Nottinghamshire Health & Wellbeing Board

# NOTTINGHAMSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

## Emotional and Mental Health of Children and Young People

### January 2021



| Topic information | |
|---|---|
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Nottinghamshire Health & Wellbeing Board

## Table of Contents





## Executive summary

Good mental health and wellbeing is crucial for the healthy development of children and young people (CYP), helping them to develop resilience, face the challenges of adolescence and adulthood, and fulfil their role in society. Mental wellbeing can be influenced by a range of individual, familial, social and environmental factors that can impact on CYP throughout their development. Whilst good emotional and social wellbeing is associated with good physical health, academic engagement and economical independence, poor mental health can have significant long lasting and far reaching impacts on CYP.

Half of all long-term adult mental health disorders are established by age 14 and three quarters by the age of 24.[1] The impacts of poor mental health can be seen on social relationships, educational attainment, physical health, crime, homelessness and employment prospects.[2]

Children are at a higher risk of developing mental illness if they experience adverse events in childhood, are looked after by the local authority, if they have a long-term illness or disability, if they are a young carer or if they have a parent with a substance misuse problem. On the other hand, children with stable home lives, who attend school regularly and who have positive relationships with their peers and adults have a reduced risk for mental illness.

Nationally, there has been a gradual rise in the number of CYP with a mental health disorder over the last decade so that in 2017 one in eight 5 to 19-year-olds had at least one mental health disorder compared to one in ten in 2014.

Currently, it is estimated that 17,600 children in Nottinghamshire have a diagnosable mental health disorder at any one time, with approximately 7,500 (local accepted referrals data) children and young people seeking formal help and support through a range of commissioned children and young people's emotional wellbeing and mental health services in the previous year (2018/2019). However, many more may in fact seek support through use of informal networks and charity/voluntary services.

Nottinghamshire has developed strong, evidence-based strategies to support CYP, particularly through improving access to mental health services, including the recent introduction of a policy to allow self-referrals. Additionally, through supporting development of robust pathways in perinatal mental health and tailored Child and Adolescent Mental Health Services (CAMHS) for targeted groups such as the Mental Health Support Teams in Schools and Colleges, the Avoidant Restrictive Food Intake Disorder (ARFID) pilot in the CAMHS Eating Disorder Service, and two pilots specific to the youth justice cohort which include the addition of speech and language therapy and clinical psychology.

There has also been significant investment in the workforce; not only in health, but across a wide range of public sector roles, in addition to this schools have made a concerted effort to build resilience. There is good evidence to show that school-based interventions can be a cost-effective investment.

However, despite good progress there are still significant unmet needs and gaps in both the understanding of CYP mental health and services provided in Nottinghamshire.

During the COVID-19 lockdown period between March and June 2020, there was a significant reduction in referrals to mental health services, partly due to school closures and restrictions on GP services, but also related to face to face work ceasing for all but the most vulnerable. Referrals have increased since then, but there is further work being undertaken to understand the impact of the reduction of referrals on CYP mental health and the impact of the reduction in face to face services.

Nationally policy (Long term Plan, 2019) recognises the need to improve the experience young people have with their mental health and that changes need to be made to improve transitions and support for young children and young adults. These ambitions are described in more detail in the targets and performance section.

**Unmet needs and gaps**

The 1001 days JSNA identified the need to better identify and support women with mild to moderate mental health needs and those with parent-infant interaction difficulties. National prevalence data suggests that 5.5% of 2- 4 year olds have mental health needs but there are currently no dedicated infant mental health services commissioned in the County.

The Self Harm JSNA (2019) identifies that there is a gap in support for people of all ages who self-harm or who are at risk of self-harm, but do not meet acceptance criteria for clinical/mental health services.

Reductions in funding to early intervention services across the system have resulted in a reduction of universal provision and of parenting support, particularly around the skills they need to help support the positive mental and emotional development of their children.

Additionally, whilst there has been progress made to improve transition from youth to adult services, the question of the quality of transition remains an issue for our young adult service users, and there is potential to tackle this through the development of a comprehensive pathway for those aged 0-25.

More emphasis is needed on targeting inequalities seen in mental health and wellbeing particularly for looked after children, young carers, children with a special educational needs and disabilities and Lesbian Gay Bisexual Transgender, queer (or questioning) and others (LGBTQ+) young people.

The precise prevalence of mental health and wellbeing in CYP in Nottinghamshire is, however, still unknown. Data on the prevalence has been extrapolated based on NHS Digital estimates. Since April 2018 all NHS commissioned providers have been developing their systems to be able to provide service level data to the Mental Health Services Data Set (MHSDS). Therefore, we are now in a better position to understand local need and further develop services to meet this need. Further work is also required to understand the impact of inequalities within Nottinghamshire.

There are also gaps around mental health support for children and young people in schools. Whilst there is additional investment in Mental Health Support Teams for Schools, the national ambition for rollout is coverage of 25% of schools by 2023/24. This means that a significant number of schools in Nottinghamshire will not have access to these teams.

**Table 1. Recommendations for consideration**

| | Recommendation | Lead(s) |
|---|---|---|
| **1.** | Review access to services by minority groups and ensure systemic barriers are mitigated or removed using the framework outlined in the Advancing Mental Health Equality Framework. This includes undertaking an equity audit, ensuring that services routinely collect data around protected characteristics and ensuring that the workforce have appropriate training and skills. This work should be overseen by a mental health equalities group. Consideration should also be given to developing specific pathways for these groups. | Clinical Commissioning Groups, Nottinghamshire Healthcare Trust (NHT), Third Sector providers |
| **2.** | Commissioning should be planned as integrated multi-agency services, ensuring that services meet the needs of the 0-25 age group. | Integrated Care System's (ICS), Public Health, Clinical Commissioning Groups (CCGs) |
| **3.** | Expand universal and selective parent education and training programmes to support preventative work around mental health and wellbeing. | Local Authority (LA), PH, CCGs |
| **4.** | Ensure that mental health and emotional wellbeing are considered in all policies relating to both staff, service users and pupils. | LA, ICS, Schools/ Colleges/Academies |
| **5.** | Embed a whole family approach to tackling children and young people's mental health needs, including qualitative work with parents. | PH, LA , CCGs |
| **6.** | Undertake research into the mental health needs of young carers across the county: their prevalence and their needs. | LA Childrens Services |
| **7.** | Invest resources to evaluate effectiveness of digital interventions locally and ensure that any beneficial changes identified from the rapid switch to digital /remote models of care are sustained beyond the COVID-19 emergency response period, in line with regional guidance from NHS England. | CCGs, PH |
| **8.** | Community assets need to be mobilised in order to generate multigenerational networks of interpersonal support, capitalising on initiatives such as lifestyle interventions, volunteering and social prescribing. | Third sector, PH, Primary Care Networks (PCNs) |
| **9.** | Consider regular collection of wellbeing data for children and young people locally. | LA |
| **10.** | Work with schools and wider partners to provide equitable access to prevention and early intervention mental health initiatives delivered at schools, focusing strategically on areas in proportion to the level of need and where the risk factors are most prevalent i.e. areas of high deprivation. | PH, LA, CCGs |
| **11.** | Undertake further work to understand the impact of COVID 19 on children and young people's mental health and identify appropriate steps to address these. | PH, LA, CCGs |
| **12.** | Continue to work with providers to improve the quality of data submitted to the Mental Health Services dataset. | PH |

Nottinghamshire Health & Wellbeing Board

**Full JSNA report**

## What do we know?

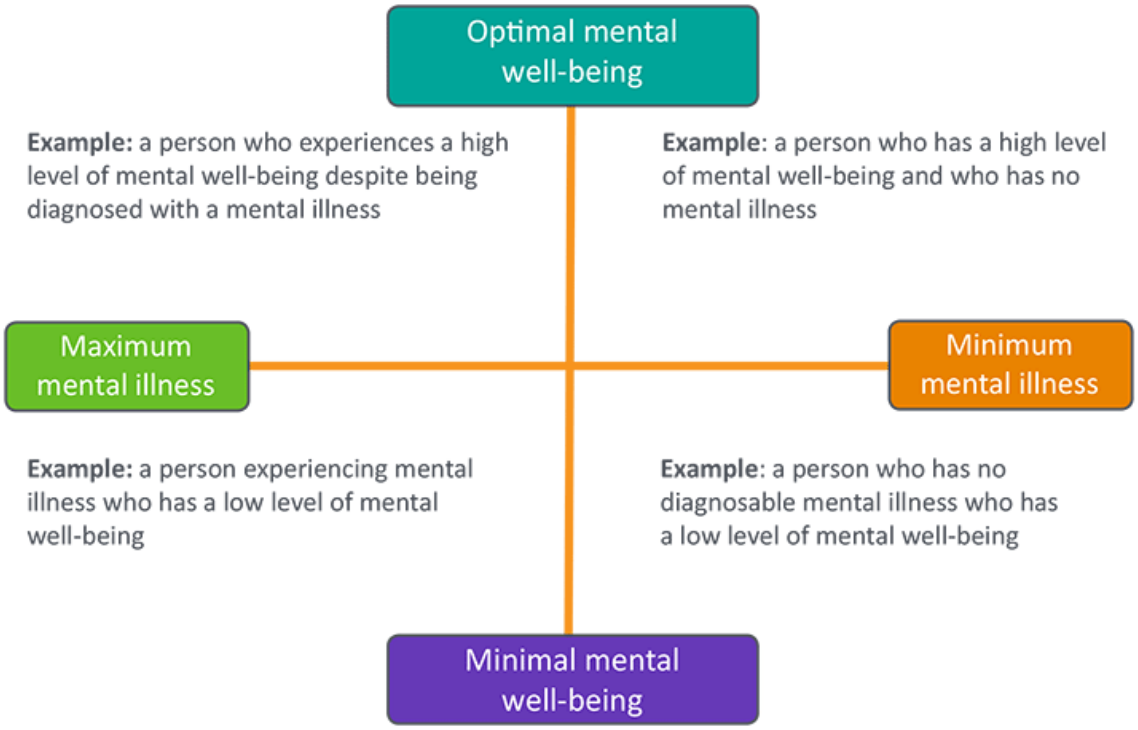
### 1. Who is at risk and why?

Mental Health and Wellbeing

Good mental health is defined by the WHO (2018) as not simply the absence of a mental disorder but "a state of wellbeing in which an individual realises his or her own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community."[3]

Mental health and emotional well-being can be described as being on a continuum, where people can move between states and languish or flourish, depending on a range of personal, social or contextual factors. The concept is centred on the ideas that mental health is not simply the absence of mental illness, and that interventions and behaviours can help individuals to move into more positive areas of the continuum (see Figure 1).

**Figure 1. The relationship between mental health and well-being.**




*Source: Public Health Agency of Canada / AMI Quebec (2016)*

It is estimated that one in four people have a mental disorder at any one time, and this costs the English economy around £105b every year. Mental disorder is also responsible for the largest burden of disease in England (23% of total burden, compared to 16% for cancer and

16% for heart disease).[4] Poor mental health starts at an early age and can have consequences throughout life, impacting on physical health, relationships, education, crime and employment. Research shows that half of all lifetime mental health disorders start by age 14 years and three quarters by age 24 years.[5]

Mental health problems range from day-to-day worries to serious long-term conditions. In children, four broad groups of disorder can be defined in national reporting[6]:

- Emotional disorders, which includes conditions such as anxiety, depressive disorders, and mania and bipolar affective disorder, along with phobias and panic disorders.
- Behavioural (or conduct) disorders, which includes repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or rules, are violated.
- Hyperactivity disorders, which includes disorders characterised by inattention, impulsivity and hyperactivity, including Attention Deficit Hyperactivity Disorder (ADHD).
- Less common disorders, which includes autistic spectrum disorder, eating disorders, tic disorders and a number of very low incidence conditions.

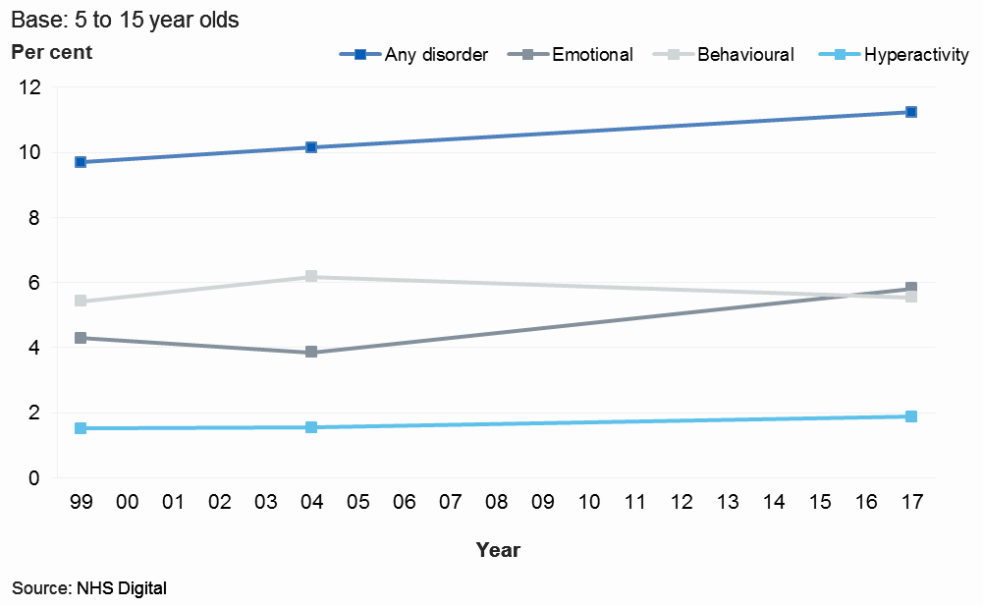
National prevalence of mental health problems in children and young people

In 2017 ONS carried out the third Mental Health of Children and Young People in England survey (MHCYP survey) of 9,117 children and young people aged 2-19 years old living in England and registered with a GP. The survey combines reports from children, their parents and teachers to identify if the child or young person met the International Classification of Disease (ICD-10) diagnostic criteria (WHO, 2016) for a range of different types of disorder. This survey provides the most robust and comprehensive data on the prevalence of mental disorders among children in the UK.

The national survey shows that one in eight Children and Young People (CYP) living in England are at risk of poor mental health at any one time. Rates of mental disorder increase with age, with around 6% of pre-school age children experiencing a mental disorder, but 17% of 17 to 19-year-olds reporting the same. Nationally, this trend has been increasing gradually over the course of the 21st Century.

Trends in the MHCYP survey show a gradual rise in mental disorders overall, largely accounted for by a proportionally large increase in emotional disorders since 2004 (see figure 2, below). However, for reasons of comparability, this chart does not include ages over 16, where prevalence is much higher for emotional disorders.

**Figure 2. Recent trends in estimated number of school-age children (5 to 15) experiencing mental ill health 1999-2017**




*Source: NHS digital (MHCYP survey 2017)*

Similar trends are evident in the annual Good Childhood Report (2019), which looks at children's wellbeing and happiness and is based on an annual survey of about 2,400 households and a longitudinal study involving 40,000 households.

The Good Childhood Index measures children's happiness with 10 aspects of life that are crucial to their wellbeing. Compared to the first survey in 2009-10, there has been a significant decrease in happiness with life from mean happiness score (0-10) of 8.17 in 2009-10 to 7.89 in 2016-17. In particular, there were significant decreases in happiness with friends and school among both boys and girls, and a significant decrease in happiness with appearance for boys.

In addition, the survey found that 33% of children are very or quite worried about having enough money in the future and 29% are worried about finding a job. In terms of broader issues, 41% of children are very or quite worried about crime and 41% are worried about the environment.

### 1.1 Risk factors

Whilst all children and young people can experience mental health problems, there are many contributing factors which can increase or decrease their risk of developing them. These factors can be separated into three broad groups[7]:

- *Individual attributes or behaviours* – innate and learned emotional intelligence, social intelligence and genetic and biological factors.
- *Social and economic circumstances* – opportunity for positive engagement with family members, friends or colleagues. Educational and employment opportunities.
- *Environmental factors*: living environment, including access to basic commodities and services. Exposure to predominating cultural beliefs, attitudes or practices, social and economic policies formed at national level. Discrimination, social or gender inequality and conflict are examples of adverse structural determinant of mental well-being.

