Halton Joint Strategic Needs Assessment 2017

Mental Health and Emotional Wellbeing of Children and Young People
Readers information

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Description: The document describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation to mental health and emotional wellbeing amongst children and young people in Halton.
Contact: Sharon.mcateer@halton.gov.uk
Related documents:
- Halton Mental Health Strategy
- SEND JSNA
- Learning Disabilities JSNA
- Health Needs Assessment of Young Offenders
- Children & Young People’s Plan

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACE</td>
<td>Adverse Childhood Experience</td>
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<tr>
<td>ASC</td>
<td>Autistic Spectrum Conditions</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Disorder (ADHD) and (ODD)</td>
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<tr>
<td>BME</td>
<td>Black &amp; Minority Ethnic</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CHIMAT</td>
<td>National Child and Maternal Health Intelligence Network</td>
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<tr>
<td>CIC</td>
<td>Children in Care</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CYP</td>
<td>Children and Young People</td>
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<tr>
<td>DFE</td>
<td>Department for Education</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HBSC</td>
<td>Health Behaviour in School-Aged Children</td>
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<td>HNA</td>
<td>Health Needs Assessment</td>
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<td>HSCIC</td>
<td>Health and Social Care Information Centre</td>
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<td>HSE</td>
<td>Health Survey for England</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>NCT</td>
<td>National Childbirth Trust</td>
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<tr>
<td>NEET</td>
<td>Not in employment, education or training</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<tr>
<td>LCR</td>
<td>Liverpool City Region</td>
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<tr>
<td>MUPS</td>
<td>Medically unexplained physical symptoms</td>
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<tr>
<td>ODD</td>
<td>Oppositional Defiant Disorder</td>
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<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
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<tr>
<td>SEN</td>
<td>Special educational needs</td>
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<tr>
<td>WAY</td>
<td>What about YOUth survey</td>
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<tr>
<td>WEMWBS</td>
<td>Warwick-Edinburgh Mental Well-being scale</td>
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Data Summary

CHILDREN'S MENTAL HEALTH AND WELLBEING

There have been four mental health chapters of the Joint Strategic Needs Assessment (JSNA) written for Halton in 2016-17. This graphic aims to pull out the headline messages from the children's mental health and wellbeing document.

- 1 in 10 aged 5-16 have a diagnosable mental illness, in Halton = 1,874 children
- 1,082 boys and 578 girls aged 5-16 in Halton estimated to have a mental health condition
- Greater prevalence (14%) in black children; 11.5% in white and 3% among Indian
- Discrimination can increase risk of mental health conditions

Increased risk of developing a mental health disorder

- Living in care
- Foster care or adoption
- Bullying
- Special education needs
- Homelessness
- Drug or alcohol issues
- Not in education, employment or training
- Youth offending

Parental mental health risk factors

10-20% of women are affected by perinatal mental health issues during pregnancy or the year after birth

Up to 2 in 3 children of parents with mental health problems may develop mental health problems in their life

Child Sexual Exploitation (CSE)

- Victims of child sexual exploitation have increased risks of poor mental health

Produced by Public Health Intelligence, Halton Borough Council
Created with Canva.com using graphics from Flaticon.com
Please see the JSNAP Halton 2017 Joint Strategic Needs Assessment for greater detail and original data sources.
Key priorities for consideration by commissioners

To give consideration of how we implement locally the ‘Future in mind’ aspirations of:

- Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled
- In every part of the country, children and young people have timely access to clinically effective mental health support when they need it
- A stepped change in how care is delivered moving away from a system defined in terms of the services organisations provide (the tiered model) towards one built around the needs of children, young people and their families
- Increased use of evidence-based treatments with services rigorously focused on outcomes
- Making mental health support more visible and easily accessible for children and young people
- Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible
- Improving access for parents to evidenced-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour
- A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it
- Improved transparency and accountability across the whole system, to drive further improvements in outcomes
- Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it
- Facilitating the successful roll out of the thrive model with wide multiagency support and access
- Educating and facilitating parents so they are empowered to support children and young people’s emotional health and wellbeing
- Training for the wider children’s workforce on emotional health and development and how to provide early help to children and young people. Target audience includes teachers, early years staff, social care, health professionals, third sector organisations
- A dedicated schools link practitioner to provide schools with help, advice and access to services
- Improve signposting to emotional health support and mental health services.
- Services (Early years and health) support parents to build strong bonding and attachment, including early identification and support for perinatal mental health difficulties and low levels of attachment
- Strengthen the perinatal mental health pathway and provision. Providing expertise and specialist services when required. For example continuation of screening for women in the perinatal period and consideration of Perinatal mental health specialist services
- Programmes that build resilience and self-efficacy in children of all ages via through schools, health improvement and third sector organisations
- Building better understanding of the impact of self-harm, and commissioning evidence based services to manage self-harming in young people
- Further develop the identification and provide targeted support for high risk groups when indicated. Such as continuing to fund the CAMHS worker focusing on Young Offenders
• Continue to assess and develop need for **culturally appropriate support** to refugees, asylum seekers and unaccompanied minors, as population demographics change
• Provide tailored support for young people with **behavioural difficulties** and associated mental health issues i.e. Autistic Spectrum Disorder, ADHD
• Ensure equality of provision in **A&E** for mental health assessments of young people between St Helens & Knowsley Acute Trust and Warrington & Halton Hospital Foundation Trust
• Continue to commission mental health professionals that are available **out of hours** to support individuals accessing A&E, and ensuring they are able to access local services quickly.
1. Introduction

A child’s mental health and wellbeing is determined predominately by their peers and parents/guardians lifestyle, behaviour and values and wider socio-economic conditions. The early years shape our healthy physical and mental development and many of our health and social behaviours.

Giving every child the best start in life is crucial to reducing health inequalities and maintaining positive wellbeing throughout the life course. If we are to tackle the health and social inequalities that shape the course of people’s lives, then they should be addressed early so that every child has a fair chance of starting and developing well.

Children experience a range of mental health problems as they get older, as the transition from late childhood and teenage years into early adulthood are a time of rapid change and development. They will experience transitions:

- During their time in education and to the world of work
- In their personal lives and relationships
- From a dependent relationship and being parented in some form, to being independent and, for some, to being a parent
- From dependent living in a home environment, to independent living and creating their own environment

Alongside these transitions, older young people experience increased pressures regarding academic achievement and major life choices such as whether to leave home, to experiment with alcohol and/or drugs, and relationships. They may also be affected by environmental factors such as greater cultural conflict, media images that are at odds with reality and greater affluence and a decline in social cohesion and responsibility. Early childhood and adolescence are therefore crucial stages in the lives of young people, as poor mental health during this time can have profound effects later in life.

Children and adolescent mental health issues have recently been widely recognised as a key issue – over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by the age of 18. The ChildLine Review 2013-14, “Under Pressure”, stated that ChildLine had seen a worrying rise in mental health concerns. Four of the top ten issues children contacted ChildLine about related to mental health and, taken together, these account for more than two thirds of counselling sessions carried out by the organisation. These four issues are: self-harm; suicidal feelings; low self-esteem and unhappiness; (diagnosable*) mental health issues. The last category has seen the highest increase in the last year (34%).

Government has recognised that child and adolescent mental health is a concern and a governmental taskforce was established in 2014 to consider ways to make it easier for children,

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a) Diagnosable mental health issues are defined as mental health issues that are prolonged or re-occurring and significantly interfere with the young person being able to lead a normal life.
young people, parents and carers to access help and support when it is needed and to improve how children and young people’s mental health services are organised, commissioned and provided. Evidence presented to the taskforce underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. The challenges include:

- Significant gaps in data and information and delays in development of payment and other incentive systems which are critical to driving change in a co-ordinated way
- The treatment gap - Indications that less than 25 -35% of those with a diagnosable mental health condition accessed support
- Difficulties in access with increases in referrals and waiting times and with providers reporting increased complexity and severity of presenting problems
- Complexity of current commissioning arrangements, a lack of clear leadership and accountability arrangements for children’s mental health across agencies
- Access to crisis, out of hours and liaison psychiatry is variable
- Specific issues facing highly vulnerable groups of children and young people and their families who may find it particularly difficult to access appropriate services

This mental health needs assessment will focus on the needs of children and young people from 0 – 18 years but will also include transition to adult services up to the age of 25. It will look at the numbers, characteristics and needs of children and young people at increased risk of mental health problems. It will also look at local service provision to support children and their parents to enable them to play an active role in the management and treatment of mental health conditions. The needs assessment will focus on universal, targeted and specialist services. Tertiary services such as residential placements and out of area referrals are commissioned by NHS England and will not be reviewed here.

**Out of scope**

Learning Disabilities and Autism were subject to a specialist JSNA conducted by Liverpool John Moores University on behalf of NHS England. It will not therefore be included in this JSNA, apart from in relation to prevalence of mental ill health amongst people with learning disabilities.

