Needs Assessment – Emotional Wellbeing and Mental Health

May 2011

Updated January 2014

Foreward to the 2014 update

The original work on this children and young people's emotional wellbeing and mental health needs assessment was carried out in 2011.

Much of the data in the document remains relevant today and therefore it was decided not to embark on a wholesale rewrite.

That said there are some areas of enquiry that were not fully covered in the original document and also there are other areas where new data is now available.

In summary there are four areas which have been refreshed. These are

1. New data on self reported wellbeing of children and young people derived from the 2012 Health Related Behaviour Questionnaire (pages 20 - 23)
2. Analysis of expected prevalence of mental health disorders in Solihull compared with actual observed activity (pages 24 - 30)
3. Ante and post natal depression (pages 34 - 35)
4. Suicide and self harm (pages 44 - 47)

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1. Introduction and Executive Summary

1.1 Good mental health and emotional wellbeing is fundamental to all our lives and to the communities where we live. It underpins everything we do; how we think, feel, act and behave. Healthier people tend to be happier, play an active role and contribute to society and the economy through their families, local communities and workplaces. Conversely, poor health and wellbeing puts a huge strain on individuals, the NHS, the economy and society.[1]

1.2 For most children and young people it is their parents and carers who have a central role in supporting their mental health. There are, however, a range of factors which are associated with poor emotional health and wellbeing and when a number of these factors come together in the lives of the most vulnerable children and young people the risks of them experiencing poor outcomes are significantly increased. Where these difficulties are picked up quickly and services intervene early these risks are reduced enabling children and young people to thrive.

1.3 The Solihull Joint Strategic Needs Assessment (JSNA) 2010[2] found that children and young people in Solihull are generally very healthy. However, there are inequalities in health across the Borough and there is differential need for services for children and young people. In general, needs are greatest in the wards in the north, where there are relatively more children and higher levels of deprivation.

What are we trying to achieve?

1.4 The aim of this needs assessment is to support the development of the Solihull Emotional Wellbeing and Mental Health Strategy. This document aims to assess the current needs of children and young people up to the age of 25 in relation to their emotional wellbeing and mental health. This includes identifying the risk factors for poor mental health as well as the prevalence of particular conditions.

Emotional wellbeing and mental health: The facts

1.5 A total of 1 in 10 children are estimated to have emotional or behavioural problems, which increases the risk of poor health and wellbeing both in childhood and later life.[3]

1.6 According to the National Advisory Council for Children's Mental Health and Psychological Wellbeing looking after and investing in children's emotional wellbeing and mental health is as important as safeguarding their physical health as it underpins positive outcomes in childhood and successes in future adulthood. It is an issue not just for parents – but for everyone working with children, for policymakers and for society as a whole.[4] It is at the heart of a child's rights to fulfil their potential; to be protected from harmful influences; and to participate fully in family, education, cultural and social life. [5]

1.7 Half of all lifetime cases of diagnosable mental illness begin by age 14 and three-quarters of lifetime mental illness arise by mid-twenties. However, 60–70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunity for maximal lifetime

[1] Our Health and Wellbeing Today, Department of Health, November 2010
[2] Solihull NHS Care Trust
[3] Healthy Live, Healthy People: Our strategy for public health in England, November 2010, White Paper
[4] One Year On, 2010
[5] As above

benefits.[6]

1.8 A review of economic evaluations of mental illness during childhood and adolescence, such as emotional and behavioural disturbances or antisocial behaviour, found mean costs to UK society to range from £11,030 to £59,130 annually per child.[7]

1.9 Not addressing poor mental health in childhood results in a proportion of young people who continue to have: mental health problems including self-harm and increased suicide; low educational and employment achievement; increased violent, anti-social behaviour and offending behaviour.[8] Poor emotional wellbeing and mental health affects educational achievement and can be a symptom of a child at risk. Children and young people frequently express their internal distress in the form of mental disorders.[9]

National Drivers

1.10 No health without mental health – A cross-government mental health outcomes strategy for people of all ages[10] specifically makes mental health a priority for Public Health England (the new national public health service) and states that mental health is 'everybody's business'. It prioritises early intervention across all ages, takes a life course approach and challenges stigma.

1.11 A priority objective within the Marmot Review[11] is to reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills. This review advocates the need to build the resilience and wellbeing of young children across the social gradient as at present the lower a person's social position, the worse his or her health. According to the review giving every child the best start in life is crucial to reducing health inequalities across the life course.

1.12 According to the Healthy Child Programme(HCP) : From 5–19 years old October 2009[12] those working with children and young people need to listen well, observe carefully, understand when things are going wrong and be able to deal with this sensitively, drawing on expert support when they reach the limit of their personal competence. Health professionals who deal with children should be familiar with the ways in which distress in or about school can present as physical illness. Equally, those working in school settings should consider the underlying causes of a child's distress and whether additional support is needed.

1.13 Following the Child and Adolescent Mental Health Service Review's final report[13], the Government at that time agreed to take forward some of its key recommendations, including:

- improving access for children, young people and their families to mental health support through universal services;
- improving mental health services for at risk children and young people (such as children in care, those with disabilities and those with behavioural, emotional and social difficulties); and
- ensuring that parents and carers can access advice and support when they are concerned about their children's mental health.

[6] No health without public mental health: the case for action, Royal College of psychiatrists Position statement PS4/2010, October 2010
[7] Suhrcke *et al*, 2008
[8] Children and Young People Promoting Emotional Health and Well-Being, Department of Health, June 2008
[9] As above
[10] February 2011
[11] Fair Society, Healthy Lives, Strategic Review of Health Inequalities Post 2010
[12] February 2011
[13] National CAMHS Review, 2008

Local drivers

1.14 An external review by the Children and Young People's Emotional Well-being and Mental Health National Support Team in February 2010 concluded that services in Solihull are providing well for the emotional and mental health of children and young people, but would benefit from more co-ordinated planning and commissioning. The NST also recommend that Solihull Partnership's Common Commissioning Framework is consistently applied, to ensure effective partnership commissioning is developed for emotional wellbeing and mental health.

What do we know about emotional wellbeing and mental health in Solihull?

1.15 The majority of children say they are happy with their lives, but still comment on the need for more support for their emotional wellbeing[14]. The Health Related Behaviour Survey (HRBQ) 2010 was carried out in Solihull during Spring 2010 and involved a total of 9889 pupils from 71 Solihull Infant, Primary, Secondary and Special schools. The pupils involved were from Years 2, 4 and 6 in the primary schools and Years 8 and 10 in the secondary schools. Solihull schools have also surveyed in 2004, 2006 and 2007 and so some emerging trends can be seen.

1.16 Results of the HRBQ show that there is an overall upward trend for Solihull pupils reporting 'high' self-esteem, although there has been a slight falling back for secondary aged pupils for 2010 compared with the 2007 survey.

1.17 The results from the HRBQ 2010 also show that there is a downward trend for bullying levels across both primary and secondary age ranges. The highest level reported was by Year 4 girls in 2006 at 39% and the lowest is now reported by Year 10 pupils in 2010 at 15%.

1.18 Local information about the mental and emotional wellbeing of children is limited; however estimates can be derived from national data. According to national and local data children and young people with a mental disorder are more likely to be boys with the highest type of disorder being conduct disorders. On the other hand emotional disorders have a much higher prevalence rate for girls.

1.19 According to the Solihull Child and Adolescent Mental Health Service (CAMHS) Annual Report 2008/9[15] approximately one third (30%) of the primary presentation caseload is for emotional disorders/problems. According to Solihull CAMHS this is slightly less than the percent for the West Midlands. A further 50% of caseload deals with hyperkinetic disorders/problems, conduct disorders/problems and autistic spectrum disorders/problems. This is 10% higher than the West Midlands.[16]

National measures

1.20 The emotional health of children has, until recently, been measured by NI 50 which measures the percentage of children with good relationships. This is defined as the percentage of children who answered 'true' to having one or more good friends and answered 'true' to at least two of the statements about being able to talk to their parents, friends or another adult. Solihull was ranked 71st out of 150 local authorities, 29th out of 36

[14] Review of Outcomes for Children and Young People in Solihull, Autumn 2009
[15] Report complied by Hazel Douglas, Strategic Lead for CAMHS
[16] Snapshot from November 2007

Metropolitan Boroughs, and 11th out of 16 members in our CIPFA comparator group of authorities for this measure for 2009-10[17]. TellUs 4 data which supports Local Authority Measures for National Indictors shows a reduction in young people's perception of emotional health and wellbeing, based on the percentage of children with good relationships, as recorded through the survey and published in February 2010.

Which children and young people are most likely to develop emotional health problems?

1.21 There are certain 'risk factors' that make some children and young people more likely to experience problems than others. Some of these factors include living in poverty or being homeless, having parents who separate or divorce, living in care and experiencing discrimination. There is also known to be higher prevalence among those with a long-term physical illness, those who have a parent with mental health problems, those acting as a carer for a relative; and teenage parents.

1.22 It is estimated that 40% of children in care (45% of those aged 5 -17)[18] have significant emotional ill health, much of which is shown in conduct disorder. Clinically significant conduct disorders were the most common among looked after children (37%), while 12% had emotional disorders (anxiety and depression) and 7% were hyperactive. Even when compared to children in a community sample from the most deprived socio-economic groups, looked after children still showed significantly higher rates of mental health disorders.[19] Many of these children have experienced abuse, neglect and removal from their family. Solihull currently is responsible for 415 looked after children and young people (260 local children and 155 unaccompanied asylum seeking children). If 40% of this total figure has significant emotional ill health, this would be 166 children and young people.

1.23 A high proportion of children and young people in contact with the youth justice system have a mental health problem (approximately 40%).[20]

1.24 In Solihull between 1st Jan 2010 - 31st Dec 2010 there were 102 young people on the caseload of the Youth Offending Service. 62 of these young people have scored 2 or above on the asset score for emotional and mental health. Scores of 2 or above mean that a referral to a specialist intervention is required as the likelihood of the young person reoffending is increased by the state of their emotional and mental health.

1.25 According to the National CAMHS Review (2008) young people who are lesbian, gay or bisexual may be more vulnerable to self-harm, suicide and bullying, though there is currently a lack of robust evidence.[21]

1.26 Many young people with ongoing mental health needs fall through the gap between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS). These are most likely to be young people with emotional/neurotic problems, neurodevelopmental disorders and emerging personality disorder. According to a TRACK Study carried out by Swaran Singh et al[22] for the vast majority, transition from CAMHS to AMHS is poorly planned, poorly executed and poorly experienced. Mutual misperceptions among clinicians contribute to pre-existing ideological, practical and structural barriers

[17] PWC Benchmarking club – 2009-10 Quarter 3 Data
[18] Meltzer et al, The Mental Health of young people looked after by local authorities in England, 2002
[19] Ford T., Vostanis P., Meltzer H. and Goodman R. (2007) 'Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households', BritishJournal of Psychiatry 190, 319-325
[20] Healthcare Commission. 2006. *A Review of Healthcare in the Community for Young People who Offend*. London: Commission for Healthcare Audit and Inspection.
[21] Hawton and Rodham (2006) and Childline (2006), cited in Bridget. 2007. *Lesbian, Gay and Bisexual Young People: Evidence-based services and resources*. Online paper available at www.cypf.csip.org.uk
[22] BJPsych.2010

between CAMHS and AMHS and even where protocols exist, there is a policy-practice gap.

1.27 Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education. 29% of disabled children nationally live in poverty. With regards to emotional wellbeing and mental health, disabled young people aged 16-24 are less satisfied with their lives than their peers and there is a tendency for support to fall away at key transition points as young people move from child to adult services. Also, families with disabled children report particularly high levels of unmet needs, isolation and stress.

What have children, young people, parents and professionals told us?

1.28 Significant consultation was undertaken to inform the development of the 2010/11 Children and Young Peoples Plan. 1929 children and young people from across the Borough participated in the consultation. They said they wanted more supportive teachers and more support and advice on eating healthy food and feeling healthy

1.29 The issues that were raised most frequently by staff and volunteers relating to emotional wellbeing included the need for better support for more emotionally fragile or vulnerable teenagers and more emphasis on the effects of family breakdown and bereavement on children and young people. The fact that one in ten children and young people have a mental health problem was also highlighted. Schools were concerned about the lack of resilience evident, the lack of stability in children's lives, increase in referrals to other agencies and the lack of 'real' play.

1.30 Ongoing consultation has also been carried out with young people who are part of a CAMHS Group in both the North and South of the Borough while developing this Strategy. Young people wanted services where they were, local and accessible in friendly environments. They also said they wanted to have someone to talk to that they had time to get to know. At these groups there appears to be a stark contrast between the needs and support required of those in the North and South. Young people in the North felt that they would have to ‘hit rock bottom’ before they would talk to a professional and even then it would only be through force not because they chose to do so. They also seemed to only talk about extreme feelings going from being happy to being suicidal. On the other hand young people in the South seemed much more aware of their own issues and where they could go to access services and certainly did not seem adverse to accessing support in the same way.

Conclusions

1.31 There are a number of general conclusions and recommendations that can be made as a result of the information provided in this document. They are;

- As 1:10 young people experience emotional or behavioural problems, this suggests there needs to be an increased focus on early intervention, particularly in universal services, with implications for the workforce in terms of awareness, confidence and expertise in identifying and supporting children and young people at risk.

- The importance of support for parents and carers, recognising that they have a central role in supporting the mental health of children and young people.

- A more detailed gap analysis may be required, to identify whether we have sufficient evidence based programmes in place for those who are identified as having a need

for support before their condition becomes serious, both to improve outcomes and reduce long term costs to society arising from mental illness continuing into adulthood.

- Children and young people in Solihull are generally emotionally healthy, but there are inequalities identified in the needs assessment , particularly focusing on children living in the regeneration area of north Solihull, boys, who are at greater risk of mental ill health, and particular groups of vulnerable young people, including looked after children and young offenders.

- There needs to be an increased focus on how we meet needs of young people 14-25, particularly around transition to adult services. Disabled children and young people 16-24 appear to be most at risk.

- The crucial role of parents and carers in supporting the mental health of children and young people is highlighted in all research, suggesting that a focus needs to remain on supporting parenting from conception onwards, concentrating on those most at risk.

- There is insufficient local intelligence about the mental health needs of Lesbian, Gay Bisexual and Transgender young people.

- Access to services when needed has been prioritised by parents and young people, which suggests action is required to identify clear pathways to access specialist support from the most appropriate source, and joint commissioning to ensure a mix of provision across the levels of need.

- Both parents and young people have identified stigma as an issue, which suggests there needs to be more action to address barriers to access support before hitting “rock bottom” and a more “positive press” for mental health

2. Why is emotional wellbeing and mental health important?

2.1 A total of 1 in 10 children are estimated to have emotional or behavioural problems, which increases the risk of poor health and wellbeing both in childhood and later life.[23] According to the National Advisory Council for Children's Mental Health and Psychological Wellbeing looking after and investing in children's emotional wellbeing and mental health is as important as safeguarding their physical health as it underpins positive outcomes in childhood and successes in future adulthood. It is an issue not just for parents – but for everyone working with children, for policymakers and for society as a whole.[24] It is at the heart of a child's rights to fulfil their potential; to be protected from harmful influences; and to participate fully in family, education, cultural and social life.

2.2 Mental illness is the largest single source of burden of disease in the UK and has an impact on every aspect of life. Half of all lifetime cases of diagnosable mental illness begin by age 14 and three-quarters of lifetime mental illness arise by mid-twenties. However, 60–70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits. Furthermore, in a UNICEF survey in 2007 the UK ranked at the bottom on children's well-being compared with North America and 18 European countries, and ranked 24th out of 29 European countries in another survey in 2009.[25]

2.3 At current rates, the costs of mental health problems will double over the next 20 years with the annual cost of mental illness in England in 2003 estimated at £77.4 billion. A review of economic evaluations of mental illness during childhood and adolescence, such as emotional and behavioural disturbances or antisocial behaviour, found mean costs to UK society to range from £11,030 to £59,130 annually per child.[26]

2.4 Not addressing poor mental health in childhood results in a proportion of young people who continue to have: mental health problems including self-harm and increased suicide; low educational and employment achievement; increased violent, anti-social behaviour and offending behaviour.[27] Poor emotional wellbeing and mental health affects educational achievement and can be a symptom of a child at risk. Children and young people frequently express their internal distress in the form of mental disorders.[28] Early intervention helps to mitigate the effects of poor emotional wellbeing and enables children to thrive and learn effectively thus reducing the risks.