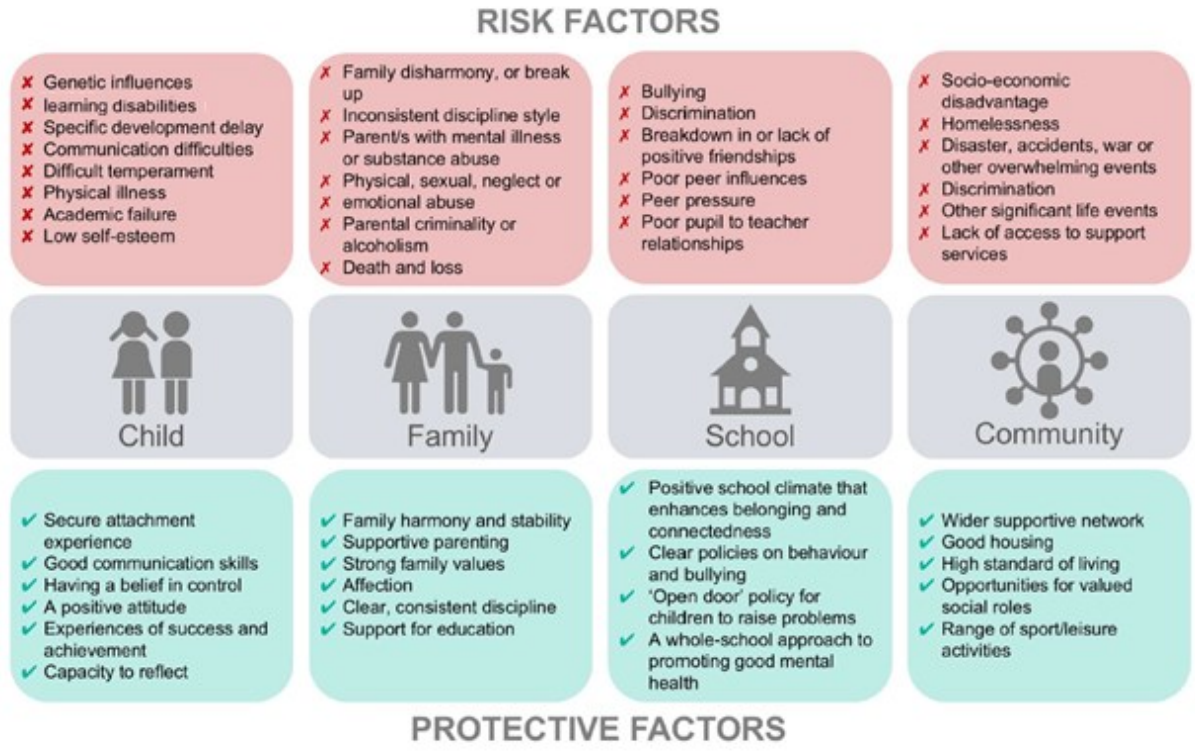
These different categories interact with each other in a dynamic way and can be either a positive of negative influence on an individual's mental health.

**Figure 3. Contributing factors to mental health and wellbeing**


*Source: World Health Organisation, 2012*

Certain individuals and groups are more at risk of developing mental health problems than others. These risks can relate to the child themselves, to their family or to their community or life events. Research also suggests that there is a complex interplay between the risk factors in children's lives, and the protective factors which can promote their resilience.[8] These risk and protective factors are highlighted in table 2.

**Table 2. Risk and protective factors in the development of mental health and emotional wellbeing**




*Source: Department of Education, 2018*

It is now known that one of the biggest risk factors to poor mental health in childhood lies in the child's experiences in their first 1,001 days (see JSNA chapter). Good attachment to main carers, a secure environment, and positive social and environmental stimulation form a strong foundation for emotional wellbeing.

Conversely, children who have been neglected are more likely to experience depressive or attentional disorders and are more likely to struggle to maintain or develop healthy social relationships in later life. Modifiable factors which can harm mental wellbeing therefore include family conflict, domestic violence, poor maternal mental health, abuse and neglect.

The National CYP Mental Health survey also identified a range of modifiable risk factors and behaviours among children and young people who have been identified as having a disorder compared with those who do not.[9] Interestingly it found that children and young people with mental disorders:

- Were more likely to have spent longer on social media on a typical day
- Were more likely to link their mental wellbeing to feedback received on social media platforms

- Were more likely to have experienced cyberbullying, either as victim or as perpetrator
- Were more likely to have experienced bullying, either as victim or as perpetrator
- Were less likely to be a member of a club. The largest positive impacts of club membership were evident in:
    - Sports clubs
    - After school clubs
    - Dramatic arts clubs associated with school
- Were less likely to report a strong score on the social support scale
- Were more likely to have experienced a stressful life event, such as family breakdown, financial crisis, family court appearances, family illness, injury or death or the breakdown of a close personal friendship or romantic relationship
- Were more likely to have tried smoking or vaping
- Were more likely to have tried alcohol
- Were more likely to have tried illicit drugs
- Were less likely to identify as heterosexual (14-19-year-olds)

These patterns were generally evident across all 11+ age groups and across male and female respondents.

**Protective Factors**

However, there are also several protective factors which can help to build good mental health and well-being. The Joint Commissioning Panel for Mental Health has identified a number of such factors which need to be considered in the development of services. They include:

- Good living environment
- Good general health
- Educational attainment
- Good start in life (see 1001 days chapter)
- Social engagement and strong networks
- Good attachment to caregivers
- Reciprocal altruism
- Positive self esteem
- Life skills (e.g. communication, problem-solving, resilience)
- Development of coherent personal values

**Impact of social media**

The impact of social media on children and young people's mental health is not yet clear due to limited evidence available but as such it has become a big topic of debate and a focus for future research.

A report from the Office for National Statistics in 2015 found that children spending more than three hours on "social websites" on a normal school night were more than "twice as likely to show symptoms of mental ill health". However, the relationship of the two is unclear, whether social media usage is a cause or a consequence of the symptoms of mental ill health.

The mental health of children and young people (MHCYP) in England survey, published by NHS digital in 2017, found that 11 to 19-year-olds with a mental disorder were more likely to use social media daily (87.2%) compared to those without a disorder (77.8%). Also, that those with a disorder who were on social media daily tended to be on for longer, with 29.4% of daily users with a disorder being on social media for four hours on a typical school day. Again, these statistics indicate an association but do not provide the direction of the relationship between social media and mental health.

Relating specifically to the health impacts of screen time, the Royal College of Paediatrics and Child Health reported that there was a "moderately-strong evidence for an association of screen time and depressive symptoms" but that there was weak evidence for an association of screen time with "behaviour problems, anxiety, hyperactivity and inattention, poor self-esteem and poor wellbeing".[10]

Conversely, it has been highlighted that some of the most robust research to date indicates that moderate engagement in digital activities has little detrimental effect on, and even some positive correlates with, well-being.[11]

**Inequalities**

Whilst any child can experience diminished mental health and well-being and suffer from a mental health disorder regardless of their background, there are many social determinants which increase the likelihood of it happening. Social inequalities are associated with increased risk of many common mental disorders.[12] This is because disadvantaged and vulnerable children and young people are at greater risk of exposure to adverse childhood events (ACEs) which are closely linked to poor mental health.[13]

The WHO defines ACEs as some of the most intensive and frequently occurring sources of stress that children may suffer early in life. Examples include multiple types of abuse; neglect; violence and conflict between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.

A survey commissioned by NHS digital on mental health of children and young people (MHCYP) in England found that the prevalence of mental health disorders varied within different population groups as shown below.[14]

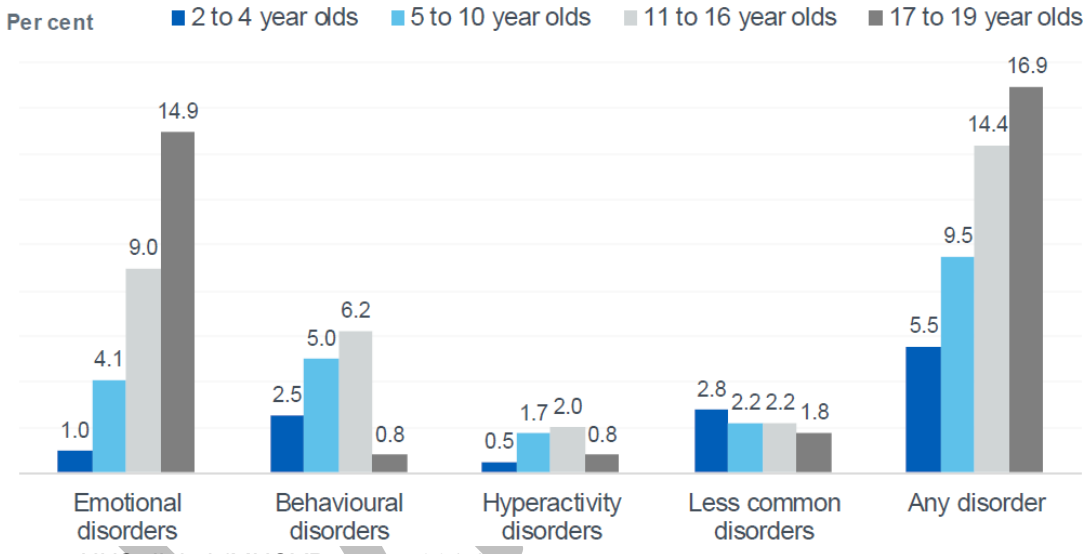
## Age

The MHCYP survey found that rates of mental health disorder increased with older age groups, resulting in:

- 1 in 18 (5.5%) in preschool children aged 2 to 4 years
- 1 in 10 (9.5%) in primary school children aged 5 to 10 years
- 1 in 7 (14.4%) secondary school children aged 11 to 16 years
- 1 in 6 (16.9%) of Adolescents aged 17 to 19 years.

There was variation in which disorders were prominent based on the different ages (see Figure 4). For example, emotional disorders were most common in 17 to 19 year-olds, while behavioural and hyperactivity disorders were highest in children aged 5 to 16 years.

**Figure 4. Rates of different types of disorder in 5 to 19 year-olds by age in England**

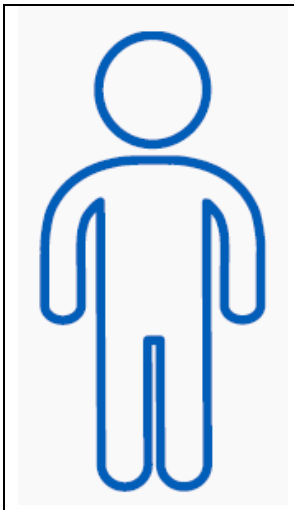



*Source: NHS digital (MHCYP survey 2017)*

## Gender

According to the MHCYP survey, significant differences can be seen in the rate as well as the type of mental health disorders between girls and boys at various ages. This is shown in Table 3. The survey does not contain data that looks at the prevalence of mental health disorders amongst transgender and non-binary children and young people.

**Table 3. The prevalence of mental health disorders between males and females at different ages.**

|  | Prevalence | Age | Prevalence |  |
|---|---|---|---|---|
| | 6.8% | 2 – 4 | 4.2% | |
| | 12.2% | 5 – 10 | 6.6% | |
| | 14.3% | 11 – 16 | 14.4% | |
| | 10.3% | 17 - 19 | 23.9% | |
| | 1 in 10 | 16 – 24** | 1 in 4 | |

*Source: NHS digital (MHCYP survey, 2017), NHS digital (MHSDS activity data, 2018)*

Among 2 to 4 year-olds, boys were more likely than girls to have a disorder, this difference increased in 5 to 10 year-olds where boys were twice as likely to have a disorder.

In 5 to 10 year-olds the rates of emotional disorders were similar between the two groups, however, other types of disorder were more than likely in boys compared to girls. For example, 2.6% of 5 to 10-year-old boys were identified with a hyperactivity disorder, compared with 0.8% of girls.

Among 11 to 16 year-olds whilst boys and girls were equally as likely to have a disorder, the type varied between them. Girls were more likely to have an emotional disorder, while boys were likely to have a behavioural or a hyperactivity disorder.

Most strikingly, girls aged 17 to 19 years were more than twice as likely as boys to have a mental health disorder with nearly one in four girls (23.9%) having a disorder compared to one in ten boys (10.3%). Emotional disorders were the most common type in this age group, with 22.4% of girls having one compared to 7.9% of boys. In addition to this, half (52.7%) of girls with a disorder reported having self-harmed or made a suicide attempt.

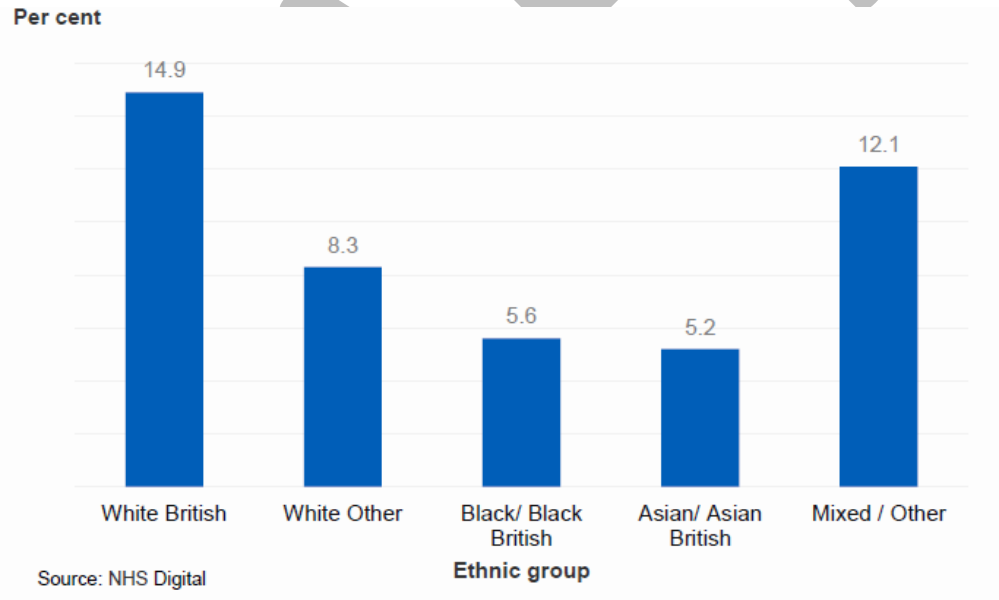
Recent research places focus on the concept that adolescence for most young people extends well into the twenties, suggesting that emotional needs for girls under 25 may be a high priority.[15]

One in four young women aged 16 to 24 have common mental health problems compared with one in ten of men the same age. Young women also have the highest rates of reported suicide thoughts, behaviours and self-harm (e.g. 25.7% of women aged 16 to 24 reported self-harm).[16]

**Ethnicity**

The MHCYP survey found rates of mental disorders in 5 to 19 year-olds varied between different ethnic groups and tended to be higher in White British children and lower in Black/ Black British or Asian/ Asian British (See Figure 5). This pattern was evident for rates of any disorder.

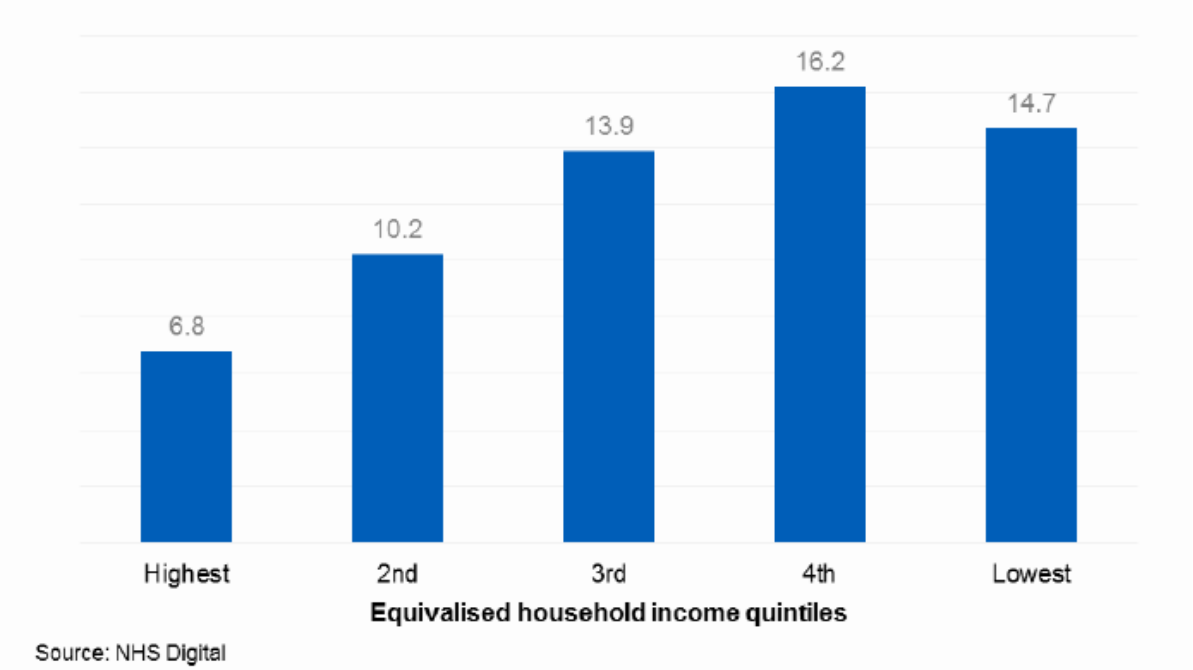
**Figure 5. Any mental disorder in 5 to 19 year-olds by ethnic group**




**Deprivation**

The MHCYP survey found that emotional and behavioural mental disorders as well as autism spectrum disorders (ASD) tended to be higher in children living in lower income households. However, this was not true of hyperactivity or eating disorders. Emotional disorders were half as prevalent in the highest income households at 4.1% compared to 9.0% in the lowest income households as shown in Figure 6. Interestingly, the survey also found that neighbourhood deprivation was not associated with most types of disorder.

**Figure 6. Percentage of emotional disorder in 5 to 19 year-olds by household income**




**Looked after children (LAC) / children in care**

Nationally, 45% of looked after children were found to have a diagnosable mental health disorder, with mental health problems thought to be even more prevalent in this group.[17] [18] This is because they are more likely to experience social and environmental risk factors as well as be exposed to more adverse childhood events (ACEs) compared to other children. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.[19]

**LGBTQ+**

The MHCYP survey found that young people identifying as lesbian, gay, bisexual or with another sexual identity were more likely to have a mental disorder (34.9%) than those who identified as heterosexual (13.2%).