The recent maternal health JSNA considered the needs of pregnant women. It included a brief section on perinatal mental health. An adult mental health JSNA has also been carried out during 2016/17. However, it should be highlighted that the Faculty of Public Health state that the most import modifiable risk factor for mental health problems in childhood, and thus in life, in general, is parenting. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent/infant/child relationships, parenting styles including behaviour management and infant and child nutrition (including breast feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, drugs and alcohol misuse are important risk factors for childhood mental health problems. As such parental mental illness including perinatal mental health will be included in this report.
2. Policy Context

2.1. National

2.1.1 No Health Without Mental Health – A cross government strategy (2011)

In 2011 The Department of Health published ‘No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages’. This strategy recognises that “By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does.”

No Health without Mental Health outlined 6 key objectives:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

The national strategy highlights that:

- One in ten children aged between 5 and 16 years has a mental health problem and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed)

2.1.2 Future In Mind - Promoting, protecting and improving our children and young people’s mental health and wellbeing (2015)

As outlined in the introduction, in March 2015 the government launched the Future in Mind report which describes ways to make it easier for children, young people, parents and cares to access help and support when needed and to improve how children and young people’s mental health services are organised, commissioned and provided.

The report focuses on five themes:

1. Promoting resilience, prevention and early intervention
2. Improving access to effective support, a system without tiers
3. Care for the most vulnerable
4. Accountability and transparency
5. Developing the workforce
The report outlines the government’s aspirations for children’s mental health to be reached by 2020. These include:

- Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled
- In every part of the country, children and young people have timely access to clinically effective mental health support when they need it
- A stepped change in how care is delivered moving away from a system defined in terms of the services organisations provide (the tiered model) towards one built around the needs of children, young people and their families
- Increased use of evidence-based treatments with services rigorously focused on outcomes
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- Improving access for parents to evidenced-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour
- A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it
- Improved transparency and accountability across the whole system, to drive further improvements in outcomes
- Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it

In July 2015 the government released guidance regarding the development of local transformation plans\(^5\) to improve mental health services for children and young people for which there has been identified additional funding. These plans will focus on:

- Building capacity and capability across the system
- Rolling out the children and young people’s Improving Access to Psychological Therapies programmes
- Developing evidence-based community eating disorder services for children and young people
- Improving Perinatal Care
- Bring education and local CAMHS services together around the needs of the individual child through a joint mental health training programme
- Local transformation plans will be required, outlining how local areas will contribute to achieving the national ambitions and principles. Plans should include a commitment to transparency, service transformation and monitoring improvement

The Public Health England framework, Improving young people’s health and wellbeing (2015)\(^6\) makes recommendations about what local authorities should be offering to children and young people, which is also relevant within the context of this JSNA:

- A holistic health and wellbeing offer which addresses all factors affecting the young person rather than single health issues
- A focus on prevention as well as intervention
- Support to help build their resilience and life skills working with others including schools, families and communities
- Provision of appropriate levels of support across universal, targeted and specialist services
- A “no wrong door” service approach so that young people may access or be referred to the service they need regardless of which organisation/service they initially contact
- That staff and organisations are trained and are delivering services in age appropriate, young people friendly settings.

2.2 Local policies

2.2.1 One Halton Health and Wellbeing Strategy 2013 – 2016

One Halton is a partnership across health and social care whose vision is:

'*Working better together to improve the care and wellbeing of the people of Halton*

One Halton involves joining up all the services that deliver care and wellbeing to the people of Halton ensuring that they have the right support, at the right time, in the right away to provide the best possible outcomes. It is recognised that there are increasing demands on all services. The difference that One Halton aims to make is to place the people at the centre of care and well-being so the emphasis is based on them rather than targets and outcomes. The ethos is simply ‘tell your story once, get seen quicker and stay well longer’.

By joining resources and working together across the Halton Borough, One Halton will simplify the current system that patients, families and carers often find complex and difficult to navigate, especially if care and treatment is being delivered by more than one organisation.

One Halton Objectives:

- To work better together regardless of discipline
- To find or identify those ‘hidden’ people who don’t access care
- To treat and care for people at the right time, in the right place by the right people
- To help people stay healthy and keep generally well
- To provide the very best in care, now and in the future

The Areas of Focus have been agreed by all local partners for the One Halton Health and wellbeing strategy 2013-16 are:

- Older people
- People with Long Term Conditions (LTC)
- People with mental health and learning difficulties
- Families and children (including women’s services)
- The generally well
- Operational and Strategic enablers

In the plan the top three actions for improving mental health included:

1. Reviewing the current Child and Adolescent Mental Health Services (CAMHs).
2. Enhancing services for adults with personality disorders.
3. Redesigning adult mental health services.

The outcomes that are being measured to determine the success of the strategy include:

- Improved diagnosis rate for common mental health problems and dementia.
- Reduced level of hospital admissions due to self-harm.
- Improved access to IAPT (talking therapy services), as well as increased percentage completing treatment and percentage recovery.
- Improved overall wellbeing scores and carer’s wellbeing scores.
- Reduce excess under 75 mortality in adults with serious mental illness (compared to the overall population).
- Increased percentage of care leavers with good mental health.

2.2.4. Halton’s Nurture Strategy

Halton is currently developing their nurture strategy. The strategy will seek to outline the rationale behind the promotion of nurturing approaches, what such an approach can achieve, and how this can be done.

Children and young people with positive mental wellbeing are more likely to be engaged and achieving in education, feel a sense of belonging and trust in relationships and experience successful transitions into adulthood\(^b\). Therefore, promoting mental wellbeing across universal and targeted services for children and young people not only serves to benefit individual children and families, but also has long lasting social and economic benefits for society.

Schools are nationally recognised as key environments that can help to promote mental wellbeing in children and young people. School approaches/systems are more likely to create environments where all pupils can flourish and thrive if they recognise risk and protective factors in mental wellbeing, seek to build a sense of connectedness and belonging for pupils.

The development of nurturing approaches across Halton has arisen through a desire within the authority to enable all children and young people to access educational settings where they can flourish and thrive.

2.2.5. Halton’s suicide Strategy

Mental health and suicide are interrelated, and have overlapping aims, objectives and methods of prevention. Halton Borough council’s Suicide Prevention Strategy 2015-2020 was written in partnership and sets out evidence-based actions, based upon national policy, research and local insight, to prevent suicide and support those bereaved or affected by suicide in Halton. Suicide is a complex and challenging issue, but there are effective solutions for many, if not most of the individual factors which contribute towards the risk of suicide. The strategy recognises the integral link between good mental health and the prevention of suicides. The vision for the strategy includes:

- We understand the root causes of suicide through effective collection and analysis of key information

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• We have created a "listening" culture where it is okay to talk about feelings and emotional wellbeing
• We pro-actively communicate so that those directly and indirectly impacted by suicide know what support is there for them
• We provide readily accessible support through services working in partnership with other agencies and organisations
• We take positive, co-ordinated action to tackle prioritised root cause issues in order to prevent suicides
3. Level of need in the population

3.1. Who is at risk and why

3.1.1. Demographic risk factors
Some demographic factors can contribute to an increased risk of mental health problems in children and young people. This section also includes those that relate to ‘protected characteristics’ under the Equality Act 2010.

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<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
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<tbody>
<tr>
<td>Age</td>
<td>1 in 10 children aged 5-16 years has a diagnosable mental health problem and 50% of lifetime cases of diagnosable mental illness begin by age 14⁷</td>
<td>There are 18,741 children in Halton aged 5-16 (2015 mid-year population estimate). This would equate to 1,874 children with a diagnosable mental health problem.</td>
</tr>
<tr>
<td>Gender</td>
<td>Boys are more likely to have a mental disorder than girls. 10% of 5-10 year old boys and 5% of girls have a mental disorder and 13% of 11-16 year old boys and 10% of girls⁸</td>
<td>There are 5,055 number of boys aged 5-10 and 4,436 aged 11-16. There are 4,948 number of girls aged 5-10 and 4,302 aged 11-16. This would equate to 1,082 boys and 678 girls.</td>
</tr>
<tr>
<td>Gender identity</td>
<td>National studies have found high rates of depression, stress and anxiety in the transgender population. Transgender people aged under 26 are twice as likely to attempt suicide.⁹¹⁰</td>
<td>There are no local figures for the number of transgender people in Halton. Based on national estimates from the 2009 GIRES report (20 per 100,000 population prevalence of people who had sought medical care for gender variance), there may be about 25 transgender people in the borough (based on 2015 mid-year population estimate of 126,528). The majority of these will be over the age of 18 and it is likely that there are low single figures for CYP</td>
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⁷ Statutory guidance on diagnosing competence and decision-making (2015).
¹⁰ Children and Young People’s Mental Health Taskforce (2015). The state of mental health services for children and young people 2015.
### Risk factor