What are we trying to achieve?

2.5 The aim of this needs assessment is to support the development of the Solihull Emotional Wellbeing and Mental Health Strategy. This document aims to assess the current needs of children and young people up to the age of 25 in relation to their emotional wellbeing and mental health. This includes identifying the risk factors for poor mental health as well as the prevalence of particular conditions.

[23] Healthy Live, Healthy People: Our strategy for public health in England, November 2010, White Paper
[24] One Year On, 2010
[25] No health without public mental health: the case for action, Royal College of psychiatrists Position statement PS4/2010, October 2010
[26] Suhrcke *et al*, 2008
[27] Children and Young People Promoting Emotional Health and Well-Being, Department of Health, June 2008
[28] As above

3. Demography – The Solihull Context

3.1 Solihull is home to 203,900 people[29], a quarter of whom are children and young people under the age of 20, who live mainly in the residential suburbs of Solihull, Shirley, Olton, Balsall Common and Knowle in the south of the borough, and in Castle Bromwich, Smith's Wood, Chelmsley Wood, Kingshurst and Fordbridge in the north of the Borough. Solihull is a metropolitan borough bounded by Birmingham to the southeast, Coventry to the east and Warwickshire to the northeast and south. The population of Solihull has very diverse needs. It is a mix of urban and rural communities; mostly white British; the more deprived communities are located in the wards in the north of the borough; there are also pockets of deprivation seen in the south and west.

3.2 Solihull's recognised economic success and general affluence masks the deprivation in the north of the Borough. In 2007, three of the wards in the north of the Borough were rated as amongst the most deprived 10% in England, and there are other pockets of deprivation such as in Bickenhill, Elmdon, Lyndon, Olton and Shirley. A significant number of local people across Solihull face poor health, education, housing and employment opportunities.

3.3 While there is economic growth in the south of the Borough, only 5% of the Borough's jobs are in the north and yet over 20% of the population lives there. North Solihull suffers from structural unemployment as a result of being on the edge of the West Midlands conurbation, with traditionally poor transport links to the south of the Borough and most of the West Midlands. People living in North Solihull have poorer health, unsuitable housing, and lower educational attainment levels. Child poverty levels are higher, (as measured by the % of children under 16 who live in families in receipt of Income Support, Job Seekers Allowance, Working Families Tax Credit and Disabled Persons Tax Credit whose equivalised income is below 60% of median before housing costs), and the proportion of people of working age in employment for the three deprived wards in the north of the borough stands at 64.14% compared to a whole Borough figure of 75.9% (based on the 2001 Census).

3.4 Solihull has an ageing population. From 2003 to 2021 it is expected that the number of people over 70 will increase by over 30%. Within this period, the number of people over 85 will increase by over 70%. Table 1 shows that the population of children in Solihull is reducing.

[29] One Borough: An Equal Chance for All Sustainable Community Strategy for Solihull 2008-2018

Table 1: Resident Population Estimates – all Persons (Census Information – Solihull MBC) Revised 16 September 2010

Age	2001	2006	Change since 2001	2007	Change since 2001	2008	Change since 2001	2009	Change since 2001
0-4 yrs	11100	10600	-4.50%	11000	-0.90%	11300	1.80%	11400	2.70%
5-9 yrs	13400	12300	-8.21%	11900	-11.19%	11800	-11.94%	11700	-12.69%
10-14yrs	14500	14000	-3.45%	13800	-4.83%	13700	-5.52%	13400	-7.59%
15-19yrs	12300	13800	12.20%	14000	13.82%	13900	13.01%	13900	13.01%
20-24yrs	8900	10400	16.85%	10900	22.47%	11400	28.09%	11600	30.34%
TOTAL	60,200							62,000	

3.5 9.4% of the Solihull population is from a minority ethnic background, though 17% of school-age children and young people identify with a black or minority ethnic heritage, and this is forecast to increase. The January 2010 School Census showed that the largest ethnic minority group in schools is Indian, with the second largest being mixed White/Black Caribbean and third Pakistani with those of an Asian heritage living predominantly in the south of Solihull and those of a White/Black Caribbean living predominantly in the regeneration Wards in the north.
Further information is available at:
http://www.solihull.gov.uk/Attachments/understandingsolihull3.pdf

Ward level population

3.6 Smith's Wood is the ward with the highest percentage of children and young people aged 19 years and under in Solihull (30.3% of the total population) whereas Shirley South has the least percentage of children and young people (20.9%).[30] Table 2 shows the percentage of children and young people by ward and that almost a quarter of children and young people live in the regeneration zone (which consists of Chelmsley Wood, Kingshurst and Fordbridge and Smiths Wood in the north of the Borough).

[30] Source mid-2009-ward-2010-quinary table from ONS

Table 2: Children and young people by Ward (2009)

Ward Name	0-4	5-9	10-14	15-19	Total	Total %
Bickenhill	726	717	744	865	3,052	6.06%
Blythe	792	838	784	756	3,170	6.29%
Castle Bromwich	465	459	585	920	2,429	4.82%
Chelmsley Wood	1,027	741	861	934	3,563	7.07%
Dorridge and Hockley Heath	533	710	887	795	2,925	5.81%
Elmdon	629	656	777	684	2,746	5.45%
Kingshurst and Fordbridge	1,059	921	969	995	3,944	7.83%
Knowle	439	499	622	612	2,172	4.31%
Lyndon	761	826	831	851	3,269	6.49%
Meriden	514	687	834	721	2,756	5.47%
Olton	595	659	732	732	2,718	5.40%
St Alphege	492	644	928	934	2,998	5.95%
Shirley East	619	670	806	840	2,935	5.83%
Shirley South	521	523	694	786	2,524	5.01%
Shirley West	666	636	739	823	2,864	5.69%
Silhill	568	645	665	649	2,527	5.02%
Smith's Wood	962	851	962	1,008	3,783	7.51%
Total	**11,368**	**11,682**	**13,420**	**13,905**	**50,375**	**100.00%**
Regeneration Zone (Chelmsley Wood, Kingshurst and Fordbridge and Smith's Wood)	**3,048**	**2,513**	**2,792**	**2,937**	**11,290**	**22.41%**
Non-Regeneration Zone	**8,320**	**9,169**	**10,628**	**10,968**	**39,085**	**77.59%**

[Source Table 2010 Ward Population Estimates for England and Wales, mid-2009 (experimental statistics) from ONS].

Further information at ward level, updated for 2010 is available from the Solihull Council website: http://www.solihull.gov.uk/about/20686.htm .

Population projections

3.7 Changes in the population age structure affect the need for services. Population projections therefore have an essential role in assessing the future need for services. Current trends in births, deaths and migration are projected forwards and used to produce population projections.

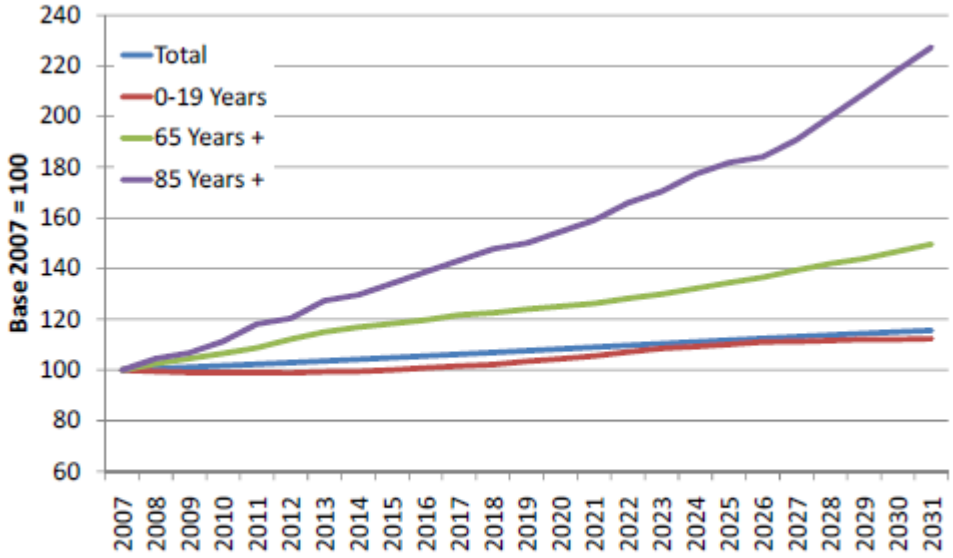
3.8 Table 3 shows population projections for children and young people to 2020, by five year age bands, for Solihull alongside the percentage change in the population over the period. It should be noted that these figures are based on the geographical population of Solihull used by the local authority which differs from the NHS whose population figures are based upon the GP register and the school population which is based on the school roll and would not just be Solihull children. Figure 1 shows the projected population change in Solihull 2007 – 2031.

Table 3: Children and young people population projections

	2010	2020	Percentage change
0-4	11,700	12,400	5.98
5-9	11,800	13,500	14.41
10-14	13,400	14,100	5.22
15-19	13,400	12,000	-10.45
20-24	11,500	10,300	-10.43
Total	61,800	62,300	0.81%

[Source Table 2b: 2008-based subnational population projections by sex and quinary age from ONS].

Figure 1: Projected Population Changer in Solihull 2007 - 2031



Source: ONS

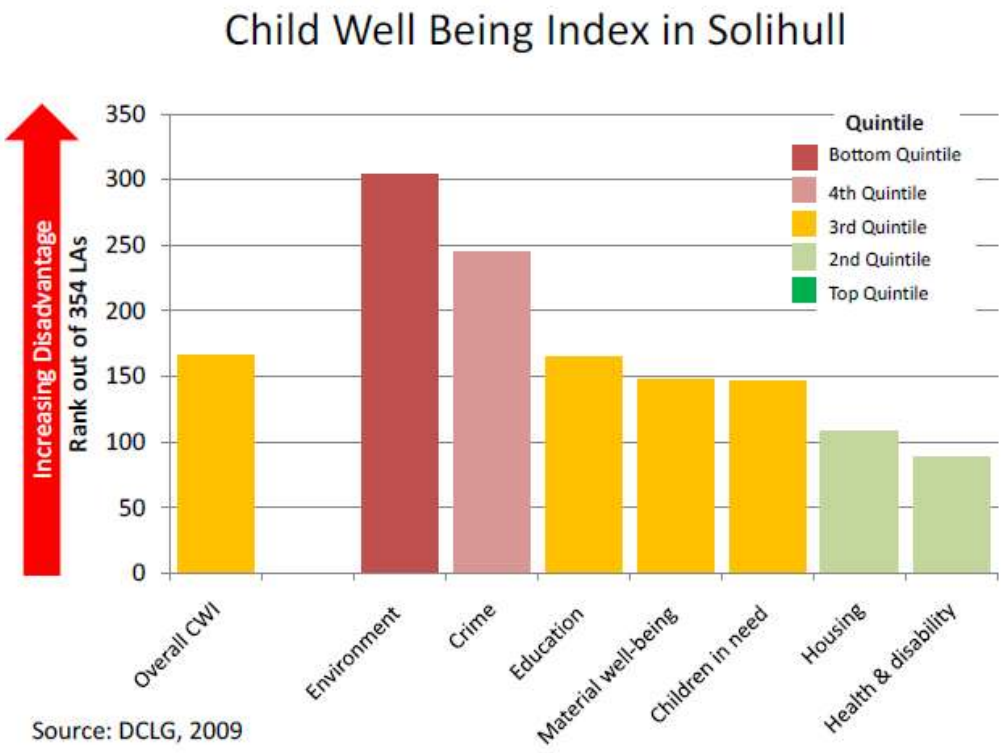
Deprivation

3.9 The 2007 Indices of Multiple Deprivation (IMD) indicate that Solihull is ranked 231 out of 353 local authorities in England (where 1 = most deprived) compared with a ranking of 223 in 2004.

3.10 The Income Deprivation Affecting Children Index (IDACI) relates to children aged 0-15 years and the index states how many children are income deprived as a percentage of all children. Children living in households in receipt of benefits such as Income Support or Job Seekers Allowance and whose household income is below 60% of the national median income before housing costs are defined as income deprived. Solihull MCB is ranked 213 overall out of 353 local authorities compared with 214 most deprived in 2004.

3.11 In February 2009 the Communities and Local Government released the Child Well-Being Index to local authority and lower super output area (LSOA) level. This is an index of child well-being rather than an index of deprivation, mainly because it contains variables that are not strictly related to deprivation. Child well-being is generally represented by how children are doing in a number of different domains of their life. Figure 2 shows how Solihull is ranked against all local authorities for the domains of the CWI.

Figure 2: Child Well Being Index in Solihull



3.12 Solihull MBC is ranked 166 of 354 local authorities in the overall Child-Well Being Index and 88 in the Health and Disability domain.

4. The Children of Solihull

4.1 The Solihull Joint Strategic Needs Assessment (JSNA) 2010[31] found that children and young people in Solihull are generally very healthy. However, there are inequalities in health across the Borough and there is differential need for services for children and young people. In general needs are greatest in the wards in the north where there are relatively more children and higher levels of deprivation.

4.2 This picture is illustrated by the proportion of babies that are of low birth weight which is a good indicator of both the current and future health of the baby. The Solihull rate (7.6%) is lower than the national average but reaches 11% in at least 1 ward. Smoking at time of delivery has increased over the last few years and is relatively high when benchmarked against similar populations. Breast feeding protects the health of mother and baby but uptake is comparatively low in Solihull and is even lower in the more deprived communities; there is an indication that this inequality is reducing. Dental health is good in Solihull, mostly due to water fluoridation; encouragingly inequalities are reducing.

4.3 The JSNA states that of concern is the establishment of unhealthy lifestyles and behaviours in young people; surveys show that patterns of smoking, drinking alcohol, poor diets and low levels of physical activity become established as young people develop. The prevalence of obesity among children is lower in Solihull than the national average but is still a cause for concern. For example in 2008/09 around 30% of children leaving primary school were overweight or obese. Teenage conception rates are falling but 2010 targets will not be met if current trends continue. **Mental health and emotional problems are relatively common in young people.**[32]

[31] Solihull NHS Care Trust
[32] Solihull Joint Strategic Needs Assessment 2010

5. Emotional Wellbeing and Mental Health

What do we mean by emotional wellbeing and mental health?

5.1 'No health without mental health' the cross-government mental health outcomes strategy for people all of all ages[33] defines good or positive mental health as being 'more than an absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and for their communities'. This strategy also defines wellbeing as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection to people, communities and the wider environment.'[34]

5.2 The National Child and Adolescent Mental Health Services (CAMHS) Review[35] noted "… there are many different ways of describing and understanding mental health and psychological well-being. Children and young people use terms such as 'feeling in control' or 'feeling balanced'. These descriptions are useful, because they highlight the fact that mental health and psychological well-being are not about feeling happy all the time. They are about having the resilience, self-awareness, social skills and empathy required to form relationships, enjoy one's own company and deal constructively with the setbacks that everyone faces from time to time."

National drivers

5.3 The White Paper 'Equity and Excellence – Liberating the NHS' – published in July 2010 proposes the development of Local Authority Health and Well-Being Boards, the Local Authority will therefore be responsible for promoting integration and partnership working between the NHS, social care, public health and other local services and strategies. GP commissioning consortia will also have a duty to promote equalities and to work in partnership with Local Authorities, to include early years, public health and wellbeing.

5.4 The government strategy 'No health without mental health' has two key goals relevant to children and young people. These are that people of all ages will have better wellbeing and mental health and that fewer people will experience stigma and discrimination[36]

5.5 The Healthy Child Programme (HCP) – Pregnancy and the first five years[37] is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families. The HCP has a major emphasis on parenting support, an increased focus on vulnerable children and families, and an emphasis on integrated services underpinned by a model of progressive universalism (Universal core programme, plus programmes and services to meet different levels of need and risk). Effective implementation of the HCP should lead to a number of outcomes including strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children.

