Emotional health and wellbeing of children and young people

# Summary

Mental and emotional health is fundamental to good health and wellbeing. There are clear links between the emotional wellbeing of children and young people, their personal and social development, and educational performance.[1] As such it is an important factor in ensuring that they achieve their full potential. According to the latest Mental Health of Children and Young People survey, 1 in 8 (12.8%) children and young people had a mental disorder in England in 2017.[2]

In reality social, emotional and behavioural difficulties are likely to be much more common and affect in excess of 30% of children and young people at some time.[3] For children in care this figure may be as high as 50% [4] and for young people involved with the criminal justice system, the figure may be as high as 70%.[5]

Risk factors that increase the likelihood of a child experiencing poor emotional wellbeing and mental health problems include:

* Environment: poverty, social housing, homelessness, or refugee status.
* Family: parental unemployment, poor parenting, or circumstances that result in a child being looked after by the local authority.
* Child health: physical disability, chronic health problems, or learning difficulties.
* School: bullying (several of the above risk factors may result in relative social exclusion at school which may further increase the risk of bullying).

Medway’s Local Transformation Plan for Children and Young People’s Mental Health and Wellbeing sets out our vision for improving access to and quality of support for emotional and mental health issues. It is refreshed annually to reflect progress against the original 2015 plan and incorporate learning and revised strategies and priorities. NELFT, the Young People’s Wellbeing Service provider, is a key strategic and delivery partner in the Plan.

At the core of Medway’s strategy for transformation is the establishment of a Young People’s Wellbeing Service (YPWS) that is NICE compliant, focussed on achieving young people’s goals, working in partnership with other agencies and in particular supporting providers of early intervention services.

The new provider, NELFT, took on the contract in September 2017 and we are already seeing improvements in the quality of care and interaction and joint working with partners. The YPWS is present in Medway’s family hubs. Demand is much higher than anticipated, as is the case nationally, so waiting lists for treatment are currently long; however, we are funding additional capacity which is starting to decrease waiting times.

# Introduction

Mental and emotional health is fundamental to good health and wellbeing. There are clear links between the emotional wellbeing of children and young people, their personal and social development, and educational performance.[1] As such it is an important factor in ensuring that they achieve their full potential.

Emotional wellbeing includes confidence and self-esteem, which contributes to an ability to form good relationships with family and friends. Poor emotional and psychological health or mental health problems may result in educational failure, family disruption, anti-social behaviour and offending. Unrecognised and untreated mental health problems create distress not only for children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

The significant majority of children and young people will experience positive emotional wellbeing most of the time and develop along normal emotional, social and behavioural pathways. They will almost certainly experience challenges and periods of instability as part of the process of growing up, but will receive sufficient support from the family, school and wider community to cope with times of stress without serious or long-term impact on their wellbeing.

Social, emotional and behavioural difficulties are common and affect in excess of 30% of children and young people at some time.[3] Normal development will include behaviour of concern to adults. Young children may show certain behaviours, such as poor concentration, aggression, lying, stealing, tantrums, toileting or bedtime problems, food fads, specific fears or anxiety; whereas teenagers may have relationship problems or poor anger control or conflict with adults over appearance, school progress or household rules.

In today’s fast-paced, ever-changing society, young people are faced with increasingly complex lives and a diverse set of challenges. For some children and young people, this can lead to emotional problems and mental ill health.

# Who is at risk and why

## Prevalence of mental disorders

Since the last publication of this chapter in 2014, new data on child mental health has been published by NHS Digital: [Mental Health of Children and Young People in England, 2017](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017). Previous surveys, in 1999 and 2004, focused only on the five to 15-year-old age group, however for the first time the 2017 survey covered children aged two to 19.[2]

Looking at the five to 15-year-old age group over time, the report reveals a slight increase in the overall prevalence of mental disorders. For this age group, this has risen from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017. When including five to 19-year-olds, the 2017 prevalence is one in eight (12.8%), but this cannot be compared to earlier years.[2]

Mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other less common disorders (see page 7 of the survey’s [Summary of key findings](https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf). Emotional disorders were the most prevalent type of disorder experienced by 5 to 19 year olds in 2017 (8.1%) and have become more common in 5 to 15 year-olds; going from 4.3% in 1999 and 3.9% in 2004 to 5.8% in 2017. All other types of disorder, have remained similar in prevalence for this age group since 1999.