A report from Stonewall (2017), highlights that LGBTQ+ young people are significantly more likely to self -harm, think about taking their own life or attempting to take their own life. This risk is even greater in female LGBTQ+ young people, transgender and non-binary young people, and LGBTQ+ young people who are disabled or BAME.

However, a quality improvement audit of local CAMHS services undertaken in 2018 indicated that 81.45% of young people were not asked their sexual orientation and that trans data was not available. Whilst the audit found some positive examples of where LGBTQ+

young people had been well supported; it also highlighted a variance in knowledge and understanding amongst CAMHS workers around LGBTQ+ issues and staff not feeling comfortable to ask a young person's sexual orientation or gender identity. It also highlighted the importance of lanyards and badges in demonstrating a safe place for young LGBTQ+ young people.

In 2020, Nottinghamshire Healthcare Trust did further work to look at how people who identify as LGBTQ+ experience CAMHS. The LGBTQ+ CAMHS action plan is being developed with young people as a result of this work.

**Physical and intellectual disability**

The MHCYP survey highlighted a close link between mental and physical health and impairment. Children with a mental disorder were more likely to have poor general health, a limiting long-term illness, a physical or development problem or a special educational need. Nearly three-quarters (71.7%) had a physical health condition or developmental problem. A quarter (25.9%) had a limiting long-term illness compared with 4.2% of children without a mental disorder.

Long-term physical illness or disability is a known risk factor for developing mental health problems in CYP as it impacts on young people themselves, their emotional and social development, and their families.[20] Children living with a long-term physical illness are twice as likely to suffer from emotional or conduct disorders.[21]

The MHCYP also found that a third of children with a mental health disorder had a recognised special educational need (SEN), compared to 6.1% of children without a mental disorder. Children and young people with intellectual disabilities are at increased risk of developing additional mental health problems.[22]

Locally, in 2017/18 and 2018/19 the number of children and young people referred to CAMHS Single Point of Access (SPA) who were recorded as having a disability was 510, which represents 14.5% of all referrals.

**Other population groups and factors**

- Youth offenders have levels of mental health problems at least three times higher than the general population, with some estimates as high as 80% of this group needing support.[23]
- Being a refugee, asylum seeker or from a traveller community are risk factors for developing a mental health problem in CYP.[24]
- Young carers - In the 2011 Census, 4% of young carers said they had a mental health condition; this compares with 1% of non-carers.[25]

- Other factors identified in the MHCYP survey as increasing the risk of mental disorder in the CYP were living with a parent with poor mental health, having low levels of social support/ a small social network or not participating in clubs or organisations and problems with family functioning.

### 1.2 Impacts

Lower levels of emotional and psychological wellbeing are linked to bullying, disruptive behaviour at school, disengagement, poor nutrition choices, lower levels of activity and poor long-term mental health.[26] Other outcomes include poor educational attainment; antisocial behaviour and criminal activity; teenage pregnancy and drug and alcohol abuse, and sometimes self-harm and suicide (See Self Harm JSNA).

More than half of children who show signs of mental health problems continue to experience them into adulthood, with an estimated three quarters of all mental health problems diagnosed having emerged in those affected before the age of 25.

## 2. Size of the issue locally

Prevalence and incidence of mental disorders is difficult to determine for a number of reasons, particularly for those conditions which fall below diagnostic thresholds for specialist support, or in cases where stigma prevents children and young people discussing their needs.

There is no local survey which collects information and data on the emotional health and wellbeing of children and young people who live in Nottinghamshire. However, the national Mental Health of Children and Young People Survey (NHSD, 2018) allows age and sex-based weighting of prevalence data by local area. Tables 4 and 5 show the estimated number of children and young people between the ages of 5 and 19 who have a mental disorder at any point in time.

Over 17,000 of 140,000 five to nineteen-year-olds in the county are thought to be dealing with a mental disorder across the county, with the total split evenly between boys and girls. However, when the type of disorder is considered, differences between the sexes are clear (see table 5). Girls are much more likely to experience emotional disorders (peaking at ages 17-19, where over one in five girls experience anxiety), and boys are more likely to experience behavioural and hyperkinetic disorders (e.g. ADHD- Attention Deficit and Hyperactivity Disorder). Eating disorders amongst girls are comparatively less common overall (peaking at 1.6% of all 17-19-year-old young women) and autistic spectrum disorders (ASD) are more likely to occur in boys (1.9%) than girls (0.4%).

**Table 4. Estimated numbers of children and young people with any mental disorder in Nottinghamshire and Nottingham (ages 5-19)**

| | Male | Female | All |
|---|---|---|---|
| **Ashfield** | 1419 | 1392 | 2811 |
| **Bassetlaw** | 1235 | 1222 | 2456 |
| **Broxtowe** | 1188 | 1136 | 2324 |
| **Gedling** | 1293 | 1227 | 2520 |
| **Mansfield** | 1170 | 1144 | 2314 |
| **Newark and Sherwood** | 1328 | 1300 | 2628 |
| **Rushcliffe** | 1336 | 1280 | 2616 |
| | | | |
| **Notts County** | 8968 | 8700 | 17669 |
| **Nottingham** | 4124 | 4117 | 8239 |
| **East Midlands** | 54461 | 53339 | 107795 |
| | | | |

*Sources: NHSD (2019); ONS MYE (2018)*

**Table 5. Estimated numbers (and percentage) of total population of children and young people (ages 5-19) with a mental disorder in Nottinghamshire at any one time by type of disorder and sex**

| Type of disorder | Male | Female | All |
|---|---|---|---|
| Emotional | 4,378 *(6.2%)* | 6,752 *(10.0%)* | 11,133 *(8.1%)* |
| *Anxiety* | 3,857 *(5.4%)* | 6,113 *(9.1%)* | 9,975 *(7.2%)* |
| *Depressive* | 991 *(1.4%)* | 1,909 *(2.8%)* | 2,902 *(2.1%)* |
| Behavioural | 4,143 *(5.8%)* | 2,267 *(3.4%)* | 6,407 *(4.6%)* |
| Hyperactivity (ADHD) | 1,860 *(2.6%)* | 408 *(0.6%)* | 2,266 *(1.6%)* |
| Other less common disorders | 1,848 *(2.6%)* | 1,071 *(1.6%)* | 2,918 *(2.1%)* |

*Sources: NHSD (2019); ONS MYE (2018)*

The number of disorders are not mutually exclusive and there is certainly going to be multiple disorders in any one individual. Therefore, the number of disorders shown in Table 4 and 5 above will not all sum.

**Table 6. Estimated numbers of 18-25 year-olds with any mental disorder in Nottinghamshire**

| | 18-25 years | | |
|---|---|---|---|
| | **Male** | **Female** | **All** |
| Ashfield | 559 | 1525 | 2084 |
| Mansfield | 461 | 1234 | 1695 |
| Newark and Sherwood | 516 | 1319 | 1835 |
| Gedling | 464 | 1271 | 1735 |

| | | | |
|---|---|---|---|
| Broxtowe | 536 | 1472 | 2008 |
| Rushcliffe | 494 | 1329 | 1823 |
| Nottingham City | 3687 | 10105 | 13792 |

| | | | |
|---|---|---|---|
| Bassetlaw | 503 | 1256 | 1759 |

| | | | |
|---|---|---|---|
| County (excl. Bassetlaw) | 3030 | 8150 | 11180 |
| County (incl. Bassetlaw) | 3533 | 9406 | 12939 |

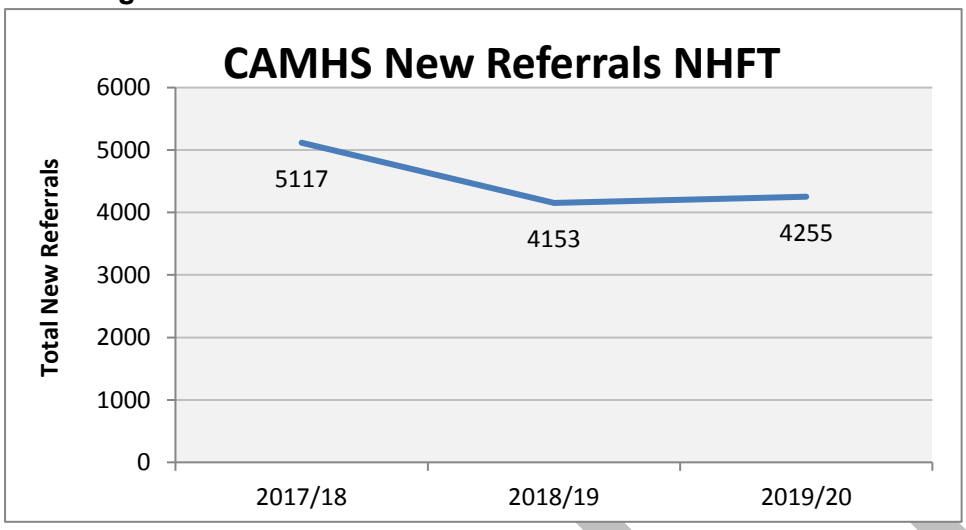
*Source: Health and Social Care Information Centre via NHS Digital using Adult Psychiatric Morbidity Survey 2014*

The above data must be interpreted with caution, however, as these are estimates of point prevalence (or the number of individuals who may have a disorder at any one point in time). The period prevalence of these disorders will normally be higher (the number of individuals identified as cases *during* a specified period of time, divided by the total number of people in that population).

**CAMHS (Child and Adolescent Mental Health Services) – Nottinghamshire Healthcare NHS Trust**

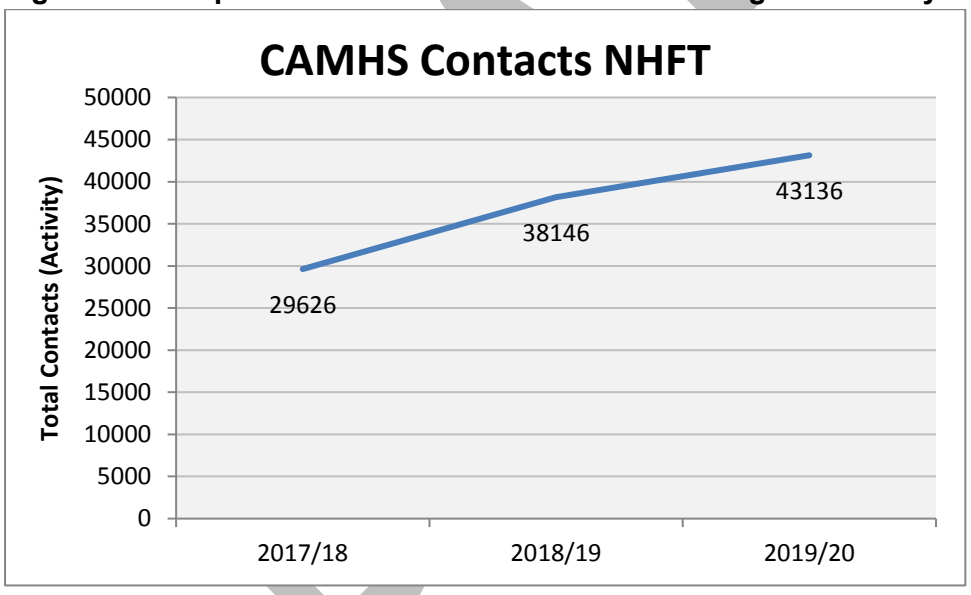
CAMHS provision is now 'tierless' in Nottinghamshire, and since 2018 has allowed self-referral for all CAMHS services, including specialist services. Advice in advance of submitting a referral can be obtained from a single point of access and/or Primary Mental Health Team who support schools, GPs and Health Family teams, which then ensures that the referral is handled by the appropriate team. In 2017/18 the Trust moved to a different reporting system which cause a level of duplications in reported figures. In 2018, a significant amount of work took place to refine data capture, so it is likely that the 2018/19 figures reflect this refinement, rather than a drop-in referral to CAMHS.

**Figure 7. New referrals to NHFT CAMHS in Nottinghamshire by financial year including Bassetlaw**



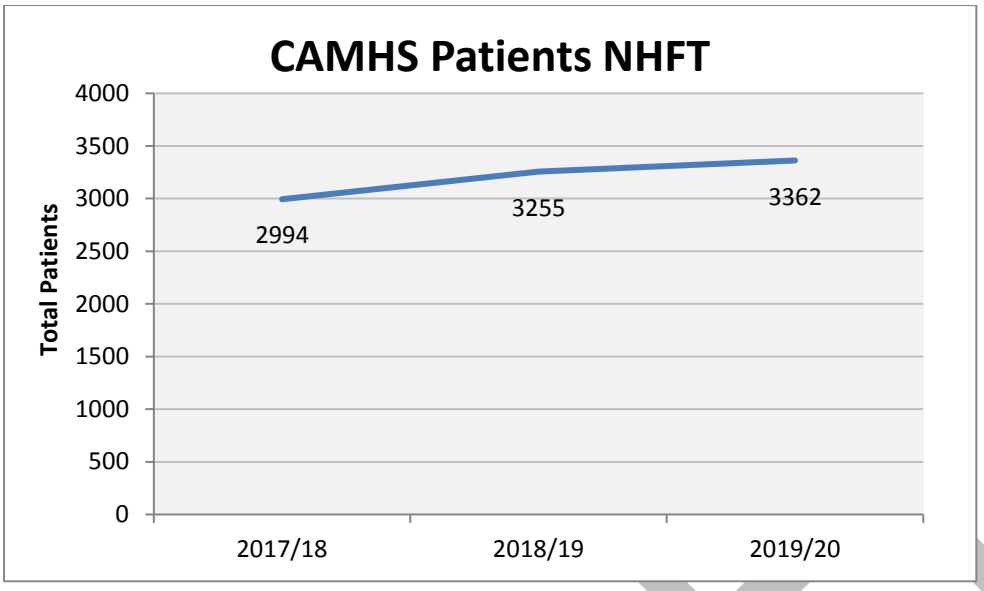

*Source: NHFT Applied Information & CAMHS Service*

**Figure 8. Total patient contacts with CAMHS in Nottinghamshire by financial year**




*Source: Source: Local PLDS supplied to CCG by NHFT*

**Figure 9. Total number of patients seen by NHFT CAMHS by Financial Year**




*Source: Local PLDS supplied to CCG by NHFT*

In 2019/20, 3362 individual patients were seen by CAMHS in Nottinghamshire, split across the following services (NB some patients have used more than one service).

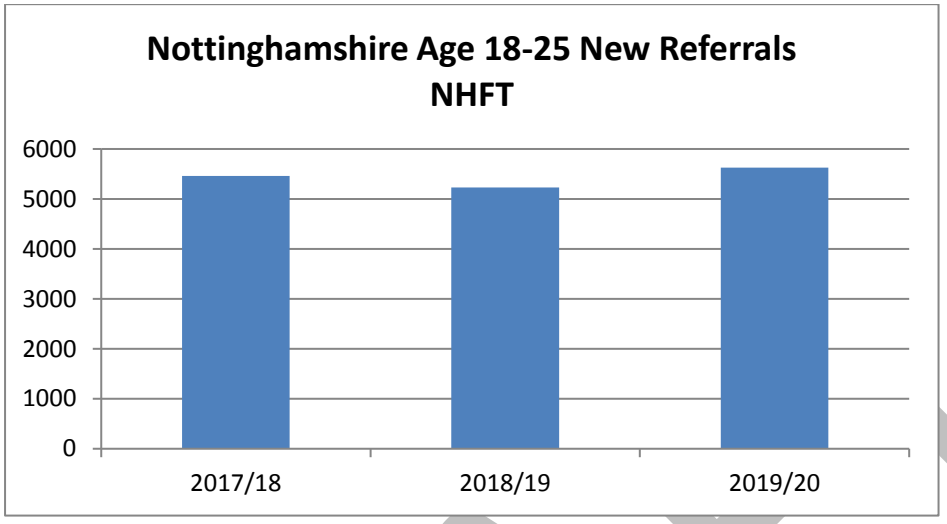
**Table 7. Number of patients contacts by each CAMHS team in Nottinghamshire for the 2019/2020 financial year.**

| | |
|---|---|
| CAMHS – South (Broxtowe, Gedling, Rushcliffe) | 12285 |
| CAMHS CRHT | 1586 |
| CAMHS – West (Mansfield and Ashfield) | 10400 |
| CAMHS Primary Mental Health | 73 |
| CAMHS - North | 8473 |
| CAMHS - Head 2 Head | 1449 |
| CAMHS Liaison - Kingsmill Hospital | 818 |
| CAMHS Liaison - NUH | 514 |
| CAMHS - LD | 2605 |
| CAMHS Paediatric Liaison | 323 |
| CAMHS - Eating Disorder | 3245 |
| CAMHS Looked After | 295 |
| CAMHS Paediatric Neurology | 518 |
| CAMHS Self Harm | 6 |
| CAMHS ADHD/ASD Al Bassetlaw Specialist | 546 |

*Source: Local PLDS supplied to CCG by NHFT*

**Services for young people aged up to 25**

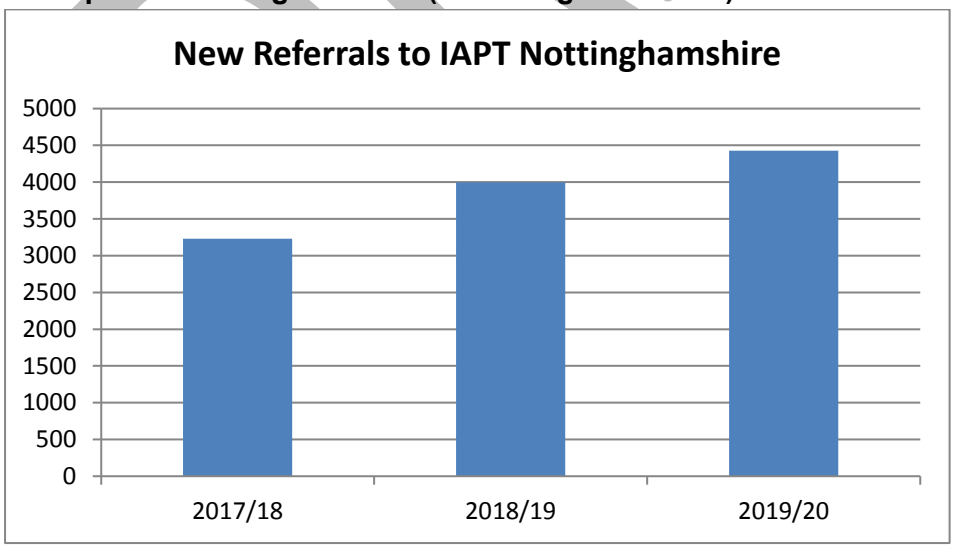
**Figure 10. New referrals for 18-25 year-olds to Nottinghamshire Healthcare Trust Adult Mental Health Services including community, outpatient and liaison contacts.**




*Source: Improving Access to Psychological Therapies (IAPT) data set (Data Service for Commissioners Regional Office)*

In 19/20, there were 5624 referrals to NHT adult mental health services, which represented 14.37% of all referrals received. This includes community, outpatient and liaison contacts. Of these 56.40% were for females.

