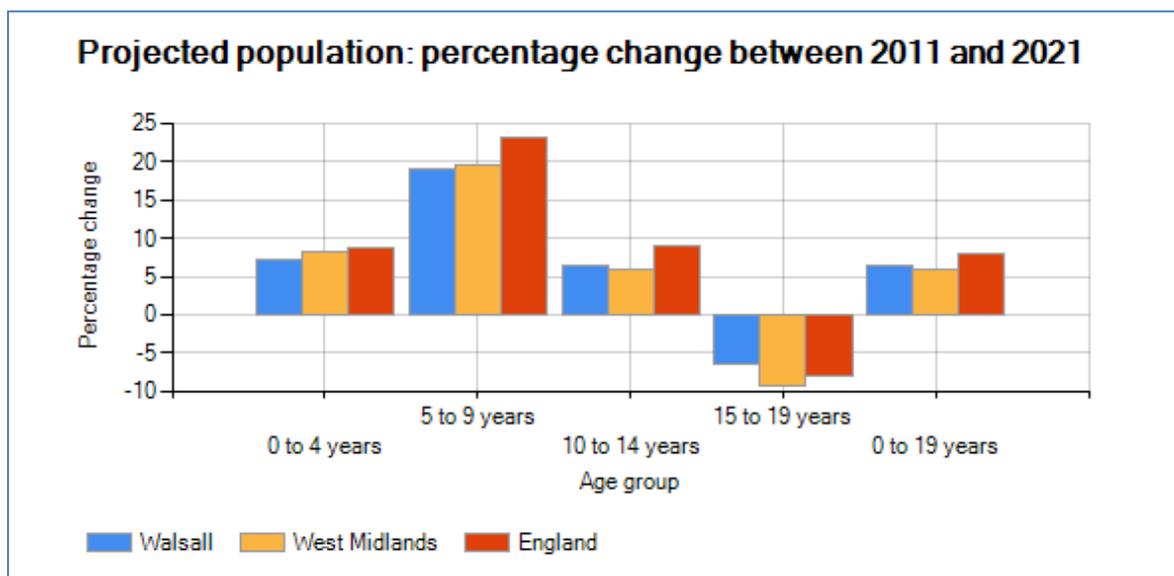
Figure 2: Walsall population projections from 2012 to 2037 by age groups.



Source: ONS, 2012 based sub national population projections.

Figure 3 below shows how the child population in Walsall is forecast to change between 2011 and 2021. The largest projected population changes in 2021 are expected to be in the 5-9 year age group and reduction in 15-19 age group.

Figure 3: Projected population percentage change between 2011 and 2021.



Source: Child and Maternal Health Observatory (CHIMAT), Office of National Statistics (ONS).

## Factors impacting on mental health

### Ethnicity

In Walsall 21% of the population 0-24 are from BME community, this compares similarly to the England population of 21.1%. Walsall South AP has the highest proportion, 52%, of children and young people from a BME background (see Table 2 below): Brownhills AP has the smallest proportion.

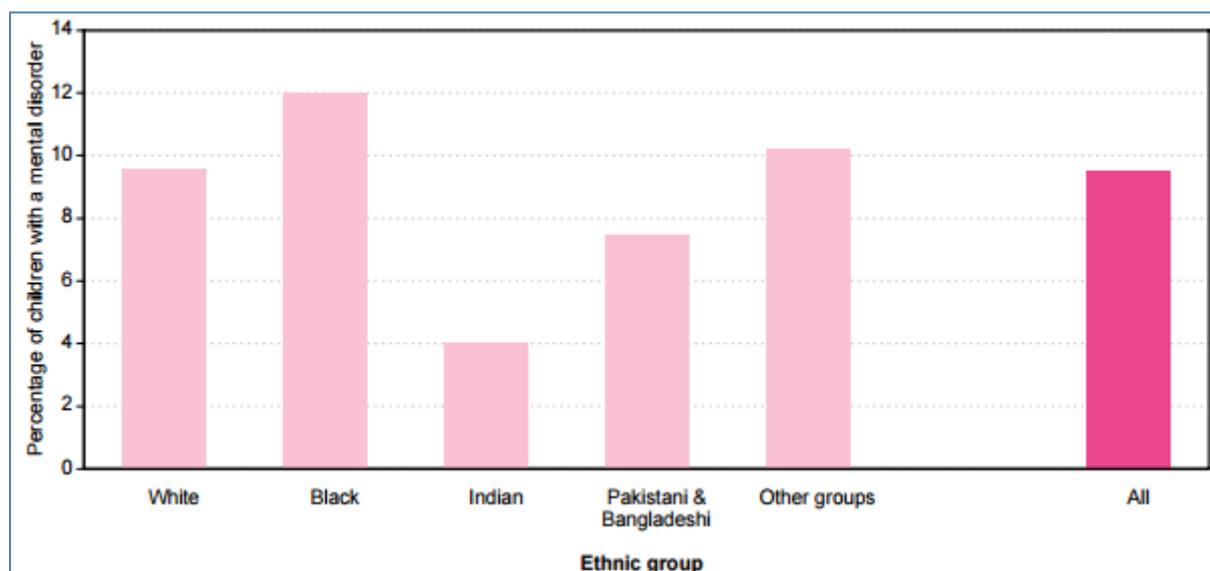
Table 2: Ethnicity populations (0-24 years) by area partnerships.

	Brownhills, Pelsall, Rushall, Shelfield	Aldridge & Beacon	North Walsall	Walsall South	Darlaston & Bentley	Willenhall & Short Heath	Walsall	West Midlands	England
0-24%	28.4%	27.2%	35.0%	36.8%	36.3%	31.4%	32.6%	31.6%	30.8%
White	9656	12910	16587	10474	7821	10554	69265		
% White	94.3%	91.4%	87.8%	47.7%	77.4%	84.2%	78.9%	79.2%	78.9%
Mixed/multiple ethnic group	290	762	1321	9263	1574	1230	13373		
Asian/Asian British	160	219	465	873	350	375	2355		
Black/African/Caribbean/Black British	109	164	444	916	308	243	2076		
Other ethnic group	24	70	65	422	46	137	730		
BME total	583	1216	2296	11474	2278	1984	18534		
% BME	6%	9%	12%	52%	23%	16%	21%	20.8%	21.1%
<b>Total</b>	<b>10239</b>	<b>14126</b>	<b>18882</b>	<b>21948</b>	<b>10099</b>	<b>12538</b>	<b>87799</b>		

Source: ONS, Census 2011

Nationally nearly 10% of white children and 12% of black children were assessed as having mental health problem whereas the prevalence rates among Asian children were 8% of Pakistani and Bangladeshi and 4% of the Indian samples<sup>1</sup> (see [Appendix 2](#) for detailed breakdown).

Figure 4: Prevalence of any mental disorder by ethnicity



Source: Mental health of children and adolescents in Great Britain.

## Educational achievement

### Early years

The overall early year's attainment of good level of development within Walsall (54%) is below national average (60%), with lowest achievement experienced within Darlaston & Bentley AP (38.4%).

Table 3: Achievement of a good level of development at early year's foundation stage, 2013/14

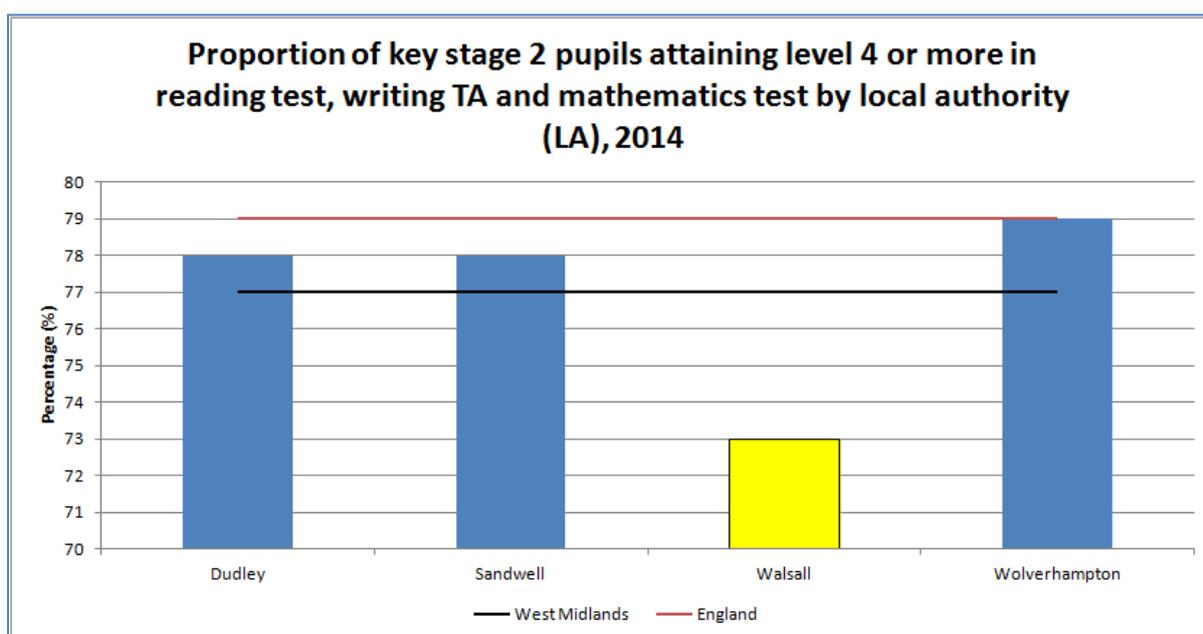
Area Partnership	Achievement of a good level of development at early years foundation stage
Aldridge & Beacon	60.0
Brownhills, Pelsall, Rushall, Shelfield	52.7
Darlaston & Bentley	38.4
North Walsall	40.3
Walsall South	39.5
Willenhall & Short Heath	54.6
<b>Walsall</b>	<b>54%</b>
<b>National</b>	<b>60%</b>

Source: Walsall Council Children's Service (WCCS) and Department of Education (DfE).

### Key Stage 2

The level of key stage 2 (KS2) pupils attaining level 4 or more in reading test, writing TA and mathematics test in Walsall (73%) is below all black country comparators, regional (77%) and national (79%) averages.

Figure 5: Attainment of key stage 2 in reading test, writing TA and mathematics test by local authorities, 2014.



Source: DfE, 2014

### **Key Stage 4**

The key stage 4 (KS4) achievement of 5 or more A\*-C grades at GCSE (or equivalent) in Walsall (48.7%) was below the national average (53.4%) in 2013/14. Within the area partnerships there is large variation from Darlaston & Bentley (43.9%) achieving lowest figures to Aldridge & Beacon (71.8%) which is above national averages.

**Table 4: Education achievement by key stage 4 by area partnership, 2013/14.**

<b>Area Partnership</b>	<b>Educational Achievement by Key Stage 4 (GCSE)</b>
Aldridge & Beacon	71.8
Brownhills, Pelsall, Rushall, Shelfield	65.1
Darlaston & Bentley	43.9
North Walsall	46.7
Walsall South	55.9
Willenhall & Short Heath	56.6
<b>Walsall</b>	<b>48.7%</b>
<b>National</b>	<b>53.40%</b>

Source: WCCS and DfE, 2013-14.

### **School Absence**

Children with emotional disorders had more time off school than other children: 43 per cent had had more than 5 days absence and 17 per cent had had more than 15 days absence in the previous term. Among those with no disorder, these proportions were much lower (21 per cent and 4 per cent)<sup>2</sup>.

Children with generalised anxiety disorder and those with depression had the most days away from school – a quarter had had more than 15 days absence in the previous term. These groups were much more likely than other children to be considered definite or possible truants (26 per cent and 33 per cent compared with 3 per cent among those with no disorder).

The overall school absence percentages in Walsall (5.8%) is slightly lower than the national average (5.9%). However there are three area partnerships (see Table 5) above the Walsall average with North Walsall being the highest at 8%.

Table 5: Proportion of pupils (primary/secondary and special schools) with persistent absence by area partnership, 2012/13.

Area Partnership	% Persistent absence
Aldridge & Beacon	2.9%
Brownhills, Pelsall, Rushall, Shelfield	3.6%
Darlaston & Bentley	6.3%
North Walsall	8%
Walsall South	5.1%
Willenhall & Short Heath	6.5%
<b>Walsall</b>	<b>5.8%</b>
<b>National</b>	<b>5.9%</b>

Source: WCCS and DfE, 2012/13.

### School Exclusion

In Walsall permanent exclusions for primary and secondary schools are above national levels whereas the proportion of fixed term exclusions are higher for primary schools and lower for secondary schools compared with regional and national levels. (See Table 6).

Table 6: Exclusions from primary and secondary schools, 2013/14.

	% Pupil Exclusions Primary School (Fixed)	% Pupil Exclusions Primary School (Permanent)	% Pupil Exclusions Secondary School (Fixed)	% Pupil Exclusions Secondary School (Permanent)
Walsall	1.73%	0.04%	6.20%	0.23%
West Midlands	1.20%	0.04%	6.33%	0.16%
<b>National</b>	<b>1.02%</b>	<b>0.02%</b>	<b>6.62%</b>	<b>0.13%</b>

Source: DfE, 2013/14

The Department of Education reported<sup>3</sup> that the most common reason for fixed period exclusions was persistent disruptive behaviour in 2013/14 (33%<sup>\*</sup>). Local provisional data for 2014/15 indicates that this reason accounted for higher proportion of exclusions (38.7%) (See Table 7).

Table 7: Fixed term and permanent exclusions in Walsall, 2014/15

Fixed Term and Permanent Exclusions in Walsall 2014/15	No. of Exclusions	%
Bullying	25	1.37
Drug/ Alcohol Abuse	37	2.03
<b>Persistent Disruptive Behaviour</b>	<b>707</b>	<b>38.70</b>
Damage	64	3.50

\* Persistent disruptive behaviour included challenging behaviour, disobedience and persistent violation of school rules.

Other	141	7.72
Physical Abuse against an Adult	159	8.70
Physical Abuse against a Pupil	291	15.93
Racist Abuse	36	1.97
Sexual Misconduct	7	0.38
Theft	22	1.20
Verbal Abuse/ Threatening Behaviour against an Adult	253	13.85
Verbal Abuse/ Threatening Behaviour against a Pupil	85	4.65

Source: unverified figure from Capita One (Walsall Children Services).

## Child deprivation/poverty

### Low-income families

In Walsall, 27.9% of children were living in families whose income fell below 60% of the median national income in 2012 which translates to almost 15,490 children aged under 16 years living in poverty (see Table 8). These rates are higher than the regional (21.9% in the West Midlands) and national rates (19.2%).

Table 8: Children in low-income families under 16 by area partnership, 2012.

Area Partnership	% Children in low-income families (Under 16)
Aldridge & Beacon	12.0%
Brownhills, Pelsall, Rushall, Shelfield	20.5%
Darlaston & Bentley	35.4%
North Walsall	39.2%
Walsall South	28.2%
Willenhall & Short Heath	26.5%
<b>Walsall</b>	<b>27.9%</b>
<b>National</b>	<b>19.2%</b>

Source: Department of Work and Pensions (DWP)

*Caveat: Figures for area partnerships are a sum of rounded ward figures, so are indicative only.*

The geographical variation in Walsall is substantial, ranging from 39.2% of children living in poverty in North Walsall AP to 12% in Aldridge & Beacon.

Table 9: Number of children living in all out-of-work benefit claimant households in Walsall, by age at May 2013.

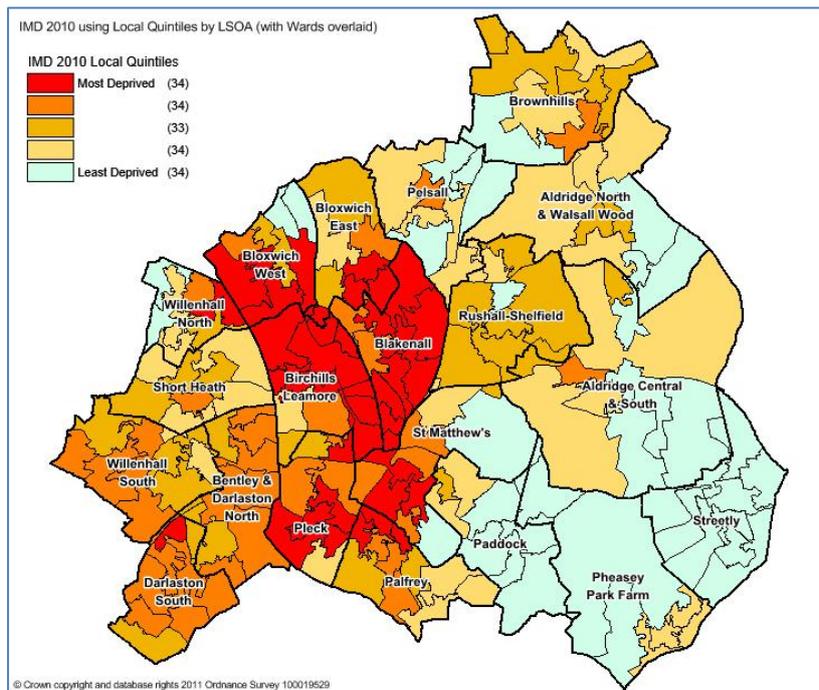
	Age 0-4	Age 5-10	Age 11-15	Age 16-18	Age 0-15	Age 0-18	Number of Households
<b>All Out of Work Benefits</b>	5,710	5,410	3,830	1,620	14,940	16,560	8,330
<i>Claimant Household Type</i>							
<b>Income Support</b>	3,900	2,270	1,330	470	7,500	7,970	3,880
<b>Jobseeker's Allowance</b>	1,150	1,880	1,220	440	4,240	4,690	2,350
<b>Employment and Support Allowance</b>	600	1,130	1,100	580	2,830	3,410	1,800
<b>Incapacity Benefit or Severe Disablement Allowance</b>	140	270	300	160	710	870	440
<b>Pension Credit</b>	10	50	90	70	140	220	150

Source: DWP and HMRC Child Benefit administrative data.

### Indices of multiple deprivations 2010

The figure details that 114,800 (44.6%) of Walsall's total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,400 (11.8%) living in the least. Looking specifically by age, 28,100 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall compared to 5,000 (9.2%) of 0 to 15 year olds living within the least deprived quintiles.

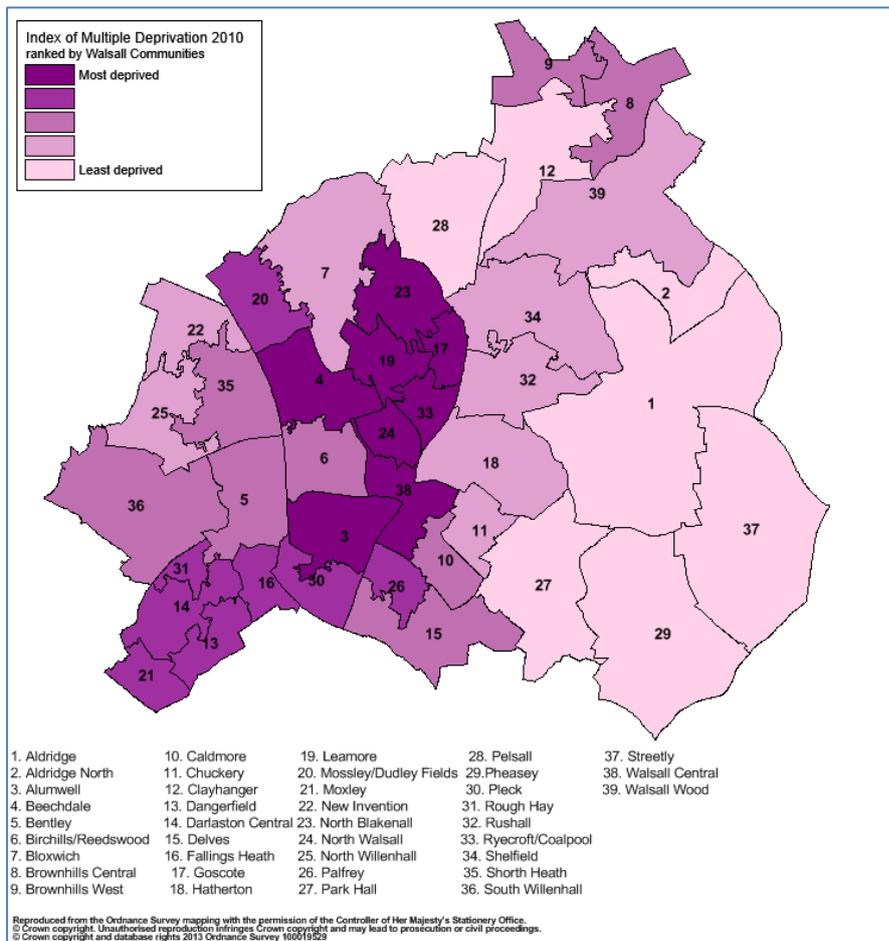
Figure 6: Indices of Multiple Deprivation local quintiles by lower super output area, 2010.



Source: English Indices of Deprivation, Department for Communities and Local Government (DCLG).

The most deprived communities are concentrated in North and South Walsall area partnerships followed by Darlaston & Bentley (see Figure 6 and Figure 7).

Figure 7: English Indices of deprivation and Department for communities and local government.



Source: English Indices of Deprivation, DCLG.

The IMD data is presented at lower super output area (LSOA) level. The community level figures for Walsall have been calculated using best fit of LSOAs for each community. A Population-weighted average score for these LSOAs was then calculated and the communities ranked.

### Free school meals uptake

Eligibility for free school meals (FSM) is an important indicator of family income levels. The uptake of FSM in Walsall (82%) is very similar to national averages (82.7%).

The latest school census data has been used to estimate the FSM uptake across the APs and Table 10 below shows that pupils attending schools in APs with highest eligibility for FSM are not taking up the offer particularly schools in Darlaston & Bentley and North Walsall.

Table 10: Free school meals eligibility and uptake across area partnerships.

Area Partnerships	Number of Pupils (Reception to Year 11)	Pupils eligible for FSM*	% Eligible FSM	Pupils taken FSM	% FSM uptake
Aldridge & Beacon	4526	395	8.7%	318	80.5%
Brownhills, Pelsall, Rushall, Shelfield	3213	812	25.3%	600	73.9%
Darlaston & Bentley	2699	862	31.9%	672	78.0%
North Walsall	3146	1037	33.0%	817	78.8%
Walsall South	4702	1259	26.8%	978	77.7%
Willenhall & Short Heath	3902	1030	26.4%	837	81.3%
<b>Walsall Maintained Schools**</b>	<b>24464</b>	<b>5892</b>	<b>24.1%</b>	<b>4641</b>	<b>78.8%</b>

Source: Walsall School Census, January 2015

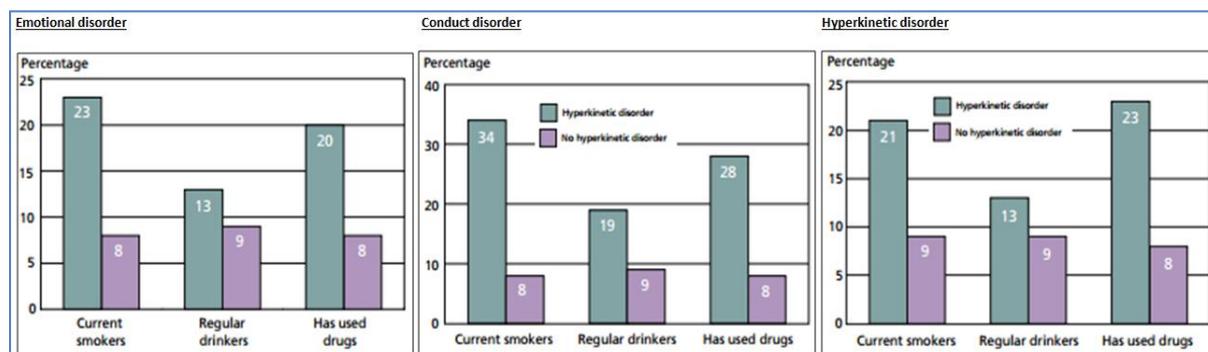
\* Number of pupils includes any pupil that has had at least one period of Free School Meal Eligibility since the last School Census. Pupils who have had more than one period of FSM eligibility are only counted once.

\*\* Excludes schools: Meadow View JMI, Pheasey Park Farm Primary, St. Thomas More Catholic Business & Enterprise College & St. Thomas of Canterbury Catholic

### Smoking, drinking and drug use

Among young people (aged 11-16), those with either an emotional, conduct or hyperkinetic disorder were more likely to smoke, drink and use drugs than other children. The largest differences were for smoking and drug use amongst young people with mental health disorders (see Figure 8).

Figure 8: Children and young people Smoking, drinking and drug use by whether has mental disorder, 1999 and 2004

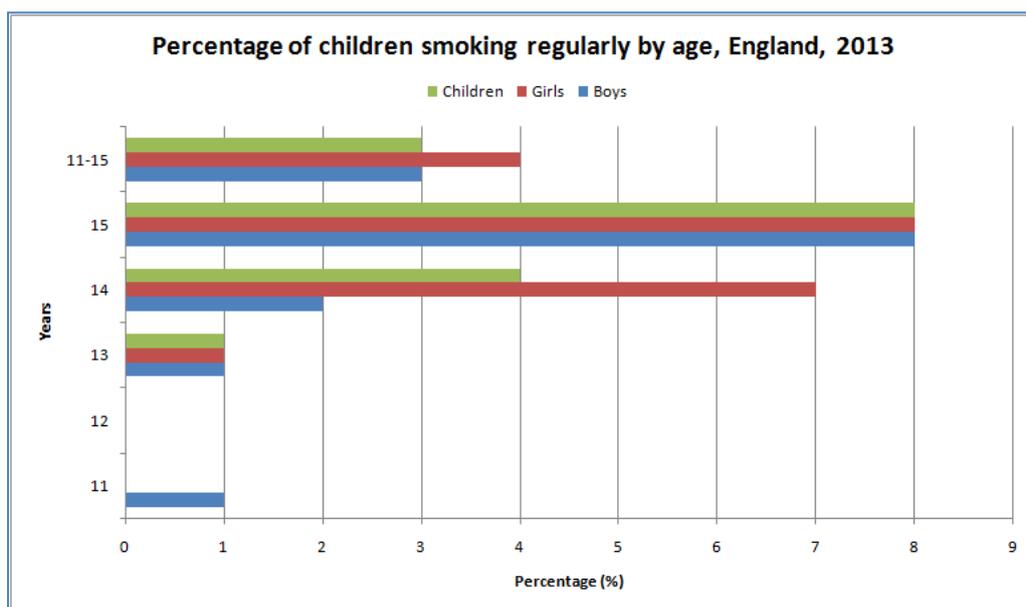


Source: ONS 2004<sup>4</sup>

### Smoking

It's estimated that every year more than 200,000 children in the UK start smoking (Childhood smokers, Cancer Research UK, 2013). Regular smoking is defined as at least one cigarette a week. By the age of 15, approximately 8% of children in England report being regular smokers.

Figure 9: Percentage of children smoking regularly by age and gender, England 2013.

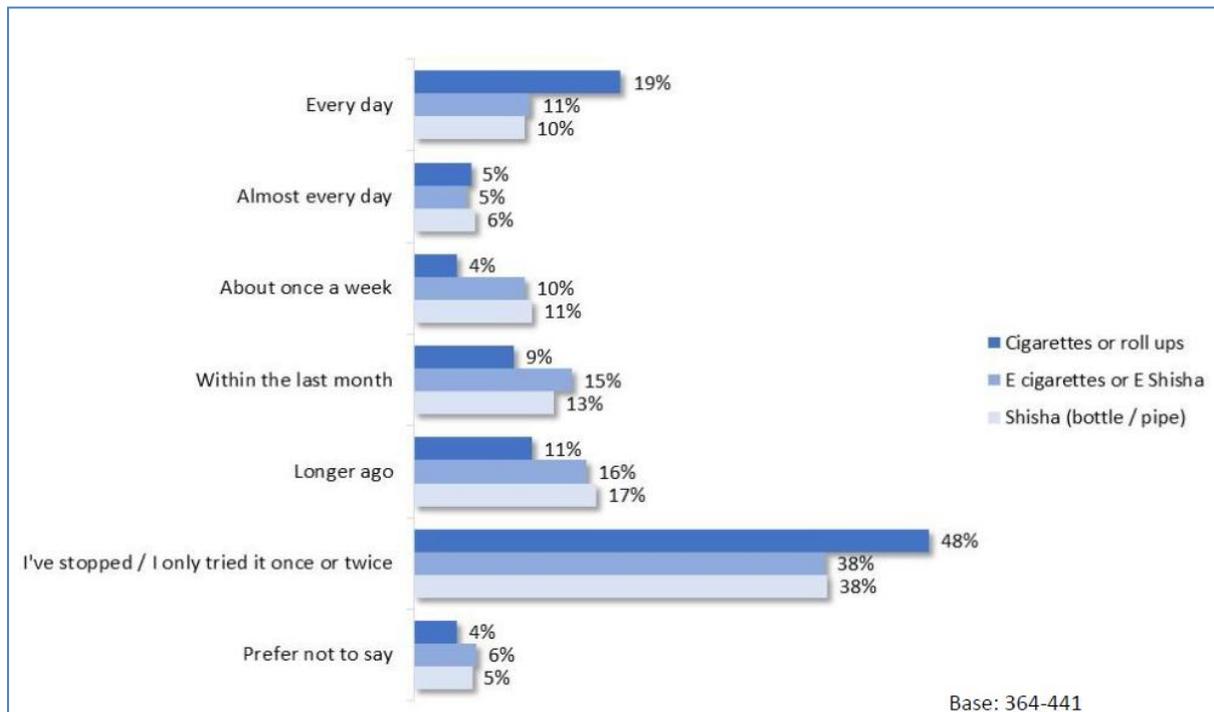


Source: Health and social care information centre (HSCIC); Smoking, Drinking and Drug Use among Young People in England in 2013.

In 2013 Walsall Council developed and launched the YOW survey, anonymised online survey for secondary school children in Walsall. The YOW survey showed that over seven in ten young people they do not or never smoked, however just under one fifth claimed they do or have smoked cigarettes or roll ups and e-cigarettes or e-shisha (18% and 17% respectively) which shows higher prevalence of smokers than national averages<sup>†</sup>. Of those young people who smoked, the majority claimed they have either stopped smoking or only tried it once or twice (see Figure 10).

<sup>†</sup> Based on YOW survey and base of 2176 young people.

Figure 10: Smoking frequency, YOW survey



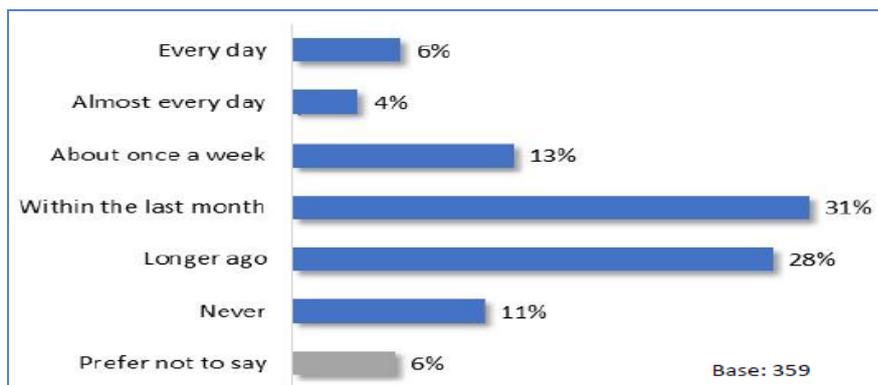
Source: Youth of Walsall Survey (YOW)<sup>5</sup>.

### Alcohol

The YOW survey reported that 24% of young people claim to have had a proper alcoholic drink, either with or without knowledge of or permission for this from their parent/carer.

Of those young people who have had an alcoholic drink in the last four weeks, almost half (48%) claim they have been drunk. Significantly more young people who have been drunk in the last four weeks also claim to smoke or have smoked cigarettes/rollups or e-cigarettes/e-shisha.

Figure 11: Frequency of alcohol consumption



Source: YOW survey

Note: based on claim to have had an alcoholic drink without permission.

From the YOW sample it was reported that around 12-13 years old children and young people first tried an alcoholic drink (see

Figure 12).

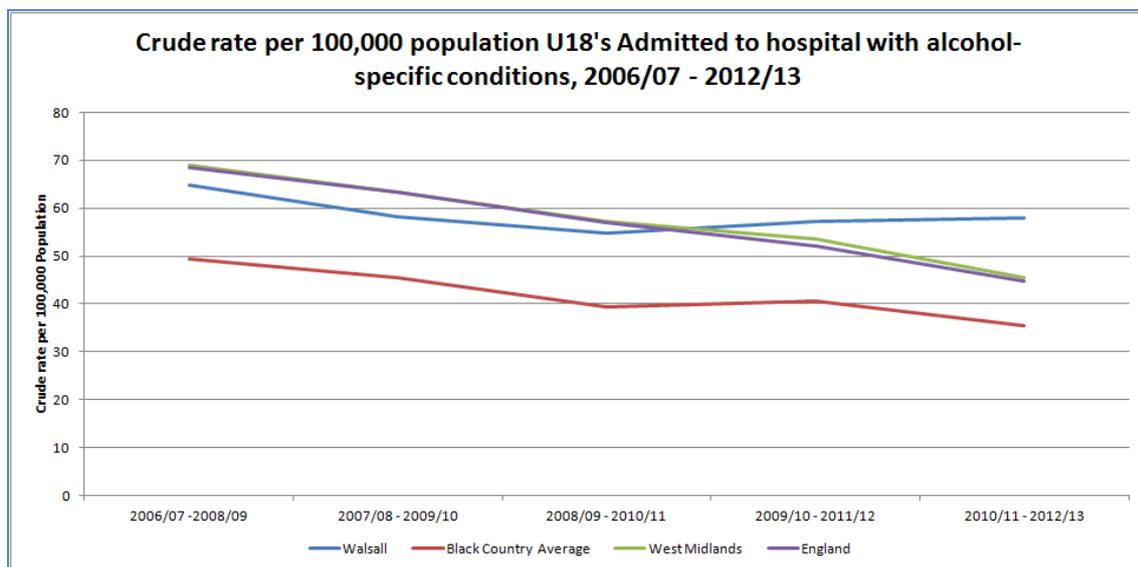
**Figure 12: Age distribution of CYP first trying alcoholic drink**



Source: YOW survey

The local alcohol profiles for England shown in Figure 13 below suggests that the number of under 18's admitted to hospital with an alcohol specific condition in Walsall seems to be increasing in recent years whereas regional and national averages are showing a decline.