It is important to note that the prevalence data presented in the survey is likely to be an under-estimation of real need. The term mental disorder is generally used in the survey. This is because the survey did not screen for general mental health ‘problems’ or ‘issues’, but applied the diagnostic criteria for specific disorders set out in the tenth International Classification of Disease (ICD-10) (World Health Organisation, 1992).[2]

In reality social, emotional and behavioural difficulties are likely to be much more common and affect in excess of 30% of children and young people at some time.[3]

For children in care this figure may be as high as 50% [4] and for young people involved with the criminal justice system, the figure may be as high as 70%.[5]

## Characteristics of children and young people with a disorder

The 2017 survey presented the characteristics of children and young people with a mental disorder:[6]

* Sex: Overall rates of disorder were similar in boys (12.6%) and girls (12.9%). Rates were highest in girls aged 17 to 19 (23.9%).
* Age: The likelihood of having a disorder increased with age: from 9.5% of 5 to 10 year olds to 14.4% of 11 to 16 year olds and 16.9% of young people aged 17 to 19.
* Ethnic group: White British 5 to 19 year olds were about three times more likely (14.9%) than Black/Black British (5.6%) or Asian/Asian British (5.2%) children to have a disorder.
* Socioeconomics: Living in a low-income household or with a parent in receipt of income-related benefits was associated with higher rates of mental disorder in children. However, there was no association with neighbourhood deprivation.

## Social and educational context

The 2017 survey also presented data to place the mental health of children and young people in England into wider social and educational contexts:[6]

* Sexual identity: A third (34.9%) of the young people aged 14 to 19-years-old who identified as lesbian, gay, bisexual or with another sexual identity had a mental disorder, as opposed to 13.2% of those who identified as heterosexual.
* Social media use: Young people with a mental disorder were more likely to use social media every day (87.3%) than those without a disorder (77.8%).
* Bullying: Children with a mental disorder were nearly twice as likely to have been bullied in the past year (59.1%) as those without a disorder (32.7%).
* Health risk behaviours: Risky health behaviours (tobacco, e-cigarettes, alcohol and illicit drug use) were more common in young people with a disorder.
* Self-harm and suicide attempt: A quarter (25.5%) of 11 to 16-year-olds with a mental disorder had self-harmed or attempted suicide at some point, compared to 3.0% of those who were not diagnosed as having a mental disorder. In 17 to 19-year-olds with a mental disorder, nearly half (46.8%) had self-harmed or made a suicide attempt.
* Exclusion: School exclusion was also more common in children with a disorder (6.8%) than in those without (0.5%). Boys with a disorder (9.9%) were more likely than girls with a disorder (2.4%) to be excluded from school.
* Special education needs: Over a third of 5 to 19 year olds with a disorder (35.6%) were recognised as having special educational needs.

It is important to note that the cross-sectional survey data can be used to profile circumstances and associations at one point in time, but cannot show whether one factor cause another.[6]

## Groups of children and young people at risk of mental health problems

Public Health England (PHE) and the National Child and Maternal Health Intelligence Network (ChiMat) previously produced Child and Adolescent Mental Health Services (CAMHS) needs assessments for all local authorities and Clinical Commissioning Groups (CCGs). Within the needs assessment the following groups were identified at being particularly at risk of experiencing mental health problems:

### Children and young people with learning disabilities

People with learning disabilities are more likely to experience mental health problems, have poorer health and much more likely to live in poverty than the general population. Further analysis of the 2004 survey found that 36% of children and young people with an intellectual disability had a mental health 6 disorder, whilst 8% of children and young people with no intellectual disability had a mental health disorder.[7]

### Looked-after children

Looked-after children are more likely to experience mental health problems. It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic.[8]

### Homelessness and sleeping rough

Homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including acquired immune deficiency syndrome (AIDS).[9] Two major studies of this group in London and Edinburgh found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were associated with sexually risky behaviours, substance misuse and comorbid psychiatric disorders, particularly depression.[10][11]

### Youth Offending

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. Mapping relevant risk factors associated with youth crime can help inform local authority and NHS commissioning of evidence based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. The impact of incorporating these vulnerable children into mainstream commissioning also has the potential benefit of impacting on a young person’s wider family now and in the future, particularly when they may already be parents themselves.[12]

### Perinatal mental health and attachment

Mental ill health during pregnancy and early motherhood, or ‘perinatal mental illness’, is a serious health issue with potentially harmful consequences for women’s life-long mental health and the health and wellbeing of their children and families. For example, postnatal depression is the most common of the potentially serious perinatal mental illnesses and can trigger a relapse or recurrence of previous mental illness. It can also signify the onset of long-term mental health problems and is associated with increased risk of maternal suicide.[13]

# Level of need in the population

The majority of Medway wards have a very high number of people aged 0 to 19 years. Based on the 2017 mid-year population estimates from the Office for National Statistics (ONS), it is estimated that there were 70,705 people aged 0 to 19 years in Medway in 2017.[14] Medway has a larger proportion of people aged 0-14 years and 15-24 years compared to the England average.