**Figure 11. New referrals for 18-25 year-olds to Increasing Access to Psychological Therapies in Nottinghamshire (excluding Bassetlaw).**



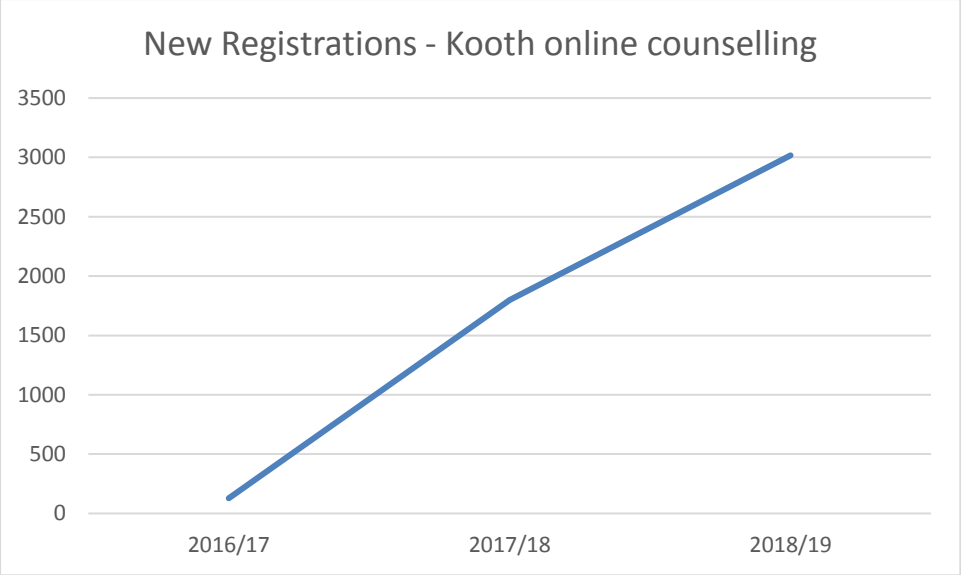

*Source: Improving Access to Psychological Therapies (IAPT) data set (Data Service for Commissioners Regional Office)*

In 2019/ 20, there were 4427 new referrals to Nottinghamshire IAPT services. This represents 20% of all referrals. Of these, 67% were for females.

**Kooth Online Counselling**

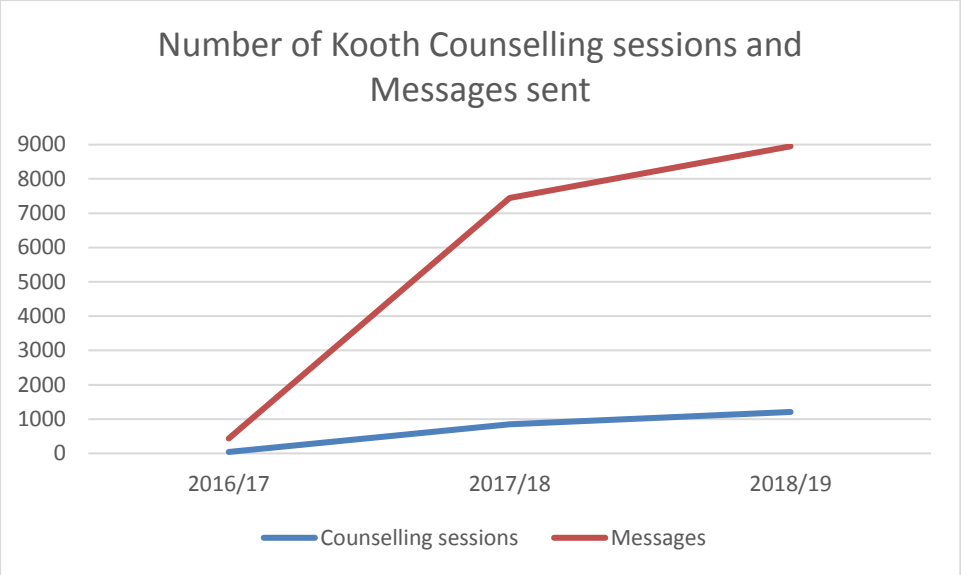
Kooth has been operational within Nottinghamshire since January 2017 and has seen a growing number of young people aged 11-24 accessing their service as seen in Figure 12. The number of young people accessing counselling sessions or using the messaging service has also increased as seen in Figure 13. This is a positive development for children and young people living in Nottinghamshire and provides alternative support with open access.

**Figure 12: Number of new young people registering with Kooth**




*Source: Kooth contract performance reports 2016 – 2019*

**Figure 13: Number of Kooth Counselling sessions delivered, and number of messages sent by young people as part of therapeutic conversation**

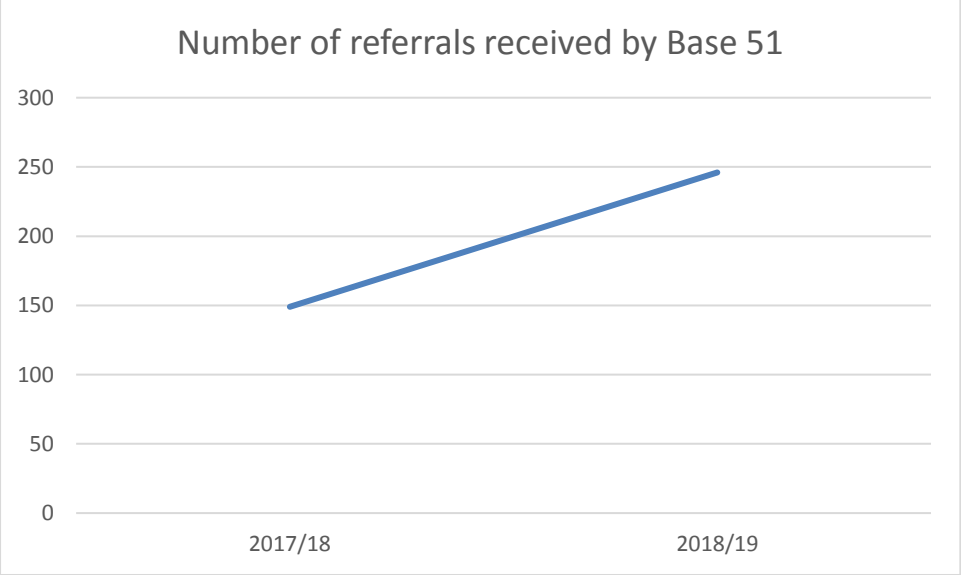



*Source: Kooth contract performance reports 2016 – 2019*

**Base 51 Counselling**

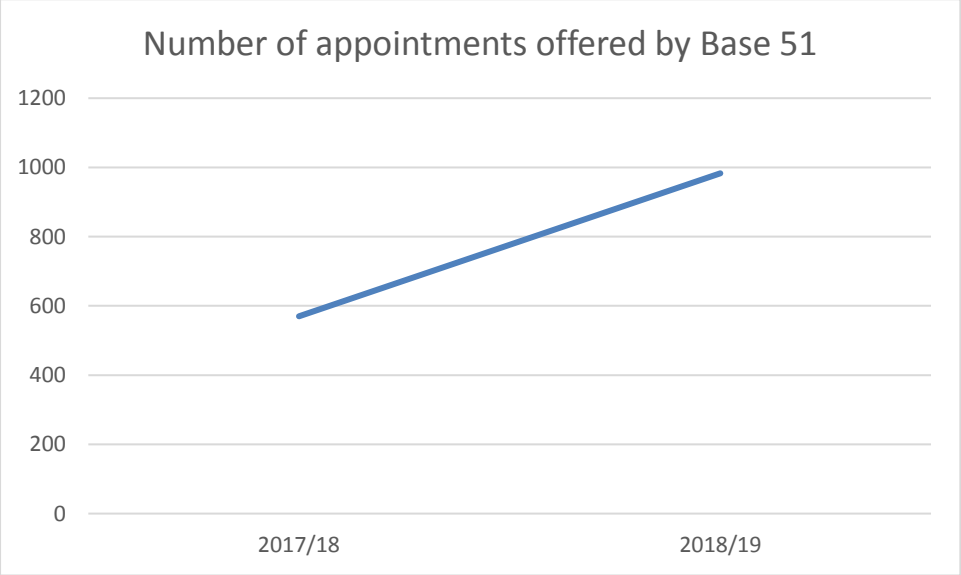
Base 51 provide emotional wellbeing and mental health support for young people aged 12-25 living within the South of Nottinghamshire and as seen within Figure 14 and 15 have seen an increase in referrals and contacts over the last two years. Young people can self-refer to Base 51.

**Figure 14: Number of referrals received by Base 51**




*Source: Base 51 contract performance reports 2017 – 2019*

**Figure 15: Number of contacts delivered by Base 51**




*Source: Base 51 contract performance reports 2017 – 2019*

### Looked After Children

A pilot local offer, *You Know Your Mind*, provides alternative mental health support to looked after children in Nottingham and Nottinghamshire through the use of a personal budget. Between April 2018 and April 2019, of the 239 looked after children who have accessed this service, over half report a mood disorder, two fifths felt socially isolated and around a quarter engaged in self-harming behaviour (see table 8). In terms of behavioural outcomes, over a fifth are known to the police, one in ten is at risk of sexual exploitation and one in five misuse drugs or alcohol. In addition, there are 15 A&E visits per 100 LAC in the county. There is an inequity in the provision of mental health services for LAC who live out of area. They remain the responsibility of the placing LA and the originating CCG and are not always able to access locally commissioned services where they are placed.

**Table 8. Percentage of Looked After Children aged 0-17 identified with a mental health need (multiple needs may be reported)**

| Mental health need | Percentage (%) |
|---|---|
| Anxiety, depression, stress or other mood disorder | 55% |
| Social isolation | 40% |
| Self-harming behaviour | 26% |
| Bereavement | 13% |
| Developmental disorders | 13% |
| ADHD / hyperkinesis | 12% |
| ASD | 11% |

| | |
|---|---|
| PTSD | 8% |
| Suicidal thoughts / behaviour | 8% |
| Conduct disorder | 4% |
| Eating disorder | 3% |
| OCD | 1% |
| *Of 239 service users (LAC and care leavers) in Nottinghamshire accessing services via You Know Your Mind project.* | |

Nottinghamshire's profile for risk groups and protective factors drawn from the national fingertips' dashboard is shown in Table 9. The proportion of our young people providing unpaid care is higher than in other rural areas of the region, but this is taken from 2010 census data, so the next update will not be available until 2021. While the proportion of looked after children is broadly comparable to the national picture, a relatively high number of our looked after children are affected by poor emotional wellbeing (48.9% compared to 38.6% nationally).

Absenteeism is lower than the national rate, and educational attainment is higher, but Nottinghamshire's breast-feeding rate is lower than that for England (42% compared to 46.2%), and school readiness in the county is slightly lower than the national average.

**Table 9. Nottinghamshire out-turn for risk and protective factors from the Public Health Outcomes Framework.**

| **Risk Groups** | **Period** | **Measure** | **England** |
|---|---|---|---|
| Looked after children | 2017/18 | 48/10,000 | 64 |
| Looked after children under 5 | 2017/18 | 28.7/10,000 | 34.9 |
| Percentage of looked after children where there is a cause for concern | 2017/18 | 48.9% | 38.6% |
| Unaccompanied asylum seekers | 2018 | 30 people | 4480 |
| Young offenders (10-18) | 2017/18 | 4/10,000 | 4.5 |
| Young people providing unpaid care (16-24) | 2011 | 4.9% | 4.8% |
| Not in Education, Employment, or Training (NEET) | 2017 | 6.0% | 6% |
| Long term illness and disability aged 15 | 2014/15 | 14.3% | 14.1% |
| Domestic Abuse | 2017/18 | 17.5/ 1,000 | 25.1 |
| Parents in drug treatment | 2011/12 | 128 /100,000 | 110.4 |
| Children in low income families (under 16s) | 2016 | 15.6% | |

| | | | |
|---|---|---|---|
| | | | 17% |
| Hospital admissions as a result of self-harm (10-24 yrs.) | 2017/18 | 498 /100,000 | 421 |
| Hospital admissions for mental health conditions (0-17 yrs.) | 2017/18 | 76/100,000 | 84.7 |
| School pupils with social, emotional and mental health needs (all school age) | 2018 | 1.7% | 2.39% |
| **Protective factors** | | | |
| Breastfeeding at 6-8 wks. | 2018/19 | 42% | 46.2% |
| School readiness: percentage of children achieving a good level of development at the end of reception | 2017/18 | 69.7% | 71.5% |
| Educational attainment (5 or more GCSEs) | 2015/16 | 61.1% | 57.8% |
| Pupil absence | 2017/18 | 4.47% | 4.81% |

*Source: PHE Children's Mental Health and Wellbeing Dashboard*

## 3. Targets and performance

### National Policy

The national strategy, *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing* (2015), set out the government's ambition to transform children and young people's mental health services by 2021. Ambitions include:

a. Promoting resilience, prevention and early intervention: acting early to prevent harm, investing in early years and building resilience through to adulthood.
b. Improving access to effective support – a system without tiers: changing the way services are delivered to be built around the needs of children, young people and families.
c. Care for the most vulnerable: developing a flexible, integrated system without barriers.
d. Accountability and transparency: developing clear commissioning arrangements across partners with identified leads.
e. Developing the workforce: ensuring everyone who works with children, young people and their families is excellent in their practice and delivering evidence-based care.

The Government Green paper Transforming Children and Young People's Mental Health Provision (December 2017) places schools at the centre for early intervention around mental health support and aims to establish the following:

- A mental health lead in every school and college by 2025 to support pupils and staff, offer advice and to refer CYP to specialist services.
- Establishment of mental health support teams to provide more specialised services and link to wider networks.
- Reduce waiting times for treatment with piloting a four-week waiting time in some 'trailblazer' areas.
- Bolster transitional care from CYP to adult services through the development of a national partnership approach.
- Invest in research in to supporting families and prevention of mental health problems.

In addition to this, the NHS 2019 Long Term Plan also includes the following key commitments around children and young people's mental health.

- Transform mental health care so more people can access treatment by increasing funding at a faster rate than the overall NHS budget – and by at least £2.3bn a year by 2023/24.
- Make it easier and quicker for people of all ages to receive mental health crisis care, around the clock, 365 days a year, including through NHS 111.
- Expand specialist mental health care for mothers during and following pregnancy, with mental health assessments offered to partners so they can be signposted to services for support if they need it.
- Embed mental health support for children and young people in schools and colleges, allowing extra capacity for early intervention and ongoing help.
- Ensure that all children and young people aged 0-25 can get support when they need it, in ways that work better for them, through a comprehensive offer that reaches across mental health services for children, young people and adults.
- Boost investment in children and young people's eating disorder services over the next 5 years.
- A new approach to young adult health services for people aged 18-25 will support the transition to adulthood.
- Continue to develop services in the community and hospitals, including talking therapies and mental health liaison teams, to provide the right level of care for hundreds of thousands more people with common or severe mental illnesses.

**Local Policy**

CCGs have been required to produce a plan which describes our local response to Future in Mind. The plan was updated annually and Nottinghamshire and Nottingham City have a joint plan which can be viewed here Children and Young People's local transformation plans (LTP). The aim of the plan was to **improve the emotional and mental health of our population of children and young people** through implementing the recommendations of *Future in Mind*.