**Figure 13: Under 18's admission to hospital with alcohol specific conditions, 2006/07 - 2012/13.**

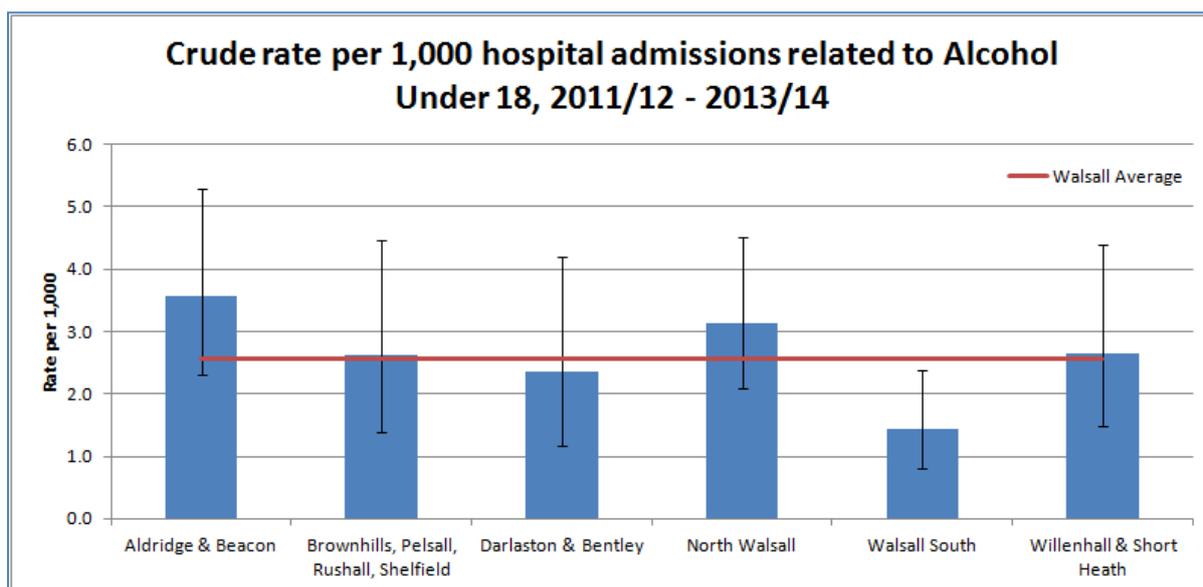


Source: Local Alcohol Profiles for England (LAPE).

**Caveat:** Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol. Does not include attendance at Accident and Emergency departments.

Figure 14 shows three area partnerships with higher rate than Walsall average with Aldridge & Beacon being highest rate followed by North Walsall.

Figure 14: Alcohol specific hospital admissions by Walsall area partnership, 2011/12 - 2013/14.



Source: Secondary Use Service (SUS), 2011/12 – 2013/14.

**Caveat:** Accident and emergency admission not included and the following ICD10 codes used in data extract : E244, F10, G312, G621, G721, I426, K292, K70, K860, Q860, R780, T510, T519, X45, X65, Y15, Y90 and Y91.

### Substance Misuse

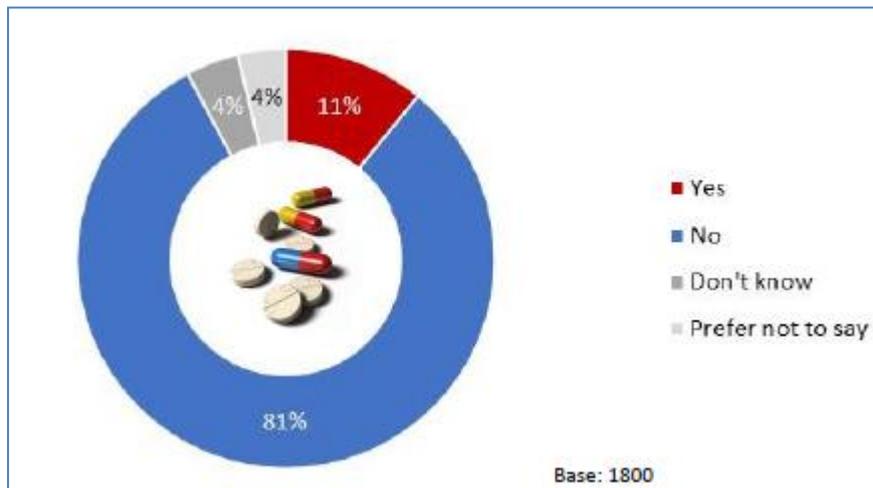
Nationally, the prevalence of drug taking by young people aged 11 to 15 is estimated to be 16% in 2013 and has similar recorded levels in 2011 and 2012<sup>6</sup>. Although between 2003 and 2011 drug use amongst this group did show a decline.

Cannabis was the most widely used drug amongst young people, with 7% reporting to have taken it in the last year. In the past 12 months, over eight in ten young people claimed to have been offered it.

Young people using cannabis by the age of 15 are 3 times more likely to develop serious mental health conditions including schizophrenia. Of those aged 11-15 who use cannabis at least once a month, around half (49%) are likely to have mental health condition<sup>7</sup>.

Local information on prevalence in Walsall is limited, however the YOW survey showed that 11% of respondents claimed they were offered or had taken illegal drugs (see Figure 15).

Figure 15: Offered or have taken illegal drugs?

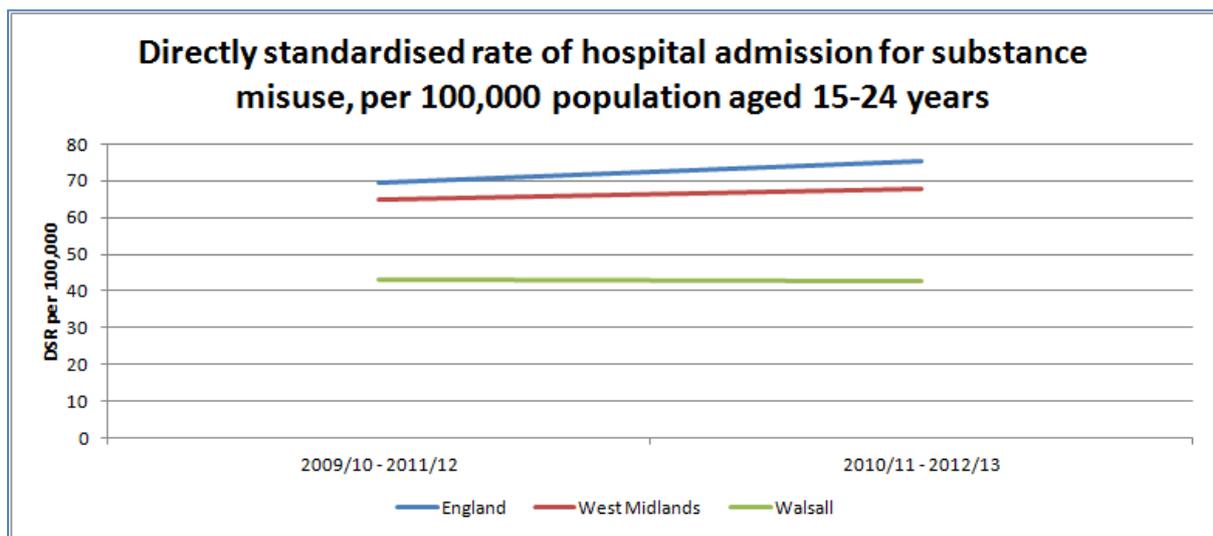


Source: YOW survey

**Caveat:** The results from survey were not weighted and are not representative of the wider Walsall CYP population.

In Walsall the rate of hospital admissions related to substance misuse is below the regional and national averages at 42.7 per 100,000 (see Figure 16).

Figure 16: Hospital admissions for substance misuse



Source: Hospital Episode Statistics (HES) and ONS

## Bullying

The Department of Education defines bullying as “behaviour by an individual or group, often repeated over time, that intentionally hurts another individual or group. Bullying can produce feelings of powerlessness, isolation, damage the sense of self-worth, and sometimes lead to victims feeling that they are at fault. It can lead to serious and prolonged damage for an individual and indeed their family<sup>8</sup>.

The relationship between bullying and mental health has bi-directional nature (see Figure 17) with both affecting and causing the other.

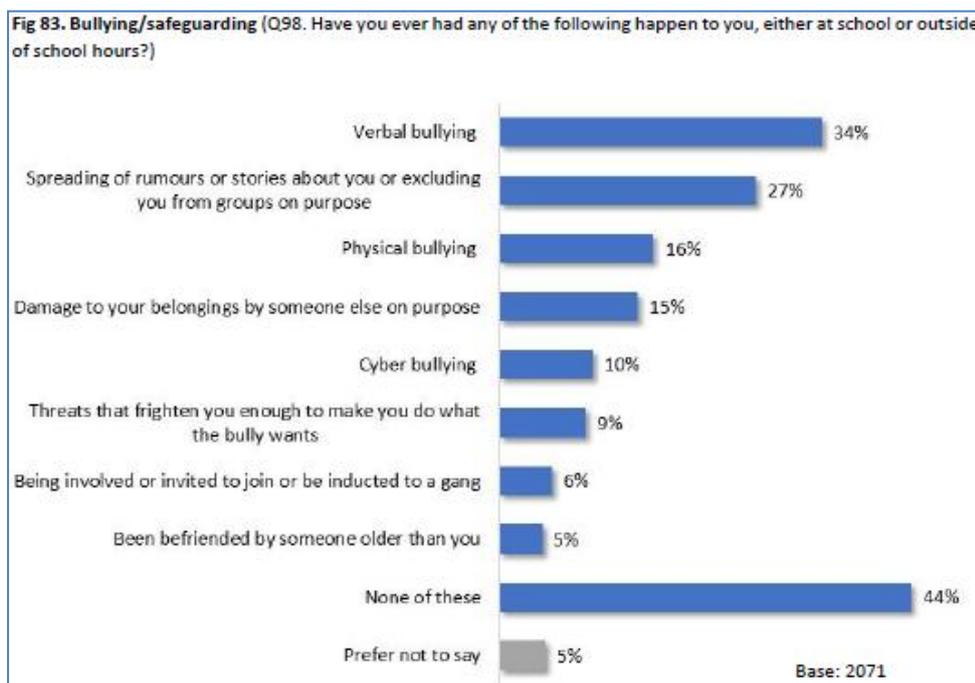
Figure 17: Link between Bullying and Mental Health



Source: Anti-bullying alliance<sup>9</sup>

There is limited data available locally on bullying however the YOW survey reported that over one in ten young people (see Figure 18) claimed to have experienced physical bullying (16%) and damage to their belongings by someone else on purpose (15%)<sup>10</sup>.

Figure 18: Bullying/Safeguarding response from YOW survey.



Source: YOW survey

Significantly more girls compared with boys claim they have:

- Been verbally bullied (40% ♀ , 28% ♂)
- Had rumours spread about them (32% ♀ , 22% ♂)
- Been cyber bullied (14% ♀ , 6% ♂)

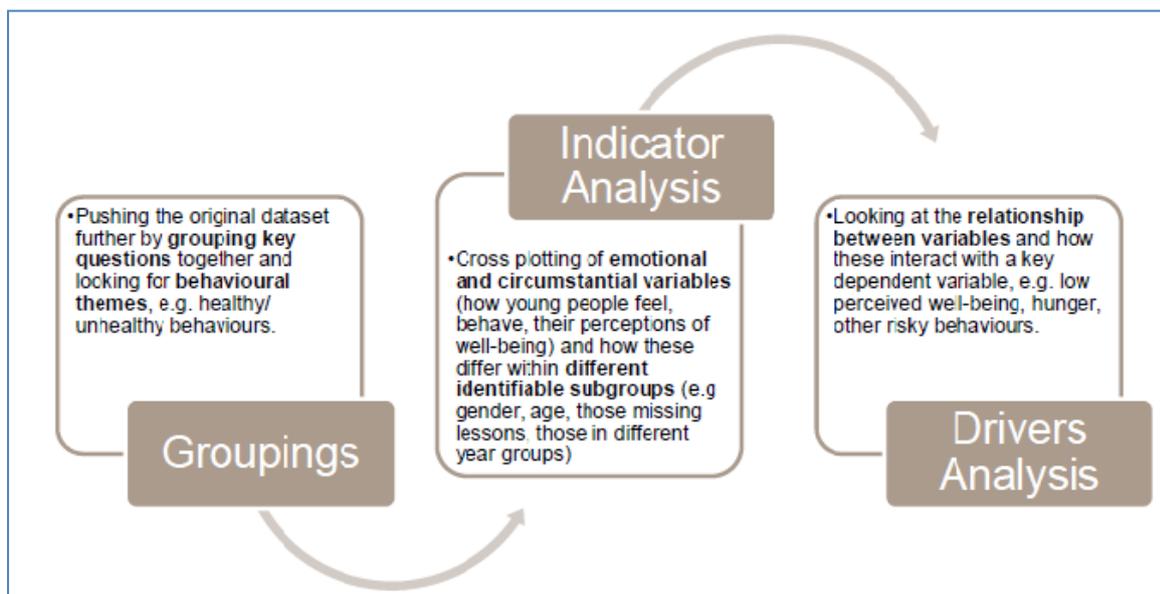
However significantly more boys compared with girls claim they have:

- Been physically bullied (21% ♂,12% ♀)
- Had belongings damaged (17% ♂,13% ♀)
- Been involved in a gang (8% ♂,3% ♀)

**This suggests that girls are more likely to experience emotional bullying whereas boys are more likely to have a physical experience.**

In January 2015, the CYP partnership board identified an opportunity for a second phase of YOW survey analysis looking to identify lead indicators for 'At risk' groups and their behaviours using a driver analysis approach (see Figure 19).

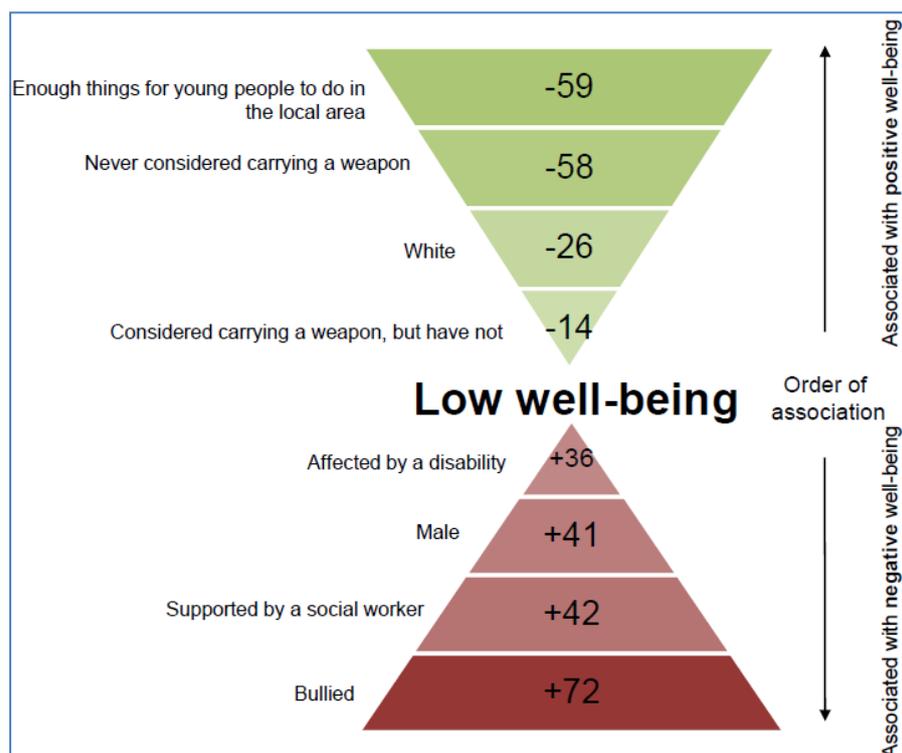
Figure 19: YOW survey phase 2 driver analysis methodology



Source: YOW, phase 2

The phase 2 analysis used Low Well-being as one the indicators to examine under the driver analysis approach and the results suggested that there was inverse association ( $R^2 = 0.14$ ) between wellbeing and those individuals supported by a social worker and bullied (see Figure 20 ).

Figure 20: YOW survey driver analysis result for well-being



Source: YOW, phase 2

## Prevalence of mental health problems

Around 9.6% of all CYP aged 16 and under are likely to experience some level of mental disorder (4,380)<sup>11,12</sup>. The most prevalent appears to be conduct disorders, affecting 6% of under 16's which could represent about 2,720 children in Walsall.

### 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"<sup>13</sup>

A literature review of four studies 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% (Egger, H et al, 2006)<sup>14</sup>. Applying this average prevalence rate to the estimated population within the area, gives a figure of 2,970 children aged 2 to 5 years inclusive living in Walsall who have a mental health disorder (attention deficit hyperactivity disorders, oppositional defiant and conduct disorders, anxiety disorders and depressive disorders).

### School-age children

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green et al (2004)<sup>15</sup>. 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 gender, 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, Table 11 below shows the estimated prevalence of mental health disorder by age group and gender in Walsall. 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.

**Table 11: Estimated prevalence of mental health conditions in children and young people.**

Indicator Description	Age group	Children		Boy		Girls	
		Prevalence	Estimate number	Prevalence	Estimate number	Prevalence	Estimate number
Number of children with mental health disorder	5-10	7.7	1,830	10.2	1,230	5.1	605
	11-16	11.5	2,550	12.6	1,435	10.3	1,115
	5-16	9.6	4,380	11.4	2,665	7.8	1,720
Number of children with conduct disorders*	5-10	4.9	1,195	6.9	850	2.8	345
	11-16	6.6	1,525	8.1	940	5.1	585
Number of children with emotional disorder**	5-10	2.4	555	2.5	260	2.2	295
	11-16	5	1,155	6.1	500	4	655
Number of children with hyperkinetic disorders***	5-10	1.6	415	2.7	360	0.4	55
	11-16	1.4	325	2.4	285	0.4	45
Number of children with less common disorders****	5-10	1.3	310	2.2	255	0.4	55
	11-16	1.4	270	1.6	180	1.1	90
Neurotic disorders - Mixed anxiety and depressive disorder	16-19			51 per 1,000	360	124 per 1,000	835
Neurotic disorders - Generalised anxiety disorder	16-19			16 per 1,000	115	11 per 1,000	75
Neurotic disorders - Depressive episode	16-19			9 per 1,000	65	27 per 1,000	185
Neurotic disorders - All phobias	16-19			6 per 1,000	45	21 per 1,000	145
Neurotic disorders - Obsessive compulsive disorder	16-19			9 per 1,000	65	9 per 1,000	65
Neurotic disorders - Panic disorder	16-19			5 per 1,000	35	6 per 1,000	45
Any neurotic disorder	16-19			86 per 1,000	605	192 per 1,000	1,295

**Source:** CHIMAT; ONS 2014 mid-year Walsall population estimate. Green,H et al (2004) and Singleton et al (2001)<sup>16,17</sup>.

**Caveats:** The numbers are calculated based on the estimated rates of mental health disorders in the relevant group, applied to the population of Walsall. Therefore boys, girls and children will all be calculated separately, and because of the complexity of rounding, estimating the rates for children will not simply be an addition of boys and girls. These shouldn’t be treated as absolute numbers, but estimates based on likely outcomes for the population groups (Source: West Midlands Knowledge and Information Team, personal communication: Nicola Dennis on 31<sup>st</sup> July 2015)

\*Conduct disorders characterised by awkward, troublesome, aggressive and antisocial behaviours

\*\*Emotional disorders such as anxiety, depression and obsessions

\*\*\*Hyperactivity disorders involving inattention and overactivity.

\*\*\*\*Less common disorders such as Autistic spectrum disorder and those with multiple disorders.

## Autistic Spectrum Disorder

Autistic spectrum disorder (ASD) is a condition that affects social interaction, communication, interest and behaviour. It includes Asperger syndrome and childhood autism<sup>18</sup>.

Table 12 below shows that the number of children with ASD in Walsall has been increasing over time and since 2009 the number of children known between health and education services (Walsall Council’s Education Service Schools and Walsall Healthcare NHS Trust Disability database) has almost doubled.

**Table 12: Number of CYP with Autistic spectrum disorder in Walsall**

<b>Autistic spectrum disorder</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Walsall Council Education services database	259	304	336	407	420	324
Walsall Healthcare NHS Trust disability database					453*	507**

\*data relates to July 2013

\*\*data related to December 2014

## Prevalence of ASD

A study of 56,946 children in South East London by Baird et al (2006) estimated the prevalence of autism in children aged 9 to 10 years at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000<sup>19</sup>.

A survey by Baron-Cohen et al (2009) of autism-spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively<sup>20</sup>. The ratio of known to unknown cases is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases.

The next table shows the numbers of children with autistic spectrum disorders if the prevalence rates found by Baird et al (2006) and Baron-Cohen et al (2009) were applied to the population of Walsall. In comparison to the figures from WHNT disability database in July 2013 the 9-10 year estimate is identical, however the 5-9 years age group shows only half the estimated numbers of children are known to health services.

**Table 13: Estimated prevalence of autistic spectrum disorders in Walsall.**

	<b>Estimated prevalence</b>	<b>Number of CYP WHNT disability database</b>
Autism in children aged 9-10 years	30	-
Other ASDs in children aged 9-10 years	55	-
Total of all ASDs in children aged 9-10 years	80	80
Autism-spectrum conditions disorders in children 5-9 years	290	145

Source: CHIMAT; ONS 2012 mid-year population estimate. Baird, G et al (2006). Baron-Cohen, S et al (2009)<sup>21,22</sup>.

## *Age*

ASD can be reliably diagnosed between the ages of 2-3 years although there's evidence that indicates that parents are able to detect change in their children as early as 18 months<sup>23</sup>.

## *Gender*

Recent studies continue to report that there is male bias in ASD prevalence, with some suggesting that 4 times as many males as females on average have the condition<sup>24</sup>. Brugha (2009) surveyed adults living in households throughout England, and found that 1.8% of males surveyed had an ASD, compared to 0.2% of females<sup>25</sup>. The odds of identification for boys over six times the odds for girls<sup>26</sup>

## *Ethnicity*

There's conflicting evidence on the association ethnic background and the prevalence of ASD. Studies in the U.S have shown that non-Hispanic white children when compared to non-Hispanic black children were likely to have a diagnosis of ASD<sup>27</sup>. Whereas cohort studies in the UK indicate that the incidence of ASD in children of Afro-Caribbean who were born outside the U.K was higher when compared to children of white UK-born mothers and even white non-uk mothers<sup>28</sup>. Another study shows that the incidence of ASD remain even in children of 2nd generation Afro-Caribbean mothers<sup>29</sup>. Although most studies show that incidence of ASD is higher in children of mothers emigrate outside Europe and North America one Australian study showed that the incidence of ASD was high in children of immigrants from Europe as well<sup>30</sup>. It would therefore be seen the risk of ASD then is associated with immigration rather than ethnic background.

A department of Education report evaluated data from school census done between 2005-2011 indicate that For ASD, Black Other and Black Caribbean groups were over-represented while there was an under-representation of Indian, Pakistani, Bangladeshi, and Other Asian pupils. On average the odds of identified ASD for these four Asian groups are about half the odds for the White British group<sup>31</sup>.

## **Psychosis and schizophrenia**

The prevalence of psychotic disorders in children aged 5-18 is 0.4%. Schizophrenia represents 24.5% of all psychiatric admissions aged 10-18 (admission rate 0.46 per 1000) with an exponential rise across adolescents from the age of 15<sup>32</sup>.

The Early intervention Psychosis service received 41 referrals in 2014/15 with 80.5% from the transition cohort and remaining to young cohort (see Table 14). The waiting times are higher for the transition cohort compared with 14-16 year old age group possibly due to higher volume of individuals accessing the service.

Table 14: Referrals and waiting times to Early Intervention in Psychosis service, 2014-15.

Age Group	Referrals to Early intervention psychosis service	Average waiting time (days)
14-16 years old	8	17
17-24 years old	33	26

Source: DWMPHT

## Eating Disorders

Eating disorders can manifest themselves in a variety of ways; the most serious are anorexia and bulimia nervosa.

### Anorexia Nervosa

**Anorexia nervosa:** is determined food avoidance resulting in weight loss, or failure to maintain a steady weight gain related to increasing age.

#### *Gender & Ethnicity*

The incidence of anorexia nervosa in the general population is 19 per 100,000 per year in females and 2 per 100,000 per year in males. Although not uncommon in ethnic minorities the prevalence still remains low<sup>33</sup>.

### Bulimia Nervosa

**Bulimia nervosa:** young person experiencing recurrent food binges followed by compensatory behaviour, such as vomiting, laxative use, excessive exercise and fasting.

#### *Gender & Ethnicity*

About 90 per cent of people diagnosed with bulimia nervosa are female. In Britain, young Muslim Asian women may be at particular high-risk of developing bulimia nervosa<sup>34</sup>.

#### *Age onset for Eating Disorders*

A surveillance study over 14 months done through the British Paediatric Surveillance System in 2011 showed an increasing incidence of eating disorders with increasing age. Their study looked at children from the age of 6-13 years and found the highest incidence was in those age 12-13 years<sup>35</sup>.

A GP Register study looking at data from 2000-09 found that incidence of diagnosis for eating disorders ED was highest for girls aged 15-19 years and for boys aged 10-14 years<sup>36</sup>. By applying these rates to the Walsall population, it is estimated that about 21 eating disorder referrals per year.

## Referrals and Waiting times

There were 61 referrals to eating disorder service (DWMPHT) in 2014/15; the transition cohort (17-25 years) had the highest proportion of the referrals in comparison to younger cohort (Under 17's) (see Table 15).

**Table 15: Referrals and waiting times to Eating Disorder Service, 2014-15**

Age group	Referrals to Community Eating Disorder Service	Average waiting time
Under 12	14	Within 2 weeks
12-16 years old	7	Within 5-6 weeks
17-25 years old	40	Within 2-3 weeks

**Source:** Dudley and Walsall Mental Health Trust

**Caveat:** The referrals to Eating Disorder Service categorises 'Eating Issues' which includes both difficulties and disorders.

The waiting times for the under 12's age group are reported to be upto 2 weeks and it is similar for the transition cohort (upto 2-3 weeks) whereas the 12-16 years cohort could have double the waiting time (within 5-6 weeks). This could indicate that those service users in 12-16 years age group may have had higher proportion of referred related to eating difficulties rather than eating disorder which would take priority.

## Suicide

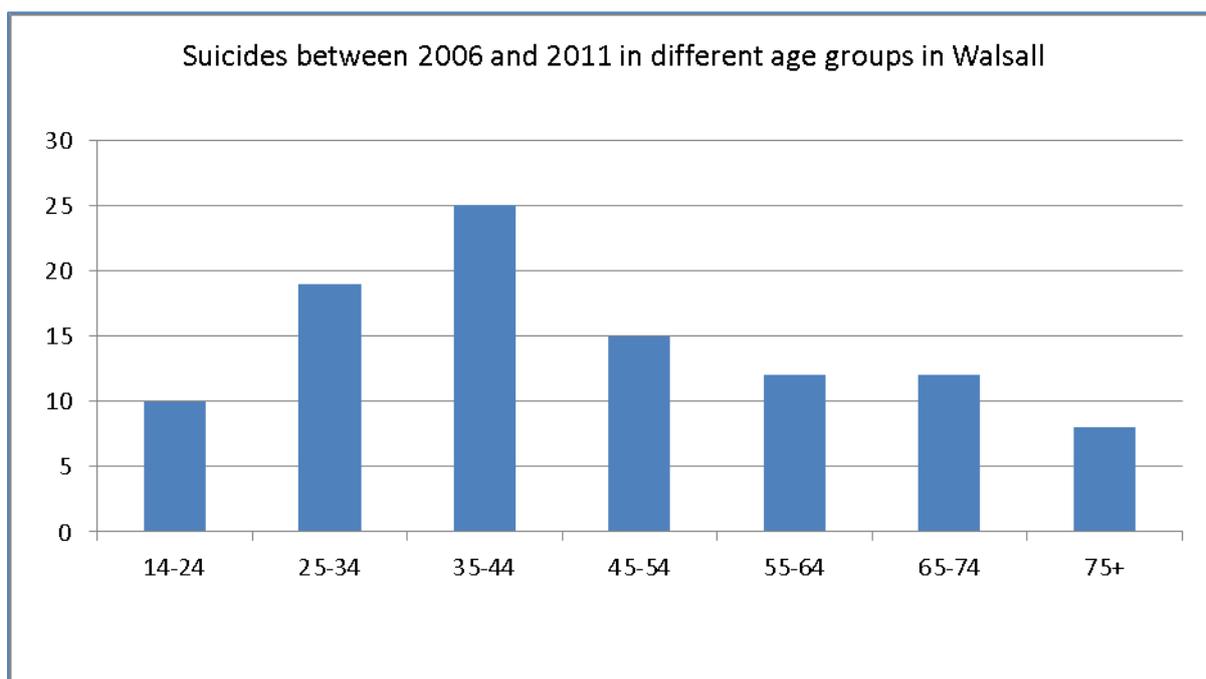
Suicide is a complex issue and one which requires further research to understand better the specific risk factors associated with it. Looking at suicides in the UK between 1997 and 2003, one study has made the following observations (Windfuhr, K., 2008)<sup>37</sup>:

- Three times as many young men as young women aged between 15 and 19 committed suicide
- Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults.
- Looking at the difference between sexes, 20% of young women were in contact with mental health services compared to only 12% of young men.

According to ONS, in 2014 there were 476 deaths of 15 to 24 year olds from intentional self-harm or undetermined intent in England and Wales. This is a rate of 6.6 deaths per 100,000 population aged 15 to 24 years.

The suicide age in Walsall, between 2006 and 2011, varied from 14 to 75+, with average age at 45 and median age 43. The highest suicide rates in Walsall were among those aged 35 - 44 for males and 65 - 74 females, whereas the young people cohort (14-24 years) had lowest number of suicides (see Figure 21).

Figure 21: Number of Suicides and injury undetermined by age, 2006-11.



Source: Public Health Mortality File (PHMF), 2006-2011.

## Self-Harm

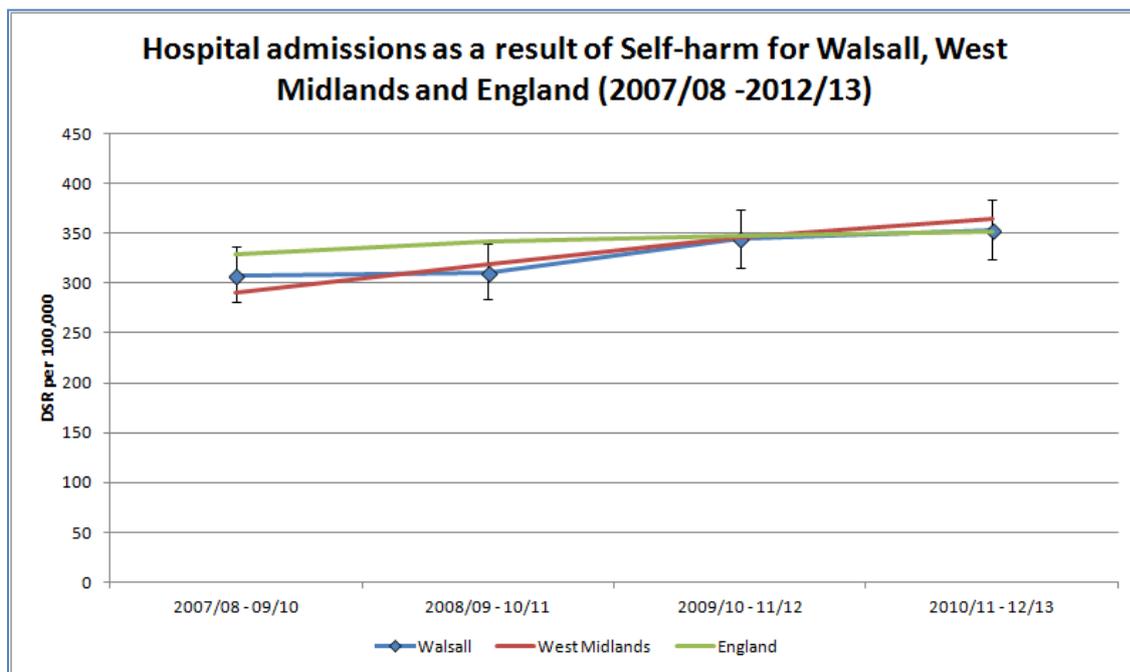
Hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment. Self-harm is a related issue:

- Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds (Hawton, K., 2012)<sup>38</sup>.
- Self-poisoning was the most common method, involving paracetamol in 58.2 % of episodes (Hawton, K., 2012)
- Presentations, especially those involving alcohol, peaked at night.
- Repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year) (Hawton, K., 2012). As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months (Hawton, K., 2005)
- Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide (Hawton, K., 2005)

- Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors (Hawton, K., 2005)
- The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital (Hawton, K., 2005)

Walsall had been below the regional and national rates over the years; however the most recent data (2010/11-2012/13) indicates that the gap has narrowed between Walsall (352.5 per 100,000) and regional, national averages (see Figure 22)

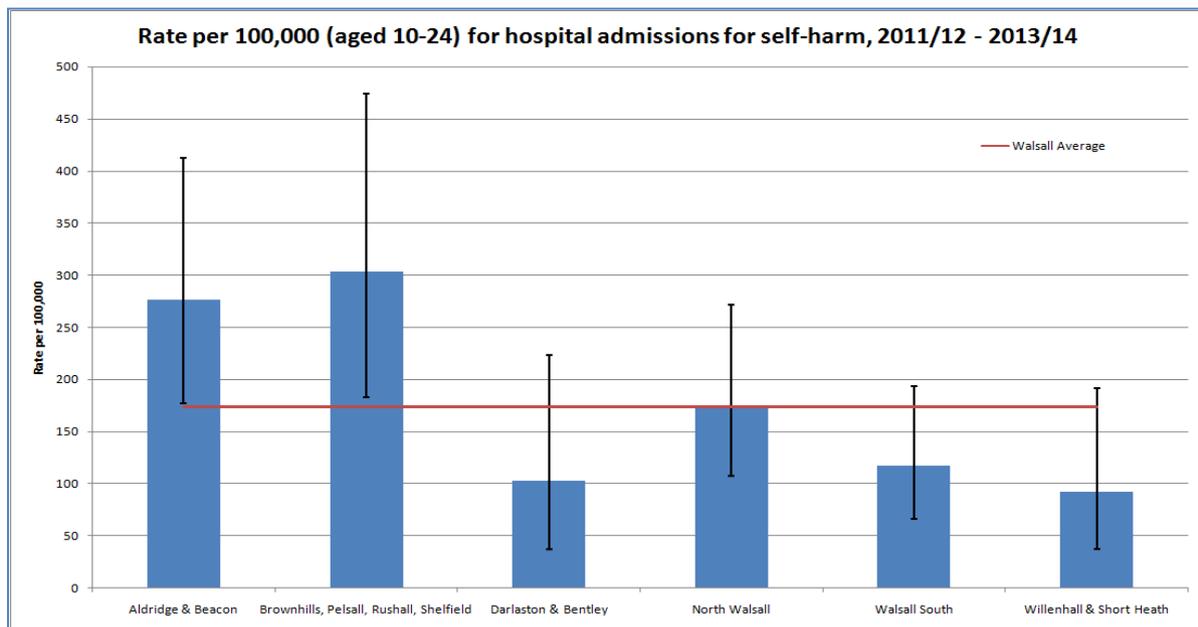
Figure 22: Hospital admissions for self harm, 2007/08 - 2012/13



Source: Local authority child health profiles

There are two area partnerships; Aldridge & beacon and Brownhills APs which were significantly higher than Walsall average over 3 year period (see Figure 23).