## Overall

The number of children and young people in Medway with a mental disorder has been estimated (Table 1) by applying national prevalence data by sex and age from the 2017 Mental Health of Children and Young People Survey[15] to the local 2017 mid-year population estimates for Medway.[14] It should be noted that these estimates do not take into account differences in other factors which may influence prevalence.

**Table 1:** Estimated prevalence of mental disorders in children and young people aged 5-19 years (2017)

|  |  |
| --- | --- |
| **Condition** | **Medway estimate (aged 5-19 years)** |
| Any mental disorder | 6,655 |
| Emotional disorder | 4,190 |
| Behavioural (or conduct) disorders | 2,418 |
| Hyperactivity disorders | 856 |
| Other less common disorders | 1,100 |

Please see the ‘Who’s at risk and why’ section for definitions of these conditions.

## Self-harm

The rate of hospital admissions in Medway as a result of self-harm among 10-24 year olds has been low historically compared to England with about 160 per year (2016/17). This represents only a small fraction of the total number, but does provide an insight into the most serious cases.[16]



**Figure 1:** Trend in hospital admissions as a result of self-harm (10-24 years)

Certain groups of children and young people are at increased risk of developing mental health problems, taking account of background, life experiences, family history and individual emotional, neurological and psychological development. The remainder of this section will examine the risks and associated factors with mental health in children and young people.

Environmental:Medway has relatively high levels of child deprivation and homelessness. The proportion of dependent children under 20 living in low income households (defined as household income less than 60 percent of median household income before housing costs) was 18.3% (2016).[17] Family homelessness (defined as priority need categories as either dependent children or pregnant woman) is 1.9% (2017/18), which equates to 222 applicants.[18]

Gillingham North, Chatham Central and Luton & Wayfield wards had the highest proportion of children living in low income families in 2011, with 35%, 33.5% and 31.8% children respectively in those wards living in low income families. Medway’s child poverty rate is significantly higher than the England and regional averages.

Family: The rate of looked after children in Medway aged under 18 years is similar to the national average. As at 31 March 2018 there were 414 children being looked after by the local authority. Over the previous five years, this number has fluctuated between 379 and 430.[19] On average, the difficulties score of looked after children is above normal indicating borderline cause for concern.[20]

Child health: The proportion of primary, secondary and special school children identified as having specific, moderate, severe, profound or multiple learning disabilities is 4.7% which is lower than the England rate of 5.5%.[21]

School: During the 2016/17 academic year, a total of 749 pupils were excluded for a fixed term from state-funded primary school and three were permanently excluded. The rate of 2.9% fixed term exclusions was the highest in England. In state-funded secondary schools, the number of fixed term exclusions was 2,159 (11.5%) and 60 (0.3%) permanent exclusions. All of these figures are significantly higher than the England average.[22]

Special educational needs and disability (SEND): Certain disabilities increase vulnerability to mental health problems, for example, studies show that children who are deaf have a higher rate of emotional and behavioural problems.[23] Families with disabled children are more likely to experience social isolation, which is a risk factor for mental health problems in children and adults[24]. Department for Education research[25] outlines the link between SEN and wellbeing in secondary school pupils.

The SEND Code of Practice defines SEN as follows: [26]

‘A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she has a significantly greater difficulty in learning than the majority of others of the same age, or has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.’

In 2019, Medway reported 6,485 school pupils receiving SEN support and 2,126 children and young people with a statement or emotional health and care plan (EHCP). Analysis of data in January 2018 shows that among children of primary school age in Medway who have an EHCP or supported at SEN Support stage, the most prominent need recorded by schools is speech, language and communication needs and this has increased over recent years. This area of need often changes as children move to secondary school. By which time they may have had a diagnosis of autistic spectrum disorder, which therefore changes the type of need that schools record on their registers.

The next two highest areas of need in primary schools in Medway are social, emotional and mental health needs (a significantly growing area of need in Medway) and moderate learning disabilities.

Nationally, 29% of children and young people have autistic spectrum disorder identified as their primary need in education health and care plans.

For further information, please see:

* Medway JSNA SEND
* [Medway's Joint SEND strategy](https://www.medway.gov.uk/info/200316/send_help/1419/read_medways_joint_send_strategy)
* [Medway's Local Offer](https://www.medway.gov.uk/localoffer)

# Current services in relation to need

Child and Adolescent Mental Health Services (CAMHS) have traditionally been commissioned as Tiered services. Tier 1 typically includes early help and support interventions for lower level and emerging emotional health and wellbeing needs below the threshold for CAMHS services, e.g. school counselling and behaviour support provision, often commissioned or provided in education settings or other targeted / universal frontline services. Tier 2 typically includes targeted support and interventions where needs cannot be effectively addressed within universal services and Tier 3 includes specialist mental health services for children and young people with more severe and pervasive difficulties. Tier 4 includes highly specialised provision, e.g. forensic services and support in inpatient settings.