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<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
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<td><strong>Ethnicity</strong></td>
<td>Data taken from the 2004 ONS survey of child an adolescent mental health shows that mental health problems vary with ethnicity. Nationally the prevalence of mental health disorders in Black children aged 11-16 years is 14% compared to 11.5% for White children. There is lower prevalence amongst Indian adolescents, approximately 3%[11]</td>
<td>The ethnic composition of children and young people with mental health problems in Halton is not known. The 2011 Census showed that there were 373 children aged 5-15 who were of Black and Mixed ethnic origin, 112 from Asian ethnic origin and 16,070 white. There were 18 from other ethnic groups but it is not possible to determine, for the purposes of estimating the numbers with mental health problems, which category they should be assigned to. Based on these figures 52 children from black and mixed ethnic backgrounds may have mental health problems, 3 from Asian backgrounds (applying the prevalence amongst Indian children) and 1,848 from white backgrounds.</td>
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<td><strong>Religion</strong></td>
<td>Children and young people can be at risk of developing mental health problems if they experience discrimination as a result of their religion[12]</td>
<td>Halton has a high proportion of young people with no religion. The 2011 Census showed of 0-17 year olds 66.8% were Christians, 0.2% were Muslims, 0.2% were Hindu and 26.9% had no religion. This compared with 29.5% 0-17 year olds with no religion in England and 23.2% in the North West.</td>
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<tr>
<td><strong>Sexual orientation</strong></td>
<td>Gay, lesbian and bisexual people are at higher risk than heterosexual people of mental health problems, substance misuse and dependence, suicide, suicidal ideation and</td>
<td>There are currently no reliable estimates of the size of the Lesbian, Gay and Bisexual (LGB) population in Great Britain. Sexual orientation has not previously been asked in a decennial census in Britain (2011 was the first time).</td>
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### Risk factor

<table>
<thead>
<tr>
<th>Children with a disability (including physical disability, learning disability, autism and Medically Unexplained Physical Symptoms)</th>
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<tr>
<td><strong>Degree of risk</strong></td>
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<td>deliberate self-harm[^13]</td>
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- Children with a physical disability have a two-fold increased risk of emotional/conduct disorders (characterised by serious antisocial behaviour, including aggressive, destructive and deceitful behaviour and violation of rules).
- Children with a learning disability have a six and a half fold increased risk of mental health problems, an increased risk of developing psychological problems, two fold increased risk of experiencing anxiety disorders and six fold increased risk of experiencing conduct disorders[^15]
- People with Autistic Spectrum Conditions (ASC) have high levels of additional needs with 70% having at least one other mental or behavioural disorder and 40% having at least two disorders, most commonly anxiety, Attention Deficit Disorder (ADHD) and Oppositional Defiant Disorder (ODD)[^16]
- 1 in 10 children have Medically Unexplained Physical Symptoms (MUPS). This overlaps with long term conditions and[^17] can contribute to depression and anxiety.[^18] No data is currently available on the prevalence of MUPS amongst children and young people locally.

**The Family Resources Survey 2014/15,**[^19] estimated that nationally between 3% and 11% of young people have a long-standing illness, disability or infirmity and experience significant difficulty with day-to-day activities (based on the average of three years 2012/13, 2013/14 and 2014/15). These rates are slightly higher than the 2011/12 data suggested. The variation is by age and gender. Of particular note are the higher levels of disability for males than females in each age category apart from 20-24 where the rate is slightly higher for females. Applying these percentages to the local resident populations aged up to age 25 years (based on 2015 mid-year population estimates) to give a total estimate of 2,826 children aged 0-25 as having a disability. These figures are higher than the Census.

Based on research by Emerson and Hatton (2004)[^20] it is estimated that 458 children and young people aged 0-19 have a learning disability.

Applying estimated prevalence reported by the National Autistic Society (2013)[^21] to local populations suggests an estimated 300 Halton children under age 18 have autism.
3.1.2. Wider risk factors

There are a large number of other factors that can increase the vulnerability of children and young people to experiencing mental health problems. These include: being a migrant, refugee or asylum seeker, living in lone parent households, living in child poverty, attending a short stay school, being home educated, being a young carer, having parents in prison, having low educational attainment, school exclusion or absenteeism, missing from home or care, having a teenage pregnancy or being a teenage parent.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
</tr>
</thead>
</table>
| Homelessness         | • Young homeless people have twice the risk of depression  
• 27% have a diagnosed mental health condition, compared to 7% of non-homeless young people.  
• They are also at increased risk of suicide, alcohol and drug problems.\(^{[22]}\) | National research indicates homelessness incidence is greatest in young adults with nearly 7.6% of 16-24 year olds reporting recent experience of being homeless. Just over half of all those statutorily homeless are aged 25-44 and 1 in 4 are aged under 25. Halton has a rate lower than England but is ranked third of the six local authorities in the Liverpool City Region (LCR) (rate of those accepted as unintentionally homeless). Care leavers are particularly vulnerable although the LCR rate is lower than nationally.\(^{[23]}\) |
| Children in Care     | Nationally, an estimated 45% of Children in Care have a mental health disorder\(^{[24]}\)  
Children in Care are nearly five times more likely to have a mental health disorder than all children  
They have a six to seven-fold increased risk of conduct disorder. Four to five-fold increased risk of suicide attempt as an adult.\(^{[25]}\) | In 2016 there were 240 children in care in Halton, the year consecutive yearly rise. This equates to 85 per 10,000 children under age 18, a lower rate than the borough statistical neighbours but higher than the North West and England rates.  
Based on national research 108 of these 240 children may have mental health problems.  
Children who are looked after by Local Authorities are required to complete a Strengths and Difficulties Questionnaire (SDQ). This is a tool used for assessing a child’s emotional wellbeing, looking at the likelihood of problems being already present or of developing in the future.  
During 2015/16 the average difficulties score for Halton was 13.5% which is similar to the average England score of 14%. One of the outcomes from the SDQ is |
<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
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<tr>
<td></td>
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<td>the identification of ‘a cause for concern’. Each child is given a single summary figure (the total difficulties score), ranging from 0 to 40. A higher score indicates greater difficulties (a score of under 14 is considered normal; 14-16 is borderline cause for concern and 17 or over is a cause for concern). During 2015/16, 27% of children in Halton recorded a score which gave ‘a cause for concern’; this percentage was lower than both the North West (33%) and England (38%).</td>
</tr>
<tr>
<td>Fostered and adopted children</td>
<td>Children adopted or fostered from care are likely to have experienced trauma or loss and have additional needs resulting from physical, emotional, or mental health.[26] difficulties or disabilities[27]</td>
<td>Pre-2015 data shows that Halton has had greater placement stability than its comparators. However, 2015 data shows 11% had three or more placements, higher than comparators. Halton has a greater percentage of children in care adopted in year at 24% (statistical neighbours 18.5%, North West 18% and England 15%).</td>
</tr>
<tr>
<td>Young offenders</td>
<td>Young offenders have a three-fold increased risk of mental health disorders[28] Approximately 95% of young people in detention have a mental health problem and 80% have more than one</td>
<td>The rate of first time entrants (aged 10-17) to the Youth Justice System is similar in Halton (304.1 per 100,000 population) to the rate seen nationally (327.1) and regionally (293.7). The Health Needs Assessment of young offenders for Halton, Warrington and Cheshire West &amp; Chester showed that mental health needs were a significant issue.[29]</td>
</tr>
<tr>
<td>Not in employment, education or training (NEET)</td>
<td>• Being unemployed or not in training or education between the ages of 16 -18 is a major predictor of later unemployment, low income, teenage motherhood, depression</td>
<td>The percentage of Halton 16-18 years old who are NEET continues to fall. The 2015 figure was 5.1% (statistical neighbours 5.6%, North West 4.8% and England 4.2%).</td>
</tr>
</tbody>
</table>
### Risk factor