5.6 Good practice guidance also exists for all organisations responsible for commissioning services for 5 – 19 year-olds' health and wellbeing as well as frontline professionals delivering those services.[38] Improving emotional health and wellbeing and delivering a comprehensive range of CAMHS is central to this guidance. Early intervention is crucial when young people first experience mental distress, by building their resilience and

[33] HM Government, 02 February 2011
[34] As above
[35] Children and Young People in Mind: the final report of the National CAMHS Review DCSF/DH 2008
[36] A cross-government mental health outcomes strategy for people of all ages, HM Government, 02 February 2011
[37] October 2009
[38] Healthy Child Programme(HCP) : From 5–19 years old (October 2009)

providing them and their families with appropriate support. Those working with children and young people need to listen well, observe carefully, understand when things are going wrong and be able to deal with this sensitively, drawing on expert support when they reach the limit of their personal competence. Health professionals who deal with children should be familiar with the ways in which distress in or about school can present as physical illness. Equally, those working in school settings should consider the underlying causes of a child's distress and whether additional support is needed.

5.7 Following the CAMHS Review's final report[39], the Government at that time agreed to take forward some of its key recommendations, including:

- improving access for children, young people and their families to mental health support through universal services;
- improving mental health services for at risk children and young people (such as children in care, those with disabilities and those with behavioural, emotional and social difficulties); and
- ensuring that parents and carers can access advice and support when they are concerned about their children's mental health.

5.8 The National Institute for Health and Clinical Excellence (NICE) has produced guidance for promoting children and young people's social and emotional wellbeing in primary and secondary education.[40] The guidance highlights the fact that good social, emotional and psychological health helps protect young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol (Adi et al. 2007[41]; Colman et al. 2009[42]; Graham and Power 2003[43]). It can also help them to learn and achieve academically, thus affecting their long-term social and economic wellbeing.

5.9 A priority objective within the Marmot Review[44] is to reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills. This review advocates the need to build the resilience and wellbeing of young children across the social gradient as at present the lower a person's social position, the worse his or her health. According to the review giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing– from obesity, heart disease and mental health, to educational achievement and economic status.[45] To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.[46] The table below shows one of the key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed by Marmot in Fair Society, Healthy Lives. Solihull compares extremely favourably when considering achievement at age 5 with the national percentage of 55.7 and Solihull's children being ranked as the

[39] National CAMHS Review, 2008
[40] NICE Public Health Guidance 12, March 2008 and NICE Public Health Guidance 20, September 2009
[41] Adi et al. (2007) Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education. London: NICE.
[42] Colman et al. (2009) Outcomes of conduct problems in adolescence: 40 year follow-up of national cohort. BMJ 338: a2981.
[43] Graham and Power (2003) Childhood disadvantage and adult health: a lifecourse framework. London: Health Development Agency.
[44] Fair Society, Healthy Lives, Strategic Review of Health Inequalities Post 2010
[45] Waldfogel J (2004) Social mobility, life chances, and the early years, CASE Paper 88, London: London School of Economics.
[46] As above

highest in the country although this should be looked at with caution as it potentially masks deprivation and inequalities in other areas.

Table 4: Children achieving a good level of development at age 5

	Solihull Value	Regional Value	England Value	England Worse	England Best
Children achieving a good level of development at age 5 (%)	69.3	56.4	55.7	41.9	69.3

*Source: Slope Index of Inequality - London Health Observatory based on analysis of the Income Domain of the Index of Multiple Deprivation 2007 from Communities and Local Government

Local drivers

5.10 An external review by the Children and Young People's Emotional Wellbeing and Mental Health National Support Team in February 2010 concluded that services in Solihull are providing well for the emotional and mental health of children and young people, but would benefit from more co-ordinated planning and commissioning. Some of the overall strengths highlighted included:

- Front line staff show strong commitment and a good understanding of children and young people's emotional wellbeing and mental health issues
- A strong commitment to partnership working
- Recruitment and retention is generally good for the whole workforce
- 'Core' CAMHS provide support and guidance to a wide range of professionals including school nurses, midwives, child and family support services, youth services and the schools community
- Early years services are strong, including support to the midwifery team and access to specialist services to under threes
- The transition of children between health visiting and school nursing services appears to be seamless
- There are two major parenting programmes attracting high demand – one, the Solihull Approach focussing on understanding children's behaviour and the second, 'Mellow Parenting' which is a more intensive course. Both of these programmes have been nationally accredited.

5.11 In terms of challenges to provision for emotional wellbeing and mental health the NST highlighted:

- A need to transform and redesign services, to do better and more for less in the context of the overall financial environment
- In order to protect and sustain the good performance of these services in the current financial climate, it is important for these to operate within an agreed strategic and commissioning framework. This needs to be jointly owned by the Children's Trust and partners working to secure the emotional wellbeing and mental health of adults.
- The need to develop an updated shared vision for addressing children and young people's EW & MH for Solihull that is owned by all partners at all levels
- The NST endorses the commitment to refresh the children and young people's emotional wellbeing and mental health strategy. We believe this is critical to guide future commissioning and investment in this area
- The NST recommend that Solihull Partnership's recently developed common commissioning framework is consistently applied, to ensure effective partnership commissioning is developed for EW & MH

5.12 The Solihull Care Trust Draft Mental Health Strategy 2010 notes that current services do not adequately meet the needs of young people aged between 14 and 25, with poor access and retention in services for this sector of our population despite evidence highlighting the high numbers of mental health presentations within this age group.

5.13 The Development and Implementation of a Children & Young Peoples Mental Health and Well-being Strategy for Solihull is one of the agreed priorities in the Children and Young Peoples Plan July 2010 – July 2011 following wide consultation with children, parents, carers and service providers.

5.14 CAMHS services are currently commissioned by Solihull Care Trust, the Children and Young People's Trust and a variety of departments within Children's Services.

5.15 Within Solihull the number of schools and academies who have achieved Healthy schools status is 83. Early indications show that a large number of schools are prioritising emotional wellbeing and mental health in their work towards Enhanced Healthy schools status. The number of schools taking part in Social and Emotional Aspects of Learning (S.E.A.L.) in Solihull is 59 primary schools, 11 secondary schools, 3 special schools and 3 pupil referral units.

What can help protect and support emotional wellbeing and mental health?

5.16 'Aiming high for young people: a ten year strategy for positive activities'[47] highlights evidence which shows that young people's participation in positive leisure time activities, as well as offering enjoyable and exciting opportunities, supports the development of resilience through building social and emotional skills. Good quality youth activities help build important characteristics that are increasingly necessary for capitalising on the opportunities available to young people and for overcoming disadvantage.[48] This includes the capacity to plan for the future, moral maturity, and levels of self-control.

5.17 Sufficient evidence now exists for the effectiveness of exercise in the treatment of clinical depression. Additionally, exercise has a moderate reducing effect on state and trait anxiety and can improve physical self-perceptions and in some cases global self-esteem. Also there is now good evidence that aerobic and resistance exercise enhances mood states.[49]

5.18 According to an interim report published by Clubs for Young People and Young Devon[50], youth clubs can help reduce young people's chances of developing mental problems. The report Somewhere to Talk — Someone to Listen looks at research evidence from across the children, youth and mental health sectors and argues that research shows that youth clubs help to develop young people's resilience, and reduce the risk of vulnerable young people experiencing "low level" mental health problems from developing a more severe mental health problem.

5.19 The report also highlights the fact that youth clubs can support young people to access youth counselling services and statutory mental health services when needed and have a role in mental health promotion. Clubs are ideally placed to young people with access to the right resources, training and information about mental health issues. Within Solihull the Youth and Community Service aims to support young people by providing a range of personal and social informal educational opportunities and ensuring young people have a voice and can achieve their full potential. There are a number of youth centres spread throughout the Borough where a variety of different activities are delivered and support provided. There are also two CAMHS youth groups supported by the youth service which are made up of service users.

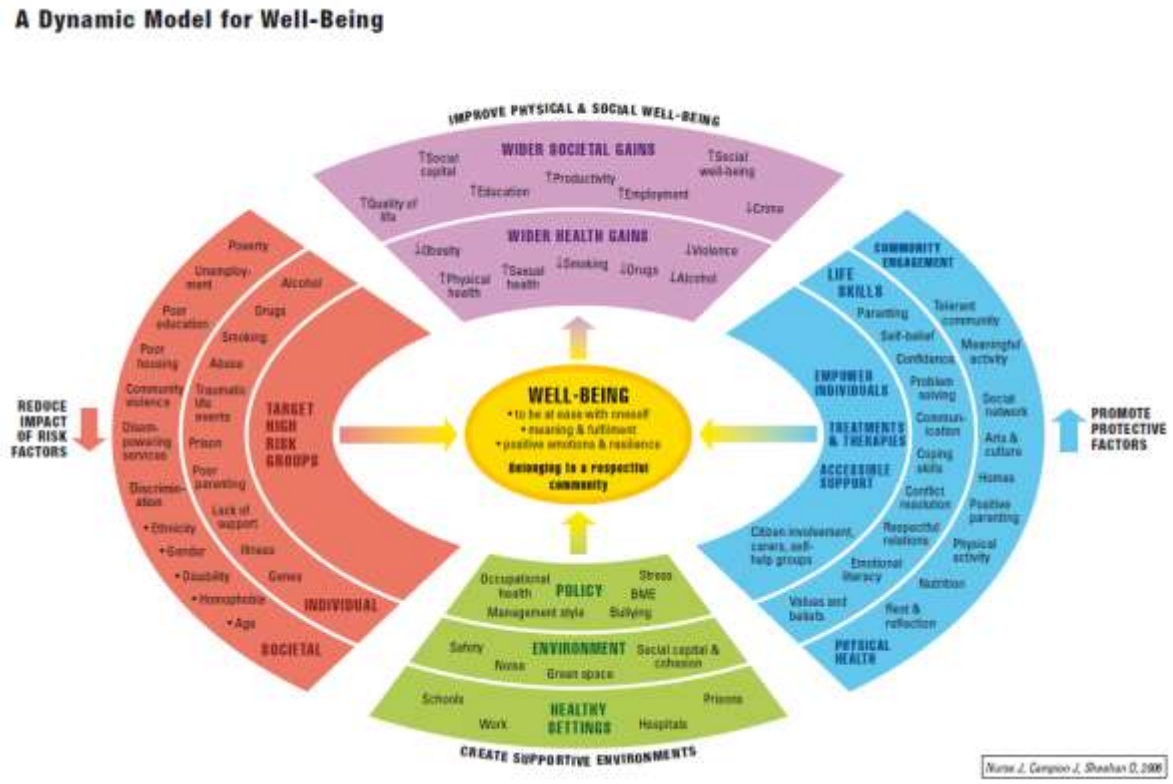
5.20 Initial recommendations from the report include that youth clubs should be given a greater role in signposting young people to youth counselling services and other mental services and they should also be encouraged to form better links with these organisations.

[47] Department for children, schools and families, July 2007
[48] *Freedom's Orphans, Raising youth in a changing world,* Margo, J et al, Institute for Public Policy Research, 2006,
[49] FOX, K. R. (1999) The influence of physical activity on mental well-being. *Public Health Nutrition,*
[50] Keith Coulston, 2010 Clubs for Young People

Additional mental health awareness training should be provided to youth workers to help them spot potential problems.

5.21 The Mental Health and Well-Being in the South East report[51] was produced in October 2006 and is based upon a Dynamic Model for Well-Being (see Figure 3 below). This model was specifically created within the South East in order to develop a comprehensive approach to promoting well-being. The model places well-being at the centre of improving physical and social well-being, and recognises the need to address risk factors, balanced with promoting protective factors. These aspects need to be contextualised within a particular setting, supported by mental health promoting policy and environments.

Figure 3: A Dynamic Model for Well-being



6. What do we know about emotional wellbeing and mental health in Solihull?

Background

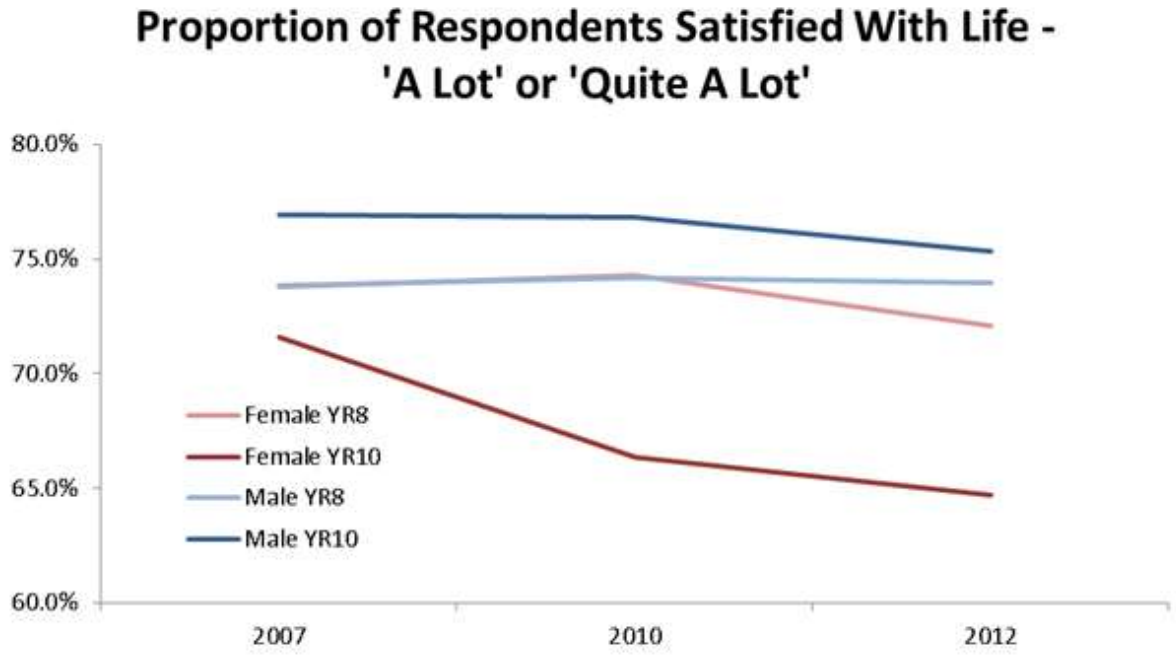
While it is possible to measure mental illness in children and young people through indicators such as levels of referral activity to CAMHS and hospital admissions data, it is less easy to gauge the mental wellbeing of children.
This was recognised by the Children and Young People's Outcomes Forum, a group that was set by the Secretary of State to help develop a new strategy for improving care for children and young people (it is now a permanent group that is chaired by the Chief Medical Officer).

Their report highlighted gaps in the Public Health Outcomes Framework indicators applicable to children and young people, in particular, those which measure emotional health and resilience.
They recommended that the Department of Health, with partners, develop a population-based survey of children and young people to look at trends in health and well-being.

[51] Jo Nurse and Jonathan Campion, Care Services Improvement Partnership and Department of Health

Situation in Solihull
In Solihull, a survey of school aged children is carried out every two years. This is called the Health Related Behaviour Questionnaire and is commissioned via the Schools Health Education Unit (SHEU) at Exeter University. Nearly 10,000 pupils from Years 2, 4, 6, 8, and 10 complete the questionnaire which is then analysed by the SHEU at Exeter University.
Some key findings from the most recent HRBQ (2012) are highlighted below.

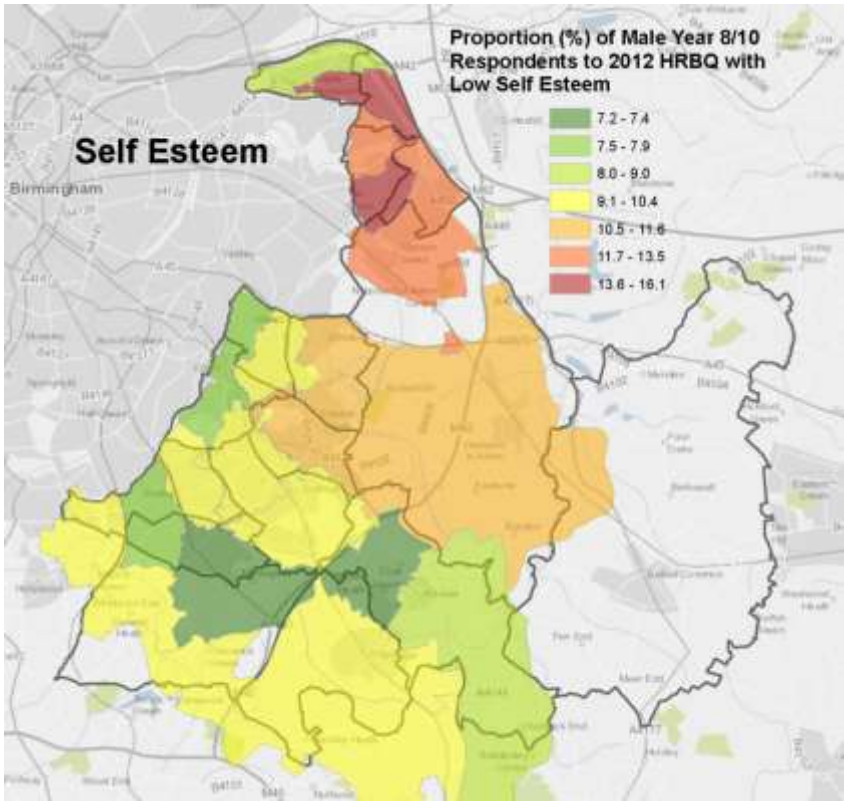
Satisfied with life
As part of the HRBQ, secondary school pupils are asked to rate their satisfaction with life on a five point scale from 0 (not at all) to 4 (a lot).
The chart below shows the trend on this measure over the last three rounds of the HRBQ. For most year/sex groups there has been little change but for year 10 girls there has been a decline in life satisfaction from 72 to 65%.