## Medway Young Persons’ Wellbeing Service

The Medway Young Persons’ Wellbeing Service (MYPWS), commissioned from 1 September 2017, progressed the integration of Tiers 2 and 3 CAMHS accommodating the provision, staffing and early intervention in collaboration with other Medway frontline services utilising a ‘Team Around the Family’ approach. This delivers an integrated service with cross fertilisation of skills and knowledge across partner agencies.

The service provider, NELFT (North East London NHS Foundation Trust), is delivering a multi-disciplinary service offering community-based NICE-concordant treatment. The MYPWS teams comprise clinical staff with significant expertise, appropriate capacity and skill-mix. The service focuses on the outcomes children and young people want to achieve, as well as clinical goals; and aims to produce higher throughput through the service by deploying a more intensive treatment model. This should, ultimately, reduce waiting times for treatment.

The service offers direct access to treatment through self-referral and primary care services and will be committed to the principles of The Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme, which include:

* evidence-based practice;
* routine outcome measures;
* high quality clinical supervision and training; and
* increased young people’s participation.

In line with the objective to support transition to adult services and better meet the needs of young people with differing levels of need, Primary Mental Health services are provided to young people up to a young person’s 19th birthday (in line with extended participation age) for initial referral and up until the age of 25 for young people with special educational needs or as part of a wider network of support for children and young people in the care of the local authority.

## CAMHS Tier 4

CAMHS Tier 4 are specialised services that have been commissioned by NHS England since April 2013. Typically these are inpatient settings ranging from generic adolescent CAMHS beds, to PICU (Psychiatric Intensive Care Units), low to medium secure units and specialist units for specific conditions, e.g. learning disabilities or eating disorders.

All NHS Trusts providing CAMHS in the South East report major difficulties in finding a bed when needed in a reliable way, with a great deal of staff time spent trying to navigate the current system. NHS England, commissioners and local provider consortia are engaged in the planning of ‘New Care Models’, a national programme to transition planning, operational delivery and ultimately budgets for these services to local areas.

## School Mental Health Services

Schools provide a substantial amount of emotional support to pupils, whether directly through their pastoral support teams and Special Educational Needs Coordinators (SENCOs), through contracts with providers such as ‘Place2Be’ or individual counsellors and/or through participation in initiatives such as peer mentoring, mindfulness training and speech and language interventions. This provision differs from school to school, in terms of what is provided, how much support is offered and how it is managed.

## Medway Local Transformation Plan

Medway Council and Medway Clinical Commissioning Group (CCG) provide direct support to schools under the Local Transformation Plan for children and young people’s mental health and wellbeing.

This includes:

* workforce development;
* projects to raise awareness of how young people can improve their own mental and emotional health, and support each other; and
* an action research project with Canterbury Christ Church University to explore and evaluate effective classroom practice.

## Other Services

Medway Public Health also deliver a range of preventative programmes in relation to emotional wellbeing, including Personal, Social and Health Education (PHSE) and Youth Mental Health First Aid.

A specialist all-age Eating Disorder service (8+ years) has also been commissioned from 1 September 2017 to provide more timely support and interventions across a range of evidence based treatment modalities for children and young people.

Most importantly, however, we are taking the opportunity presented by new providers of children’s community health to join up services that have previously been disparate. The main aim is to support earlier intervention. To this end, MYPWS and children’s community health services are working with schools to provide staff development and consultation. They are also working with the School Improvement team to develop a more effective philosophy around behaviour management that seeks to understand what a child is trying to communicate through their behaviour, rather than to punish and often exclude them. Giving schools the insight and practical support to do this will make a big difference to inclusion in Medway.

# Projected service use

## Population projections

Current population projections predict that Medway’s under 25 population will change considerably over the next 20 years, increasing by 8.6% from 2018-2028 and 14.3% from 2018-2038.[27]

Assuming that the current levels of mental health disorders remain constant within age bands, the predicted growth of the population aged 25 years and below is likely to result in an increase in the numbers of children living with a mental health disorder in Medway over the next two decades.

## Accessing community mental health services

The [Five Year Forward View for Mental Health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) was published in February 2016 and outlines a strategic approach to improving mental health outcomes across the health and care system. One of the priority actions to be achieved by the NHS by 2020/21 is to help at least 70,000 more children and young people access high-quality mental health care when they need it (Mental Health Taskforce, 2016). To achieve this target there is an expectation that there will need to be an increase in the percentage of those accessing services. At least 30% of children and young people with a diagnosable mental health condition will need to receive treatment from an NHS-funded community mental health service in 2017/18, with a trajectory rising to 35% by 2020/21.[28]

The number of children and young people in Medway with a mental disorder has been estimated by applying national prevalence data by sex and age from the 2017 Mental Health of Children and Young People Survey [15] to the local 2017 mid-year population estimates for Medway.[14] It is estimated that 6,655 children and young people in Medway aged 5 to 19 years had a mental disorder in 2017. Based on this estimate, 35% equates to approximately 2,329 children and young people in Medway requiring treatment within commissioned services in 2017/18.