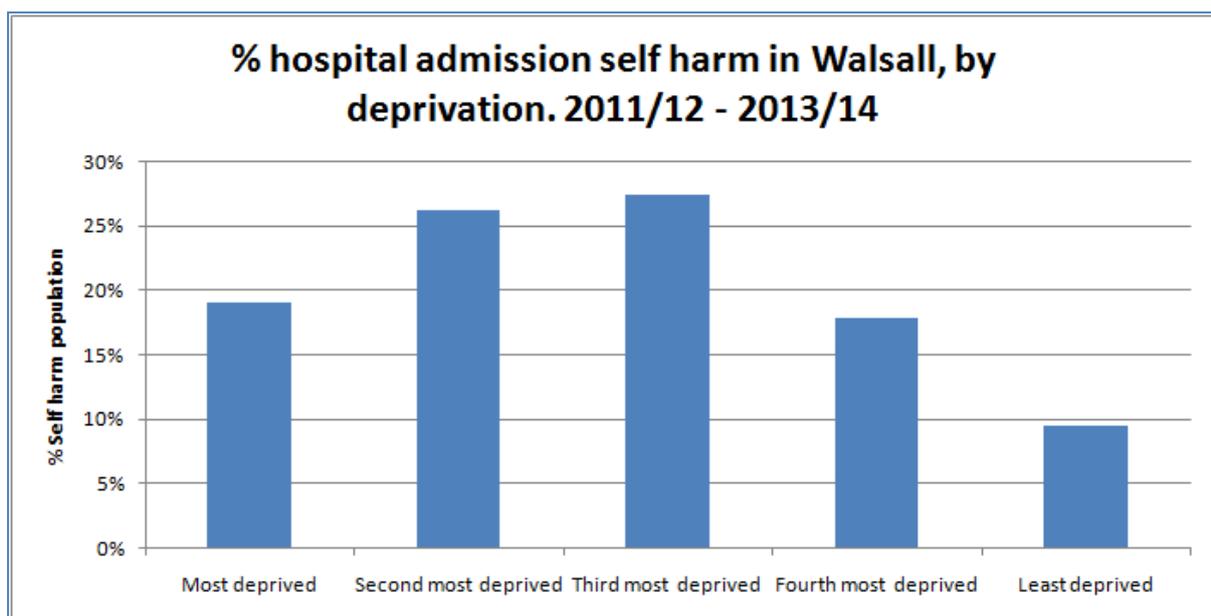
Figure 23: Rate per 100,000 (aged 10-24) for hospital admissions for self-harm, 2011/12 - 2013/14.



Source: Secondary uses service dataset (SUS) and ONS; census 2011.

Figure 24 shows the highest percentages of admissions for self harm are young people from local IMD quintiles 2 and 3. There was twice the proportion of young people admitted to hospital for self harm from the most deprived population compared with least deprived.

Figure 24: Proportion of hospital admission self harm in Walsall by deprivation (local quintiles), 2011/12 - 2013/14.



Source: SUS 2011/12 – 2013/14.

The largest numbers of self harm related inpatient spells were CYP from 15-19 year age group (see Table 16). Information from DWMPHT (see Figure 25) shows that referrals related to self harm has been decreasing over the last couple of years whereas inpatient spell seems to be increasing. There is much higher number of girls referred to CAMHS for deliberate self harm compared with boys.

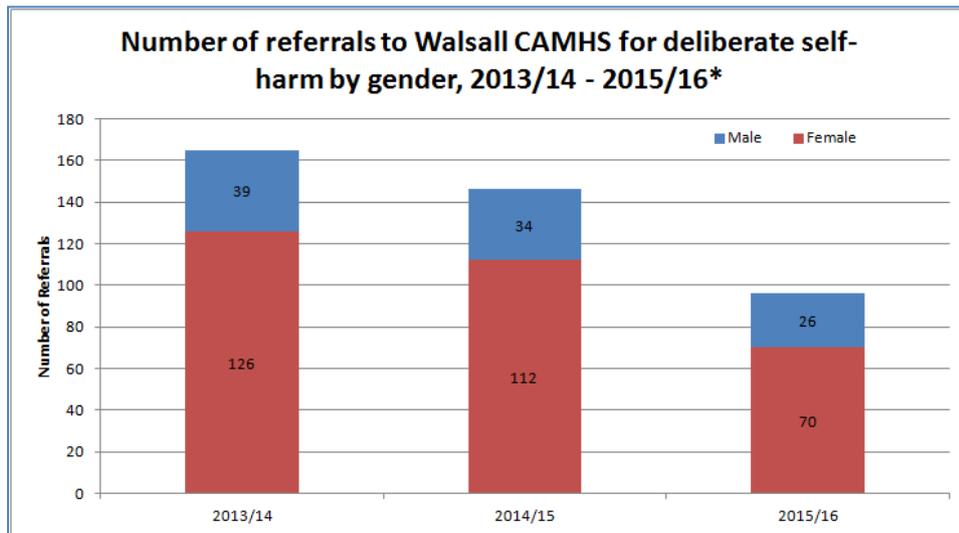
**Table 16: Walsall CCG self harm related Inpatient spells**

Age Band	Number of self harm inpatient spells	
	2013/14	2014/15
5-9	<5	<5
10 - 14	30	54
15 - 19	96	100
20 - 24	59	62

Source: Walsall CCG

Notes: Walsall CCG registered inpatient spells with a diagnosis of Y10 to Y34 and X60 to X84 in any diagnosis position.

**Figure 25: Deliberate self harm referrals to Walsall CAMHS, 2013/14 - 2015/16**



Source: DWMPHT

\*2015/16 data represents information between 1<sup>st</sup> April 2015 and 17<sup>th</sup> August 2015.

## What works - Summary of national guidance

### Emotional wellbeing

Good emotional health, including social and psychological health will help protect our children and young people against emotional and behavioural problems, violence and crime, teenage pregnancy and drug and alcohol misuse<sup>39</sup>. NICE define this as;

*happiness, confidence and not feeling depressed (emotional wellbeing) a feeling of autonomy and control over one's life, problem-solving skills, resilience, attentiveness and a sense of involvement with others (psychological wellbeing) the ability to have good relationships with others and to avoid disruptive behaviour, delinquency, violence or bullying (social wellbeing<sup>40</sup>)*

*Promoting social and emotional wellbeing in education<sup>41 39</sup>,*

- Local authorities should ensure schools provide an emotionally secure environment that prevents bullying, encourages young people's sense of self-worth, promotes positive behaviour, 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 into all aspects of the curriculum and tailored to the developmental needs of children and young people. Staff should be trained to deliver it effectively. Practitioners should have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing.
- 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.
- Education establishments should have access to the specialist skills, advice and support they require.

### Depression

NICE Guidelines Depression in children and young people: Identification and management in primary, community and secondary care issued in March 2015 set out how to manage depression for any professional in contact with Children aged 5 to 18. It clearly identifies the 10 symptoms, split into the 4 categories (not depressed to severe depression) and how to manage them. It also states that with children you must assess how they are function in different environments (school, with peers and family) alongside their depressive symptoms. All professionals should be aware that abuse can be a contributing factor to their mood.

The Stepped Care model below is to help professionals identify the most appropriate service for the patient's level of depression.

**Table 17: Stepped Care Model**

<b>FOCUS</b>	<b>ACTION</b>	<b>RESPONSIBILITY</b>
Detection	Risk profiling	Tier 1
Recognition	Identification in presenting children or young people	Tiers 2-4
Mild depression (including dysthymia)	Watchful waiting Non-directive supportive therapy/ group cognitive behavioural therapy/ guided self-help	Tier 1 Tier 1 or 2
Moderate to severe depression	Brief psychological therapy +/- fluoxetine	Tier 2 or 3
Depression unresponsive to treatment/recurrent depression/psychotic depression	Intensive psychological therapy +/- fluoxetine, sertraline, citalopram, augmentation with an antipsychotic	Tier 3 or 4

Another important recommendation notes that young people within the transition age group should be managed by both CAMHS and AMHS so they can both provide joint “assessment and services to young people with depression. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.”

**Step 1: Detection and risk profiling**

Healthcare professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression, and to assess children and young people who may be at risk of depression. Child and Adolescent Mental Health Services (CAMHS) tier 2 or 3 should work with health and social care professionals in primary care, schools and other relevant community settings to provide training and develop ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed.

**Step 2: Recognition**

Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions.

**Step 3: Mild depression**

Antidepressant medication should not be used for the initial treatment of children and young people with mild depression.

**Steps 4 and 5: Moderate to severe depression**

Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months. [Do not offer antidepressant medication to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy. Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and

general progress; for example, weekly contact with the child or young person and their parent(s) or carer(s) for the first 4 weeks of treatment. The precise frequency will need to be decided on an individual basis, and recorded in the notes. In the event that psychological therapies are declined, medication may still be given, but as the young person will not be reviewed at psychological therapy sessions, the prescribing doctor should closely monitor the child or young person's progress

## Psychosis and Schizophrenia

The NICE guidelines for psychosis and schizophrenia in children and young people covers recognition and management of children to the age of 18yrs

The guidelines are for professionals in primary, secondary, tertiary and community health and social care and cover treatment options for first and subsequent episodes of psychosis and schizophrenia. They recommend consideration of care within the community where possible prior to referral for hospital care<sup>42</sup>.

Some of the general principles of care state that professionals working with children and young people suffering with psychosis or schizophrenia should be able to work with all levels of learning ability, cognitive capacity, emotional maturity and development. They should be able to assess capacity and competence in children (Gillick Competence) and use local safeguarding procedures if concerned<sup>25</sup>.

## Eating disorders

NICE produced guidelines in 2004 which covers "identification, treatment and management of anorexia nervosa, bulimia nervosa and atypical eating disorders (including binge eating disorder) in primary, secondary and tertiary care." It applies to children aged 8 and over up to and including adults.

All people with eating disorders should have their physical, social and psychological needs assessed together.

If the patient presents in primary care "GPs should take responsibility for the initial assessment and the initial coordination of care. This includes the determination of the need for emergency medical or psychiatric assessment."<sup>43</sup> (Pg 5)

However, "Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals on the responsibility for monitoring patients with eating disorders. This agreement should be in writing (where appropriate using the care programme approach) and should be shared with the patient and, where appropriate, his or her family and carers."

Specific advice is listed below:

### Anorexia nervosa

- Most should be managed on an outpatient basis with psychological treatment
- People requiring admission should be admitted to a setting that's provides skilled implementation of re-feeding with careful physical monitoring in combination with psychosocial interventions
- Family interventions

### Bulimia nervosa

- Self help programme
- May be offered trial of anti depressant as an alternative or addition
- CBT –BN - adapted as needed to suit their age/level of development , including family as appropriate

### Atypical eating disorder

- Follow guidance on eating disorder that most resembles individuals presentation

### For all eating disorders

- Family members and siblings should be included in treatment – sharing of information, advice on behavioural management and facilitating communication.

## Autism

NICE has produced guidelines which covers the signs and symptoms that should prompt professionals working with children, young people, and their parents or carers to consider autism; information requirements from other agencies; components of diagnostic assessment after referral; appropriate information and day-to-day support for children, young people and their parents or carers during referral, assessment and diagnosis; and ineffective diagnostic interventions and approaches<sup>44</sup>.

## Conduct disorders

The guidance covers conduct disorders and antisocial behaviour which are the most common mental and behavioural problems in children (pg 4). The disorders will almost always have a “significant impact on functioning and quality of life” for the child or young person.

NICE classifies these disorders as

*“repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age appropriate social expectations.”*

The child or young person will usually have another mental health problem alongside the conduct disorder. NICE state that “40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD”<sup>45</sup>

The initial assessment should entail:

1. Considering using the Strengths and Difficulties Questionnaire (completed by a parent, carer or teacher).
2. Assess for the presence of the following significant complicating factors:
  - a. coexisting mental health problem (for example, depression, post-traumatic stress disorder)
  - b. a neuro-developmental condition (in particular ADHD and autism)
  - c. a learning disability or difficulty
  - d. substance misuse in young people

## Self harm

NICE separates the acute treatment of children and young people who have recently self harmed and their long term management.

The key priorities for a patient's initial assessment within the first 48 hrs are:

- Respect, understanding and choice
- Staff training
- Activated charcoal (within 1 hour of ingested poison)
- Triage
- Treatment
- Assessment of needs
- Assessment of risk
- Psychological, psychosocial and pharmacological interventions<sup>46</sup>

The longer term guideline is relevant to children and adults aged 8 and over. Again, NICE broke it down into key areas:

- Working with people who self-harm
  - Professionals working with people who self harm should aim to establish trust with their patients and encourage the patient to be fully involved with their treatment plans.  
Regarding children aged 8-17 (scope of this guidance), local safeguarding procedures should be followed along with multi agency approaches (schools and social services). "CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with perceived risks and the responsibilities and views of parents or carers."<sup>47</sup>
- Psychosocial assessment
- Risk assessment
- Risk assessment tools and scales
  - advice given is not to use them
- Care plans
- Interventions for self-harm
- Treating associated mental health conditions
  - Bipolar disorder, depression etc...

## Antenatal and postnatal mental health

NICE recognises that depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point. It also notes that many women may experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth.

NICE have produced guidance (2014) for 3 groups of women, as follows:

### Women of childbearing potential

Discuss with all women of childbearing potential who have a new, existing or past mental health problem:

- The use of contraception and any plans for a pregnancy
- How pregnancy and childbirth might affect a mental health problem, including the risk of relapse
- How a mental health problem and its treatment might affect the woman, the fetus and baby
- How a mental health problem and its treatment might affect parenting

#### Women who are pregnant and in the postnatal period

Recognising mental health problems in pregnancy and the postnatal period and referral:

- At a first contact with primary care or booking visit and during early postnatal period, asking depression identification question as a part of women mental health and wellbeing.
- Effective communication of any past or present mental health problems between all healthcare professionals referring to maternity services.

#### Coordinated care

Develop an integrated care plan for a woman with mental health problems in pregnancy and in postnatal period which sets out:

- Care and treatment
- Roles of all health professionals (including those responsible for; care plan, monitoring and providing intervention and agreeing outcomes).

## At Risk groups

The reasons why a child or young person experiences mental health problems are likely to be complex. However, certain factors are known to influence the likelihood of someone experiencing problems. The next sections explore the particular vulnerable groups in greater detail.

The following at risk groups have been described in this document

- [Children in need](#)
- [Children with special education needs and learning disabilities](#)
- [Youth offenders](#)
- [Transitional age groups](#)
- [LGBT](#)
- [Refugees and Travellers](#)
- [Teenage Pregnancy](#)
- [Maternal Mental Health](#)
- [Homeless young people](#)
- [Not in education, employment or training](#)
- [Domestic Abuse](#)
- [Young carers](#)

While children and young people in these groups may be at higher risk, this does not mean that as individuals they are all equally vulnerable to mental health problems. A range of protective factors in the individual, in the family and in the community influence whether a child or young person will either not experience problems or not be significantly affected by them, particularly if receiving consistent support from an adult whom they trust.

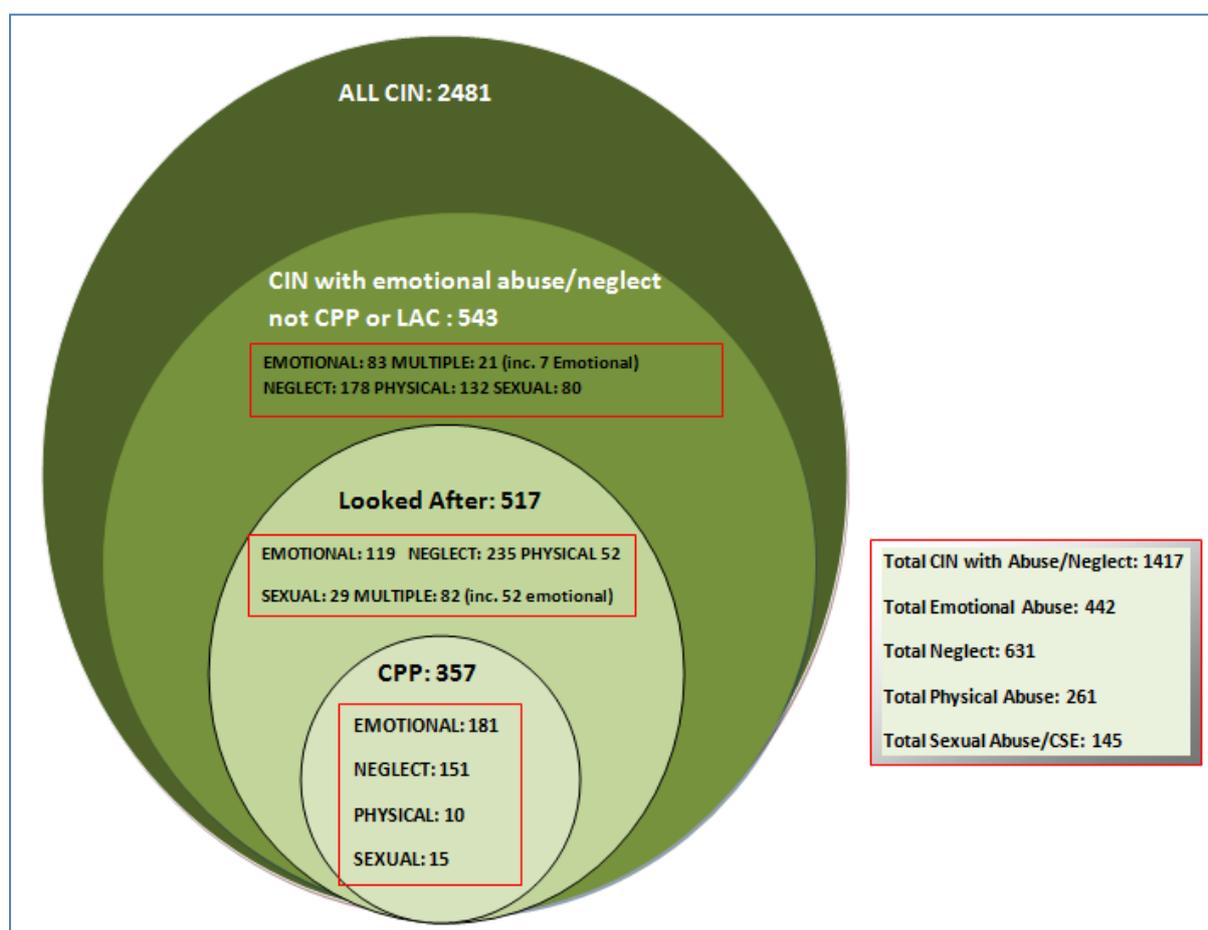
## Children in Need

The Children Act 1989 made provision for a specific group of vulnerable children described as 'children in need'. These children were defined as those whose vulnerability was such that they were unlikely to reach or maintain a satisfactory level of health and development, their health and development would be significantly impaired without the provision of services, or they were disabled<sup>48</sup>.

The Children in Need (CIN) category encompasses children and young people on children protection plans, CIN plans and looked after children which accounted for 2,481 children as of 31<sup>st</sup> March 2015 (see Figure 26).

There is strong evidence that child maltreatment is leading cause of poor mental health in childhood and throughout later life<sup>49,50</sup>. As of 31<sup>st</sup> March 215, 442 CIN had experienced some form of emotional abuse which represented 17.8% of all CINs.

Figure 26: Diagram showing relationship of different severity of children in need



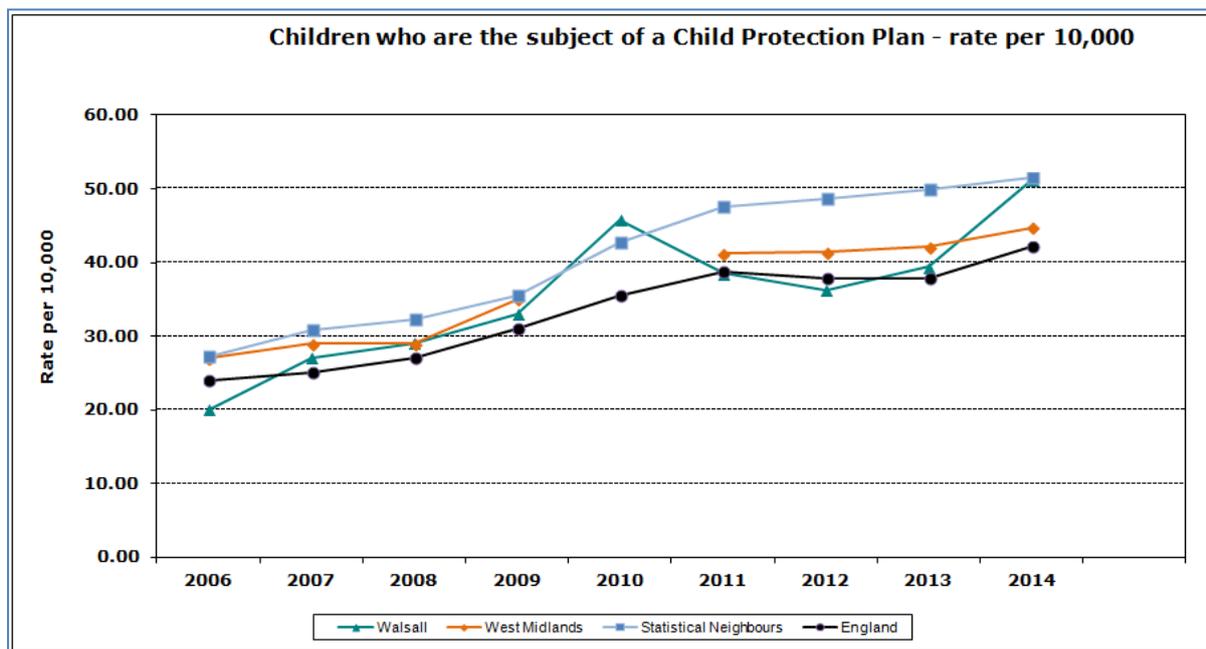
Source: Walsall Children Services

## Child Protection Plan

### Demographics

In Walsall as of 31<sup>st</sup> March 2015, there were 360 children on CPP. This equates to rate of 51.2 per 10,000 0-18 year olds. The number of children entering care since 2013 has increased at fast rate than regional and national averages (see Figure 27).

Figure 27: Rate per 10,000 Child Protection Plan in Walsall, 2006-2014



Source: DfE, LAIT (Accessed: 3<sup>rd</sup> June 2015).

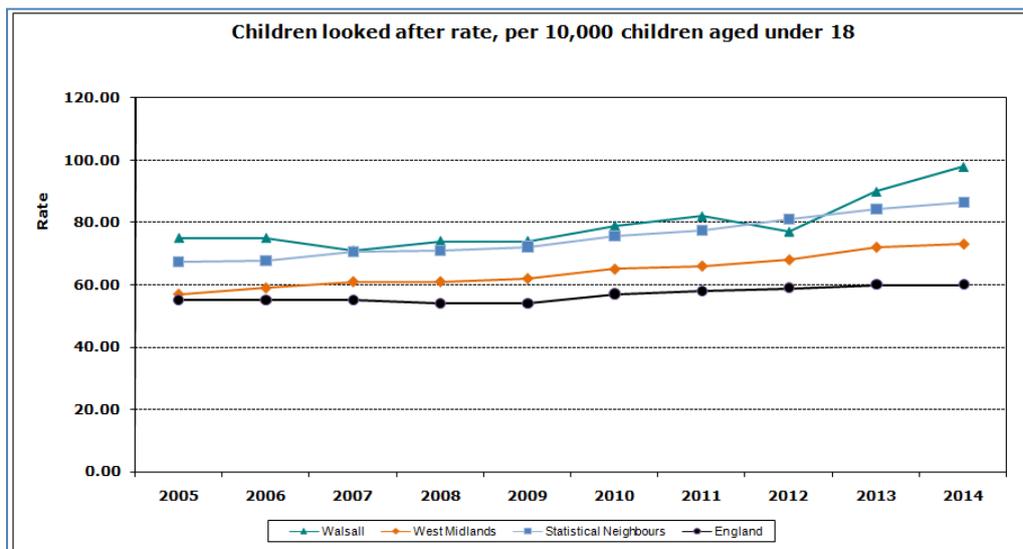
### Looked After Children

All local authorities have a statutory duty to protect children and young people from harm. Following a comprehensive assessment carried out by Children’s Social Care Services, if the child or young person (CYP) is considered unsafe in their present environment, following a court decision (or voluntary agreement with parents) Local Authorities take on the role of ‘corporate parent’ which involves placing the CYP in suitable safe placement – usually with a foster carer – and the CYP is then known as child in care<sup>51</sup>.

### Demographics

In Walsall as of 31st March 2015, there were 612 looked after children. This equates to rate of 90.4 per 10,000 0-18 year olds. The number of children entering care since 2012 has increased at faster rate than regional and national averages (see Figure 28).

Figure 28: Rate per 10,000 looked after children under 18, 2005-14.

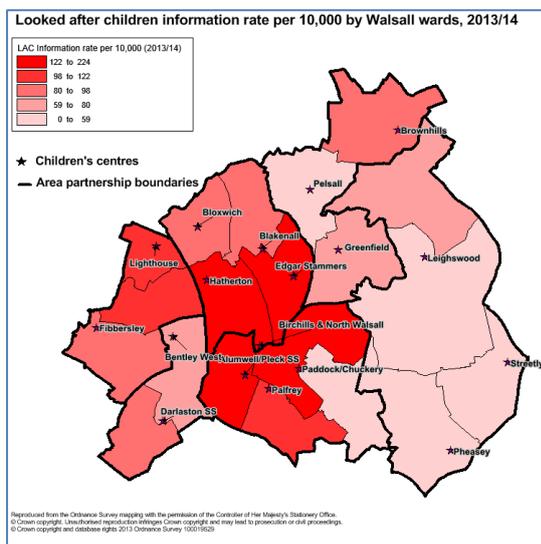


Source: DfE.

**Caveat:** Number of children looked after as 31<sup>st</sup> March express as rate per 10,000 using 2009 mid-year ONS population estimates.

The rate of LAC varies across the borough (see Figure 29) with North Walsall AP having highest prevalence wards (Blakenall and Birchills Leamore).

Figure 29: Rate per 10,000 looked after children in Walsall, 2013/14.



Source: WCCS.

The CAMHS service in Walsall have received 93 LAC referrals in last two years (2013/14 – 2014/15) which represented 89 patients<sup>‡</sup>.

<sup>‡</sup> Dudley and Walsall Mental Health NHS Trust information

## Links with emotional wellbeing and mental health

Looked after children are a particularly vulnerable group. They are more likely to suffer with mental health problems compared to children in private households<sup>52</sup>. Current NICE guidelines state that early intervention to promote emotional and mental wellbeing should improve rates of placement breakdown and long term mental wellbeing. The service needs to be flexible, accessible and able to manage groups such as BME children as well as asylum seeking children who will have specific needs<sup>57</sup>.

It is estimated that 45% of looked after children suffer with mental health issues, rising to 72% in residential settings<sup>53</sup>. They are more likely to have difficulty at school and with the police, “26% of young people with mental health problems had been in trouble with the police compared to 5% with no such problem”<sup>54</sup>.

NICE also note that children and young people placed out of their local authority area are less likely to receive services from CAMHS in their new location<sup>55</sup>

**Table 18: The Mental Health of young people looked after by LA in England**

Disorder	5-10 yrs (%)		11-15 yrs (%)	
	LAC	Private household	LAC	Private household
Emotional disorder	11	3	12	6
Conduct disorder	36	5	40	6
Hyperkinetic disorder	11	2	7	1
Any disorder	42	8	49	11

*Source: ONS 2003*

Statutory guidance states that “all vulnerable children will have their mental health needs assessed along with their physical health and that short or unplanned placements are not a reason to delay a referral to mental health services. And, that the referral pathway should be clear and easy to use for all involved.”<sup>56,57</sup>

CAMHS provision aims to support looked after children through multiple avenues. They will reduce psychological distress by improving placement support and stability, by promoting psychologically minded care plans aimed at improving positive emotional health and wellbeing.

Their therapeutic intervention will be based on current NICE recommendations. They will support carers more to understand the needs and behaviours of the children in their care.

Walsall Council does not currently commission any specific emotional health and wellbeing support for looked after children. However, this should change in September 2015 as funding will be redistributed specifically to support looked after children, children subject of an SGO and children who have been adopted

## Care leavers

The Children (Leaving Care) Act 2000 specifically stated that Local Authorities would need to keep in touch with care leavers until they were at least 21, and they should continue to provide assistance with education, employment and training as they were regarded as a vulnerable group. In general it can be said that a vulnerable child is one who is unable to keep him or herself from harm or who is at risk of not reaching their potential and achieving their outcomes.

There were 165 young people (18-24 years) known to Walsall Children Services and eligible under the care leavers classification (as of 30<sup>th</sup> June 2015)<sup>5</sup>.

The latest quarter data (2014/15 Q4) shows for aged 19-21:

- 56 CYP out of 120 eligible cases were engaged in suitable employment or training (58.2%),
- 106 CYP out of 120 are in suitable accommodation (88.3%).

## Strengths and Difficulties Questionnaires

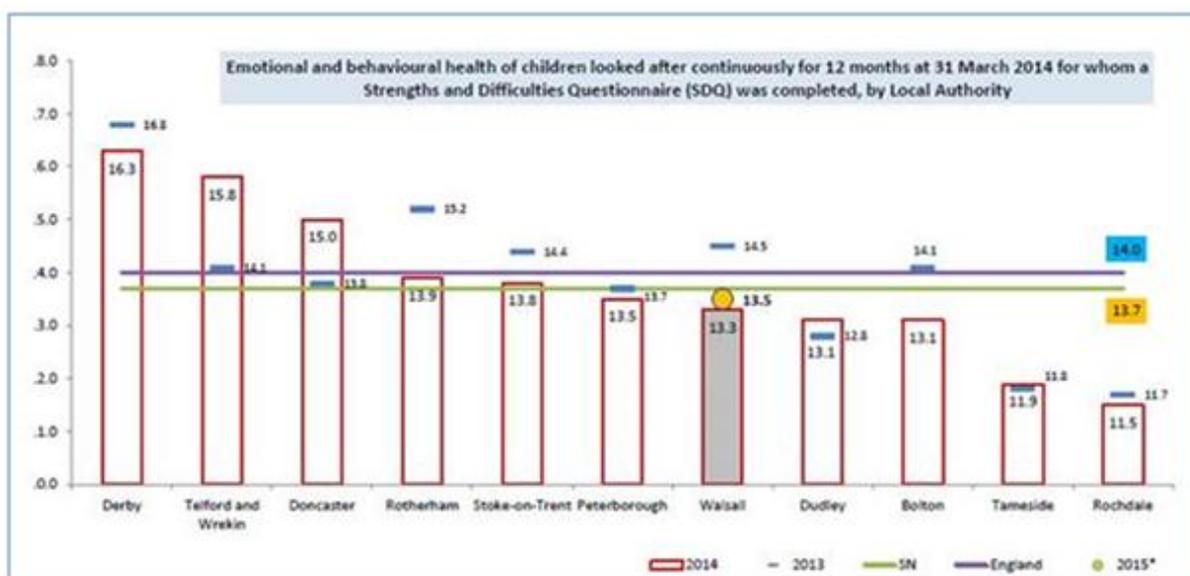
From April 2008 all local authorities in England were required to provide information on the emotional and behavioural health of children and young people in their care. This data is collected using Strengths and Difficulties Questionnaires (SDQs) which is a behavioural screening tool<sup>58</sup>. They provide an opportunity to establish and review emotional and behavioural well-being of children and young people. Questionnaires can be completed by young people, parents or carers and teachers. The higher the score, the more likely there could be a mental health concern. SDQs are used as a proxy for emotional well-being for looked after children and this information is benchmarked to enable us to look at comparisons between local authorities. These are completed each year by the carers of children and young people who have been looked after for longer than a year. Recent information shows the most recent SDQ scores benchmarked against Walsall's statistical neighbour group. Based on returns for 2013/14, 39% of this cohort in Walsall had SDQ scores which were cause for concern, compared to 37% in the statistical neighbour group.

The proportion of SDQ completed for LAC in Walsall is lower than statistical neighbours and national averages (see Figure 30).

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<sup>5</sup> Data received from Walsall Council Children Services

Figure 30: Looked after children completed SDQ by local authorities



Source: DfE LAIT 2015 and Walsall 2015

Note: The above data only includes a proportion of LAC; those in care for 12 month period.

### Service provision for children in need

There are no specific services commissioned to meet the needs of children who have a Child in Need Plan. These children's needs will be met using the general array of services from universal through targeted to Tier 3, 3plus and 4.

Currently there are no specific services commissioned to meet the emotional health needs of looked after children; but it is hoped that the funding currently provided by Children's Services which is currently being used to support the general Tier 3 CAMH Service will be reshaped to provide a specific service to support the emotional health needs of looked after children, children subject of an SGO and children who have been adopted. These children will have emotional health needs that sit below Tier 3 ~ if they have Tier 3 needs then they will access CAMHS; they will also access, if required and appropriate, all the other Tier 1 & 2 emotional health and well being services currently in place across Walsall ~ school nurse provision, KOOOTH etc

Social care teams have skills to deal with lower level need. Universal services available e.g. School nursing service, Kooth

### Service provision for care leavers

Once a young person leaves care there is no dedicated service provision to address their emotional wellbeing and mental health needs

## Special Educational Need and Learning Disability

The Education Act 1996 defined children with SEN if they have learning difficulty which calls for special educational provision to be made for them. The learning difficulty is further classified as:

- Have a significantly greater difficulty in learning than the majority of children of the same age; or
- Have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local education authority
- Are under compulsory school age and fall within the definition at (a) or (b) above or would so do if special education provision was not made for them<sup>59</sup>.

## Demographics

### Disability

According to the ONS there are an estimated 0.7 million disabled children in the UK; Boys are more likely than girls to be disabled and children under five are less likely to be counted. ONS estimates 42.3 per 1,000 children who are disabled. The Thomas Coram Research Unit (TCRU) estimate is slightly lower, at 40.3 per 1,000. Using these figures the 2013 mid-year population estimates the prevalence of under-18 disability in Walsall is estimated to be between 2716 and 2851.

**Table 19: Estimated disability prevalence under 18s by area partnerships.**

Area Partnership	Mid-2013 Populations estimates	ONS (42.3 per 1,000)	TCRU (40.3 per 1,000)
Aldridge & Beacon	10,864	460	438
Brownhills, Pelsall, Rushall, Shelfield	7,936	336	320
Darlaston & Bentley	7,854	332	317
North Walsall	14,831	627	598
Walsall South	16,700	706	673
Willenhall & Short Heath	9,207	389	371
<b>Walsall</b>	<b>67392</b>	<b>2851</b>	<b>2716</b>

**Source:** Thomas Coram Research Unit (TCRU) and ONS 2013 mid-year population estimates.

### Special Educational Needs

Within Walsall we had 48,920 children on schools rolls in January 2014. 14.9% of these children (7,442) were classed as having special educational needs. 5.8% (2,845) of children are on the disability register, 1,240 at primary school, 1,015 at secondary school and 590 in specialist schools<sup>60</sup>.

