Future in Mind

Gloucestershire’s Transformation Plan for Children & Young People’s Mental Health & Wellbeing

Needs Assessment

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<table>
<thead>
<tr>
<th>Title</th>
<th>Gloucestershire’s Transformation Plan for Children &amp; Young People’s Mental Health &amp; Wellbeing - Needs Assessment</th>
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<tbody>
<tr>
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<td>This needs assessment covers the whole spectrum of services for children and young people’s mental health and wellbeing: from health promotion and prevention to support and interventions for children and young people who have existing or emerging mental health problems. This needs assessments considers service provision across the whole of Gloucestershire, for children and young people aged 0-18. Further work on the needs of young people over the age of 18 (e.g. those with special educational needs, learning difficulties or disabilities) will be considered as part of the transformation plan, not this needs assessment.</td>
</tr>
<tr>
<td>Purpose</td>
<td>To inform the development of the transformation plan for children and young people’s mental health and wellbeing, clearly articulating the local offer. This needs assessment will informs and accompanies the submission of Gloucestershire’s transformation plan.</td>
</tr>
<tr>
<td>Data</td>
<td>Latest available data used 2014-15; combines local and national data</td>
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<tr>
<td>Audience</td>
<td>NHS Gloucestershire CCG; HWB; Commissioners</td>
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Executive Summary

The report of the Future in Mind Taskforce's Data and Standard Task and Finish Group identifies significant gaps in children's mental health data right across the spectrum, including on prevalence, mental health promotion, prevention and risk reduction as well as on service level data and spend. These gaps are also reflected in Gloucestershire.

With this in mind, the needs assessment first considers the prevalence of mental illness in Gloucestershire's children and young people and finds that, on the basis of the 2004 ONS survey, the local prevalence is lower than in the South West and England. This is most likely to be because Gloucestershire is not a particularly deprived county and, as a later chapter describes, the domains across which deprivation is measured, e.g. low income, poor housing, etc. are also factors which can lead to poor mental health. The needs assessment also considers self-harm and suicide, which have in the past been an area of concern but which now appear to be improving amongst young people under the age of 18 in Gloucestershire, as well as the specific areas of perinatal mental health and eating disorders. In both of these latter areas, robust data is limited and conclusions are therefore difficult to draw.

The needs assessment moves on to consider the factors which can affect a child's emotional wellbeing and focuses specifically on deprivation and parental mental illness and substance misuse. It also considers the specific needs of groups of children and young people that may be at a higher risk of developing poor mental health, e.g. children in care, young offenders, children with long term conditions. Service data from both statutory and voluntary sector partners, where this is available, is analysed and there is an overview of available evidence on what works in two key areas of mental health promotion: parenting and school-based interventions.

The full recommendations can be found in Chapter 7 and have informed the development of Gloucestershire's transformation plan. However, these are the key messages that have emerged:

Joining up the system

This needs assessment identifies factors that can influence a child's emotional wellbeing, which are in turn supported by wider systems outside children and young people's mental health services, e.g. parental mental illness or substance misuse. The needs assessment identifies areas where improvements could be made to the way in which different parts of the system that support children and their families are joined up, for the benefit of children and young people's mental health and wellbeing. In particular, it suggests that:

- Those commissioning and providing children's social care should be actively engaged in the development and implementation of the transformation plan, to ensure that the emotional wellbeing and mental health needs of vulnerable children and young people, e.g. those that are in care or subject to a child protection plan are met.
- There should be coordination between adult mental health services, children's social care and children and young people's mental health services to ensure the impact of parental mental illness on a child's own mental health is taken into account. This should include specific attention to the needs of children who care for someone with a mental illness.
- A whole family approach should be taken to addressing those parental issues that put children at a greater risk of developing poor mental health, e.g. substance misuse. This
would require coordination of effort across a range of agencies, including providers of substance misuse treatment and recovery services.

- Links should be made to existing structures, partnerships and activities, including those focusing on teenage pregnancy, child sexual exploitation (CSE) and young offenders to ensure consideration of the emotional wellbeing and mental health is embedded.
- Learning should be shared from both the local Suicide Audit process and the ‘near misses’ review exercise undertaken by the Child Death Overview Panel.

**Providing family and parenting support**

Evidence suggests that parenting is a key modifiable factor affecting emotional wellbeing and that parenting programmes and family therapy can be beneficial. The needs assessment acknowledges that there is a range of interventions currently used in Gloucestershire and suggests that these should be reviewed with a view to coordinating and targeting their delivery, and focussing on several key features: they should be evidence-based; delivered at a time when parents are ready to make improvements; delivered in the context of wider support for the family; delivered by staff that are highly trained and supervised; and focused on the wellbeing of both the parent(s) and child(ren) and the relationships between them.

Parents and families are also an important resource in supporting children and young people’s emotional wellbeing but require information, advice and guidance to do this confidently and effectively. The needs assessment recommends a consistent and coordinated approach to the provision of telephone or online advice and peer support groups for parents and carers.

**Building emotional resilience in schools**

Schools, colleges and other educational settings have a unique reach to children and young people across the county and are also seen by parents, carers and professionals as an accessible reference point to available support. There could be improvements to the way in which schools and mental health services are linked, so that this is more consistent across Gloucestershire.

A great deal of work has already been done to build children and young people’s emotional resilience through interventions in school settings in Gloucestershire. However, the needs assessment identifies a number of ways in which these approaches could be further improved or targeted. This includes a balance between adaptation to the specific setting and retention of core, evidence-based components; a focus on promoting good mental health (rather than on preventing mental illness); and on younger children receiving interventions as a priority.

There is good evidence that interventions that build emotional resilience work well to support children with learning disabilities. Consideration should be given to the accessibility of existing and future interventions to children with learning disabilities, including targeting these activities in educational settings attended by children with learning disabilities.

The needs assessment also makes specific reference to interventions to reduce eating disorders in schools. It identifies a need to underpin targeted approaches to those most at risk with the implementation of universal interventions to promote an understanding of social norms relating to body image.
Access to support when it is needed

The needs assessment shows that there has been a rise in demand for some mental health services provided by 2gether NHS Foundation Trust, as well as services delivered by the wider partnership, such as counselling provided by Teens in Crisis (TIC+). In some areas, this is having an impact on how long children and young people are having to wait for treatment or an intervention, for example in services for children with a learning disability. The needs assessment suggests that consideration should be given to increasing capacity in the areas where demand has increased and waiting times are too long.

The needs assessment also identifies a gap in data that might help to provide an understanding of the level of indirect activity, e.g. professional advice provided by the Primary Mental Health Worker (PMHW) Team. Better information about the range of services and support that is available to support children and young people and how these can be accessed should help to reduce the burden on demand for services. There has been an increase in the use of the Practitioner Advice Line and this should be further promoted to those working with children and young people, alongside better information for parents and carers.

There are also opportunities to explore different ways of supporting children and young people that are below the threshold for CYPS support, for example by building knowledge and skills amongst the wider workforce and delivering services through web-based ‘live chat’ support and the use of mobile ‘apps’.

Supporting those who are most vulnerable

There is evidence that some groups of children and young people are at a higher risk of developing poor mental health and the needs assessment makes a number of recommendations to help reduce this risk and to ensure the right support is available to those who need it.

A number of groups, such as unaccompanied asylum seeking children or those children who are victims of child sexual exploitation (CSE) or sexual abuse, are identified in the needs assessment as being at a higher risk of developing poor mental health as a result of the trauma they have experienced. The needs assessment suggests that the provision of evidence-based trauma recovery support be considered.

The needs assessment also recommends that psychological support, including support for low-level emotional wellbeing needs, should be provided to children and young people with long-term conditions. Based on national and local evidence, it identifies children and young people with epilepsy as a key group to target in the first instance.

Young offenders are highlighted as particularly vulnerable to poor mental health and the needs assessments suggests that recent national recommendations should be reviewed to ensure they have been embedded in the local services that support this group. It also recommends that methods to increase the number of young people accepting Liaison & Diversion services should be explored.

Finally, the needs assessment suggests that, when planning improvements to support women in the perinatal period, consideration should be given to the support required to meet the emotional wellbeing and mental health needs of young women who are pregnant, including those who have a termination.
1. Introduction
One in ten children needs support or treatment for mental health problems. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them.

In September 2014, a Children and Young People’s Mental Health and Wellbeing Taskforce was established to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people’s mental health services are organised, commissioned and provided.

The Taskforce published its findings and recommendations in its report, *Future in Mind: Promoting, protecting and improving our children and young people’s mental health and wellbeing*, in March 2015.

*Future in Mind* required local areas, led by Clinical Commissioning Groups (CCGs), to develop and agree a transformation plan for children and young people’s mental health and wellbeing, clearly articulating the local offer. This needs assessment will inform and accompany the submission of Gloucestershire’s transformation plan.

1.1 Needs Assessment
A Health Needs Assessment (HNA) can help to inform a system that properly balances need, demand and supply (Stevens and Gabbay, 1991). Figure 1 shows the three areas as differently sized and overlapping but not aligned. In this model, need is the eligibility for a service, demand is what service users and professionals want and ask for and supply is the service that is provided.

![Figure 1 Need, demand and supply model](image_url)

When the three areas are not properly aligned, there is a range of issues. For example, when a service is supplied where there is need but not demand, for example because it is not accessible or delivered in the way people want or people are not aware of it, the service is underutilised and need is still unmet. Or when there is demand for a service, but no evidenced need, resources may be allocated to provision that does not improve outcomes for those who most need it, reinforcing health inequalities.
The ideal position is for needed services to be in demand and supplied. This needs assessment seeks to inform improvements to the system for children and young people’s mental health and wellbeing, in order to achieve this ideal position.

1.2 Objectives
The objectives of this needs assessment are:

- To achieve a shared understanding of the need and demand for children and young people’s mental health and wellbeing services, across the system
- To make recommendations for the transformation of children and young people’s mental health and wellbeing services.

1.3 Scope
The Transformation Plan – and this needs assessment – will cover the whole spectrum of services for children and young people’s mental health and wellbeing: from health promotion and prevention to support and interventions for children and young people who have existing or emerging mental health problems.

This needs assessments considers service provision across the whole of Gloucestershire, for children and young people aged 0-18. Further work on the needs of young people over the age of 18 (e.g. those with special educational needs, learning difficulties or disabilities) will be considered as part of the transformation plan, not this needs assessment.

1.4 Methodology
This is a primarily epidemiological health needs assessment and includes a statement of the ‘problem’; prevalence and incidence data; and the services available.

However, in preparing this needs assessment, evidence of ‘what works’ in protecting and improving the mental health and wellbeing of children and young people has also been considered.

Work to engage children and young people, including those who do and do not currently use mental health services, has taken place alongside this needs assessment, to ensure their views and experiences are taken in to account and inform the transformation plan.

Early findings were tested with stakeholders at a workshop on 23rd July 2015 and their feedback informed subsequent drafts of this needs assessment. The first set of conclusions and recommendations were again tested with stakeholders on 27th August 2015, both to strengthen them and to encourage buy-in, particularly where the recommendations may lead to changes in the way stakeholders work or to the services they commission or deliver.

1.5 Note on the data
The Chief Medical Officer’s Annual Report 2013 highlights a lack of nationally collated data on the present extent of children and young people’s mental health problems and service provision. The latest data available on the prevalence of mental health conditions amongst children and young people is over ten years old (Green et al, 2004). The report of the Taskforce’s Data and Standard Task and Finish Group goes further in identifying significant gaps in relation to children’s mental health data right across the spectrum, including on prevalence,
mental health promotion, prevention and risk reduction as well as on service level data and spend.

This needs assessment examines the data that is currently available but acknowledges that there are gaps and that the quality of available data is not necessarily robust. It identifies those areas where further work should be done at a local level to improve the data available on need, service availability and use.

There is also some discrepancy between the definition of localities by the clinical commissioning group (CCG), county council (GCC) and mental health trust (2gether). Where possible, data has been adjusted to account for this. However, this is not always possible and caution should be exercised when drawing conclusions from data covering different localities.

Finally, the timescales available to complete this needs assessment has been limited and, as a result, some of the formatting and presentation of data, i.e. in graph form, is inconsistent. This can be rectified in future updates of the needs assessment.
2. Incidence and prevalence of children and young people’s mental illness in Gloucestershire

In order to establish the level of need for children and young people’s mental health and wellbeing services or support in Gloucestershire, it is important to understand the prevalence of mental health disorders in children and young people in the county.

This chapter describes some of the key demographic issues in Gloucestershire, which are pertinent to the mental health and wellbeing status of the county’s population of children and young people. It also uses population data and a national survey on the prevalence of mental health disorders in children and young people to estimate the prevalence in Gloucestershire.

National guidance requires local areas to ensure transformation plans include a focus on eating disorders and perinatal mental health. To inform this focus, this chapter also uses population data and national research to look specifically at the prevalence of eating disorders in children and young people in the county. Local data on the prevalence of perinatal mental illness is limited. However, this chapter considers national data on prevalence, how this might impact on local services and what further work is needed to understand need in Gloucestershire.

Finally, this chapter describes key issues relating to self-harm and the incidence of suicide amongst children and young people in Gloucestershire. Self-harm is not a mental health problem but may be a sign of one. There are many people who self-harm who are not in touch with mental health services and do not have a diagnosed mental health problem. Similarly, the majority of people (all age) who die by suicide have not previously been in touch with mental health services (Gloucestershire County Council, 2014). As such, the local issues relating to self-harm and suicide can help inform an understanding of the level of potential need for mental health and wellbeing services and support.

2.1 Demography of Gloucestershire

Gloucestershire is a two-tier county, having a county council and six district councils, and covers an area of 1,220 square miles. Whilst Gloucester and Cheltenham are the two main urban centres, there are conurbations in each of the districts. However, Gloucestershire is a predominantly rural county. Almost 80% of the county comprises Lower Super Output Areas (LSOAs) classified as a village or hamlet or containing isolated dwellings. However, 20% of the county's population resides in these areas, compared to 40% in Gloucester and Cheltenham.

According to the Office of National Statistics 2014 mid-year estimates, there are 611,332 residents of Gloucestershire, of which 123,806 are aged under 18. Gloucestershire has a lower proportion of 0-19 year olds and 20-64 year olds compared to the national average but the 65+ population exceeds the national average.

However, Table 1 gives the population of the six Gloucestershire districts by age band and shows that the age structure of the population differs across the county. Gloucester has a 'younger' profile with 22.4% of its population under 18 years of age, compared to 20.3% in Gloucestershire as a whole. Stroud also has a higher proportion of children and young people than Gloucestershire as a whole. Cotswold has the lowest proportion of children and young people (18.7%).

Table 1 Gloucestershire population estimates by age band and district
Figure 2 shows the ONS population projection for Gloucestershire between 2012 and 2037 by age band and sex. This shows that the population of children and young people will increase but not as significantly as the older population (aged 60+).

<table>
<thead>
<tr>
<th>Age Band</th>
<th>0-17</th>
<th>18-64</th>
<th>65+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>22,924</td>
<td>72,554</td>
<td>21,017</td>
<td>116,495</td>
</tr>
<tr>
<td>Cotswold</td>
<td>15,863</td>
<td>48,191</td>
<td>20,583</td>
<td>84,637</td>
</tr>
<tr>
<td>Forest of Dean</td>
<td>16,102</td>
<td>48,391</td>
<td>19,181</td>
<td>83,674</td>
</tr>
<tr>
<td>Gloucester</td>
<td>28,196</td>
<td>77,544</td>
<td>19,909</td>
<td>125,649</td>
</tr>
<tr>
<td>Stroud</td>
<td>23,389</td>
<td>67,162</td>
<td>24,542</td>
<td>115,093</td>
</tr>
<tr>
<td>Tewkesbury</td>
<td>17,332</td>
<td>49,885</td>
<td>18,567</td>
<td>85,784</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>123,806</td>
<td>363,727</td>
<td>123,799</td>
<td>611,332</td>
</tr>
</tbody>
</table>

Source: Office of National Statistics 2014 mid-year estimates

Therefore, services are likely to see an increase in demand from a larger population of children and young people, whilst public sector resources will be required to meet the significant increase in the older population.

According to the 2011 Census, 95.4% of Gloucestershire's population is white. Gloucestershire has a small Black and Minority Ethnic (BME) population (4.6%) compared to England (14.1%);
however there are variations between districts, with Gloucester having the highest BME population (10.9%).

Table 2 shows the ethnicity of the 0-19 population of Gloucestershire by age band. This shows that the proportion of the Gloucestershire population from BME groups is larger amongst 0-19 year olds than the whole population. 7.6% of 0-19 year olds in Gloucestershire are from BME groups, with the proportion increasing amongst younger children (e.g. 8.9% of 0-4 year olds).

Table 2 Gloucestershire 0-19 population by ethnicity as of 2011 Census

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age 0 to 4</th>
<th>Age 5 to 7</th>
<th>Age 8 to 9</th>
<th>Age 10 to 14</th>
<th>Age 15</th>
<th>Age 16 to 17</th>
<th>Age 18 to 19</th>
<th>0 - 19 total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Asian British</td>
<td>3.0%</td>
<td>3.0%</td>
<td>2.9%</td>
<td>2.6%</td>
<td>2.2%</td>
<td>2.8%</td>
<td>2.3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Black/African/Caribbean/</td>
<td>1.1%</td>
<td>1.0%</td>
<td>1.1%</td>
<td>0.9%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Black British</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed/multiple</td>
<td>4.6%</td>
<td>4.2%</td>
<td>3.5%</td>
<td>3.3%</td>
<td>3.2%</td>
<td>2.7%</td>
<td>2.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>White</td>
<td>91.1%</td>
<td>91.5%</td>
<td>92.3%</td>
<td>93.0%</td>
<td>93.6%</td>
<td>93.5%</td>
<td>94.1%</td>
<td>92.4%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

When services are introduced or changed as a result of the transformation, the impact on and access by children and young people with protected characteristics, including those from BME groups, should be carefully considered.

2.2 Prevalence of mental health disorders

The National Child and Maternal Health Intelligence Network (CHIMAT, 2015) has produced an updated summary of the prevalence of certain mental health disorders, based primarily on the estimates made by Green et al (2004) in the 2004 ONS survey of children and young people’s mental health. This is the most recent national survey available.