There are three main providers which will flow data to the Mental Health Services Data Set (MHSDS) in Medway:

1. NELFT Medway Young Persons Wellbeing Service and All-Age Eating Disorder Service;
2. Medway Community Healthcare (MCH) who provide ASD and ADHD assessment and diagnostic services for children under the age of eleven; and
3. Kent and Medway NHS and Social Care Partnership Trust (KMPT) who provide specialist Early Intervention in Psychosis services for a small cohort of young people aged 14 and above.

Other mental health providers may also flow data into the MHSDS for Medway in cases where treatment has been provided for residents out of area or for specialist treatments.

In 2017/18, the average referral rate to the Medway Young Persons’ Wellbeing Service was 200 per calendar month (or 2,400 per year). Around 30% of these referrals (720) are signposted to other sources of support, which means that approximately 1,680 are accepted into the service. It will therefore be necessary to look at how the gap of approximately 649 children and young people per annum might be addressed.

# Evidence of what works

## Guidance and Quality Standards

The National Institute for Health and Care Excellence (NICE) provide evidence-based recommendations for antenatal/postnatal mental health (CG192)[29], as well as for pre-school, primary and secondary school aged children.[30] [31] [32] Pre-school guidance includes support through home visiting, childcare and early education to those children classified as “vulnerable”; children who are at risk of or are already experiencing social and emotional problems.[30] In later years, preventative measures can be taken up in schools to help children develop their social and emotional wellbeing and to ensure that the child is in a supportive and safe environment.[31] [32] Public Health England (PHE) also promotes the building of resilience of children and young people in schools.[33]

The Department for Education provides guidance to schools on how to identify and support pupils whose behaviour suggests they may have unmet mental health needs.[34] NICE advise local authorities and schools to make sure that teachers and other staff are trained to identify when children show signs of anxiety or social and emotional problems and ensure that children have access to specialist advice and support that they require.[31] NICE have also produced clinical guidance and quality standards for young people with specific mental health disorders, such as depression, psychotic disorders, ASD, ADHD, bipolar disorder and self-harm.[35] [36] [37] [38] [39] [40]

All of the work funded by the Local Transformation Plan has reinforced the core Public Health England messages about what supports good emotional and mental health, i.e.:

* Physical exercise
* Talking
* Sleep
* Limiting screen time
* Good diet
* Positivity
* Taking time to relax

In addition to a whole school approach to supporting emotional wellbeing, all of our services promote these messages to young people in Medway.

## Future in Mind

In April 2015, NHS England and the Department of Health published [Future in Mind](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf).[41] The report established a clear direction and some key principles about how to make it easier for children and young people to access high quality mental health care when they need it. The key themes of the report include:

* Promoting resilience, prevention and early intervention
* Improving access to effective support - a system without tiers
* Care for the most vulnerable
* Accountability and transparency
* Developing the workforce

Following this report, in May 2015 Clinical Commissioning Groups (CCGs) were asked to initiate work with local partners across the NHS, public health, children’s social care, youth justice and education sectors to jointly develop and take forward local plans to transform the local offer to improve children and young people’s mental health and wellbeing at the local level.

The Medway Local Transformation Plan (LTP) was first published in September 2015 and set out shared commitment and priorities towards achieving a brighter future for children and young people’s emotional and mental health and wellbeing in Medway, regardless of their circumstances. The plan is updated annually and describes the progress made against the objectives and actions set out in the original LTP, as well as progress against the delivery plan: [Medway Local Transformation Plan for Children and Young People’s Mental Health and Wellbeing](https://www.medway.gov.uk/info/200170/children_and_families/612/young_people_s_emotional_wellbeing/2).

## Five Year Forward View for Mental Health

In February 2016, the independent Mental Health Taskforce published a [Five Year Forward View for Mental Health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) for the NHS in England.[42] This national strategy, which covers care and support for all ages, signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system. In July 2016, NHS England published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health. The [Implementation Plan](https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf) brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Taskforce and secured an additional £1 billion in funding for mental health.

Children and young people are a priority group for mental health promotion and prevention, and the strategy called for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital - especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. One of the priority actions to be achieved by the NHS by 2020/21 is to help at least 70,000 more children and young people access high-quality mental health care when they need it (as discussed in the previous section, Projected service use).