### Primary schools

For primary school pupils with statement of SEN or School Action Plus by type of need (see Table 20), Walsall is above the regional and national average for the below:

- Moderate and Severe Learning difficulties (32.4% and 2.7% respectively),
- Profound & Multiple learning difficulty (0.60%),
- Hearing and visual impairment (3.30% and 3.60% respectively),
- Multi-Sensory Impairment (0.40%),
- Autistic Spectrum Disorder (9%).

## Secondary schools

For secondary school pupils with a statement of SEN or School Action Plus by type of need (see Table 20), Walsall is above the regional and national average for the below:

- Moderate and Severe Learning difficulties (38.6% and 0.9% respectively),
- Visual impairment (2.9%),
- Multi-Sensory Impairment (0.3%),
- Autistic Spectrum Disorder (11.3%)

**Table 20: Pupils with statements of SEN or at School Action Plus by their primary type of needs as at 31st January 2014.**

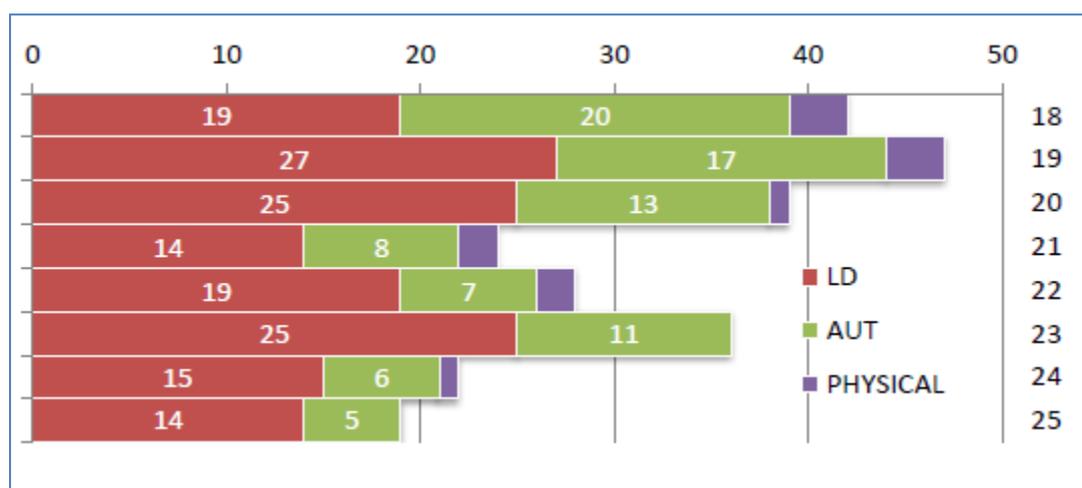
Needs	Primary School			Secondary School			Special School		
	Walsall	WM	England	Walsall	WM	England	Walsall	WM	England
Specific Learning Difficulty	5.20%	7.30%	8.70%	13.70%	14.80%	16%	1.20%	1.00%	1.20%
Moderate Learning Difficulty	32.40%	30.40%	19.10%	38.60%	29.80%	20.30%	37.20%	21.50%	17.20%
Severe Learning Difficulty	2.70%	1.00%	1.30%	0.90%	0.60%	0.90%	26.20%	23.60%	24.80%
Profound & Multiple Learning Difficulty	0.60%	0.30%	0.40%	0.00%	0.10%	0.10%	9.90%	8.00%	8.80%
Behaviour, Emotional & Social Difficulties	13.30%	15.00%	18.40%	16.40%	22.10%	26.70%	14.10%	13.50%	13.40%
Speech, Language and Communications Needs	22.50%	28.80%	31.60%	8.20%	9.00%	11.00%	1.20%	5.00%	5.30%
Hearing Impairment	3.30%	2.10%	2.30%	2.30%	3.00%	3.00%	0.00%	1.00%	1.40%
Visual Impairment	3.60%	1.30%	1.30%	2.90%	1.70%	1.70%	X	1.50%	0.80%
Multi-Sensory Impairment	0.40%	0.20%	0.20%	0.30%	0.20%	0.10%	0.00%	0.10%	0.20%
Physical Disability	4.00%	3.70%	4.10%	3.30%	3.30%	4.00%	0.00%	4.10%	3.50%
Autistic Spectrum Disorder	9.00%	6.90%	8.30%	11.30%	10.90%	10.70%	9.70%	19.50%	22.50%
Other Difficulty/Disability	2.90%	3.10%	4.30%	2.10%	4.70%	5.80%	X	1.00%	0.90%
Total Numbers	1,240	41,180	341,405	1,015	27,720	233,935	590	13,895	99,760

WM - West Midlands

Source: WCCS (31<sup>st</sup> January 2014).

## Learning disorders

**Figure 31: Young people (aged 18-25) with learning, physical and autism spectrum disorders, November 2014.**



LD – Learning Disability, AUT – Autism Spectrum Disorders and PD - Physical disability.

Source: WCCS (November 2014).

The total number of pupils on Walsall's schools rolls was 48,920 as at 31<sup>st</sup> January 2014.

- 14.9% of children (7,442) were classed as have special educational needs (SEN).
- 9% who receiving School Action Support (4,493), 3.5% receiving School Action Plus support (1,727).
- 2.3% who have a statement (EHC Plan) of SEN (1,166).
- 0.2% children (94) in Walsall have a statement and attend schools outside of the borough.
- 5.8% of children (2,845) on the disability register.

The Speech Language Therapy Occupational and Physiotherapy Service in Walsall see approximately 955 children (birth to 19 years) with recognised physical diagnosis conditions:

- Physical disability = 357
- Profound and multiple learning difficulty = 47
- Autism spectrum = 551\*\*

## Learning Disabilities and Special Educational Needs- links with emotional wellbeing and mental health

One in ten children in the general population is likely to have a mental health condition: in those with SEN around quarter are likely to suffer poor mental health.

Applying these proportions to the Walsall population shows an estimated 1861 children with SEN who are likely to have a mental health condition (see Table 21). Of those with SEN statement approximately 292 would be likely to have mental health condition<sup>61,62</sup>.

**Table 21: Total Number of Children with SEN and Estimated mental health conditions**

	<b>Total Number of Children</b>	<b>Estimated Number Children with mental health conditions</b>
<b>Special Education Needs</b>	7442	1861
<b>Special Education Needs with Statement</b>	1166	292

Source: WCCS

Children and adolescents with learning difficulties and disabilities are at a much higher risk of developing mental health problems than those without. These children are also much more likely to suffer with more than one mental health illness.

Children with learning disabilities are 6 times more likely to have a mental health problem than those without, 40% will suffer with some form of mental health disorder, rates are higher with sever learning disabilities<sup>63</sup>. Information from the national autistic society state that 'more than 7 in 10 children with autism have a co-morbid mental health problem', and that many of these could be prevented with the correct support<sup>64</sup>.

A paper written in 2007, The Mental Health of Children and Adolescents with Learning Disabilities in Britain looked into rates of mental health problems and associated risk factors for children with learning difficulties and disabilities.

\*\* Data received from Walsall Healthcare NHS Trust

They found that children with learning disabilities are more likely to be boys, have poor general health and will have been exposed to a greater variety of adverse life events (abuse, domestic violence, bereavement). These children are also more likely to be brought up by a single parent (usually a mother) who suffers with poor physical health or who has mental health needs. If they do live in a family unit it will usually be a poorly functioning family. They are likely to live in poverty and in a family with lower educational attainments and higher rates of unemployment<sup>65</sup>.

They also compared the social situation of children in Britain who have learning disabilities and mental health problems. These rates compare children with and without learning disabilities:

- 53% are living in poverty (compared with 30% of all British children)
- 48% have been exposed to two or more adverse life events (compared with 24% of all British children)
- 45% are supported by a primary carer with no educational qualifications (compared with 20% of all British children)
- 44% are supported by a mother who is likely to have mental health needs herself (compared with 24% of all British children)
- 38% are living in families in which no adult is in paid employment (compared with 15% of all British children)
- 38% are supported by a single parent (compared with 23% of all British children)
- 34% are living in 'unhealthily' functioning families (compared with 18% of all British children)
- 25% are supported by a mother who is in less than good physical health (compared with 7% of all British children)
- 92% are facing at least one of the above adversities (compared with 65% of all British children)
- 38% are facing four or more of the above adversities (compared with 14% of all British children)

## Service Provision

Within Walsall all schools have a local offer, this aims to monitor for and support children who may have LD and SEN's. Special Education Need is covered by educational psychology and children with disabilities. Children and young people with Learning Disabilities and a mental health need are supported by specific CAMHS service including a psychiatrist and psychology service.

In the period April 2014 - March 2015 there were 116 referrals to the CAMHS learning disability service with 87% of these accepted after screening. On average each accepted referral received 6 sessions of support

**Table 22: Walsall CAMHS referrals to Learning Disability, 2014/15**

F2F contacts	612
DNA's	35 (5.4%)
Referrals	116
Referrals accepted (after screening)	101 (87%)

Discharges	45
------------	----

Source: DWMPHT

### *ADHD*

There are currently no ADHD patients on waiting lists as they are all included within the ADHD clinic. Waits to see a clinician vary between 1 and 4 weeks and waits to see a medic vary between 1 and 8 weeks unless there is a cancellation.

## Young offenders

Those aged 17 or under, who have committed an offence, are classified as ‘young offenders’. A wide range of sentences is available to the youth justice system for young offenders, and imprisonment is last resort<sup>66</sup>.

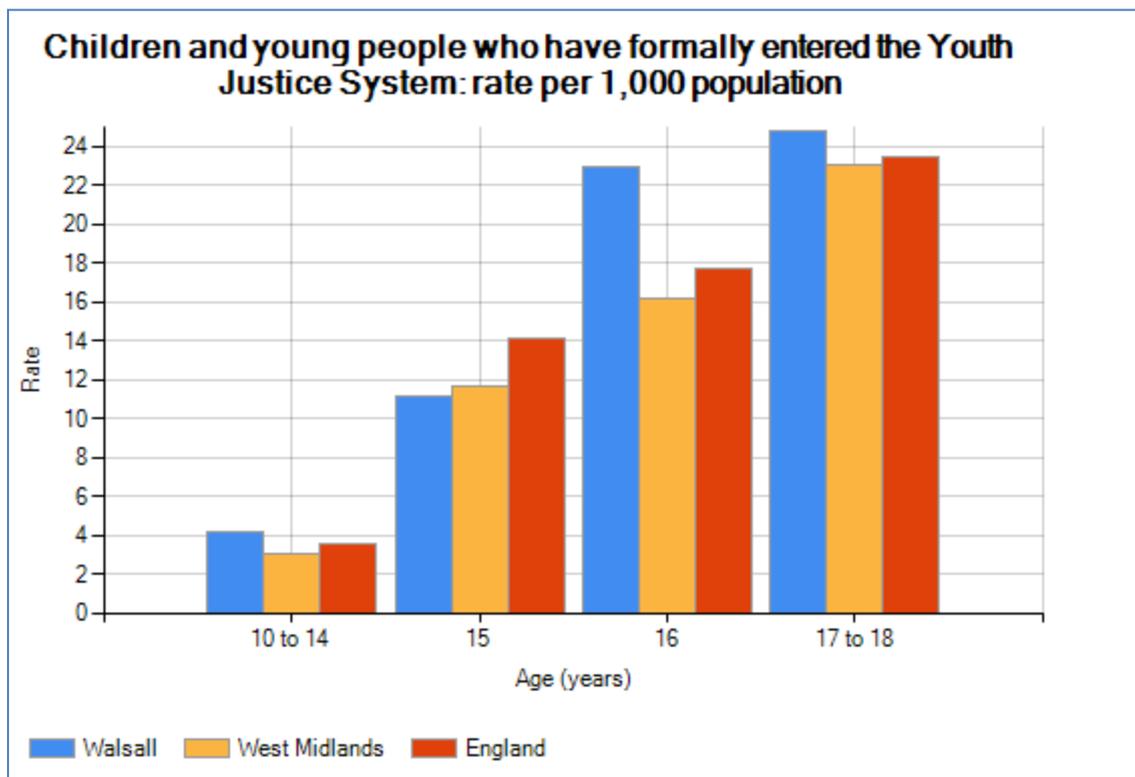
Children under the age of ten are not considered to have reached an age where they can be held responsible for their crimes because they are under the age of ‘criminal responsibility’. Children aged 10-14 can be convicted of a criminal offence if it can be proven they were aware of serious wrongdoing. After the age of 14, young people are considered to be fully responsible for their own actions (as an adult would). However, there are differences in sentencing young offenders.

## Demographics

In 2009/10 there were 389 sentences passed on Walsall young people. In 2014/15 this reduced to 215, a reduction of 44.7% over 5 years. In 2014/15 a greater percentage of youth justice assessments identified substance misuse (6.7% increase) and mental and emotional health concerns (a 9.1% increase) than in the previous year.

The rates per 1,000 of CYP formally in the youth justice system aged 16-18 are higher than regional and national averages.

Figure 32: Rate per 1,000 populations CYP (aged 16-18) who have formally entered the youth justice system.



Source: CHIMAT, Ministry of Justice (MOJ) and ONS.

Almost 1 in every 5 young people known to Youth Justice Services showed self-harm risks, compared to the wider population of young people; this makes young people who offend in Walsall twice as likely to be at risk of self-harm.

When first in contact with the Youth Justice Service, young people undergo an initial assessment (as known as Asset) to assess their risk of future offending and/or self harm. A score of 4 indicates a very high risk of self harm and offending, 3 an increasing risk of offending and self harm and 2 a lesser risk. These Asset scores inform court reports so that appropriate intervention programmes can be drawn up on individual needs<sup>67</sup>.

**Table 23: Young offender’s assessment risk of future offending and/or self harm**

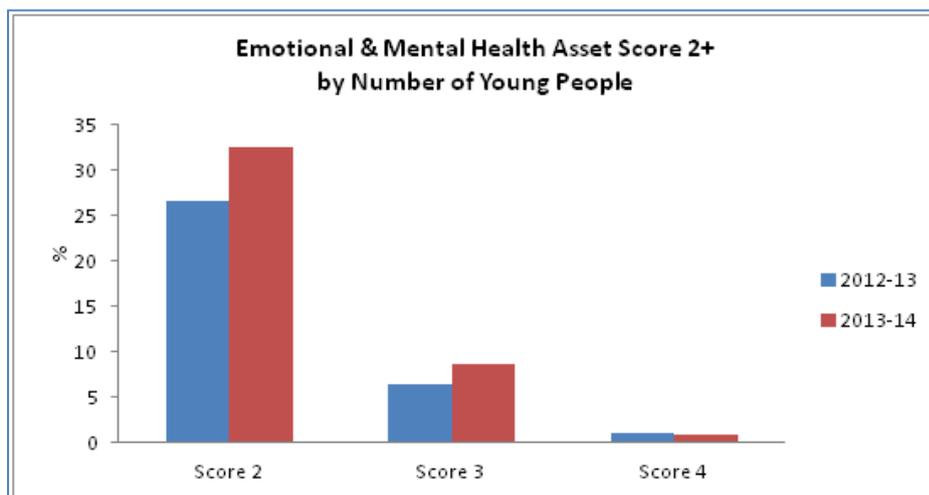
	2012-13	2013-14
<b>Total number of Assets</b>	897	744
<b>Total number of Young People</b>	277	233
<b>Number YP Scoring 2+</b>	95	98
<b>% Score 2+</b>	34.3%	42.1%

Source: Youth Justice Service

Even though the number of Assets carried out has reduced, the actual number of young people that these refer to has also reduced from 277 in 2012-13, to 233 in 2013-14, a reduction of 44 young people (15.8%).

The actual numbers of young people who have scored 2+ and 3 have roughly remained the same due to the smaller number of young people in 2013-14; the percentage is higher at 42.1% compared to 34.3% in 2012-13.

**Figure 33: Emotional & Mental Health Assessment**



Source: Walsall Youth Justice Service 2014

### Youth offending and links with emotional wellbeing and mental health

Youth offenders and children in the criminal justice system are more likely to experience mental health problems than those who are not, 40% have a diagnosable disorder. Within secure settings rates of psychosis, self harm and suicide are raised with multiple factors contributing to these<sup>68</sup>. In 2003, 13 young people killed themselves while in prison. There is a positive correlation between time lost from education and crime, with half of all male prisoners having been excluded from school<sup>69</sup>. One in five offenders have some form of learning disability.

The prevalence of mental health disorders range from 25% in young people in contact with the justice system to 81% for those in custody<sup>70</sup>. They make up 5% of the CAMHS work load.

Adults from BME communities are more likely to enter mental health services via criminal justice referral routes and there is evidence that young people from BME communities are less likely to access primary care for help when they first experience mental health problems, leading to the need for increased crisis intervention<sup>71</sup>.

To understand how these children develop mental health problems or suffer with worsening mental health it helps to know some back ground information;

- two in five young females and one in four young males in custody report violence in the home (Social Exclusion Unit, 2002)<sup>72</sup>
- three quarters of children and young people in custody have lived with someone other than a parent (Healthcare Commission, 2007)<sup>73</sup>
- 40% of children and young people in the youth justice system were homeless in the six months before they entered custody (Prison Reform Trust, 2009a)<sup>74</sup>
- 84% of 12–18 year olds in custody have problematic drug use and a further 64% have concurrent mental health difficulties (Galahad SMS Ltd, 2009)<sup>75</sup>
- 86% of young men and 79% of young women in the youth justice system aged 15–18 years have been excluded from school (Parke, 2009)<sup>76</sup>
- one in three girls and one in 20 boys in custody have disclosed sexual abuse (Social Exclusion Unit, 2002)
- one in ten young women in custody have been paid for sex (Douglas & Plugge, 2006)<sup>77</sup>.

The Sainsbury Centre for mental health produced a report in 2009 looking at conduct disorders in children and risk of progression to offending. It found that approximately “80% of all criminal activity is attributable to people who had conduct problems in childhood and adolescence”<sup>78</sup>. And that prevention and intervention in young children (pre-school children) can reduce offending rates by 50%.

## Service Provision

When a young person enters the youth justice service they are all allocated a youth offending worker. The youth offending worker will compile an Assets report on each young person, which looks at their housing and emotional wellbeing needs (including any previous involvement with CAMHS). If, after completing the report there are concerns about the child the screening tool SQUIFA is used to assess their mental health. From there (with the young person’s consent) the lead consultant for youth offenders in CAMHS is contacted to discuss the case. They will then be seen by this consultant or referred on to the most appropriate service. CAMHS will see a youth offender up to the age of 18.

### ***Lead consultant for youth offenders in CAMHS***

This service is currently being provided by DWMHPT through a practitioner who is employed to work across Youth Justice Service and CAMHS 0.5wte in each locality since December 2014. The aim of this service is to maximise opportunities for individuals and their families by enabling them to look beyond their limitations and to achieve their goals and aspirations whilst being supported in this area. This service offers tier 2 talking therapy support to this group. If a need is identified through “asset identification” the CAMHS worker working with this group can refer to CAMHS for diagnosis and intensive support.

**Table 24: Youth Offenders in CAMHS Caseload, April-June 2015**

Month	Number
April	11
May	9
June	8

Source: DWMHPT

In CAMHS, the same practitioner provides support to the ADHD clinic which is linked to the clientele within the Youth Justice Service in order to alleviate any difficulties early in anticipation that it will not escalate to need the support of the Youth Justice Service.

The outreach CAMHS worker based with the YOS provides training consultation and liaison to YOS workers to develop skills and knowledge about emotional and mental health and wellbeing in the Youth Justice Service and to help them understand any mental health issues that are impacting on the presenting problems. This service also offers individual work, youth justice behaviour support group work and Targeted Youth Support (TYSP) as well as a social skills group which includes parents and young people and a Positive Parenting programme to support the parents in managing the difficult behaviours that are being displayed.

If a young person, or youth offending worker doesn't feel that CAMHS is the best option as there can be huge stigma associated with attending CAMHS they will also refer to another service provider like Barnardo's or Samaritans.

## Transition phase

The transition phase is between the ages of 16 to 18 up to age 24 when specific needs have been identified. These are young people who may have been involved with CAMHS and still need support or who have newly emerging mental health problems<sup>79</sup>.

## Demographics

The transition phase represents the transition between CAMHS service and adult mental health for young people in Walsall, in 2014/15 there were 158 young people (16-17 year olds) awaiting transition to AMHS<sup>††</sup>.

Table 25 shows the proportion of 17-24 year olds in each AP to illustrate where the population resides in Walsall, Walsall South AP has the highest proportion (11.4%).

Table 25: Proportion of 17-24 (years) population estimates by area partnership.

Area partnership	Total AP population	17-24 population	% 17-24 year old of AP population
Brownhills, Pelsall, Rushall, Shelfield	36,198	3,141	8.7%
Aldridge & Beacon	52,311	4,606	8.8%
North Walsall	54,888	5,744	10.5%
Walsall South	60,602	6,913	11.4%
Darlaston & Bentley	28,209	3,107	11.0%
Willenhall & Short Heath	39,953	4,077	10.2%
<b>Walsall</b>	<b>272,161</b>	<b>27,588</b>	<b>10.1%</b>

Source: ONS, 2013 mid-year population estimates.

The total numbers of young people accessing primary and secondary mental health services in Walsall has increased between 2013/14 and 2014/15 (see Table 26).

Table 26: Number of 17-24 year old service users known to Primary and secondary mental health services in Walsall.

Year	Number known to Primary Mental Health Walsall	Number known to Secondary Mental Health
2013-14	1603	2063
2014-15	1756	2206

Source: DWMHPT

## Links with emotional wellbeing and mental health

The House of Commons did a review of CAMHS in 2014 and from their investigations they found that all the young people who had transitioned to Adult Services reported needing more information on the differences between CAMHS and Adult Services, especially surrounding the different thresholds for support. They also gathered information from NHS England that stated “transition from child centred to adult services is currently poorly planned, poorly executed, and poorly experienced. This can lead to the "cliff edge" where support falls away; the young person disengages, and may present as their first episode of transition acutely in crisis to an adult Emergency Department.”<sup>80</sup>

<sup>††</sup> Data received from Dudley and Walsall Mental Health Partnership Trust

Young Minds gathered information from service users to compile SOS: stressed out and struggling, looking at service provision for 16 to 25 yr olds. They found that CAMHS and AMHS commissioners need to make sure that they are working together to “support young people in transition, rather than allowing age related commissioning to exacerbate fragmentation of care.”<sup>81</sup> This means that young people and their families can find themselves in limbo, as AMHS, CAMHS and commissioners argue about whose budget or service takes responsibility<sup>34</sup> (2 pg 12)

The report also highlighted that if 16-25 year-olds are struggling to make transitions it may stem from delayed emotional and psychological development, and it is therefore all the more appropriate – and necessary – “that these young people are seen ‘in the round’ in terms of their emotional and social networks”

The Department of Health’s recent report, Future in Mind, found that adult mental health services are not universally equipped to meet the needs of young people with conditions such as ADHD, mild to moderate learning difficulties or autistic spectrum disorder.

The report recommends “flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care.”<sup>82</sup>

### Service provision

It is recognised that it will take multiple meetings, involving both child and adult services and should be started up to 6 months before the young person is due to move on to adult services. The CAMHS consultant will be responsible for initiating the transition into AMHS and for all clinical records until the transition is complete. There is a specific care plan for each individual which outlines what will happen during the transition and any specific interventions that will continue on from CAMHS into AMHS. Eating disorders will be managed in the same way but with the addition of the CAMHS eating disorder worker informing the adult eating disorder worker about the patient, usually after their 17<sup>th</sup> birthday. Young people with severe and profound LD will be referred to the Adult Learning Disabilities Service via the transition pathway.

There is a need for CAMHS offer a post 17 years service but until age 18. There is no CAMHS service for young people 18+, as the mental health services are commissioned from the same trust the process is transition rather than referral to different organisation.

## Lesbian, Gay, Bisexual and Trans community

Lesbian, gay, bisexual and transgender (LGBT) people experience a number of health inequalities which are often unrecognised in health and social care setting, in the area of mental health and wellbeing during sexual orientation information is not always captured to identify this community<sup>83</sup>.

### Demographics

A national based survey (see Table 27) estimated that 2.9% of 16-24 years identified themselves as Gay/Lesbian, bisexual or other, which is slightly higher than the overall percentage of 2%. Using these estimates on Walsall population, there could be potentially around 909 of young people from this community.

Table 27: Sexual identity prevalence result from integrated household survey by age group, UK 2013.

Age groups	16-24	25-34	35-49	50-64	65+	Total
Heterosexual / Straight	89.3	91.6	92.4	94.2	94.6	92.7
Gay / Lesbian	1.6	1.8	1.5	0.9	0.3	1.2
Bisexual	1.1	0.6	0.4	0.3	0.2	0.5
Other	0.2	0.2	0.2	0.3	0.3	0.3
Don't know / Refusal	4.4	4.1	3.9	3.2	4.1	3.9
No response <sup>2</sup>	3.4	1.7	1.5	1.1	0.4	1.5

Source: ONS Integrated Household Survey: 2013.

**Caveat:** In 2013 there were 178,820 eligible respondents (aged 16 and over) to the sexual identity questions and 169,102 valid responses.

### Links with emotional wellbeing and mental health

A survey in 2012 of young LGBT people found 55% had experienced homophobic bullying, and of those, 44% reported deliberately missing school as a consequence<sup>84</sup>. "They are more likely to be exposed to higher levels of isolation, school bullying, and conflict around sexual identity, parental non-acceptance and homelessness."<sup>85</sup>

One study found that "62% of LGB homeless youth had attempted suicide, compared to 29% of non-LGB homeless youth"

As a result LGTB young people are subsequently more likely to develop mental health problems than their peers. Among LGBT youth in the UK, one in two reported self-harming at some point in their life and 44% reported having thought about suicide.<sup>86</sup>

### Service Provision

Walsall's sexual health service does offer psycho-sexual counselling which will encompass young people who are LGTB. Young people can access it via the sexual health service team. Currently, a new sexual health contract is being commissioned and it is hoped that specific LGTB services will be incorporated. No specific CAMHS service available for this group unless there is specific mental health need but there are universal services available such as school nursing and kooth.

## Refugees/travellers

### Refugees

The definition of a refugee as stated by United Nations is “A person who owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion in outside of the country of his nationality”. In the UK the classification is someone who has applied for refugee status and is still waiting for decision on that application, so incorporates asylum seekers and refugees<sup>87</sup>.

### Demographic

In 2013/14 there were 64 asylum seeker families in Walsall; some may have dependent children<sup>††</sup>.

### Links with emotional wellbeing and mental health

‘Asylum seekers, refugees and their families are known to be at high risk of mental health problems (Ehnholt & Yule, 2006)<sup>88</sup>. Services and support for these groups need to be flexible and responsive to the different cultural understandings of and ways of managing mental health issues (Montgomery & Foldspang, 2005)’

Within the refugee community cultural differences, language barriers and mental health stigma play a huge role in parents and children’s poor access to services.

Mind produced a report in 2009 looking into the overall health of refugees. Children were at an increased risk of ongoing emotional health and wellbeing issues because they were more likely to be bullied at school, and struggle due to language, cultural and curriculum differences<sup>89</sup>

### Travellers

The definition of traveller community can be collective term used to describe a wide variety of cultural and ethnic groups (Gypsy, Roma and Traveller). Defining a person as a Gypsy, Roma or Traveller is a matter of self-ascription and does not exclude those who are living in houses<sup>90</sup>. Gypsy or Irish travellers are recognised under the Equality Act 2010 and are widely considered by government (national and local) and charities to be vulnerable marginalised group who suffer from poor outcomes<sup>91</sup>.

### Demographic

The 2011 census reports that 0.21% of Walsall 0-24 year’s population were from the GRT community (184), however more up to date information indicates that there were 226 school aged children (5-16 years) known to the local authority in Spring 2015 (see Table 28).

Table 28: GRT community pupils in Walsall School (Spring 2015).

	Total Numbers of Pupils	Male	Female
Primary School	130	60%	40%
Secondary School	96	54%	46%

Source: Walsall Council Children Services, Capita One database (Spring 2015)

<sup>††</sup> West Midlands Strategic Migration Partnership

**Caveats:** 17 Walsall secondary schools (including 10 academies) and 37 primary schools (including 7 academies).

### ***Links with emotional wellbeing and mental health***

Traveller communities have one of the lowest life expectancies and the highest child mortality rates in England<sup>92</sup>. They are amongst the lowest achieving ethnic group within schools...“are more likely to have SEN, and are four times more likely than any other group to be excluded from school as a result of behaviour”<sup>93</sup>.

### ***Service provision***

The Refugee and Traveller communities are small in Walsall but the needs of their children can be great.

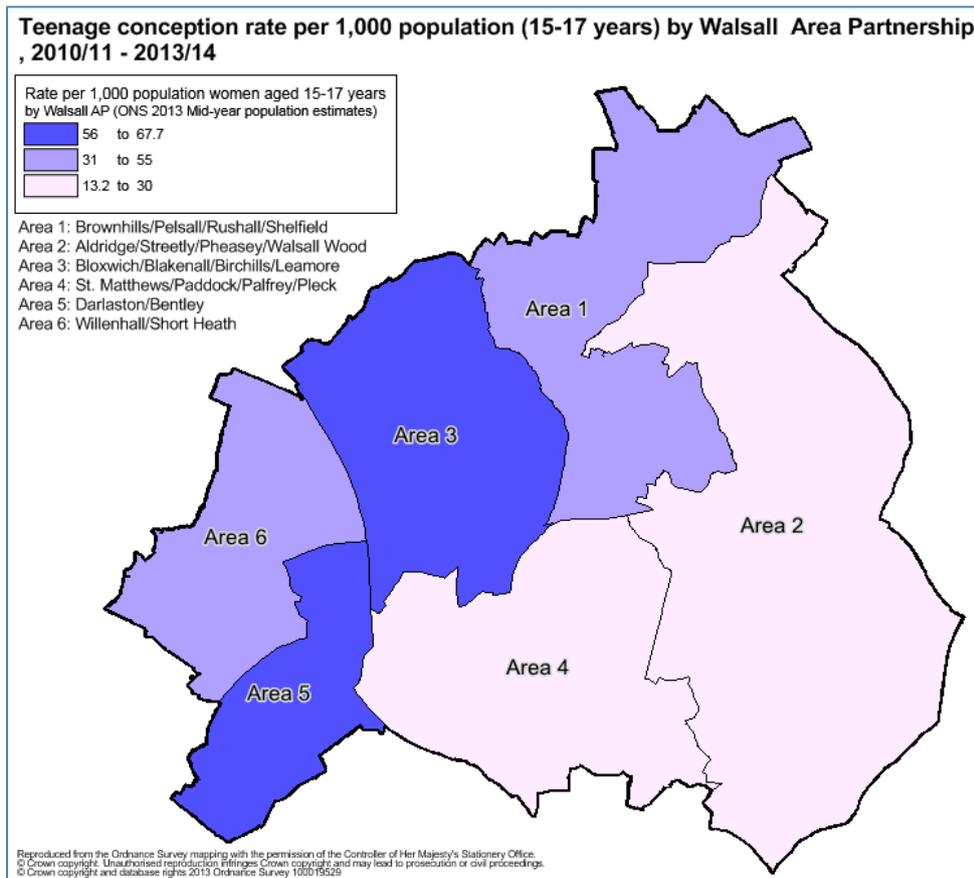
The Walsall Health Visiting team provides comprehensive care to new refugees and migrants with a lead Health Visitor, a ‘movement in’ assessment which is completed for all children and kept in the red book. There is also a monthly meeting attended by the HV team regarding asylum seekers/refugees where they can voice concerns. The Travelling community isn’t offered a specific service but pregnant mothers are reviewed at home, like all pregnant mothers, at 28 and 32 weeks. There is no specific mental health provision for refugees or traveller children and young people unless there is specific mental health need however the universal services are available such as school nursing service and Kooth.

## Teenage pregnancy

Teenage mothers are a unique group (under 18) and they can be particularly vulnerable to experiencing postpartum depression, stress and feelings of isolation<sup>94</sup>. In 2013, Walsall had 192 teenage conceptions (under 18)<sup>95</sup>.

The rates of teenage conception across the borough varied (see Figure 34) with Walsall North and Darlaston & Bentley AP having the highest rates (56 – 67.7 per 1,000).

**Figure 34: Teenage conception rate per 1,000 populations by area partnership by area partnerships, 2010/11 - 2013/14.**



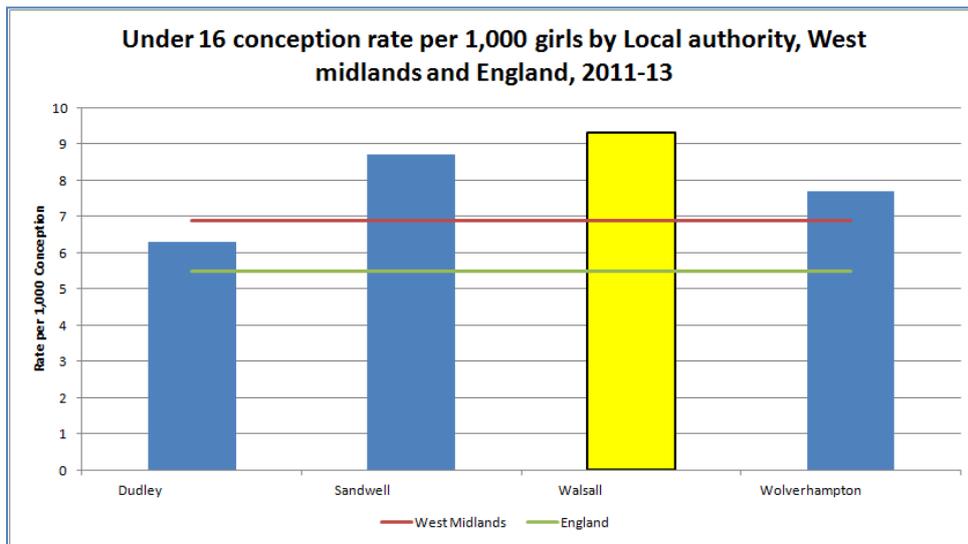
Source: WHNT and ONS 2013 mid-year population estimates.

## Under 16 Conceptions

The under-16 conception rate per 1,000 for Walsall is shown in Figure 35 below. With a rate of 9.3 per 1,000 Walsall is above the regional and national averages (6.9 and 5.5 per 1,000 respectively).

<sup>95</sup> ONS 2013 Teenage Conception

Figure 35: Under 16 conception rate per 1,000, 2011-2013.