In this survey, 1 in 10 children between the ages of 5-16 years are identified as having a clinically diagnosed mental disorder (Green et al, 2004). Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years old are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems.

Using the rates identified in this survey, Table 3 shows the estimated prevalence of mental health disorders by age group and sex in Gloucestershire. (Note: the numbers in the age groups 5-10 years and 11-16 years do not add up to the numbers in the 5-16 age group due to different rates in each group.)

Table 3 Estimated number of children with mental health disorders by age group and sex

<table>
<thead>
<tr>
<th>Estimated number of children</th>
<th>Estimated number of children</th>
<th>Estimated number of boys aged 5-10</th>
<th>Estimated number of boys aged 11-14</th>
<th>Estimated number of boys aged 5-16</th>
<th>Estimated number of girls aged 5-10</th>
<th>Estimated number of girls aged 11-14</th>
<th>Estimated number of girls aged 5-16</th>
</tr>
</thead>
</table>
These prevalence rates have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders, which can be described as:

- **Conduct disorders** – serious behavioural and emotional disorders that may be characterised by a pattern of disruptive and violent behaviour and problems following rules, e.g. oppositional defiant disorder or unsocialised and socialised conduct disorders
- **Emotional disorders** – a group of disorders that include e.g. separation anxiety, specific phobia, social phobia, generalised anxiety or depression
- **Hyperkinetic disorders** – hyperkinetic disorders describe the problems of children who are hyperactive, impulsive or inattentive and have difficulty concentrating, e.g. Attention-Deficit Hyperactivity Disorder (ADHD).

Figure 3 shows the estimated prevalence of mental health disorders as a percentage of the population aged 5-16 in 2013 in Gloucestershire, the South West and England. As the Gloucestershire estimates are calculated by applying the national prevalence to the local populations, it is no surprise that Gloucestershire is notably lower than England. This is because local authority and regional estimates are based on age, gender, and deprivation of local populations and Gloucestershire’s population is generally less deprived than England’s (see chapter 3).
This methodology is far from perfect, but it is the best available for giving a broad estimate of how Gloucestershire is likely to compare to its benchmarks, and particularly how the types of disorder compare to each other. For example, it is clear from Figure 3 that conduct disorders make up the most significant proportion of all mental health disorders in children and young people, whilst hyperkinetic disorders are less prevalent.

Table 4 shows the estimated number of children with conduct disorders, emotional disorders and hyperkinetic disorders in Gloucestershire, by applying these prevalence rates. It breaks this down to show the differences between age band and sex.

These data show that conduct and hyperkinetic disorders are much more commonly found in boys of all ages than girls. However, emotional disorders are more commonly found in older children than younger children and more commonly found in girls aged 11-16 than boys and younger girls.

(Note: the numbers in the tables relating to these disorders do not add up to the numbers in Table 3 because some children – around 1 in 5 of the children with a diagnosis – have disorders in more than one of the main categories. Again, the numbers in the age groups 5-10 years and 11-16 years do not add up to the numbers in the 5-16 age group due to different rates in each group.)

Table 4 Estimated number of children with conduct disorders, emotional disorders and hyperkinetic disorders by age group and sex

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Estimated number of children aged 5-10 years (2014)</th>
<th>Estimated number of children aged 11-16 years (2014)</th>
<th>Estimated number of boys aged 5-10 years (2014)</th>
<th>Estimated number of boys aged 11-16 years (2014)</th>
<th>Estimated number of girls aged 5-10 years (2014)</th>
<th>Estimated number of girls aged 11-16 years (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct disorders</td>
<td>1,820</td>
<td>2,385</td>
<td>1,320</td>
<td>1,500</td>
<td>505</td>
<td>890</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>850</td>
<td>1,915</td>
<td>385</td>
<td>795</td>
<td>470</td>
<td>1,125</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>610</td>
<td>535</td>
<td>525</td>
<td>445</td>
<td>90</td>
<td>90</td>
</tr>
</tbody>
</table>


Drawing robust conclusions from this data is challenging, given that it is based on a survey that is so out of date and that the methodology for benchmarking is so imperfect. The Future in Mind report recommends a new national survey to establish up to date prevalence rates and this needs assessment should be reviewed in line with that survey’s findings, once available.

2.3 Incidence and prevalence of eating disorders in Gloucestershire

Eating disorders mainly affect young women, although up to 1 in 10 of those affected by Anorexia Nervosa is male. It is difficult to give an exact figure for the numbers of people affected, especially since these conditions are often concealed and may go unnoticed and untreated. However, the Royal College of Psychiatrists estimate that as many as 4 in 100 young women under 35 may have an eating disorder (2014) and, on this basis, we can estimate the potential implications for the Gloucestershire population (Table 5).

Table 5 Estimated projection of Eating Disorders in Gloucestershire
Projected estimate of Eating Disorders in Gloucestershire female population under 35

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4732</td>
<td>4775</td>
<td>4711</td>
<td>4713</td>
</tr>
</tbody>
</table>

Source: ONS Sub-national population projections

However, Public Health England suggests that the prevalence of potential eating disorders amongst young people (male and female) aged 16-24 in Gloucestershire in 2013 is considerably higher at 8,335\(^1\). As with previous sections, it is not helpful to benchmark the Gloucestershire picture with other areas because the estimated prevalence applies the same percentage to all areas without making adjustments for local characteristics, which may impact on prevalence. This is because these factors are not well understood and there is no clear correlation with income or socio-demographic factors.

The following sections consider research on the incidence and prevalence of specific eating disorders. However, caution should be exercised when drawing conclusions about the prevalence in Gloucestershire, given the estimates used and the caveats outlined above.

### 2.3.1 Anorexia Nervosa

Anorexia Nervosa is a syndrome defined by a preoccupation with body weight, in which an individual maintains a low weight and a body mass index below 17.5. Weight loss is usually achieved through the avoidance of foods but, in some cases, individuals also exercise excessively, induce vomiting or use laxatives. It is approximately 8-11 times more common in females than males (Golden et al, 2003) and the mean age of onset is 16-17 years.

The incidence of Anorexia Nervosa in a population of 100,000 has been estimated to be 8 new cases per year (Hoek and Hoeken, 2003). However, it is not possible to project this in a way that is useful to this needs assessment because the estimation is based on total population and is unlikely to be accurate as, whilst we know the total population will increase, it will not do so at a consistent rate across age bands (Figure 2).

The prevalence of Anorexia Nervosa is reported to be 0.2% for females aged 11-15 and 1% for females aged 16-17. It is estimated that only 50% of the persons suffering with Anorexia Nervosa attend outpatient services and only some of these cases will receive specialised inpatient treatment (Goodman 2007).

### 2.3.2 Bulimia Nervosa

Bulimia Nervosa is characterised by recurrent episodes of binge eating and compensatory behaviour including vomiting, purging, fasting and exercise. It is more common than Anorexia Nervosa; it peaks at 19 years old and is far more common in girls (Golden et al 2003). The mean age of onset of illness is 18-19 years.

The incidence of Bulimia Nervosa in a population of 100,000 has been estimated to be 12 new cases per year (Hoek and Hoeken 2003). As above, this estimation is based on total population.

---

\(^1\) Estimated number of people aged 16-24 who score two or more (the clinical threshold for diagnosis of an eating disorder) on the SCOFF scale, based on applying the percentages for this age group given in the Adult Psychiatric Morbidity Survey (APMS) to the resident population aged 16-24. The percentages used were 6.1% for males and 20.3% for females.
Therefore it is not possible to accurately project the incidence, as, whilst we know the total population will increase, it will not do so at a consistent rate across age bands (Figure 2).

The average rate of prevalence for Bulimia Nervosa in young women and men has been estimated to be respectively 1% and 0.1% (Hoek and Hoeken 2003).

2.3.3 Atypical Eating Disorders

Atypical Disorders are also known as Eating Disorders Not Otherwise Specified (EDNOS) (American Psychiatric Association 1994). About half of referrals to eating disorders services are for an atypical eating disorder (Fairburn and Harrison 2003). Few studies have been designed to detect EDNOS, but a recent study found a prevalence of 2.37% amongst young women (Machado et al 2007).

The prevalence of Binge Eating Disorder has been estimated to be at least 1% in the general population (Hoek and Hoeken 2003).

Modelling the prevalence and incidence of specific eating disorders in Gloucestershire has not been attempted as these would be extremely rough estimations. However, the number of adolescents with eating disorders can be expected to fall slightly over the next 15 years, due to a decline in the population amongst the relevant age bands (Figure 2). Whilst it is thought that incidence and prevalence figures have been static over the recent years, it remains uncertain if the recent increase in obesity and resulting activities to encourage people to lose weight will have an effect on this in the coming years.

As in Section 2.2, it is difficult to draw conclusions from these estimations. However, stakeholders should continue to monitor research that may lead to more robust estimations of prevalence at a Gloucestershire level and, where appropriate, use this to inform future iterations of the transformation plan.

Chapter 6 examines the effectiveness of interventions in schools and identifies that the optimum approach is to deliver universal interventions that reinforce more targeted approaches. This recommendation is particularly pertinent to eating disorders. Where targeted approaches are delivered to reduce the incidence of eating disorders amongst those most at risk (i.e. teenage girls), consideration should also be given to the implementation of universal interventions, such as those that promote an understanding of social norms relating to body image.

2.4 Perinatal mental health

Perinatal mental illness includes those problems that complicate pregnancy and the postpartum year. Perinatal mental health problems are very common, affecting up to 20% of women at some point during the perinatal period (Bauer et al, 2014). Research also shows that suicide is a leading cause of death in women during pregnancy and in the year after giving birth.

Not only do perinatal mental health problems have an adverse impact on the mother, but they have also been shown to compromise the child’s emotional wellbeing and development.

Local data on the prevalence of perinatal mental illness is fairly limited. However, Table 6 shows the modelled rates of perinatal psychiatric disorder per thousand maternities (Joint Commissioning Panel for Mental Health, 2012).
Table 6 Rates of perinatal psychiatric disorder per thousand maternities

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum psychosis</td>
<td>2/1,000</td>
</tr>
<tr>
<td>Chronic serious mental illness</td>
<td>2/1,000</td>
</tr>
<tr>
<td>Severe depressive illness</td>
<td>30/1,000</td>
</tr>
<tr>
<td>Mild-moderate depressive illness and anxiety states</td>
<td>100-150/1,000</td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>30/1,000</td>
</tr>
<tr>
<td>Adjustment disorders and distress</td>
<td>150-300/1,000</td>
</tr>
</tbody>
</table>

Source: Joint Commissioning Panel for Mental Health, 2012

From this, we can extrapolate the likely rates for Gloucestershire, based on the local population and birth rate. Given the range of estimations of the local birth rate, Table 7 models the above rates against annual deliveries of 6,160, 7,000 and 7,463.

Table 7 Perinatal psychiatric disorder per 1,000 maternities and extrapolation to Gloucestershire

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Frequency per 1,000</th>
<th>6,160 births</th>
<th>7,000 births</th>
<th>7,463 births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum psychosis</td>
<td>2</td>
<td>12</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Chronic serious mental illness</td>
<td>2</td>
<td>12</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Severe depressive illness</td>
<td>30</td>
<td>185</td>
<td>210</td>
<td>224</td>
</tr>
<tr>
<td>Mild-moderate depressive illness and anxiety states</td>
<td>100-150</td>
<td>616-924</td>
<td>700-1,050</td>
<td>746-1,120</td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>30</td>
<td>185</td>
<td>210</td>
<td>224</td>
</tr>
<tr>
<td>Adjustment disorders and distress</td>
<td>150-300</td>
<td>924-1,848</td>
<td>1,050-2,100</td>
<td>1,120-2,239</td>
</tr>
</tbody>
</table>

Source: Joint Commissioning Panel for Mental Health, 2012 and ONS local population estimates

Work has already begun in Gloucestershire, with support from the West of England Academic Health Science Network, to develop an action plan to prevent mental ill health amongst women during the perinatal period and ensure appropriate support is in place for those with poor mental health. This focuses on four areas:

- Reducing stigma, fear and increasing early identification and prevention
- Advice, guidance and knowledge to enable women with mental health needs to feel supported in their community
- Providing a choice of joined up appropriate responses for women, partners and their families who have mild to moderate needs
- Offering a timely joined up response for families with high level mental needs or with risks of developing severe mental illness.

Further work to improve the local understanding of need and demand for perinatal mental health services should be a core element of this and the findings incorporated into the transformation plan.

Whilst some sources suggest that universal approaches or screening are inefficient (FPH, 2010), the latest NICE guidance on antenatal and postnatal mental health (NICE, 2014) recommends that, at a woman’s first contact with primary care or her booking visit, and during the early postnatal period, a number of depression identification questions should be considered as part
of a general discussion about a woman’s mental health and wellbeing. This should be underpinned by more targeted information, advice and support for women who are at a higher risk of developing poor mental health.

2.5 Self-harm in young people
The National Institute for Health and Clinical Excellence guidelines on the management and prevention of self-harm (NICE, 2011) define self-harming behaviour as:

“An expression of personal distress usually made in private by an individual who hurts him/herself. The nature and meaning of self-harm may vary greatly from person to person. The reasons a person harms him/herself may be different on each occasion and should not be presumed to be the same”.

Self-harm is broadly categorised as self-injury (cutting, burning, hanging, strangulation, scratching, banging or hitting body parts, and mutilation of parts of the body) or self-poisoning. Self-harm is not used to refer to harm arising from overeating, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

Self-harm in adolescents is common and increasing. In 2010 the Royal College of Psychiatrists (RCP) reported that “the incidence of self-harm has continued to rise in the UK over the past 20 years and, for young people at least, is said to be among the highest in Europe”.

The scale of the problem is not easy to define as the majority of acts of self-harm (especially ‘cutting’) are not reported and do not come to the attention of health care or other professionals. The majority of young people regard self-harm as a ‘private experience’ and often, parents themselves are unaware of the problem. Furthermore, the majority of studies are now over 10 years old and/or focus on hospital admissions for self-harm (where presentation is predominantly for self-poisoning and not self-injury). These studies show that:

- The rate of self-harm is relatively low in early childhood (1.3% of 5-10 year olds) but increases rapidly with the onset of adolescence (5.8% of 11-15 year olds) (Meltzer et al, 2001)
- 13.2% of 6,020 year 11 pupils (age 14-15) were self-harming (Hawton et al, 2006)
- Self-harming behaviour is more common in girls by a factor of 2 to 4 (Evans et al, 2005)
- 80% of people presenting to emergency departments following an episode of self-harm have self-poisoned (Horrocks et al, 2003).

The Gloucestershire Online Pupil Survey (OPS) is a good indicator of the extent of self-harming behaviour amongst secondary school children in the county. Direct comparison with 2012 is not possible because the questions were changed in 2014. However, in the 2012 survey 11% of children and young people had ‘thought’ about deliberately hurting themselves daily to weekly; in 2014 4.5% reported that they were self-harming daily to weekly.

The findings from the 2014 OPS show that the majority (84.2%) of children and young people had never self-harmed, however, 15.8% (n=3,763) reported they had self-harmed. Figure 4 shows that girls are more likely to have self-harmed once or twice, sometimes or weekly/daily than boys.
Figure 4 Children and young people's self reported experience of self-harm by gender

A specific survey on self-harm was undertaken in schools and colleges in July 2015 and the findings from this are currently being analysed. When available, these findings should inform the ongoing development of action to reduce the incidence of self-harm and provide appropriate support for children and young people who self-harm.

However, whilst most incidences of self-harm do not come to the attention of health professionals, some do result in attendance to Accident & Emergency (A&E) departments or Minor Injury Units (MIUs). In 2014/15, 85% of people who attended A&E and 89% of people who attended MIUs for self-harm were female, reflecting the findings of the OPS.

Figure 5 shows that attendances at A&E for self-harm rose significantly between 2012/13 and 2013/14 with a slight decline in 2014/15, whereas attendance at Minor Injury Units (MIUs) has seen a steady increase since until 2013/14 and with a 42% increase in 2014/15. These are individual attendances and not numbers of children and young people who may have attended on several occasions during the year with repeat self-harm behaviour.
The age profile of attendances by children and young people for self-harm in Gloucestershire also reflects prevalence studies in that there are low rates of self-harm in early childhood (5-10 year olds), which increases rapidly with the onset of adolescence (11-15 year olds). Attendances at A&E and MIUs in Gloucestershire in 2014/15 show the rate of self-harm increases between the ages of 12 and 17 (Figure 6).

In 2014, the OPS asked pupils how they had self-harmed. Both boys and girls reported cutting as the most prevalent method. However, boys report more punching behaviour than girls. Very few young people mentioned overdosing as a method for self-harm. However, Figure 7 shows that, in 2014/15, the majority of attendances (68%) at A&E were for self-poisoning. The majority of attendances (55%) at MIUs were for cutting. This is unsurprising given the role of these health settings.

In the past, attendances for self-poisoning have been predominantly paracetamol-related. However, anecdotal evidence suggests that young people are presenting having taken a range of
medications, often prescribed to other members of the family, found in the home. Further work should be undertaken to establish whether or not there is evidence of this and should inform any future implementation of or change to self-harm and mental health support services.

Given the rise in A&E attendances in 2013/14, the Gloucestershire Children & Young People’s Self-Harm Task Group has developed an action plan to reduce the incidence of self-harm and ensure support is available to those young people who do self-harm or are thinking about it. This group’s intended outcomes from its 2015/16 workstreams are:

- Improved mental health/self-harm awareness in schools, quality of support commissioned by schools, children and young people’s access to support and emotional health and wellbeing capacity within schools;
- Reduced danger to children and young people from bulk paracetamol; wider awareness across stakeholders of risks, causes and what is available;
- Prevention of repeat self-harm presentation at A&E (through the new Building Emotional Resilience Service), improved resilience and reduced risk of repetition amongst individual children and young people following incidents of self-harm, specifically aimed at those not requiring mental health services;
- Improved access to assessment and support within NHS system; improved environment in A&E; reduced unnecessary admissions to hospital;
- Alternative overnight or shared care options for self-harm explored and appraised; new provision offers a safe alternative for children and young people, post self-harm;
- Data collated across services; needs analysis underpins service developments.

Significant progress has been made by this group to date and momentum to reduce the incidence of self-harm amongst Gloucestershire’s young people should be maintained through the transformation plan.