## Transforming children and young people’s mental health provision: a green paper

At the end of 2017, the Department of Health and Social Care and Department for Education published [Transforming children and young people’s mental health provision: a green paper.](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf) [43] This green paper builds on Future in Mind and the ongoing expansion of NHS-funded provision, and focuses on earlier intervention and prevention, especially in and linked to schools and colleges. The proposals include:

1. Incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing.
2. Fund new Mental Health Support Teams, supervised by NHS children and young people’s mental health staff, to provide specific extra capacity for early intervention and ongoing help.
3. Trial a four week waiting time for access to specialist NHS children and young people’s mental health services.

## The NHS Long Term Plan

The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf) was first published in January 2019 and sets out the key ambitions for the service over the next 10 years - to improve the quality of patient care and health outcomes.[44] Under this Long Term Plan, the NHS is making a new commitment that funding for children and young people’s mental health services will grow faster than both overall NHS funding and total mental health spending.[45] In its Long Term Plan, NHS England make the following pledges:

* Continue to invest in expanding access to community-based mental health services to meet the needs of more children and young people.
* Boost investment in children and young people’s eating disorder services.
* Children and young people experiencing a mental health crisis will be able to access the support they need.
* Mental health support for children and young people will be embedded in schools and colleges.
* A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood.

The [NHS mental health implementation plan (2019/20 – 2023/24)](https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/) provides guidance for local systems to meet the Long Term Plan targets beyond the Five Year Forward View to ensure transformation of mental health services becomes a reality.

# User views

To inform the commissioning of a new Child and Adolescent Mental Health Service (CAMHS), Medway Council and Medway Clinical Commissioning Group (CCG) launched a consultation exercise which ran from 6 May to 29 July 2016.

The Draft Service Model formed the basis of the consultation and provided stakeholders with a detailed description of how commissioners felt the new service could be structured, together with operational functions and service standards. The new service has been designed to meet the expectations of stakeholders, as well as NICE Guidance.

A summary of responses, by interest group, is set out below.

## From a focus group of children and young people who have used either CAMHS or emotional support services

Feedback from children and young people highlighted the value they placed on direct access to advice and also support outside of core school/working hours and outside of formal services, e.g. GP and school pastoral support. They also valued services which reduce the stigma that many young people associate with mental health counselling, offering them anonymous, anytime, free access to a range of counselling and peer group support services and enabling them to maintain a degree of control about what happens next.

## Service users and their families/carers

Users and their families were especially keen to see improvements to communications and clarity about who is doing what. This applied both to information about service availability and improved levels of contact and information once a referral has been made. They felt strongly that we should take the opportunity to deliver all support for emotional and mental health needs in a continuum where practitioners communicate with each other and offer some level of support to children and their families once the treatment phase has ended.

Speedier response times were a big issue, though it is striking that families were as dissatisfied with lack of communication from the current service as with the length of the wait for treatment.

The hope was expressed that mental health needs could be prioritised more and that schools might be more proactive in offering support to children who are likely to be affected by their situation, for example if they have been bereaved or are a carer; or are transferring to secondary school, having had additional support in the primary phase.

Finally, they talked about trust. The importance of gaining the trust of children and young people in order to be able to meet their emotional needs; of respecting confidentiality; and practitioners delivering what they say they will do. This also applied to not over promising on the service overall.

## Schools and colleges

School based staff also wanted to see quicker response times and better communication with specialist mental health workers.

Schools overwhelmingly supported the concept of reducing escalation of demand through prevention, early intervention and increasing awareness of emotional and mental health issues. They believed that this is only possible, however, with better professional development for school based staff in each of these areas and with greater provision of more specialist support, for example from primary mental health workers within school.

School based staff would also value additional support from and contact with practitioners working with pupils who have more severe mental health needs.

Practitioners in partner agencies also strongly supported the provision of better advice and professional development for school based staff, so that issues do not escalate, along with more preventative, universal support for children and young people.

## Emotional health and wellbeing practitioners

As with other groups, they responded that the speed of access should be improved. This group felt particularly strongly that is should be possible to provide immediate access to support for young people and that initial assessments should be fast tracked to assess risk and ensure children and young people are not left trying to manage quite difficult situations and emotions. They also felt that this system needs to be as simple and clear as possible from the user’s point of view.

This group was strongly in favour of a holistic approach to support, that included the family where appropriate and makes use of other expertise, for example in parenting support, to build resilience. They also felt that a nominated mental health worker should be the point of contact for colleagues and the family.

## Role of schools

This was a distinct question within the survey. It is highlighted here because of the very strong level of agreement among all of the interested parties, including schools, about what this should mean. This includes:

* Provision of an effective universal offer, supported by ongoing training and support and good links to more specialist provision.
* Ideally placed to coordinate support, for families as well as their pupils, but other services (not just those to support emotional wellbeing) need to be more willing to offer their time and expertise.
* Fuller involvement of schools in decisions about how the continuum of support works.