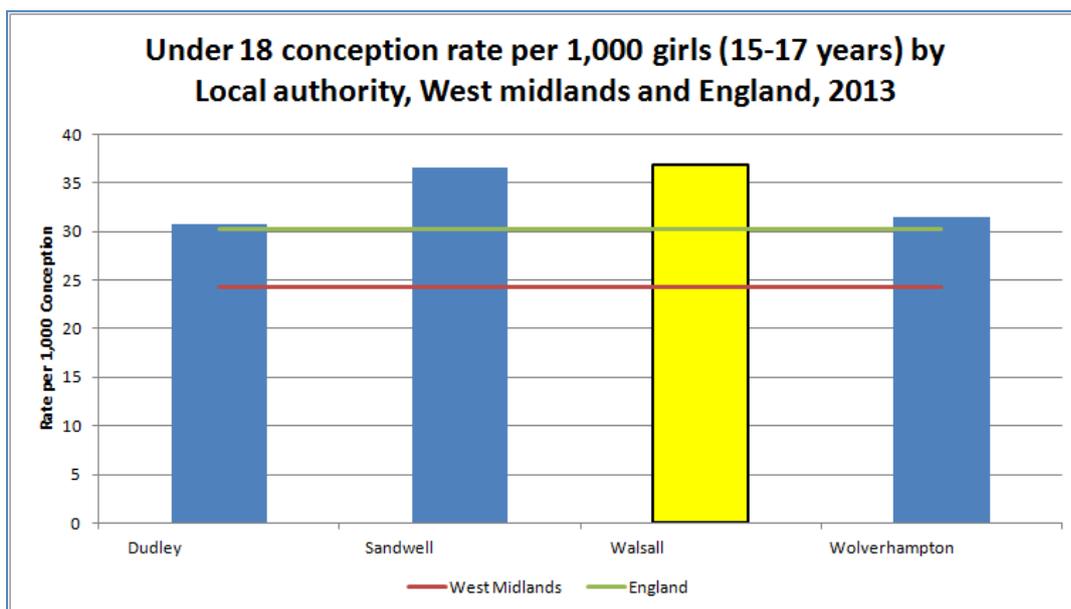


Source: ONS Conception Statistics, 2013

### Under 18 Conceptions

Figure 36 below shows the under-18 conception rate per 1,000, with a rate of 36.8 per 1,000 Walsall is above the regional and national averages (30.3 and 24.3 per 1,000 respectively).

Figure 36: Under 18 conception rate per 1,000, 2013.



Source: ONS Conception Statistics, 2013

### Links between teenage pregnancy and emotional wellbeing and mental health

There are a range of risk factors associated with early pregnancy, most notably with higher rates of depressive illness<sup>95</sup>.

A study has reported that 53% of teenage mothers experienced post-partum depression (reference). Depressive illness in young mothers is associated with feelings of loneliness and low self-esteem, which indicates that support programmes for young parents should focus on reducing isolation and providing parenting support<sup>96</sup>.

The effects of unchecked post-partum depression can have long term impact on the child's cognitive and psychological development (reference), however programmes focused on mediating risk factors common to adolescent mothers such as lower level of education, low employment rates, lone parenting and isolation, have shown to reduce the rates of post-partum depression<sup>97</sup>.

### **Service Provision**

Teen parents are offered additional support beyond the universal health visiting service for pregnant women through the Family Nurse Partnership (FNP) service who will visit weekly for the first month after recruitment and then fortnightly thereafter. Once the baby is born, parents are visited 1 per week first 6 weeks after delivery and after this every other week until 21 months. These visits can be used to assess and support the mental health of the parents and reduce stress. If additional support is needed, the FNP team will refer to appropriate support

If parents do not accept the FNP service or the FNP caseload is full, they are offered help through the teenage pregnancy service who will also refer to appropriate support if required.

## Maternal Mental Health

### Demographics

The Joint Commissioning Panel for Mental Health (JCPMH) has suggested that rates of perinatal mental illness (PMI) can range from 2 to 300 per 1,000 depending on the severity of PMI. Table 29 below shows estimated numbers of women in Walsall that may fall into the different PMI categories using national rates.

**Table 29: Estimated Prevalence of women affected by perinatal mental illness**

Perinatal mental illness	Rate per 1,000 maternities	Number of women affected	
		England	Walsall estimate*
Postpartum psychosis	2 per 1,000	1380	7
Chronic serious mental illness	2 per 1,000	1380	7
Severe depressive illness	30 per 1,000	20640	112
Post traumatic stress disorder (PTSD)	30 per 1,000	20640	112
Mild - Moderate depressive illness and anxiety states	100-150 per 1,000	86020	375-562
Adjustment disorders and distress	150-300 per 1,000	154830	562-1124

**Source:** Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.

**Caveat:** There may be some women who experience more than one of these conditions

### Links with emotional wellbeing and mental health

Maternal mental health during pregnancy and after birth can have lasting effects on the emotional health and development of the child. NICE guidance produced in 2014 found that “Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth.”<sup>98</sup>

Young mothers are at an even greater risk. They can face social isolation, increased levels of poverty and are more likely to become lone parents.

“Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth.”<sup>99</sup>

Young mothers need support throughout pregnancy and afterwards to help improve the outcomes for themselves and their children.

“The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers; children born to teenage mothers have higher mortality rates under 8 years and are more likely to have accidents and behavioural problems”<sup>100</sup>

In 2015 the department of Health found that the lack of support for mother with mental health disorders contributes to a long term cost to society and to their children.

“According to a recent study, maternal peri-natal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK... Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother”<sup>101</sup>

## Service Provision

The midwifery service assesses women for mental health issues when women attend their booking appointment and will also note issues that might cause additional stress such as experiencing domestic abuse. If an issue is identified, they will refer to the CAMHS service or to Walsall Psychology Help but these are felt to not meet the needs of women

DWMHT offer a service called Primary Mental Health and Talking Therapies that the women can self refer into or request a referral from her GP if she is feeling low.

Health Visitors assess women for mental health issues when they visit at 28 weeks and after birth and are able to offer low level support. If a referral to CAMHS is required, they will refer the woman to her GP for onward referral.

## Homelessness

A household is legally homeless if, either, they do not have accommodation that they are entitled to occupy, which is accessible and physically available to them<sup>102</sup>.

**Homeless households** – a family or individual who has applied for LA housing support and been judged to be homeless.

**Homeless families** – people with dependent children

## Demographics

There were 103 families which were known to local authority under the homeless legislation statutory return (P1E) in 2014/15<sup>\*\*\*</sup>.

In a study by Quilgars et al (2011), the estimated number of young people aged 16 to 24 sleeping rough in England in 2008/9 was 3200, giving a rate of 51.3 per 100,000<sup>103</sup>. In a study of 16 to 25 year olds who were sleeping rough in London, Vasiliou (2006) found that 67% had mental health problems<sup>104</sup>. Applying these rates to the population in Walsall provides an estimate of 15 young people with mental health problems who are sleeping rough.

The following table shows the rate of family homeless in Walsall and how it compared to the regional average. Walsall shows an increase in rate between 2011/12 and 2012/13; however it remains below the regionally average (see Table 30).

**Table 30: Rate of Family homelessness**

	Family homelessness (2011/12)	Family homelessness (2012/13)
Walsall	0.9	1.9
West Midlands	2.9	2.8

**Source:** CHIMAT; Department for Communities and Local Government.

**Caveat:** This is only a measure of those homeless children and families who are known to local authorities and accepted as being unintentionally homeless and in priority need.

## Links with emotional wellbeing and mental health

Homelessness Link's National Health Audit found that eight-in-ten have one or more physical health needs, and seven-in-ten have at least one mental health problem. Being homeless means you are more likely to suffer from mental and physical ill-health and at the same time unable to access the health services you need<sup>105</sup>.

Vonstanis, P. (2002) states that homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including acquired immune deficiency syndrome (AIDS)<sup>106</sup>. Two major studies of this group in London (Craig, T. et al, 1996)<sup>107</sup> and Edinburgh (Wrate, R.

\*\*\* Walsall Council Housing Department

et al, 1999)<sup>108</sup> found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were associated with sexually risky behaviours, substance misuse and co morbid psychiatric disorders, particularly depression.

Homelessness is something no child or young person should have to think about let alone experience. However, it is a problem that is on the rise in 16 to 17 year olds<sup>109</sup>. Causes of homelessness are often complex, including mental health problems, drug problems and financial issues. Research by Homeless Link published in 2014 showed that over half of new people seeking help with homelessness are under 25 (1). And the majority of youth homelessness (62%) happens when family relationships breakdown and the young person is no longer allowed to stay. Children and young people are also more at risk of becoming homeless if they are youth offenders (13%) or care leavers (11%).

A lot has been done over the last few years to improve access to children's services for young people at risk of homelessness and the overall rate is improving. Unfortunately, Councils are still only preventing homelessness in 19% (1) to 41% (2) of cases<sup>110</sup>.

It was recommended in the No Excuses, preventing homelessness for the next generation report (2013) that "Statutory agencies such as Child and Adolescent Mental Health Services (CAMHS), youth offending teams, and drug and alcohol teams should have strong links with local homeless agencies. This should include agreed referral routes and other partnership agreements to ensure that young people with more complex needs receive the support they require."

### **Service provision**

Children's service within Walsall Council provides all young people who come into contact with them or homeless service a child and family assessment. Within this assessment the young person's EHWP will be assessed and if concerns are raised the children's service team are able to make direct referrals to CAMHS.

## Not in Education, Employment or Training

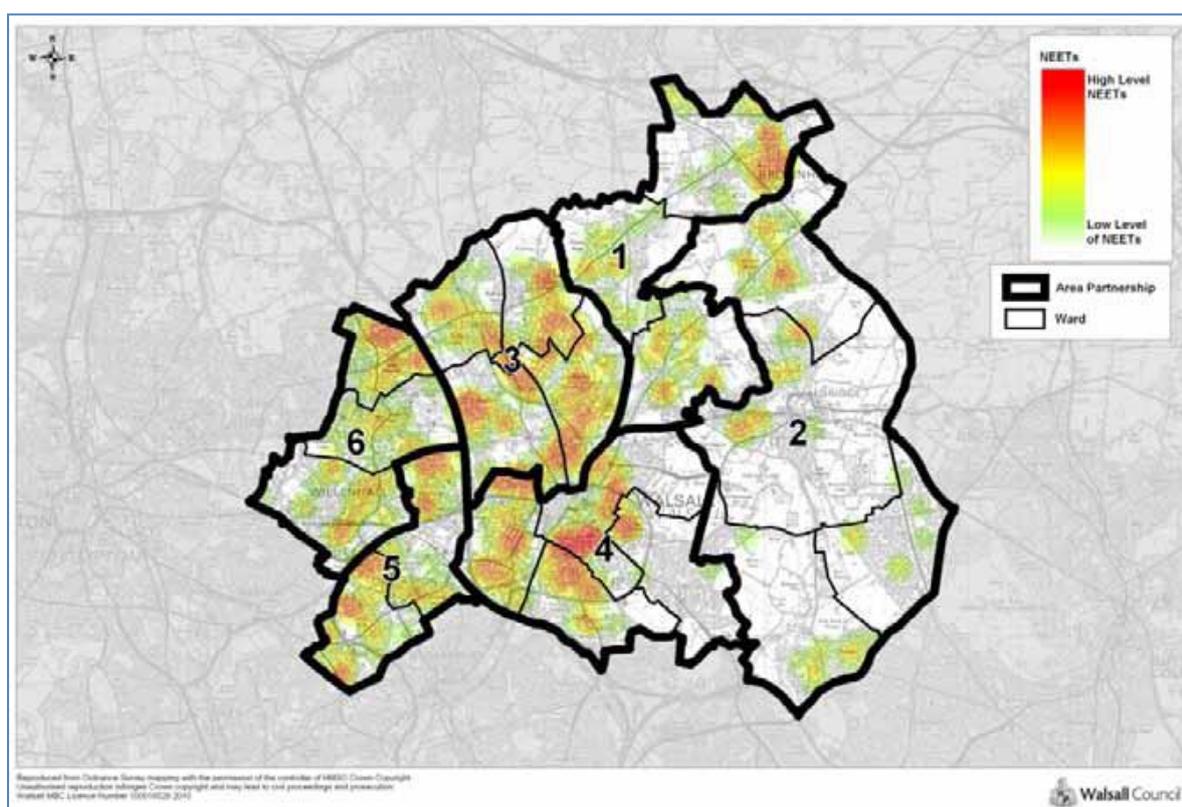
Young people aged 16-24 are described as NEET'S if they are not in employment, education or training.

### Demographics

Walsall currently has around 630 16-18 year olds who are not in education, employment or training (NEET)<sup>111</sup>. The proportion of young people classed as NEET has fallen every year in the Borough from 10.3% in 2005/06 to 6.4% in 2011/12. However, despite this achievement, this still remains slightly above the average for England (5.8%) and the West Midlands (6.2%).

There are certain parts of the borough with particularly high numbers in the West and North; in Brownhills AP, North and South Walsall and Darlaston & Bentley (see Figure 37).

Figure 37: Walsall NEET 'hotspots' November 2010



Source: Walsall Joint Strategic Needs Assessment 2013-Prospects 2010.

Note: Area 1: Brownhills/Pelsall/Rushall/Shelfield, Area 2: Aldridge & Beacon, Area 3: North Walsall, Area 4: Walsall South, Area 5: Darlaston & Bentley and Area 6: Willenhall & Short Heath.

### Links with emotional wellbeing and mental health

There are multiple effects on young people's health when they are unemployed or not in training, and these increase as the length of time increases.

- Association between youth unemployment and increased alcohol consumption: evidence suggests that reducing the number of those who are NEET would reduce harm from alcohol. In one survey, 11% of 16-25 year-olds who had been

unemployed said that they had “turned to drugs or alcohol” as a result of their unemployment<sup>112</sup>

- Young men who are NEET are 3 times more likely to suffer with depression than their peers.

“Evidence shows that almost half of those who are NEET at age 17-18 are still NEET one year later, and those who are NEET at age 18-19 are 28% more likely than others to be unemployed five years later and 20% more likely to be so ten years later”.

However, if we can encourage young people to stay in some form of education or training, the report found that four more years of schooling (in total, up to age 25) on average relates to a 16% reduction in mortality rates. The report found a clear association, people who have lower levels of education or fewer qualifications tend to have lower life expectancy and poorer health outcomes than those who are more qualified or stayed in education

### **Service Provision**

There is an integrated Young People’s Support Service in Walsall which is targeted on those aged 9-19 (25) in need. If a mental health need becomes apparent then referral through general CAMHS or AMHS is appropriate.

The Walsall Works programme who’s primary aim is to help NEET’s into training or employment has also recently started a pilot programme with one of its providers to use the WEBMEBS (Warwick-Edinburgh mental well being scale) mental health assessment tool. This will be used at the beginning and end of the programme to see if there has been an improvement in mental wellbeing associated with being in training or employment. Walsall Public Health transformation funding is being used to enhance the Works programme to increase access to health support. This will subsequently improve access to employment as well as resident’s fitness for work as they get older. Currently, there is no provision to refer onto another service if concerns are raised. However, at the end of the pilot this is likely to be reviewed. There is no specific CAMHS provision; however services available where needed through traded services in schools to support this group.

## Domestic Abuse

The cross-government definition of domestic violence and abuse is<sup>113</sup>:

“any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- Psychological
- Physical,
- Sexual,
- Financial,
- Emotional.

## Demographics

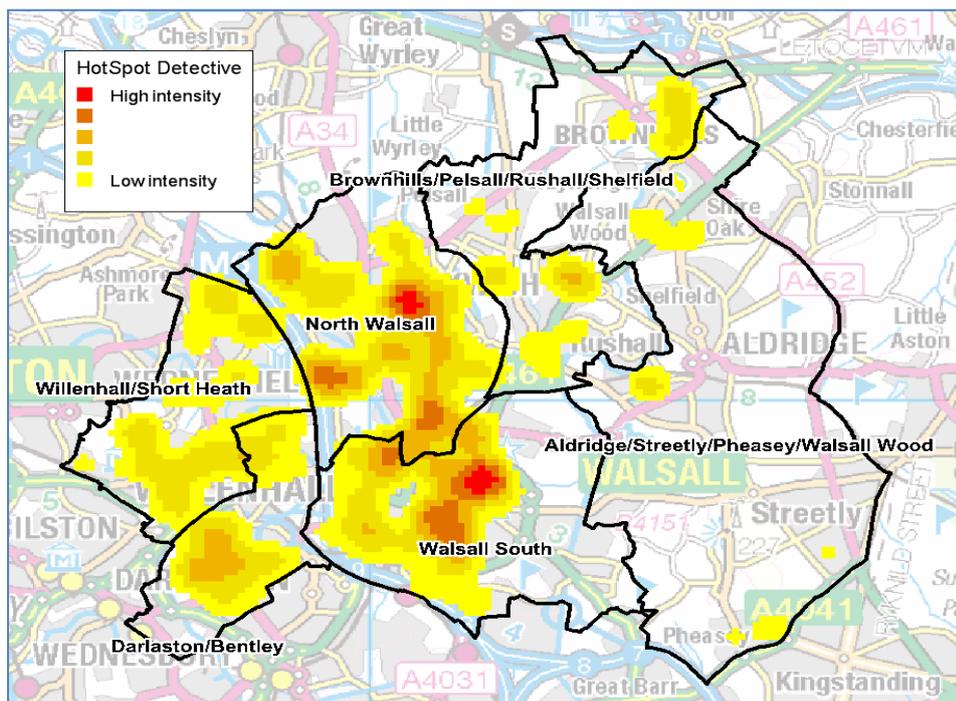
In 2014/15, 767 young people aged 14-24yrs were referred to Domestic Assault Response Team (DART) as victims of abuse. This age group represents almost 28% of all referrals in this year.

Table 31: Referral to Walsall DART service, 2013/14 -2014/15

Number of referrals	Support provided				
	Telephone	Signposting	1-to-1	Other (Group work and visits)	No Role
560	298	188	7	31	36
767	255	85	8	12	5

Source: Domestic Assault Response Team

Figure 38: Walsall domestic violence offences November 2013 - October 2014.



Source: Community safety Strategic Assessment (CSSA).

Figure 38 shows the intensity of Domestic Violence across the Borough (boundaries show Area Partnerships, AP). The highest intensity occurred within Chuckery and Caldmore (Walsall South AP), and Birchills, Leamore and Blakenall (North Walsall AP). See Table 32 above for further information on the scale of the increase.

Table 32: Number of domestic violence by area partnership, Nov/12 - Oct/13 and Nov/13 - Oct/14.

Area Partnership	Nov 2013 - Oct 2014	Nov 2012 - Oct 2013	Difference	% Difference
Aldridge/Streetly/Pheasey/Walsall Wood	130	91	39	42.9%
Brownhills/Pelsall/Rushall/Shelfield	189	134	55	41.0%
North Walsall	454	308	146	47.4%
Walsall South	400	314	86	27.4%
Willenhall/Short Heath	240	183	57	31.1%
Darlaston/Bentley	191	137	54	39.4%
Total	1604	1167	437	37.4%

Source: CSSA.

### Links with emotional wellbeing and mental health

Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life<sup>114</sup>

The government’s definition of domestic abuse is “any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional”<sup>115</sup>

Children of abused parents will see about 3/4 of the incidents and about half of these children will have been abused themselves. They are also more likely to be sexually and emotionally abused.

Children of any age (including those still in the womb) are affected by domestic abuse. A child at any age may go on to develop post traumatic stress disorder. They may show changes in behaviour like becoming anxious, start bed wetting and show problems separating from the abused parent. Older Girls are more likely to become withdrawn, may develop eating disorders, may self harm and are more likely to choose abusive partners themselves. Older boys are more likely to become aggressive and start using alcohol and drugs as coping strategies<sup>116</sup>.

NICE state that safeguarding services and commissioners are responsible for ensuring children and young people affected by domestic violence are managed appropriately. They must “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”<sup>117</sup>

## Service Provision

Walsall Councils service provision for children affected by domestic violence requires that an initial referral be made to children's services. From there, the referral is passed onto MASH (multi-agency safeguarding hub), previously DART, who then assesses the children using a screening tool to look for any mental health needs. If concerns are raised then the team are able to refer directly to CAMHS.

## Young Carers

*"The term young carer should be taken to include children and young people under 18 who provide regular or ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substance"*<sup>118</sup>

## Demographics

The 2011 census indicated that 2.8% children and young people (0-24 years old) provide some level of unpaid care which represents 2,428 people.

Youth Support Services provide a service for young carers, at its Myplace centre having ended its commissioning arrangements. The youth population within Walsall from 6 to 18 years at midyear 2010 was 39,437. Guidance from NSPCC research estimates that 4% of the youth population have a caring role be it from 1 to 9 hours or over, this would identify Walsall as having approximately 1327 children and young people that are undertaking this role. The Youth of Walsall Survey (2014) which reached around 3482 children and young people identified that 911 children and young people claimed to be a young carer, with a range of time spent undertaking the caring role. The young carers were significantly more like to have support from a social worker, frequently drink alcohol and claimed they were always hungry due to lack of food at home.

## Links with emotional wellbeing and mental health

The mental health foundation trust commissioned the MyCare report in 2010 which looked specifically at the lack of support for young carers and how it affects their mental health. The report highlighted that young carers are 'frequently overlooked and poorly-served' and the "Pressures on young carers can lead to feeling of anger, anxiety, frustration, guilt, resentment and stress"<sup>119</sup>.

Key findings showed that young carers 'often miss out on opportunities to play and learn... and become isolated with no relief from pressures at home'. This is re-iterated by other organisations such as the Carers Trust who found that "Many experience traumatic life changes such as bereavement, family break-up, losing income or housing, and seeing the effects of an illness or addiction on the person they care for. All these things alongside the pressures of school or college and the social isolation experienced by many, can lead to stress, anxiety and depression"<sup>120</sup>

Research conducted by the university of Nottingham found that "...almost a third of young carers surveyed (29%), reported that their own physical health was 'just OK', and 38% reported having a mental health problem."<sup>121</sup>

## Service provision

Walsall Young Support Services run a support group for young carers in Walsall. When a young carer attends the group they are assessed according to their needs and appropriate support is given. If support is required the group will see what they can offer but will also refer to Early Help, suggest support from a Youth Worker or sign post them to on-line counselling services. The support service will also look to see if there is any support via adult social services that they can access because of the adult they are supporting.

## Emotional Wellbeing and Mental Health Services

The Figure 39 below describes emotional wellbeing and mental health services for children and young people at different levels of need or by tier. Mental health services and Children's Services categorise by tier whereas Healthy Child Programme services are categorised from community through to Universal Partnership +. It is important to gain a common understanding of different levels of need and categorisation of thresh holds.

### Definitions

**Community** Services available that all can access to support their emotional health such as physical activity, parenting courses, PHSE in schools or Childrens Centre services

**Tier 1** Services for young people when an issue is first identified requiring more support than is available in the community for all. This might be provided by school nurses, health visitors, GPs or parenting practitioners. The Healthy Child Programme would categorise this as **Universal**

**Tier 2 targeted services** commissioned by JCU, CCG and WBC

**Description:** Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services) with vulnerable groups. This can include primary mental health workers, psychologists and counsellors. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1. The Healthy Child Programme would categorise this as **Universal +**

**Tier 3** Specialist services commissioned by the CCG

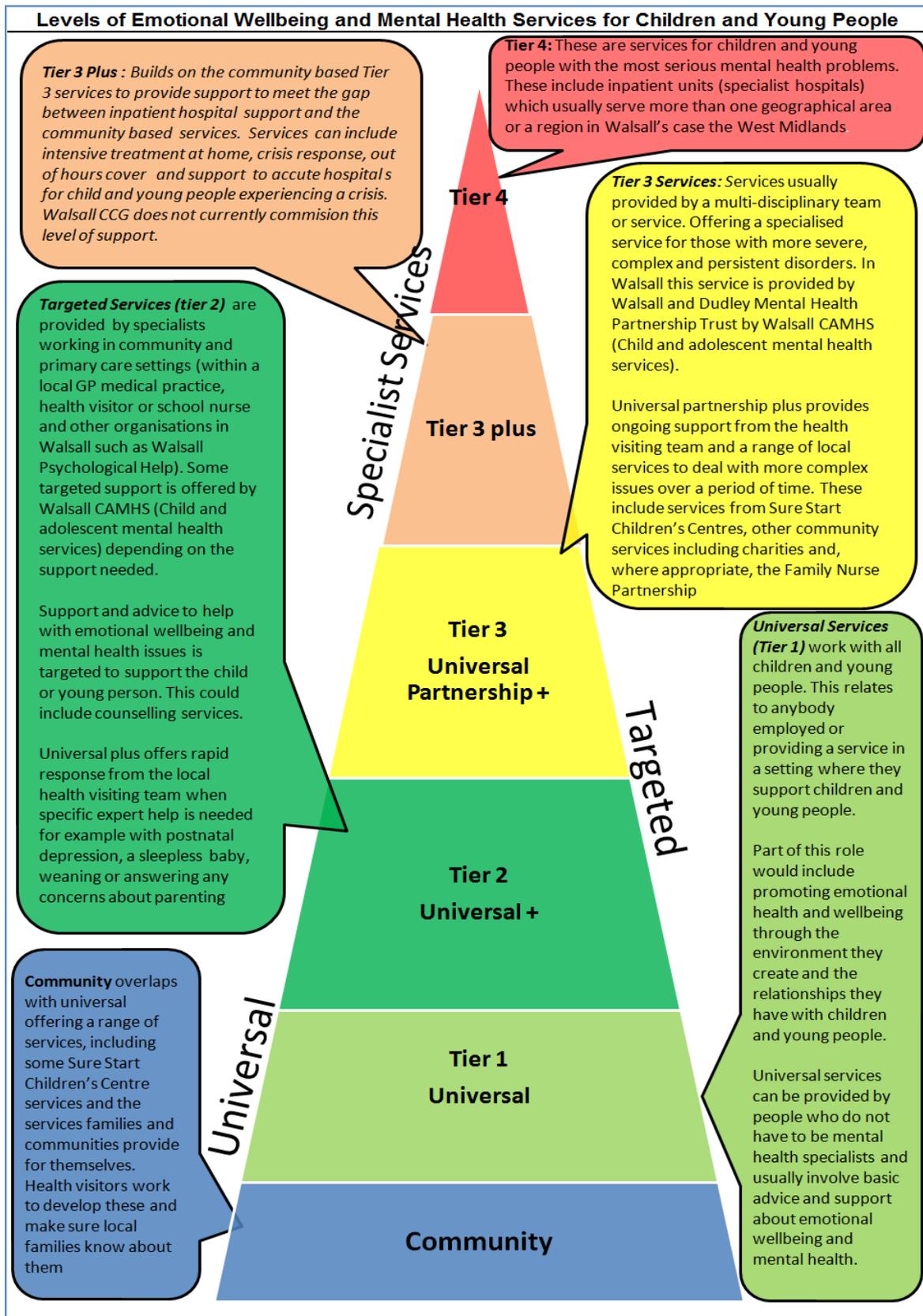
**Description;** a multi-disciplinary team or service, providing a specialised service for children and young people with more severe, complex and persistent disorders made up of child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists. The Healthy Child Programme would categorise this as **Universal Partnership +**

**Tier 4;** Commissioned nationally by NHS England and more locally by CCG

**Description;** tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-

psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.

Figure 39: Levels of Emotional wellbeing and mental health service for CYP in Walsall



## Children and Adolescent Mental Health Service Provision

Figure 40 summarises the services in each tier and who commissions the services. From this it can be seen that there is a need for an out of hours service at tiers 4 and 3 and that there are minimal services for children under the age of 11 at all tier levels. While there are many services offered at tier 2, some do not have the capacity for referrals by large numbers of young people requiring support and the level of support, where available, may not be consistent from service to service even in the same tier.

Stakeholders have identified that they are not aware of all the different services that are available to support young people's emotional wellbeing and mental health. The ability of each service to cope with an increased client group should awareness be raised would need to be investigated.

**Figure 40: Summary of services available to support the Emotional Wellbeing and Mental Health of Children and Young People in Walsall.**

Service Provided				
<p><b>Tier 4;</b> Commissioned nationally by NHS England and more locally by CCG</p> <p><b>Description;</b> tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.</p> <p><b>General Gaps;</b> Need for a local service Need for a pathway to reduce need for inpatient stay/ reduce length of stay</p>				
Service	Provided by	Commissioned by	Available to	Comments
Out of area tertiary level services	Various out of Walsall providers	NHSE	Young people diagnosed as having a need at this level	Out of area inpatient bed offered where possible within region but often further away based on availability of beds
Crisis level response in paediatric ward The Manor	DWMHT	CCG	Young people diagnosed as having a need at this level in response to a crisis involving the act or significant risk of self harm	No CAMHS out of hours service

				and/or suicide	
Tier 3 plus					
<b>Description;</b> Intermediary service established to meet the local need					
<b>General Gaps;</b> Access to consultant support required. Not available after 8pm					
Service	Description	Provided by	Commissioned by	Available to	Comments
Nurse led crisis service at home and to paediatric ward	Nurse led CAMHS crisis service, including daily support to the acute trust children's ward, treatment at home and support to enable discharge into community setting from specialist inpatient. Available every day 8am to 8pm	DWMHT	CCG	Young people diagnosed as having a need at this level in response to a crisis	No access to consultant support when needed
<b>Tier 3</b>					
<b>Description;</b> a multi-disciplinary team or service, providing a specialised service for children and young people with more severe, complex and persistent disorders made up of child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists					
<b>General Gaps;</b> No out of hours provision. Eligibility for service based on assessment and diagnosis that a treatable mental health condition exists. Delays in reaching assessment stage Approx 9 month waiting list for specialist psychology due to small staff team					
Service	Description	Provided by	Commissioned by	Available to	Comments
Community mental health clinic or child psychiatry outpatient service.	Multi disciplinary team for CYP with more severe, persistent and complex disorders. Community mental health or child	DWMHT	CCG	Young people diagnosed as having a need at this level.	No out of hours provision Referral to diagnosis may take up to 8 weeks for this service.

	psychiatry outpatient service.				
Learning Disability CAMHS	Multi disciplinary team supporting young people with SEN, learning disability and attending specialist education provision	DWMHT Child and family psychology service	CCG	Young people with learning difficulties and mental health issues	No out of hours provision
Specialist Psychology service		DWMHT	CCG		9 month waiting list
Complex Communication Clinic	Multidisciplinary team supporting young people with SEN. Learning disability and attending specialist education provision	WHT and Walsall Education services	CCG Local Authority	Young people with social and communication difficulties	Need to continue to clarify the interface and embed joint working with CAMHS

### Tier 2

**Tier 2 targeted services** commissioned by JCU, CCG and WBC

**Description:** Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services) with vulnerable groups. This can include primary mental health workers, psychologists and counsellors. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

**General Gaps:** No direct 1:1 counselling for children under age of 11 - this is a specialist area and unless the needs are met through family therapy or parenting courses the child would need to be referred through to the tier 3 CAMHS - where they would need to meet the eligibility criteria to access the service.

No single point of access for all emotional wellbeing and mental health needs - pathway needs to be clarified and confirmed No primary mental health worker in position to advise of most appropriate approach and/or to make decision for referral through to CAMHS when recognising other approaches will not meet need due to emerging mental health condition. Children can be referred back and forward between SN's and GPs if referral not clear

Long waiting lists esp in Educational Psychology team core service

Traded services rely on investment schools chose to allocate to this issue so may be disinvested.