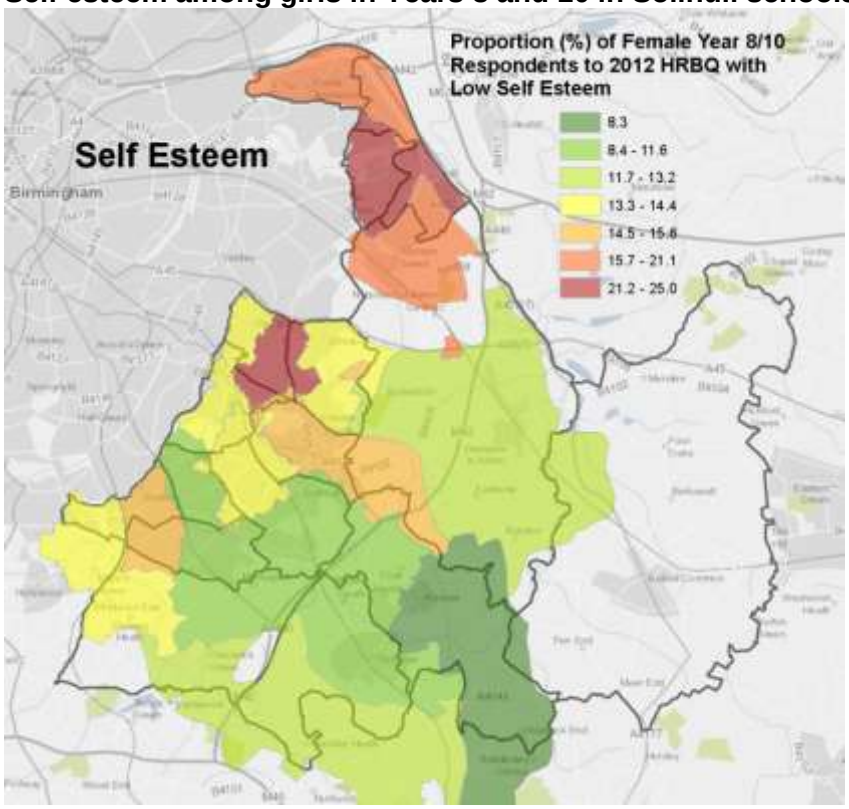
Self esteem
There are a number of questions in the HRBQ which combine to produce a measure of self esteem.

The charts below maps the findings from this for the borough as a whole for girls and boys.

Self esteem among boys in Years 8 and 10 in Solihull schools (2012 data)



Self esteem among girls in Years 8 and 10 in Solihull schools (2012 data)



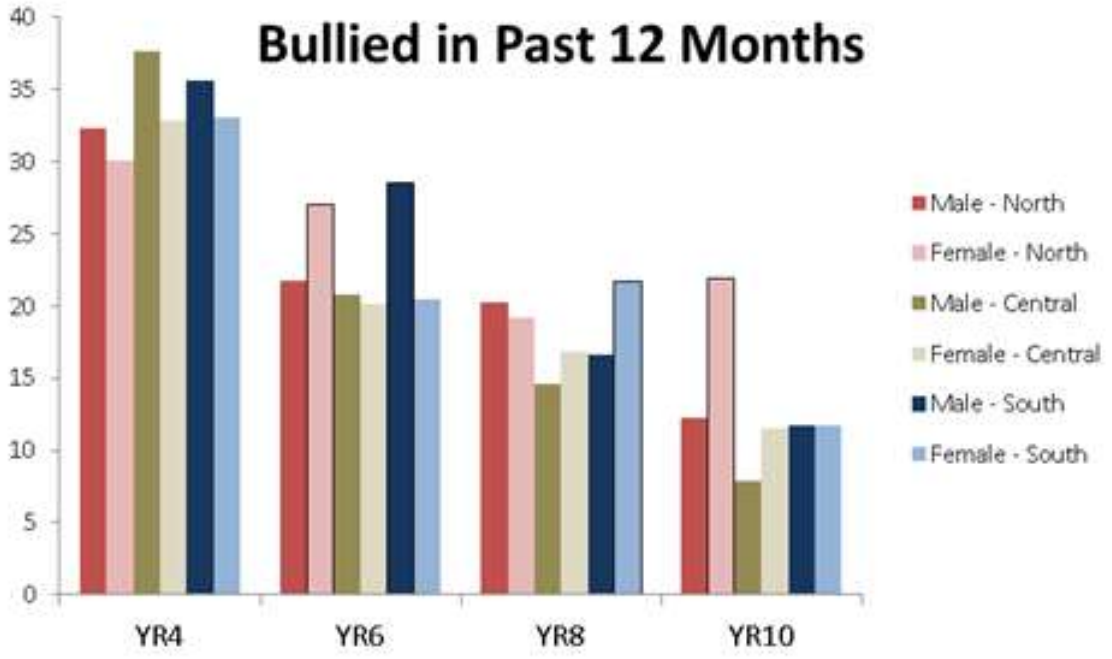
Source Health Related Behaviour Questionnaire 2012 (maps produced by Solihull Observatory)

The two key conclusions that can be drawn from these charts are, first, that low self esteem is higher in the north of the borough and, second, that the proportion of girls with low self esteem is considerably higher than boys.

Examining the last three rounds of the HRBQ it appears that, whereas levels of self esteem are unchanged in south Solihull, in the north they are getting worse. For example, 28% of

year 10 girls living in north Solihull had low self esteem in 2012 as compared to 16% in 2007.
We know that children living in more economically disadvantaged areas, such as North Solihull, are more likely to experience mental health disorders than their counterparts in more affluent areas. This social gradient across Solihull is also apparent on measures of self esteem as well.
Compared to ten other authorities who undertake the HRBQ, boys in Solihull are more likely to score highly on self esteem. Girls in Solihull, however, are less likely to be seen in the 'high' bracket compared with girls in the reference sample.

Bullying



- Bullying levels continue to show a downward trend across both primary and secondary age ranges. The highest level reported was by Year 4 girls in 2006 at 39% and the lowest is now reported by Year 10 pupils in 2012 at 14%.
- 78% of Year 6 pupils said that their school takes bullying seriously. This is higher than the 68% seen in the reference sample
- 22% of primary pupils said they had been bullied at or near school in the last 12 months. For secondary aged pupils, 17% of pupils said the same.
- 18% of Year 10 boys said they had been the victim of violence or aggression in the area where they lived. This is higher than the 9% seen in the reference sample
- There has been an upward trend for girls saying they would like to lose weight: In 2006, 55% of Year 10 girls said this, in 2007, it increased to 56%, by 2010 59% of girls said this and in 2012, 60% of Year 10 girls said they would like to lose weight.

School factors

80% of Year 6 pupils said that their school cared whether they were happy or not. This is higher than the 66% reported in the reference sample. However, there is a marked tailing off on this measure among the older age groups.

	School cares whether I am happy or not – AGREE	School teaches me how to deal with my feelings - AGREE
Year 4	80%	74%
Year 6	80%	72%
Year 8	52%	32%
Year 10	41%	21%

6.8 A Cyber-Bullying Survey was carried out in 2009 with 1,307 children and young people in Solihull. The young people from Solihull who were surveyed showed that 55.4% of them had experienced unpleasant name calling via new technology. 22.6% had experienced pranks that lead to them being embarrassed, ridiculed or socially excluded. Homophobic insults were reported to be above average of the whole sample surveyed with 29% of young people in the Solihull survey registering this. In terms of getting help for cyber bullying only 48.9% of young people in Solihull surveyed said that they had actually reported incidents of those who did report cyber bullying only 48.9% felt that they had received effective support to manage it.

6.10 Disorders of mental health, behavioural problems and poor emotional wellbeing are relatively common in children and young people. Local information about the mental and emotional wellbeing of children is limited; however estimates can be derived from national data which is the subject of the next section.

Solihull CAMHS needs assessment

Prevalence of certain disorders

Pre-school children

There are relatively little data about prevalence rates for mental health disorders in pre-school age children. The Report of the Children and Young People's Health Outcomes Forum (Department of Health, 2012, p.32) "recommends a new survey to support measurement of outcomes for children with mental health problems. In particular, we recommend a survey on a three-yearly basis to look at prevalence of mental health problems in children and young people." A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H et al, 2006). Applying this average prevalence rate to the estimated population within the area, gives a figure of 1,880 children aged 2 to 5 years inclusive living in Solihull who have a mental health disorder.

School-age children

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green et al (2004). Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life. Prevalence varies by age and 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 olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the table below shows the estimated prevalence of mental health disorder by age group and sex in Solihull. Note that the numbers in the age groups 5-10 years and 11-16 years do not add up to those in the 5-16 year age group as the rates are different within each age group.

Estimated number of children in Solihull with mental health disorders by age group and sex

Estimated number of children aged 5-10 yrs with mental health disorder (2012)	Estimated number of children aged 11-16 yrs with mental health disorder (2012)	Estimated number of children aged 5-16 yrs with mental health disorder (2012)
1,110	1,840	2,915

Source: Office for National Statistics mid year population estimates for 2012 (local authority report Green, H. et al (2004))

These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders (Green, H. et al, 2004). The following table shows the estimated number of children with conduct, emotional, hyperkinetic and less common disorders in Solihull, by applying these prevalence rates (the numbers in this table do not add up to the numbers in the previous table because some children have more than one disorder).

Estimated percentages and number of children in Solihull by type of disorder, age and sex

	National prevalence			**Local estimate for number aged 5-10 with condition**
Condition	Males	Females	Total	Total
Conduct disorder	6.9%	2.8%	4.9%	705
Emotional disorder	2.2%	2.5%	2.4%	345
Hyperkinetic disorder	2.7%	0.4%	1.6%	230
Less common disorder	2.2%	0.4%	1.3%	190
Any diagnosed mental disorder	10.2%	5.1%	7.7%	1110

	National prevalence			**Local estimate for number aged 11-16 with condition**
Condition	Males	Females	Total	Total
Conduct disorder	8.1%	5.1%	6.6%	1060
Emotional disorder	4%	6.1%	5%	800
Hyperkinetic disorder	2.4%	0.4%	1.4%	225
Less common disorder	1.6%	1.1%	1.4%	225
Any diagnosed mental disorder	12.6%	10.3%	11.5%	1840

Source: Office for National Statistics mid year population estimates for 2012 (local authority report,Green, H. et al (2004))

Young people aged 16 to 19

A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 inclusive living in private households. The tables below show how many 16 to 19 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Solihull.

Estimated number of Solihull males aged 16 to 19 with neurotic disorders

Mixed anxiety and depressive disorder (males 16-19 yrs) (2012)	Generalised anxiety disorder (males 16-19 yrs) (2012)	Depressive episode (males 16-19 yrs) (2012)	All phobias (males 16-19 yrs) (2012)	Obsessive compulsive disorder (males 16-19 yrs) (2012)	Panic disorder (males 16-19 yrs) (2012)	Any neurotic disorder (males 16-19 yrs) (2012)
270	85	50	35	50	30	455

Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report); Office for National Statistics mid year population estimates for 2012 (local authority report). Singleton, N. et al (2001).

Estimated number of Solihull females aged 16 to 19 with neurotic disorders

Mixed anxiety and depressive disorder (females 16-19 yrs) (2012)	Generalised anxiety disorder (females 16-19 yrs) (2012)	Depressive episode (females 16-19 yrs) (2012)	All phobias (females 16-19 yrs) (2012)	Obsessive compulsive disorder (females 16-19 yrs) (2012)	Panic disorder (females 16-19 yrs) (2012)	Any neurotic disorder (females 16-19 yrs) (2012)
640	60	140	110	50	35	985

Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report); Office for National Statistics mid year population estimates for 2012 (local authority report). Singleton, N. et al (2001).

Autistic Spectrum Disorder (ASD)

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

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

The European Commission (2005) highlights the problems associated with establishing prevalence rates for Autistic Spectrum Disorders. These include the absence of long-term studies of psychiatric case registers and inconsistencies of definition over time and between locations.

Nevertheless the Commission estimates that according to the existing information, the age-specific prevalence rates for 'classical autism' in the European Union (EU) could be estimated as varying from 3.3 to 16.0 per 10,000. These rates could however increase to a range estimated between 30 and 63 per 10,000 when all forms of autism spectrum disorders are included. Debate remains about the validity and usefulness of a broad definition of autism. The EU definition of rare diseases focuses on those diseases lower than 5 per 10,000. The Commission notes that ASD could be considered as a rare disease using the most restrictive diagnosis criteria but it seems more appropriate to not refer to ASD as a rare disease.

The next table shows the numbers of children with autistic spectrum disorders if the prevalence rates found by Baird et al (2006) and by Baron-Cohen et al (2009) were applied to the population of Solihull.

Estimated number of children in Solihull with autistic spectrum disorders

Autism in children aged 9-10 years (2012)	Other ASDs in children aged 9-10 years (2012)	Total of all ASDs in children aged 9-10 years (2012)	Autism-spectrum conditions disorders in children aged 5-9 years (2012)
20	40	55	190

Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report);
Office for National Statistics mid year population estimates for 2012 (local authority report).
Baird, G. et al (2006). Baron-Cohen, S. et al (2009).

Estimated need for services at each tier

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been provided by Kurtz (1996). A description of the services offered at each tier can be found in the notes section below. The following table shows these estimates for the population aged 17 and under in Solihull.

Estimated number of children / young people in Solihull who may experience mental health problems appropriate to a response from CAMHS

Tier 1 (2012)	Tier 2 (2012)	Tier 3 (2012)	Tier 4 (2012)
6,770	3,160	835	35

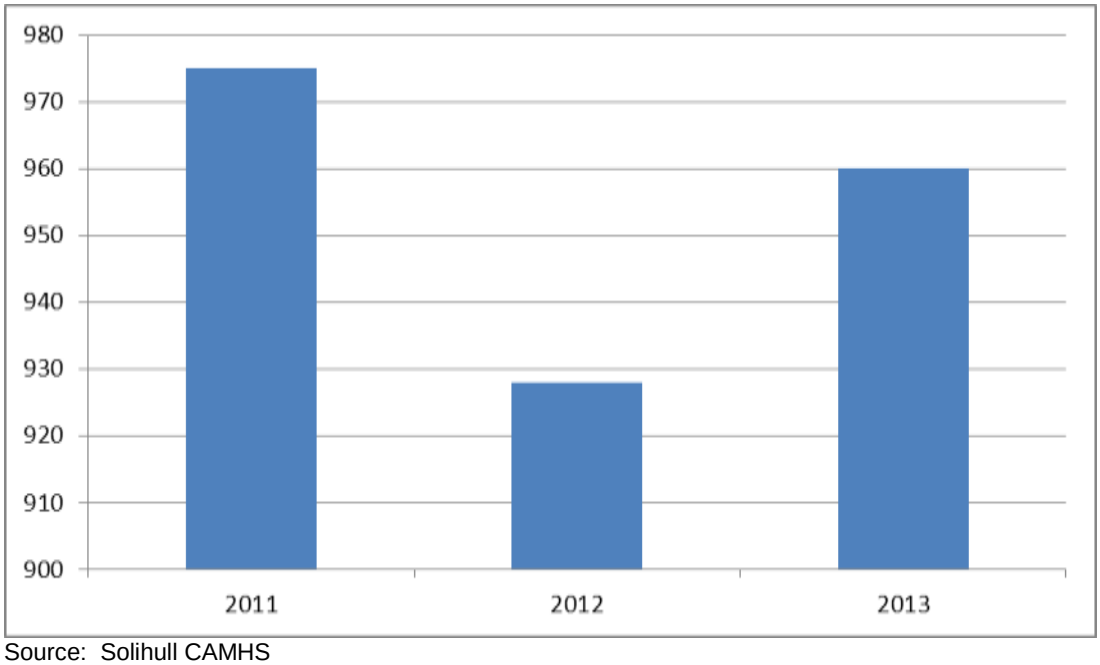
Source: General Practice (GP) registered patient counts aggregated up to CCG level (CCG report);
Office for National Statistics mid year population estimates for 2012 (local authority report).
Kurtz, Z. (1996).