All partners remain committed, by 2021, in delivering the following *Future in Mind* priorities:

- more young people to have good mental health, including those in vulnerable groups such as children looked after, children subject to child protection plans, children with disabilities and young offenders
- more children and young people with mental health problems to recover
- more children and young people to have a positive experience of care and support
- fewer children and young people to suffer avoidable harm
- fewer children and young people to experience stigma and discrimination

Other relevant indicators to monitor at a county and unitary authority level include those on the Children and Young People's Mental Health and Wellbeing Profiling Tool, which provides a wide range of national, regional and local data on the need, protective factors, risk factors and services that support children and young people's mental health.

## 4. Current activity, service provision and assets

### 4.1 Prevention and Early Intervention

The following provides further detail about the early support/intervention offer across Nottinghamshire County.

**Perinatal**

The perinatal mental health pathway for the Nottingham and Nottinghamshire ICS area has been redeveloped, along with enhanced capacity in the Perinatal Psychiatry Service to include peer support, nursery nurse, mother infant therapist and speciality doctor posts. A full description of these services can be found in the 1001 days JSNA.

**Parenting Support**

Advice and support sessions for parents and carers of under-12s are bookable with the Healthy Families Team, along with drop in support sessions and web resources for older children. Support is also available for parents of children under 5 via Children's Centres.

Families who may be struggling with aspects of parenting can access support through the graduated Family and Parenting offer from the Family Service.

Where parents have concerns, they can also access GPs who can further refer to appropriate services including community paediatricians where applicable, and the Educational Psychology Service.

**Primary Mental Health Team (Nottinghamshire Healthcare NHS Trust)**

The Primary Mental Health Team work with GPs, Healthy Family Teams and schools across Nottinghamshire County providing case consultation, advice and training around a range of mental health issues, including self-harm. Feedback from the system has been extremely positive and by offering case consultation there has been an increase in the number of appropriate referrals received by CAMHS. During 2018 the Primary Mental Health Team delivered 218 training sessions to 2,905 colleagues across schools. The team also provided 696 consultations to professionals.

**Mental Health Support Teams (MHST) in Schools**

Nottinghamshire has also received funding from NHS England to rollout 6 MHSTs across the 7 districts. These teams will provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing. The teams will act as a link with local children and young people's mental health services and be supervised by NHS staff.

**Kooth**

Kooth offers open access support to young people across Nottinghamshire County, providing online counselling as well as a range of other online emotional health support tools such as moderated forums and self-care tools. Kooth is available to all young people aged 11-24. In 2018/19, around 3000 young people registered to use the service, and over 1200 counselling sessions were delivered. The service was rated very positively by service users, with 93% of them reporting that they would recommend it to a friend.

**Base 51**

Base 51 serves the South of Nottinghamshire County and offers emotional wellbeing and mental health support in the form of counselling and drop-in sessions, along with crisis support. During 18/19 246 young people were referred/self-referred to Base 51 counselling with 983 appointments offered.

**Mustard Seed**

Mustard Seed, who are embedded within the CAMHS service offer, deliver one to one therapeutic intervention to support emotional health, wellbeing and resilience.

**Health for Kids and Health for Teens**

A health promotion website, covering subjects that promote a healthy body and mind written by health experts. Provides information for children, parents and teachers. The children friendly site was developed with the help of children and contains interactive games as well as information.

**ChatHealth**

This is a confidential text service, where young people aged 11-19 can receive confidential advice on a wide range of issues such as bullying and emotional health and well-being.

Nottingham Recovery College runs co-produced short- and longer-term courses to help people manage their physical and mental health.

**Developing resilience in schools**

The Tackling Emerging Threats to Children team is a universal service provided by the County Council to coach teachers and parents in supporting children and young people's resilience and awareness of threats to their wellbeing. Activities include:

- Training schools in how to deal with bullying and cyber bullying
- Advocacy and advice for teachers and parents
- Support in developing local policies (such as behaviour policy)
- Development of curriculum resources for PSHE education
- Development of online safety resources and links between IT and emotional wellbeing
- Advice on emerging technology and its potential impact on children and young people (for example the Internet of Things)
- Have supported 60 schools to become *United against bullying* accredited, with further schools applying this year

The service also offers consultations to schools to support social transition of Trans & Non-binary pupils and will liaise with the Tavistock & Portman Gender Identity Clinic where necessary as well as other local services. There is a dedicated section on their portal pages which provides guidance including a Trans Toolkit for schools and resources including lesson plans etc. The service also run training for school staff and have also delivered training to the Family Service, Foster Carers, Residential and Secure Care Homes, the NSPCC in relation to Sport and Trans Young People and have delivered recently to Broxtowe Borough Council who opened this up to professionals working across the wider children's workforce.

Resilience development is supported through partnership working across the county through the work of Public Health and the Schools Health Hub. The programme of work set out aims to capitalise on the fact that young people spend the majority of their waking hours in school

and college, and recognises the opportunities afforded to make a significant positive impact on the lives and mental health of children and young people.

Local schools have been a strong focus of activity in prevention and early intervention initiatives. Thirty schools have been taking part in resilience programmes, such as Take Five at School and the Young Minds Academic Resilience approach. These approaches are further supported by the incremental roll-out of the Mental Health Services and Schools Link programme, which empowers local professionals and support staff to develop better services for children and young people through developing a coherent local vision for children and young people and sharing expertise, networks and resources.

**Emotional Literacy Support Assistants (ELSAs)**

Within Nottinghamshire, ELSAs are teaching assistants who have received additional training from the Educational Psychology Service. Following the training course, ELSAs receive ongoing group supervision from an Educational Psychologist every 6 weeks to support them in their casework. The ELSA project is nationally recognised and there is an ever-increasing body of research to support ELSA work in schools.

Since 2016, Nottinghamshire EPS has trained 249 ELSAs across the county, within mainstream primary, secondary and special schools. The ELSAs are spread across all districts, with slightly more in Mansfield/Ashfield and Rushcliffe currently.

Nottinghamshire's Educational Psychology service provides general and specialist services for children and young people in need and for school's staff. Recent promotions have focused on reduction and early intervention in self-harm and suicidal feelings.

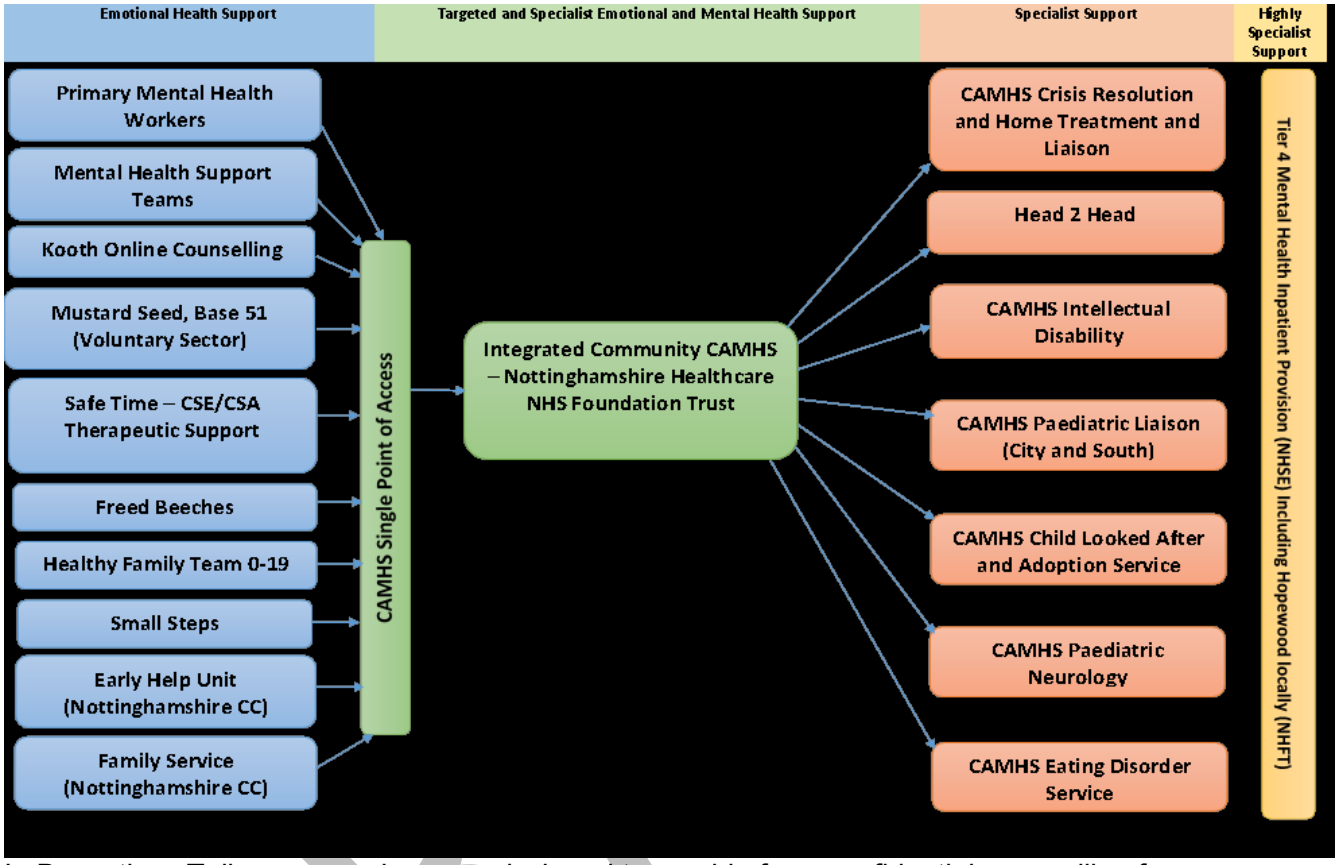
### 4.2 Treatment

'Treatment' services including specialist services are provided predominantly by Nottinghamshire Healthcare NHS Trust under the umbrella of CAMHS (Child and Adolescent Mental Health Services). The information below details the 'treatment' service provision across Nottinghamshire.

**CAMHS – Nottinghamshire Healthcare NHS Trust**

The current service provision across Nottinghamshire County can be seen in Figure 16. This should not be seen as a linear process, however it expected that a level of 'universal' provision can be evidenced prior to referral CAMHS (NHFT) provision.

**Figure 16. Nottinghamshire County Children and Young People's Emotional Wellbeing and Mental Health provision**




In Bassetlaw, Talkzone are also commissioned to provide free, confidential counselling for children and young people aged 11-25.

CAMHS provision is now 'tierless' in Nottinghamshire, and self-referral to all CAMHS services is possible through accessing the Single Point of Access (SPA). CAMHS is funded by Nottinghamshire Clinical Commissioning Groups (CCGs). The main CAMHS services include:

- Community CAMHS (South, West, North locality teams) - provides Community Emotional and Mental Health Services for all children and young people, from birth up to age of 18 in Nottinghamshire. Care is delivered in a locality based, integrated and multi-disciplinary approach which is monitored through routine measurement of outcomes. The service provides a blend of consultation, assessment, evidence-based intervention and multi-agency integrated working which contributes to a continuum of care through the spectrum of need as identified in the THRIVE model.

- CAMHS Crisis Resolution and Home Treatment Service (CRHT) - responds to young people experiencing mental health crisis, offering crisis assessments in the

community and in acute hospital settings, in-reach support to acute hospitals and inpatient mental health settings, and intensive home treatment to those young people deteriorating into crisis.

- CAMHS Intellectual Disability Team –The team work with children and young people up to 18 years old who have an intellectual disability and suffer emotional distress. They work with parents/carers, schools, health professionals, social care and short breaks and offer individual tailored advice and strategies to support the young person.

- CAMHS Eating Disorder Team – They assess and provide a range of treatment options for children and young people up to 18 years old with a moderate/significant diagnosable eating disorder. The team have taken part in the national Avoidant Restrictive Food Intake Disorder (ARFID) pilot. This cohort of young people with ARFID have been identified as a group who currently do not meet service thresholds and therefore an unmet need. The pilot aims to develop a delivery model for these young people, acknowledging that a multi-disciplinary approach is required to meet their needs.

- CAMHS Children Looked After and Adoption Team – The team works with children and young people up to 18 years old who are looked after and living away from their birth parents, in the care of Nottinghamshire Children's Services. These children and young people may be living with foster carers or living in residential care. The team will also offer specialist consultation and support to children and young people who have been adopted, and their families.

- Head2Head - aims to offer accessible and timely mental health assessment and intervention to those vulnerable groups of young people who may be experiencing first episode psychosis, be involved in the criminal justice system, and have dual diagnosis needs or displaying harmful sexual behaviour.

**Neurodevelopmental disorder services**

Neurodevelopmental disorders, including attention deficit hyperactivity disorder (ADHD) and Autism Spectrum disorders (ASD) commonly present with behaviour difficulties alongside atypical patterns of development. ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. ASD is a lifelong spectrum condition which affects how a person communicates with and relates to other people and the world around them, but is also very variable and although defined by core difficulties with social communication and interaction together with inflexibility of thinking and behaviour, these difficulties can manifest in different ways in different individuals.

The behaviours that children with ADHD and ASD present with can also occur in children without such diagnoses and may also be attributed to many other factors such as adverse home environments, abuse and neglect and attachment difficulties.

In Nottingham and Nottinghamshire pathways are in place to ensure that that where a child or young person presents with behaviour which challenges or may be indicative of a neurodevelopmental disorder health, care and education professionals are all involved to ensure that the right support at the right time is provided.

The Long Term Plan (2019) states children and young people must wait less time for a diagnostic assessment, have more access to support within the community and volunteers should be supported in new service models. These three priorities are fundamental within the service model.

NICE guidance NG87 for ADHD (2018) reinforces the importance of parenting programmes and early support prior to diagnosis. Similarly, NICE guidance (CG128) reinforces the need to identify developmental or behavioural concerns about a child or young person with parents or carers and the child or young person, discuss sensitively the possible causes, which may include autism, emphasising that there may be many explanations for the child's or young person's behaviour.

In 2018 a review of Nottinghamshire's concerning behaviour took place and identified that further work is required to strengthen the pathway. It found that the early intervention pathway needed strengthening and the diagnostic process required improvement. In response to the first recommendation a pilot was initiated throughout the county.

**Small Steps**

The Nottinghamshire Small Steps service offers parenting programmes, 1:1, peer support and group work to children and young people and their families with behaviour which is indicative of ASD and ADHD. Following an independent review of the service a number of improvements were proposed and these are managed by a steering group.

The role of the Small Steps service is to work with children and young people (aged 0-18) and their families/carers. The service supports children and young people who present with behavioural/ conduct which is indicative of ASD and or ADHD. The service's aim is to provide families and carers with the tools and support to support and modify behaviour and where appropriate sign post for diagnostic assessment and/or mental health support.

The service aims to work with 3000 Families per year in the County providing interventions within a multidisciplinary pathway, utilising consultation and advice from Clinical Psychology, Educational Psychology and Paediatrics ensuring that children and young people have their needs met.  Drop in groups and evidence-based models of support include:

*New Forest Parenting Programme*
Parent training is recommended as the first-line treatment for attention-deficit/hyperactivity disorder (ADHD) in preschool children. The New Forest Parenting Programme (NFPP) is an evidence-based parenting program developed specifically to target preschool ADHD. Parents are made aware of symptoms and signs of ADHD and the ways in which they may affect their child's behaviour and their relationship with their child. Parents also learn strategies for managing their child's behaviour and attention difficulties.

*Cygnet*
Cygnet is a parenting support programme for parents and carers of children and young people with a diagnosis of autistic spectrum disorder (ASD). The programme aims to increase parents' confidence in understanding of Autism and managing their child's behaviour. Cygnet combines practical strategies and support for parents including autism and its diagnosis, communication strategies, sensory issues, understanding and managing behaviour.

*Sleep Tight programme*
Offers training regarding poor sleep routines and sleep associated problematic behaviours. The Sleep Tight programme has been produced in partnership with Professor Heather Elphick from Sheffield Children's Hospital's sleep clinic.

In Bassetlaw, APTCOO is commissioned to provide the support for children, young people and their families where there are behaviours indicative of, or a diagnosis of ASD or ADHD and the Sleep Charity is commissioned to provide support and education for all children, from 1-19 years where there are sleep difficulties.

Referrals to Community Paediatrics follow the Bassetlaw Pathway and are made by educational settings or the Healthy Families Team.

**Community Paediatrics**

In Nottingham and Nottinghamshire diagnostic assessment of children and young people presenting with possible neurodevelopmental disorders is undertaken by the Community Paediatric services, except for a small number of children and young people where there are significant mental health concerns, where the assessment may be arranged within the Specialist CAMHS service.

In Nottinghamshire, referrals for neurodevelopmental assessment all come via the Concerning Behaviour Pathway. This ensures that information is gathered from all relevant sources (e.g. parents, and school) to build up a thorough understanding of the child or young

person and family's needs prior to referral for diagnostic assessment, ensuring that assessment is required, and that support is offered pending that assessment.

The only exceptions are if there are "red flags" warranting urgent paediatric assessment, when paediatric assessment may be arranged without the initial steps in the pathway.

Red flags include:

- Significant delay in development in a preschool aged child
- Developmental regression at any age
- Concerning behaviours associated with medical conditions warranting paediatric assessment e.g. seizures.

The table below shows the number of referrals received, assessments and follow up work undertaken between June 2018 and June 2019. It should be noted that during some of this time that where there is a reduction in referrals from December 2018 that this may be due cases awaiting assessment in Small Steps, rather than a reduction in need.