Service	Description	Provided by	Commissione	Available to	Comments
---------	-------------	-------------	-------------	--------------	----------

			d by		
CAMHS specialists working in community and primary care		DWMHT	CCG	Young people diagnosed as requiring support	No direct counselling for children under 11 years in this tier No single point access Long waiting lists. Children can be referred back and forward between SN's and GPs if referral not clear
Educational Psychology 2-19 (core service available for all schools - up to age 25)		DWMHT	CCG	Available in schools	9 month waiting list A less robust service since becoming a traded service
Educational Psychology ( <b>traded service</b> )	Applied psychologists working with school staff parents and pupils to achieve positive outcomes for children	DWMHT	Schools	Young people at school and to age 25	Traded services rely on investment schools chose to allocate to this issue On average primary schools offer 2 hours support per week and secondary

					buy in between 8-20 hours support
LAC support (Edge of Care, Troubled Families, CAMHS team)	Support to LAC presenting with mental health issues		WBC	Available to LAC group only	
Semi supported accommodation for care leavers with support for EHwb as part of housing support		Supported housing providers	WBC	Available to care leavers	
Behavioural support in primary schools and link to CAMHS ( <b>traded service</b> )	CAMHS workers in primary schools offering support to school staff around behaviour issues Work directly with children and can refer directly to CAMHS if need emerges	DWMHT	schools	Available to primary school age children	72 primary schools 4 days per week service for whole of Walsall. More practitioners required. Traded services rely on investment schools chose to allocate to this issue
Primary Care CAMHS clinical Psychology + SNS collaboration	School nurse led service based on ASQ referral. Support by school nurses for those young people with lower scores. Support from specialist school nurses for those young people with	WHT	WBC		High referral rates with longer than desired waiting times Schools, parents and young people can refer

	higher scores				
Corner House for young children					Long waiting list but parents can self refer
Aspire Counselling (YSS)		Youth Support Services (YSS)			
Substance misuse services	Offering assessment core planning and 1:1 psychosocial interventions to young people aged 10 to 19 who are using or misusing drugs or alcohol. All appointments conducted in a community setting or the home	The Beacon (CRI) Adult and Young people integrated substance misuse service	WBC	Support for young people receiving support for substance use All young people 10-19 or up to 25 years if they have a learning disability Direct supported transition into adult provision for those over 18 when appropriate	Outreach appointments in the community , therefore flexible and no waiting lists Also have specialist substance misuse worker based in Edge of Care and Youth offending teams
Crisis Point – Blakenhall Village Centre	CSE specialist service	Street Teams	WBC		
Walsall Psychology Help family counselling	for families with children under 11, Once a child is over 11 years WPH offer 1:1 work Also funded by the Children’s Society to work specifically with ethnic groups around radicalisation and honour based married	WPH	CCG	Available to families and children over 11 years	
Bereavement Services				For young people having been bereaved	

Kooth online 11-25 years	An online service for young people for initial support	Kooth	CCG		Not available for children under 11
Family Work self referral		Street teams	WBC		All return home interviews for missing children under 18
YOS Mental Health Worker	Able to support young people who score as high risk of emotional wellbeing and mental health issues Referral directly to CAMHS should need emerge	DWMHT	WBC	For young people in the Youth Offending Service only	
Think Family team	Peer mentoring scheme where vulnerable young people are partnered with another young person leading to development of skills and CV for mentor and stability for mentee				
Community Paediatrician	0-19 service Children with medical needs	WHT	CCG	Children with medical needs 0-19 via TAC and community Paediatrician referral panel	Interface with CAMHS under discussion. Looking to revise criteria
Social Care/Health Team for children with disabilities		WHT			
School Attendance	Sourcing alternative		schools		In 24 primary

officer ( <b>traded service</b> )	support for children at risk of exclusion. Support for children, families and schools in managing the move between schools Offering training to school staff around exclusion legislation				schools for on average 2 hours pw. 8-20 hours in secondary schools. Special schools buy in 1-2 hours pw
Education Welfare Staff ( <b>traded service</b> )	Investigate irregular school attendance. Offer direct support to children, families and schools		Schools		In primary schools on average 2 hours per week
Group Friends Programme (School Nurses) for primary and secondary ages		School Nurses	WBC		
Anger management courses via school nursing		School Nurses	WBC		
“Wishes and feeling” course delivered by school nurses		School Nurses	WBC		
Family support advisors, learning mentors and teachers with EHWb as part of role			Schools		25% of schools do not identify that this resource exists in their school
Sensory processing (OT) 3-19	Advice and support offered by occupational therapy	Occupational Therapy - WHT	CCG		Not trained in sensory integration . Need clarity of interface

					with CAMHS OT
Living with autism training SLT (pre school to 19)	Multiagency delivery Link with training pathway	Speech and Language Therapy Service	CCG		Need more support for parents of young children with ASD including parenting programmes aimed at newly diagnosed children
Understanding your child with autism (pre school)					
Post AS diagnosis support – to individual children (up to 19 years)					
Acorns					
Team around the child u 5s (Walsall Child Development Service)					
Homeless Services		WBC			
Team around the child u5s (Walsall Child Development Service)	Birth to 5 years			For children who require 3 or more services	
Speech and language therapy service	2-18 years Communication needs	WHT	CCG	Open referral	Bercow report identify this as a particularly vulnerable group
<b>Tier 1</b>					
<b>Tier 1</b> Commissioned by a variety of providers inc. NHS England, Public Health, WBC (some services offered in Tier 2 also provide services at this level)					
<b>Description;</b> Provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice					

workers and voluntary agencies. Behaviour support team. Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

**General Gaps:** STORM training - identification of young people at risk of self harming. Consistency across practitioner training (esp. GPs and teachers) to recognise problems and know how to support or refer onwards. Mental Health first aid training available

Service	Description	Provided by	Commissioned by	Available to	Comments
Parenting programmes	Support to parents universally but also to those experiencing difficulties	various	Various	Parents of children from pre birth to teenage	<b>Cygnets parenting course available for parents of children with autism</b>
GP services		Individual GPs			Need for support identified
School Nurse Service	A universal service offering support to children 5-19 and their families	WHT	WBC	Children and their families 5-19	
Health Visiting	A universal service offering support to children 0-5 and their families. Skills available to identify emotional and mental health issues in young children and offer support	WHT	WBC	Children and their families 0-5	
FNP service	Support offered to teen parents under 19 years and their children 0-2. Skills available to identify emotional and mental health issues in young children and	WHT	WBC	Teen parents and their first child up to 2 years of age	

	offer support				
MindEd e based learning for school staff and youth workers					Training not offered consistently across Walsall
Everybodys Business Training					
Mental Health 1 <sup>st</sup> Aid training					
Young Carers support	Young carers group meeting weekly to offer support	IYPSS	WBC	Young people who have a caring responsibility	
Anti bullying support in schools	Anti bullying strategy and support to implement is available across Walsall	schools			
Asylum seeker support	Support for asylum seekers through health visiting and Council services	WBC WHT	WBC		
Sport and Recreation behaviour and Inclusion officer <b>(traded service)</b>	1 member of staff offering support to young people with behaviour difficulties and at risk of exclusion through sport and physical activity	WBC	WBC	young people with behaviour difficulties and at risk of exclusion	Traded services rely on investment schools chose to allocate to this issue
Early Help services	Various according to need	WBC	WBC	To all young people identified as requiring Early Help multiagency support	
Mental health resources offered to schools from school nursing service – key stage teaching resource 1-4		WHT	WBC		

“Getting the lowdown” 5 Ways to wellbeing Voice Notes to self (docu drama)					
<b>Universal</b>					
<b>Description:</b> Provided in the community (schools, youth clubs and in families) to promote emotional health and wellbeing for all young people to promote self respect, problem solving and resilience. Begins with support for parent/baby bonding					
<b>General Gaps:</b> TAMHS, SEAL, Consistency across schools and early years settings in support offered and training for staff in supporting emotional health and wellbeing, Mental Health 1st Aid not offered consistently across Walsall					
Service	Description	Provided by	Commissioned by	Available to	Comments
PHSE in schools and Healthy Schools	Curriculum based education around keeping well physically and emotionally	Schools	Schools	All children	The profile of PHSE in schools is lower than core subjects
Parenting course	Support to parents around behaviour and increasing child and family resilience	Variety of providers	Variety	Parents of children prebirth to teen	
Physical activity opportunities		Variety			
Children’s Centre services	Support to families of young children through support, information and child care	WBC	WBC		Outreach support available to work with families
Early Years Education provision	Education for 40% of 2 year olds whose families are eligible 3 -4 year old provision	Nursery schools	Schools	Those children eligible to receive early years education	
SLT Talk Together groups (pre school) Early	Universal signposting Referral to Talk Together	WHT	CCG	Those children identified as requiring this support aimed at	

identification intervention and signposting	groups Open access with parental consent			2-4 years with delayed speech and language	
HomeStart Walsall	Volunteer support for families with at least one child under 5 Support for 2 hours per week in the family home	HomeStart		Children under 5	

## Referrals to the CAMHS service

Appropriate numbers of young people who may experience mental health problems needing a response from CAMHS at Tier 1, 2, 3 and 4 have been extrapolated from Kurtz (1996)<sup>122</sup>. According to the ONS midyear estimates for 2013, there were 60,407 children and young people aged 0-16 in Walsall and Table 33 below shows estimated demand by each CAMHS tier:

**Table 33: CAMHS service estimate prevalence and numbers of CYP by tier**

CAMHS	Estimate prevalence (%)	Expected number of CYP	CAMHS referrals
Tier 1	15%	9690	-
Tier 2	7%	4525	-
Tier 3	1.85%	1195	1557*
Tier 4	0.08%	50	24**

**Source:** Chimat, Dudley & Walsall Mental Health Partnership Trust (DWMHPT) and NHS England.

\*All accepted referrals in 2014/15.

\*\*24 referrals between December 2013 and April 2015, with 3 patients referred more than once. The ages of the patients ranged from 8-17, of which 15 were female and 9 male.

There were 1,946 referrals to CAMHS during 2014/15 which was slightly higher than previous year (see Table 34), with 80% of referrals accepted by the service (1,557).

**Table 34: Referrals to CAMHS, 2013/14 - 2014/15**

	2013/14	2014/15
Number of referrals to CAMHS	1878	1946
Number of accepted referrals	1521	1557
Acceptance Rate (%)	81%	80%

**Source:** DWPMHT

\*All referrals with more than one seen appointment

The CAMHS service had 10,591 face to face contacts in 2014/15 with 9.5% of young people not attending appointments (see Table 35).

**Table 35: Walsall CAMHS referral & contact data, 2014-15**

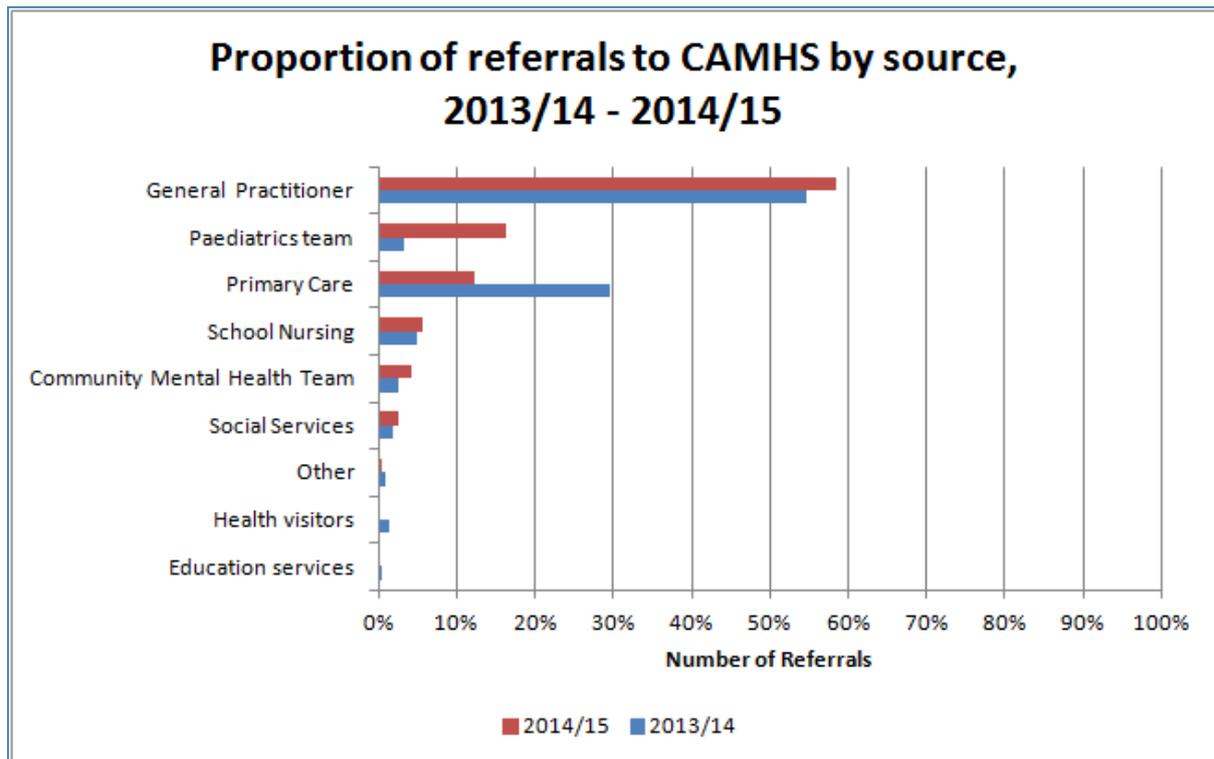
F2F contacts	10,591
DNA's	1,117 (9.5%)
Referrals	1941
Referrals accepted (after screening)	1532 (79%)
Discharges	1092

**Note:** Not including Learning Disabilities or Tier 3.5.

### CAMHS referral sources

Over half of all referrals received by CAMHS come from general practitioners in the past two years (see Figure 41), however there has been an fivefold increase in the referrals from paediatric teams (acute and community) in the last two years (61 to 304 referrals). DWMPHT service believe that paediatric departments may feel that they have more children and young people presenting with mental health issues and therefore are referring more patients to CAMHS (Source: DWMPHT; Personal communication from Zoe Gilbert on 20<sup>th</sup> August 2015).

**Figure 41: Source of CAMHS referrals, 2013/14 - 2014/15**



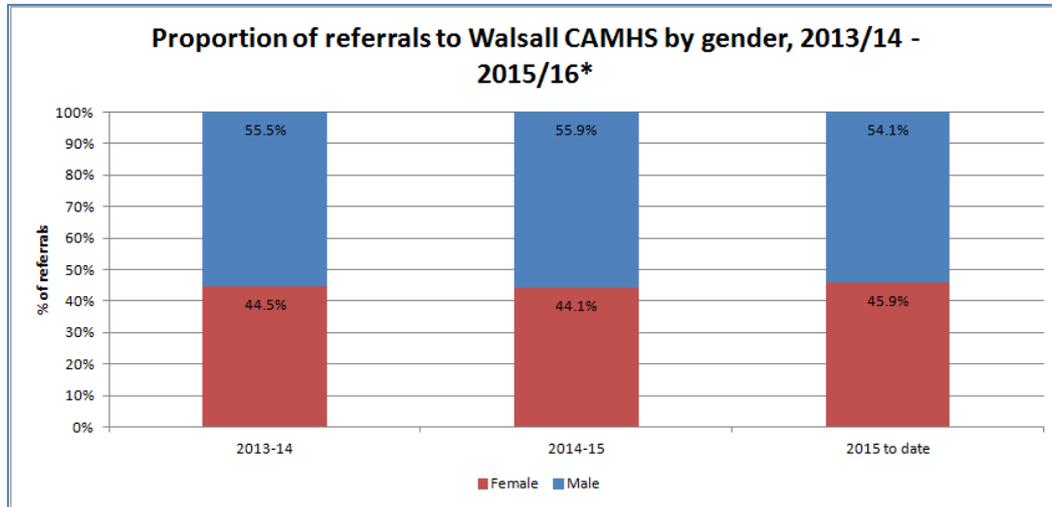
**Source:** DWMPHT

**Note:** The data above represents all referrals received by DWMPHT.

## CAMHS Service User Demographics

Over the last two years more male service users were referred to CAMHS (approximately 55%) and this trend seems to be continuing at the first quarter of 2015/16 (see Figure 42).

Figure 42: Referrals to Walsall CAMHS including Learning disabilities by gender, 2013/14 - 2015 to date

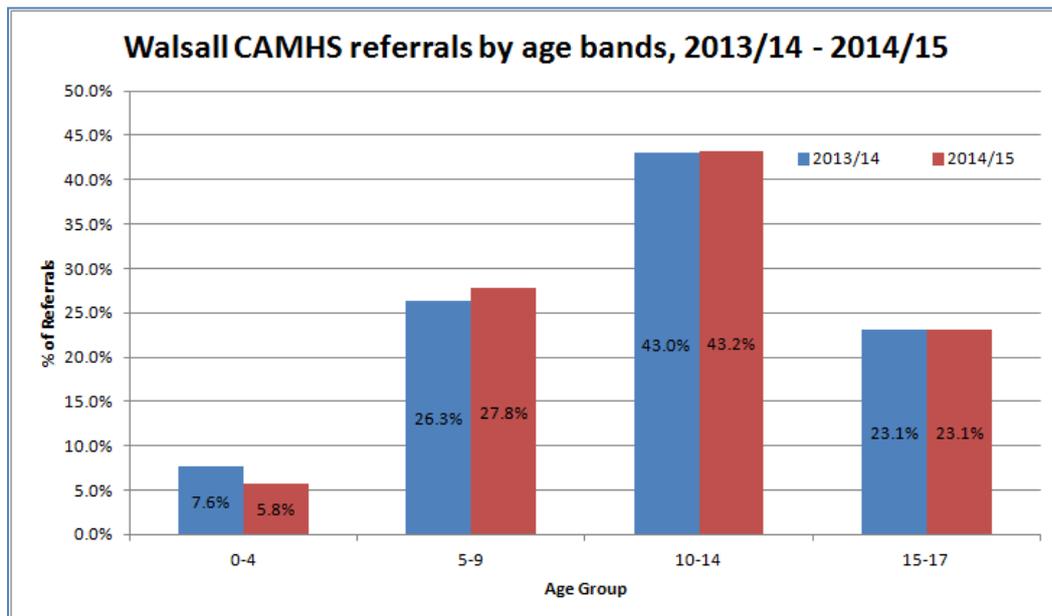


Source: DWMPHT

**Caveat:** Data for 2015 to date comprises of referrals between 1<sup>st</sup> April 2015 and 17<sup>th</sup> August 2015.

The largest proportion of services users referred to CAMHS was from the 10-14 age bands in the last two years (see Figure 43).

Figure 43: CAMHS referrals by age, 2013/14 - 2014/15

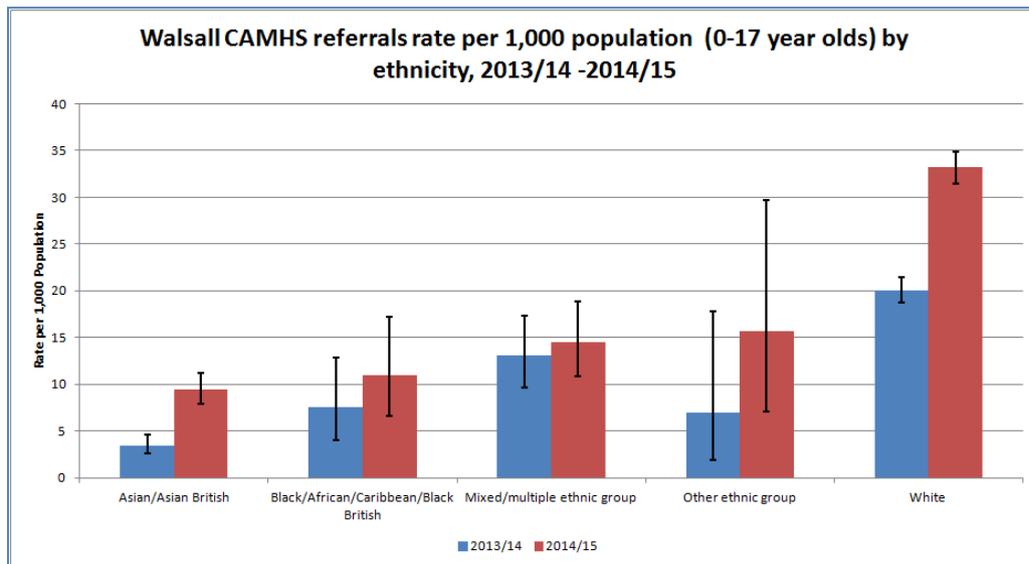


Source: DWMPHT

The vast majority of CAMHS service users were white with 12.3% from black minority ethnic group<sup>+++</sup>.

Figure 44 shows the highest rates of Walsall CAMHS referrals come from the White ethnic group followed by Mixed/multiple ethnic group. The lowest rate was observed in the Asian/Asian British group, however all groups have seen an increase in rate between 2013/14 and 2014/15.

Figure 44: Walsall CAMHS referral rate per 1,000 by ethnicity, 2013/14 -2015/16



Source: DWMPHT

**Caveat:** Approximately 5% of all CAMHS referrals were out of borough residents which were included in the numerator as data could not be distinguished. So the above figure should be used as indicator rather than based on absolute values.

### Waiting times for Walsall CAMHS

The waiting times for Walsall CAMHS are very much dependent on the team/specialty, it can range from no waiting lists (CBT and Eating Disorder) to occasions where waiting times have reach a year and over (as seen in Speech & Language and Psychology).

Below the internal waiting times have been reported as of July 2015, no trend data was available at that point.

#### CBT

There is currently no waiting list to receive CBT as appointments are given as soon as a patient is referred.

#### Eating Disorders

There is currently no waiting list for Eating Disorder patients as they receive an appointment as soon as a patient is referred due to them being extremely high risk.

<sup>+++</sup> Those referrals which had ethnic group recorded as Not stated/Not Recorded/Unknown were removed from calculations but represented 31.5% of total number of referrals between 2013/14 and 2014/15.

## Medics

There are currently 51 patients on the medic waiting list. The shortest wait is 1 day however the longest waiting time is currently 52 weeks to be seen.

## Speech & Language

There are currently 65 patients on the SaLT waiting list. The shortest wait is up to 4 weeks however the longest wait is 52 weeks to be assessed.

## Psychology

There are currently 66 patients on the psychology waiting list. The shortest wait is 1 day however the longest wait is 66 weeks to be seen.

## Psychotherapy

There are currently 5 patients on the individual Psychotherapy waiting list. The shortest wait is 8 weeks for this service. There are currently 2 patients on the Under 5's Psychotherapy waiting list. The shortest wait is 8 weeks for this service.

## Family Therapy

There are currently 10 patients on the family therapy waiting list. The shortest wait is 1 day however the longest wait is 12 weeks to be seen.

## ADHD

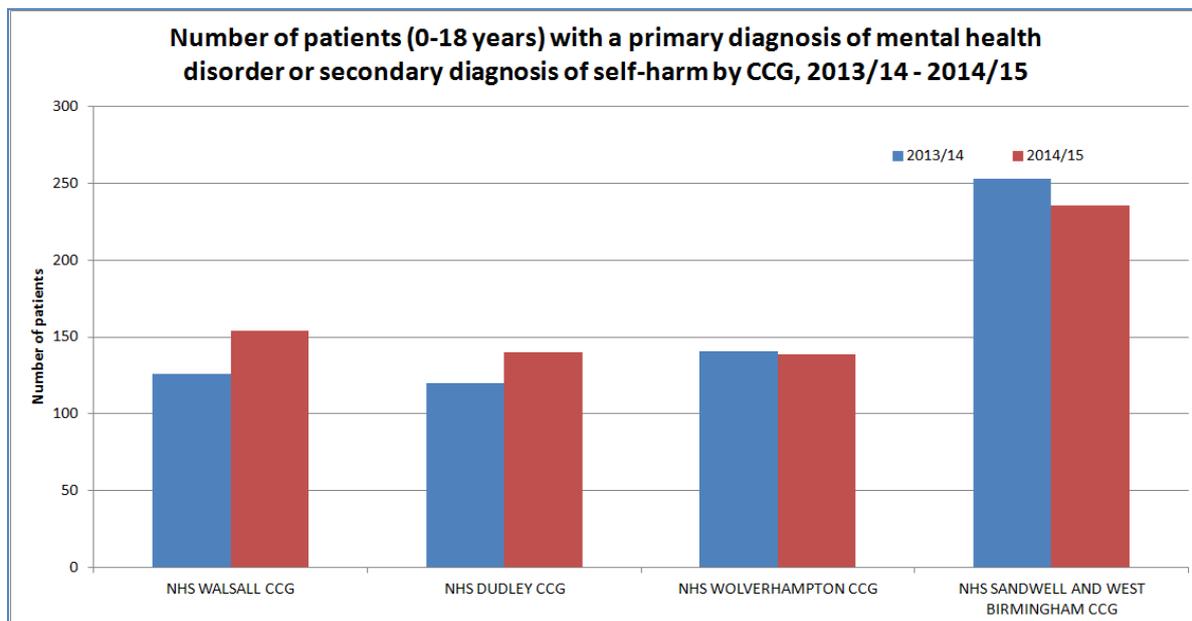
There are currently no ADHD patients on waiting lists as they are all included within the ADHD clinic. Waits to see a clinician vary between 1 and 4 weeks and waits to see a medic vary between 1 and 8 weeks unless there is a cancellation.

## Admissions to hospital

A report commissioned by Walsall Public Health (Improving access to out of hours and Tier 4 Child and Adolescent Mental Health Services in The Black Country) identified an increasing trend in numbers of children and young people admitted to hospital with self-harm and delays in discharges due to lack of out of hours services and difficulty in accessing Tier 4 beds. Data from the report shows that Walsall PCT had 597 admissions where the primary diagnosis was mental health disorder or secondary diagnosis of self-harm between 2009 and 2013.

Current data shows that number of child and young people in Walsall have shown greater increase than other Black Country counterparts (Dudley and Wolverhampton) in last two years (See Figure 45).

Figure 45: Number of patients with primary mental health disorder or secondary diagnosis of self-harm by Clinical Commissioning Group



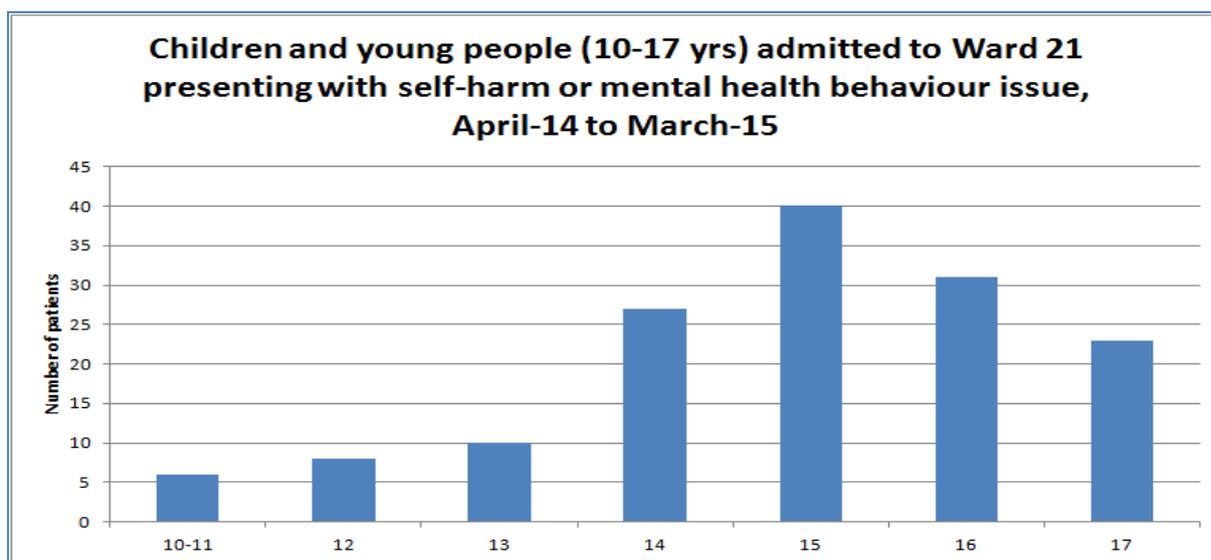
Source: Central Midlands CSU

### Manor Hospital Paediatric ward

There were approximately 148 CYP admitted to Children & Adolescent inpatient ward at manor hospital (ward 21) between April 2014 and March 2015 presenting with either self-harm or other mental health behaviour issues, the vast majority were admitted via Accident & Emergency (A&E).

Two thirds of all CYP admitted in 14/15 were girls and the highest numbers of patients were seen from the 15-16 age groups (see Figure 46).

Figure 46: Children and young people admitted to paediatric ward in Walsall presenting with self-harm or mental health behaviour issues, 2014/15



Source: WHNT

## Referrals to Tier 4 services

There were 24 referrals between December 2013 and April 2015 with 3 patients referred more than once and patient's age ranging from 8 to 17 years<sup>+++</sup>.

## Behaviour Support Service in Schools

There is a service level agreement in place for 0.8wte (4 days per week)/52 weeks per year for this service to be provided. This service commenced in February 2015 and since that time they have provided the following therapeutic interventions:

<b>Therapeutic Intervention</b>
Consultation to teachers, Lead Behaviour Professionals and SENCO's
Consultations to Behaviour Support clinicians and Behaviour support workers – signposting to alternative resources
School meetings which involve planning or consultation. There is discussion about pupils or consulting on teachers approach
School observations : Direct observations of pupils from a CAMHS perspective so impact on learning, social relationships and concentration or hyperactivity
Face to face meetings with parents Initial assessment Completing of specialist forms, i.e. Connors, ASD screening, SDQ scoring F2F with Staff: Completion of specialist forms, i.e. Connors, SDQ complex communication Q's
Links to exclusions team: Identifying high risk pupils who may be involved with CAMHS Support and signposting or formal assessments
Referral request to CAMHS: Following assessments with parents and school being completed it is decided if a CAMHS referral would be appropriate. This is currently requested by writing to the GP. A direct pathway is now being developed so clinicians can refer to most appropriate pathway in CAMHS by cc to GP in referral letter.

## Cluster meetings

These will involve clinicians providing workshops with the Lead Behaviour Professionals from schools regarding CAMHS with the view to aiding communication and working collaboratively. There are currently feedback evaluation and a pathway policy regarding referral to CAMHS in development. The aim is to also support advisory teachers in training schools and parents.

## Primary Care CAMHS

The current emotional health pathway is an open referral system. So any professional or self referral can be accepted. They referral is accompanied by SDQ's and the scores dictate where the CYP is seen. Those with high risk SDQ scores are seen on PCC by either me or Gary. Low and medium are seen within school nurse service.

<sup>+++</sup> NHS England Freedom Of Information request # 007224

The ones in PCC have a CHOICE appt the same as if they are seen in specialist CAMHS. They are then offered short term intervention, self help or sign posting, stepped down for management by SNS or put into spec CAMHS partnership if further assessment is required. At the moment all PCC referrals are recorded on CAMHS Oasis system so none of my contacts are attributed to SNS (an issue in new commissioning world I think) CAMHS manage Oasis system and can give you data. In addition my time and Gary's is also given to training across partnership and consultation groups for SNS.

Those seen by SNS have an EHWP assessment and can be offered a range of tier 1/tier 2 support or if necessary referred to spec CAMHS for CHOICE appt.

## Commissioning and Finance

### Commissioning responsibilities

The commissioning responsibilities for CAMHS tiers are shared across several key partners; NHS England, Walsall CCG, Walsall Council (see [appendix 4](#) for detailed breakdown).

### Governance structures

Governance structures for emotional wellbeing and mental health services for children and young people have been through the CAMHS Service Transformation and Redesign Group led by Walsall CCG. This has been accountable to the Mental Health Programme Board chaired by the CCG.

### Finance

There has been significant investment nationally in the emotional health and wellbeing of children and young people:

**Figure 47: National investment in emotional health and wellbeing**

- £60m into the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme over 2011-15/16;
- £7m in an extra 50 CAMHS specialised Tier 4 beds for young patients in the areas with the least provision (as identified by the NHS England CAMHS Tier 4 Report, July 2014);
- £150 million over the next five years in England to improve services for children and young people with mental health problems, with a particular emphasis on eating disorders; and
- £3 million in the MindEd e-portal launched in March 2014. The e-portal provides clear guidance on children and young people's mental health, wellbeing and development to any adult working with children, young people and families.
- NHS England is investing £15 million in health provision in the Children and Young People's Secure Estate.

In Walsall a total of £3,155mill is allocated to mental health core services from the CCG. This is divided as follows;

Mental Health Service provision	£2.75mill
Counselling Services	£100k
Placements	£300k

Walsall Borough Council invests £266,000 into mental health services specifically supporting Looked After Children and also children who have been adopted or are subject to a Special Guardianship Order (SGO). This service is currently being reconfigured.

There is an additional £15,000 contribution from Walsall Borough Council towards a nurse/psychology post within the YOS.

In addition, Walsall Council funds 3 Social Worker posts who are based within the current CAMH Service and 2 (1 wte) of these will move across to the reconfigured service for Looked After Children.

## Consultation with children, young people and their parents

### Finding from national surveys – including stigma

YoungMinds was commissioned to engagement of children, young people and families for Children and Young People’s Mental Health and Wellbeing.

There were 1,100 CYP (14-24 years old) and over 400 parents involved on-line survey and 2,000 CYP (aged 14-24) polled to increase participation of males as well as 17 discussion groups and six telephone interviews<sup>123</sup>.

The key findings from the engagement report are specified below (full report available: );

### Mental health information

- Younger respondents to the survey and young carers were the least informed about their mental health (with 25% of 14 -15 years old and 24% of young carers),
- Young people and parents found that mental health apps or website were considered useful most commonly source of information as well as information from charities; however they had more value and impact when corroborated by professionals with ease of access and anonymity.
- Parents felt least informed about how to support their child with mental health and emotional wellbeing needs.
- All audiences highlighted the need of information to provided earlier and GPs, teachers, other professionals, parents and young people specified focus on prevention and spotting early signs to avoid intervention later.

### Mental Health services

- Online services, such as counselling were less commonly used than online information resources by young people due to concerns about confidentiality and knowing who is providing the support. This concern was echoed by parents that they preferred face-to-face counselling (94%) due to concerns with online unsupervised support could be dangerous.

- Professional should be supportive and take time to understand the child and Looked after children mentioned trust (“a familiar face, somebody that understood me”).

### **The role of schools**

- Many young people expressed concern about lack of support available at school and not enough right people available to help.
- The two forms of support that is valued were; lessons about mental health delivered by outside organisations and online counselling for pupil as it alleviated concerns about confidentiality but rarely available.
- Similarly, forms of support considered to be helpful by parents namely information on the school intranet, evening sessions for parents looking after their child’s mental health, lessons about mental health for pupils, and signposting to access support, are not provided by schools very often.

### **GPs**

- Young people and parents are often concerned they are not listened to – sometimes complaining that GPs are ignorant of mental health issues and turn a blind eye to worrying signs.

### **The image of CAMHS**

- Children and Young People prioritise accessing CAMHS support over concerns about the specific name of the service.

### **Findings related to having a co-ordinated system**

- Use of multiple services is greater amongst some vulnerable groups with 72% of those who have had looked after status, and 55% of those who have been a young carer have used four or more services.

### **An ideal CAMH Service**

- Across the engagement, participants commented that the characteristics of an ideal service include being accessible and available, providing support in a timely fashion, privacy and confidentiality.
- Young people described the need for services to be available outside of school hours, or to be delivered in ways that didn’t impact on learning or add to the stigma of needing to attend a mental health appointment. Also there was importance of services in non-clinical building.

### **Transition to adult services**

- Service users conclude that transition should not be when CYP reach 18, but that a level of flexibility should be allowed right up to 25.

### **Patient and family thoughts on service**

Focus groups were run by MEL Research with the following groups in order to understand which services young people who are not in the mental health system access to maintain their emotional health and wellbeing, and to find out their views as to what services In Walsall they would use or currently use;

- Young people in care
- Young people previously in care
- Students at Walsall College
- Members of the Youth of Walsall (YOW) group
- Parents of children who attend Elmwood School
- Parents who have attended parenting courses
- Parents at Walsall's Dyslexia Support Group
- Parents at the FACE Parent/carer forum

It needs to be recognised that while qualitative research is a very effective way of exploring a range of experiences, perceptions, attitudes and views, it cannot be quantified or measured and may not be representative of the wider population.

### Consultation aim

The overall aim of the consultation was:

***'To carry out qualitative consultation with young people and their parents/carers to understand in more detail young peoples' perceptions about the services available to support their emotional health'.***

### Objectives

- To discover what services or support young people access to maintain their emotional health and wellbeing
- To discover what symptoms might lead a young person to seek help
- To discover what services supporting emotional health and wellbeing parents/carers might access on behalf of children where there is a concern

### Summary of key findings

#### ***How do children & young people cope if feeling anxious or sad?***

Young people indicated that they are most likely to try 'not to panic' if they felt sad; participants in the 'older' group suggested that it was 'normal' to feel sad some of the time. Young people feel generally that there is less stigma regarding mental health than there used to be.

#### ***How do parents cope?***

Parents describe needing good support networks with fellow parents. The relationships with school staff is key, and parents cope with their children's support health and wellbeing support needs much better if there is a good quality of communication between themselves and the range of professionals delivering services.

#### ***Who would young people turn to for support, and why?***

Parents, carers or other family members are the ones most likely to be turned to for support. There is a big issue regarding trust and respondents would only seek support from someone they considered they could trust implicitly. Being able to trust peers also

vital if support is sought. Young people said they were aware of advice and support services in schools.

### ***Are children & young people comfortable talking about things if feeling anxious or sad?***

Generally yes, with recognition that ‘*bottling things up*’ wasn’t good for emotional good health. Young people will often have a reliance on phone-based communication. Relationships with social workers/teachers is fundamental. There is a concern regarding the quality of pastoral care in schools and the inevitable stress of testing and exams.

### ***How do children & young people cope with things at present?***

Some young people consulted had experienced things in the past which they were still unwilling to share with others, choosing to internalise their experiences. Parents suggested that their children responded well to being in an environment in which they were not the only ones with emotional wellbeing difficulties.

### ***What might trigger young people seeking help or support?***

Some young people said they would seek help if something serious happened like someone close to them dying. For those who experienced being in care, there are an established set of relationships which are used when necessary. Being physically isolated at school or being the recipient of unwanted or inappropriate behaviour by an adult would also trigger seeking help or support.

### ***What might local services for emotional health and wellbeing look like?***

Many of the young people who took part in the consultation argued for a town-centre ‘physical space’ which would house different support services and which could be accessed informally on a ‘drop-in’ basis. Others suggested that a ‘phone-based service’ would be welcome. Both young people and parents suggested that there was a lack of ‘talking therapies’ – counselling services available to support children and young people before mental health issues escalated. Some took the view that CAMHS should make more of an effort with ‘home visiting’; some parents suggest that a professional office environment isn’t always appropriate for assessments and on-going support.