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
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<tr>
<td>and poor physical health.</td>
<td></td>
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</tr>
<tr>
<td>A Princes Trust study found young people not in work aged 16-25 are less likely to be happy[30]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils with Special Educational Needs</td>
<td>Pupils with statements of Special Educational Needs have a three-fold increased risk of conduct disorder[31]</td>
<td>The percentage of Halton pupils with SEN statements was 2.2% in 2016, lower than its statistical neighbours 2.7%, North West 2.8% and England 2.8%. However pupils with SEN support needs was higher at 13.6% although rates have been falling (statistical neighbours 12.9%, North West 11.5% and England 11.6%)</td>
</tr>
<tr>
<td>Bullying</td>
<td>Generally children who are bullied have one or more of the following risk factors: are LGBT, have a disability, socially isolated, perceived as being different to peers, or seen as weak, or are depressed, anxious, have low self-esteem, or have few friends</td>
<td>The What About YOUth? survey showed that Halton had lower rates of 15 year olds who had been recently bullied (in the past couple or months); Halton 52.3%, North West 54.2% and England 55%. There were also lower levels of children who said they had bullied others recently; Halton 7.5%, North West 8.5% and England 10.1%. Despite Halton’s relatively good position, it does show bullying to be a recent feature in over half of all 15 year olds lives.</td>
</tr>
<tr>
<td></td>
<td>Children who are bullies tend to be either well connected to peers and like to dominate or are isolated from others, anxious and depressed and do not have empathy with the emotions of others[32]</td>
<td></td>
</tr>
<tr>
<td>Risk factor</td>
<td>Degree of risk</td>
<td>Halton context</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Alcohol and drugs</td>
<td>Alcohol misuse has links to depression, anxiety, personality disorders and psychosis. People self-medicate with alcohol when they are feeling anxious or depressed. Substance misuse can increase the risks of developing psychosis, depression or anxiety. It can make symptoms worse for an existing mental disorder, and can also trigger mental illness where there is an inherited family risk factor.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The What about YOUth survey of 15 year olds showed that overall Halton pupils experience of alcohol and drugs was similar to England, apart from a statistically higher proportion who had ever tried alcohol. The rate of under 18s admitted to hospital for alcohol-specific conditions in Halton has been falling. For the latest reporting period it was similar to the England rate whereas all previous reporting periods it was statistically higher.</td>
<td></td>
</tr>
<tr>
<td>Refugee and Asylum seekers</td>
<td>There are physical and mental health issues specific to asylum seekers which, coupled with the impact of going through the asylum process, places them at risk of destitution and inequalities. Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As in many areas, there has been an increase in refugee and asylum seeking families and unaccompanied asylum seeking children in Halton. Whilst the numbers are low, the projected numbers continue to change making planning services difficult. Health services will need to plan to respond to and meet the unique and complex needs of this population, including the development of skills within the workforce to respond to the trauma experienced by families and the ability of services to meet their cultural and language needs.</td>
<td></td>
</tr>
</tbody>
</table>

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[^33]: [https://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132874/pat/6/par/E12000002/ati/102/are/E06000006](https://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132874/pat/6/par/E12000002/ati/102/are/E06000006)

[^34][^35]: [https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132982/pat/6/par/E12000002/ati/102/are/E06000006](https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132982/pat/6/par/E12000002/ati/102/are/E06000006)
<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
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<tbody>
<tr>
<td>Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and underdiagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area.(^{[36]}) A shortage of mental health services for asylum seekers has been recognised.(^{[37]}) According to guidelines produced by the World Health Organisation, it is established that an average of more than 50% of refugees present mental health problems.(^{[38]})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 3.1.3. Parental risk factors

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
</tr>
</thead>
</table>
| Perinatal mental health              | Poor maternal mental health in pregnancy and during the postnatal period can have serious consequences for the health and well-being of the baby, as well as the mother and family. It is estimated 10-15% of new mothers suffer some form of perinatal mental health difficulty.\(^{[39]}\)  
The most common perinatal mental health problem is postnatal depression.  
It is estimated that 10-20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth.\(^{[40]}\) | There are approximately 1,500 women giving birth each year in Halton.  
It is estimated that 150-225 women experience moderate depressive illness and a further 45 severe depressive illness during pregnancy or in the first year after childbirth.\(^{[41]}\) Additionally, it is estimated about 45 suffer from post-traumatic stress disorder and 5 postpartum psychosis. Between 225-450 women may suffer adjustment disorders and distress.  
Halton has higher levels of sole parent registered births at 8.2%, compared to 6.3% across the North West and 5.4% for England as a whole. |
| Children with parents who have mental health issues | Up to 18% of children in the UK live with a parent who has a mental health problem.  
33% -66% children whose parents have mental health problems will develop problems in childhood or adult life.  
Children whose mothers had mental health problems are more than twice as likely to develop emotional disorders.  
Children of depressed parents have a 50% risk of developing depression by age 20.\(^{[42]}\) | With a 0-18 population of 28,274 (2015 mid-year estimate) this would equate to 5,089 children living with a parent with a mental health problem.  
Of these 1,679-3,359 are likely to develop mental health problems themselves. |
<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Degree of risk</th>
<th>Halton context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children of parents with substance misuse problems</td>
<td>Living with a parent with a substance misuse problem can result in the child developing behavioural problems, problem drinking and is associated with risk taking behaviours. Approximately 30% of children under the age of 16 live with at least one adult binge drinker and 22% with a hazardous drinker.</td>
<td>Halton has a level of parents in drug and alcohol treatment services twice that of England: Drug services: 245.2 per 100,000 children aged 0-15 (England 107.4) Alcohol services: 257.3 per 100,000 children 0-15 (England 145.9)</td>
</tr>
<tr>
<td>Domestic and sexual violence and abuse and violence against women and girls</td>
<td>Specific impacts on mental health and emotional wellbeing can include post-traumatic stress disorder, anxiety and panic attacks, depression, social phobia, substance abuse, eating disorders, self-harm and suicide. Violence witnessed or experienced in the home can normalise violence in future relationships for both girls and boys.</td>
<td>Levels of domestic abuse are lower in Halton than the North West or England. However, data is only available at a Cheshire Constabulary level which masks local variations). Halton has more similar social and economic circumstances to Merseyside than Cheshire. The Merseyside rate of domestic abuse is much higher.</td>
</tr>
<tr>
<td>Child sexual exploitation (CSE)</td>
<td>Children who have been the victims of child sexual exploitation had a 15.5-fold increased risk of minor depression as a child, 8.9-fold increased risk of suicidal ideation, 8.1-fold increased risk of anxiety, 5.5-fold increased risk of substance misuse. They have a 7.8-fold increased risk of recurrent depression as an adult and 9.9-fold increased risk of adult PTSD.</td>
<td>In 2012-13 158 children across Cheshire had been identified as being at risk of or being sexually exploited.</td>
</tr>
</tbody>
</table>
3.2 Level of mental wellbeing

The Health Behaviour in School-Aged Children (HBSC) study is a multi-national survey from the World Health Organisation aiming to improve the health and wellbeing of young people.[47] This survey covers several aspects of young people’s health and wellbeing in a similar fashion to the What about YOUth survey (WAY) 2014. The 2014 HBSC survey included a question on body image using the same measure as WAY 2014 ranging from ‘much too thin’ to ‘much too fat’. This school-based survey was conducted across a range of European countries with 11, 13 and 15 year olds. The Office for National Statistics (ONS) has reports on the wellbeing of children[48] and young people[49] in the UK. These reports use data from the UK Household Longitudinal Study (Understanding Society), an annual study about social and economic circumstances. The Children’s Society uses these ONS measures in their annual reports on the wellbeing of children.[50] These studies used the same measure for life satisfaction as WAY 2014. ONS also reports on children’s and young people’s satisfaction with their physical appearance, although the measures used are not comparable to the measure of body image used in WAY 2014. These publications report on a wider range of ages than WAY 2014, with the report on the wellbeing of children covering ages 10–15 and the report on the wellbeing of young people covering ages 16–24. The Health Survey for England (HSE) is designed to monitor the nation’s health, and in addition to survey questions also includes health measures such as blood pressure, height and weight, and analysis of blood and saliva samples. The HSE 2013 included the WEMWBS scale for participants aged 16 and above.[51] WEMWBS results are available from the HSE for adults in the 16–24 age group. Methodological differences between HBSC, ONS, HSE and WAY 2014 mean that comparisons should be made with caution.

Bullying is detrimental to physical and mental health and research suggests that it is a problem for many young people, particularly within schools.[52] Legislation means that by law, every school must have measures in place to prevent all forms of bullying.[53] The government acknowledges that bullying in schools can negatively impact both health and educational attainment and can pose a suicide risk.[54] A number of initiatives are in place to prevent and reduce bullying particularly among young people.[55] Bullying can take several forms, including physical bullying and psychological/emotional bullying. Bullying can also take place virtually using technology such as social media websites and text messages; this type of bullying is known as cyber-bullying. The Home Office, in collaboration with the National Society for the Prevention of Cruelty to Children (NSPCC),[56] and other organisations have recently launched an initiative to combat cyber-bullying.[57] Previous research on bullying within schools by the Department for Education (DfE) has identified young people of secondary school age as being at risk of bullying, particularly in the 14–16 year old age range.[58]
Table 1: Wellbeing indicators: Halton outcomes compared to North West and England