**Table 10 – Numbers of referrals, assessments and follow up work undertaken by community paediatricians in Sherwood Forest Hospital (SFHT) and Nottingham University Hospital (NUH)**

| | | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SFHT** | Referrals Received (incl. red flags) | 54 | 78 | 46 | 25 | 32 | 24 | 12 | 7 | 7 | 4 | 12 | 10 | 12 |
| **SFHT** | Referrals Rejected | 40 | 37 | 25 | 45 | 44 | 49 | 33 | 13 | 18 | 19 | 19 | 15 | 12 |
| **SFHT** | Assessment (Patients) | 103 | 101 | 102 | 135 | 101 | 118 | 83 | 86 | 90 | 44 | 65 | 76 | 60 |
| **SFHT** | ASD Follow up (patients) | 176 | 203 | 157 | 198 | 209 | 252 | 211 | 260 | 254 | 283 | 203 | 230 | 246 |
| **SFHT** | ADHD Follow up (patients) | 126 | 144 | 172 | 249 | 177 | 231 | 213 | 239 | 200 | 302 | 231 | 255 | 268 |
| **NUH** | Referrals Received (Pre-vetting) | 73 | 81 | 44 | 39 | 38 | 52 | 42 | 50 | 38 | 40 | 39 | 50 | 28 |
| **NUH** | Referrals Rejected | 16 | 29 | 40 | 22 | 26 | 26 | 43 | 20 | 22 | 26 | 13 | 25 | 24 |
| **NUH** | Assessment (individuals) | 38 | 36 | 34 | 41 | 79 | 57 | 33 | 49 | 32 | 48 | 33 | 26 | 38 |
| **NUH** | ASDF - ASD Follow-up | 81 | 84 | 51 | 54 | 77 | 86 | 55 | 102 | 65 | 82 | 56 | 65 | 85 |
| **NUH** | ADHD Medicine Reviews | 80 | 88 | 22 | 157 | 175 | 180 | 39 | 69 | 68 | 76 | 28 | 78 | 80 |
| **NUH** | ADHD Treatment | 14 | 11 | 7 | 26 | 21 | 29 | 13 | 14 | 7 | 13 | 1 | 15 | 19 |

Once referred, an initial paediatric appointment will be offered to review the concerns, conduct a general assessment of the child's health and development and decide if a more detailed assessment is required.

Where a diagnosis of ADHD is suspected, further assessment will include gathering information from school and sometimes direct observation in the classroom. Standardised behavioural questionnaires (e.g. Swann, Vanderbilt, Conners) are used to support diagnosis. Once a diagnosis is confirmed a management plan will be agreed which will usually include referral for a parenting programme targeted towards ADHD. Medication may be initiated and for these children there will be long term monitoring and adjustment of medication by the paediatrician and ADHD nurse specialists.

Where a diagnosis of ASD is suspected further paediatric assessment will include a detailed developmental history and observational assessment, and information from school in all cases. However, each assessment will be tailored to the individual situation and may also include observation in an environment with other children, referral for a speech and language assessment, Occupational therapy assessments (where coordination difficulties are prominent), medical tests such as Magnetic resonance imaging (MRI) scans, electrocardiogram (EEG), hearing and vision or blood tests, and more detailed educational assessment e.g. by an educational psychologist if available. Once all this information is gathered a diagnostic report is completed by the paediatrician, and information regarding the diagnosis and its implications shared with parents. Referrals are made for post diagnostic support e.g. in the form of a Cygnet Course, for speech or occupational therapy, or support over specific issues such as behaviour, continence or sleep. Children and young people are only followed up long term in the paediatric service if there are associated medical problems requiring paediatric support.

Colleagues from the specialities have fed back that a more integrated assessment and treatment pathway would be beneficial to strengthen the assessment and treatment pathway and avoid young people not having their needs met in an integrated way.

**Digital interventions**

Nationally there is a drive to increase digital interventions for tackling mental health issues in children and young people due to the increasing prevalence of mental health issues alongside a low general understanding.

Digital health interventions, including computer-assisted therapy, smartphone apps and wearable technologies, have been seen to have enormous potential to improve uptake and accessibility, efficiency, clinical effectiveness and personalisation of mental health interventions. However, current evidence regarding its efficacy is still unclear and one systematic review found that more research was needed before definitive conclusions could be drawn.[27]

Another systematic review looking at 63 studies of e-mediated or computer-based therapies found that computer-based CBT showed promise in reducing depression and reducing anxiety in young people. However, again it acknowledged the evidence was predominantly of low quality, with limited data, inadequacies in study design and unreliable outcome measures.[28]

All recent research acknowledges that the digital climate is a fast evolving one and does yield potential opportunity, but that more research is needed into its efficacy and best delivery. Locally there has been positive feedback for Kooth, an online counselling service for children aged 11 and over, which also provides access to a community of peers.

The onset of COVID-19 has necessitated a rapid switch from face-to-face to digital interventions. Early evidence from providers and from young people indicates that some children and young people do not wish to access support digitally. However, the number of young people accessing KOOTH on-line support has been steadily increasing since 17/18. Further work is being undertaken across the region by NHS England to understand children and young people's use of digital support and to develop regional guidelines on implementing digital services.

NICE have published a number of guidelines on to support positive development and to build emotional capacity and resilience among children and young people.

**Services for 18-25 year-olds**

**Adult IAPT Services**

IAPT services offer a range of NICE recommended therapies for a wide range of common mental health issues including depression, anxiety, obsessive compulsive disorder and post-traumatic stress disorder in line with a stepped care model. Low intensity interventions are offered to those with mild to moderate anxiety and depression. These include guided self-help, computerise Cognitive Behavioural Therapy (CBT) and group-based programmes. For those who do not benefit from a lower intensity intervention, higher intensity interventions such as CBT, psychotherapy and counselling can be accessed.

**Transition from CAMHS to Adult Mental Health services**

Transition between adolescent and adult services is a difficult time for service users (see section 7). During 2017/18 and 2018/19, there was a national Commissioning for Quality and Innovation (CQUIN) payment in place to focus on and improve the quality of care received by those in transition. This process has involved the creation of 'transition champions' and also a new transition protocol which involves a joint panel of adult and children's staff to facilitate the process. In 2018/19, 70 young people left the CAMHS service

to receive another commissioned service, and 19 were discharged to primary care. Of these, 79 young people left the CAMHS service with a plan in place, but a survey of patients reported that only 55% of those who replied felt that they were prepared, pre-transition. Transition is a key area which needs to be addressed as part of the provision of a 0-25 services.

During the two years of the CQUIN the following has been achieved;

- A clear **transition protocol** is in place across multiple partner providers utilising NICE guidance for the management of transitions from CAMHS to Adult Mental Health
- A quarterly meeting between CAMHS and Adult Mental Health leads has been established to ensure continued compliance to the transition protocol and maintain relationships
- CAMHS and Adult Mental Health have identified **Transition Champions** who meet on a monthly basis to ensure timely response to all children and young people approaching transition age of 17.5 years
- Three transition questionnaires have been developed to monitor transition from young person perspective at three points of the transition process.

**Table 11: Transition Case Note Audit**

| | **17/18** | **18/19** |
|---|---|---|
| Percentage of young people appropriate to transition to AMH (Adult Mental Health) services with a transition plan in place | 80% | 100% |
| Percentage of young people who have been part of joint agency planning prior to transition to AMH services | 93% | 100% |
| Percentage of young people who have been discharged back to Primary Care with a discharge plan that has been developed by and shared with the young person | 62.5% | 100% |

*Source: 17/18 and 18/19 NHFT CQUIN Report*

The data above shows there has been a significant improvement in the transition process over the two year period, not only in the relationships that have been built between CAMHS and Adult Mental Health but in the number of young people who have been involved in their transition process and the number who have a clear transition plan in place. This improvement in process will hopefully ensure that young people feel that they have a positive transition experience and therefore achieve better outcomes from their therapeutic interventions.

Transition Survey

There continues to be challenges with ensuring young people complete the pre and post transition survey as they are not mandatory, and the current completion rate is low.

**Table 12: Transition Survey Results**

| | 17/18 | 18/19 |
|---|---|---|
| Percentage of young who in their pre-transition survey reported feeling prepared at point of transition/discharge | 68% | 92% |
| Number of young people who in their post-transition survey reported that they are meeting their transition goals | 16% | 55% |

*Source: 17/18 and 18/19 NHFT CQUIN Report*

There has been a positive increase in the experience of transition for young people (those who responded to the survey) and more young people feel that they are meeting their transition goals once they are accessing AMH services.

Whilst transitions between CAMHS and Adult Mental Health (provided by Nottinghamshire Healthcare NHS Trust) have improved there is still a gap in transitions between CAMHS and IAPT services. Transitions will be a key focus of the 0-25 developments.

Young people aged 18-25 can access local IAPT services. These provide psychological assessment and treatment (talking therapies) for common mental health problems. This includes depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress, as well as supported self-help.

Those with more severe mental illness can also access local mental health teams and community mental health teams. These services require a GP referral.

A more detailed description of all services available to support adults with mental health difficulties, including third sector services can be found in the JSNA Mental Health (Adults and Older People) 2017.

**Targeted provision for vulnerable groups**

Specific services are commissioned across Nottingham and Nottinghamshire ICS and including Bassetlaw, which are evidence-based including:

- Forensic CAMHS team
- CAMHS Health and Justice Speech and Language Therapist and Clinical Psychology
- Bespoke therapeutic services for victims of sexual abuse or exploitation
- Paediatric Sexual Assault Referral Centre (Regional footprint commissioned by NHS England and Police and Crime Commissioner)

- Children's Independent Sexual Violence Advisors (commissioned by Police and Crime Commissioner)

**You Know Your Mind**

Since April 2018, the You Know Your Mind Project has been operating across Nottinghamshire County, supporting looked after children aged 0-17 and care leavers aged 18-25 who are experiencing poor or deteriorating mental health.

Through a 'Different Conversation', the child or young person is empowered to determine what they think will genuinely improve their mental health outcomes and make every day a 'good day'. By offering children and young people the choice and control over their mental health support, personalised and non-clinical support arrangements have been commissioned for over 300 children and young people, including community-based activities.

Evaluation of outcomes are complete and being reviewed by commissioners.

**Inpatient Provision**

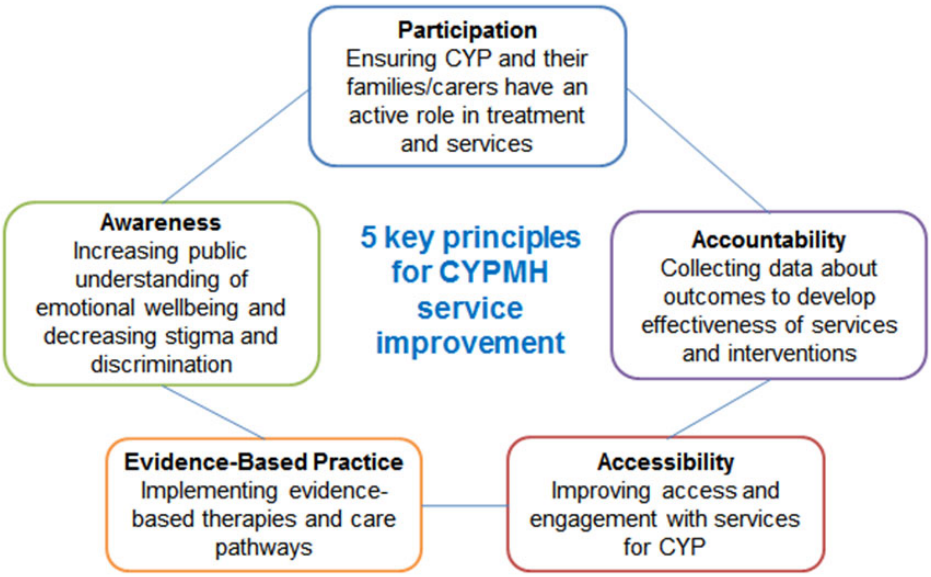
Children and young people mental health Inpatient provision is commissioned by NHS England Specialised Commissioning. Within Nottinghamshire there is the Hopewood inpatient unit that enables children and young people to remain close to home during their inpatient stay, where bed availability allows. If a young person is placed outside of Nottinghamshire the system works together to repatriate the young person at the earliest opportunity. The Hopewood site includes inpatient provision for dedicated specialist eating disorders and psychiatric intensive care unit along with inpatient perinatal services.

**CYP-IAPT (Improving Access to Psychological Therapies)**

The Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT) is a change programme for existing services delivering CYP mental health care. It aims to improve outcomes and experience of care for children, young people and their families by increasing access to effective services and evidence-based therapies through system-wide service improvements.

The programme works with existing services that deliver mental health care for children and young people across the system (provided by NHS, Local Authority, Voluntary Sector, Youth Justice) and aims to create, within teams, a culture of full collaboration between child, young person and/or their parents or carers by embedding the following principles:

**Figure 17: Five key principles for CYPMH service improvement**




## 5. Local Views

### Children and Young People

In 2017-18, the MH:2K project was rolled out in Nottingham and Nottinghamshire. It provides a powerful model for engaging young people in conversations about mental health and wellbeing.

The MH:2K Local Advisory Panel drives work to improve children's emotional and mental health outcomes and links closely to the local *Future in Mind* transformation plan.

The project has recruited over 30 young people as Citizen Researchers and has delivered a series of workshops and roadshows that have engaged over 670 local young people. Based on this engagement, five priorities for children and young people's mental health in Nottingham and Nottinghamshire have been identified along with a set of recommendations for action. These are:

### Stigma and public awareness

Key issues include: lack of education and awareness of mental health; use of negative language; fear of judgement; lack of visibility of support services; and, stigma being affected by different cultural and religious viewpoints, as well as notions of masculinity.

Recommendations:

i. Mental health education should be provided to children and young people from an early age, ideally on a compulsory basis.
ii. Harness social media as a positive tool to challenge stigma and raise awareness among young people.
iii. Provide information in discreet ways, to direct young people to the support available, without fear of exposure in public.
iv. Target information specifically for religious and cultural groups.
v. Use peer-to-peer approaches to combat stigma among young people.

**Treatment and therapies**

Key issues include: long waiting times and insufficient duration of treatment; poor communication with professions and not feeling understood; opening hours that didn't work well for young people; treatment not meeting individual need; and, transitions from child to adult services not being smooth.

Recommendations:

i. Young people should be able to access support on a 24/7 basis.
ii. Increase the coverage of staff across mental health services, so that young people are able to access help when they need it.
iii. Provide treatment based on a continuous assessment of the individual's needs and stop limiting treatment to a specified number of weeks.
iv. Provide training for professionals to equip them to communicate more effectively with young people.
v. Provide treatment in spaces where children and young people feel comfortable.

**Education and prevention**

Key issues include: barriers to seeking help in schools including not being aware of help available; not having enough privacy when seeking help in schools; teachers not equipped to spot the signs or support young people with mental health issues; and, academic pressure.

Recommendations:

i. Increase the privacy and confidentiality of support.
ii. Provide training for all members of staff on mental health.
iii. Make sure all students are aware of the support available, inside and outside school.
iv. Offer informal peer support for mental health and wellbeing.

v. Schools should do more to alleviate stress and help students cope with exam pressure.

**Cultures, genders and minorities**

Key issues include: lack of mental health education reaching religious and ethnic minority groups; barriers to access services for underrepresented groups; LGBTQ+ facing homophobia and transphobia, including bullying, within education and on social media; pressures facing young males, including ideas of masculinity and being told to 'man up'; and, addition to drugs, alcohol, gambling, social media, gaming and pornography.

Recommendations:

i. Services need to work more closely with the voluntary sector to reach minority groups with knowledge and awareness around mental health.
ii. Where possible, young people should be given a choice of professionals to speak to, with consideration of their gender, age, or cultural preferences.
iii. Campaigns and programmes should prioritize young men to tackle 'toxic masculinity'.
iv. Schools and teachers must take firmer action on homophobia and transphobia, to create an environment where LGBTQ+ students feel safe.
v. Deliver PSHE or Citizenship lessons to ensure that all students have a good understanding of mental health.

**Family, friends and carers**

Key issues include: feelings of isolation; fear of being different; parents having lack of knowledge about mental health; and, finding it hard to communicate with friends and family about mental health.

Recommendations:

i. Run PHSE lessons in school to talk to friendship groups about self-esteem and mental health.
ii. Ensure that students can seek support without their friends and peers finding out.
iii. Invite parents to compulsory talks about mental health & stress throughout the school years.
iv. Consider innovative ways to target and engage parents in conversations about mental health.

Further local consultation undertaken with young people around their experiences of COVID -19 indicates that their use of social media has increased during this time and overall that they found their experience of using social media to be neutral. In addition, 60% of young

people stated that they would like to access information on mental health issues via social media.

Feedback from young people who used the You Know Your Mind project tells us:

- 94% of young people evaluated feel better or a lot better about **their quality of life**
- 85% of young people evaluated feel better or a lot better about **their health and wellbeing**
- 78% of young people evaluated **feel that their support arrangement has improved their confidence and self-esteem**
- 86% of young people evaluated **feel their support arrangement has given them something to look forward to**
- 64% of young people evaluated **feel that their support arrangement has helped them to make friends**

## 6. Evidence of what works

### 6.1 Preventative approaches

Arango et al's review (2018) lists several effective courses of preventative action across populations and age bands.[29] They cite as key features of any preventative approach a strong focus on the wider determinants of good mental health (for example, addressing income inequality) and the development of selective preventative interventions throughout the life course, such as parental training courses for parents of children with specific needs. The review also points out the strong case for investing in processes and systems to improve early identification, such as the routine enquiry about adverse childhood experiences (ReACH).