2.6 Suicides in young people

The latest Gloucestershire Suicide Audit (Gloucestershire County Council, 2014a), covering the years 2009-2012, identifies that suspected suicides in children and young people up to the age of 18 over the past two decades have been about two annually at the most, except for 1997 (when there were seven deaths) and in 2012 (when there were four suspected suicides, two of which are included in the audit as suicide/open conclusion by the Coroner at the time of data collection).

The total number of suicides in children and young people over the four year period of the audit is nine. There were three further deaths in the first 10 months of 2013. Initial information from the Child Death Review Process on the seven deaths in 2012 and 2013 show that six of them were males with ages at death ranging from 12+ to 17 years. Though three of the seven were known to mental health services, the Child Death Review Process did not think that mental illness was a factor in these specific deaths. Family discord/relationship problems and bullying were thought to be contributory factors in four of the seven deaths.

However, because these numbers are very small, there is potential to make misleading inferences from them. Instead, we can learn a little bit more from the Child Death Overview Panels of Local Safeguarding Children Boards in the NHS South West Region, who have analysed the data available to them on suicide in young people in the region from January 2008 to
January 2013. They considered 25 case histories (which is still a relatively small sample). 72% of these deaths occurred in the home, with 84% by hanging/strangulation.

Their findings highlighted the following apparently significant factors:

- Families (parents/siblings) affected by mental health/emotional health problems (including substance misuse)
- Families experiencing unemployment/financial distress and/or debt
- Relationship difficulties between parents and parenting problems
- Domestic abuse
- Previous or current child protection concerns
- Birth father not playing a role
- History of being bullied
- Evidence for low self-worth
- Relationship difficulties
- Previous threat of self-harm or suicidal ideation
- Previous self-harm
- Being known to police/courts/social care
- Internet searches for suicide methods
- Some discussion within their peer group about suicide
- Triggering event – family row, worsening of relationship difficulties.

Given the small sample size and also the time lag in Coroner’s conclusions, Gloucestershire Suicide Audit suggests that the collation and monitoring of information on ‘near misses’ could be of help in identifying potential trends and possible preventive interventions.

The Gloucestershire Child Death Review Process undertook a pilot of reviewing ‘near miss’ suicide cases in young people aged under 18 years with a view to identifying any potential modifiable factors and to identify any lessons about how to best safeguard and promote children’s welfare. The pilot, which ran from 1st April 2013 to 31st March 2014, identified two completed suicides and 14 ‘near misses’.

A report on the outcome of this pilot was taken to the Gloucestershire Children Safeguarding Board (GSCB) and the Board agreed for the reviews to continue to be managed as part of the Child Death Review Process, linking closely with the Serious Case Review. It was recommended that the GCSB consider sharing any findings on modifiable factors or lessons learned with the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) to ensure a broader engagement with prevention of further deaths as appropriate.

However, whilst this pilot had positive feedback from those involved, there is little capacity to continue to undertake reviews of ‘near misses’. This needs assessment recommends that consideration is given to resourcing this process and also that its up to date findings are shared with relevant partners, to inform the development and implementation of the transformation plan.

The GSPPF has recently reviewed its Suicide Prevention Strategy (2015-2020) and accompanying action plan. This is informed, in part, by the Suicide Audit. There are many more
deaths by suicide amongst adults, but the strategy identifies a number of priorities to prevent suicide amongst children and young people:

- Ease of access by children and young people to treatment/support
- Influence and impact of internet and social media (not specifically for children and young people)
- Effective and timely support for children bereaved by suicide
- Reduce the prevalence of self-harm
- Support for the Child Death Review process to continue to identify ‘near misses’ in young people, together with recommendations to prevent them.

Those leading the development and implementation of the Future in Mind transformation plan should link effectively to the GSPPF to ensure that those priorities in its strategy relevant to preventing suicide amongst children and young people are, where appropriate, embedded in the transformation plan.

2.7 Summary of conclusions and recommendations

- Section 2.1 – When services are introduced or changed as a result of the transformation, the impact on and access by children and young people with protected characteristics, including those from BME groups, should be carefully considered.
- Section 2.2 – The Future in Mind report recommends a new national survey to establish up to date prevalence rates and this needs assessment should be reviewed in line with that survey’s findings, once available.
- Section 2.3 – Where targeted approaches are delivered to reduce the incidence of eating disorders amongst those most at risk (i.e. teenage girls), consideration should also be given to the implementation of universal interventions, such as those that promote an understanding of social norms relating to body image.
- Section 2.4 – Further work to improve the local understanding of need and demand for perinatal mental health services should be a core element of the local action plan and the findings incorporated into the Future in Mind transformation plan.
- Section 2.4 – At a woman's first contact with primary care or her booking visit, and during the early postnatal period, a number of depression identification questions should be considered as part of a general discussion about a woman's mental health and wellbeing. This should be underpinned by more targeted information, advice and support for women who are at a higher risk of developing poor mental health.
- Section 2.5 – When available, findings from the self-harm survey in schools and colleges should inform the ongoing development of action to reduce the incidence of self-harm and provide appropriate support for children and young people who self-harm.
- Section 2.5 – Further work should be undertaken to understand trends in self-poisoning amongst children and young people and should inform any future implementation of or change to self-harm and mental health support services.
- Section 2.5 – The momentum created by the significant progress of the Children & Young People’s Self-Harm Group to reduce the incidence of self-harm amongst Gloucestershire’s young people should be maintained through the transformation plan.
- Section 2.6 – Consideration should be given to resourcing the process of reviewing ‘near misses’ and its up to date findings should be shared with relevant partners, to inform the development and implementation of the transformation plan.
Section 2.6 – Those leading the development and implementation of the Future in Mind transformation plan should link effectively to the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) to ensure that those priorities in its strategy relevant to preventing suicide amongst children and young people are, where appropriate, embedded in the transformation plan. These recommendations are:

- Ease of access by children and young people to treatment/support
- Influence and impact of internet and social media (not specifically for children and young people)
- Effective and timely support for children bereaved by suicide
- Reduce the prevalence of self-harm
- Support for the Child Death Review process to continue to identify ‘near misses’ in young people, together with recommendations to prevent them.
3. Risk factors for mental illness or poor emotional wellbeing in children and young people

There is evidence that there is a range of particular factors that may put children and young people at greater risk of developing poor emotional wellbeing or mental illness. This chapter gives an overview of the available research on these risk factors and then focuses on two of them – deprivation and poverty and parental mental illness and substance misuse – by describing how children and young people in Gloucestershire experience them.

From this, conclusions are drawn and recommendations made to inform action to reduce the risk of children and young people in Gloucestershire developing poor emotional wellbeing or mental illness.

This chapter does not consider those groups of children and young people who are vulnerable to or at particular risk of mental illness as this is addressed in Chapter 4. However, there are clear links between the risk factors described here and 'high risk' groups of children and young people.

3.1 Summary of research

Mental health and wellbeing is not only influenced by individual attributes (constitutional factors/genetics) but also by social circumstances in which persons find themselves and the environment in which they live. These determinants interact with each other and may threaten or protect an individual's mental health state.

Children experiencing any of or a combination of risk factors may exhibit an ability to cope and are resilient despite risk. However, some children appear to be more susceptible to these risk factors and the result of exposure may lead to a mental disorder. Although any child or young person can develop a mental health problem there are individual and family/social factors and experiences that can increase vulnerability to developing mental health problems.

The 2004 Office of National Statistics (ONS) survey on the mental health of children and young people in Great Britain identified the following risk factors as being associated with increased prevalence rates of mental disorders (Green et al, 2004):

- Lone parent households
- Reconstituted families
- Parent with no qualification
- Parents not working
- Low income
- Receipt of disability benefit
- Household reference person in routine occupational group
- Living in social or privately rented accommodation
- Living in 'hard-pressed' areas.

Taking a life course approach, additional antenatal factors (maternal lifestyle and illness in pregnancy) and postnatal factors contribute to an increase in risk for mental illness in childhood, these are:
• Alcohol, tobacco and drug use during pregnancy increase the likelihood of a wide range of poor outcomes that include long term neurological and cognitive-emotional development problems (WHO, 2004)
• Maternal stress during pregnancy is associated with increased risk of child behavioural problems (O’Connor et al, 2003)
• Poor parental mental health with a four-to-five fold increased risk of emotional conduct disorder (Meltzer et al, 2003)
• Insecure attachment in infancy or family violence in childhood-can affect mental wellbeing or predispose towards mental disorder (Zeanah et al, 2000)

Departmental advice for school staff from the Department for Education outlines risk and protective factors in the child, in the family, in the school and in the community (Table 8).

Table 8 Risk and protective factors for child and adolescent mental health

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the child</strong></td>
<td><strong>In the family</strong></td>
</tr>
<tr>
<td>Genetic influences</td>
<td>Overt parental conflict including Domestic Violence</td>
</tr>
<tr>
<td>Low IQ and learning disabilities</td>
<td>Family breakdown (including where children are taken into care or adopted)</td>
</tr>
<tr>
<td>Specific development delay or neuro-diversity</td>
<td>Inconsistent or unclear discipline</td>
</tr>
<tr>
<td>Communication difficulties</td>
<td>Hostile or rejecting relationships</td>
</tr>
<tr>
<td>Difficult temperament</td>
<td>Failure to adapt to a child’s changing needs</td>
</tr>
<tr>
<td>Physical illness</td>
<td>Physical, sexual or emotional abuse</td>
</tr>
<tr>
<td>Academic failure</td>
<td>Parental psychiatric illness</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>Parental criminality, alcoholism or personality disorder</td>
</tr>
<tr>
<td>Being female (in younger children)</td>
<td>Death and loss – including loss of friendship</td>
</tr>
<tr>
<td>Secure attachment experience</td>
<td>At least one good parent-child relationship (or one supportive adult)</td>
</tr>
<tr>
<td>Outgoing temperament as an infant</td>
<td>Affection</td>
</tr>
<tr>
<td>Good communication skills, sociability</td>
<td>Clear, consistent discipline</td>
</tr>
<tr>
<td>Being a planner and having a belief in control</td>
<td>Support for education</td>
</tr>
<tr>
<td>Humour</td>
<td>Supportive long term relationship or the absence of severe discord</td>
</tr>
<tr>
<td>Problem solving skills and a positive attitude</td>
<td>Experiences of success and achievement</td>
</tr>
<tr>
<td>Faith or spirituality</td>
<td>Positive peer influences</td>
</tr>
<tr>
<td>Capacity to reflect</td>
<td>Clear policies on behaviour and bullying</td>
</tr>
</tbody>
</table>

• Bullying |
• Discrimination |
• Breakdown in or lack of positive friendships |
• Deviant peer influences |
• Peer pressure |
• Poor pupil to teacher relationships |
• Clear policies on behaviour and bullying |
• ‘Open-door’ policy for children to raise problems |
• A whole-school approach to promoting good mental health |
• Positive classroom management |
• A sense of belonging |
• Positive peer influences
Using this evidence, it is possible to further explore how children and young people in Gloucestershire experience risk factors for poor emotional wellbeing or mental illness. However, this would require extensive work, so this needs assessment focuses on two key factors, covering a child or young person’s experiences within their family and wider community:

- **Deprivation and poverty** – this underpins many of the risk factors described above, particularly those highlighted by the 2004 ONS survey, e.g. low income, living in socially or privately rented accommodation or in ‘hard pressed’ areas. Whilst many of these issues are complex and, arguably, beyond the scope of the Future in Mind transformation plan, they can inform the targeting of services and support or the method by which they are delivered.

- **Parental mental illness and substance misuse** – there is growing attention on what is referred to as the ‘toxic trio’ (mental illness, substance misuse and domestic abuse) and its impact on children and families. During the development of this needs assessment, feedback from stakeholders suggested this should be an area of focus and that it is an issue where partners involved in the development and implementation of the transformation plan may be able to have some influence.

### 3.2 Deprivation and poverty

A key measure of deprivation is the Indices of Multiple Deprivation (IMD), last undertaken in 2010. Figure 8 shows the areas of Gloucestershire that are most deprived based on the national quintiles. This shows that, compared with the national picture, Gloucestershire is not a particularly deprived county. However, despite it being a predominantly affluent county, there are pockets of deprivation in the county, primarily in urban areas of Gloucester, Cheltenham and Tewkesbury.
Figure 8 Map of Gloucestershire showing IMD 2010 national quintiles: overall deprivation

Figure 9 shows the areas of Gloucestershire that are most deprived based on the county quintiles. This helps to identify the local areas of deprivation and shows that there are further pockets of deprivation that do not show up based on national quintiles, most notably in the Forest of Dean, but also some smaller pockets in Stroud, Dursley, Nailsworth and Cirencester.
Relative poverty can be measured based on children living in households where income is less than 60 per cent of median household income before housing costs. Figure 10 shows that poverty rates are lower in Gloucestershire than the England rate, which reflects the conclusions drawn from the IMD data above. However, we again find that pockets of poverty within Gloucestershire and variation between districts, with 18.3% of dependent children under 20 living in poverty in Gloucester and 8.9% in Stroud and 8.7% in Cotswold.
Similarly, Figure 11 shows that Gloucestershire has a lower family homelessness rate – another indicator of disadvantage – than the South West and a significantly lower rate than England.

These indicators all tell a similar story: that deprivation and poverty – a key risk factor in child mental illness – is lower in Gloucestershire than in England or the South West. Although the prevalence data set out in Chapter 2 is problematic, the fact that this particular risk factor is less prevalent in Gloucestershire might contribute to an argument that there is a lower prevalence of child mental illness in the county. However, it is unclear whether this can be attributed to an issue with the data or if it is a reflection of the actual prevalence. Indeed, the conclusion drawn...
in Chapter 2 notes the influence of Gloucestershire’s low levels of deprivation on the calculation used to benchmark prevalence rates.

However, these indicators also highlight the variance across Gloucestershire and the fact that children and young people are more likely to be at risk of mental illness due to deprivation and poverty in some areas than others. These are likely to be:

- Gloucester
- Cheltenham
- Parts of the Forest of Dean
- Urban areas of Tewkesbury.

A key caveat to note here is that these data can hide rural pockets of deprivation. This data will not show areas where there may be deprived households or smaller deprived communities within relatively affluent areas.

Whilst the factors that lead to deprivation and poverty are complex and, for the most part, outside the control of the partners engaged in the development and implementation of the transformation plan, the information in this section can inform the geographical focus for the provision of support for children and young people’s mental health and wellbeing. Based on this data, provision of support should focus in areas of highest deprivation, including Gloucester, Cheltenham and part of the Forest of Dean.

However, given the caveat above, there should be access to support for children and young people living outside of these areas and, therefore, models of practice in a range of urban and rural settings should be tested and, where appropriate, rolled out.

Schools, colleges and other educational settings are uniquely placed in that they are accessibly across the county and attended by most (although not all) children and young people. However, Chapter 5 identifies a lack of consistency in access to mental health and wellbeing support across educational settings. Therefore, consideration should be given to the development of more robust and consistent links between mental health services and schools and colleges.

### 3.3 Parental mental illness

Data on children with one or more parent with a mental illness is limited. However, local social care data can provide part of the picture. The following information is a snapshot of data from Gloucestershire County Council’s social care database, showing cases where parental mental health is a concerning factor.

Table 9 shows the number of children in open social care cases where parental mental health is a concerning factor, by district in 2013/14 and 2014/15 financial years. It is evident that the majority of children live in the urban areas of Gloucester and Cheltenham, which is to be expected, given the demographic and deprivation profiles of these districts, described in previous chapters. However, it should also be noted that the proportion of children in the Forest of Dean and Tewkesbury reduced between 2013/14 and 2014/15, whilst the proportion of children in all other districts remained the same or increased.

Table 9 also shows that the number of children in open cases where parental mental health is a concerning factor almost doubled from 475 in 2013/14 to 931 in 2014/15. This is likely to have
been influenced by the local and national increase in social care assessments and an increasing awareness of the influence of the ‘toxic trio’. As such, this increase should be treated with caution.

Table 9 Children in open social care cases where parental mental health is a concerning factor, by district in 2013/14 and 2014/15

<table>
<thead>
<tr>
<th>District</th>
<th>Number of children</th>
<th>% of total children where parental mental health is a concerning factor</th>
<th>Number of children</th>
<th>% of total children where parental mental health is a concerning factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>106</td>
<td>22.3%</td>
<td>224</td>
<td>24.1%</td>
</tr>
<tr>
<td>Cotswold</td>
<td>22</td>
<td>4.6%</td>
<td>62</td>
<td>6.7%</td>
</tr>
<tr>
<td>Forest of Dean</td>
<td>58</td>
<td>12.2%</td>
<td>66</td>
<td>7.1%</td>
</tr>
<tr>
<td>Gloucester</td>
<td>178</td>
<td>37.5%</td>
<td>346</td>
<td>37.2%</td>
</tr>
<tr>
<td>Stroud</td>
<td>61</td>
<td>12.8%</td>
<td>105</td>
<td>11.3%</td>
</tr>
<tr>
<td>Tewkesbury</td>
<td>50</td>
<td>10.5%</td>
<td>128</td>
<td>13.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>475</strong></td>
<td><strong>100% (not precise due to rounding)</strong></td>
<td><strong>931</strong></td>
<td><strong>100% (not precise due to rounding)</strong></td>
</tr>
</tbody>
</table>

Source: Gloucestershire County Council Social Care Database

These data seem to reinforce the recommendation made in the previous section, to focus support in areas of highest need in Gloucester and Cheltenham but, again, suggests that there is also need in other areas of the county and that it is difficult to identify which of these areas stand out.

Figure 12 shows the age breakdown of the children involved. This graph shows the significant increase in cases, as described above, and that 13.7% of children in 2013/14 and 12.3% of children in 2014/15 were under the age of 1. Just under half of children in 2013/14 and 43.8% of children in 2014/15 were aged 0-5. However, in 2014/15, there is also an increase in the proportion of 6 and 7 year olds.
Although there is likely to be a range of reasons for the larger proportion of younger children, e.g. the universal services in contact with families in the first years of a child’s life and, perhaps, extra caution by professionals at this time in a child’s early development, it may also help to tell part of the story about perinatal mental health (see Chapter 2).