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Halton</th>
<th>North West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting general health as excellent</td>
<td>32.2%</td>
<td>30.7%</td>
<td>29.5%</td>
</tr>
<tr>
<td>Long-term illness, disability or medical condition (doctor diagnosis)</td>
<td>12.4%</td>
<td>14.2%</td>
<td>14.1%</td>
</tr>
<tr>
<td>3+ risky behaviours</td>
<td>16.9%</td>
<td>16.9%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Eat 5+ portions of fruit and veg per day</td>
<td>39.9%</td>
<td>48.7%</td>
<td>52.4%</td>
</tr>
<tr>
<td>Mean daily sedentary time in the last week over 7 hours per day</td>
<td>76.9%</td>
<td>71.2%</td>
<td>70.1%</td>
</tr>
<tr>
<td>Physically active for at least one hour per day seven days a week</td>
<td>12.0%</td>
<td>13.2%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Current smokers</td>
<td>8.9%</td>
<td>8.0%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Regular smokers</td>
<td>6.5%</td>
<td>5.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Occasional smokers</td>
<td>2.4%</td>
<td>2.5%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Tried e-cigarettes</td>
<td>24.7%</td>
<td>24.5%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Tried other tobacco products</td>
<td>7.1%</td>
<td>11.3%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Ever had an alcoholic drink</td>
<td>68.2%</td>
<td>64.3%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Regular drinkers</td>
<td>7.7%</td>
<td>6.5%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Been drunk in the last 4 weeks</td>
<td>16.5%</td>
<td>15.8%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Ever tried cannabis</td>
<td>12.2%</td>
<td>10.9%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Taken cannabis in the last month</td>
<td>3.8%</td>
<td>5.0%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Taken drugs (excluding cannabis) in the last month</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Think they're the right size</td>
<td>53.5%</td>
<td>52.1%</td>
<td>52.4%</td>
</tr>
<tr>
<td>Low life satisfaction</td>
<td>11.5%</td>
<td>13.3%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Were bullied in the past couple of months</td>
<td>52.3%</td>
<td>54.2%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Bullied others in the past couple of months</td>
<td>7.5%</td>
<td>8.5%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Mean score of the 14 WEMWBS statements</td>
<td>48.3</td>
<td>47.8</td>
<td>47.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly better than England</td>
</tr>
<tr>
<td>No significant difference to England</td>
</tr>
<tr>
<td>Significantly worse than England</td>
</tr>
</tbody>
</table>

Source: PHE Fingertips tool
3.3. Perinatal mental health

Mental health problems in women during pregnancy (the antenatal period) and the postnatal period, which is defined as up to one year after childbirth,[59] are often called the perinatal period, when referring specifically to mental health. This definition applies to most perinatal mental health services. Whilst some fathers have mental health problems during this period data and other information about this period refers to women only. Mental health problems occurring during the perinatal period can range from symptoms that do not meet the threshold for clinical diagnosis (subthreshold) to severe mental illness.[60]

Mental health problems in the perinatal period are very common, affecting up to 20% of women. Examples of these illnesses include antenatal and postnatal depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. Untreated perinatal mental illness affects maternal morbidity and mortality with almost a quarter of maternal deaths between six weeks and one year after pregnancy attributed to mental-health related causes; 1 in 7 maternal deaths during this period were by suicide. Perinatal mental illnesses cost the NHS and social services around £8.1 billion for each annual cohort of births. A significant proportion of this cost relates to adverse impacts on the child.[61] The Chief Medical Officer’s Report (2013)[62] highlighted that, “Just as the seeds of a long and healthy life are sown in childhood so too are the origins of much mental illness”. Ensuring that all women receive access to the right type of care during the perinatal period is a key Government priority to reduce the impact of maternal mental health during pregnancy and the first 2 years of life on infant mental health and future adolescent and adult mental health.

Children of affected mothers are at higher risk of poor mental health, physical health, social and educational outcomes. Cost implications run across the wider system, from infant and child & adolescent mental health, through to social care adult mental health, physical health, welfare and social justice costs. Perinatal mental illness can impact on parent’s ability to bond with their baby and be sensitive and attuned to the baby’s emotions and needs. This in turn will affect the baby’s ability to develop a secure attachment. Untreated perinatal mental illness can have a devastating impact on mothers, fathers and their families. The effects can be of particular concern in the absence of other carers able to provide the quality emotional contact every infant needs. About half of all cases of perinatal depression and anxiety go undetected and many of those which are detected fail to receive evidence-based forms of treatment.[63]

Based on 1,498 (1,489 live births and 9 still births) in 2015, the latest available data from Office for national Statistics,[64] the following estimates have been made using national prevalence rates per 1,000 deliveries (Table 2).
### 3.4. Levels of mental ill health amongst children and young people

#### 3.4.1. Preschool (0-4)

Mental health in babies and toddlers refers to their social and emotional development and wellbeing. The phrase ‘infant mental health’ is sometimes used, particularly when referring to services, and is often defined as the “healthy social and emotional development of a child from birth to 3 years” [65]. The NICE guidance on ‘Social and emotional wellbeing: early years’ [66] defines emotional wellbeing as “being happy and confident and not anxious and depressed” and social wellbeing as having “good relationships with others and ...(not having) behavioural problems”. Healthy social and emotional development includes attachment which is defined by NICE as “a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually”. [67]

There is relatively little data about prevalence rates for mental health disorders in pre-school age children. However, a literature review of four studies, looking at over 1,000 children aged 2 – 5 years found an average rate of any mental health disorder was 19.6%. [68] Applying this average prevalence rate to the estimated Halton population indicates that 1272 children aged 2 to 5 years (19.6%) would be living with a mental health disorder.

#### 3.4.2. 5-16

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green et al (2004). [69] 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, Table 3 shows the estimated prevalence of mental health disorder by age group and sex in Halton. 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.

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**Table 2: Estimates of numbers of women with mental health problems during pregnancy and after childbirth**

<table>
<thead>
<tr>
<th>Type of perinatal mental health condition</th>
<th>National prevalence rate per 1,000 deliveries</th>
<th>Halton estimate based on 1,498 deliveries (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of women with postpartum psychosis</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Estimated number of women with chronic SMI</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Estimated number of women with severe depressive illness</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)</td>
<td>100</td>
<td>150</td>
</tr>
<tr>
<td>Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)</td>
<td>150</td>
<td>225</td>
</tr>
<tr>
<td>Estimated number of women with PTSD</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Estimated number of women with adjustment disorders and distress (lower estimate)</td>
<td>150</td>
<td>225</td>
</tr>
<tr>
<td>Estimated number of women with adjustment disorders and distress (upper estimate)</td>
<td>300</td>
<td>449</td>
</tr>
</tbody>
</table>

Source: Chimat and DNS

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These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders. Table 4 shows the estimated number of children with conduct, emotional, hyperkinetic and less common disorders in Halton, 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).

Table 4: Estimated number of children with emotional disorders by age group and sex

<table>
<thead>
<tr>
<th></th>
<th>children aged 5-10</th>
<th>children aged 11-16</th>
<th>boys aged 5-10</th>
<th>boys aged 11-16</th>
<th>girls aged 5-10</th>
<th>girls aged 11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorders</td>
<td>245</td>
<td>490</td>
<td>115</td>
<td>205</td>
<td>135</td>
<td>285</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>505</td>
<td>660</td>
<td>365</td>
<td>405</td>
<td>145</td>
<td>255</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>180</td>
<td>140</td>
<td>160</td>
<td>125</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>135</td>
<td>120</td>
<td>110</td>
<td>80</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>

3.4.3. Children with mental health co-morbidity

- 1.9% of all 5-16 year olds have more than one diagnosed mental disorder. The most common combination is conduct and emotional disorders[^70].
- 77% of children with multiple disorders are boys, reflecting the high proportion of children with conduct disorders in this group.
- Children diagnosed with multiple disorders are more likely to have a physical or developmental problem, be behind with their schooling, and be in the bottom quartile on a scale measuring strengths compared with those with a single disorder.

Based on the above prevalence rate of the 18,741 children aged 5-16 living in Halton 356 of them may have multiple mental health conditions.

3.4.4. 16-19

Research[^71] has estimated prevalence rates for neurotic disorders in young people aged 16 – 19 years. Applying the figures to Halton would mean an estimated 830 young people aged 16 – 19 years would have a neurotic disorder (265 males, 565 females). In this age group, females are much more likely to suffer from anxiety and depressive disorders as well as phobias. Table 5 shows the types of neurotic disorders and the estimated prevalence levels.

Table 5: Estimated number of males and females in Halton, aged 16 to 19, with neurotic disorders

<table>
<thead>
<tr>
<th>Disorder Type</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>155</td>
<td>365</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>50</td>
<td>35</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>All phobias</td>
<td>20</td>
<td>65</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Any neurotic disorder</td>
<td>265</td>
<td>565</td>
</tr>
</tbody>
</table>
3.5 Hospital admissions

The Public Health England (PHE) profile presents an indicator illustrating the rate of hospital admissions for those aged less than 18 years where the main cause of admission is due to a mental health condition. This indicator illustrates that there were 32 admissions made by Halton residents during 2015/16, this resulted in a rate of 113.2 per 100,000 population; this was statistically similar to the England rate (85.9 per 100,000).

Figure 1: Hospital admissions for mental health age 0-17

To gauge an indication of the numbers of young people being admitted into hospital due to mental health conditions on more than one occasion, further analysis of a local hospital admissions dataset revealed that of those admitted to hospital over a three year period (2013/14 through to 2015/16), approximately 10% of individuals were admitted on more than one occasion (over the three year period there were 78 admissions made by 71 individuals).