The key prevention messages from a life-course perspective are:

- Translate scientific evidence for prevention into locally relevant, cost effective public health initiatives, clinical practice and service delivery frameworks
- Invest in mental health prevention and promotion exercises
- Move clinical practice toward risk-oriented detection and intervention, particularly around development of new tools for early detection and quality training for professionals in helping those at risk to understand options, benefits and risks
- Tailor interventions for developmental stage
- Promote multi-disciplinary approaches and improve collaborative infrastructure
- Promote healthy lifestyles
- Encourage school-based interventions

**Parenting Programmes**

As mentioned in the 1001 days JSNA, it is known that parenting behaviour and the quality of the parent-child relationship are strongly associated with children's outcomes.

The Healthy Child Programme (HCP) 0 - 5 brings together the evidence on delivering good health, wellbeing and resilience for every child. This is achieved through a schedule of services covering care of 28 weeks of pregnancy though to age 5 and is delivered as a universal service. The programme includes health promotion, child health surveillance and screening, proving a range of services to families.

The HCP promotes parent-infant interaction and sensitive and attuned parenting as well as screening for poor maternal mental health which helps minimise risk factors and reinforces protective factors for a child's mental health.

Beyond this period, it is known that parents continue to play a vital role in supporting the mental health of young people. The Association for Young People's health (AYPH) conducted a survey looking at the role of parents in supporting young people with mental health problems. The survey was completed by 316 parents of the charity Young Minds parents' network; made up of parents with children with mental health problems who discuss issues and share information online.

It found that parents of adolescents are the most unsupported of all groups of parents, and those who have teenagers with mental health problems seem to be particularly isolated.

The findings identified some common and reoccurring themes that could help improve support for young people at home.[30] These included:

- Development of parent support groups.
- Provision of more practical advice for parents – to successfully navigate crises, avoid escalating the situation and generally manage the young person at home.
- Provision of mentors, advocates or liaison staff for parents – to support and assist in knowing where to go for help, ensuring parents views were considered.
- More consistency in how schools operate as intermediaries and supporters.
- Easier access in relation to early intervention.
- Provision of more consistent, widely available, reliable crisis support.

Parents can access www.helpforparents.org.uk, a website managed by AYPH, which aims to support, advice and provide information to parents about children and adolescents mental health addressing the areas set out above.

**Embedding Whole School Approaches**

Schools play a hugely important role to in supporting the mental health and wellbeing of their pupils, through developing approaches tailored to the needs of their pupils. All schools are

under a statutory duty to promote the welfare of their pupils, including: preventing impairment of children's health or development, and acting to enable all children to have the best outcomes.[31]

Identifying issues promptly and providing early intervention and effective support is crucial. The school role in supporting and promoting mental health and wellbeing can be summarised as:

- **Prevention:** creating a safe and calm environment where mental health problems are less likely, improving the mental health and wellbeing of the whole school population, and equipping pupils to be resilient so that they can manage the normal stress of life effectively. This includes teaching pupils about mental wellbeing through the curriculum and reinforcing this teaching through school activities and ethos;
- **Identification**: recognising emerging issues as early and accurately as possible;
- **Early support**: helping pupils to access evidence based early support and interventions; and
- **Access to specialist support**: working effectively with external agencies to provide swift access or referrals to specialist support and treatment.

Coherent frameworks for early intervention and prevention exist for developing schools resilience. In response to guidance from PHE and the Children and Young People's Mental Health Coalition (2015), Nottinghamshire have developed a mental health and wellbeing pathway based around the eight key principles to achieving whole school approach to mental health (see figure 18).

**Figure 18. Eight principles to promote mental and emotional health and wellbeing in schools and colleges.**


*Source: PHE (2015)*

There is some health economics evidence to suggest that several interventions delivered at schools can be cost effective ventures.[32] These are shown below:

| Activity | Intervention | Benefit-cost ratio | Study population | Summary of evidence |
|---|---|---|---|---|
| **Investing in social and emotional learning** | School based resilience | £5.08: £1 | Pupils in Year 7, Key Stage 3 (Age 11-12) | Costs avoided by NHS and families, and some small impacts on schools. In addition (not quantified in ROI tool), benefits to school and children related to short term improvements in academic performance. |
| | School-based social and emotional learning | £83.73: £1 | 10-year-old children | School-based Social and Emotional Learning (SEL) programmes help children and young people to recognise and manage emotions, set and |

| | | | | |
|---|---|---|---|---|
| | programmes to prevent conduct problems in childhood | | | achieve positive goals, appreciate the perspectives of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively. International evidence shows that SEL participants demonstrate significantly improved social and emotional skills, attitudes, behaviour, and academic performance. |
| **Investing in school-based interventions** | School anti-bullying programme | £1.58: £1 | Children aged between 7 -11 | Outcome evidence on likelihood of avoiding bullying drawn from RCT in Finland. Outcomes per pupil over 4-year period and costs to school of delivery. Benefits to families, schools and health sector. |
| | School-based interventions to reduce bullying | £14.35: £1 | - | Anti-bullying programmes in schools show mixed results, depending on the design of the intervention and its implementation. That said, there is a consensus in the literature that whole-school programmes with a range of components operating at different levels within the school are more effective in reducing the prevalence of bullying than curriculum-based programmes. One high-quality evaluation of a school-based anti-bullying intervention found a 21–22% reduction in the proportion of children victimised. Benefits include improvements in the emotional, physical and social health of victims, school attendance and educational attainment, all of which are associated with better long-term employment and earnings outcomes. |

*Source: Public Health England, Mental health services: cost-effective commissioning (2017)*

More research is acknowledging the important role played by groups and communities in promoting wellbeing.[33] The protective factors which demonstrated the strongest association with mental health and positive behaviours in this systematic review of 55 papers were:

- Positive parent-child relations (e.g. family mealtimes)
- Social support networks including peers and non-familial adults
- High quality neighbourhoods (knowing neighbours, fewer hazards)
- Attendance at religious events (e.g. church services)

**Universal provision**

**Social and emotional wellbeing of children and young people**

NICE has developed guidance to support schools and local government to promote emotional health and wellbeing for teachers and school governors, and for staff in local authority children's services, primary care and CAMHS by specific school setting (either primary or secondary school). The specific details of this can be found following the links in the table below:

| NICE guidelines | Key guidance |
|---|---|
| PH40 Social and emotional wellbeing: early years (2012) | Defines how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. The aim is to ensure universal, as well as more targeted services, to offset the risk of disadvantage. |
| QS128 Early years: promoting health and wellbeing in under 5s (2016) | It includes the following statement:<br>• Statement 1. Parents and carers of children under 5 have a discussion during each of the 5 key contacts about factors that may pose a risk to their child's social and emotional wellbeing. |
| PH12 Social and emotional wellbeing in primary education (2008) | • Comprehensive approach: ensure all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing. Schools to work closely with local authority children's services, CAMHS and other services.<br>• Universal approach: Provide a comprehensive programme to help develop children's social and emotional skills and wellbeing including curriculum, training, support to parents/carers and integrated activities.<br>• Targeted approaches: targeting children showing early signs of anxiety or emotional |

| | |
|---|---|
| | distress or at risk of developing disruptive behavioural problems; and, parents or carers of children showing difficulties. |
| PH20 Social and emotional wellbeing in secondary education (2009) | It includes the following (extract).<br>• Adopt organisation-wide approaches to promoting the social and emotional wellbeing of young people including curriculum and extra-curriculum provision.<br>• Provide a safe environment which nurtures and encourages young people's sense of self-worth and self-efficacy.<br>• Provide a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying.<br>• Work in partnership with parents, carers and other family members.<br>• Develop partnership between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing. |
| PHE Promoting children and young people's emotional health and wellbeing: A whole school and college approach (2015) | Outlines 8 key principles for headteachers and college principals to promote emotional health and wellbeing:<br>1. Leadership and management that supports and champions efforts to promote emotional health and wellbeing;<br>2. An ethos and environment that promotes respect and values diversity;<br>3. Curriculum, teaching and learning to promote resilience and support social and emotional learning;<br>4. Enabling student voice to influence decisions;<br>5. Staff development to support their own wellbeing and that of students;<br>6. Identifying need and monitoring impact of interventions;<br>7. Working with parents/carers;<br>8. Targeted support and appropriate referral. |

### 6.2 Treatment approaches

A comprehensive set of NICE guidelines exist for treatment approaches for specific disorders and for building responses to specific conditions too. A digest of these is reported below:

| Mental Health Disorder | NICE guidelines and summary |
|---|---|
| **Depression** | • NG134 Depression in children and young people: identification and management (2019)<br>• QS48 Depression in children and young people includes the following quality statements:<br>  ○ Statement 3 Children and young people with suspected severe depression and at high risk of suicide are assessed by CAMHS within a maximum of 24 hours of referral.<br>  ○ Statement 4 Children and young people with suspected severe depression but not at high risk of suicide are assessed by CAMHS within a maximum of 2 weeks of referral. |
| **Anxiety** | • QS53 Anxiety disorders (2014) – covers generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder.<br>• CG159 Social anxiety disorder: recognition, assessment and treatment (2013)<br>• NG116 Post-traumatic stress disorder (2018)<br>• CG31 Obsessive Compulsive Disorder and Body Dysmorphic Disorder (2005) |
| **Bipolar disorder, psychosis and schizophrenia** | • CG185 Bipolar disorder: assessment and management (2014)<br>• CG155 Psychosis and schizophrenia in children and young people: recognition and management (2013)<br>• QS102 Bipolar disorder, psychosis and schizophrenia in children and young people (2015) includes the following quality statement:<br>  ○ Statement 1. Children and young people who are referred to a specialist mental health service with a first episode of psychosis start assessment within 2 weeks. |
| **Personality disorders** | • CG77 Antisocial personality disorder: prevention and management (2009)<br>• CG78 Borderline personality disorder: recognition and management (2009) |
| **Self-harm** | • CG16 Self-harm in over 8s: short-term management and prevention of recurrence (2004)<br>• CG133 Self harm in over 8s: long-term management (2011) |
| **Suicide prevention** | • NG105 Preventing suicide in community and custodial settings (2018) |

| | |
|---|---|
| **Behavioural (or conduct) disorders** | • CG158 Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013)<br>• QS59 Antisocial behaviour and conduct disorders in children and young people (2014) |
| **Hyperactivity disorders** | • NG87 Attention deficit hyperactivity disorder: diagnosis and management (2018)<br>• QS39 Attention deficit hyperactivity disorder (2018) |
| **Autism** | • CG128 Autism spectrum disorder in under 19s: recognition, referral and diagnosis (2011)<br>• CG170 Autism spectrum disorder in under 19s: support and management (2013)<br>• QS51 Autism (2014)<br>  ○ Statement 1. People with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral. |
| **Eating disorders** | • NG69 Eating disorders: recognition and treatment (2017)<br>• QS175 Eating disorders (2018) includes the following quality statement:<br>  ○ Statement 1 People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults. |

**Table 12. NICE recommended psychological interventions**

| | Condition | Psychological therapies | Source |
|---|---|---|---|
| **Step 2: Low-intensity interventions (delivered by PWPs)** | Depression | Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme | NICE guidelines: CG90, CG91, CG123 |
| | Generalised anxiety disorder | Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT | NICE guidelines: CG113, CG123 |
| | Panic disorder | Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT | NICE guidelines: CG113, CG123 |
| | Obsessive-compulsive disorder | Guided self-help based on CBT | NICE guidelines: CG31, CG123 |
| **Step 3: High-intensity interventions** | Depression<br><br>For individuals with mild to moderate severity who have not responded to initial low-intensity interventions | CBT (individual or group) or IPT<br>Behavioural activation<br>Couple therapy[d]<br>Counselling for depression<br>Brief psychodynamic therapy<br><br>Note: psychological interventions can be provided in combination with antidepressant medication. | NICE guidelines: CG90, CG91, CG123 |
| | Depression<br><br>Moderate to severe | CBT (individual) or IPT, each with medication | |
| | Depression<br><br>Prevention of relapse | CBT or mindfulness-based cognitive therapy[e] | |

**System-wide guidance**

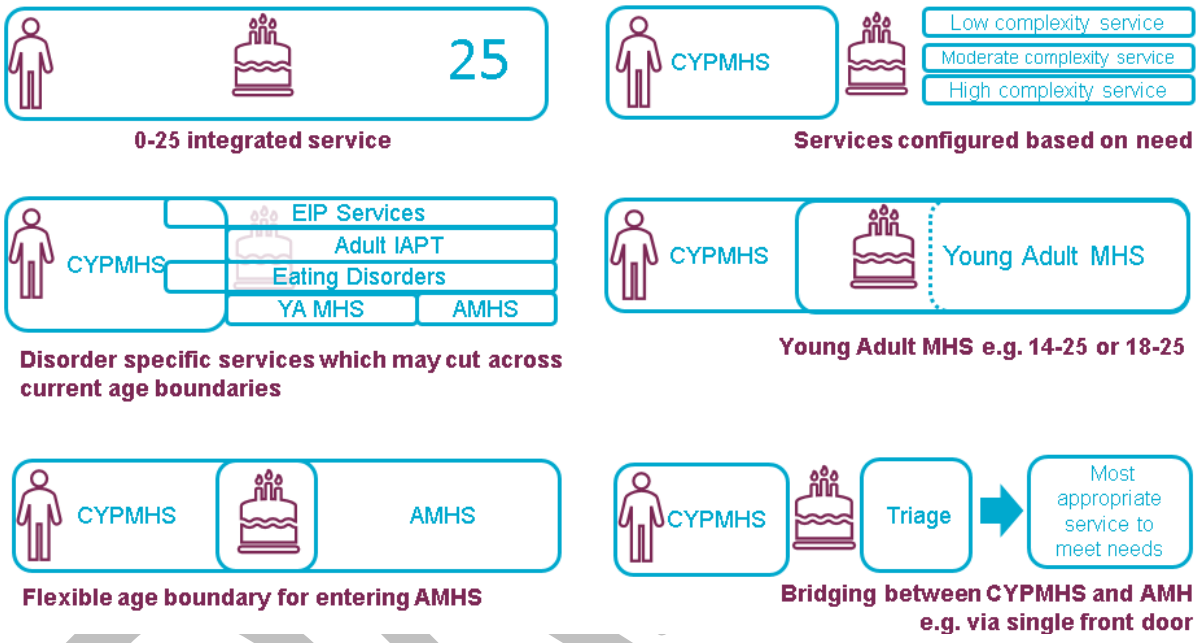
| | |
|---|---|
| **Child abuse and neglect** | • NG76 Child abuse and neglect (2017) – guideline covers recognising and responding to abuse and neglect in children and young people aged under 18.<br>• CG89 Child maltreatment: when to suspect maltreatment in under 18s (2009) |
| **Transition to adult services** | Transitioning from CAMHS to adult mental health services (AMHS) can be daunting for children and their families, especially if the young person will not receive the same level of support from adult services. In some cases, young people will not be eligible for any support from AMHS.<br><br>• NG43 Transition from children's to adults' services for young people using health or social care services (2016)<br>• QS140 Transition from children's to adult's services (2016) |

**Re-shaping services for 18-25 year-olds**

Evidence shows when proposing pathway redesign models of care for 18-25, they must be person-centred, holistic, delivered closer to home and are age appropriate, with transition to adult services based on need not age.

Figure 19 below details service models that have been developed across the country to meet the needs of the 18-25 cohort.

**Figure 19. Service models for 0-25 year olds**




*Source: NHS England*

## 7. What is on the horizon?

The onset of the COVID -19 pandemic is likely to increase the number of children and young people developing mental health problems. There may also be an increase in children and young people presenting with mental health issues for the first time. Emerging evidence indicates that children and young people with neurodevelopmental issues are likely to being more severely impacted in terms of mental health and well-being. Overall, the impact of COVID has fallen more heavily on communities already facing multiple disadvantages.

Over a 10-year period the Long Term Plan explains what the NHS aims to do to improve CYP mental health and wellbeing from ages 0 – 25. It seeks to expand the mental health

services for CYP including a robust and accessible mental health crisis team. It also sets out how to reduce unnecessary delays and deliver care in ways that young people, their families and carers have highlighted as working better for them.

The requirement to develop a comprehensive 0-25 service will require much closer working between adult and children's services, both at provider and commissioner level and across the wider system.

Additionally, the Long Term Plan recognizes the need for embedding a whole school approach, including introducing mental health support teams and focusing resources on early intervention on those who those most likely to face mental health problems. In addition to this, the OFSTED Inspection Framework now includes mental health provision, which may also drive a greater focus on developing whole school approaches.

However, the NHS Long Term Plan does not describe change in the same whole system way as Future in Mind did.

The Long Term Plan has a continued focus on increasing the workforce for CYP mental health. Table 13 shows expected workforce increase for Nottingham and Nottinghamshire up to 2023/2024, split by Community CAMHS, Crisis and 18-25 pathway. A Workforce Development Steering Group is in place and will have oversight of plans to increase the workforce and identify areas of need.