### ***Awareness of local services***

Both parents and young people demonstrated a good understanding of CAMHS, but the service was singled out for particular criticism. Delays in diagnosis and long waiting lists for assessments and other appointments were identified by parents and young people. Both cohorts suggested that there were not enough staff and that service availability needed to be wider than standard ‘office hours’. Outside of statutory services, young people appear to be less well-informed once they leave school.

### ***Support available in schools***

Support to improve emotional health and wellbeing in schools not considered to be available to parents and any sort of pastoral care was thought to be lacking. Parents thought that schools could do much more, with all staff being professionally trained to deal with the educational, health and social care needs of children and young people. Young people still in school expressed satisfaction with the systems and procedures in place to support resilience and wellbeing.

### ***What could services in Walsall do to support mental health resilience & wellbeing?***

Both young people and parents suggested the need to do something about reducing the turnover of social workers and mental health professionals. It was thought that communication mechanisms need to be improved, both between professionals and service providers and parents. There is a need for improved integration of health and educational services. The availability of counselling services for children and young people is considered to be much-needed.

### **Summary of consultation findings and possible actions**

The need for up-to-date, accessible information – for both parents and young people – in respect of good emotional health and wellbeing and resilience was seen as vital. There is no preferred mechanism, but full use of social media and information leaflets making available details of local services in Walsall is necessary. For younger children there is a reliance on securing information via parents or other responsible adults (teachers, social workers, youth workers, school nurses etc) and all need to ensure that advice and information disseminated is both current and appropriate.

This consultation encountered and documented a number of young people and parents who described ‘battling’ to access CAMHS services with serious impacts for some young people of lengthy delays as a result of increased demand and reduced funding. CAMHS may wish to consider how they are able to make the availability of services more transparent, setting out their commitment in terms of waiting times for initial assessments and expected service standards with regard to staffing and communication mechanisms.

Support for parents appears to be patchy; but where school-based groups exist they appear to meet the needs of parents, using peer support, underpinned by school professional input. There may be benefits in making available training for parents who wish to set up their own support networks as it was felt that parenting courses are not as widely available as they used to be.

Children and young people appear to be in favour of a ‘physical’ space located in the centre of Walsall which could house a range of services, from basic advice and information on counselling to on-site services for those with severe and complex needs. Further, there was a suggestion that such a centre could serve as a base for a range of statutory and voluntary services, including the Council, the Health Trust and CAMHS, youth support and education.

Finally, Walsall may wish to consider undertaking an audit of early intervention services, referral thresholds, service delivery models and service standards. This should be used to help inform funding priorities for Emotional Health & Wellbeing Support for children and young people in the Borough.

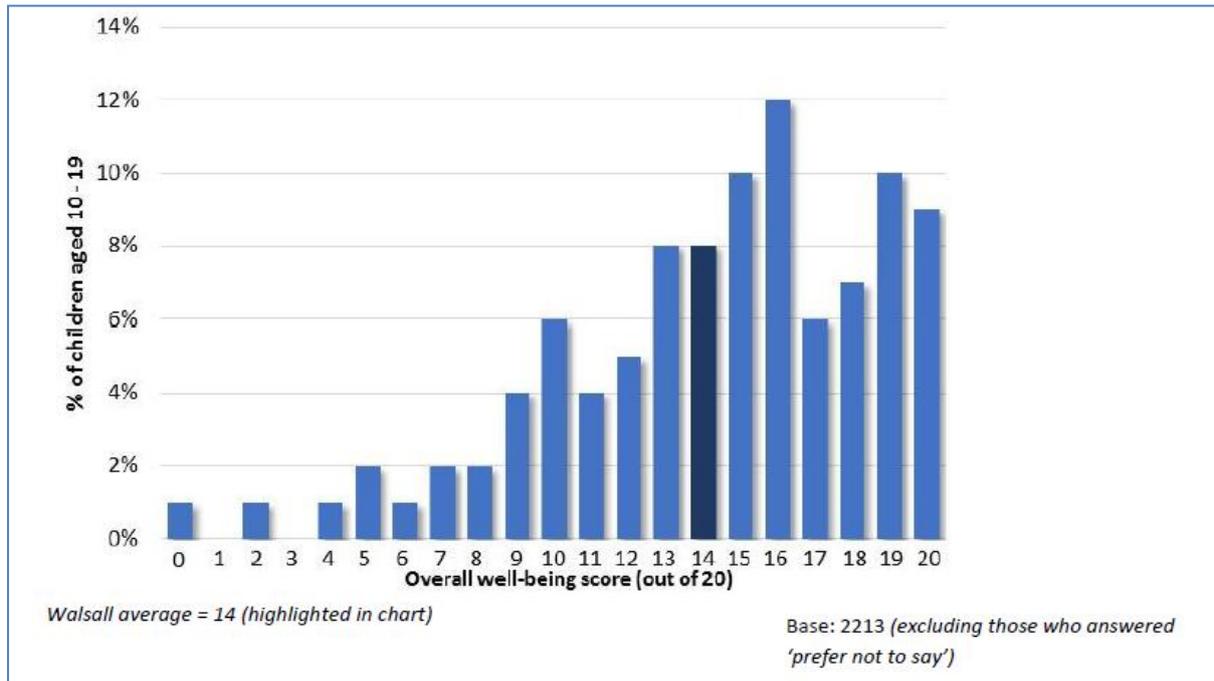
### **Youth of Walsall survey – Wellbeing section**

Across each of the statements, with the exception of ‘I wish I had a different kind of life’, significantly more young people in Years 7 and 8 strongly agree with the statements compared with young people in Years 9 to 13. This suggests perceptions of positive wellbeing decrease with age.

Those who strongly agree with the statement 'I wish I had a different kind of life' are those young people who feel significantly more...

- Unsafe at school
- Unsafe at home
- Always or often hungry due to a lack of food available at home
- Go to bed feeling hungry every day or most days

**Figure 48: Wellbeing score calculation (Please say how much you agree or disagree with each of the sentence below?)**



Source: Youth of Walsall survey,

When provided with a list of issues/worries, young people were asked which, if any, are worrying them at the moment. School/homework/exams is the issue worrying most young people (48%). 36% are worried about what to do after Year 11/their future and 28% are worried their appearance or their weight.

The risky behaviours of smoking, drinking alcohol, and taking drugs are worrying between 5 and 7% of young people.

15% of young people claim nothing is worrying them at the moment.

Significantly more girls are worried about the following issues compared with boys:

- School work / homework / exams
- Being healthy
- Weight
- Appearance
- Relationships / girlfriends / boyfriends
- Feelings and emotions
- What to do after Year 11 / my future
- Friendships

- Parents / carers or family

## Service user feedback

### WPH user feedback

The WPH service captures individual outcomes measures and a final survey to measure satisfaction with a statistical report produced on an annual basis. Data for this year has not recorded any negative feedback

### CAMHS user feedback

D&WMHPT Walsall CAMHS measures outcomes with each young person and uses a range of tools including HONSCA. The service also has complaints and compliments process and has an annual survey.

### Kooth user feedback

Kooth undertake a user survey quarterly and annually

From April 2014 to March 2015, there were 457 registrations.

16% (77) of these were male and 84% (380) were female with the peak of registrations in the 13 -17 year old age group.

365 young people classified themselves as white British or While Irish with 19% (87) from a BME community

The top 10 issues that young people requested help with were;

Anxiety or stress	Depression	Family Relationships
Self Worth	Confidence	Friendships
Self harm	Suicidal thoughts	Boyfriend/girlfriend
Loneliness		

## Consultation with Key Stakeholders

### Aim:

It was important to understand what service providers offered in regards to EHWPB, their thoughts on current services and how they would like to see them improved.

Their involvement will help us shape our recommendations for the evolution of services in Walsall.

### Stake holders involved:

- Beacon Integrated Substance Misuse Service (CRI)
- Children's social workers including those people supporting care leavers and residential young people support

- Dudley and Walsall Mental Health Partnership Trust
- Early help workers
- Family Link workers
- Family support workers
- General Practitioners
- Health transition team
- Health Visitors
- Kooth
- Occupational therapy
- Paediatric ward
- Physiotherapy
- School Nurses
- School readiness workers
- Schools
- Senior Mental Health practitioner
- Speech and language therapy
- Targeted youth support worker
- Troubled families
- Walsall Psychological Help
- Youth Justice

## Methodology

We have approached 22 different groups with 58 individual responses in total. These groups consisted of health care professionals, allied health care teams and front line professionals working with children; they were approached because of their direct involvement in providing a service to children and young people to promote or improve their emotional health and wellbeing.

We developed similar questionnaires for each group, varying the questions slightly to account for the differences in the services provided.

GP's were engaged with at locality meetings to discuss the reasons behind the questionnaires and to drum up interest. The questionnaire was then sent out to all GP's in Walsall via the CCG e-mail system and followed up with prompts to Practice Managers to improve the response rates from primary care. We had a total of 15 responses.

We attempted to do something similar with the Health Visiting team but unfortunately were unable to meet as a group to discuss the questions. Instead we relied solely on the questionnaires being distributed via e-mail, with a total of 5 responses. The professional lead for School Nursing answered our questions on behalf of school nurses via a telephone conversation.

Occupational Therapists, Speech and Language Therapists and Physiotherapists questionnaires were filled in by the heads of the teams. Other allied health professionals and front line workers including family support workers, early help workers, and targeted youth support works were e-mailed, and we had 1 to 3 responses from each group.

Dudley and Walsall Mental Health Partnership Trust as the provider completed a consolidated questionnaire.

A face to face meeting was held with the matron of the paediatric ward, the questions directed to her were focused on how the ward managed the patients, the tier 3 + service and their experiences of admissions to Tier 4 and social services.

Schools have had the questionnaires e-mailed out to them and we have had a total of 5 responses so far.

Children's social workers have had the questionnaires e-mailed to them, with responses from the post adoption social work team and leaving care support workers.

### ***Main themes:***

The questions were based around

- the service provider's confidence in assessing potential mental health problems in children and young people,
- what they are able to offer in-house
- who they refer to if more support is needed,
- how easy they find the referral processes and
- their thoughts on the services provided.
- they were all asked what further support they thought would be useful to help them meet their service user needs.

### **Summary of findings from stakeholder consultation**

(Caveat – despite repeated effort to engage with a representative sample of stakeholders, the response rates from the different service groups was relatively low. We would therefore caution against making generalisations from this feedback)

No group (where individuals were asked) apart from DWMPHT were more than 50% confident in their ability to assess the mental health of children and young people. Most felt there was a need for improved training, particularly around the assessment of younger children and on universal services and use of the different assessment tools

The amount of time spent on EHWP varied according to the profession.

There were mixed responses on the clarity of different referral pathways, depending on who was making the referral and where it was going.

CAMHS was the most frequently listed between the groups as a 'used service'. There was a general consensus that CAMHS was difficult to refer into, with long waiting times. However, once the child or young person received help it was considered to be very good.

It was mentioned a few times that a clear, up to date directory is needed to help the referral process. It is apparent that it would benefit all the different health professionals who have contact with children and young people to have a better idea of what is available within each age group and who to contact.

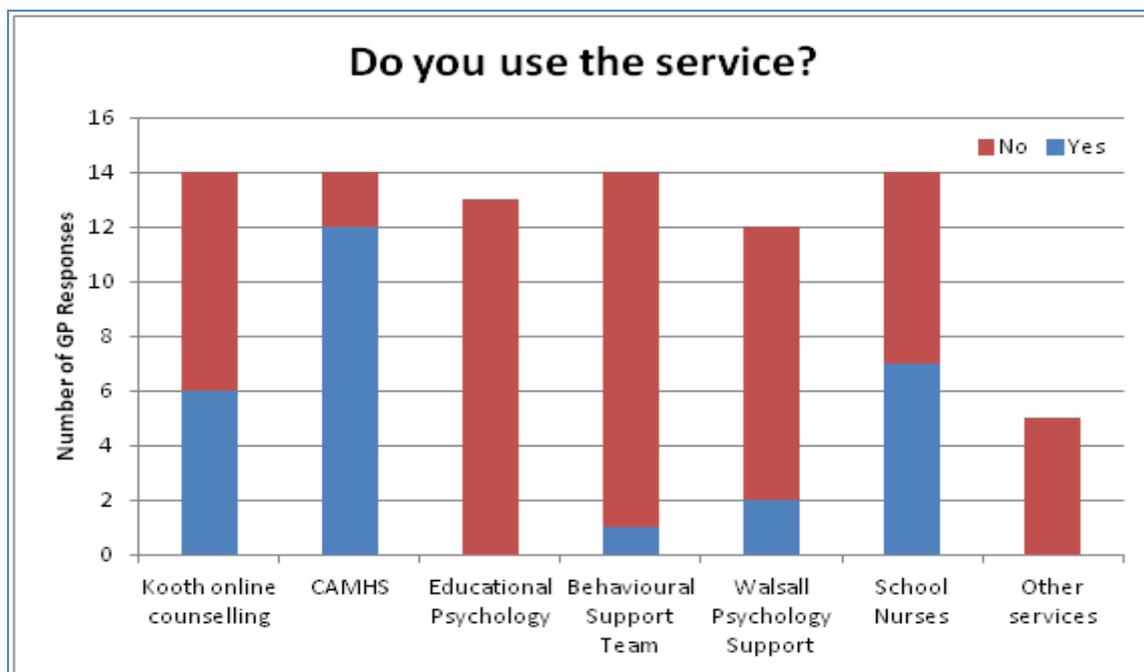
### ***General Practitioners***

Only 47% of GP's felt confident in assessing the emotional health and wellbeing of children and young people.

Approximately 93% of GP's were aware of CAMHS, 80% were aware of school nurses and 60% of Kooth. CAMHS was the most frequently used, followed by school nurses and then Kooth

When the child is discharged back to the GP, only 36% felt they had received enough information to manage them appropriately in the community.

Figure 49: GP responses to EWMH services used.



They were asked what might improve the pathways to access the EHWB services for children and young people;

*“Combined services-single point of access”*

*“I do not need any more pathways or complicated referral forms.”*

*“I should be able to pick-up the phone and make an appointment for the child or adolescent to be seen within a couple of weeks.”*

*“Parents should be able to access this service directly.”*

### **Paediatric Matron**

The paediatric ward manages children when they have hit crisis point. Their main priority is to manage any medical concerns and to keep the young person safe until a more appropriate service can take over if required.

In the past this has been extremely difficult, with long waiting times to be seen. However, things are improving with improved training on the ward and with Tier 3+ (see service mapping [Appendix 5](#) for description). Within their own teams each young person now has a named consultant and will have been risk assessed by a STORM trained nurse. This allows the ward to better manage the risks to the young person with one to one specialist nursing (RMN) when required.

The introduction of the Tier 3+ service has improved the waiting time for children to be seen by CAMHS (this has yet to be audited). The majority of the delays in discharge relate to waiting for a tier 4 bed and when social services need to be involved due to an unsafe discharge. When asked what the ideal crisis service would look like this was the response

*“We would like to have a crisis ward for the region, so that these children are seen in an environment that is better for them with the appropriately trained staff around them at all times”*

### **KOOTH**

Offers online assessment, counselling, information advice and support to people aged 11-25 and runs 7 days a week. Where risk is identified they are referred onto the appropriate face to face service including school nursing, CAMHS, WPH counselling, Sexual health clinic, Crisis support, and bereavement support, all with ‘Good’ ease of access.

Kooth are currently developing models of working around resilience. In other areas of the country the service has been commissioned to offer a therapeutic service to Looked after children as young as 4 with complex needs. They feel gaps in the service are associated with LAC, especially children placed out of borough. The respondents from Kooth felt that Walsall needs more targeted support and early intervention for children who self harm.

### **Walsall Psychological Help**

Offers general counselling/psychotherapy service for adolescents and adults. It also provides psychological intervention for emotional issues for mild to moderate mental health problems, short term interventions and they will look after mild autism and ADHD.

WPH will refer to GP’s, CAMHS and Talking Therapies (if over 18). WPH have found Talking therapies are easily accessible, CAMHS’ new referral pathway with a telephone contact pre referral is also deemed good. However, to refer the patient back to their GP for support depends on the surgery.

Anyone can refer into WPH and they would like to expand the service, especially in Schools. They feel gaps within Walsall are around support services for children and young people with serious behavioural issues. WPH would like appropriate services and pathways to become available for young people fitting into traits identified above i.e serious behavioural problems/ADHD/Autism.

### **Schools**

A total of 5 schools responded, all stating that they offered something to support any mental health concerns though the amount on offer varied between schools. All were aware of CAMHS but describe not receiving any feedback from them. One school stated that they were unaware ‘if and when’ a child was being seen by CAMHS. The schools were also just as likely to use educational psychology followed by school nurses. However, they felt that the long CAMHS waiting list and frequent change of staff at Educational Psychology were an issue. They also suggested also wanted to be regularly updated on the changes of services

None of the schools were aware of KOOTH.

In addition, training was requested to improve confidence in assessing children together with provision of a directory of available services.

When asked what they thought would improve the pathways into services these were the responses

*“simple user guide with contact info of all services offered in Walsall”*

*“Accessing appropriate services QUICKLY often children/families/schools have to hit crisis point before the full ranges of services are available.”*

*“feedback/ communication from other agencies”*

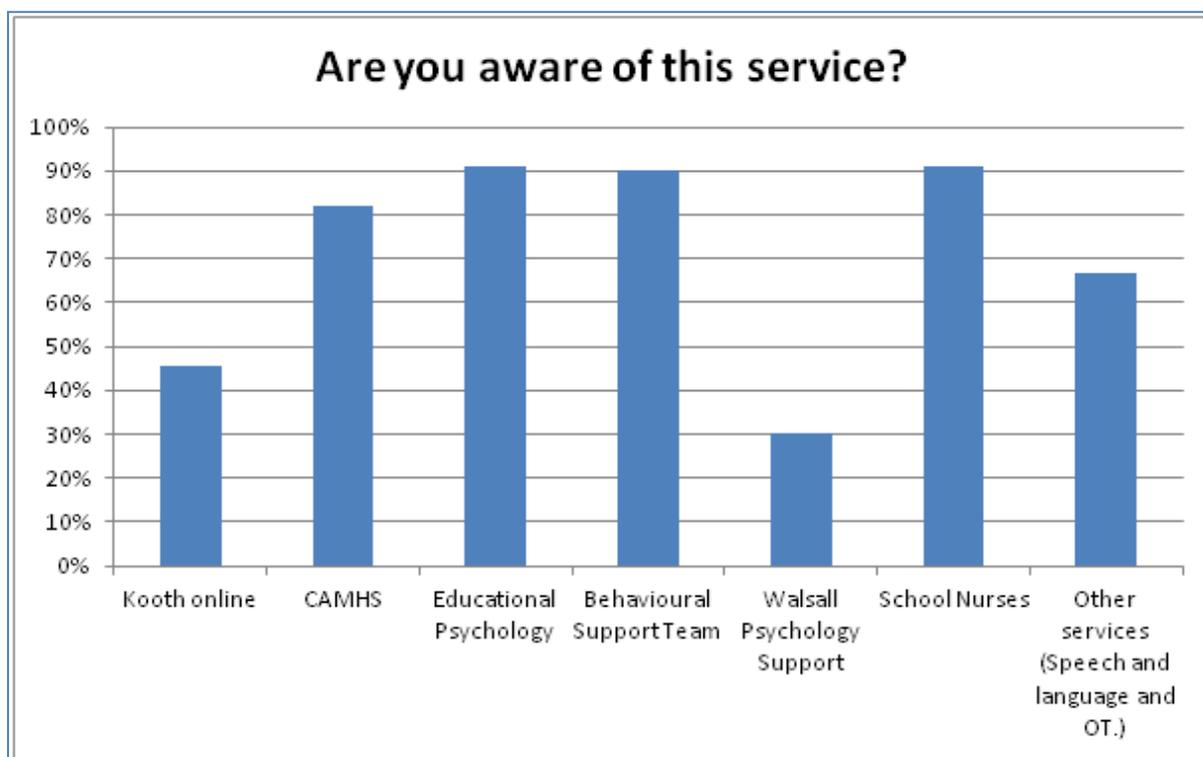
### **Allied Health professionals**

Only 30% felt confident in their ability to assess the emotional health and wellbeing of children and young people.

Educational psychology, behavioural support and school nurses were the most widely acknowledged by all the services. However, CAMHS and School Nurses were the most widely used (8 out of 11 professionals) followed by behavioural support and educational psychology.

Feedback from services varied, all had negative and positive responses from different individuals without these being an overall consensus.

**Figure 50: Allied Health Profession awareness of EHMH services.**



When asked what they thought might improve the pathways to access the EHWP services for children and young people, most of the responses were similar to the 2 below.

*“Training to update on referral process for the services I am not familiar with e.g Walsall Psychology, Kooth online counselling”*

*“A directory of all the services that can support around mental health and wellbeing in children, with details of the support on offer, referral criteria and method”*

### **School Nurses**

Referrals to school nurses relating directly to EHWB make up about 50%-75% of all requests. Different members within the nursing team will manage differing amounts according to their specific job roles. All children referred will have an emotional health screen and if concerns are raised they will be referred onto the most appropriate service.

School nurses are able to refer to CAMHS, Primary Care CAMHS and can sign post C&YP to WPH and KOOTH, with Corner house is used for younger children (under 11). According to the professional lead for School Nurses they would like to be more involved in promoting EHWB within the school curriculum.

### **Health Visitors**

50% or more of HV time is spent managing the emotional health and well being of children and young people. This is mostly spent supporting parents through a variety of programmes. However, only 2 out of the 5 felt they actually had enough training to assess a young person's mental health.

The HV team use different services including CAMHS, WPH, sure start children's centres and parenting groups. All the services offered good support to families, but there were some comments on the difficulty in referring C&YP to CAMHS, particularly the long waiting times and there are concerns over the closures of the sure start centres. When asked what they would like to see improved on these are 2 of the responses;

*“More structured supervision and training around supporting parents and children with emotional issues”*

*“we would like a directory of all the services a HV can access and what age the child needs to be”*

### **Children's Social Workers**

They do not feel that they are confident of their abilities to assess children and young people's emotional wellbeing and mental health. They feel that they have not been appropriately trained to do so. The team offer practical support, information and advice or try to identify external resources to meet the relevant need. They can undertake some direct work with carer/adoptive parent/child but this is limited and is not really therapeutic. They have also identified access to specialist services as an issue to be addressed.

*“It would be beneficial if we had easy access /consultation with a qualified Psychotherapist/Psychologist who understood attachment difficulties and related issues, concerning children who are in the care system or children who are in adoptive placements.*

*The aim would be for social workers to receive guidance from a Psycho therapist/psychologist in identifying the most appropriate support/therapeutic interventions for the child and their carer/adoptive parent. Consultation may also guide the social worker in how best to work with the child, carer/adoptive parent.”*

### ***Education Support Services***

These include Education Liaison and Welfare officers. 3 officers returned their questionnaires. They all felt confident to assess children and young people's mental health and wellbeing. They were familiar with most available services however they mostly engaged with CAMHS and the School Nursing team.

### ***Health Advisor Service***

One questionnaire was received from a health advisor working in Transition and Leaving Care Services and also Looked After Children. They felt that an assessment tool would be useful and feedback from referred services would build their confidence in continuing assessing children and young people's mental health and wellbeing. They engaged mostly with CAMHS and felt that the service was easily accessible but there was not enough support for the children while transition into adult services and also that the out of area links for Walsall children was inadequate. Support would be in the form of resilience training, carer support and reading resources for the service users.

### ***Youth Justice Service***

Two responses were received. They were familiar with services and works with CAMHS. They felt confident in assessing children however did not refer in their current role. They felt that Educational Psychology, Behavioural Support, and Walsall Psychology should offer Out of Hours support and would welcome training to develop joint working.

There was also a request for support for young people as they move between areas

### ***Residential Young People Support***

One response was received. They felt there could be better collaboration between the services

*"CAMHS services are currently unproductive as they do not meet the needs of individual young people by their allocated workers given the length of time between visits. And that do not always correspond with services provided by Children Residential Services or by working together holistically. The young people state that services are not, accessible or responsive or person centred as they should be... they do not always have the opportunity to develop trusting relationships with staff for the length of time they required"*

Of Walsall Psychology Support they felt,

*"WMBC Children Services needs to be using NHS Psychology services to be more proactively as some of the young people have been affected by life events good or bad. However there is no clear clinical intervention"*

### ***Safeguarding & Family Support***

One response from a Support Manager based at a local primary school. They felt that more training was required to improve confidence in assessing children together with provision of a log of available services. They were familiar with all the services available and found it

easy to access and make referrals. However, they felt that the long CAMHS waiting list and frequent change of staff at Educational Psychology an issue. They also suggested also wanted to be regularly updated on the changes of service.

### **Dudley and Walsall Mental Health Partnership Trust**

As the provider of mental health services for Walsall children and young people, Dudley and Walsall Mental Health Trust (DWMHT) offer specialist tier 3 and 3.5 services to young people with severe and enduring mental ill health including learning disabilities. The service also offers outreach services to other agencies including Behaviour Support Services and the Youth Offending Service. The service works in partnership with the local authority with vulnerable groups such LAC and with WPH for counselling and Kooth for online counselling.

They feel the need for a greater emphasis on early help to prevent rather than responding when there is crisis. They also identified the need for more health promotion work to raise the profile of good mental health and emotional resilience. Linked to early help services, DWMHT suggested that greater multi-agency working would support early help prevention work, specifically mentioning the need for specialist staff to train school nurses and school staff in mental health and wellbeing

DWMHT also identified the need for a CAMHS Clinician in A&E to assess young people to stop them being admitted to the ward if this is not needed and to signpost young people to the best possible support.

### **The Beacon Integrated Substance Misuse Service (CRI)**

This service offers assessment and face to face psychosocial support for young people using and misusing drugs and/or alcohol up to the age of 19. They offer personal care plans and support to build resilience including coping and refusal strategies.

This service requested more consideration of the impact of legal highs on the incidence of psychosis and suicidal feelings. They also requested more direct access counselling

## **Conclusions**

### ***Training***

From the feedback received it is evident that all health care professionals and Front Line service providers would like to have more training on how to assess and manage the emotional health and wellbeing of children and young people in Walsall.

### ***Awareness of support services for emotional wellbeing and mental health***

Our stakeholder consultation revealed that CAMHS was listed most frequently by individuals and across the different professional groups within universal services. However, awareness of alternate provision of alternate sources of support around mental health and emotional wellbeing appears to be limited. For instance GP's awareness of practitioners from education and other children's services is less well developed.

Feedback from different professional groups suggests that there is a mismatch between expectations and the level of support currently available from the specialist services.

### ***Referral pathways***

A clearer referral process (to CAMHS and other services) and a directory of services was requested by many consultees.

### ***Single point of access***

Some consultees requested a single point of access for referrals.

### ***Waiting times***

A shorter waiting time was listed a few times for different services as an area that needed improving. It was felt that some children and families were being left too long before receiving help.

### ***Early help***

The need for earlier support for self harm and improved support for younger children was also a clear theme in the feedback from stakeholders.

### ***Feedback***

It was noted that feedback between the different providers could be poor at times. A review into feedback offered and how it could be shared to best support the child or young person as well as the other teams involved in their care may be beneficial.

*\*Detailed spreadsheets on individual responses are available on request from the Public Health Intelligence Team*

## Glossary

ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Services
AP	Area Partnership
ASD	Autistic Spectrum Disorder
BME	Black and Minority Ethnic
BN	Bulimia Nervosa
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CIN	Children In Need
CPP	Child Protection Plan
CQUIN	Commissioning for Quality and Innovation
CSSA	Community Safety Strategic Assessment
CYP	Children and Young People
DART	Domestic Assault Response Team
DCLG	Department of Communities and Local Government
DfE	Department of Education
DoH	Department of Health
DWMHPT	Dudley and Walsall Mental Health Partnership Trust
DWP	Department of Work and Pensions
EHC	Education Health And Care Plan
EU	European Union
FSM	Free School Meals
GCSE	General Certificate of Secondary Education
GP	General Practitioner
HES	Hospital Episode Statistics
HMRC	Her Majesty's Revenue and Customs
HSCIC	Health and Social Care Information Centre
ICD10	International Classification of Disease and Related Health Problems
IMD	Index of Multiple Deprivation
JCPMH	Joint Commissioning Panel for Mental Health
KS2	Key Stage 2
KS4	Key Stage 4
LA	Local Authority
LAC	Looked
LAPE	Local Alcohol Profiles for England
LBG	Lesbian, Gay, Bisexual
LD	Learning Disability
LGBT	Lesbian, Gay, Bisexual or Transgender
LSOA	Lower Super Output Area
MOJ	Ministry of Justice

NCHOD	National Centre for Health Outcome Development
NCMP	National Child Measurement Programme
NEET	Not In Education Employment or Training
NHS	National Health Service
NICE	National Institute For Clinical Excellence
ONS	Office of National Statistics
PD	Physical Disability
PH	Public Health
PHMF	Public Health Mortality File
PMI	Perinatal Mental Illness
SDQ	Strengths and Difficulties Questionnaire
SEN	Special Educational Needs
SLT	Speech Language Therapy
SUS	Secondary Use Service
TA	Teacher Assessment
TCRU	Thomas Coram Research Unit
UCL	University of Central London
WCCS	Walsall Council Children Services
WTE	Whole Time Equivalent
WHNT	Walsall Healthcare NHS Trust
WM	West Midlands
YOW	Youth of Walsall

# Typical behaviour patterns of children with some mental health disorders

## Emotional Disorders

### Separation anxiety

Typical symptoms are concerns about: separation from an attachment figure, for example, because of loss of or harm to that person or the child being taken away; not wanting to go to school; being afraid of sleeping or being at home alone. The child may feel sick, anxious or have nightmares about the possibility of separation.

### Specific phobia

This disorder is characterised by excessive fears about particular objects or situations, for example: animals, storms, the dark, loud noises, blood, infections or injuries, dentists or doctors, vomiting, choking or diseases, types of transport, enclosed spaces, toilets, people who look unusual, monsters, etc. The child becomes very upset each time the stimulus is triggered and tries to avoid such situations.

### Social phobia

Typical symptoms are anxiety about: meeting new or large groups of people, eating, reading or writing in front of others, speaking in class. The child may be able to socialise with familiar people in small numbers but is frightened of interacting with other adults or children. The anxiety is typically due to fear of embarrassment. The child becomes distressed (for example, blushes or feels sick) and tries to avoid such social situations.

### Generalised anxiety

The child worries about a wide range of past, present or future events and situations, for example: past behaviour, school work and exams, disasters and accidents, his/her own health, weight or appearance, bad things happening to others, the future, making and keeping friends, death and dying, being bullied and teased. The anxiety is accompanied by physical symptoms such as restlessness, fatigue, poor concentration, irritability, muscular tension or insomnia.

### Depression

Depression is characterised by feelings of sadness, irritability and loss of interest which last for most of the day and persist over a period of time. Associated features may be: tiredness, changed appetite, weight loss or gain, insomnia, hypersomnia, agitation, feelings of worthlessness or guilt, poor concentration, thoughts of death, recent talk or experience of deliberate self harm.

## Conduct Disorders

### Oppositional defiant disorder

This is characterised by: temper outbursts, arguing with adults, disobedience, deliberately annoying others, passing on blame, being easily annoyed, angry, resentful, spiteful and vindictive. The behaviour is likely to have caused complaints from parents and teachers.

### Unsocialised and socialised conduct disorders

Typical behaviour includes: telling lies, fighting, bullying, staying out late, running away from home, playing truant, being cruel to people or animals, criminal behaviour such as robbery, rape, using weapons. This type of behaviour would often have resulted in complaints from school staff or contact with the police.

In socialised conduct disorder, the young person has friends (though usually antisocial friends). They may engage in antisocial behaviours such as shoplifting or stealing cars together. In unsocialised conduct disorder, the young person lacks any real friends and typically engages in solitary antisocial activities. These are the opposite ends of a spectrum, so dividing conduct disorder into these two categories is somewhat arbitrary.

### Hyperkinetic disorder

The child is hyperactive (for example, fidgeting, running around, climbing on furniture, always making a lot of noise), impulsive (for example, blurts out answers, cannot wait his/her turn, butts into conversations or games, cannot stop talking) and inattentive (for example, cannot concentrate on a task, makes careless mistakes, loses interest, does not listen, is disorganised, forgetful and easily distracted). The child's teachers are likely to have complained about his/her overactivity, impulsiveness and poor attention.

### Autistic spectrum disorder

Typical symptoms include: impaired social interaction (e.g. abnormal eye contact, inability to pick up non-verbal cues, difficulty making friends), lack of social or emotional reciprocity (e.g. difficulty sharing or co-operating with others), delayed or absent speech, repetitive language, impoverished play, inflexible routines and rituals, repetitive mannerisms and preoccupation with unusual parts of objects.

## Appendix 1: Summary Local Facts and Figures

### Local facts and figures about children and young people in Walsall

- Just under a third of Walsall population is under 25's (87,995) and this is projected to increase by 1.6% over the next 10 years.
- 21% of the Walsall population is from Black Minority Ethnic groups and is forecasted to grow.
- Walsall is ranked 29<sup>th</sup> most deprived local authority area in England from the Index of multiple deprivations (2010). Child poverty variation in Walsall, ranging 39.2% of children living in poverty in North Walsall area partnership to 12% in Aldridge & Beacon.
- 54% of children overall have a good level of development by age 5, compared with the national average of 60% at the early years foundation stage.
- Children with mental health disorders have higher proportion of school absences compared with children with no disorders. School absences in Walsall (5.8%) are slightly lower than national average of 5.9%.
- In Walsall, 38.7% of fixed period exclusions were for persistent disruptive behaviour. This is higher than the national average (38.7%).
- Young people (aged 11 -16), with mental health disorders were more likely to smoke, drink and use drugs than other children. The alcohol admission specific rates (under 18's) in Walsall have increased slightly over recent years and are above Black Country, regional and national averages.
- In March 2015, there were 612 Looked After Children in Walsall
- 14.9% (or 7,442) of Walsall children were considered to have special educational needs (SEN) and 5.8% (or 2,845) of Walsall children are on the disability register.
- The rates of Walsall young offenders (aged 16-18) in the criminal justice system are higher than the West Midlands and England.
- Children from refugee families are more likely to be bullied and increased risk of emotional health and wellbeing issues. In 2013-14 there were 64 asylum seeker families in Walsall with some dependent children.
- Teenage pregnancy rates in Walsall (36.8 per 1,000 births) are above national averages (24.3 per 1,000 births).
- Women are more likely experience depression (12% of women) and anxiety (13% of women) during pregnancy and the year after labour (15 to 20% of women). There are about 3800 births in Walsall each year.
- In Walsall, 103 families were known to local authority classified as homeless. Homeless persons are more likely to suffer with mental health issues and are often unable to access health services.
- An estimated 6.4% of 16-18 year olds on average were not in education, employment or training (NEET = 630) in May 2012. The proportion of NEET's has nearly halved over the last 6 years.
- Children who live with domestic violence are at an increased risk of behavioural problems and emotional trauma and mental health difficulties. In 2014/15, 767 young people (aged 14-24 years) were referred to the DART (Domestic Abuse Response Team) as victims of abuse.
- In Walsall 2.8% (or 2,428) of children and young people provide some level of unpaid care to family members.