Expected prevalence compared to actual activity in Solihull

In this section an attempt will be made to compare the expected prevalence of mental health disorders in children with the observed prevalence based on figures provided by the CAMHS service.

First, however, we need to be clear on our definitions. Prevalence refers to the numbers of people in an area with the condition in question at a point in time. Our comparator in the case of Solihull CAMHS is not prevalence – that would amount to the caseloads of the CAMHS team – but incidence which is defined as the number of new people who are diagnosed with the condition, or in this case referred with the condition, in a certain period of time.

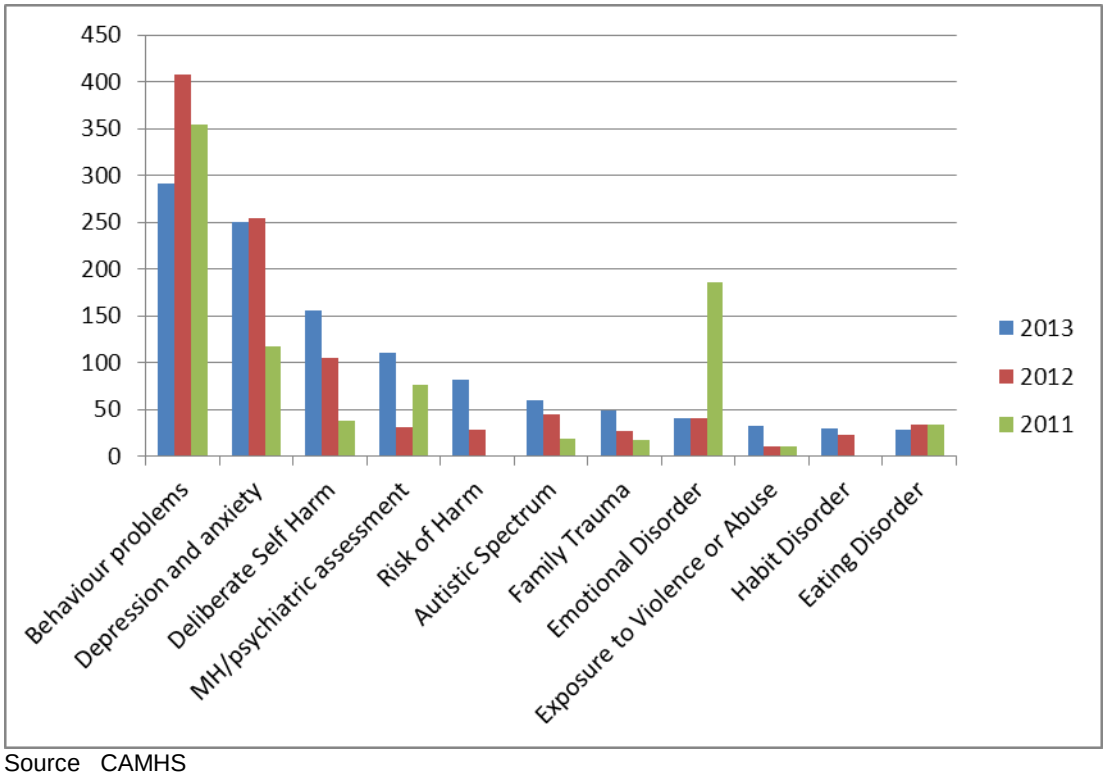
Referrals to CAMHS



Source: Solihull CAMHS

The number of referrals has fluctuated between 2011 and 2013.

Reason for referral



Source CAMHS

The 11 disorders that are identified in the above graph make up 87% of the reasons for referral over the period 2011 - 2013 (note the numbers of unique referrals to CAMHS does not equate to the number of reasons for referrals as some patients are referred for more than one reason).

Points to note

- Behaviour problems are the single biggest reason for referral accounting for 31% of all referrals. This accords with figures from national prevalence studies which found conduct disorders to be the biggest single disorder.
- However the national findings were that conduct/behaviour problems were higher in the older age group (prevalence of 6.6% in 11 – 16 year olds compared to 4.9% in 5-10 years) whereas in Solihull this is reversed and the rate of referrals is slightly lower in the older age group).
- The gender breakdown on behaviour problems accords with national estimates - that is 60 - 70% of referrals for behavioural problems are among boys with younger boys accounting for the higher end of that range (which is again in line with national estimates)
- Referrals for self harm have quadrupled between 2011 and 2013
- ASD referrals have tripled in the same period
- Violence as a reason for referral has increased considerably (particularly if you add in domestic violence which only appears as a separate category in 2013)

Some differences between the annual totals may be due to coding anomalies (coding fashion or terminology?). Examples of this may be the high number of emotional disorders recorded in 2011 compared to subsequent years or the much higher proportion of 'other' reasons for referral in 2011.

Referrals by age

Actual CAMHS referrals

Age band	Count	As %
0-4	44	4%
5-10	337	27%
11-16	792	64%
17	61	5%
TOTAL	1234	100%

Expected numbers from national prevalence

Age band	Count	As %
0-4	1880	30%
5-10	1110	18%
11-16	1840	29%
17-19	1440	23%
TOTAL	6270	100%

Points to note

- Two thirds of referrals to Solihull CAMHS are 11-16 yr olds whereas national estimates are more evenly spread across the age groups (eg 11-16 yr olds account for less than 1/3rd of MH disorders)
- There are relatively few referrals in <5s and over 16s (but Solihull CAMHS upper age limit is 17 so some of the upper age group will presumably be seen in AMHS)

Referrals in the 5 – 16 age group

Actual (total referrals to CAMHS)

Age band	**Female**	**Male**	**Total**
5-10	134	203	337
5-10 (%)	40%	60%	100%
11-16	490	302	792
11-16 (%)	62%	38%	100%
Overall			
5-16	624	505	1129
5-16 (%)	55%	45%	100%

Expected (prevalence estimates)

Age band	**Female**	**Male**	**Total**
5-10	350	770	1120
5-10 (%)	31%	69%	100%
11-16	805	1035	1840
11-16 (%)	44%	56%	100%
Overall			
5-16	1145	1795	2940
5-16 (%)	39%	61%	100%

Points to note

- in the 5-10 age group more boys than girls were referred (but note the proportion of boys is less than predicted from national estimates)

- in the 11-16 age group more girls than boys are referred to Solihull CAMHS (the ratio is roughly 60/40 in favour of girls whereas the ratio is 60/40 in favour of boys in the national prevalence estimates

Existing Services

6.11 Solihull Child and Adolescent Mental Health Services (CAMHS) is an integrated service bringing together different CAMH providers in Solihull in to one service. Some of the provided services have achieved international and national recognition (Intensive community outreach service (ICOS), CHESS and LAATCH). In the year 08/09 there were 953 referrals to core CAMHS of which 525 were accepted into service. The rest were either not accepted, inappropriate referrals or referred elsewhere. A small number declined offered appointments.

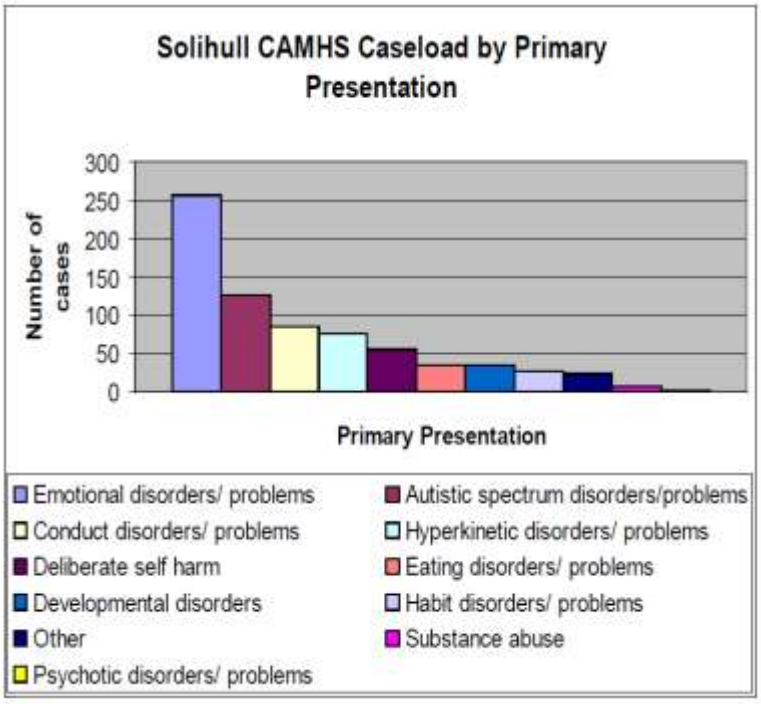
Table 10: CAMHS Caseload Overview[52]

Service	Total caseload	Total number of consultations[1]	Total caseload with consultations	Total number of new cases[2]	Total number of cases waiting[3]	Total team caseload on 30th November[4]	CAMHS referrals received in the last year[5]	CAMHS referrals accepted in the last year[5]
Autism Team	58	76	134	12	132	218	249	204
CHESS	8	2	10	-	-	8	-	-
Child and Family Unit	273	-	273	9	-	273	851	665
Child Psychology and Psychotherapy Service	66	23	89	16	-	66	851	665
ICOS - Intensive Community Outreach Service	13	-	13	1	-	13	5	5
Looked After Children Team	32	-	32	-	-	32	97	86
YOT	29	-	29	-	-	29	3	3
Total	479	101	580	38	132	639	2056	1628

6.12 According to the Solihull CAMHS Annual Report 2008/9[53] approximately one third (30%) of the primary presentation caseload is for emotional disorders/problems. According to Solihull CAMHS this is slightly less than the percent for the West Midlands. A further 50% of caseload deals with hyperkinetic disorders/problems, conduct disorders/problems and autistic spectrum disorders/problems. This is 10% higher than the West Midlands.[54]

[52] CAMHS Mapping Report
[53] Report complied by Hazel Douglas, Strategic Lead for CAMHS
[54] Snapshot from November 2007

Figure 8: Solihull CAMHS Caseload



6.13 In terms of Child and Adolescent and Mental Health (CAMHS) services (measured via NI 51), Solihull achieved a maximum score of 16 for CAHMS for the period of 2008-9.[55] The self assessment was undertaken in January 2009 and is broken down into 4 categories looking at a number of different factors including the range of CAMH services for children and young people with learning disabilities, the range of early intervention services for children experiencing mental health problems commissioned by the local authority, and PCT in partnership and arrangements for urgent mental health needs.

6.14 The Targeted Mental Health in Schools (TAMHS) programme in Solihull was carried out during 2010/ 11. The aim of the progrmamme was to use the available evidence base and focus on sustainable developments to improve levels of integrated support for children and young people experiencing emotional health difficulties. This was going to be achieved by:

- Training for the school workforce, including staff in Pupil Referral Unit's (PRU's) and special schools, to develop awareness, confidence and expertise and enhance capacity and capability to deliver appropriate interventions in school wherever possible

- Working with third sector organisations to provide targeted support for children and young people whose schools identify with particular issues, i.e. bereavement, family breakdown

- Developing and communicating clear care pathways, to make it easier for schools to make effective referrals to appropriate agencies for specialist support for more complex needs, including specialist CAMHS

[55] Solihull CAMHS Annual report 2008/09

Interim findings show that:

- Schools were enthusiastic, ambitious and creative
- There is an effective training module for mental health awareness raising in schools
- School's have an increased ability to 'evaluate' the impact it can make upon the 'soft skills' of mental health and well-being
- Very early to tell, but case studies suggests that early intervention work at the PRU's is improving mental health and well being - a high proportion of YP in PRU's go onto have poor mental health, often associated with criminal activity
- Early data collection indicates significant improvements in the mental health and well-being of targeted pupils in Solihull TaHMS

National Measures

6.15 The emotional health of children has, until recently, been measured by NI 50 which measures the percentage of children with good relationships. This is defined as the percentage of children who answered 'true' to having one or more good friends and answered 'true' to at least two of the statements about being able to talk to their parents, friends or another adult. Solihull was ranked 71st out of 150 local authorities, 29th out of 36 Metropolitan Boroughs, and 11th out of 16 members in our CIPFA comparator group of authorities for this measure for 2009-10[56]. TellUs 4 data which supports Local Authority Measures for National Indictors shows a reduction in young people's perception of emotional health and wellbeing, based on the percentage of children with good relationships, as recorded through the survey and published in February 2010.

6.16 NI 58 was a new indicator for 2008/9 looking at the emotional and behavioural health of looked after children. The indicator is a clear outcome measure – it is not about service provision. Therefore, the indicator and associated targets provide a good holistic measure of efforts to improve the emotional and behavioural health of looked after children. The score is the average from the Strengths and Difficulties Questionnaire on Looked after Children aged 4-16, completed by carers. Possible scores range from 0-40 with the higher score indicating greater degree of difficulties. For 2008/9 Solihull score was 13.6, the England average was 13.9 and statistical neighbour was 12.3 (the 2009/10 score for Solihull was 12, England and statistical neighbour data not available).

6.17 NI 69 looks at children who have experienced bullying and was also measured via the TellUs 4 survey. The result of 22.7% places Solihull in the 'Best Banding'. Solihull is the only LA in West Midlands Government Office Region to be placed in this banding. The England Average Score is 28.8%.

Table 10: % of children who have experienced bullying (NI 69)

	2007/8	2008/9	2009/10
Solihull	25	44.3	23
National	30	48.0	29
Stat Neighbours	-	47.8	28

(Data Source: - DCSF: Local Authority Measures for National Indicators supported by the Tellus4 Survey – Released February 2010)

[56] PWC Benchmarking club – 2009-10 Quarter 3 Data

7. Which children and young people are most likely to develop emotional health problems?

7.1 There are certain 'risk factors' that make some children and young people more likely to experience problems than others. Some of these factors include living in poverty or being homeless, having parents who separate or divorce, living in care and experiencing discrimination. There is also known to be higher prevalence among those with a long-term physical illness, those who have a parent with mental health problems, those acting as a carer for a relative; and teenage parents.

Key risk factors for Emotional Wellbeing & Mental Health (for Solihull)

Risk Factor	Degree of Risk (OR)	Prevalence
Child Abuse	15.5% increased rate of minor depression as child8.7% increased rate of suicidal ideation 8.1% increased risk of anxiety 7- 8 times increased rate of recurrent depression as adult 9.9% Post Traumatic Stress Disorder 5.4% increased rate substance misuse	20% of children report experiencing some form of child abuse in their lifetime (UK)
Looked After Children	6- 8 times increased conduct disorder 4- 5 times increased suicide attempt	1-2% children are 'looked after'
Young Offender	18 times increased suicide risk	9,000 young offenders
LGBT	4 times increased risk of suicide	6% of population

(taken from the feedback presentation from the Children and Young People's Emotional Wellbeing and Mental Health National Support Team - February 26th 2010)

Ante and Post natal depression

Background

Mental disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members. (NICE Guideline 45)
The children of mothers with mental health issues are twice as likely to experience a childhood psychiatric disorder.

Post-natal depression and other forms of mental illness are linked to an increase in insecure attachment in toddlers, behavioural disturbance at home, less creative play and greater levels of disturbed or disruptive behaviour at primary school, poor peer relationships, and a decrease in self-control with an increase in aggression.
Ante-natal depression (AND) and anxiety pose a significant risk for the baby through the direct action of chemicals on the brain of the foetus; and the fact that AND is a strong indicator for the later development of post-natal depression (PND).

Prevalence rates

Nationally it is estimated that 10% of mothers suffer from post-natal depression (Source: NICE (2007) *Antenatal and postnatal mental health: clinical management and service guidance*, NICE Guideline 45).
Research on ante-natal depression indicates that about 10-20% of pregnant women suffer antenatal depression and anxiety, and that levels at 32 weeks of pregnancy are greater than postnatally.