# Unmet needs and service gaps

The Medway Young People’s Wellbeing Service (MYPWS), and other activities stimulated by the Local Transformation Plan (LTP), are focussed on meeting the needs identified in the 2015 LTP. Many of those needs - and certainly the groups most at risk - still exist, but Medway is now in a position to monitor progress against our priorities, reflected in a set of KPIs with NELFT.

## Key service improvements

* The MYPWS operates within the context of the whole continuum of support, with newly the appointed providers developing strong pathways with other providers and partners in health, education and social care.
* Evidence-based, IAPT treatment from appropriately qualified practitioners which is already reducing referrals to tier 4 mental health services.
* Substance misuse support, post abuse support, support dedicated to harmful sexualised behaviours, multi-disciplinary neurodevelopmental assessment and parental support are included in the new service model, facilitating more effective support for children and young people with multiple needs.
* A whole family approach is expected of all providers, whereby we proactively seek to resolve any issues in a child or young person’s environment that are impacting on their emotional wellbeing. This is facilitated by MYPWS’s presence in our locality based family hubs.
* A dedicated neurodevelopmental pathway for young people aged 11 and over, able to provide support to families and linked to additional health services for those young people who need them.
* A clinician led Single Point of Access, which is developing the ability to provide information about the alternative support that is available.
* An option for self-referral and a quick response through online, telephone and drop-in support.
* A mobile workforce, that works with children and families where they are most comfortable.
* Stronger emphasis on crisis support and interventions which support young people and their families within the family home and, wherever possible, prevent unnecessary admissions to inpatient settings.
* Greater emphasis on the needs of fostered, looked after and adopted children.

## Work still to be done

As MYPWS becomes established, we continue to support their in-reach and pathway development work and continue to work with other providers to develop awareness, skills and access. The actions below are for the whole system.

* Continue to improve prevention and early identification in response to emotional and mental distress by building a pre-CAMHS (Child and Adolescent Mental Health Services) pathway.
* Work with schools to support them in identifying additional needs earlier and more accurately.
* Develop better awareness in universal services and the community of how to help people with low level emotional and mental health issues and ensure expert advice is more widely available to non-specialist practitioners.
* Promote better understanding of effective low level interventions that can be delivered in schools and elsewhere to promote good mental and emotional health.
* Clarity about what is expected of schools and other non-specialist practitioners.
* A continuing programme of workforce development to enable expert practitioners in schools and elsewhere (e.g. special educational needs coordinators) to deliver key interventions.
* Better communication between commissioned service providers and schools about individual children and young people, in particular about the nature of their support plan and ensuring school nurses are linked into sustaining progress made in treatment.
* Development of the Positive Behaviour Support model across Medway, so that children with challenging behaviours and their families benefit from the support and understanding they need.
* Enhancement of young people’s role in informing and improving the MYPWS.

More widely it is recognised that there are gaps and issues regionally and nationally in relation to effective management and support for children and young people experiencing an escalation and crisis in their mental health.

All NHS Trusts providing CAMHS in the South East report major difficulties in finding a bed when needed in a reliable way, with a great deal of staff time spent trying to navigate the current system. This issue also leads to a number of out of area placements, which has a major impact on the ability of families to keep in touch with their children, especially when a placement may be many miles away. Evenings and weekends can be particularly difficult times to find an appropriate bed in a timely manner.

Across the South there is a need for a broader network of specialist services and local beds, including re-provisioning beds for specific groups, such as low secure, CAMHS acute and eating disorders.

There is also a lack of funding and appropriate placements for residential provision when young people are unable to return home on discharge from a Tier 4 bed. This has led to young people post-discharge being placed in residential care or schools a long way from home. CAMHS staff report a lack of multi-agency assessment and discharge planning on admission, which may lead to possible gaps in step-down services. It therefore important to ensure that Clinical Commissioning Groups (CCGs), local authorities and any other relevant agencies are engaged to ensure that young people receive care in the least restrictive environment, as close to home as possible.

## Self-harm

A multi-agency task and finish group, including key representatives from across the child health and social care system, was convened in early 2018 led by Public Health. This working group was formed as a result of some of the needs analysis and primary research undertaken in 2017 as part of the reconfiguration of Child Health services in Medway, which identified gaps in knowledge and a lack of clear pathway, and approved resources across the system in this area of need. The working group meets every 8/10 weeks to look at the following areas:

1. Identify the levels of need in this area via existing data sets, primary research and engagement with young people.
2. Co-produce an action plan and clearly identify the infrastructure/resource that is in place to implement this plan and also identify any gaps or opportunities for service development in this area.
3. Ensure there are clear pathways in place and that these are clearly communication to schools, GPs and any other services coming into regular contact with young people, including clear communication and information sharing protocols.
4. Identify a common set of resources to be promoted by all professionals in Medway (including preferred online resources).
5. Improve data collection and use of data on self-harm.