Whilst the data here is not comprehensive and only shows part of the picture, there should be coordination between adult mental health services and children’s social care and children and young people’s mental health services to ensure the impact of parental mental illness on a child’s own mental health is taken into account and, where possible, minimised.

Chapter 6 identifies that targeted parenting programmes delivered in the perinatal period can also support parents with their own mental wellbeing and that, where programmes are delivered to families with older children, those with a greater emphasis on the wellbeing of both the parent and child and the relationships between them may be more appropriate for preventing mental illness. The transformation plan should seek to establish which parenting programmes are delivered in Gloucestershire and review them in line with the evidence outlined in Chapter 6, with a view to coordinating delivery, to ensure they are as effective as possible and contribute to reducing the risk to children and young people’s mental health and wellbeing.

Chapter 4 also considers the impact on children who care for someone with a mental illness and further recommendations are made there.

### 3.4 Parental substance misuse

Nationally, research estimates that 2.6 million children in the UK are living with parents who are drinking hazardouslly and 705,000 are living with dependent drinkers (Manning et al, 2009). It is estimated that there are between 200,000 and 300,000 children of problem drug users in England and Wales – about one for every problem drug user (Advisory Council on the Misuse of Drugs, 2011).
As with parental mental illness, social care data can also show us part of the picture of children whose parents misuse drugs and/or alcohol. Within a national study of serious case reviews between 2007 and 2009, 22% of cases reviewed identified parental drug use and 22% percent of cases identified parental alcohol misuse (Brandon et al, 2010).

### 3.4.1 Drug misuse

As with parental mental health, Table 10 shows that there are a larger proportion of children in open social care cases where parental drug misuse is recorded in the urban centres of Cheltenham and Gloucester.

**Table 10 Children in open social care cases where parental drug misuse is recorded, by district in 2013/14 and 2014/15**

<table>
<thead>
<tr>
<th>District</th>
<th>Number of children</th>
<th>% of total children where parental drug misuse is recorded</th>
<th>Number of children</th>
<th>% of total children where parental drug misuse is recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>34</td>
<td>20.6%</td>
<td>73</td>
<td>28.5%</td>
</tr>
<tr>
<td>Cotswold</td>
<td>9</td>
<td>5.5%</td>
<td>21</td>
<td>8.2%</td>
</tr>
<tr>
<td>Forest of Dean</td>
<td>15</td>
<td>9.1%</td>
<td>14</td>
<td>5.5%</td>
</tr>
<tr>
<td>Gloucester</td>
<td>75</td>
<td>45.6%</td>
<td>99</td>
<td>38.7%</td>
</tr>
<tr>
<td>Stroud</td>
<td>14</td>
<td>8.5%</td>
<td>20</td>
<td>7.8%</td>
</tr>
<tr>
<td>Tewkesbury</td>
<td>18</td>
<td>10.9%</td>
<td>29</td>
<td>11.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>100% (not precise due to rounding)</strong></td>
<td><strong>256</strong></td>
<td><strong>100% (not precise due to rounding)</strong></td>
</tr>
</tbody>
</table>

Source: Gloucestershire County Council Social Care Database

It is also clear from Figure 13 that the age breakdown of children is similar to that for parental mental health, in that the majority of cases where parental drug concerns are recorded are found where younger children are involved.
Figure 13 Number of children assessed by social care where concerns about parental drug misuse are recorded, by age in 2013/14 and 2014/15

3.4.2 Alcohol Misuse

Table 11 shows that the short term trend for children in open social care cases where parental alcohol misuse is recorded does not reflect that for parental mental health or parental drug misuse, but actually declines between 2013/14 and 2014/15.

Table 11 Children in open social care cases where parental alcohol misuse is recorded, by district in 2013/14 and 2014/15

<table>
<thead>
<tr>
<th>District</th>
<th>Number of children</th>
<th>% of total children where parental alcohol misuse is recorded</th>
<th>Number of children</th>
<th>% of total children where parental alcohol misuse is recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheltenham</td>
<td>66</td>
<td>20.6%</td>
<td>44</td>
<td>14.1%</td>
</tr>
<tr>
<td>Cotswold</td>
<td>48</td>
<td>15.0%</td>
<td>33</td>
<td>10.5%</td>
</tr>
<tr>
<td>Forest of Dean</td>
<td>39</td>
<td>12.2%</td>
<td>36</td>
<td>11.5%</td>
</tr>
<tr>
<td>Gloucester</td>
<td>99</td>
<td>30.9%</td>
<td>88</td>
<td>28.1%</td>
</tr>
<tr>
<td>Stroud</td>
<td>41</td>
<td>12.8%</td>
<td>55</td>
<td>17.6%</td>
</tr>
<tr>
<td>Tewkesbury</td>
<td>27</td>
<td>8.4%</td>
<td>57</td>
<td>18.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>320</strong></td>
<td><strong>100% (not precise due to rounding)</strong></td>
<td><strong>313</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Gloucestershire County Council Social Care Database

However, the pattern of younger children being most affected by parental mental illness and drug misuse, also applies to those children assessed with parental alcohol concerns (Figure 14).
Figure 14 Number of children assessed by social care where concerns about parental alcohol misuse are recorded, by age in 2013/14 and 2014/15

3.4.3 Drug and alcohol misuse

Table 12 shows that the location of children in open social care cases where parental drug and alcohol misuse is recorded follows the pattern of parental mental illness and individual drug or alcohol misuse in that most children live in Gloucester and Cheltenham.

Table 12 Children in open social care cases where parental drug and alcohol misuse is recorded, by district in 2013/14 and 2014/15

<table>
<thead>
<tr>
<th></th>
<th>Children in open cases where parental drug and alcohol misuse is recorded, by district 2013/14</th>
<th>Children in open cases where parental drug and alcohol misuse is recorded, by district 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of children</td>
<td>% of total children where parental drug and alcohol misuse is recorded</td>
</tr>
<tr>
<td>Cheltenham</td>
<td>33</td>
<td>31.4%</td>
</tr>
<tr>
<td>Cotswold</td>
<td>8</td>
<td>7.6%</td>
</tr>
<tr>
<td>Forest of Dean</td>
<td>11</td>
<td>10.5%</td>
</tr>
<tr>
<td>Gloucester</td>
<td>39</td>
<td>37.1%</td>
</tr>
<tr>
<td>Stroud</td>
<td>8</td>
<td>7.6%</td>
</tr>
<tr>
<td>Tewkesbury</td>
<td>6</td>
<td>5.7%</td>
</tr>
<tr>
<td>Total</td>
<td><strong>105</strong></td>
<td><strong>100% (not precise due to rounding)</strong></td>
</tr>
</tbody>
</table>

Source: Gloucestershire County Council Social Care Database

Although it does not capture parents who misuse drugs and/or alcohol but are not known to local social care or substance misuse services, 2011/12 data from Public Health England gives a fuller picture of the number of parents in drug and alcohol treatment and how this compares with the regional and national picture. Figure 15 shows that the rate of parents who live with their child(ren) and are in drug or alcohol treatment is lower in Gloucestershire than in the South West and England, significantly lower for those in alcohol treatment (60.9 per 100,000 in Gloucestershire, compared with 147.2 per 100,000 in England).
However, Figure 15 should be treated with caution as the data is relatively old (from 2011/12) and does not, therefore, take account of progress that has been made to align drug and alcohol treatment with children and families services (see below) in Gloucestershire. Nor does it benchmark the proportion of the population who are in treatment and are also parents.

Gloucestershire’s local drug and alcohol treatment provider, Turning Point, works closely with children and families services to ensure joint working, with recovery workers providing input to core group and case conference meetings. The provider also works closely with the Family Drug and Alcohol Court (FDAC) and has staff within the Gloucester PODS (multi-disciplinary teams working with families of children at risk).

Turning Point’s end of year performance report shows that within the year 2013-14, they were working with a total of 124 clients who are known to Children and Families Services, 81 drug users and 43 alcohol users. 59% of drug using service users and 77% of alcohol service users known to Children & Families Services have children on the child protection register.

Given the impact on the child’s outcomes and, in particular, their emotional wellbeing and mental health, a whole family approach should be taken to addressing those parental issues that put children at a greater risk of developing poor mental health, e.g. substance misuse. This will require coordination of effort across a range of agencies, including providers of substance misuse treatment and recovery services. The recommissioning of the community drug and alcohol recovery service by Gloucestershire County Council provides an opportunity to do this.

3.5 Summary of conclusions and recommendations

- Section 3.2 – Provision of support should focus in areas of highest deprivation, including Gloucester, Cheltenham and part of the Forest of Dean. However, given the caveat on deprivation data, there should be access to support for children and young people living outside of these areas and, therefore, models of practice in a range of urban and rural settings should be tested and, where appropriate, rolled out.
• Section 3.2 – Consideration should be given to the development of more robust and consistent links between mental health services and schools, colleges and other educational settings, which are accessible across the county and attended by most (although not all) children and young people.

• Section 3.3 – There should be coordination between adult mental health services and children’s social care and children and young people’s mental health services to ensure the impact of parental mental illness on a child’s own mental health is taken into account and, where possible, minimised.

• Section 3.3 – The transformation plan should seek to establish which parenting programmes are delivered in Gloucestershire, including those delivered in the perinatal period, and review them in line with the evidence outlined in Chapter 6, with a view to coordinating delivery, to ensure they are as effective as possible and contribute to reducing the risk to children and young people’s mental health and wellbeing.

• Section 3.4 – Given the impact on the child’s outcomes and, in particular, their emotional wellbeing and mental health, a whole family approach should be taken to addressing those parental issues that put children at a greater risk of developing poor mental health, e.g. substance misuse. This will require coordination of effort across a range of agencies, including providers of substance misuse treatment and recovery services. The recommissioning of the community drug and alcohol recovery service by Gloucestershire County Council provides an opportunity to do this.
4. Prevalence amongst higher risk groups

Whilst the previous chapter focused on the risk factors for poor emotional wellbeing and mental illness in children and young people, this chapter addresses a number of ‘higher risk’ groups, that are known to be more vulnerable to poor mental health. These are:

- Children in care
- Children subject to a Child Protection Plan
- Unaccompanied asylum seeking children
- Gypsies and Travellers
- Young carers
- Children with learning disabilities
- Children with long-term conditions
- Teenage mothers
- Young people not in education, employment or training (NEETs)
- Young offenders
- Victims of child sexual exploitation (CSE) and sexual abuse.

This chapter describes – where known – the numbers of children and young people in Gloucestershire that make up these groups; how this compares regionally and nationally; trends in the data; and what evidence tells us about the groups’ vulnerability to poor mental health. It then draws conclusions and makes recommendations about areas for focus to reduce the risk of children and young people developing poor mental health and ensure appropriate support is available to those who have.

4.1 Children in care

Children in care are more likely to experience mental health problems (Ford et al, 2007). Figure 16 shows that the number of children in care in Gloucestershire aged between 5 and 15 has increased between 2010/11 and 2014/15, increasingly sharply from 2013/14. The number of very young children, aged 0-4, in care has reduced and levelled off since a peak in 2012/13.
Data is available that helps us to understand how many children in care in Gloucestershire experience poor emotional wellbeing or mental health problems. The Strengths & Difficulties Questionnaire (SDQ) measures the emotional wellbeing of children and young people in care. A single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted by the local authority to the Department for Education. A higher score indicates greater difficulties. Specifically, scores are categorised as follows:

- a score of under 14 is considered normal;
- a score of 14-16 is borderline cause for concern; and
- a score of 17 or over is a cause for concern.

Figure 17\(^2\) shows that the average SDQ score in Gloucestershire (15.1) was higher than the average score in England (13.9) and similar to the South West (15) in 2010/11 and was considered borderline cause for concern. However, the average score in Gloucestershire has reduced (and therefore improved) to 13.9 in 2013/14 to bring it in line with the national average and below the South West average (14.8).

Figure 17 Average emotional well-being scores of looked after children in Gloucestershire, the South West and England between 2010/11 and 2013/14

Whilst this trend appears to be promising, the latest available SDQ data is from 2013/14. Given that Figure 16 shows a sharp increase in the number of children in care aged 5-15 in

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\(^2\) The mean of total difficulties score for all looked after children aged between 5 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31st March is calculated by taking the sum of all individual SDQ 'total difficulties scores' for looked after children aged 5 to 16 (inclusive), who have been in care continuously for 12 months at 31 March divided by the number of valid primary carer SDQs that have been completed for looked after children aged 5 to 16 (inclusive), who have been in care continuously for 12 months at 31st March excluding any children who were looked after on that date under an agreed series of short term-placements.

Average scores have been rounded to one decimal place and have been derived from unrounded numerator and denominator values.
Gloucestershire in 2014/15, it is possible that this trend may change when more recent data is available.

Figure 18 shows the percentage of eligible children in care in Gloucestershire with an emotional and behavioural health assessment considered 'of concern' between 2010/11 and 2012/13. It shows that the percentage has reduced since 2010/11, bringing Gloucestershire below the South West. Gloucestershire is still slightly higher than the England rate, but this is increasing. As above, more recent data, reflecting the sharp increase in the number of children in care aged 5-15 in Gloucestershire in 2014/15 may have an impact on this trend.

![Graph showing percentage of eligible children in care in Gloucestershire, the South West and England with an emotional and behavioural health assessment considered 'of concern'.](image)

Figure 18 Percentage of eligible looked after children in Gloucestershire, the South West and England with an emotional and behavioural health assessment considered 'of concern'

Further work should be undertaken with those working in children’s social care to monitor Gloucestershire’s average SDQ score and the percentage of children in care in Gloucestershire with an emotional and behavioural health assessment considered 'of concern' between 2010/11 and 2013/14. Any learning from this should inform future activity to support or improve the emotional wellbeing of children in care and, where relevant and appropriate, activity to support other vulnerable children and young people.

### 4.2 Children subject to a child protection plan

A child is made the subject of a child protection plan when they are considered to be at risk of significant harm from physical abuse, sexual abuse, emotional abuse, and/or neglect. As outlined in the previous chapter, these forms of abuse and poor parenting capacity are key risk factors for poor emotional wellbeing and mental illness in children and young people.

Figure 19 shows that the number of children subject to a child protection plan in Gloucestershire between 2010/11 and 2014/15 has remained fairly level, with a small dip in 2011/12.
Unfortunately, there is no available comparative data to help us to understand whether or not the number of children subject to a child protection plan in Gloucestershire is similar to, higher or lower than the number nationally and regionally.

However, those commissioning and providing children’s social care should be actively engaged in the development and implementation of the transformation plan, to ensure that the emotional wellbeing and mental health needs of children that are subject to a child protection plan are met.

Chapter 6 describes the evidence base for interventions to improve parenting capacity and makes recommendations for their implementation. These will be relevant to support provided to children that are subject to a child protection plan.

4.3 Unaccompanied asylum seeking children
The experiences of unaccompanied asylum seeking children are likely to have been unusually stressful, including traumatic experiences in their country of origin, their journey to the UK and their arrival and settlement in the UK. As such, their mental health and wellbeing needs are likely to be complex (Chase, Knight, & Statham, 2008). There is a likelihood these children will be experiencing clinically significant disorders, especially post traumatic stress disorders, depression and anxiety.

The number of unaccompanied asylum seeking children looked after by Gloucestershire County Council is relatively small and, as shown in Figure 20, has decreased from 40 in 2008 to 10 in 2014. (Note: these numbers have been rounded to the nearest 5 and there is no data for 2013).
Whilst these numbers are relatively low, the number of unaccompanied asylum seeking children looked after in Gloucestershire has consistently made up at least 20% of the unaccompanied asylum seeking children in the South West between 2008 and 2014. At the time of writing this needs assessment, there is some debate nationally about the potential increase in numbers of refugees seeking to arrive in the UK. The impact of this on support required in Gloucestershire should be monitored during the lifetime of the transformation plan and action taken where required.

The emotional wellbeing and mental health needs of these children and young people are likely to be complex and the services that support them must take into account this complexity, as well as differences in language and culture. Stakeholder feedback has suggested that there is a gap locally in the provision of specialist support for children and young people who have experienced trauma, including the children described in this section but also those who have experienced other trauma, e.g. those that have witnessed domestic abuse or been a victim of child sexual exploitation or sexual abuse.

Many of the treatments that traumatised children and young people receive have not been empirically studied. However, there is some evidence that cognitive–behavioural therapy (CBT) techniques have been shown to be effective in treating children and young people who have persistent trauma reactions. CBT has been demonstrated to reduce serious trauma reactions, such as post-traumatic stress disorder (PTSD), other anxiety and depressive symptoms, and behavioural problems (APA, 2015).

This evidence also emphasises safe, secure, and trusting therapeutic relationships which can support recovery from trauma, particularly when working with children and parents from BME groups. Culturally responsive efforts to engage families in treatment can be effective in meeting those challenges. Consideration should be given to this provision in the future.
4.4 Gypsy, Roma & Traveller children

Gypsy, Roma or Traveller children can experience a number of the risk factors for poor mental health outlined in the previous chapter, including social exclusion; bullying and discrimination; absence from school and low educational attainment; and domestic abuse (OPM, 2010). Gypsy and Traveller families are also less likely to access statutory services, including health services, and experience significant health inequalities.

Figure 21 shows the percentage of school age children who are Gypsy or Roma. In Gloucestershire, 0.24% of school age children are Gypsy or Roma, which is similar to the England rate but slightly higher than the South West rate. (N.B. The scale used in Figure 21 exaggerates this difference). However, it should be noted that the numbers are low.

The fact that numbers in Gloucestershire are low suggests that it is not necessary to prioritise Gypsy, Roma or Traveller children over other ‘higher risk’ groups. However, as with other minority groups, services and activities that support children and young people’s emotional wellbeing and mental health should take account of the particular needs of and be accessible to Gypsy, Roma and Traveller children. For example, it is important to note that there is a stigma amongst Gypsy and Traveller communities about commonly used language relating to mental health (Twiselton & Huntingdon, 2009).

4.5 Young carers

In this needs assessment, young carers are defined as children and young people under 25 years old, who provide unpaid care for family members, friends, neighbours or others because of long-term physical or mental ill-health, disability, or problems relating to old age.

National research (SCIE, 2005) suggests young carers are likely to experience a negative impact on their health and wellbeing, including feelings of stress, anxiety, depression, loss and panic and mental health problems such as with sleeping; risk of self-harm and neglect of their own
health. In a 2013 survey of young adult carers (with an average age of 15.5), 38% reported having a mental health problem (Sempik and Becker, 2013).