Currently there is no national outcomes measure regarding post or antenatal depression. The Children and Young People's Health Outcomes Forum has recommended a new Public Health outcomes indicator measuring the proportion of mothers with mental health problems, including postnatal depression.

In Solihull a screening questionnaire (the Edinburgh Post Natal Depression Score) is used to identify mothers who are likely to have postnatal depression. However, it is unclear whether this screen is carried out in all cases. Figures from the period January to September 2013 reveal that 6.5% of mothers scored above the threshold for likely post natal depression (ie. 8 or more).
No data are collected on antenatal depression in Solihull.

Evidence for what works

The UK National Screening Committee states there is insufficient evidence that screening and intervention improve the health outcomes for the mother or the baby and therefore recommends that screening for post natal depression should not be offered. However it states that the EPDS may serve as a checklist as part of a mood assessment for postnatal mothers when it should only be used alongside professional judgement and clinical interview. (National Screening Committee, 2006)
NICE guidance recommends that:

At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

1) During the past month, have you often been bothered by feeling down, depressed or hopeless?
2) During the past month, have you often been bothered by having little interest or pleasure in doing things?

(these are known as the Whooley questions).

NICE goes on to recommend the use of self-report measures suchas the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire-9 (PHQ-9) as part of a subsequent assessment or for the routine monitoring of outcomes.
NICE is reviewing the perinatal mental health guidance and will almost certainly reiterate its importance as the research base is ever strengthening for the early detection of depression.

The Wave Trust in its report 'Conception to age 2 – the age of opportunity' calls for maternal mental health during pregnancy to be given equal prominence to optimising maternal physical health. It recommends that information on ante and post natal depression should be routinely gathered through the Healthy Child Programme and goes on to recommend that further education and training for those who work with pregnant women and new mothers be provided.

Existing practice in Solihull

The Special Health Visitor for maternal mental health at HEFT has developed pathways for the detection and management of ante and postnatal depression. These recommend the use of screening tools such as the Whooley and EDPS.

The guidance is based on best practice evidence from both NICE and the National Screening Committee.

However, routine data reporting is not currently in place so it is unclear whether the pathways are followed in practice.

Children at risk of abuse

7.2 In Solihull there are 149 children who are the subject of a child protection plan (31st March 2010). A national Review of serious case reviews from 2003-5[57] highlighted deaths by suicide of older adolescents who had been abused in their families, had typically had a long history of involvement from agencies, and had turned to self harm, neglecting themselves, and substance misuse. They had become difficult to contain and as they became older, services had been reduced. There had been reluctance to see these young people as emotionally unwell, and a failure to provide a coordinated accessible service which would engage and stick with them.

[57] Analysing Child Deaths and Serious Injuries through Abuse and Neglect : What can we learn? DfES 2008

Looked after children and young people

7.3 In accordance with the findings in 'In it Together II: Redefining Value in Children's Services'[58] there are a number of poor outcomes which are associated with contact with the care system:

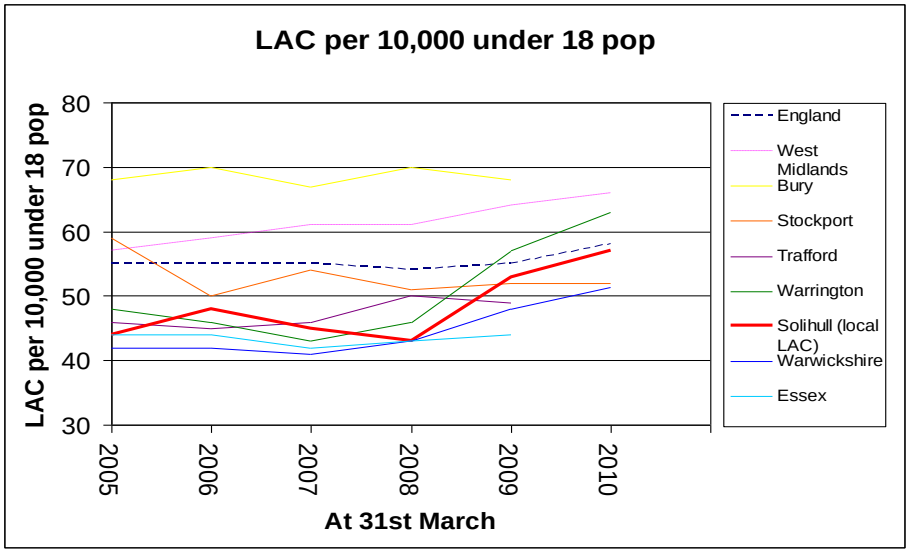
• Children in care are 4-5 times more likely to have mental health issues than their peers
• Over 20% of women who leave care between the ages of 6 and 9 become mothers within a year compared to just 5% of the general population
• A third of homeless people were formerly in care
• 30% of children in custody have been in care
• 23 % of the adult prison population has previously been in care[59]
• 14% of looked after children were unemployed the September after leaving school[60]

7.4 It is estimated that 40% of children in care (45% of those aged 5 -17)[61] have significant emotional ill health, much of which is shown in conduct disorder. Clinically significant conduct disorders were the most common among looked after children (37%), while 12% had emotional disorders (anxiety and depression) and 7% were hyperactive. Even when compared to children in a community sample from the most deprived socio-economic groups, looked after children still showed significantly higher rates of mental health disorders.[62] Many of these children have experienced abuse, neglect and removal from their family. Solihull currently is responsible for 415 looked after children and young people (260 local children and 155 unaccompanied asylum seeking children). If 40% of this total figure has significant emotional ill health, this would be 166 children and young people.

7.5 The number of looked after children has increased nationally and regionally, but the rise in Solihull has been significant. From March 2006 to March 2010 there has been a 47.5% increase in the total number of looked after children (281 – 415). Whilst the majority of this increase is attributable to UASC, the increase in the number of local looked after children for the same period is 19% (219 – 261) excluding respite. Nationally the increase from March 2006 to 2010 has been 7%.
7.6 In August 2010, the number of local looked after children per 10,000 child population in Solihull was 56.8. Figure 12 below illustrates, Solihull is just below the national average, but has seen a more significant increase in numbers than most of Solihull's statistical neighbours.

[58] Children's Services Development Group in collaboration with Donald Hirsch, December 2010
[59] Centre for Social Justice, Couldn't Care Less, October 2008, http://www.centreforsocialjustice.org.uk/client/downloads/Couldn%27t%20Care%20Less%20Report%20WEB%20VERSION.PDF
[60] DfE, Outcome indicators for children looked after: twelve months to 0 September 2009, England, http://www.education.gov.uk/rsgateway/DB/SFR/s0009 0/SFR08-20 0.pdf
[61] Meltzer et al, The Mental Health of young people looked after by local authorities in England, 2002
[62] Ford T., Vostanis P., Meltzer H. and Goodman R. (2007) 'Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households', BritishJournal of Psychiatry 190, 319-325

Figure 9: Looked after Children per 10,000 populations at 31st March, for Solihull, statistical neighbours and the West Midlands and England averages.



Young Offenders

7.7 A high proportion of children and young people in contact with the youth justice system have a mental health problem (approximately 40%).[63] This rises to more than 90% for those in custody.[64] These children and young people are vulnerable for many reasons. For example, they tend to be exposed to multiple risk factors; frequently have more than one disorder (including more 'stigmatised' disorders such as emerging personality disorder or inappropriate sexual behaviour); frequently miss out on universal promotion and preventive services; and engage with the system at a point that does not offer the most appropriate treatment and placement solutions for mental health problems.

7.8 In Solihull between 1st Jan 2010 – 31st Dec 2010 there were 102 young people on the caseload of the Youth Offending Service. 62 of these young people have scored 2 or above on the asset score for emotional and mental health. Scores of 2 or above mean that a referral to a specialist intervention is required as the likelihood of the young person reoffending is increased by the state of their emotional and mental health.

Lesbian, Gay, Bisexual and Transgender (LGBT)

7.9 According to the National CAMHS Review (2008) young people who are lesbian, gay or bisexual may be more vulnerable to self-harm, suicide and bullying, though there is currently a lack of robust evidence.[65] However, the Children and Young People's Mental Health Coalition highlights the need for more explicit policy around LGBT young people particularly because New Horizons is less explicit about their needs.[66]

7.10 Stonewall reports that about 65% of gay young people experience homophobic bullying in school [this rises to 75% in faith schools] and 35% of these young people do not feel safe at school. Over 60% of lesbian and gay young people feel that there is no adult,

[63] Healthcare Commission. 2006. *A Review of Healthcare in the Community for Young People who Offend*. London: Commission for Healthcare Audit and Inspection.
[64] Department of Health. 2007. *Promoting Mental Health for Children in Secure Settings: A framework for commissioning services*. London: DH.
[65] Hawton and Rodham (2006) and Childline (2006), cited in Bridget. 2007. *Lesbian, Gay and Bisexual Young People: Evidence-based services and resources*. Online paper available at www.cypf.csip.org.uk
[66] Children and young people's mental health: the policy, the progress made and the challenges

either at home or school who they can talk to about being gay. 30% report that adults are responsible for homophobic incidents in their school.

7.11 Evidence suggests that lesbian, gay, bisexual and transgender (LGBT) young people are over-represented amongst homeless young people and face particular vulnerabilities. Studies in the US have found that between 25 per cent and 40 per cent of homeless youth identify as LGBT, compared to 5 per cent – 7 per cent in the population as a whole.[67]

Associated Risk Factors for Poor Mental Health in Children and Young People

Risk Factor	Impact upon Mental Health	Prevalence
Poor maternal mental health	5.5 / 5.3 increased rate in onset of emotional / conduct disorder in childhood	10% of mothers have post natal depression
Parent unemployed	5.0 / 4.0 increase in onset of emotional / conduct disorder in childhood	1.8 million children live in workless households and 1 in 10 of these have a mental health problem
Poor parenting skills	5.6 increase rate of conduct disorder in childhood	

(taken from the feedback presentation from the Children and Young People's Emotional Wellbeing and Mental Health National Support Team – February 26th 2010)

Poor maternal mental health

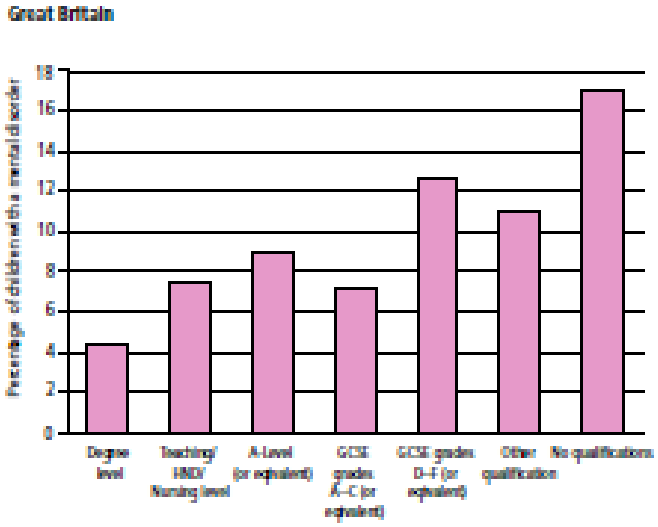
7.12 The Department of Health estimates that 30% of mentally ill adults have dependent children and that between 33 and 66% of children with a mentally ill parent will develop emotional ill health.[68]

Children from Economically Disadvantaged Families and Areas

7.13 According to the Office of National Statistic's (ONS) report on Mental Health of Children and Young People in Great Britain (2004) children with an emotional disorder within their sample were more likely than other children to have parents with no educational qualifications and to live in low-income families. Over a third (35 per cent) of children with an emotional disorder had parents who had no educational qualifications compared with only a fifth (20 per cent) of those with no such disorder.

[67] Nation Youth Homeless Scheme, LGBT Young People
[68] Department of Health, National Strategy for Carers 2006 9-1-2006

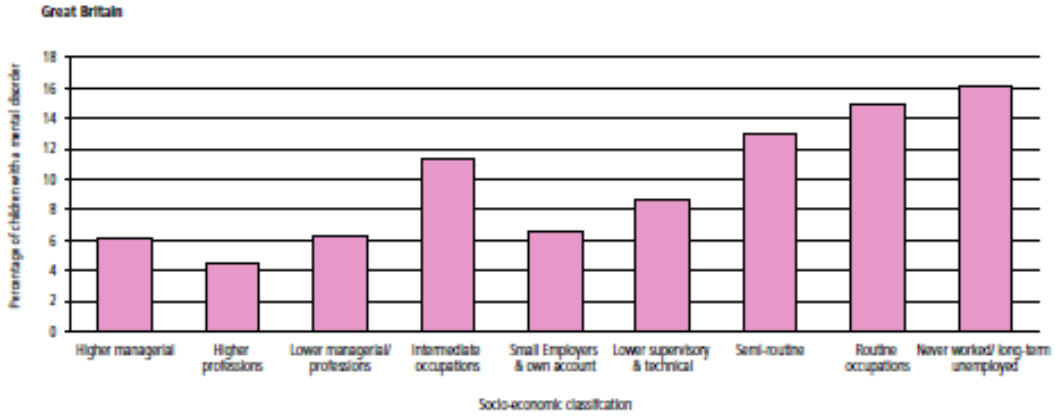
Figure 10: Prevalence of mental disorders by educational qualifications of parents, 2004



*__Source ONS__ Mental Health of Children and Young People in Great Britain (2004)

7.14 One-fifth (20 per cent) of children in families without a working parent had a mental disorder, more than twice the proportion among children with one or both parents working (9 per cent and 8 per cent). The highest prevalence was found among boys aged 11–16 with neither parent working of whom one quarter (25 per cent) had a mental disorder. Among boys of a similar age with both parents working, the proportion with a mental disorder was 10 per cent.

Figure 11: Prevalence of mental disorders by socio-economic classification, 2004

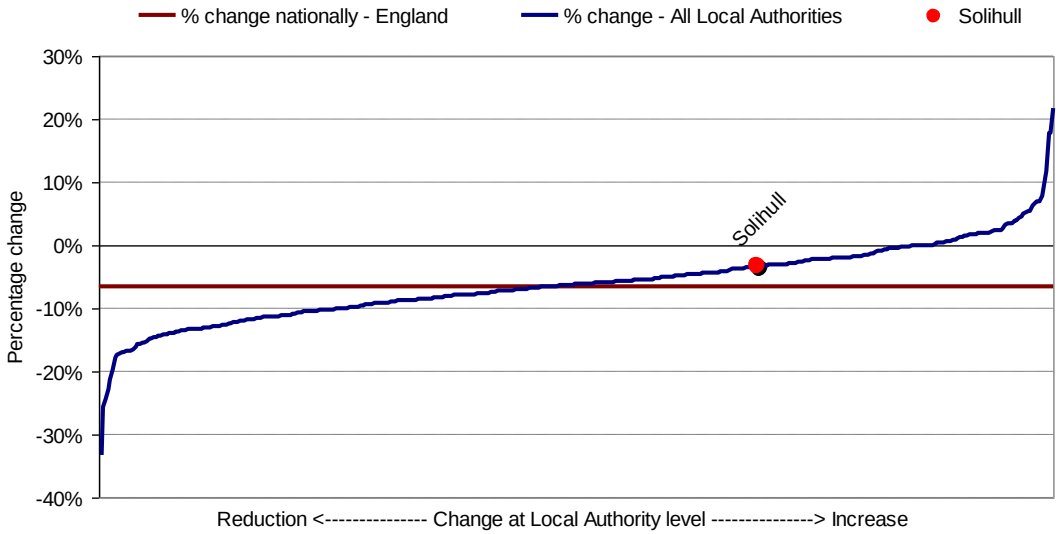


*__Source ONS__ Mental Health of Children and Young People in Great Britain (2004)

7.15 The Households Below Average Income (HBAI) survey 2008/09 showed 13.4 million people (22%) in the UK are income poor.[69] Of these 53% are in households that include at least one child. Solihull, although widely recognised as affluent has high levels of the deprivation in the north of the Borough. In 2007, three of the wards in the north of the Borough were rated as amongst the most deprived 10% in England, and there are other pockets of deprivation such as in Bickenhill, Elmdon, Lyndon, Olton and Shirley. Smith's Wood, which is in the North of the Borough, is the ward with the highest percentage of children and young people aged 19 years and under in Solihull (31.2% of the total population) A significant number of local people across Solihull and particularly in the North face poor health, education, housing and employment opportunities.