Figure 2 illustrates the main causes of mental health admissions made between 2013/14 to 2015/16 for Halton residents aged 0 to 17 years. The most common cause of admission was due to mental and behavioural disorders due to psychoactive substance use (26%). The second most common cause of admission was due to disorders of psychological development (18%).

e Direct comparisons between data sourced from PHE and the local hospital admissions dataset should not be conducted as slightly differing search queries were conducted when extracting the datasets. The PHE dataset is based on first finished episodes for each financial year, whilst the local hospital admissions dataset is based on the date of admission falling within the three year period of 2012/13, 2013/14 and 2014/15.
3.5. Self-harm

The World Health Organisation defines self-harm as:

‘an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences’

NICE defines self-harm as

‘Self-poisoning or self-injury, irrespective of the apparent purpose of the act’

The 2004 NICE guidance and updated 2011 guidance explains their decision to shorten the definition. It states that the guideline focuses on those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person’s control or even awareness, during ‘trance-like’, or dissociative, states. It therefore uses the term ‘self-harm’ rather than ‘deliberate self-harm’. The scope has been limited in this way because the term ‘self-harm’ is a broad one and could be applied to the actions of many people at some time in their lives. Many behaviours that are culturally acceptable can result in self-inflicted physical or psychological damage, such as smoking, recreational drug use, excessive alcohol consumption, over-eating or dieting. Also, self-harm can occur as part of religious practice, as a form of political or social protest or as an act of ‘body enhancement’.\(^{[72]}\)
**Prevalence**

The prevalence of self-harm can be difficult to determine, as individuals do not always seek help or advice from medical professions.

- Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds. Self-poisoning was the most common method, involving paracetamol in 58.2% of episodes.
- 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).
- Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide.
- 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.
- 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.
- 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.
- NICE guidance on the longer term management of self-harm reported a survey of 15-16 year olds that found more than 10% of girls and 3% of boys had self-harmed in the previous year. NICE also reported lifetime prevalence of 0.5% across all age groups, and that self-harm increases the likelihood of death by suicide by between 50-100 times the population risk in a 12 month period.

Based on a 11-25 year old population of 23,706 (mid-2015 population estimates (ONS)) there may be between 1,580- 2,371 young people who self-harm in Halton (using the 1 in 15 and 1 in 10 rates)

The NICE guidance identifies that there are multiple factors that put children and young people at risk of self-harm, including:

- being bullied at school
- not getting on with parents
- stress and worry about academic performance and not getting on with examinations
- parental divorce
- bereavement
- unwanted pregnancy
- experience of abuse in earlier childhood (sexual, physical, neglect and/or emotional) – severe and prolonged sexual abuse is known to lead to a higher incidence of self-harm.
- difficulties associated with sexuality - lesbian, gay, bisexual and transgender young people are estimated to be 2 or 3 times more likely to self-harm than heterosexual young people, and homophobic bullying at school is implicated in higher rates of self-harm
- problems to do with race, culture or religion
- low self-esteem
• feeling rejected.

NICE also identified factors in adults which may also be relevant in some adolescents and young adults such as alcohol and substance misuse, phobic and psychotic disorders, domestic violence, physical illness and poverty.

Local analysis of accident and emergency (A&E) attendances compared to hospital admissions data 2011/12 to 2014/15 shows that a large percentage of A&E attendances due to self-harm aren’t identified for that reason when a young person first enters A&E. Only 57.3% of admissions due to self-harm were identified as such at A&E.

If all the attendances due to self-harm were identified within the A&E department, it could be assumed that the attendance number would be higher than the number of admissions, as not everyone would need to be admitted to hospital. If all suspected self-harm cases in young people were admitted, in line with NICE guidance, A&E figures and admission figures should be 100%.

However, looking at the annual figures A&E departments have improved in identifying self-harm as the reason for attending. In 2011/12 only 48% of admissions, where self-harm was the reason, were identified in A&E, where as in 2013/14 the percentage had increased to 68%.

Table 6: Number of A&E attendances and hospital admissions for self-harm, 10 to 24 year olds

<table>
<thead>
<tr>
<th>Year</th>
<th>A&amp;E attendances</th>
<th>Admissions</th>
<th>% of admissions identified in A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>79</td>
<td>165</td>
<td>47.9%</td>
</tr>
<tr>
<td>2012/13</td>
<td>80</td>
<td>146</td>
<td>54.8%</td>
</tr>
<tr>
<td>2013/14</td>
<td>119</td>
<td>174</td>
<td>68.4%</td>
</tr>
<tr>
<td>Total</td>
<td>278</td>
<td>485</td>
<td>57.3%</td>
</tr>
</tbody>
</table>

Source: TIG, Centre for Public Health, LIMU

Hospital admission rates for the past three years data available shows that rates in Halton were statistically significantly higher than both the North West and England, despite the drop between the last two years.
Compared to the borough’s statistical neighbours group Halton had the fifth highest rate of self-harm in 2014/15. Of the local authorities in Cheshire & Merseyside only Liverpool had a rate statistically similar to England. Cheshire West and Chester had a rate that was statistically lower than England.

Ward level analysis using a three-year aggregated dataset shows the wards in Halton with a high rate of emergency admissions due to self-harm for 10 to 24 year olds (dark purple areas). When comparing these wards with the most deprived areas in Halton, generally the highest admission rates are seen in the most deprived wards.
Local analysis for each year 2012/13, 2013/14 and 2014/15 shows that the main type of self-harm was overdose or abuse of over the counter drugs that do not contain morphine. It accounts for over 40% each year. Sharp objects account for between 14.4% and 18% each year and prescription drugs between 14%-16%. In 2012/13 the use of these drugs decreased compared to 2011/12, but then increased again in 2013/14 and 2014/15. The percentage of self-harm admissions due to narcotics and hallucinogens decreased between 2012/13 and 2014/15, but remains higher than in 2011/12. The percentage due to the use of sharp objects stayed at a similar level in 2014/15 as in 2013/14.

Table 7: Method of self-harm, Halton 10-24 year olds, 2011/12 to 2014/15

<table>
<thead>
<tr>
<th>Method</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the counter painkillers that don't contain morphine (e.g. paracetamol, co-codamol, aspirin)</td>
<td>46.4%</td>
<td>40.9%</td>
<td>44.8%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Sharp object</td>
<td>18.5%</td>
<td>16.1%</td>
<td>14.4%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Prescription drugs (e.g. valium, antidepressants, sleeping tablets and tranquillisers)</td>
<td>15.5%</td>
<td>16.1%</td>
<td>14.9%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Narcotics and hallucinogens (e.g. morphine, cocaine, heroin)</td>
<td>5.4%</td>
<td>17.4%</td>
<td>14.9%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Unspecified drugs, medicaments and biological substances</td>
<td>7.7%</td>
<td>6.0%</td>
<td>4.6%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Hanging, strangulation and suffocation</td>
<td>2.4%</td>
<td></td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>Blunt object</td>
<td></td>
<td></td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>Other (e.g. jumping from high place, alcohol, other drugs)</td>
<td>4.2%</td>
<td>3.4%</td>
<td>6.3%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Source: SUS data
3.6. Eating Disorders

Eating disorders are a group of illnesses defined by the National Institute of Mental Health as being those in which the sufferer experiences a preoccupation with body weight and shape which disturbs their everyday diet and attitude towards food. Unusually, compared with other mental health issues, eating disorders result in both physical and psychological symptoms and can have long term physical side effects including organ failure. They include Anorexia Nervosa and Bulimia Nervosa as well as lesser known disorders such as binge eating disorder. The Royal College of Psychiatrists suggest that a combination of influencing factors (including genetics, age and social pressures) cause eating disorders and that they are often seen alongside other conditions (most frequently depression or anxiety disorder). This makes recognition of the underlying eating disorder much more difficult.\(^8\)

Not only may sufferers delay seeking help but the Beat survey of nearly 500 eating disorder sufferers showed delays of a year or more for a diagnosis with further waiting periods for treatment to begin. As six out of ten people have at least one relapse, total duration can be 6 years or more for about half of sufferers.

Figure 6: Treatment, recovery and relapse cycle

3.6.1 Prevalence

In 62% of cases symptoms first occur under the age of 16, 24% between 16-19 and 9% between 20-24. Very few cases first appear in people older than this. Between 90-95% of cases are females with 5-10% being males. Data from both GP records and hospital admissions indicates the incidence and prevalence of eating disorders is increasing. The APMS 2014 did not cover eating disorders so the last national survey was the APMS 2007. It showed that eating disorders remains more common in females compared with males (9.2% overall prevalence in adult females compared with 3.5% in adult males). Eating disorders have the highest prevalence in younger adults (20.3% in 16-24 year old
women and 6.1% in 16-25 year old men). 2.5% of adult women will have an eating disorder that has a significant impact on their life.