**Table 13: Workforce Increase to 2023/24**

| | | NHS Five Year Forward View | | NHS Long Term Plan | | |
|---|---|---|---|---|---|---|
| | | Year 4 | Year 5 | | | |
| | | Year 1 2019/20 | Year 2 2020/21 | Year 3 2021/22 | Year 4 2022/23 | Year 5 2023/24 |
| Workforce additional required to deliver LTP (cumulative) | <u>Community services for CYP aged under 18</u> | | | | | |
| | Psychiatrist- consultant | - | - | 0.5 | 1.4 | 2.2 |
| | Nursing/midwifery | - | - | 1.7 | 4.3 | 7.0 |
| | Psychologist | - | - | 1.4 | 3.4 | 5.6 |
| | Psychotherapists and psychological professionals | - | - | 0.8 | 2.1 | 3.3 |
| | Support to clinical staff/ other therapists | - | - | 1.0 | 2.6 | 4.2 |
| | Social worker | - | - | 0.3 | 0.9 | 1.4 |
| | Admin | - | - | 1.0 | 2.6 | 4.2 |
| | | | | **6.8** | **17.2** | **27.9** |
| | <u>Crisis services for CYP</u> | | | | | |
| | Psychiatrist- consultant | - | - | 0.1 | 0.2 | 0.3 |
| | Psychiatrist- non consultant | - | - | 0.1 | 0.2 | 0.3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Nursing/midwifery | - | - | 4.3 | 8.6 | 12.9 |
| | Psychologist | - | - | 0.4 | 0.8 | 1.2 |
| | Occupational Therapists | - | - | 0.4 | 0.8 | 1.2 |
| | Support to clinical staff/ other therapists | - | - | 2.7 | 5.5 | 8.2 |
| | Social Worker | - | - | 0.4 | 0.8 | 1.2 |
| | Admin | - | - | 1.2 | 2.3 | 3.5 |
| | | | | **9.5** | **19.1** | **28.7** |
| | Community services for CYP aged 18-25 | | | | | |
| | Psychiatrist- consultant | - | 0.3 | 0.5 | 0.8 | 1.0 |
| | Nursing/midwifery | - | 0.9 | 1.7 | 2.4 | 3.2 |
| | Psychologist | - | 0.7 | 1.3 | 2.0 | 2.5 |
| | Psychotherapists and psychological professionals | - | 0.4 | 0.8 | 1.2 | 1.5 |
| | Support to clinical staff/ other therapists | - | 0.5 | 1.0 | 1.5 | 1.9 |
| | Social Worker | - | 0.2 | 0.3 | 0.5 | 0.6 |
| | Admin | - | 0.5 | 1.0 | 1.5 | 1.9 |
| | | | | **6.7** | **9.8** | **12.7** |

A proportion of the workforce are at retirement age which will have an impact on capacity and capability over the coming years. Further work is required to understand what this means locally and that there are recruitment plans in place to mitigate any gaps in provision.

Following the recommendation in the Nottinghamshire Director of Public Health report in 2017 that all agencies should work together to prevent ACEs in order to reduce health and social inequalities, work has continued on developing training and support for professionals across the system. A number of training programmes and learning packages have been rolled out at all levels of the system; trauma-informed approach is included in commissioning intentions and service specifications; and consideration of ACEs is a fundamental part of the All Ages Mental Health Strategy.

It is unclear as to whether there will be additional funding for Local Authorities and wider services over the coming years, however, it is likely that there will be further funding cuts, resulting in further re-shaping of services and further reductions in universal services. This will impact on the reach and effectiveness of the whole systems approaches to Children and Young People's Mental Health.

The onset of the COVID-19 pandemic has increased the drive towards providing more digitalized support in order to widen access and reduce waiting times.

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## What does this tell us?

### 8. Unmet needs and service gaps

Many services in the public sector are still commissioned in isolation. With mental health in particular, this is untenable due to the complexity of interactions between different risk factors and behaviours. For example, parental substance misuse may cause poverty and familial stress, which may result in a mental disorder, which then becomes a risk factor for other behaviours such as crime or risk-taking. There needs to be a whole-systems approach to mental health commissioning.

The 1001 days JSNA (2019) identified the need to better identify and support women with mild to moderate mental health needs and those with parent-infant interaction difficulties.

National prevalence data suggests that 5.5% of 2- 4 year olds have mental health needs but there are currently no dedicated infant mental health services commissioned in the County.

The Self Harm JSNA (2019) identifies that there is a gap in support for people of all ages who self-harm or who are at risk of self-harm, but do not meet acceptance criteria for clinical/mental health services.

Transition to adult care is still cited by young people as needing improvement, and although work has been undertaken recently to improve the process, there could still be more done to improve the quality of the experience. Many patients do not currently return their post-transition surveys, however, and alternative methods of assessing the quality of transition may need to be undertaken.

More emphasis is needed on targeting inequalities seen in mental health and wellbeing particularly for looked after children, young carers, children with a special educational needs and disabilities and Lesbian Gay Bisexual Transgender, queer (or questioning) and others (LGBTQ+) young people.

Local CAMHS are only commissioned to work with children and young people with neurodevelopmental issues where mental health is the primary presenting issue. There is a significant need for children, young people, adults and families to be supported to understand the impact that neurodevelopmental needs have on their functioning and support with developing positive coping strategies. This is being partially addressed by the provision of Small Steps, however, demand for the service exceeds capacity.

There is also a gap around lack of formal psychology input specifically where children have adverse childhood experiences, or below CAMHS threshold emotional health difficulties e.g.

anxiety which can impact on a behavioural/developmental presentation, and lack of formal cognitive assessments to determine whether behavioural/developmental needs are related to an underlying learning disability.

There are gaps around mental health support for children and young people in schools. Whilst there is additional investment in Mental Health Support Teams for Schools, the national ambition for rollout is coverage of 25% of schools by 2023/24. This means that a significant number of schools in Nottinghamshire will not have access to these teams.

Additionally, there appears to be a gap for school staff in accessing support for their own mental health and well-being. National data from the 2019 Teacher Well-Being Index indicates that 78% of all education professionals experience either behavioural, psychological or physical symptoms due to their work and a large proportion of these were reluctant to seek support. Local anecdotal evidence indicates that staff stress levels have increased as a result of COVID 19 and that further work needs to be undertaken to address this.

## 9. Knowledge gaps

There is currently a gap in knowledge around access to services, particularly for the wide range of online support contact. We know that over half of those in the county who may have mental health support needs are not accessing CAMHS services, but we do not know how many are accessing any services.

The precise prevalence of mental health and wellbeing in CYP in Nottinghamshire is still unknown. Data on the prevalence has been extrapolated based on NHS Digital estimates. Since April 2018 all NHS commissioned providers have been developing their systems to be able to provide service level data to the Mental Health Services Data Set (MHSDS). Therefore, we are now in a better position to understand local need and further develop services to meet this need. Further work is also required to understand the impact of inequalities within Nottinghamshire.

Furthermore, there are many interventions being undertaken in the community which are not monitored or evaluated. An audit of these should be undertaken and a co-ordinated evaluation.

Parenting confidence and capability remains a largely unknown factor. Many parents may express doubts about their skills but may not access parenting courses on offer due to time availability or perceived stigma in attending such a course. We need to engage with parents to understand what their support needs are.

There is a lack of information about the needs or even the composition of some groups, especially those with protected characteristics. In particular, we do not have robust data on young carers across the county, a group that is likely to have significant mental health and wellbeing needs. There are also groups who we know exist, but for whom we do not fully understand needs, for example children under the age of five. Locally, there are significant gaps around data collection around inequalities, despite national evidence that highlights poor outcomes for a number of groups including children and young people who are disabled, LGBTQ+ and from minority ethnic groups. We do not routinely collect data on the number of LGBTQ+ young people who access our services.

The changing technological landscape also offers challenges. Developments such as the "internet of toys", where the objects that young children may be using on a daily basis connect to other objects and users may lead to emergent issues which are difficult to predict. This said, the opportunities offered by new technology to assist in supporting our young people through difficult circumstances must also be recognised.

## What should we do next?

### 10. Recommendations for consideration

| | Recommendation | Lead(s) |
|---|---|---|
| **1.** | Review access to services by minority groups and ensure systemic barriers are mitigated or removed using the framework outlined in the Advancing Mental Health Equality Framework. This includes undertaking an equity audit , ensuring that services routinely collect data around protected characteristics and ensuring that the workforce have appropriate training and skills. This work should be overseen by a mental health equalities group. Consideration should also be given to developing specific pathways for these groups. | Clinical Commissioning Groups, Nottinghamshire Healthcare Trust (NHT), Third Sector providers |
| **2.** | Commissioning should be planned as integrated multi-agency services, ensuring that services meet the needs of the 0-25 age group. | Integrated Care System's (ICS), Public Health, Clinical Commissioning Groups (CCGs) |
| **3.** | Expand universal and selective parent education and training programmes to support preventative work around mental health and wellbeing. | Local Authority (LA), PH, CCGs |
| **4.** | Ensure that mental health and emotional wellbeing are considered in all policies relating to both staff, service users and pupils. | LA, ICS, Schools/ Colleges/Academies |
| **5.** | Embed a whole family approach to tackling children and young people's mental health needs, including qualitative work with parents. | PH, LA , CCGs |

| | | |
|---|---|---|
| **6.** | Undertake research into the mental health needs of young carers across the county: their prevalence and their needs. | LA Childrens Services |
| **7.** | Invest resources to evaluate effectiveness of digital interventions locally and ensure that any beneficial changes identified from the rapid switch to digital /remote models of care are sustained beyond the COVID-19 emergency response period., in line with regional guidance from NHS England. | CCGs, PH |
| **8.** | Community assets need to be mobilised in order to generate multigenerational networks of interpersonal support, capitalising on initiatives such as lifestyle interventions, volunteering and social prescribing. | Third sector, PH, Primary Care Networks (PCNs) |
| **9.** | Consider regular collection of wellbeing data for children and young people locally. | LA |
| **10.** | Work with schools and wider partners to provide equitable access to prevention and early intervention mental health initiatives delivered at schools, focusing strategically on areas in proportion to the level of need and where the risk factors are most prevalent i.e. areas of high deprivation. | PH, LA, CCGs |
| **11.** | Undertake further work to understand the impact of COVID 19 on children and young people's mental health and identify appropriate steps to address these. | PH, LA, CCGs |
| **12.** | Continue to work with providers to improve the quality of data submitted to the Mental Health Services dataset. | PH |

**Key contacts**

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## Appendix: Local and National Strategies

### National strategies

- NHS Long Term Plan. NHS England, 2019
- Mental Health and behaviour in schools. Department for Education, 2018
- The Five Year Forward View for Mental Health. NHS England, 2016
- Future in Mind. Department of Health, 2015
- Right Here, Right Now: help, care and support during a mental health crisis. Care Quality Commission, 2015
- Closing the Gap: Priorities for essential change in mental health. Department of Health, 2014
- Guidance for commissioners of eating disorder services: Joint Commissioning Panel for Mental Health, 2015
- Green Paper: Transforming Children and Young People's Mental Health Provision, 2018

### Local strategies

- Nottingham/Nottinghamshire ICS All-age integrated mental health and social care strategy (2019-2024) (NNICS, 2019)
- Nottingham City and Nottinghamshire Joint Local Transformation Plan Children and Young People's Emotional and Mental Health (2016 -2021)
- Nottingham City and Nottinghamshire Suicide Prevention Strategy (2019 - 2023)

## References


[1] Kessler, R. B. P. D. O. J. R. M. K. a. W. E., 2005. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry,* 6(62), pp. 593-602.

[2] Department of Health, 2009. *New Horizons: Towards a shared vision for mental health: Consultation.* Available at: https://www.nhs.uk/NHSEngland/NSF/Documents/NewHorizonsConsultation_ACC.pdf [Accessed 20.01.2020].

[3] World Health Organisation, 2018. *Mental Health: Strengthening Our Response*. Available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[4] JCPMH, 2016. *Ten Key Messages for Commissioners. Public Health Services.* Available at: https://www.jcpmh.info/wp-content/uploads/10keymsgs-publicmentalhealth.pdf [Accessed 17.01.2020].

[5] Kessler, R. B. P. D. O. J. R. M. K. a. W. E., 2005. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication.. *Archives of general psychiatry,* 6(62), pp. 593-602.

[6] NHS Digital, 2018. *Mental Health of Children and Young People in England*. Available at: https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf

[7] World Health Organisation, 2012. *Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors.* Available at: https://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf

[8] Department of Education, 2018. *Mental Health and Behaviour in Schools.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755135/Mental_health_and_behaviour_in_schools.pdf [Accessed 20.12.2019].

[9] NHS Digital, 2017. *Mental Health of Children and Young People in England, 2017.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 [Accessed 20.12.2019].

[10] Royal College of Paediatrics and Child Health, 2018. *Impact of Social Media and Screen-use on Young People's Health*. Available at: https://www.rcpch.ac.uk/sites/default/files/2019-04/final_rcpch_response_to_social_media_and_screentime_consultation.pdf [Accessed 4.12.2020]

[11] Przybylski, A. a. W. N., 2017. A large-scale test of the Goldilocks Hypothesis: Quantifying the relations between digital-screen use and the mental well-being of adolescents. *Psychological Science ,* 2(28), pp. 204-215.

[12] World Health Organisation, 2014. *Social deteminants of mental health.* Available at: https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/ [Accessed 20.01.2020].

[13] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine,* 14(4), pp. 245–258. Available at: https://doi.org/10.1016/S0749-3797(98)00017-8 [Accessed 4.12.2020].

[14] NHS Digital, 2017. *Mental Health of Children and Young People in England, 2017.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 [Accessed 20.12.2019].
[15] Sawyer, S. A. P. W. D. P. G., 2018. The age of adolescence. *The Lancet Child and Adolescent Health,* 3(2), pp. 223-228.
[16] MHSDS activity data, 2018. *Children and Young People's Health Services Data Set.* Available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/children-and-young-people-s-health-services-data-set [Accessed 20.02.2020].
[17] McAuley, C., Davis, T. 2009. Emotional well-being and mental health of looked after children in England. *Child & Family Social Work*, 14(2), pp. 147-155.
[18] Meltzer et al., 2002. The mental health of young people looked after by local authorities in England. *National Statistics.*
Available at: https://sp.ukdataservice.ac.uk/doc/5280/mrdoc/pdf/5280userguide.pdf
[Accessed 04.12.2020]
[19] Department for Education and Department of Health and Social Care, 2015. *Promoting the health and wellbeing of looked-after children,* s.l.: Department of Health and Social Care.
[20] JCPMH, 2013. *Guidance for commissioners of child and adolsecent mental health services.* Available at: https://www.jcpmh.info/good-services/camhs/ [Accessed 17.01.2020].
[21] Woodward, L. & Fergusson, D., 2001. Life Course Outcomes of Young People With Anxiety Disorders in Adolescence. *Journal of the American Academy of Child and Adolescent Psychiatry,* 40(9), pp. 1086 -1093.
[22] Department for Education and Department of Health and Social Care , 2015. *Promoting the health and wellbeing of looked-after children ,* s.l.: Department of Health and Social Care.
[23] The Mental Health Foundation, 2002. The Mental Health Needs of Young Offenders. *The Mental Health Needs of Young Offenders Updates*, 13(18).
[24] Department for Education and Department of Health and Social Care , 2015. *Promoting the health and wellbeing of looked-after children ,* s.l.: Department of Health and Social Care.
[25] Scottish Government, 2017. *Mental Health Strategy: 2017 - 2027.*
Available at: https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/5/
[Accessed 12.02.2020].
[26] Royal College of Paediatrics and Child Health, 2017. *State of Child Health Report 2017.*
Available at: https://www.rcpch.ac.uk/sites/default/files/2018-05/state_of_child_health_2017report_updated_29.05.18.pdf [Accessed 4.12.2020]
[27] Hollis, C. F. C. M. J. W. C. S. S. G. C. a. D. E., 2017. Annual Research Review: Digital health interventions for children and young people with mental health problems–a systematic and meta-review. *Journal of Child Psychology and Psychiatry,* 4(58), pp. 474 - 503.
[28] National Collaborating Centre for Mental Health, 2014. *E-therapies systematic review for children and young people with mental health problems.*
Available at: https://www.e-lfh.org.uk/wp-content/uploads/2017/07/e-Therapies-Systematic-Review-submission-to-RCPCH31.01.2014.pdf [Accessed 6.02.2020].

[29] Arango, C. a. D.-C. C. M. a. M. P. a. R. J. a., 2018. Preventive strategies for Mental Health. *The Lancet Psychiatry*.

[30] AYPH, 2016. *"There for you": The role of parents in supporting young people with mental health problems.* Available at: http://www.youngpeopleshealth.org.uk/wp-content/uploads/2016/11/AYPH-Parenting-briefing-11-nov-2016.pdf [Accessed 20.02.2020].

[31] Department of Education, 2016. *Mental health and behaviour in schools.* Available at: https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2 [Accessed 21.01.2020].

[32] Public Health England, 2017. *Mental health services: cost-effective commissioning.* Available at: https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning [Accessed 21.01.2020].

[33] McPherson et al, 2013. "The Role and Impact of Social Capital on the Health and Wellbeing of Children and Adolescents – A systematic Review." *The Glasgow Centre for Population Health.* Available at: https://www.gcph.co.uk/assets/0000/3647/Social_capital_final_2013.pdf [Accessed 04.12.2020]