[69] Income poor means those living in households with less than 60% median income

Figure 12: Children in Workless Families - Change Over Time



Source: DWP Information Directorate: Work and Pensions Longitudinal Study (latest data - May 2008)

Other risk factors

Transition

7.16 Many young people with ongoing mental health needs fall through the gap between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS). These are most likely to be young people with emotional/neurotic problems, neurodevelopmental disorders and emerging personality disorder. According to a TRACK Study carried out by Swaran Singh et al[70] for the vast majority, transition from CAMHS to AMHS is poorly planned, poorly executed and poorly experienced. Mutual misperceptions among clinicians contribute to pre-existing ideological, practical and structural barriers between CAMHS and AMHS and even where protocols exist, there is a policy-practice gap.

7.17 A Call to Action: Commissioning Mental Health Services for 16 – 25 year olds (YoungMinds 2006) highlights a number of statistics that illustrate how many vulnerable young adults there are. It should be noted that as no national data set primarily concerned with young adults exists the statistical information has to be gathered from a range of sources and does not provide a comprehensive picture. In fact it is likely that the data underestimates the need. According to this information:

- 16-25 year-olds account for 12% of the total population – approximately 7 million.
- 0.2% have had an assessment of psychotic disorder in the past year, or two or more indicators of psychosis – approximately 13,000.30
- The average age of first onset psychosis is 22. The average time it takes for a young person experiencing psychosis to receive help is 18 months. 80% are hospitalised during their first episode of psychosis. 50% of young people admitted to hospital are admitted under the Mental Health Act.14, 31
- 13.3% of 16-19s, and 15.8% of 20-24 year-olds have a neurotic disorder – approximately 946,000.30
- 1.4% of 16-19s, and 1.5% of 20-24 year-olds have a generalised anxiety disorder – approximately 94,000.
- 1.7% of 16-19s, and 2.2% of 20-24 year-olds have had a depressive episode – approximately127,000.
- 3.4% of 16-34 year-olds have a personality disorder – approximately 450,000.30

[70] BJPsych.2010

- Between 1 and 2% of young women have anorexia, and between 1 and 3% of young women have bulimia.
- Just over 2 million 16-25 year-olds are full time students; 55% of 16 to 19 year-olds are full time students; and 20% of those aged 20-24 are full time students.
- Approximately 2.1 million of 16-25 year-olds are in full time employment; 327,000 are unemployed; 213,000 are economically inactive and looking after the home/family; and 62,000 are permanently sick or disabled.

Young Carers

7.18 There are estimated to be: 150,000 young carers in the UK, 30 per cent of whom are believed to be caring for adults with mental health needs; 250,000 to 350,000 children and young people living with a parent whose drug use is problematic (almost one child for every problem drug user), and 1.4 million children are living with at least one parent who drinks excessively.[71] Young carers take on practical and/or emotional caring responsibilities that would normally be expected of an adult and can therefore be at risk of social isolation due to additional home life responsibilities, missing out on many of the leisure opportunities available to their peers. They are also more at risk of bullying, often in relation to the adult they care for, for example having a parent with poor mental health or a substance misuse problem.[72]

7.19 'Hidden Harm: Responding to the needs of children of problem drug users'[73] states that parental problem drug use can and does cause serious harm to children at every age from conception to adulthood and that reducing the harm to children from parental problem drug use should become a main objective of policy and practice. By working together, services can take many practical steps to protect and improve the health and wellbeing of affected children. The number of affected children is only likely to decrease when the number of problem drug users decreases.

7.20 The 2001 Census indicated that at that time there were 658 children and young people between the ages of 4 and 19 providing care of between 1 and 50+ hours in Solihull. However this is likely to be an underestimate as national studies show that between 4 and 10% of the population will have been carers at some time in their childhood. In 2005, a local needs analysis of children of substance misusing parents identified 368 children, and estimated a total of approximately 1606 children and young people up to 18 in the Borough, as affected by this issue.

[71] C4EO, Improving the safety, health and wellbeing of children October 2010
[72] Solihull's Young Carers Strategy
[73] Executive Summary of the report of an Inquiry by the Advisory Council on the Misuse of Drugs June 2003

Teenage parents

7.21 Teenage mothers have significantly poorer emotional health for up to the three years after the birth of their child than older mothers or that of their peers[74]. Social isolation and high rates of relationship breakdown are key factors which contribute to this situation. Groups that are more vulnerable to becoming teenage mothers include:

- Young people in or leaving care
- Homeless young people
- Young people excluded from school, truanting or under performing
- Children of teenage mothers
- Some minority ethnic groups
- Young offenders

7.22 Solihull has a comparatively low level of teenage conceptions at around 150 per year, consistently below National and Regional levels. Half of these conceptions result in child birth. The under 18 conception rate has fallen by 13.9% since the 1998 baseline. The overall teenage conception rate for Solihull masks the fact that some areas of the borough have significantly higher rates. The highest under 18 conception rates are seen in Chelmsley Wood, Fordbridge, Kingshurst and Smith's Wood, but under 18 conceptions occur in all Solihull wards.

Children from Black Minority Ethnic Communities

7.23 BME children are more vulnerable to emotional ill health, being over represented in a number of the high risk groups above. National research shows that families with an African, Caribbean or Black British mother are more likely than families with a white mother to be lone parents (45% compared with 25%), live in social housing (44% compared with 20%) and be in the lowest income quintile (30% compared with 16%). Pakistani and Bangladeshi families experience the highest rates of poverty, with 65% of children living in poverty (calculated after housing costs). 30% of children in Black families and 28% of children in families of Indian origin also live in poverty. On the other hand, parents of South Asian and Chinese origin are least likely to be lone parents.[75] According to the ONC 2004 children aged 5-10 years who are white, Pakistani or Bangladeshi are more likely to have an emotional disorder that black children. Indian children are the least likely to have such problems.

7.24 Just over 8% of the Solihull population is from a minority ethnic background, though 14% of school-age children and young people identify with a black or minority ethnic heritage, and this is forecast to increase. The January 2009 School Census showed that the largest ethnic minority group in schools is Indian, with the second largest being mixed White/Black Caribbean and third Pakistani.

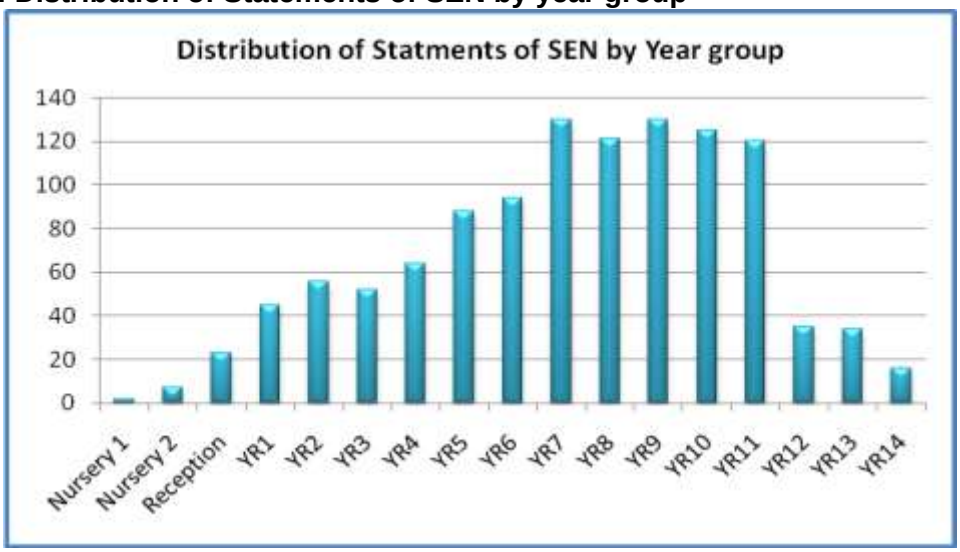
Disabled Children

7.25 Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education. 29% of disabled children nationally live in poverty. With regards to emotional wellbeing and mental health, disabled young people aged 16-24 are less satisfied with their lives than their peers and there is a tendency for support to fall away at key transition points as young people move from child to adult services. Also, families with disabled children report particularly high levels of unmet needs, isolation and stress.

[74] Teenage Pregnancy Unit, Long term consequences of teenage births for parents and children 2004
[75] Cabinet Office: Reaching Out: Think Family (2007)

7.26 The number of children with statements of special educational needs in Solihull in February 2010 was 1142 (73% are girls and 26.9% boys). This is 2.5% of the pupil population – in line with national averages. There are approximately 140 new statements a year; around 130 statements are predicted to end in 2010. The following graph shows the distribution of statements per year group.

Figure 13: Distribution of Statements of SEN by year group



The table below shows the type of assessed need for which a statement of special education need has been agreed.

Table 12: Type of assessed need

Type of Need	Nos.	As a %
Moderate Learning Difficulties	249	21.8
Autism Spectrum Disorder	204	17.9
Speech language and Communication Difficulties	175	15.3
Emotional Social Behavioural Difficulties	147	12.9
Specific learning Difficulties (dyslexia)	123	10.8
Severe Learning Disability	85	7.4
Medical	64	5.6
Physical Disability	45	3.9
Hearing Impairment	27	2.4
Visual Impairment	15	1.3
Profound and Multiple Learning Disability	6	0.5
Multi Sensory impairment	2	0.2
Total	**1142**	**100.0**

7.27 The number of Education day placements has risen significantly as a result of local provision not currently meeting need for secondary EBD provision. In 2007/8 there were 44 placements solely funded by education, which has increased to 72 placements in the current year, 20 of these placements are out of borough secondary school additional resource centres. The following table shows the education placement provision for children with a statement of special educational need; the out of authority provision is highlighted.

Table 13: Education placement provision for children with a statement of special educational need

Placement Type	Number	As a %
Mainstream (North)	150	13.1
Mainstream (South)	406	35.6
Special (North)	160	14.0
Special (South)	185	16.2
Borough-wide Special (Lanchester)	35	3.1
Elective Home Education	3	0.3
Home Based Programme (ASD)	4	0.4
Short Stay School (PRU)	19	1.7
Other LEA Mainstream	**39**	**3.4**
Other LEA Special	**52**	**4.6**
Independent non-maintained sector Special and 'mainstream'	**89**	**7.8**
Total	**1142**	**100.0**

8. What are the symptoms of children and young people's emotional problems?

8.1 The symptoms of poor emotional health may look different in different children and is likely to depend on the child's personality, personal history, community and environmental factors.

Self harm and suicide

Background

Suicide is the leading cause of death in young people. According to ONS, in 2011 there were 159 deaths of 10 to 19 year olds from intentional self-harm or undetermined intent in England and Wales. This is a rate of 2.35 deaths per 100,000 population aged 10 to 19 years.

In a 2007 survey of young adults (McManus et al, 2009) 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. Recent research has shown a significant fall in the rates among young men in the period 2001–2010.

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

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

Self-harm is a related issue:

- Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds but rise dramatically to 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds (Hawton, K., 2012). Self-poisoning was the most common

method, involving paracetamol in 58.2 % of episodes (Hawton, K., 2012)

- Presentations, especially those involving alcohol, peaked at night. Repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year) (Hawton, K., 2012). Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide (Hawton, K., 2005)

- Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors (Hawton, K., 2005)

- As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months (Hawton, K., 2005)

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

Prevalence rates

- **Suicide**
  Applying the national rate of suicides in the 10 to 19 year population to Solihull would equate to one suicide every 2 years.
  The actual situation is that there has only been one suicide in this age group in the period 2006-2012. By comparison there were 49 cases in the adult population in the same period.
- **Self harm**
  In Solihull there are between 30 and 50 admissions of young people for self harm every year.

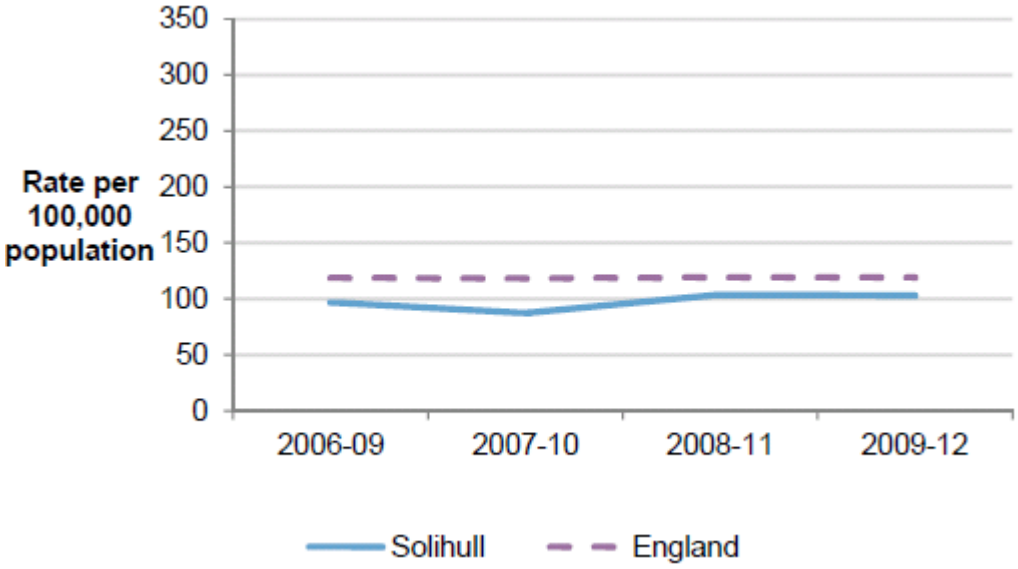
If the national rates of self harm were applied to the Solihull youth population the expected number of self harmers would be 23 in the 10-14 age group and 105 in the 15-18 age group. The estimated rates in young women is three times that in young men.

Not all incidents of self harm result in hospital admission. Future developments of the Public Health Outcomes Framework are looking at an indicator with two elements:

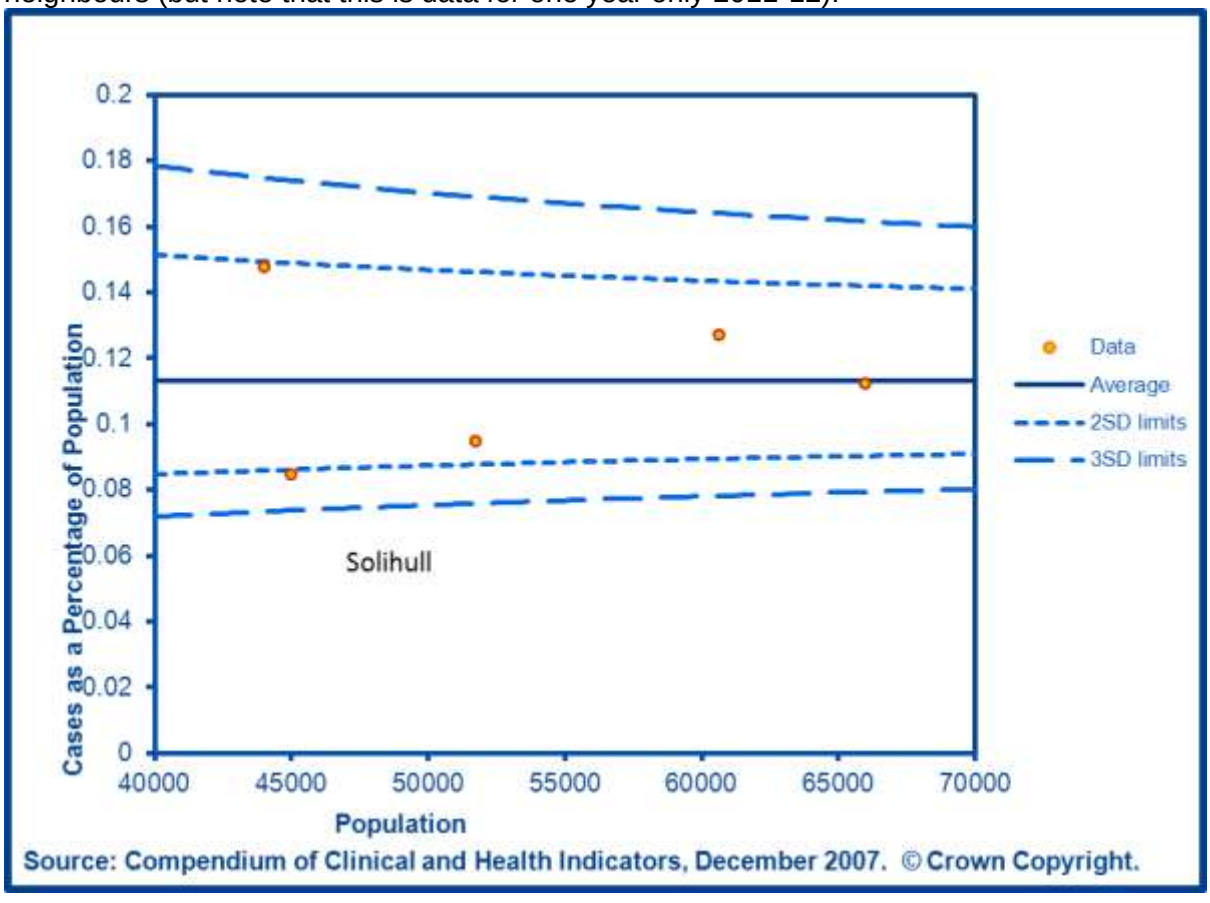
1) Attendances at A&E for self-harm per 100,000 population
2) 2) Percentage of attendances at A&E for self-harm that received a psychosocial assessment

In comparison with the 2006-09 period, the rate of young people under 18 who are admitted to hospital as a result of self-harm remains broadly similar in the 2009-12 period. Overall rates of admission in the 2009-12 period are similar to the England average.