These are applied to the population of Halton and show that between 6,320-6,534 adults in Halton may have an eating disorder (depending on whether using all age prevalence of total of age specific rates). A smaller but nevertheless significant proportion identify that their feelings about food have a significant impact on their lives. Applying the age-specific and all-age national prevalence rates to Halton’s population estimates 16+ for males and females gives an estimate of between 1,558-1,604 of the population having feelings about food that has a significant impact on their life. However, activity data shows 13 referrals for eating disorders among people aged under 18 between April 2013 to November 2015 in Halton CCG. Between February and October 2017 there were 31 referrals into 8-18 year old eating disorder service from Halton. Between 2010/11 and 2014/15 there were less than 20 admissions to hospital due to eating disorders with just over half in those aged under 25.

3.7. Mental Illness amongst those with learning disabilities and Autism

Children and adolescents with learning disabilities have high rates of mental health problems and behavioural difficulties. Comorbid disorders such as epilepsy, autism and attention-deficit hyperactivity disorder are common. [81] Children and adolescents with learning disabilities are over six times more likely to have a diagnosable psychiatric disorder than their peers who do not have learning disabilities. In total, over one in three children and adolescents with a learning disability in Britain (36%) have a diagnosable psychiatric disorder. [82] This compares to 8% among children without learning disabilities. Children with learning disabilities accounting for 14% of all British children with a diagnosable psychiatric disorder.

They can find it hard to build social relationships, and are more likely to say that they have difficulties getting on with their peers than children without learning disabilities. The increased risk of having a mental health problem cuts across all types of psychiatric disorders. Children with learning disabilities are: [83]

- 33 times more likely to have an autistic spectrum disorder than the general population
- 8 times more likely to have ADHD
- 6 times more likely to have a conduct disorder
- 4 times more likely to have an emotional disorder
- 3 times more likely to experience schizophrenia
- 1.7 times more likely to have a depressive disorder

3.7.1 Autism and mental health

People with an ASD are at much higher risk of developing a mental health problem than the general population. 70% children with ASD will have a mental health concern at some point in their life and 40% will have two or more This high prevalence rate of mental health problems is reflected in the use of Child and Adolescent Mental Health Services (CAMHS). 1 in 10 of the children who use CAMHS have autism. [84]

These rates for different age groups reflect the fact that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities [85] estimates an upper estimate of 40% prevalence for mental health problems associated with learning disability,
with higher rates for those with severe learning disabilities. The following table shows how many children with learning disabilities who also experience mental health problems might be expected in Halton.

Table 8: Estimated total number of children with learning disabilities with mental health problems

<table>
<thead>
<tr>
<th>Estimated Number</th>
<th>5-9 yrs</th>
<th>10-14 yrs</th>
<th>15-19 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35</td>
<td>65</td>
<td>80</td>
</tr>
</tbody>
</table>

Source: Chimat (using ONS mid year population estimates 2014)

3.8. Mental health needs in Young Offenders

During 2016 there were 36 first time entrants to the youth justice system in Halton. This resulted in a rate of 304 per 100,000 population; this rate is similar to England (327 per 100,000) and the North West (293 per 100,000). The trend in the rate of first time entrants has been steadily reducing in Halton since 2010 when there were 161 first time entrants (1,258 per 100,000).[86]

A Young Offender Health Needs Assessment (HNA) conducted across Halton, Warrington, Cheshire West and Chester during 2015[87] identified that young offenders in the sample population had higher levels of health need compared to their peers who are not engaged with offending services in relation to several areas – mental health, learning difficulties, substance misuse and social issues. It was also identified that this population also experienced high levels of dual diagnosis, in which young people experienced both mental health and substance misuse needs.

Within the sample population who resided in Halton:

- 83% had their functioning impacted by mental health
- 14% had received a formal mental health diagnosis
- 39% were in contact with mental health services
- 31% had either in the past or currently self-harmed or attempted suicide.

Young people in Halton had the highest levels of recorded mental health needs. They were the most likely to be reported as having their functioning impacted by their mental health, and be in contact with services. They were also more likely to have a history of self-harm or suicide attempts (31%, against an average of 23% across all areas). However young offenders in Cheshire West and Chester were most likely to have a formal diagnosis.
3.9. Adverse Childhood Experiences

Individuals’ childhood experiences are fundamental in determining their future health and social prospects. The term Adverse Childhood Experiences (ACEs) incorporates the wide range of stressful events that children can be exposed to while growing up, such as child maltreatment, exposure to domestic violence, family breakdown and living in a household affected by substance misuse, mental illness or crime. ACEs are one of the strongest predictors of poor health and social outcomes in adults. Thus, the more ACEs an individual suffers as a child the greater their risks of: poor educational attainment; unemployment; substance misuse; risky sexual behaviour and sexually transmitted infections; involvement in violence and crime; poor mental wellbeing and mental illness; poor diet and obesity; chronic health conditions (including cancer, heart disease and stroke); and ultimately premature mortality.\(^{[88]}\)

The underlying theory linking ACEs to poor outcomes is that trauma and chronic stress in childhood have negative impacts on children’s developing brains and physiological systems that persist throughout the lifespan. Children that are abused, neglected or exposed to other toxic stress can ‘adapt’ to function under these harsh conditions, developing heightened stress responses, attachment difficulties and dulled emotions, and lacking trust and self-esteem. These characteristics can also lead to communication problems, difficulties forming healthy relationships and vulnerability to harmful behaviours such as substance use, risky sexual activity and overeating. Such behaviours can also emerge as coping mechanisms, and contribute to the development of diseases such as cancer and heart disease. Importantly, the heightened physiological stress responses that develop through chronic childhood stress can also increase allostatic load – the wear and tear that stress causes to the body – which further increases vulnerability to disease.

Preventing ACEs and moderating their impacts is fundamental to improving population health and reducing inequalities. Building multi-agency awareness and knowledge on ACEs is therefore critical to enabling the development of effective service delivery that addresses ACEs throughout the life course. This includes early years support to prevent ACEs and develop parenting skills; building resiliency in young people to protect against the harmful impacts of ACEs; and trauma-focused care for those suffering the health and social impacts of ACEs in adulthood.

A large study in Wales of over 2,000 adults\(^{[89]}\) showed 14% had suffered four or more ACEs (Figure 7). It also showed the impact it can have into adulthood increasing the likelihood of unhealthy behaviours and development of ill health. It also outlined the literature indicating the extent to which tackling ACEs can reduce such negative outcomes (Figure 8).

**Figure 7: Proportion of adults suffering ACEs: Welsh Study 2015**
Figure 8: Impact of ACEs

There is no local data on the proportion of adults living in Halton who have suffered ACEs.
4. Service provision

4.1. Governance

Halton CCG is the lead accountable body for the commissioning of Young People’s mental health services. In order to undertake effective commissioning it works in partnership with Local Authority children’s services and public health.

Halton has an established multi-agency partnership board known as the Children and Young Peoples’ Emotional Wellbeing Board (CYEWB) that oversees the delivery of the current Children and Young Peoples Emotional and Wellbeing Delivery Plan that is the Children’s element of the all age mental health action plan and will take responsibility for overseeing the delivery of the Transformation Plan. The partnership board has the responsibility to look at prevention, early detection and support and treatment. Partners include:

- CCG
- Local Authority – Public Health and Children’s Services
- Schools
- 3rd Sector – including Barnardo’s, Young Addaction, Wellbeing Enterprises, Xenzone
- Statutory provider organisations – Mental Health Trust
- Young Peoples representation

Currently the targeted Emotional Health and Wellbeing Service is commissioned jointly by Halton CCG and Public Health. The longer term vision for Halton is to undertake more joint commissioning with the local authority in order to have services that are streamlined, have integrated pathways in place, are efficient and effective, accessible to young people and can demonstrate improvements in outcomes.

4.2 Perinatal Mental Health

Parenthood and the first 1001 days of a child’s life, from conception to Age 2 is widely recognised as a critical period that will have an impact and influence on the rest of the life course. There is a significant body of evidence that demonstrates the importance of sensitive attuned parenting on the development of the brain and in promoting secure attachment and bonding. The universal Healthy Child Programme is in place to ensure that children get the best start in life and support is available to families in difficulty. Preventing and intervening early to address attachment issues has an impact on the child’s resilience and physical and mental health in childhood and later life.

During the antenatal period all mothers are able to access the community midwifery service, and the antenatal period is also a key time for health visitor involvement as parents are receptive to messages. At this stage the health visitors undertake a holistic assessment of the family and parenting capacity to meet their infant’s needs, enabling early identification of risks. Midwives and health visitors universally screen mothers for depression before and after the child is born.

The Family Nurse Partnership (FNP) programme provides intensive support to first time teenage mothers. The nurses work closely with mothers during the antenatal stage and up to the child being two years old. The nurses complete a number of sessions with parents on emotional health and wellbeing, including building the mothers understanding of child development and brain
development, their role as a parent and useful techniques that support bonding and attachment. FNP also works to build the mothers self-efficacy, self-esteem and aspirations.