### **The emotional wellbeing and mental health of children and young people in Walsall**

- The youth of Walsall survey reported that 1 in 10 young people had experience some form of bullying and girls were more likely to experience emotional bullying whereas boys were more likely to have a physical experience.
- An estimated 9.6% or around 4,380 children aged between 5-16 overall are estimated to have an emotional health and wellbeing problem, of which 3.3% are likely to have an anxiety disorder; 0.9% depression, 5.8% conduct disorder and 1.5% a severe hyperkinetic condition.
- In Walsall, the estimated pre-school aged children likely to have mental health disorder is 2,970 which cover disorders such as Attention deficit hyperactivity disorders, oppositional defiant and conduct disorders, anxiety disorders and depressive disorders.
- Boys are more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%).
- Hospital admissions as a result of self harm in Walsall have increased in recent years, especially in young women.
- Between 2006 and 2011, there were 10 suicides in Walsall residents (aged 14-24 years).
- In 2014-15, 1946 referrals were made to child and adolescent mental health services (CAMHS) with 80% accepted into the service.
- In 2014-15, there were 61 referrals to the Eating Disorder service which is above expected estimates.

## Appendix 2: Prevalence of any mental disorder by ethnicity

<i>All children</i>						
	Ethnic group					All
	White	Black	Indian	Pakistani & Bangladeshi	Other groups	
<b>All</b>	<i>Percentage of children with each disorder</i>					
<b>5-10 year olds</b>						
Emotional disorders	3.2	2.9	2.7	2.0	6.0	3.3
Conduct disorders	4.7	5.0	2.8	3.5	3.6	4.6
Hyperkinetic disorders	1.6	-	-	-	0.7	1.5
Less common disorders	0.5	0.8	-	-	1.3	0.5
Any disorder	8.2	8.6	4.6	4.4	10.5	8.1
<i>Base</i>	<i>5305</i>	<i>143</i>	<i>121</i>	<i>99</i>	<i>158</i>	<i>5826</i>
<b>11-15 year olds</b>						
Emotional disorders	5.7	3.6	3.2	9.0	5.2	5.6
Conduct disorders	6.3	12.6	1.3	2.4	4.5	6.2
Hyperkinetic disorders	1.5	0.8	-	-	-	1.4
Less common disorders	0.7	-	-	-	-	0.6
Any disorder	11.3	15.7	3.4	10.7	9.7	11.2
<i>Base</i>	<i>4168</i>	<i>129</i>	<i>103</i>	<i>96</i>	<i>107</i>	<i>4604</i>
<b>All children</b>						
Emotional disorders	4.3	3.3	2.9	5.5	5.6	4.3
Conduct disorders	5.4	8.6	2.1	3.0	3.9	5.3
Hyperkinetic disorders	1.6	0.4	-	-	0.4	1.4
Less common disorders	0.6	0.4	-	-	0.8	0.5
Any disorder	9.6	12.0	4.0	7.5	10.2	9.5
<i>Base</i>	<i>9474</i>	<i>271</i>	<i>224</i>	<i>196</i>	<i>265</i>	<i>10430</i>

## Appendix 3: Autistic Spectrum Pathway



## Appendix 4: Commissioning responsibility matrix

		Service Type	Responsible Commissioning Agency			
			School	Local Authority	CCG	NHS England
Tier 1	Universal services	GPs and practice staff				
		School nurses and Health Visitors				
		Social workers				
		Youth workers				
		Teacher				
Tier 2	Targeted	Outreach into schools by CAMHS				
		School counsellors				
		Educational Psychologists				
		Community based counselling				
		Parenting Programmes				
Tier 3	Specialists	Looked after children/adoption				
		Specialist CAMHS (T3) community				
Tier 3+	Specialists	Specialist Outreach services to prevent admission/speed discharge				
Tier 4	Inpatient	Inpatient or regional specialist community e.g. deaf CAMHS				

*Darker shade reflects most likely responsible commissioned; Lighter indicates variation based on local agreements*

## Appendix 5: Parenting Support Services in Walsall

<p><b>Tier:</b> Tier 3 and 4 Universal Partnership +</p> <p><b>Description:</b>            High risk/low protective factors            Aimed at children on CPP, families experiencing domestic abuse, mental illness, substance misuse and learning disability            Families of children with MH issues, physical disability or learning disability</p>	
<b>Services available</b>	<b>Comments</b>
Walsall Housing Group support for client parents	
HV and FNP 1:1 support for parents experiencing difficulties	
SN support for parents	
Fostering and adoption teams working to take forward Solihull approach	There do not appear to be any clear referral pathways to other parenting services for those adopting and/or fostering (should additional support be needed) Budget restrictions for fostering team is affecting delivery
Targeted “Understanding Your Child” groups running with parents of LAC	It is unclear whether current parenting programmes would be of benefit to LAC/carers
Mellow 14 weeks - in house using specialist parenting practitioners  Cygnet course for ASD 6 week course offered to parents of children aged 7-16	CPP programmes are lacking for children 6 years and older (Mellow only covers 0-5 years of age). CYGNET (autism parenting) can support a maximum 120 families with 500+ families and for children with autistic tendencies identified in Walsall. Not always able to offer evenings and week ends  In consideration; Mellow for families experiencing domestic abuse

<p>Development of course for parents of children 0-5 with autism underway with Health Visiting. Health visitors working to train in “understanding your Child” ASD package</p> <p>Mellow dads run</p> <p>Mellow dads delivered by intensive family support team in prisons</p>	
<p><b>Tier 2</b></p> <p><b>Description;</b> Available on request as needed. Offered in the home, in Childrens Centres and Health Centres</p>	
<p><b>Services available</b></p>	<p><b>Comments</b></p>
<p>Childrens Centre Ante- Natal Courses Family Support from Childrens Centres Early Help parenting Targeted Parenting support via HVs and FNP</p> <p>Strengthening Families/Strengthening Communities (14 weeks)</p> <p>Teen Triple P Teen Triple P primary care Triple P</p>	<p>With the closure of Childrens Centres and reduction in staff there is the risk that courses and 1;1 support will be reduced esp at weekends and evenings</p>
<p><b>Tier 1 Universal</b></p> <p><b>Offered:</b> In Childrens Centres In the home via Health Visitors. In schools eg FAST</p>	
<p><b>Services available</b></p>	<p><b>Comments</b></p>

<p>Health Visitor and FNP pre and post birth visits and support HomeStart Walsall Pregnancy Help</p> <p>NCT ante natal parenting courses (birth and beyond) Understanding your child using Solihull method (10 weeks) HV 28 week visit and post birth visits Triple P, Teen Triple P, Solihull, Mellow Bumps School nurses parenting courses. School nurses developing parenting workshops to introduce parents to Solihull approach</p> <p>Some schools developing Solihull approach</p> <p>10 Health Visitors delivering Understanding Your Child groups to parents</p>	<p>Families and Schools together, • Universal programmes for parents of primary school-aged children could be strengthened. Families and schools together could meet provide a universal approach here (and rated by the Department for Education as 4 stars) but has not been rolled out to schools yet. Two pilot studies in Walsall have shown good outcomes • Targeted interventions for 0-5 year olds may need strengthening. FNP deals with some of this group but eligibility requirements are very specific (and only deals with antenatal – 2years old) so there will be many families who are not eligible.</p> <p>Measurable 1-1 interventions for 0-11 year olds. Provision in place for teen triple P primary care, but not for younger age groups. Health visitors use Solihull approach 1-1 but outcomes data not captured and recorded. Teen programmes need strengthening More courses needed for 16-19 years. Outcomes for Solihull need capturing</p>
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## Appendix 6: Services offered in Schools to support Young Person Emotional Health and wellbeing

**Educational Psychology (traded service)** (2-19 years) up to the age of twenty five years.

Applied psychologists working in a range of schools and settings, providing support to children and young people their families and the adults who work with them. Working collaboratively with pupils, school staff and other key adults in a process of problem solving offering

- Additional individual sessions
- School based training and projects
- Development initiatives
- Support to vulnerable children and young people
- Work with children with complex needs in the early years
- Support to parents and carers to achieve positive outcomes for children and young people
- Long term collaborative interventions at a whole school level
- Bespoke training and project work for school and settings
- Critical incident support
- Central training opportunities

On average primary schools offer 2 hours support over 38 weeks On average secondary schools buy in between 8-20 hours support. Special schools buy in 1-2 hours per week. As a traded service this relies on investment schools chose to allocate to this issue

**Behavioural Support in Primary Schools (traded service)** CAMHS practitioners fast tracking into CAMHS and support for staff Not offered in every primary school. Delivered in 72 primary schools 4 days per week service for whole of Walsall

**School Attendance officer (traded service)**

Sourcing & brokering alternative provision to suit the needs of an older child who is at risk of permanent exclusion;

Supporting children schools and families engaged with managed moves to create a basis for moving a child successfully between schools;

Training available to help school staff, clerks and around exclusions legislation.

Resourced and direct project work aimed at reducing the risk of permanent exclusion.

Transition support for children at risk of permanent exclusion

Acting as Lead Professional for children and young people at risk of exclusion

**Education Welfare Staff (traded service)**

investigation for irregular school attendance; home visits; direct work with schools, children and families; In 24 primary schools for on average 2 hours per week. Long waiting list but parents can self refer

**School level support** in certain schools with full time family support advisors, learning mentors and teachers who have this as part of their role Out of the 34 schools approached, 25% did not have early Help resource identified

**Sport and Recreation Behaviour and Inclusion service (traded service)**

Delivery of alternative curriculum provision to a range of pupils with challenging behaviour or disability. Key stages 2-4 As a traded service this relies on investment schools chose to allocate to this issue

## References

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- <sup>1</sup> MELTZER, H., GATWARD, R., GOODMAN, R. and FORD, T., 2000. *Mental health of children and adolescents in Great Britain*. TSO London:.
- <sup>2</sup> GREEN, H., MCGINNITY, Á., MELTZER, H., FORD, T. and GOODMAN, R., 2005. *Mental health of children and young people in Great Britain, 2004*. Palgrave Macmillan Basingstoke.
- <sup>3</sup> Department of Education. (2015). *Permanent and Fixed Period Exclusions in England*. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/449433/SFR27\\_2015\\_Text.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449433/SFR27_2015_Text.pdf) . Last accessed 16th Oct 2015.
- <sup>4</sup> GREEN, H., MCGINNITY, Á., MELTZER, H., FORD, T. and GOODMAN, R., 2005. *Mental health of children and young people in Great Britain, 2004*. Palgrave Macmillan Basingstoke.
- <sup>5</sup> Research By Design (2014) *Youth of Walsall Survey, 2014*: Walsall Council.
- <sup>6</sup> Statistics on Drug Misuse, England 2014: <http://www.hscic.gov.uk/catalogue/PUB15943/drug-misu-eng-2014-rep.pdf>
- <sup>7</sup> The fundamental facts: [http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental\\_facts\\_2007.pdf?view=Standard](http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard)
- <sup>8</sup> Walsall safeguarding children board. (2014). *Walsall anti-bullying policy*. Available: [http://wlscb.org.uk/wp-content/uploads/2014/07/anti\\_bullying\\_policy-2.pdf](http://wlscb.org.uk/wp-content/uploads/2014/07/anti_bullying_policy-2.pdf) . Last accessed 31st Jul 2015.
- <sup>9</sup> Anti-Bullying Alliance. (2013). *Bullying and mental health: guidance for teachers and other professionals*. Available: <http://www.anti-bullyingalliance.org.uk/send-resources/mental-health/> . Last accessed 28th Jul 2015.
- <sup>10</sup> Research By Design (2014) *Youth of Walsall Survey, 2014*: Walsall Council.
- <sup>11</sup> 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.
- <sup>12</sup> GREEN, H., MCGINNITY, Á., MELTZER, H., FORD, T. and GOODMAN, R., 2005. *Mental health of children and young people in Great Britain, 2004*. Palgrave Macmillan Basingstoke.
- <sup>13</sup> LEWIS, I. and LENEHAN, C., 2012. Report of the children and young people’s health outcomes forum, *London: Children and Young People’s Health Outcomes Forum 2012*.
- <sup>14</sup> Egger, H. L. and Angold, A. (2006), Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47: 313–337.
- <sup>15</sup> GREEN, H., MCGINNITY, Á., MELTZER, H., FORD, T. and GOODMAN, R., 2005. *Mental health of children and young people in Great Britain, 2004*. Palgrave Macmillan Basingstoke.

- 
- <sup>16</sup> GREEN, H., MCGINNITY, Á., MELTZER, H., FORD, T. and GOODMAN, R., 2005. Mental health of children and young people in Great Britain, 2004. Palgrave Macmillan Basingstoke
- <sup>17</sup> O'BRIEN, M., SINGLETON, N., BUMPSTEAD, R. and OFFICE FOR NATIONAL STATISTICS, LONDON (UNITED KINGDOM). SOCIAL SURVEY DIV., 2001. Psychiatric morbidity among adults living in private households, 2000. London (United Kingdom): The Stationery Office.
- <sup>18</sup> NHS. (2013). *Autism spectrum disorder*. Available: <http://www.nhs.uk/conditions/autistic-spectrum-disorder/Pages/Introduction.aspx> . Last accessed 16th Oct 2015.
- <sup>19</sup> Baird, G, Simonoff, E, Pickles, A, Chandler, S, Loucas, T, Meldrum, D & Charman, T 2006, 'Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP)' *The Lancet*, vol 368, no. 9531, pp. 210-215.
- <sup>20</sup> BARON-COHEN, S., SCOTT, F.J., ALLISON, C., WILLIAMS, J., BOLTON, P., MATTHEWS, F.E. and BRAYNE, C., 2009. Prevalence of autism-spectrum conditions: UK school-based population study. *The British journal of psychiatry : the journal of mental science*, 194(6), pp. 500-509.
- <sup>21</sup> BARON-COHEN, S., SCOTT, F.J., ALLISON, C., WILLIAMS, J., BOLTON, P., MATTHEWS, F.E. and BRAYNE, C., 2009. Prevalence of autism-spectrum conditions: UK school-based population study. *The British journal of psychiatry : the journal of mental science*, 194(6), pp. 500-509.
- <sup>22</sup> BAIRD, G., SIMONOFF, E., PICKLES, A., CHANDLER, S., LOUCAS, T., MELDRUM, D. and CHARMAN, T., 2006. Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). *The lancet*, 368(9531), pp. 210-215.
- <sup>23</sup> BAIRD, G., CASS, H. and SLONIMS, V., 2003. Diagnosis of autism. *BMJ (Clinical research ed.)*, 327(7413), pp. 488-493.
- <sup>24</sup> WERLING, D.M. and GESCHWIND, D.H., 2013. Sex differences in autism spectrum disorders. *Current opinion in neurology*, 26(2), pp. 146-153.
- <sup>25</sup> BRUGHA, T., MCMANUS, S., MELTZER, H., SMITH, J., SCOTT, F., PURDON, S., HARRIS, J. and BANKART, J., 2009. Autism spectrum disorders in adults living in households throughout England: Report from the adult psychiatric morbidity survey 2007. *Leeds: The NHS Information Centre for Health and Social Care*, .
- <sup>26</sup> STRAND, S. and LINDSAY, G., 2012. Ethnic disproportionality in the identification of speech language and communication needs (SLCN) and autism spectrum disorders (ASD): 2005-2011.
- <sup>27</sup> DURKIN, M.S., MAENNER, M.J., MEANEY, F.J., LEVY, S.E., DIGUISEPPI, C., NICHOLAS, J.S., KIRBY, R.S., PINTO-MARTIN, J.A. and SCHIEVE, L.A., 2010. Socioeconomic inequality in the prevalence of autism spectrum disorder: evidence from a U.S. cross-sectional study. *PloS one*, 5(7), pp. e11551.
- <sup>28</sup> KEEN, D.V., REID, F.D. and ARNONE, D., 2010. Autism, ethnicity and maternal immigration. *The British journal of psychiatry : the journal of mental science*, 196(4), pp. 274-281.
-

- 
- <sup>29</sup> GOODMAN, R. and RICHARDS, H., 1995. Child and adolescent psychiatric presentations of second-generation Afro-Caribbeans in Britain. *The British journal of psychiatry : the journal of mental science*, **167**(3), pp. 362-369.
- <sup>30</sup> HAPER, J. and WILLIAMS, S., 1976. Infantile autism: the incidence of national groups in a New South Wales survey. *The Medical journal of Australia*, **1**(10), pp. 299-301.
- <sup>31</sup> STRAND, S. and LINDSAY, G., 2012. Ethnic disproportionality in the identification of speech language and communication needs (SLCN) and autism spectrum disorders (ASD): 2005-2011.
- <sup>32</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2013. Psychosis and schizophrenia in children and young people: Recognition and management. *Public Health Guidance*, **155**.
- <sup>33</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE and NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2004. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. *Clinical guideline*, **9**.
- <sup>34</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE and NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2004. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. *Clinical guideline*, **9**.
- <sup>35</sup> MICALI, N., HAGBERG, K.W., PETERSEN, I. and TREASURE, J.L., 2013. The incidence of eating disorders in the UK in 2000-2009: findings from the General Practice Research Database. *BMJ open*, **3**(5), pp. 10.1136/bmjopen-2013-002646.
- <sup>36</sup> NICHOLLS, D.E., LYNN, R. and VINER, R.M., 2011. Childhood eating disorders: British national surveillance study. *The British journal of psychiatry : the journal of mental science*, **198**(4), pp. 295-301.
- <sup>37</sup> WINDFUHR, K., WHILE, D., HUNT, I., TURNBULL, P., LOWE, R., BURNS, J., SWINSON, N., SHAW, J., APPLEBY, L. and KAPUR, N., 2008. Suicide in juveniles and adolescents in the United Kingdom. *Journal of child psychology and psychiatry*, **49**(11), pp. 1155-1165.
- <sup>38</sup> HAWTON, K. and JAMES, A., 2005. Suicide and deliberate self harm in young people. *BMJ (Clinical research ed.)*, **330**(7496), pp. 891-894.
- <sup>39</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2008. Promoting children's social and emotional wellbeing in primary education. *Public Health Guidance*, **12**.
- <sup>40</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2009. Promoting children's social and emotional wellbeing in secondary education. *Public Health Guidance*, **20**.
- <sup>41</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2015. Depression in children and young people: Identification and management in primary, community and secondary care. *Public Health Guidance*, **28**.
-

- 
- <sup>42</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2013. Psychosis and schizophrenia in children and young people: Recognition and management. *Public Health Guidance*, **155**.
- <sup>43</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2004. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. *Public Health Guidance*, **9**.
- <sup>44</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE 2011 Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum *Clinical Guidance 128*
- <sup>45</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2013. Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management. *Public Health Guidance*, **158**.
- <sup>46</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2004. Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. *Public Health Guidance*, **16**.
- <sup>47</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2011. Self-harm: longer term management. *Public Health Guidance*, **133**.
- <sup>48</sup> Walsall JSNA 2013
- <sup>49</sup> <http://www.nspcc.org.uk/globalassets/documents/research-reports/achieving-emotional-wellbeing-for-looked-after-children.pdf>
- <sup>50</sup> Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., and Janson, S. (2009) Burden and consequences of child maltreatment in high-income countries. *The Lancet*, 373(9,657), pp.68–81.
- <sup>51</sup> Walsall JSNA 2013
- <sup>52</sup> BRITISH MEDICAL ASSOCIATION, 2006. *Child and Adolescent Mental Health: A guide for healthcare professionals*. British Medical Association.
- <sup>53</sup> No Health Without Mental Health: Delivering better mental health outcomes for people of all ages. Department of Health.  
<http://tinyurl.com/6hd4sdj>
- <sup>54</sup> BRITISH MEDICAL ASSOCIATION, 2006. *Child and Adolescent Mental Health: A guide for healthcare professionals*. British Medical Association.
- <sup>55</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2010. *Looked after children and young people*. *Public Health Guidance*, **28**. Modified in May 2015.
- <sup>56</sup> DEPARTMENT OF HEALTH, 2009. *Promoting the health and wellbeing of looked-after children*. Department for children, schools and families.
- <sup>57</sup> DEPARTMENT OF HEALTH, 2015. *Promoting the health and wellbeing of looked-after children*. Department for children, schools and families.
- <sup>58</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413368/Promoting\\_the\\_health\\_and\\_well-being\\_of\\_looked-after\\_children.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf)
- <sup>59</sup> Department of Education. (2011). *Special Educational Needs*. Available:  
<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/dfes%200581%20200mig2228.pdf> . Last accessed 16th Oct 2015.
-

- 
- <sup>60</sup> WALSALL COUNCIL, 2014. *Pupils with statements of SEN or at School Action Plus by their primary type of needs as at 31<sup>st</sup> January 2014*. The children's commissioning team.
- <sup>61</sup> Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave.
- <sup>62</sup> CAMHS Review. 2008. *Children and Young People in Mind: The final report of the National CAMHS Review*. London: DfES.
- <sup>63</sup> BRITISH MEDICAL ASSOCIATION, 2006. *Child and Adolescent Mental Health: A guide for healthcare professionals*. British Medical Association.
- <sup>64</sup> National CAMHS Support Service. (2011). *Better Mental Health Outcomes for Children and Young People: a resource directory for commissioners*. Available: <http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCgQFjAB&url=http%3A%2F%2Fwww.chimat.org.uk%2Fresour%2Fview.aspx%3FRID%3D104048&ei=lb92VdmmLafW7AaCkoH4Dw&usg=AFQjCNGsRhgavm3Sq1> . Last accessed 9th Jun 2015.
- <sup>65</sup> EMERSON, E. and HATTON, C., 2007. The Mental Health of Children and Adolescents with Learning Disabilities in Britain. *Adv Mental Hlth Learn Disabil*, 1(3), pp. 62-63.
- <sup>66</sup> Directgov. (2009). *Young Offenders*. Available: [http://webarchive.nationalarchives.gov.uk/+www.direct.gov.uk/en/CrimeJusticeAndTheLaw/Thejudicialsystem/DG\\_4003100](http://webarchive.nationalarchives.gov.uk/+www.direct.gov.uk/en/CrimeJusticeAndTheLaw/Thejudicialsystem/DG_4003100) . Last accessed 16th.
- <sup>67</sup> Youth Justice Board. (2014). *Young Offenders: assessment using 'Asset'*. Available: <https://www.gov.uk/government/publications/asset-documents> . Last accessed 16th Oct 2015.
- <sup>68</sup> WALSALL COUNCIL, 2014. *Pupils with statements of SEN or at School Action Plus by their primary type of needs as at 31<sup>st</sup> January 2014*. The children's commissioning team.
- <sup>69</sup> BRITISH MEDICAL ASSOCIATION, 2006. *Child and Adolescent Mental Health: A guide for healthcare professionals*. British Medical Association.
- <sup>70</sup> Leon, L. (2002). *The Mental Health Needs of Young Offenders*. Available: [http://mentalhealth.org.uk/content/assets/PDF/publications/mental\\_health\\_needs\\_young\\_offenders.pdf?view=Standard](http://mentalhealth.org.uk/content/assets/PDF/publications/mental_health_needs_young_offenders.pdf?view=Standard) . Last accessed 9th Jun 2015.
- <sup>71</sup> KHAN, L., 2010. Reaching out, reaching in: Promoting mental health and emotional well-being in secure settings. *London: Centre for Mental Health*, , pp. 16-18.
- <sup>72</sup> UNIT, S.E., 2002. Reducing re-offending by ex-prisoners. *London: Social Exclusion Unit*, 9.
- <sup>73</sup> CARE QUALITY COMMISSION, 2010. Count Me In 2009. Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales. *Care Quality Commission, London*, .
- <sup>74</sup> PRISON REFORM TRUST, 2009. Bromley Briefings Prison Factfile June 2009.

- 
- <sup>75</sup> GALAHAD, S., Ltd.(2009) Evaluation of the substance misuse project in the young person's secure estate
- <sup>76</sup> PARKE, S. and BOARD, Y.J., 2009. *Children and Young People in Custody 2006-2008: An Analysis of the Experiences of 15-18 Year Olds in Prison*. HM Inspectorate of Prisons: Youth Justice Board.
- <sup>77</sup> DOUGLAS, N. and PLUGGE, E., 2006. A health needs assessment for young women in young offender institutions. *Youth Justice Board for England and Wales*, .
- <sup>78</sup> SAINSBURY CENTRE FOR, M.H., 2009. *The chance of a lifetime: preventing early conduct problems and reducing crime*. Centre for Mental Health, 2009.
- <sup>79</sup> Parker, C. (2011). *Transitions in mental health care*. Available: [http://www.youngminds.org.uk/assets/0000/1331/YM\\_Prof\\_Transitions\\_Guide\\_email\\_version.pdf](http://www.youngminds.org.uk/assets/0000/1331/YM_Prof_Transitions_Guide_email_version.pdf) . Last accessed 18th Aug 2015.
- <sup>80</sup> HOUSE OF COMMONS HEALTH COMMITTEE, 2015. *Children's and adolescents' mental health and CAMHS*. Third report of session 2014-15.
- <sup>81</sup> PUGH, K., MEIER, R. and MINDS, Y., 2006. *Stressed Out and Struggling Project: Report 1: Service-mapping*. YoungMinds.
- <sup>82</sup> Department of Health. (2015). Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414024/Childrens\\_Mental\\_Health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf) . Last accessed 9th Jun 2015.
- <sup>83</sup> FISH, J., 2007. *Reducing Health Inequalities for Lesbian, Gay, Bisexual and Trans People: Briefings for Health and Social Care Staff*. Department of Health.
- <sup>84</sup> Public Health England. (2015). Preventing suicide among lesbian, gay and bisexual young people. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/412427/LGB\\_Suicide\\_Prevention\\_Toolkit\\_FINAL.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412427/LGB_Suicide_Prevention_Toolkit_FINAL.pdf). Last accessed 10th Jun 2015.
- <sup>85</sup> Gay and Lesbian Youth in Calderdale (GALYIC) (March 2007). *An introduction to Lesbian, Gay and Bisexual Young People and Mental Health (PDF)*. Accessed from <http://www.chimat.org.uk/resource/item.aspx?RID=87133> on 05/05/15
- <sup>86</sup> Public Health England. (2007). An introduction to Lesbian, Gay and Bisexual Young People and Mental Health. Available: <http://www.chimat.org.uk/resource/view.aspx?RID=87133> . Last accessed 10th Jun 2015.
- <sup>87</sup> ASSEMBLY, U.G., 2015. Convention relating to the status of refugees, 28 July 1951, United Nations, Treaty Series, vol. 189. Retrieved April, 20, pp. 137.
- <sup>88</sup> EHNTHOLT, K.A. and YULE, W., 2006. Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry*, **47**(12), pp. 1197-1210.
- <sup>89</sup> MIND. (2009). Improving mental health support for refugee communities - an advocacy approach. Available: [www.mind.org.uk/media/192447/Refugee\\_Report\\_1.pdf](http://www.mind.org.uk/media/192447/Refugee_Report_1.pdf) . Last accessed 10th Jun 2015.
-

- 
- <sup>90</sup> National Association of Teachers of Travellers. (2010). *Gypsy, Roma and Traveller Communities*. Available: <http://www.natt.org.uk/gypsy-roma-and-traveller-communities> . Last accessed 16th Oct 2015.
- <sup>91</sup> Office of National Statistics. (2014). *What does the 2011 Census tell us about the characteristics of Gypsy or Irish Travellers in England and Wales?*. Available: [http://www.ons.gov.uk/ons/dcp171776\\_349352.pdf](http://www.ons.gov.uk/ons/dcp171776_349352.pdf). Last accessed 16th Oct 2015.
- <sup>92</sup> PARRY, G., VAN CLEEMPUT, P., PETERS, J., WALTERS, S., THOMAS, K. and COOPER, C., 2007. Health status of Gypsies and Travellers in England. *Journal of epidemiology and community health*, **61**(3), pp. 198-204.
- <sup>93</sup> WILKIN, A., DERRINGTON, C. and FOSTER, B., 2009. Improving the outcomes for Gypsy, Roma and Traveller pupils. *Literature Review*, .
- <sup>94</sup> Jenkins, K. (2013). *Promoting young mothers' wellbeing*. Available: <http://www.mentalhealth.org.uk/content/assets/PDF/publications/young-mums-together-report.pdf> . Last accessed 20th Oct 2015.
- <sup>95</sup> REID, V. and MEADOWS-OLIVER, M., 2007. Postpartum depression in adolescent mothers: an integrative review of the literature. *Journal of Pediatric Health Care*, **21**(5), pp. 289-298.
- <sup>96</sup> MOFFITT, T.E., 2002. Teen-aged mothers in contemporary Britain. *Journal of Child Psychology and Psychiatry*, **43**(6), pp. 727-742.
- <sup>97</sup> LORETTA SECCO, M., PROFIT, S., KENNEDY, E., WALSH, A., LETOURNEAU, N. and STEWART, M., 2007. Factors affecting postpartum depressive symptoms of adolescent mothers. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, **36**(1), pp. 47-54.
- <sup>98</sup> NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE, 2014. Antenatal and postnatal mental health: clinical management and service guidance. *Public Health Guidance*, **192**.
- <sup>99</sup> Department of Health. (2011). Teenage Pregnancy National Support Team: Effective Public Health Practice. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216332/dh\\_127470.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216332/dh_127470.pdf) . Last accessed 10th Jun 2015 .
- <sup>100</sup> Department of Health. (2011). Teenage Pregnancy National Support Team: Effective Public Health Practice. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216332/dh\\_127470.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216332/dh_127470.pdf) . Last accessed 17th Jun 2015.
- <sup>101</sup> Department of Health. (2015). Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414024/Childrens\\_Mental\\_Health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf) . Last accessed 9th Jun 2015.
- <sup>102</sup> Crisis. (2005). *What is homelessness?*. Available: [http://www.crisis.org.uk/data/files/document\\_library/factsheets/homlessdefs\\_2005.pdf](http://www.crisis.org.uk/data/files/document_library/factsheets/homlessdefs_2005.pdf) . Last accessed 20th Oct 2015.
- <sup>103</sup> QUILGARS, D., FITZPATRICK, S. and PLEACE, N., 2011. Ending youth homelessness: Possibilities, challenges and practical solutions. *York, UK: Centre for Housing Policy, University of York & School of the Built Environment, Heriot-Watt University*, .
- <sup>104</sup> VASILIOU, C. and SOHO, C., 2006. *Making the link between mental health and youth homelessness: a pan-London study*. Mental Health Foundation.

- 
- <sup>105</sup> Homeless Link. (2014). *The unhealthy state of homelessness: Health audit results 2014*. Available: <http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf> . Last accessed 20th Oct 2015.
- <sup>106</sup> VOSTANIS, P., 2002. Mental health of homeless children and their families. *Advances in Psychiatric Treatment*, **8**(6), pp. 463-469.
- <sup>107</sup> CRAIG, T., HODSON, S., WOODWARD, S. and RICHARDSON, S., 1996. *Off to a bad start: A longitudinal study of homeless young people in London*. Mental Health Foundation London.
- <sup>108</sup> WRATE, R. and BLAIR, C., 1999. Homeless adolescents. *Homeless children: problems and needs*, , pp. 83-96.
- <sup>109</sup> Homeless link. (2014). *Young and homeless research*. Available: <http://www.homeless.org.uk/facts/our-research/young-and-homeless-research> . Last accessed 27th Jul 2015.
- <sup>110</sup> Homeless link. (2013). *No excuses preventing homelessness for the next generation*. Available: <http://www.homeless.org.uk/sites/default/files/site-attachments/No%20Excuses%20Report%202013.pdf> . Last accessed 27th
- <sup>111</sup> Prospects services, may 2012. Department for Education, 2012 local authority NEET figures
- <sup>112</sup> Public Health England. (2014). Local action on health inequalities: Reducing the number of young people not in employment, education or training (NEET). Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/356062/Review3\\_NEETs\\_health\\_inequalities.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356062/Review3_NEETs_health_inequalities.pdf) . Last accessed 10th Jun 2015.
- <sup>113</sup> Home Office. (2015). *Domestic Violence and Abuse Guidance*. Available: <https://www.gov.uk/guidance/domestic-violence-and-abuse> . Last accessed 20th Oct 2015.
- <sup>114</sup> Barron, J. (2009). *The Survivor's Handbook*. Available: <http://www.womensaid.org.uk/domestic-violence-survivors-handbook.asp?section=0001000100080001&ionTitle=The+Survivor%27s+Handbook> . Last accessed 21st Jun 2015
- <sup>115</sup> Home office. (2013). *Domestic violence and abuse*. Available: <https://www.gov.uk/domestic-violence-and-abuse> . Last accessed 27th Jul 2015.
- <sup>116</sup> Balaguru, V and Davis, V. (2014). *Mental Health and Growing Up Factsheet*. Available: <http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/domesticviolence.aspx> . Last accessed 28th Jul 2015.
- <sup>117</sup> Nice.org.uk, (2014). *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively | Introduction | Guidance and guidelines | NICE*. [online] Available at: <https://www.nice.org.uk/guidance/ph50/chapter/Introduction> [Accessed 6 Aug. 2015].
- <sup>118</sup> Anon, (2015). [online] Available at: [http://www.childrensociety.org.uk/sites/default/files/tcs/report\\_hidden-from-view\\_young-carers\\_final.pdf](http://www.childrensociety.org.uk/sites/default/files/tcs/report_hidden-from-view_young-carers_final.pdf) . Last accessed 21st Jul 2015
-

- 
- <sup>119</sup> Mentalhealth.org.uk, (2015). *Lack of support putting young carers at risk of mental health problems*. [online] Available at: <http://www.mentalhealth.org.uk/our-news/news-archive/2010/2010-12-03/?view=Standard> . Last accessed 6<sup>th</sup> Jun 2015
- <sup>120</sup> Professionals.carers.org, (2015). *Protecting the Health and Wellbeing of Young Carers | Professionals*. [online] Available at: <https://professionals.carers.org/protecting-health-and-wellbeing-young-carers> . Last accessed 6<sup>th</sup> Jun 2015
- <sup>121</sup> Anon, (2015). [online] Available at: [https://professionals.carers.org/sites/default/files/young\\_adult\\_carers\\_at\\_school-8\\_11\\_13-1\\_proof\\_4\\_final.pdf](https://professionals.carers.org/sites/default/files/young_adult_carers_at_school-8_11_13-1_proof_4_final.pdf) . . Last accessed 7<sup>th</sup> Jun 2015
- <sup>122</sup> KURTZ, Z., 1996. *Treating children well*. London: Mental Health Foundation.
- <sup>123</sup> Young Minds. (2014). *Report on Children, Young People and Family Engagement*. Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413411/Young\\_Minds.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413411/Young_Minds.pdf) . Last accessed 20th Oct 2015