Young people aged under 18 admitted to hospital as a result of self-harm (rate per 100,000 population aged 0-17 years)



Solihull's rate of self harm would appear to be low when compared to our statistical neighbours (but note that this is data for one year only 2011-12).



NOTE: Solihull's statistical neighbours are Warrington, Stockport, Trafford and Cheshire West & Chester

Evidence for what works

There is a preventing suicide strategy (2012) which targets five high risk groups, one of which is young and middle-aged men https://www.gov.uk/government/publications/suicide-prevention-strategy-launched
The e-learning packages for non-health professionals, being developed as part of the Interpersonal Psychotherapy for Adolescents (IPT-A) programme, will help all those working with children (eg police officers, teachers, GPs) recognise and support children and young people with mental health problems. The e-portal will also include specific support materials in relation to self-harm, suicide and risk in children and young people. The e-learning packages are expected to launch in spring 2014. http://www.rcpch.ac.uk/training-examinations-professional-development/continuing-professional-development-cpd/current-edu-1
There is NICE guidance on self harm (The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) published in 2004.

Existing practice in Solihull
Draft self harm guidance is in place.

References
McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. Adult psychiatric morbidity in England, 2007. Results of a household survey. Leeds: The Health & Social Care Information Centre, 2009.

Substance misuse

8.5 A clear association exists between mental illness and drug and alcohol dependence. Those experiencing mental ill-health have a higher risk of substance misuse.[76] For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence[77]. The recent Public Health White Paper and Mental Health Strategy set out actions not only to prevent mental illness in the first place, but to intervene early when it does arise. Such an approach will also reduce the increased risk of substance misuse in this group.

8.6 Some young people face increased risks of developing problems with drugs or alcohol. Vulnerable groups - such as those who are truanting or excluded from school, looked after children, young offenders and those at risk of involvement in crime and anti-social behaviour, those with mental ill health, or those whose parents misuse drugs or alcohol - need targeted support to prevent drug or alcohol misuse or early intervention when problems first arise.

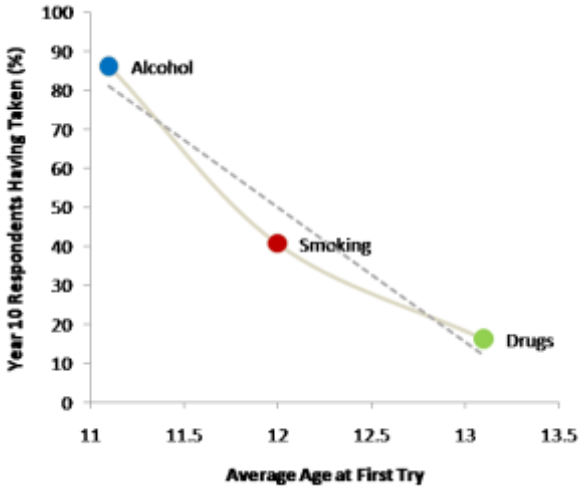
8.7 Around 1 in 3 young people drink to the point of drunkenness, the highest rates among any age group.[78] Accidents due to alcohol (including drink-driving accidents) are the leading cause of death among 16 – 24 year-olds.[79]
8.8 In the ONS 2004 survey, young people were asked about the social context of the last occasions on which they had smoked, drunk alcohol and taken drugs. Young people with conduct disorders were much more likely than other young people to have drunk alcohol

[76] Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery : Supporting People to Live a Drug Free Life, HM Government
[77] 19 Green H, McGinnity A, Meltzer H et al (2005). Mental Health of Children and Young People in Great Britain 2004. Office for National Statistics
[78] NHS Information Centre (2009) Statistics on Alcohol: England 2009
[79] Jones, L., Bellis, M.A., Dedman, D. et al. (2008) Alcohol-attributable Fractions for England: Alcohol-attributable Morality and Hospital Admissions

outside in a public place (25 per cent compared with 6 per cent) and less likely to have drunk at home (31 per cent compared with 43 per cent).

8.9 The Tell Us 4 results for Solihull showed that overall 12.1% have been drunk in the last four weeks; 11.6% male and 12.7% female. 77% have never been drunk (71% never had a drink) and the highest drinking is amongst White ethnicities (very low numbers with other groups). The results from the Health Related Behaviour Survey 2010 indicate that the average age for respondents who have engaged in substance misuse in Solihull is particularly low and it is notable that drinking (legal age 18) is around 11 compared with smoking (legal 16) at 12.

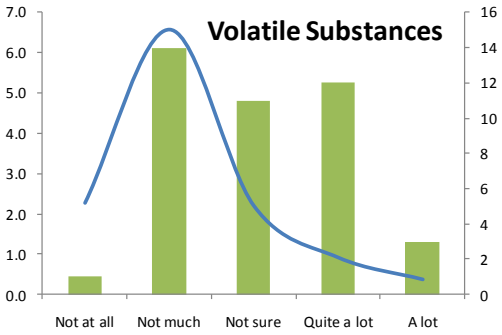
Figure 14: Average age of first try



8.10 By Year 10, 86% of respondents have drunk alcohol - this could be a reflection of the illegal status of drugs. The gender difference in alcohol use is interesting, as although the proportion of girls who have ever drunk alcohol by Year 10 has fallen from 89.1% in 2007 to 88.1% in 2010 (boys 85.8% to 84.1%), the proportion who got drunk in the past week has increased from 21.7% to 25.2% (boys 16.6% to 19.6%). [80]

Figure 15

Figure 16



8.11 Satisfied with life is a measure within the HRBQ that correlates with substance misuse. The results of the 2010 HRBQ show that 16.5% of girls are not satisfied with life which has increased from 12% in the previous survey, the figure for boys on the other hand has remained relatively unchanged (10.1% to 10.5%). Figure 18 and 19 show a comparison of those 'stating' they aren't satisfied with life and those who are, with regard to how this might impact on substance misuse. Those who are not satisfied with life are 5.64 times as likely to be affected by Class A drugs and 8.26 times as likely to be affected by volatile substances as those who are satisfied.

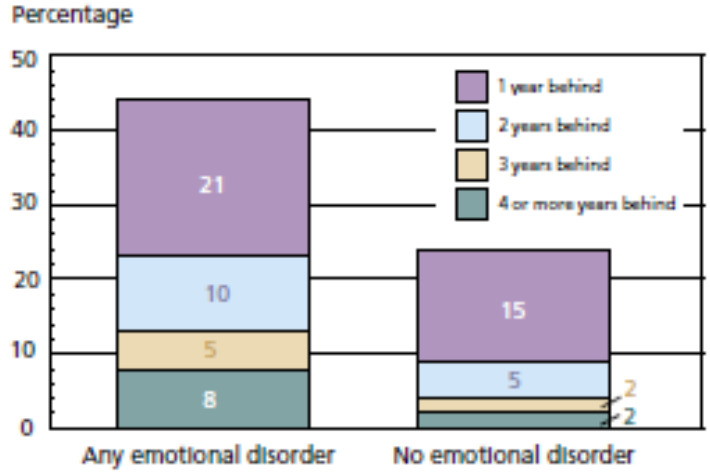
[80] Health Related Behaviour Survey 2010

Exclusion from schools

8.12 Children and young people with mental health disorders also have increased difficulties with social functioning, scholastic ability and school attendance compared with other children. A high risk of school exclusion means that there is also an increased risk of the child or young person being excluded from school-based services that are designed to meet their needs.[81]

8.13 This considerable impact upon educational achievement, especially for conduct and emotional disorders is illustrated by Figure 20. Some of this difference will be accounted for by the co-occurrence of learning disabilities with mental disorders.

Figure 17 – Proportion of children who were behind in their overall scholastic ability by whether they had an emotional disorder, 1999 and 2004 combined

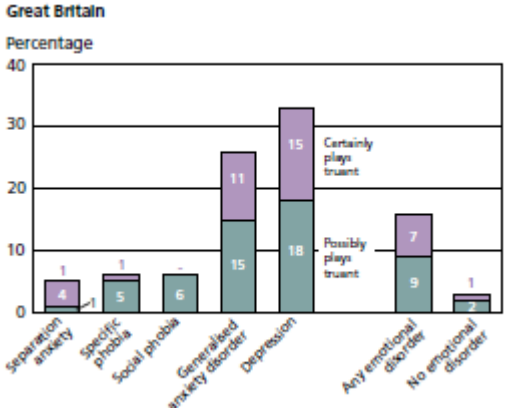


Source: Office for National Statistics, Mental Health of Children and Young People in Great Britain, (Green, 2004)

8.14 As many as one in three children in the ONS 2004 survey with a conduct disorder had been excluded from school and nearly a quarter had been excluded more than once. Children with generalised anxiety disorder and those with depression had the most days away from school – a quarter had had more than 15 days absence in the previous term. These groups were much more likely than other children to be considered definite or possible truants (26 per cent and 33 per cent compared with 3 per cent among those with no disorder).

[81] *Office for National Statistics, Mental Health of Children and Young People in Great Britain, (Green, 2004)*

Chart: Proportion of children whose teacher thought they played truant by type of emotional disorder, 1999 and 2004 combined



8.15 In Solihull there are 74 children and young people permanently excluded from primary, secondary and special schools with the majority being accounted for by young people in secondary education.

Not in Education, Employment or Training (NEET)

8.16 National figures for 2009 show 9.2 per cent (183,200) of young people aged 16 – 18 were NEET. The 2008 cohort will cost an estimated £13 billion in public finance costs and £22 billion in opportunity costs over their lifetimes. Young men who were not in education, employment or training (NEET) are three times more likely to suffer from depression and five times more likely to have a criminal record than their peers.[82]

8.17 The national indicator regarding NEETs measures the percentage of young people aged 16-18 who are NOT in education employment or training. 16 to 18 year old is defined as being in education or training if they are in full-time education, Work Based Learning (WBL), employer funded training, or other education and training. Solihull scored 6.1% which is about the same as the average in England for young people not in education, employment or training.

9. What have children, young people, parents and professionals told us?

9.1 Significant consultation was undertaken to inform the development of the 2010/11 Children and Young Peoples Plan. 1929 children and young people from across the Borough participated in the consultation. They said they wanted more supportive teachers and more support and advice on eating healthy food and feeling healthy

9.2 The issues that were raised most frequently by staff and volunteers relating to emotional wellbeing included the need for better support for more emotionally fragile or vulnerable teenagers and more emphasis on the effects of family breakdown and bereavement on children and young people. The fact that one in ten children and young people have a mental health problem was also highlighted. Schools were concerned about the lack of resilience evident, the lack of stability in children's lives, increase in referrals to other agencies and the lack of 'real' play.

[82] 'Against the odds – Re-engaging young people in education, employment or training' Summary of our report published in July 2010, Audit Commission

9.3 429 parents and carers completed the 'Ask Parents 2010' questionnaire, and 109 parents took part in focus groups. The Solihull Parent's Forum identified 16 common themes and issues from the range of views- these include:

- Children and young people's emotional and mental health, particularly linked to bullying and tolerance of others, with teachers/parents having greater understanding of how to develop tolerance in children
- Better health education for children and more information/support for parents in how to keep their children healthy
- Bullying – more education for children about tolerance and diversity. More information and support for parents about what to do and how to work with agencies / schools to resolve issues quickly.
- Improved relationships between teachers and children, with greater understanding and tolerance of the child and families individual needs.
- Early intervention – support for parents to help them deal with things before they become a crisis

9.4 Consultation was also carried out prior to the Targeted Mental Health in Schools (TaMHS) programme being commissioned in June 2010. Young people involved in this consultation viewed mental health issues as being specific 'conditions' or 'disorders'. It was only after discussions during the session that the group started to recognise mental health as being something we all have. The group felt that people were cautious when it came to talking about this topic and labelling people. When looking at what support young people thought would be beneficial and helpful to have within schools they wanted 1 to 1 support from someone you don't know and from somebody that's been through the same situation.

9.5 A half day event was held in January with key stakeholders including practitioners, commissioners, parents and young people. The purpose of this event was to get stakeholders to consider what was working well in Solihull and what needed improvement with regards to emotional wellbeing and mental health services. Initially, young people presented their feedback around their experience of services and what they felt worked well and needed to improve. The key themes that arose were: flexible services, regular contact, confidentiality, professionals working together, access to services when needed and positive press for mental health.

9.6 All stakeholders then participated in a 'World Café' style session where they considered a number of key questions. The key themes that arose were:

1. The accessibility of services and pathways into services
2. Taking a family approach to issues using existing processes and systems such as CAF
3. Mental health is everybody's business and the Strategy should be something everyone signs up to
4. Early intervention is essential
5. Parentingprogrammes and courses were seen as a key support mechanism
6. The need for a one stop shop in a non-health setting where young people can access the support they need
7. Promotion around mental health to challenge the stigma attached
8. Young people are vulnerable at key transitions between school and services
9. Services need to be needs led
10. Partnership working is essential recognising that this includes parents
11. A common language is needed so we understand each other
12. Equitable access to services throughout the Borough
13. 'At risk' young people being prioritised

9.7 Ongoing consultation has also been carried out with young people who are part of a CAMHS Group in both the North and South of the Borough while developing this Strategy. Young people wanted services where they were, local and accessible in friendly environments. They also said they wanted to have someone to talk to that they had time to get to know. At these groups there appears to be a stark contrast between the needs and support required of those in the North and South. Young people in the North felt that they would have to 'hit rock bottom' before they would talk to a professional and even then it would only be through force not because they chose to do so. They also seemed to only talk about extreme feelings going from being happy to being suicidal. On the other hand young people in the South seemed much more aware of their own issues and where they could go to access services and certainly did not seem adverse to accessing support in the same way.

Conclusions

1.31 There are a number of general conclusions and recommendations that can be made as a result of the information provided in this document. They are;

- As 1:10 young people experience emotional or behavioural problems, this suggests there needs to be an increased focus on early intervention, particularly in universal services, with implications for the workforce in terms of awareness, confidence and expertise in identifying and supporting children and young people at risk.
- The importance of support for parents and carers, recognising that they have a central role in supporting the mental health of children and young people
- A more detailed gap analysis may be required, to identify whether we have sufficient evidence based programmes in place for those who are identified as having a need for support before their condition becomes serious, both to improve outcomes and reduce long term costs to society arising from mental illness continuing into adulthood
- Children and young people in Solihull are generally emotionally healthy, but there are inequalities identified in the needs assessment , particularly focusing on children living in the regeneration area of north Solihull, boys, who are at greater risk of mental ill health, and particular groups of vulnerable young people, including looked after children, young offenders
- There needs to be an increased focus on how we meet needs of young people 14-25, particularly around transition to adult services. Disabled children and young people 16-24 appear to be most at risk
- There is insufficient local intelligence about the mental health needs of Lesbian, Gay Bisexual and Transgender young people
- Access to services when needed has been prioritised by parents and young people, which suggests action is required to identify clear pathways to access specialist support from the most appropriate source, and joint commissioning to ensure a mix of provision across the levels of need
- Both parents and young people have identified stigma as an issue, which suggests there needs to be more action to address barriers to access support before hitting "rock bottom" and a more "positive press" for mental health