Figure 22 shows the percentage of young people aged 16-24 who provide unpaid care (4%), which is slightly lower than the England rate (4.8%).

Figure 22 % of young people aged 16-24 who provide unpaid care

However, this does not show the proportion of younger children providing care in the county. Gloucestershire Young Carers currently supports 1,155 young carers in the county (August 2015), ranging from 5 to 25 years of age.

Chapter 3 identified that parental mental illness or substance misuse is a risk factor for poor mental health in children and young people. Gloucestershire Young Carers also records the number of young carers caring from someone with a mental health or substance misuse problem (Table 13).

Table 13 Young carers in Gloucestershire caring for someone with a mental health or substance misuse problem (August 2015)

<table>
<thead>
<tr>
<th>Age</th>
<th>Number caring for someone with a mental health problem</th>
<th>Number caring for someone with a substance misuse problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-7 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8-11 years</td>
<td>101</td>
<td>11</td>
</tr>
<tr>
<td>12-16 years</td>
<td>240</td>
<td>39</td>
</tr>
<tr>
<td>17-25 years</td>
<td>135</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>477</td>
<td>65</td>
</tr>
</tbody>
</table>

This data shows that there are far more children – currently being supported by Gloucestershire Young Carers – caring for someone with a mental health problem than there are children caring for someone with a substance misuse problem. In both cases it is unusual for very young children to be carers but most common for young people aged 12 to 16 years.
Chapter 3 concludes that a family approach should be taken to supporting parents with a mental illness or substance misuse problem, in order to reduce the risk that the child will develop mental health problems. A joint report by Ofsted and the Care Quality Commission (CQC) (2013) found that most adult mental health and drug and alcohol services were not proactive in helping families to access early support and that, in particular, young carers were not well identified. For example, where parents or carers had been admitted to hospital, joint working to ensure that plans in place for discharge took into account the child’s needs was found to be poor.

Adult mental health and drug and alcohol services in Gloucestershire should be engaged in the transformation of services for children and young people’s mental health and wellbeing, to ensure that the specific needs of those children living with adults with mental ill health or substance misuse problems are considered. In particular, the needs of young carers of these adults should be taken into account when planning and providing support to the family.

4.6 Children with learning disabilities

Children with learning disabilities are at increased risk of exposure to all of the major categories of social determinants of poorer physical and mental health (Emerson, 2015).

However, estimation of the population prevalence of learning disability is problematic (CHIMAT, 2015). Emerson et al (2011) estimates that there were 286,000 children and young people aged 0 to 17 in England with learning disabilities in 2011. Of these, just under two thirds are boys.

**Table 14 Estimated total number of children with a learning disability**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloucestershire</td>
<td>335</td>
<td>750</td>
<td>975</td>
</tr>
</tbody>
</table>


Whilst it is problematic, CHIMAT (2015) applies mental illness prevalence data to the Gloucestershire population of children and young people with learning disabilities (Table 15). Whilst this should be treated with caution, it does suggest that mental health problems may be more likely in older children with learning disabilities than those aged between 5 and 9 years old.

**Table 15 Estimated total number of children with learning disabilities with mental health problems**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloucestershire</td>
<td>135</td>
<td>300</td>
<td>390</td>
</tr>
</tbody>
</table>


Emerson (2015) recommends action at three levels to reduce the physical and mental health inequalities faced by children with learning disabilities:

- reducing child poverty
- reducing exposure to specific hazards
- building resilience.

Of these three areas, there is most scope for the transformation plan to have influence over the emotional resilience of children and young people with learning disabilities.

Specifically, Emerson (2015, p.8) recommends that:

“Local Health and Wellbeing Boards should in their JSNA ensure that children with learning disabilities are identified as priority groups for specific resilience-building initiatives (e.g. specific early intervention services) and that all general local initiatives (e.g. parent training and support interventions) are inclusive of children with learning disabilities.”

Therefore, when planning interventions to promote good mental health and prevent mental illness, e.g. emotional resilience activities in educational settings, consideration should be given to the accessibility to these interventions by children with learning disabilities. There may also be an argument that these interventions should be targeted in educational settings attended by children with learning disabilities and, although the prevalence data might suggest that interventions should be focused on older children, broader evidence suggests that it is best to start building emotional resilience in younger children.

Chapter 6 describes the level of service activity in Gloucestershire for children and young people with learning disabilities and identifies an issue with waiting times for this service. Given the vulnerability of children and young people with learning disabilities to poor mental health, attention should be paid to improving access to and reducing waiting times for this service in the transformation plan.

4.7 Children with long-term conditions

A report by the NHS Confederation (2012) identifies that approximately 11% of children experience significant chronic illness, including chronic mental health disorders, while 10–13% of adolescents report living with a chronic condition that substantially limits their daily life. Living with a severe physical illness impacts on young people themselves, their emotional and social development, and their families. Children living with long-term physical illness are twice as likely to suffer from emotional or conduct disorders.

In 2000, a report published by the Office of National Statistics identified the percentage of children with a mental disorder by type of physical complaint (Meltzer and Gatward, 2000). This showed that children with epilepsy are more likely to also have a mental disorder than children with other physical complaints or conditions.

Local data in this area is limited. However, recent work by the Gloucestershire Hospitals NHS Foundation Trust’s Paediatrics Department has identified a local need, particularly for lower-level emotional support for those who do not reach the threshold for mental health services. This work has estimated the numbers of children and young people in the county with long-term conditions, who might require support for their emotional wellbeing (Table 16).

Table 16 Estimated number of children with long-term conditions, who require support for their emotional wellbeing
<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated number requiring support per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy</td>
<td>90</td>
</tr>
<tr>
<td>New diagnosis or deteriorating condition</td>
<td>50</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>35</td>
</tr>
<tr>
<td>Oncology/haematology</td>
<td>30</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>30</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>40</td>
</tr>
<tr>
<td>Renal/Nephrology</td>
<td>50</td>
</tr>
<tr>
<td>Chronic fatigue/pain</td>
<td>12</td>
</tr>
<tr>
<td>Allergy</td>
<td>10</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>540</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>Approx 900 per annum</strong></td>
</tr>
</tbody>
</table>

The Health Psychology Department at Gloucestershire Hospitals NHS Foundation Trust currently only provides support for children with diabetes. However, the findings of the ONS research and the estimated numbers in Table 16 suggest that support should be provided to children and young people with other long-term conditions and, perhaps, trialled with those with epilepsy in the first instance.

**4.8 Teenage mothers**

Chapter 2 outlined the prevalence of perinatal mental illness. However, young mothers are at an even higher risk of developing mental health issues; one study reports that 53% of teenage mothers develop post-partum depression (Mental Health Foundation, 2013).

Since 1998, teenage pregnancy rates have been falling locally, regionally and nationally. Gloucestershire has consistently had a lower teenage pregnancy rate than regional and national comparators.

Figure 23 and Figure 24 show that the conception rate for both under 18s and under 16s is lower in Gloucestershire than for both the South West and England. The conception rate for under 18s has been in decline from 421 in 1998 to 192 in 2013 and for under 16s from 55 in 2009 to 31 in 2013. However, Gloucestershire has not seen the same consistent downward trend for its under 16 conception rate as the South West and England, with a spike in 2011 before a subsequent reduction.

The reduction in Gloucestershire’s rate of under 18 conceptions puts the county in the top 10 most improved counties in the country.
Figure 23 Rate of conceptions per 1,000 females aged 15-17 in Gloucestershire, the South West and England

Figure 24 Rate of conceptions per 1,000 females aged 13-15 in Gloucestershire, the South West and England

There is variance in the conception rate across the districts of Gloucestershire. In 2012, conception rates for young women aged 15-17 were notably higher in Gloucester than the England, South West and Gloucestershire rates. This is unsurprising because, historically, areas with high teenage conception rates have also had relatively high deprivation measures. Rates in Stroud were higher than the Gloucestershire rate. Rates were lowest in Cheltenham and Cotswold.
The Gloucestershire Teenage Pregnancy Partnership Board maintains a partnership approach between the local authority, NHS, education and voluntary sector organisations to ensure a countywide approach to this work. The development of the transformation plan should make effective links with this board to ensure the implementation of recommendations relating to perinatal mental health (see chapter 2) take into account the needs of teenage mothers.

Of the total number of under 18 conceptions in 2010 (262), 55.3% (145) led to abortion, which is similar to the national picture (FPA, 2010). Consideration should be given to the support required to meet the emotional wellbeing and mental health needs of these young women, as well as those who have carried their pregnancy to full term and may be at risk of postpartum mental health conditions.

4.9 Young people not in education, employment or training (NEETs)

A study by the University and College Union (2013) found that 33% of young people not in education, employment or training (NEETs) have suffered from depression and 15% have a mental health condition.

Figure 25 shows that, apart from seasonal spikes, the number of NEETs in the county has shown a downward trend since peaking at 953 young people in 2011, which reflects a national trend.

![Figure 25 Number of 16-18 year olds not in Education, Employment or Training (NEETs), 2011 to 2015](image)

Public Health England suggests that, in 2014, 4.5% of young people aged 16-18 were not in education, employment or training. This was the same at the South West rate and statistically similar to the England rate.
Table 17 shows that at the end of May 2015 there were 476 young people aged 16-18 not in education, employment or training in Gloucestershire and that this figure translates into an adjusted\(^3\) 16-18 NEET population of 3.72%.

Table 17 NEET data by district (May 2015)

<table>
<thead>
<tr>
<th></th>
<th>Cheltenham</th>
<th>Cotswold</th>
<th>Forest</th>
<th>Gloucester</th>
<th>Stroud</th>
<th>Tewkesbury</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total NEET</strong></td>
<td>93</td>
<td>66</td>
<td>51</td>
<td>150</td>
<td>62</td>
<td>54</td>
<td>476</td>
</tr>
<tr>
<td><strong>Cohort</strong></td>
<td>2372</td>
<td>1890</td>
<td>1847</td>
<td>4116</td>
<td>2519</td>
<td>1537</td>
<td>14281</td>
</tr>
<tr>
<td><strong>% NEET</strong></td>
<td>3.92%</td>
<td>3.49%</td>
<td>2.76%</td>
<td>3.64%</td>
<td>2.46%</td>
<td>3.51%</td>
<td>3.72%</td>
</tr>
</tbody>
</table>

Although the largest number of NEETs is in Gloucester City (150), the highest adjusted NEET population is in Cheltenham (3.92%). This mirrors a number of other spatial patterns described in this needs assessment.

Clearly, the primary preventative action that can be taken is to support the emotional wellbeing and mental health of this potential cohort of young people to help them to access education, training and employment opportunities. This needs assessment has already addressed the need to engage schools, colleges and other educational settings in the development and implementation of this transformation plan. However, this should also extend to wider training and employment support providers.

4.10 Young offenders

Many young people involved in the criminal justice system have mental health problems, both diagnosed and undiagnosed. An evaluation of the Youth Justice Liaison & Diversion pilot found that 80% of young people had between one and five vulnerabilities, which ranged from mental health issues, behavioural issues, and social problems (Haines et al, 2012). Another report suggests that 95% of young people in young offender institutions have a mental illness, many of them more than one condition (Lader et al, 2000). Leon (2002) describes the reasons for this vulnerability:

- The original risk factors that led to their offending, such as poor parenting, hyperactivity as a child and wider social and environmental factors, also predict, in the general population, to mental health problems.
- Offending includes characteristically risky behaviour, which itself is stressful and may cause mental health problems.
- Interactions with the criminal justice system can be stressful and may on their own lead to anxiety and depression, particularly for those who have been kept in custody.

Figure 26 shows that Gloucestershire has a lower rate of young people who have entered the youth justice system (rate per 1,000 aged 10–18) than the South West rate and England rate and that this has steadily reduced from 9.8 per 1,000 (634 young people) in 2010/11 to 5.8 per 1,000 (364 young people) in 2013/14.

\(^3\) Adjustment includes a proportion of young people aged 16-18 whose outcomes are not-known to Gloucestershire Youth Support Team
Similarly, rates of young people aged 10–17 receiving their first conviction, caution or youth caution (rate per 100,000 aged 10-17) have also been lower in Gloucestershire than the South West and England since 2010 and has been reducing, from 667 per 100,000 (386 young people) in 2010 to 362 per 100,000 (200 young people) in 2014. However, the Gloucestershire rate has not reduced as sharply as the England rate and, in 2014, became similar to the England rate (Figure 27).

Whilst the Gloucestershire rates against the England benchmark and recent trends are generally positive, the significant vulnerability of young offenders to developing poor mental health suggests a need for focus on this group of young people.
In 2013, Young Minds published a report, which included five critical issues and recommendations for professionals working in the youth criminal justice system:

- There should be consistency in relationships, in order to build trust, mutual respect and empathy;
- Professionals working with young offenders should build skills in identifying and supporting mental health issues;
- Coordination of, access to and transitions between services supporting young offenders should be improved;
- A single professional should be responsible for leading young offenders’ health care pathway management; and
- There should be easy access to information for young offenders, their parents, carers and advocates.

The transformation plan should take into account these recommendations and ensure the specific needs of young offenders are considered in any changes to the system to support their emotional wellbeing and mental health.

4.11 Victims of child sexual exploitation and sexual abuse

Victims of child sexual exploitation (CSE) and sexual abuse are at greater risk of developing poor mental health or a mental illness, including self-harm. Equally, children and young people with a mental illness are also at greater risk of being sexually exploited (Department of Health, 2014).

The Future in Mind report refers to the need to ensure those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services, as one of its key aspirations.

4.11.1 Child Sexual Exploitation (CSE)

In Gloucestershire, there is developing understanding amongst partners about the numbers of children and young people being sexually exploited and the impact on their emotional health and wellbeing.

Between June 2014 and May 2015, there were 250 CSE referrals to the Police. As of July 2015, there was concern for around 560 children in Gloucestershire, 19.9% of whom were considered to be at significant risk. 58 (around 10%) were male and 502 were female. Referrals to Gloucestershire Police have involved children and young people aged between 9 and 17 years of age, with the majority between 15 and 16 years of age.

29% of the children in Gloucestershire for whom there is some concern are recorded as having mental health issues, including self-harm. Further anecdotal evidence of the connection between CSE and self-harm has been shared by clinical staff working with children and young people. However, further work should be undertaken to better understand this and what it suggests about the support needed by these particularly vulnerable young people. This will require input from and joint working with those partners already coordinating support for victims of CSE.

4.11.2 Sexual Abuse
Findings of a research report by the NSPCC in 2011 found declining rates of sexual abuse in children under 16 years old. However, there has been an increase in reported sexual offences in recent years both locally and nationally, as a result of a series of high-profile historic sexual abuse cases.

A very small proportion of all sexual offences are reported and, therefore, available data does not show the full picture of what is essentially a hidden issue. However, just over a quarter of all recorded sexual offences in Gloucestershire between April 2010 and September 2013 were in the category ‘Sexual Assault on a Female over 13’ with 120 victims of these crimes (just under 25%) aged 15 years or younger. 5% of all recorded sexual offences in this period were in the category ‘Sexual Assault on a Female under 13’.

There were 158 recorded crimes in Gloucestershire between April 2010 and September 2013 that were categorised as ‘Sexual Activity Involving a Child under 16’ and 105 recorded crimes categorised as ‘Sexual Activity Involving a Child under 13’.

As with CSE, women and girls of any age are much more likely to be recorded by the police as victims of a sexual offence than men and boys. Girls and young women in the age group 10 to 19 are the age/gender most likely to be recorded as victims of sexual offence crimes (Gloucestershire County Council, 2014b).

As described earlier in this chapter, stakeholders have commented on the gap in provision of specific support for children and young people who have experienced trauma, including those who have been victims of CSE and sexual abuse. The provision of this support should be considered by partners.

4.12 Summary of conclusions and recommendations

- Chapter 4 – Services should be accessible to and meet the specific needs of groups of children and young people at higher risk of developing poor mental health. Proposals for service transformation should be equality impact assessed to help inform this.
- Section 4.1 – Further work should be undertaken with those working in children’s social care to monitor Gloucestershire’s average SDQ score and the percentage of children in care in Gloucestershire with an emotional and behavioural health assessment considered ‘of concern’ between 2010/11 and 2013/14. Any learning from this should inform future activity to support or improve the emotional wellbeing of children in care and, where relevant and appropriate, activity to support other vulnerable children and young people.
- Section 4.1 – Those commissioning and providing children’s social care should be actively engaged in the development and implementation of the transformation plan, to ensure that the emotional wellbeing and mental health needs of children that are subject to a child protection plan are met.
- Section 4.3 – The impact of potential changes in trends of unaccompanied asylum seeking children on the support required in Gloucestershire should be monitored during the lifetime of the transformation plan and action taken where required.
- Sections 4.3 and 4.11 – Consideration should be given to the provision of evidence-based support for children and young people who have experienced trauma, including unaccompanied asylum seeking children, children who have witnessed domestic abuse or have been a victim of child sexual exploitation or sexual abuse. This might include the use of
CBT but should always be based around the development of safe, secure, trusting and culturally sensitive therapeutic relationships.

- **Section 4.5** – Adult mental health and drug and alcohol services in Gloucestershire should be engaged in the transformation of services for children and young people’s mental health and wellbeing, to ensure that the specific needs of those children living with adults with mental ill health or substance misuse problems are considered. In particular, the needs of young carers of these adults should be taken into account when planning and providing support to the family.

- **Section 4.6** – When planning interventions to promote good mental health and preventing mental illness in children and young people, e.g. emotional resilience activities in educational settings, consideration should be given to the accessibility to these interventions by children with learning disabilities.

- **Section 4.6** – There may also be an argument that these interventions should be targeted in educational settings attended by children with learning disabilities and, although the prevalence data might suggest that interventions should be focused on older children, broader evidence suggests that it is best to start building emotional resilience in younger children.

- **Section 4.6** – Attention should be paid to improving access to and reducing waiting times for the service for children and young people with learning disabilities.

- **Section 4.7** – Psychological support, including support for low-level emotional wellbeing needs, should be provided to children and young people with long-term conditions and, perhaps, trialled with those with epilepsy in the first instance.