# Recommendations

The Medway Young Person’s Wellbeing Service has been commissioned to address many of the identified gaps and issues within children and young people’s emotional wellbeing and mental health support services. Changes to be fully embedded include:

* Support across an extended age range (>0-<25) for the most vulnerable children and young people.
* Quicker response times.
* All enquiries assessed and appropriate next steps recommended.
* Self-referrals and referrals by parents and carers encouraged.
* No more distinction between mental health issues and emotional issues; children and young people who require help will get the support they need.
* Evidence based and outcomes focussed treatment plans, intensive support, and recovery expected quickly in most cases.
* Most patients seen by mental health practitioners, under supervision of psychologists and psychiatrists, in a care pathway appropriate to their individual needs.
* Five distinct pathways i.e. behaviour and conduct; mood and anxiety neurodevelopmental; sexual trauma and recovery; substance misuse.
* A more family focussed approach, which develops resilience around the child or young person.

These changes will be achieved more quickly and sustainably if they are developed collaboratively, so that key players understand each other’s’ position; new approaches are embedded widely across the work force; and we make the best use of available resources and expertise. This includes:

* Creating the knowledge and capacity in the Medway workforce that will facilitate a focus on early, insightful, identification and swift, appropriate treatment.
* Establishing strong links between the provider, schools and other providers, in order to promote collaboration and clear mutual expectations.
* Developing a working group of head teachers, with the provider, Public Health and commissioners, who take forward these ideas and advises on the specific actions that will support the provider’s service transformation plan and ensure widespread participation.

## Reduce inpatient bed use

A new clinical model is required to reduce the total length of stay and numbers of children and young people needing an inpatient mental health bed as a result of crisis. This includes additional investment in innovative community services to keep children and young people closer to their homes and out of hospital. Together with better bed utilisation and management and improved co-ordination amongst services, we will be able to have the biggest impact on length of stay and discharge processes. ‘Tier 4’ beds are currently commissioned by NHS England but the New Models of Care Programme will see responsibility and budgets devolved to local provider consortia, and Clinical Commissioning Groups (CCGs) and community Child and Adolescent Mental Health Services (CAMHS) providers are expected to have increasing influence.

The Transforming Care programme ensures that children and young people with a learning disability receive the support they need to thrive and ultimately live as independently as possible. Many of Kent and Medway’s ‘tier 4’ mental health beds are occupied by children and young people with a learning disability or autism spectrum disorder (ASD). Providing the right support for them and their families from an early stage will mean they do not find themselves inappropriately in inpatient mental health beds, but in community-based, supported arrangements for education and work.

# Further needs assessment required

More local information is required on the mental health needs of specific at-risk groups including Black and Minority Ethnic (BME), homeless, lesbian, gay, bi-sexual, transgender, questioning and traveller communities and any potential barriers, perceived or otherwise, to accessing commissioned services by these groups. With regards to children in care, this JSNA has focused on children in the care of Medway Council; however, as it is known that many children are placed in Medway by other local authorities, this may also be an area for further investigation in terms of equity of access and any potential impact on service capacity. In accordance with Responsible Commissioner Guidance Medway Clinical Commissioning Group and Medway Council are responsible for ensuring adequate service capacity locally to meet the needs of all children and young people placed in Medway. Additionally, the higher than average ‘strength and difficulties scores’ of Medway’s looked after children requires further investigation.

Data from the January 2018 school census shows that 73.7% of pupils in Medway are White British and 25.7% of pupils are of minority ethnic origins. This may suggest a large change in the overall population distribution in Medway since the 2011 Census. There is, therefore, a need for better research into the prevalence of child mental health problems in minority ethnic groups, service utilisation among these groups and whether perceived or actual service barriers are specific to certain groups.

Medway (and Kent) currently have significantly higher volumes of inpatient admissions for children and young people with mental health needs, as well as those with challenging behaviour arising from Learning Disabilities or Autism Spectrum Disorder diagnoses. This trend requires further investigation to identify any underlying causal issues and potential gaps in community services.

Further work needs to be done to understand what interventions, if any, schools are directly commissioning as well as to understand the scope and capacity of services operating below referral thresholds for NHS commissioned services and service user experiences. Greater alignment with school-based provision may be beneficial in responding to established and emergent risk factors such as bullying, cyber-bullying and harms arising from websites or online forums that normalise anorexia and self-harm.

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