- **Section 4.8** – The development of the transformation plan should make effective links with the Gloucestershire Teenage Pregnancy Partnership Board to ensure the implementation of recommendations relating to perinatal mental health (see chapter 2) take into account the needs of teenage mothers.

- **Section 4.8** – Consideration should be given to the support required to meet the emotional wellbeing and mental health needs of young women who have had an abortion, as well as those who have carried their pregnancy to full term and may be at risk of postpartum mental health conditions.

- **Section 4.9** – Wider training and employment support providers should be engaged in the development and implementation of this transformation plan.

- **Section 4.10** – The transformation plan should take into account the recommendations of the Young Minds report on the mental health of young offenders and ensure the specific needs of young offenders are considered in any changes to the system to support their emotional wellbeing and mental health. These recommendations relate to:
  - Consistency in relationships
  - Professionals with skills in mental health support
  - Improved coordination of, access to and transitions between services
  - Assertive health care pathway management
  - Easy access to information.

- **Section 4.11** – Further work should be undertaken to better understand the local prevalence of self-harm amongst victims of child sexual exploitation and what this suggests about the support needed by these particularly vulnerable young people. This will require input from and joint working with those partners already coordinating support for victims of CSE.
5. Service Provision & Activity

Previous chapters have described the need for children and young people’s mental health services, based on estimated prevalence and the presence of risk factors for and vulnerability to poor emotional wellbeing and mental illness in Gloucestershire.

This chapter identifies services available to children and young people in Gloucestershire, including, where relevant, the localities in which they are provided. It also considers the level of activity by these services, including trends in demand and capacity, in order to understand how services may be able to best meet need. It is in this chapter that conclusions can be drawn as to how well the need and demand for and supply of services are currently aligned and where improvements could be made.

The scope of this needs assessment is broad and covers the promotion of good mental health and prevention of mental ill health through to the most intensive services for children and young people with severe mental illness. There is an extensive range of activities, interventions and services, including those provided by voluntary sector organisations and community groups. Whilst every effort has been made to include the key services, it is not necessarily a comprehensive summary. In particular, there are many services that improve children and young people’s emotional wellbeing but do not do so as their primary purpose and, in this case, have not been included.

5.1 2gether NHS Foundation Trust – Children & Young People Service (CYPS)

Gloucestershire’s Child & Adolescent Mental Health Service (CAMHS) is provided by 2gether NHS Foundation Trust (2gft) and, on the basis of feedback from children and young people is known locally as the Children & Young People Service (CYPS).

5.1.1 Primary Mental Health Worker (PMHW) Team

The CYPS Level 2/Primary Mental Health Worker (PMHW) team is responsible for screening all referrals on a daily basis and undertaking the majority of initial CHOICE assessments for routine and priority referrals to CYPS.

In addition, the team aims to provide:

- Direct support and consultation to front line professionals regarding the ongoing management of emotional wellbeing and mental health issues for children and young people, i.e. consultation with schools, GP’s, school nurses, social workers.
- Targeted interventions for those children and young people presenting with mild to moderate emotional wellbeing or mental health needs.
- A consistent CYPS link role into all secondary schools and GP clusters via a cluster link role undertaken by each Level 2 worker.
- A CYPS Practitioner Advice Line, which supports referral management (see below).

Since December 2014, CYPS has established a new model of service wide referral management, where PMHW and Vulnerable Children Service staff offer consultation, triage, networking, training and advice to professionals, as an alternative to children and young people being referred directly to CYPS where they have mild to moderate needs. Where this happens, it is recorded on internal systems as an ‘inappropriate referral’ and information about where a
young person has been signposted or the final destination of these young people is not recorded. As such, it is not appropriate to draw conclusions about demands for PMHW team services from current referral data.

Similarly, Figure 28 shows a much reduced PMHW caseload of 0-18 year olds, from 243 in April 2013 to 82 in March 2015.

![Primary Mental Health Worker Team Caseload April 2013 - March 2015](image)

**Figure 28 Primary Mental Health Worker (PMHW) Team caseload, aged 0-18, April 2013-March 2015**

Given the narrative describing the new referral management process, this reduction in caseload is unlikely to describe a reduction in demand but to reflect the nature of the team’s work, including as an initiator of internal referrals.

In order to improve understanding about how those children and young people with mild to moderate needs are currently supported and the scale of demand for this support, information about the consultation, networking and advice activity undertaken by the PMHW team should be captured and shared.

### 5.1.2 Practitioner Advice Line

However, there is information that helps us to understand part of this picture. 2gether provides a Practitioner Advice Line for professionals to speak to a Primary Mental Health Worker about concerns they may have for a child’s mental health and wellbeing, before or instead of making a formal referral to CYPs. Figure 29 shows that there has been an upward trend in calls to the Advice Line, although further data would be required to confirm that this trend is continuing, given that the number of calls has reduced from a peak during the autumn/winter of 2014/15.

(Note: the dip in August 2014 is likely to have been caused by reduced use by school staff during the summer holidays.)
Promotion of the CYPS Practitioner Advice Line should continue, in order to help professionals working with children and young people to provide appropriate support and to help reduce unnecessary or inappropriate referrals to CYPS. In particular, the Advice Line should be seen as an integral part of developing links between schools and mental health services.

5.1.3 Level 2 Parenting Programme Team

The Level 2 Parenting Programme Team provides positive parenting groups, targeting the management of children with features of conduct disorder and ADHD. These programmes are currently led by external facilitators.

There has been a slight decline in activity between April 2013 and March 2015. The team undertook 370 initial assessments and 2,690 face-to-face attendances in 2013/14, and 354 initial assessments and 2,493 face-to-face attendances in 2014/15. However, Figure 30 shows that the team’s caseload has increased over the two financial years.

![Figure 29 Total number of calls to the Practitioner Advice Line April 2014-June 2015](image)

Figure 29 Total number of calls to the Practitioner Advice Line April 2014-June 2015

![Figure 30 CYPS Parenting Programme Caseload April 2013-March 2015](image)

Figure 30 CYPS Parenting Programme Caseload April 2013-March 2015
However, this increase in caseload may be explained by the downward trend in community discharges from this team, from a total of 1,032 in 2013/14 to a total of 868 in 2014/15. This should be further explored to ensure there is a shared understanding of the reasons for the downward trend in activity with an increasing caseload.

Chapter 6 outlines the evidence for the effectiveness of parenting programmes in supporting the emotional health and wellbeing of children and young people and recommends that there is a review of the range of parenting programmes offered in Gloucestershire to ensure they are appropriately targeted, consistently offered to those who would benefit and delivered in line with evidence. However, there is also an opportunity that should be explored for the delivery of these programmes by CYPS registered professionals, to assist with early intervention where there is identified need.

5.1.4 Infant Mental Health Service

The Infant Mental Health Service (IMHS) is a highly specialist, countywide service, which offers direct work with very high risk and vulnerable families, including parents with severe mental ill health in the care of specialist adult mental health services and babies at risk of entering the care system.

Referrals to the IMHS showed a slight increase from 78 accepted referrals in 2013/14 to 106 accepted referrals in 2014/15 (Figure 31).

As might be expected, there was also a slight upward trend in the IMHS caseload, although the caseload began to reduce again in the last few months of this period (Figure 32).
Chapter 3 highlights the risk to children’s mental health where their parent or parents have a mental illness and this service plays an important role in supporting children’s mental health at the earliest stage. However, it is a small team (2.6 whole time equivalents (wte)) and so even a small increase in referrals is likely to place pressure on the team. Therefore, further to the recommendations in Chapter 3, consideration should be given to increased capacity for professionals supporting vulnerable families – including social care and adult mental health services – to develop skills in supporting parental and infant mental health and to work together across the system.

This service is currently commissioned to support children up to the age of two. However, stakeholders have identified a gap in support for children up to the age of five. Further work should be undertaken to understand the level of need amongst children aged three to five and this should inform any future commissioning.

5.1.5 Level 3 Service

The CYPS Level 3 Team comprises three locality based teams – Gloucester & Forest, Stroud and Cheltenham & Cotswold – which provide specialist assessment and goal/outcome based interventions to support those children and young people who have moderate to severe mental health needs or where there are high levels of complexity, vulnerability and/or clinical risk. Level 3 also operates a number of specialist CYPS clinics.

Accepted referrals in to the Level 3 service doubled from 157 in 2013/14 to 318 in 2014/15. There has been a corresponding increase in caseload across all three area teams during this time (Figure 33).
Given the higher level of need in Gloucester and Cheltenham, as described in Chapters 2 and 3, it is unsurprising that the relevant Level 3 area teams have the largest caseloads. However, all three teams have seen an upward trend in their caseloads.

Despite this increase in demand, it appears from data that the waiting list from referral to a CYPS appointment has decreased significantly from a total of 187 at the end of October 2014 to a total of 59 at the end of August 2015 (Table 18). In particular, there have been efforts to reduce the number of children and young people who are waiting the longest, with no child or young person waiting 16 weeks or longer in the most recent month.

Table 18 Level 3 Service Waiting List October 2014-August 2015

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-8 wks</td>
<td>98</td>
<td>92</td>
<td>90</td>
<td>93</td>
<td>104</td>
<td>105</td>
<td>146</td>
<td>105</td>
<td>52</td>
<td>43</td>
<td>35</td>
</tr>
<tr>
<td>9-12 wks</td>
<td>31</td>
<td>26</td>
<td>37</td>
<td>25</td>
<td>37</td>
<td>35</td>
<td>21</td>
<td>21</td>
<td>26</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>13-18 wks</td>
<td>33</td>
<td>33</td>
<td>33</td>
<td>12</td>
<td>7</td>
<td>17</td>
<td>15</td>
<td>10</td>
<td>11</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>19+ wks</td>
<td>25</td>
<td>19</td>
<td>14</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>187</td>
<td>170</td>
<td>174</td>
<td>138</td>
<td>151</td>
<td>159</td>
<td>182</td>
<td>137</td>
<td>89</td>
<td>57</td>
<td>59</td>
</tr>
</tbody>
</table>

However, the service indicates that this does not necessarily show the true picture because of changes to the way in which new referrals are assessed by the PMHW team (described in Section 5.1.1 above). Work is already underway to try to understand this picture and to identify which part of the system requires attention in order to provide a more efficient service to children and young people.
5.1.6 CYPS Learning Disabilities Team

The CYPS Learning Disabilities (LD) team supports children and young people up to the age of 18, with a Gloucestershire GP and a moderate to severe learning disability or development disability, attending Betteridge School, Milestone School, Paternoster School, Shrubberies School or Heart of the Forest School. The team provides assessment, intervention and support to children and families with health issues related to their learning disability, including:

- Behaviour management
- Sleep difficulties
- Mental health problems
- Risk management
- Medication
- Health promotion
- Siblings groups
- Parenting programme
- Chronic Sorrow Group.

Total accepted referrals in to the CYPS LD team reduced slightly from 127 in 2013/14 to 119 in 2014/15. However, the team’s caseload increased slightly from 236 at month end in April 2013 to 274 at month end in March 2015, peaking at 292 in February 2015 (Figure 34).

![CYPS LD Team Caseload April 2013 - March 2015](image)

**Figure 34 CYPS Learning Disabilities Caseload April 2013 to March 2015**

However, this increase in caseload is likely to reflect the team’s efforts to reduce the waiting list inherited when the service moved in to CYPS. The latest waiting list data suggests there is a backlog of referrals in to this service, with 66 children waiting for an appointment – 59 (89%) of whom have been waiting for over 10 weeks – as at 10th September 2015 (Table 19).

**Table 19 Number of children on waiting list for CYPS LD service as at 10th September 2015**
This has reduced from the position as at 31st May 2015, when there were 77 children and young people on the waiting list for the CYPS LD team. Whilst this appears to be reducing, Chapter 4 describes the vulnerability of children and young people with learning disabilities to poor mental health. Therefore, attention should be paid to continuing to improve access to and reduce waiting times for this service in the transformation plan.

5.1.7 Eating Disorders Service

Gloucestershire’s Eating Disorders Service is an ‘all-age’ service, meaning that transition issues are avoided when a young person is 18. The service consists:

- Community Team - assesses and treats children, adolescents and adults
- Child and Adolescent Home Treatment Team (ChAHTT) - intensively supports severely ill young people and their parents in their homes, enabling them to avoid hospital admission
- Day Treatment Team – (age 16+) provides 2 meals and 2 snacks, 5 days per week in a group only therapy setting as an alternative to hospital admission.

This service has seen an increasing caseload, which has doubled between April 2013 and March 2015 (Figure 35). Of the 208 cases held in March 2015, the vast majority (204 cases) were held by the Community Team.

<table>
<thead>
<tr>
<th></th>
<th>0-6 wks</th>
<th>&gt;6-8 wks</th>
<th>&gt;8-10 wks</th>
<th>&gt;10 wks</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYPS LD</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>59</td>
<td>66</td>
</tr>
</tbody>
</table>

Figure 35 Eating Disorders Team Caseload (0-18 year olds), April 2013-March 2015

Accepted referrals in to the service have remained static at 134 in 2013/14 and 2014/15. Again, the majority of these (122) were in the Community Team

Gloucestershire’s service is showcased as a model of good practice in the detailed Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning
Guide issued alongside the Future in Mind guidance. Despite the larger caseload, the waiting times for services are within current standards and are not currently of concern. This will be monitored on an ongoing basis and, should the situation change, action should be taken to ensure the service can meet demand.

5.1.8 Level 3.5 Services

The CYPS Level 3.5 Team is staffed by Level 3 clinicians who have dual roles; providing management of full caseloads for specialist interventions, daily cover to the Level 3.5 rota (self-harm assessments, self-harm follow-up appointments and crisis home treatment to avoid inpatient admission).

There has been a modest increase in demand for Level 3.5 services between 2013/14 and 2014/15 – even when the relatively small number of ‘inappropriate’ referrals is removed – with the biggest increase seen in internal referrals (Figure 36).

![Figure 36 Referrals to Level 3.5 Services in 2013/14 and 2014/15](image)

As may be expected from this increase in referrals, there has been a corresponding increase in this team’s activity in both face-to-face and telephone contacts, with a sharper increase in telephone contacts (Figure 37).
It may be that the increase in telephone contacts reflects a lack of capacity to meet demand face-to-face or it may just be that telephone contacts are more appropriate for the particular caseload but further exploration could help to understand potential capacity issues.

Level 3.5 services are not delivered by a standalone team but on a rota basis by Level 3 staff members, who hold a full Level 3 caseload. Given the increased demand for these services and the limited capacity of those delivering them, consideration should be given to the allocation of sufficient resources to meet demand.

5.1.9 In-patient care

Tier 4 services for children and young people (including day and in patient care) are commissioned by NHS England Specialised Commissioning, although referrals to these services come via community tier 3 CAMHS (CYPS in Gloucestershire) and children and young people are discharged back to community tier 3 CAMHS when safe to do so.

Figure 38 shows that the number of new out of county adolescent (under 18) inpatient admissions is relatively small and that, between April 2013 and July 2015, most months have seen one or two admissions. However, there have been spikes of up to five admissions in May 2013 and June 2015 and four admissions in December 2014 and a very slight upwards trend. This slight upwards trend appears to be caused by the inclusion of data from the early months of 2015/16, as there was a total of 22 admissions in both 2013/14 and 2014/15.
Gloucestershire does not have any CAMHS Tier 4 inpatient provision within the county. When there are no local beds, young people can be placed in private units as far afield as Kent, Surrey, Maidenhead, Manchester, Birmingham and further. As well as being unsatisfactory for a young person and their family, this can create difficulties with discharge to local services.

Local commissioners should continue to explore closer collaboration with NHS England to ensure the needs of this small cohort of local young people are met; that, where appropriate, alternatives to in-patient care are available; that support is available as close to home as possible; and that pathways are seamless.

5.1.10 S136 Admissions to Maxwell Suite

Between January 2012 and July 2015, there was a slight increase in admissions of young people under the age of 18 to the Maxwell Suite, Gloucestershire’s place of safety for people detained by police under Section 136 of the Mental Health Act because they appear to be suffering from a mental disorder and need immediate care (Figure 39). Numbers are relatively small but there have been peaks of up to five or six admissions in individual months.
5.2 Other 2gether NHS Foundation Trust Services

5.2.1 Gloucestershire Recovery in Psychosis (GRiP)

The GRiP team works with young people aged between 14 and 35 who are experiencing or who are at risk of experiencing a first episode of psychosis. The team is sometimes referred to as ‘the early intervention service’.

In 2014/15, 29 young people aged 17 and under were referred to the GRiP team, with the majority (69%) referred from another 2gft team. There were 4 referrals by a GP and 2 by schools.

During the year, the team held an average caseload of 10 young people aged 17 and under at month end. However, there was a clear upward trend in the monthly caseload in 2014/15 (Figure 40).
Figure 41 shows a corresponding increase during 2014/15 of activity – both face-to-face contacts and telephone contacts – by the GRiP team with young people aged 17 and under.

![Graph showing number of contacts by GRiP team (aged 17 and under) 2014/15](image)

Figure 41 Number of contacts by the GRiP team (aged 17 and under) 2014/15

Given the increase in use of this service by young people aged 17 and under during 2014/15 and its focus on early intervention, those involved in the development and implementation of the transformation plan should take into account the GRiP service and its role in the system for children and young people.

### 5.3 Youth Support Service

Prospects runs the Youth Support Service on behalf of Gloucestershire County Council. The team works with approximately 6,000 vulnerable young people in the county, targeting specific groups who are most at risk of not making a successful transition into adulthood. This includes young offenders and those on the edge of the criminal justice system; looked after children and care leavers over the age of 16; unemployed young people; homeless young people; teenage parents; young people who run away from home or care; young people with disabilities and/or learning difficulties; and young people with substance misuse issues or other health needs.

As outlined in Chapter 4, many of these young people are at a higher risk of developing poor mental health and, as such, much of the work of Prospects is relevant to supporting children and young people’s emotional wellbeing and mental health. However, for the purpose of this needs assessment, this chapter will consider activity in two of its services most directly relevant to the subject matter: Building Emotional Resilience Service (BERS) and Youth Justice Liaison & Diversion (L&D) Service.

Note: at the time of writing, databases were being updated and information about activity is therefore limited. Further work should be undertaken as part of the implementation of the transformation plan to better understand any trends in levels of activity in this service.

#### 5.3.1 Building Emotional Resilience Service (BERS)
BERS was established in response to concerns about the number of children and young people presenting at hospital having self-harmed. The team offers additional support to those presenting in order to reduce the likelihood of them re-presenting in future.

Between July 2014 and June 2015, there were 138 referrals to BERS, just over 10% of all referrals to the Youth Support Team. Figure 42 shows that, of these referrals, BERS worked with triage was offered and accepted on 56 occasions, with triage declined on 10 occasions.

Figure 42 Referrals to Building Emotional Resilience Service (BERS) July 2014-June 2015

Section 2.5 recommends that the momentum created by the significant progress of the Children & Young People's Self-Harm Group to reduce the incidence of self-harm amongst Gloucestershire's young people – including the implementation of BERS – should be maintained through the transformation plan.

5.3.2 Youth Justice Liaison & Diversion (L&D) Team

The aim of Youth Justice Liaison and Diversion is to intervene early to improve health outcomes for children and young people in contact, or at risk of contact, with the youth justice system. Diversion can be action to avoid a young person coming into the youth justice system in the first place (diversion away from the system) or action to improve what happens if they do come in (diversion within the system).

Between July 2014 and June 2015, there were 749 referrals to the Gloucestershire L&D team, just over half of all referrals to the Youth Support Team. Figure 43 shows that, of these referrals, 612 (81.7%) were accepted for triage, although where referrals were not accepted for triage, in some cases, low-level restorative justice work was undertaken with the young person.
Figure 43 also shows that triage was declined on 277 occasions or in 45.2% of referrals accepted for triage. This is unsurprising given the client group and is similar to the rate of declined triage for L&D services elsewhere. However, consideration should be given to any potential actions that might lead to an increase in the number of young people accepting the offer of L&D triage.

**5.4 Services provided by the voluntary and community sector**

As well as the main commissioned services outlined above, children and young people in Gloucestershire access a range of other services to support their emotional wellbeing and mental health. This section describes the activity of two of these services: counselling provision delivered by TIC+ and support provided by the Gloucestershire Self-Harm Helpline.

**5.4.1 TIC+ Counselling Provision**

TIC+ is a Gloucestershire based registered charity, providing counselling to children and young people aged between 9 and 21. In 2014/15, TIC+ employed 36 part time counsellors, who are able to cover the whole of the county.

TIC+ provides counselling via a number of service level agreements with schools and colleges, as well as a formal referral relationship with 2gether NHS Foundation Trust’s Children and Young People’s Service (CYPS). Table 20 shows the service levels agreements held by TIC+ with schools and colleges in 2014/15.

**Table 20 TIC+ counselling provision in schools (2014/15)**

<table>
<thead>
<tr>
<th>School</th>
<th>Type of School</th>
<th>District</th>
<th>Weekly Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bredon School, Tewkesbury</td>
<td>Independent day and boarding school, for boys and girls aged 3-18 with a specialism for children with dyslexia, dyspraxia and associated learning needs</td>
<td>Tewkesbury</td>
<td>1 day per week</td>
</tr>
<tr>
<td>Lakers School, Coleford</td>
<td>Foundation school for boys and girls, with sixth form</td>
<td>Forest of Dean</td>
<td>1 day per week</td>
</tr>
</tbody>
</table>
This shows that, whilst there is a dedicated service in a number of schools in the county, there is by no means a consistent service and, indeed, Table 20 suggests that there are gaps in areas such as Stroud and Cotswold districts. However, there will be other provision, including that provided by schools themselves and this should therefore be seen in the context of data in Section 5.5.

TIC+ also provides services to young people who have been identified by CYPS as having moderate mental health issues. In 2014/15, CYPS referred 240 young people to TIC+ for counselling. The formal partnership with 2gether NHS Foundation Trust also allows TIC+ to refer young people to CYPS where appropriate. However, the narrative underpinning the number of TIC+ clients shown in Figure 44 suggests that there may be more young people who have been signposted, rather than referred, by CYPS and are therefore accessing the free access counselling and not counted in the referral rate above.

Figure 44 shows the number of clients seen by TIC+ from 2013-2016 (projected), broken down by those seen within contracts with schools, those referred by CYPS and those accessing the service directly. This shows a general increase in demand for services but, most significantly an increase in demand for the free access counselling, which is likely to have more than doubled since 2013.
TIC+ suggests that the majority of young people who (self) refer to the free access counselling service have been signposted from statutory services, including GPs, schools and colleges, social workers and, as described above, CYPS.

Despite this increase in referrals, average waiting times for TIC+ counselling reduced from 3.36 weeks in 2013/14 to 2.94 weeks in 2014/15. However, TIC+ has indicated that this will be more challenging to maintain given the greater increase in referrals, particularly to the free access counselling during 2015/16.

Consideration should be given to ensuring consistent and financially sustainable access to counselling services across the county. There may also be opportunities to explore different ways of meeting demand, for example through new ways of accessing services online.

5.4.2 Gloucestershire Self-Harm Helpline

The Gloucestershire Self-Harm Helpline is provided by Rethink Mental Illness and provides telephone, text messaging and online messaging support for people who self-harm, thinking about self-harming or concerned about someone who might be self-harming, including but not limited to children and young people.

Given the confidential nature of the service, it is difficult to break down the number of contacts received by the service by the age of service user. However, the age of the service user is recorded where it is given and, on this basis, in 2014/15 there were at least 26 calls by those under the age of 18 and at least 121 text and live chat conversations by those under the age of 18. This clearly shows a preference by young people for accessing the service by text or live chat. Learning from the Self-Harm Helpline about children and young people’s preferences for accessing support by text or live chat should be shared to help inform the way other services are offered.

However, use of the service by young people under the age of 18 still makes up a very small proportion of all contacts to the helpline (Figure 45).

![Contacts to Self-Harm Helpline Q1 2015/16 by age range](image)
Furthermore, feedback from stakeholders has suggested that there is insufficient knowledge about the helpline amongst professionals who support children and young people, whilst Section 2.5 identifies a need to continue to support those who are self-harming. The helpline is due to be recommissioned by Gloucestershire County Council from April 2016 and this presents an opportunity that should be taken to shape the service to ensure it meets the needs of children and young people and that it is embedded within the local self-harm pathway.

5.5 Provision in or via schools and colleges

Children and young people often access support through their school, college or other educational setting. However, the provision by schools and colleges of interventions to support the emotional health and wellbeing of their students differs across the county and is largely dependent on the individual school or college.

In a recent survey of schools and colleges, over half of respondents said their setting had a range of interventions in place, including peer mentoring, parenting support, a school counsellor or access to voluntary sector services (Figure 46). Peer mentoring and a qualified first aider were the most commonly reported interventions. However, only 12% of respondents said they have access to a Primary Mental Health Worker.

![Figure 46](image)

**Figure 46** % of schools and colleges reporting that they have in place one or more interventions to support student emotional health and wellbeing

Chapter 3 recommends that more robust and consistent links between schools and mental health services are developed and the data in Figure 46 supports the need for this improvement. This data also suggests that CYPS should continue to promote their Practitioner Advice Line, as recommended above, in order to support this link.

Further analysis of which schools are providing a counselling intervention by a school nurse, school counsellor, primary mental health worker or voluntary organisation shows that 18% of schools and colleges do not provide any kind of counselling support and a further 11% only
have one source of counselling provision. However, 46% have 3 or more types of counselling support available (Table 21).

Table 21 Availability of counselling support in schools and colleges

<table>
<thead>
<tr>
<th>Counselling support (school nurse, school counsellor, primary mental health worker, voluntary organisation)</th>
<th>Number of schools / colleges</th>
<th>% of schools/colleges</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>5</td>
<td>18%</td>
</tr>
<tr>
<td>1 of the above</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>2 of the above</td>
<td>8</td>
<td>25%</td>
</tr>
<tr>
<td>3 of the above</td>
<td>18</td>
<td>37%</td>
</tr>
<tr>
<td>All of the above</td>
<td>5</td>
<td>9%</td>
</tr>
</tbody>
</table>

Other support used by schools and colleges to support their students’ emotional health and wellbeing include:

- Adult volunteer mentors to support young people with a variety of issues
- Outside agencies, such as social care, Families First, Gloucestershire Young Carers, Youth Support Team, Eating Disorders Clinic, fly2help, Infobuzz, Winston’s Wish, Family Lives, Engage programme, local PCSO
- Multi-agency meetings
- Psychiatrists and psychologists who work closely with the school
- Rethink Mental Illness
- Teens in Crisis (TIC+)
- Drug and alcohol information and support.

What is most apparent from the findings of the schools and colleges survey is that, whilst there appears to be a wide range of interventions available, access to support for children and young people’s emotional wellbeing through educational settings is inconsistent. This is unsurprising given the way in which schools and colleges manage their own budgets. However, consideration should be given to improving the consistency of the provision of support through schools and colleges. In particular, there should be consistent access to counselling support for children and young people with ‘sub clinical’ emotional wellbeing needs.

5.6 Summary of conclusions and recommendations

- Section 5.1 – In order to improve understanding about how those children and young people with mild to moderate needs are currently supported and the scale of demand for this support, information about the consultation, networking and advice activity undertaken by the PMHW team should be captured and shared.
- Section 5.1 – Promotion of the CYPS Practitioner Advice Line should continue, in order to help professionals working with children and young people to provide appropriate support and to help reduce unnecessary or inappropriate referrals to CYPS. In particular, the Advice Line should be seen as an integral part of developing links between schools and mental health services.
- Section 5.1 – There is also an opportunity that should be explored for the delivery of parenting programmes by CYPS registered professionals, to assist with early intervention where there is identified need.
- Section 5.1 – Consideration should be given to increased capacity for professionals supporting vulnerable families – including social care and adult mental health services – to
develop skills in supporting parental and infant mental health and to work together across the system.

- **Section 5.1** – Further work should be undertaken to understand the level of need for infant mental health services amongst children aged three to five and this should inform any future commissioning.
- **Section 5.1** – Attention should be paid to continuing the positive progress to date to reduce the waiting list for a Level 3 CYPS appointment but also to ensuring that children and young people do not have to wait as long between referral and treatment.
- **Section 5.1** – Given the vulnerability of children and young people with learning disabilities to poor mental health, attention should be paid to improving access to and reducing waiting times for this service in the transformation plan.
- **Section 5.1** – Given the increased demand for Level 3.5 services and the limited capacity of those delivering them, consideration should be given to the allocation of sufficient resources to meet demand.
- **Section 5.1** – Local commissioners should continue to explore closer collaboration with NHS England to ensure the needs of local young people are met; that, where appropriate, alternatives to in-patient care are available; that support is available as close to home as possible and that pathways are seamless.
- **Section 5.2** – Given the increase in use of the GRiP service by young people aged 17 and under during 2014/15 and its focus on early intervention, those involved in the development and implementation of the transformation plan should take into account the service and its role in the system for children and young people.
- **Section 5.3** – Further work should be undertaken as part of the implementation of the transformation plan to better understand any trends in levels of activity in the services provided by the Youth Support Team.
- **Section 5.3** – Consideration should be given to any potential actions that might lead to an increase in the number of young people accepting the offer of L&D triage.
- **Section 5.4** – Consideration should be given to ensuring consistent and financially sustainable access to counselling services across the county. There may also be opportunities to explore different ways of meeting demand, for example through new ways of accessing services online.
- **Section 5.4** – Learning from the Self-Harm Helpline about children and young people’s preferences for accessing support by text or live chat should be shared to help inform the way services are offered.
- **Section 5.4** – Commissioners should ensure that, when recommissioning the Self-Harm Helpline, it meets the needs of children and young people and is embedded within the local self-harm pathway should be taken.
- **Section 5.5** – Consideration should be given to improving the consistency of the provision of support through schools and colleges. In particular, there should be consistent access to counselling support for children and young people with ‘sub clinical’ emotional wellbeing needs.
6. What works?

As well as understanding the need for services, the demand and the current level of supply, it is important to understand what works. This helps to ensure that services meet the local need, are accessed by those who will benefit most and lead to the intended outcomes. This chapter considers the evidence available for the effectiveness for interventions to promote emotional wellbeing and prevent mental ill health in children and young people and makes recommendations for improvements in Gloucestershire based on this evidence.

Childhood programmes represent by far the largest group of evidence-based approaches to promoting mental health. These relate primarily to interventions to support parenting and interventions to promote mental wellbeing in schools.

6.1 Parenting Programmes

As outlined in Chapter 3, parenting is one of the most important modifiable risk factors for mental health problems in childhood. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating).

The majority of evidence-based parenting programmes are designed for targeted populations. Current policy recommends universal underpinning and targeted provision for identifiable high-risk groups, such as teenage parents, or high-risk, socially disadvantaged areas (Faculty of Public Health, 2010). However, learning from the delivery in Gloucestershire of parenting programmes, including some of those outlined in this chapter, suggests that they are most effective when:

- Carefully targeted at those families that would most benefit;
- Delivered at a time when the parents are ready to make a change to their parenting behaviour; and
- Delivered in the context of, rather than in isolation from, wider required support, e.g. drug or alcohol treatment.

6.1.1 Infancy

Universal infant programmes can be offered in the context of antenatal care or at birth, e.g. maternity and health visiting services, to help all parents develop sensitivity to their infants, identify temperamental differences and provide them with knowledge of child development and the management of infant behaviours, such as sleep and crying.

These services also help parents to be more adept at addressing their own mental health needs. As described in Chapter 2, whilst some sources suggest that universal approaches or screening are inefficient (FPH, 2010), the latest NICE guidance on antenatal and postnatal mental health (NICE, 2014) recommends that, at a woman's first contact with primary care or her booking visit, and during the early postnatal period, a number of depression identification questions should be considered as part of a general discussion about a woman's mental health and wellbeing. This should be underpinned by more targeted information, advice and support for women who are at a higher risk of developing poor mental health.
Targeted infant parenting programmes are usually delivered to high-risk groups, commonly teenage mothers. These are usually offered on a one-to-one basis through home visiting and may be intensive, providing weekly visits for up to two years, starting before birth. The best-known example of this approach is the Family Nurse Partnership.

**Case study** (from Faculty of Public Health, 2010)

**The Family Nurse Partnership:** has an established evidence of its effectiveness. It is an intensive, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive relationship with the family. Initial research in England has found that mothers who receive support from family nurses show positive results, including:

- stopping smoking during pregnancy
- high levels of breastfeeding
- improved self esteem
- being much more likely to return to education or employment when their children are old enough

The Family Nurse Partnership is now well recognised as a successful and well-established programme with strong Government support. ([http://fnp.nhs.uk/](http://fnp.nhs.uk/))

In Gloucestershire, the principles behind the Family Nurse Partnership approach were used to help inform the development of the local multi-agency Turn Around for Children Service (TACS) which provides a specific targeted approach for families where young children are experiencing severe and chronic neglect as a result of the mental health, substance misuse and/or other needs / behaviour of their parents. It includes a Family Drug & Alcohol Court, and the locally developed Journey into Positive Parenting Programme to achieve many of the same outcomes that are desired through Family Nurse Partnership.

Targeted programmes to prevent postnatal depression in high-risk groups and in mothers with established depression include cognitive behavioural therapy (CBT) and person-based counselling, both of which are equally effective if the practitioner can establish a trusting relationship with the mother (NICE, 2014).

**6.1.2 Older children**

Most parenting programmes or family therapy target families where children have or are at high risk of developing behaviour problems. For the most part, they address behaviour management but the Faculty of Public Health (2010) argues that programmes with a greater emphasis on the wellbeing of both the parent and child and the relationships between them may be more appropriate for preventing mental illness.

Parenting programmes and family therapy approaches are often group-based but may be one-to-one and most are strengths-based, i.e. they identify and build on what parents are getting right, rather than on problems. The Faculty of Public Health describes effective programmes as:

- manualised (i.e. facilitators use a manual that includes a description of the programme, each session and guidance for facilitation);
- involving experiential learning; and
- requiring 'homework' by parents between sessions.
**Case Studies** (from Faculty of Public Health, 2010)

**Functional Family Therapy/FFT** is for families with a young person (between 10 and 18 years) involved in serious delinquent behaviour and/or substance misuse. Its primary aims are to reduce youth offending, substance misuse and out-of-home placement.

Young people are typically referred into FFT through the youth justice system. The young person and their parents then attend 8 to 30 weekly sessions (depending on need), where they develop strategies for improving family functioning and addressing the young person's behaviour.

FFT has strong (established) evidence of improving family functioning and reducing young people's involvement in crime and/or substance misuse.

http://www.fftllc.com

**Standard Triple P** is a targeted prevention programme for parents of children aged 2 to 12 with concerns about the child's emotions or behaviour. Triple P is a suite of programmes from universal media based through to intensive one-to-one support for families. Parents attend between 8 and 10 individual or group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour.

Standard Triple P has strong (established) evidence of improving child behaviour, improved parenting practices/competency, and improved parent wellbeing

http://www.triplep-parenting.uk.net/uk-en

Two large trials of Triple P offered at all levels are among the few studies to have demonstrated impact of a universal and targeted approach combined; one of the studies also showed an effect on abusive parenting.

A study in the UK showed that even evidence-based programmes like Triple P may be ineffective in some settings (Little et al, 2012). Implementing these programmes effectively requires considerable attention to detail, high levels of staff training and supervision, and strong backing from local child health and education services.

The transformation plan should seek to establish which parenting programmes are delivered in Gloucestershire and review them in line with this evidence with a view to coordinating delivery, to ensure they are as effective as possible and contribute to reducing the risk to children and young people's mental health and wellbeing.

The Faculty of Public Health (2010) also identifies the following interventions or support:

- **Parenting advice lines or Internet based parenting support** can provide targeted support confidentially to parents who are concerned about their child’s mental health and wellbeing and can facilitate networking and peer support, as well as access to local services.

- **Peer support** projects have been developed to support parents and parenting. Properly run, with good training and supervision of volunteers, these programmes can increase confidence, social networks and engagement.
• **Prevention of abuse and neglect**, including programmes such as Parents under Pressure (http://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/parents-under-pressure/parents-under-pressure-evidence-impact-and-evaluation-evidence-impact/), which has shown some success with families in which parents abuse drugs and alcohol. It is currently being evaluated and the final report expected in 2016.

Local feedback to the earliest iterations of this needs assessment suggests that a focus on parenting programmes can appear to cast parents and carers as a problem, rather than an important resource to support children and young people to promote emotional wellbeing and prevent mental ill health. Some of support and interventions described above – including advice lines, Internet based parenting support and peer support groups – can ensure parents and carers understand issues relating to mental health and wellbeing and can provide appropriate support for their children. Whilst there is some provision of this support in Gloucestershire, mostly through voluntary and community sector organisations, consideration should be given to the provision of this support in a more coordinated and consistent way.

6.2 Interventions to promote mental health in schools

Schools have a key role to play in supporting children to be resilient and mentally healthy and Stewart-Brown (2006) argues that programmes to promote mental health are among the most effective of school health promotion programmes.

Universal approaches are effective but can also reinforce targeted approaches. The optimum approach is to offer both (Weare & Markham, 2005 and Weare, 2010). NICE (2008) has also recommended universal and targeted programmes in both primary and secondary schools.

Gloucestershire schools benefit from an extensive programme of interventions to improve the emotional resilience of their pupils through the Gloucestershire Healthy Living & Learning (GHLL) service. However, further consideration should be given to the way in which these kinds of interventions in schools are planned, so that there is coordination of both universal and targeted approaches to achieve maximum benefit. A good example of this would be the provision of interventions to address eating disorders, where targeted approaches with those groups who are at most risk can be underpinned by universal approaches focusing on social norms relating to body image, to create a school culture that supports the prevention of eating disorders.

6.2.1 Universal

Evidence suggests that long-term interventions promoting good mental health (rather than the prevention of mental illness) and involving changes to the school culture are likely to be more successful than brief, class-based mental illness prevention programmes (Wells et al, 2003).

School engagement has been highlighted as necessary for the effectiveness and sustainability of these programmes and, therefore, programmes can work better if offered by teachers than by people unknown to or from outside the school. Support from the headteacher is essential, particularly where significant change to the school culture is sought. School engagement is enhanced if programmes can be adapted for each school setting, but this should not be at the cost of core components that have been developed on the basis of robust evidence.

Case Studies (from Faculty of Public Health, 2010)
Promoting Alternative Thinking Strategies (US in origin, found in the UK, the Netherlands, Germany, Switzerland, Croatia and Northern Ireland): classroom-based and grounded in social and emotional learning (SEL). The PATHS programme covers 5 domains of social and emotional development, self-control, emotional understanding, positive self-esteem, relationships and interpersonal problem solving skills. The program has established evidence of effectiveness.

www.channing-bete.com/prevention-programs/paths/paths.html

Incredible years (US in origin, found in UK, Ireland and Norway): The programme focuses on strengthening teachers’ classroom management strategies; promoting student’s prosocial behaviour; emotional self-regulation and school readiness; and reducing children’s classroom aggression and noncooperation with peers and teachers. The training also helps teachers collaborate with parents to support their school involvement and promote consistency of learning between home and school. The program has initial evidence of effectiveness.

http://incredibleyears.com

6.2.2 Targeted

One of the most well-known targeted schools programme in the UK is the Targeted Mental Health in Schools Programme (TaMHS), which provides cognitive behavioural therapy (CBT) and social skills training to individual children identified as experiencing difficulty. The programme underwent a national evaluation between 2008 and 2011. A range of recommendations were made, including the following, which are of relevance to this needs assessment:

<table>
<thead>
<tr>
<th>Targeting mental health in primary schools</th>
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<tbody>
<tr>
<td>• It may make sense to prioritise interventions with primary school pupils to have maximum impact before problems become too entrenched.</td>
</tr>
<tr>
<td>• It may be worth considering further use of evidence-based self-help materials for primary school pupils at risk of or with behavioural difficulties.</td>
</tr>
<tr>
<td>• Caution should be taken when giving information to pupils in primary school with emotional problems to ensure the material does not impact negatively.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Targeting mental health in secondary schools</th>
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<tbody>
<tr>
<td>• It may make sense to prioritise improved inter-agency working (such as by use of systems such as the CAF).</td>
</tr>
<tr>
<td>• It may be beneficial to prioritise improved relationships and referral routes between schools and specialist mental health services (CYPS in Gloucestershire).</td>
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<tr>
<th>Evidence based practice</th>
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<tbody>
<tr>
<td>• It may be helpful for schools to be encouraged to consider using more manualised approaches as these have been found to have the greatest impact. However, this should be combined with local ownership to aid uptake.</td>
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<table>
<thead>
<tr>
<th>Inter-agency working</th>
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<tr>
<td>• It may be important to ensure that schools continue to be able to refer their pupils for appropriate help, given that parents identify them as the key point of contact and advice.</td>
</tr>
<tr>
<td>• Educational psychologists appear to be a key group in relation to mental health provision in schools and their potential role as a conduit between schools and specialist mental health services (CYPS in Gloucestershire) should be encouraged.</td>
</tr>
</tbody>
</table>
Future implementation of policy

- It may be helpful to ensure that attention is paid to ensuring a common language and as full integration as possible of services in schools.

- When implementing interventions such as TaMHS on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support and how such support can be sustained – for example, by not requiring that provision be “innovative” or “new” and rather allowing areas to draw on existing good practice.

Another example of a successful targeted intervention in schools is Place2B (for more information, see [http://www.place2be.org.uk/](http://www.place2be.org.uk/)). This provides a staffed facility in which children with problems can take themselves when they start feeling overwhelmed or causing problems and offers 1-2-1 counselling, as well as a drop-in service and group or whole class work.

6.3 Summary of conclusions and recommendations

- Section 6.1 – At a woman’s first contact with primary care or her booking visit, and during the early postnatal period, a number of depression identification questions should be considered as part of a general discussion about a woman’s mental health and wellbeing. This should be underpinned by more targeted information, advice and support for women who are at a higher risk of developing poor mental health.

- Section 6.1 – The transformation plan should seek to establish which parenting programmes and family therapy approaches are delivered in Gloucestershire and review them in line with the evidence outlined in this chapter, with a view to coordinating delivery, to ensure they are as effective as possible and contribute to reducing the risk to children and young people’s mental health and wellbeing.

- Section 6.1 – As well as being evidence-based, parenting programmes and family therapy approaches should be appropriately targeted; delivered at a time when parents are ready to make improvements to their parenting; and delivered in the context of wider support for the family. There should be high levels of staff training and supervision and coordination with local child health and education services.

- Section 6.1 – Consideration should be given to a more coordinated and consistent provision of telephone or online advice and peer support groups for parents across Gloucestershire.

- Section 6.2 – Further consideration should be given to the way in which interventions to improve pupils’ emotional resilience and mental health in schools are planned, so that there is coordination of both universal and targeted approaches to achieve maximum benefit. For example, this approach may work well with interventions relating to eating disorders.

- Section 6.2 – Universal interventions in schools should focus on promoting good mental health, rather than preventing mental illness, and should make positive changes to the school culture. Where possible, they should be delivered by school staff and, although they can be adapted, they should retain core, evidence-based components.

- Section 6.2 – Interventions with primary school pupils should be prioritised and could include the use of evidence-based self-help material, but caution should be exercised to ensure material does not impact negatively.

- Section 6.2 – Inter-agency working, and particularly relationships between schools and mental health services, should be improved. Educational Psychologists should be seen as an
important conduit to support this link. Schools should also be able to be a referral point to available support.

- Section 6.2 – Manualised interventions in schools should be preferred but with local ownership to ensure their success.
- Section 6.2 – Attention should be paid to using a common language throughout Gloucestershire and to the full integration of interventions into the school environment.

### 7. Conclusions & Recommendations

**Chapter 2 – Incidence and prevalence of mental illness in Gloucestershire**

- **Section 2.1** – When services are introduced or changed as a result of the transformation, the impact on and access by children and young people with protected characteristics, including those from BME groups, should be carefully considered.

- **Section 2.2** – The Future in Mind report recommends a new national survey to establish up to date prevalence rates and this needs assessment should be reviewed in line with that survey’s findings, once available.

- **Section 2.3** – Where targeted approaches are delivered to reduce the incidence of eating disorders amongst those most at risk (i.e. teenage girls), consideration should also be given to the implementation of universal interventions, such as those that promote an understanding of social norms relating to body image.

- **Section 2.4** – Further work to improve the local understanding of need and demand for perinatal mental health services should be a core element of the local action plan and the findings incorporated into the Future in Mind transformation plan.

- **Section 2.4** – At a woman's first contact with primary care or her booking visit, and during the early postnatal period, a number of depression identification questions should be considered as part of a general discussion about a woman's mental health and wellbeing. This should be underpinned by more targeted information, advice and support for women who are at a higher risk of developing poor mental health.

- **Section 2.5** – When available, findings from the self-harm survey in schools and colleges should inform the ongoing development of action to reduce the incidence of self-harm and provide appropriate support for children and young people who self-harm.

- **Section 2.5** – Further work should be undertaken to understand trends in self-poisoning amongst children and young people and should inform any future implementation of or change to self-harm and mental health support services.

- **Section 2.5** – The momentum created by the significant progress of the Children & Young People's Self-Harm Group to reduce the incidence of self-harm amongst Gloucestershire’s young people should be maintained through the transformation plan.

- **Section 2.6** – Consideration should be given to resourcing the process of reviewing ‘near misses’ and its up to date findings should be shared with relevant partners, to inform the development and implementation of the transformation plan.

- **Section 2.6** – Those leading the development and implementation of the Future in Mind transformation plan should link effectively to the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) to ensure that those priorities in its strategy relevant to
preventing suicide amongst children and young people are, where appropriate, embedded in the transformation plan. These recommendations are:
  o Ease of access by children and young people to treatment/support
  o Influence and impact of internet and social media (not specifically for children and young people)
  o Effective and timely support for children bereaved by suicide
  o Reduce the prevalence of self-harm
  o Support for the Child Death Review process to continue to identify ‘near misses’ in young people, together with recommendations to prevent them.

Chapter 3 – Risk factors for mental illness or poor emotional wellbeing

- Section 3.2 – Provision of support should focus in areas of highest deprivation, including Gloucester, Cheltenham and part of the Forest of Dean. However, given the caveat on deprivation data, there should be access to support for children and young people living outside of these areas and, therefore, models of practice in a range of urban and rural settings should be tested and, where appropriate, rolled out.
- Section 3.2 – Consideration should be given to the development of more robust and consistent links between mental health services and schools, colleges and other educational settings, which are accessible across the county and attended by most (although not all) children and young people.
- Section 3.3 – There should be coordination between adult mental health services and children’s social care and children and young people’s mental health services to ensure the impact of parental mental illness on a child’s own mental health is taken into account and, where possible, minimised.
- Section 3.3 – The transformation plan should seek to establish which parenting programmes are delivered in Gloucestershire, including those delivered in the perinatal period, and review them in line with the evidence outlined in Chapter 6, with a view to coordinating delivery, to ensure they are as effective as possible and contribute to reducing the risk to children and young people’s mental health and wellbeing.
- Section 3.4 – Given the impact on the child’s outcomes and, in particular, their emotional wellbeing and mental health, a whole family approach should be taken to addressing those parental issues that put children at a greater risk of developing poor mental health, e.g. substance misuse. This will require coordination of effort across a range of agencies, including providers of substance misuse treatment and recovery services. The recommissioning of the community drug and alcohol recovery service by Gloucestershire County Council provides an opportunity to do this.

Chapter 4 – Prevalence amongst higher risk groups

- Chapter 4 – Services should be accessible to and meet the specific needs of groups of children and young people at higher risk of developing poor mental health. Proposals for service transformation should be equality impact assessed to help inform this.
- Section 4.1 – Further work should be undertaken with those working in children’s social care to monitor Gloucestershire’s average SDQ score and the percentage of children in care in Gloucestershire with an emotional and behavioural health assessment considered ‘of concern’ between 2010/11 and 2013/14. Any learning from this should inform future
activity to support or improve the emotional wellbeing of children in care and, where relevant and appropriate, activity to support other vulnerable children and young people.

- **Section 4.1** – Those commissioning and providing children’s social care should be actively engaged in the development and implementation of the transformation plan, to ensure that the emotional wellbeing and mental health needs of children that are subject to a child protection plan are met.

- **Section 4.3** – The impact of potential changes in trends of unaccompanied asylum seeking children on the support required in Gloucestershire should be monitored during the lifetime of the transformation plan and action taken where required.

- **Sections 4.3 and 4.11** – Consideration should be given to the provision of evidence-based support for children and young people who have experienced trauma, including unaccompanied asylum seeking children, children who have witnessed domestic abuse or have been a victim of child sexual exploitation or sexual abuse. This might include the use of CBT but should always be based around the development of safe, secure, trusting and culturally sensitive therapeutic relationships.

- **Section 4.5** – Adult mental health and drug and alcohol services in Gloucestershire should be engaged in the transformation of services for children and young people’s mental health and wellbeing, to ensure that the specific needs of those children living with adults with mental ill health or substance misuse problems are considered. In particular, the needs of young carers of these adults should be taken into account when planning and providing support to the family.

- **Section 4.6** – When planning interventions to promote good mental health and preventing mental illness in children and young people, e.g. emotional resilience activities in educational settings, consideration should be given to the accessibility to these interventions by children with learning disabilities.

- **Section 4.6** – There may also be an argument that these interventions should be targeted in educational settings attended by children with learning disabilities and, although the prevalence data might suggest that interventions should be focused on older children, broader evidence suggests that it is best to start building emotional resilience in younger children.

- **Section 4.6** – Attention should be paid to improving access to and reducing waiting times for the service for children and young people with learning disabilities.

- **Section 4.7** – Psychological support, including support for low-level emotional wellbeing needs, should be provided to children and young people with long-term conditions and, perhaps, trialled with those with epilepsy in the first instance.

- **Section 4.8** – The development of the transformation plan should make effective links with the Gloucestershire Teenage Pregnancy Partnership Board to ensure the implementation of recommendations relating to perinatal mental health (see chapter 2) take into account the needs of teenage mothers.

- **Section 4.8** – Consideration should be given to the support required to meet the emotional wellbeing and mental health needs of young women who have had an abortion, as well as those who have carried their pregnancy to full term and may be at risk of postpartum mental health conditions.

- **Section 4.9** – Wider training and employment support providers should be engaged in the development and implementation of this transformation plan.
• Section 4.10 - The transformation plan should take into account the recommendations of the Young Minds report on the mental health of young offenders and ensure the specific needs of young offenders are considered in any changes to the system to support their emotional wellbeing and mental health. These recommendations relate to:
  o Consistency in relationships
  o Professionals with skills in mental health support
  o Improved coordination of, access to and transitions between services
  o Assertive health care pathway management
  o Easy access to information.

• Section 4.11 – Further work should be undertaken to better understand the local prevalence of self-harm amongst victims of child sexual exploitation and what this suggests about the support needed by these particularly vulnerable young people. This will require input from and joint working with those partners already coordinating support for victims of CSE.

Chapter 5 – Service Provision & Activity

• Section 5.1 – In order to improve understanding about how those children and young people with mild to moderate needs are currently supported and the scale of demand for this support, information about the consultation, networking and advice activity undertaken by the PMHW team should be captured and shared.

• Section 5.1 – Promotion of the CYPS Practitioner Advice Line should continue, in order to help professionals working with children and young people to provide appropriate support and to help reduce unnecessary or inappropriate referrals to CYPS. In particular, the Advice Line should be seen as an integral part of developing links between schools and mental health services.

• Section 5.1 – There is also an opportunity that should be explored for the delivery of parenting programmes by CYPS registered professionals, to assist with early intervention where there is identified need.

• Section 5.1 – Consideration should be given to increased capacity for professionals supporting vulnerable families – including social care and adult mental health services – to develop skills in supporting parental and infant mental health and to work together across the system.

• Section 5.1 – Further work should be undertaken to understand the level of need for infant mental health services amongst children aged three to five and this should inform any future commissioning.

• Section 5.1 – Attention should be paid to continuing the positive progress to date to reduce the waiting list for a Level 3 CYPS appointment but also to ensuring that children and young people do not have to wait as long between referral and treatment.

• Section 5.1 – Given the vulnerability of children and young people with learning disabilities to poor mental health, attention should be paid to improving access to and reducing waiting times for this service in the transformation plan.

• Section 5.1 – Given the increased demand for Level 3.5 services and the limited capacity of those delivering them, consideration should be given to the allocation of sufficient resources to meet demand.

• Section 5.1 – Local commissioners should continue to explore closer collaboration with NHS England to ensure the needs of local young people are met; that, where appropriate, alternatives to in-patient care are available; that support is available as close to home as possible and that pathways are seamless.
- **Section 5.2** – Given the increase in use of the GRiP service by young people aged 17 and under during 2014/15 and its focus on early intervention, those involved in the development and implementation of the transformation plan should take into account the service and its role in the system for children and young people.

- **Section 5.3** – Further work should be undertaken as part of the implementation of the transformation plan to better understand any trends in levels of activity in the services provided by the Youth Support Team.

- **Section 5.3** – Consideration should be given to any potential actions that might lead to an increase in the number of young people accepting the offer of L&D triage.

- **Section 5.4** – Consideration should be given to ensuring consistent and financially sustainable access to counselling services across the county. There may also be opportunities to explore different ways of meeting demand, for example through new ways of accessing services online.

- **Section 5.4** – Learning from the Self-Harm Helpline about children and young people’s preferences for accessing support by text or live chat should be shared to help inform the way services are offered.

- **Section 5.4** – Commissioner should ensure that, when recommissioning the Self-Harm Helpline, it meets the needs of children and young people and is embedded within the local self-harm pathway should be taken.

- **Section 5.5** – Consideration should be given to improving the consistency of the provision of support through schools and colleges. In particular, there should be consistent access to counselling support for children and young people with ‘sub clinical’ emotional wellbeing needs.

**Chapter 6 – What works?**

- **Section 6.1** – At a woman’s first contact with primary care or her booking visit, and during the early postnatal period, a number of depression identification questions should be considered as part of a general discussion about a woman’s mental health and wellbeing. This should be underpinned by more targeted information, advice and support for women who are at a higher risk of developing poor mental health.

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• Section 6.2 – Manualised interventions in schools should be preferred but with local ownership to ensure their success.
• Section 6.2 – Attention should be paid to using a common language throughout Gloucestershire and to the full integration of interventions into the school environment.
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