Women are encouraged to access midwifery services as early as possible in their pregnancy. The midwives provide an ‘Early Bird’ booking system which supports women in the early days of their pregnancy. Halton also provide Baby boxes, which offer an opportunity for increased engagement and discussion with women on their pregnancy, and what they can do to support a healthy pregnancy.

In order to prepare families for parenthood all families are booked onto the antenatal transition to parenthood programme; ‘Your Baby and You’. The sessions are available in Widnes and Runcorn on a consecutive 4 week rolling programme. It’s a collaborative approach to antenatal care which is delivered by: midwives, family nurses, infant feeding team, health visitors and children centre staff. Themes of attachment, self-efficacy and human ecology run throughout the sessions to help parents feel prepared and confident for the birth of their baby, with an understanding of babies needs and how to respond.

The leaflet ‘building a happy baby UNICEF’ is distributed to pregnant women to build their understanding of bonding and attachment, and supporting the development of this through their pregnancy.

Where it is identified that additional support is needed, women can be referred to a new NHS perinatal mental health service. “Time for Me” is also available which is a creative arts group for antenatal and postnatal mothers with children under two who are experiencing mild to moderate perinatal depression or anxiety. The aim is to improve mood, lessen anxiety, increase confidence and self-esteem. It is developed in partnership with children centres, facilitated by a volunteer artist and a health visitor. The outcomes of the group demonstrate a reduction in depression, anxiety and an increase in confidence.

In 2017 the National Childbirth Trust (NCT) began a pilot of ‘Parents in mind’ in Halton. Parents in mind is a peer support service that is being developed by the Department of Health and NCT to support women experiencing mild to moderate anxiety and depression.

4.3. Early years

All families in Halton have access to the universal Healthy child programme, through their midwife, health visitor, family nurse and community services. The overall aim of the Healthy Child programme is to deliver an integrated approach to improving the emotional wellbeing of children and young people by focusing on prevention and early intervention, with appropriate support to help reduce the need for more specialist interventions.

The Healthy Child Programme emphasises the importance of positive maternal mental and infant mental health, transition to parenthood in the early weeks, promoting secure attachment, postnatal depression and parenting. The two of the Department of Health early years high impact areas; ‘transition to parenthood and the early weeks’ and ‘perinatal mental health’ focus on the importance of bonding, attachment, parenting and perinatal mental health for positive outcomes.
All children aged 0-5 have a named health visitor and are offered five assessments at key stages of development:

- Pre Birth Assessment
- New Birth Assessment
- 6-8 Week Health Assessment and review of maternal mental health
- By 12 months Child Health Review
- By 2½ years Child Health Review

The healthy child programme provides key contacts points with families, early identification of poor attachment, develop parenting skills, and family emotional health issues. They offer opportunities for the family to receive additional help and support, health promotion messages, screening and the early identification of additional needs. When required health visitors offer parents expert timely advice, guidance and support for issues such as attachment, toilet training, behaviour management and infant feeding.

Where needs are more complex the Health Visitor will offer additional support as part of a multi-agency plan often led by a specialist service e.g. for children subject of Child Protection Plan, children in care, children with with complex health needs.

In order that health visitors have the skills to identify and support families in the early days they have been trained in the Brazelton system. The Brazelton systems is an evidence based practice that health visitors use to assess needs and support families with bonding and attachment, and interpreting their new-born’s behaviour. Brazelton involves two tools, the Newborn Behavioural observation (NBO) which is useful for all families and those with mild attachment difficulties, and the Newborn Behavioural Assessment tool which provides more intensive support.

**Newborn Behavioural Observation (NBO)**

NBO is a relationship-based structure, neurobehavioral observation which enables clinicians to describe and interpret newborn behaviour for parents.\(^9\)\(^1\) It is relationship building tools designed to help parents develop a relationship with their new baby, but also for parents to build a relationship with the Health Visitor and is based on over 30 years of research using the Newborn Behavioural Assessment Scale.

**NBO :-**

- Is a validated observational tool that describes the capacities and behavioural adaptation of babies from birth to 3 months
- provides parents with individualized information about their infant’s behaviour. So that they can appreciate their baby's unique competencies and vulnerabilities and thereby understand and respond to their baby, in a way that meets her/his developmental needs
- is identified as a universal tool
- Referral for a NBAS where a need is identified

**Newborn Behavioural Assessment Scale (NBAS)**

- includes a more detailed assessment of behavioural, reflex and supplementary items
- is early intervention to prevent attachment difficulties
- is identified as the early intervention tool

NBAS has shown to improve motor abilities and increased mental development (Wismayer, 1981, Parker et al, 1982), mothers become more confident and sensitive, improves mother-infant reciprocity and enhances parental involvement (Beal 1989). Studies using NBAS have shown mothers spend more time playing and talking with their babies, fathers are more involved in care giving at one month, premature babies had a higher cognitive scores and low birth weight babies had higher developmental scores at 4 years.

In 2017 a Baby and Infant Bonding (BIBS) Bonding and attachment Service was piloted with psychotherapists providing parent infant psychotherapy and Video interactive guidance for families with more complex attachment issues. From 2018 this service will be routinely commissioned.

4.4. Schools

Each school in Halton has a school nurse, who is available to support emotional health needs of children and young people in the school, and advise teachers accordingly. In the secondary schools the school nurses also offer a health drop in, which are available for pupils to discuss emotional health and wellbeing concerns.

4.4.1 Schools Link Pilot

Halton was part of a pilot for a national initiative developing a schools link model. The pilot supported 10 local schools in accessing bespoke training from the Anna Freud Center in London who are partners with NHS England in the project. The model identified specific leads within schools that then support the rest of the staff team with information and assistance to identify young people within the school setting who may be experiencing problems. The pilot received a positive evaluation and led to wider developments with local schools. Halton schools now have a named contact within the CAMHS Service. The CAMHs link worker acts to liaise with the school providing expertise and advice and can facilitate referrals into services if appropriate.

4.4.2 Promoting positive mental health

A programme called Healthitude is available for schools in Halton, it a collaboration between the Health Improvement Team with the support of the School Health Service, Young Addaction, and Police. Sessions cover healthy eating, smoking, alcohol, emotional wellbeing, drugs, cyber bullying, relationships education and activity/fun games. Other sessions have also been made available to schools to support positive emotional health, such as mindfulness and work to prevent bullying and training for staff in areas such as mental health, suicide and self-harm awareness.

4.5. Community

Halton Borough council employ a mental health lead and small team within in the Health Improvement Team, who are working to promotion emotional health and wellbeing across all ages.

In September 2017 monthly mental health hubs were launched by the Health improvement team, one in Widnes market and one in Runcorn shopping city. The unique concept brings local support organisations together to raise awareness of mental health among Halton residents. The aim of the hubs is to give residents direct link to many different services which can help and support local people to manage their mental health.
The Hubs are a central point of contact and referral (where appropriate) into mental health services for the residents of Halton, over 27 organizations have signed up to be part of the monthly hubs (signing a SLA) including: Citizens Advice, CAMHs, Bridge Builders, North West Boroughs Healthcare, Adult Learning, Recovery team, Amparo, Papyrus, Send, CGL, Parents in Mind, Adult safeguarding and Child Bereavement UK.

In 2016/17 ‘Youth Connect Five’ sessions were provided for families. Youth Connect 5 is a free course that gives parents and carer’s skills and understanding to help their children develop strong emotional wellbeing through resilience-building techniques. This was a pilot programme, which is awaiting evaluation outcomes.

Through external funding a pilot ‘wellbeing model’ targeting young people on the waiting list for specialist mental health services was trialled. The aim was to make offer early help and support and make them more receptive to receiving therapeutic interventions and equipping them with self-management and coping strategies.

4.6 Mental health services

As a borough we want to ensure effective local intervention and also appropriate referrals or signposting will be made, which will, in turn, help us to have a step change in how care is delivered as we move away from the traditional ‘tiered model’ of service delivery to a blended model of service provision that puts the young person at the centre of delivery based on their individual needs. Research evidence shows that successful access to education is one of the major protective factors for mental and emotional health.

4.6.1. Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT)

CYP IAPT is being delivered by mental health service providers and involves transforming mental health services for children and young people and their families/carers. The programme is centred on the principles of offering effective and efficient evidence-based, outcome focussed treatments within a collaborative therapeutic relationship, and with full participation of children, young people and their families and carers in service delivery and design.

These aims are met through a focus on:

- Meaningful participation with children, young people and families/carers embedded within all services and within local, regional and national service planning and development, including co-production wherever possible.
- A range of high quality treatments delivered by staff trained to expert level in evidence based therapeutic modalities
- Greater accessibility to evidence based interventions for children and young people
- A culture of clinically relevant session by session outcome monitoring embedded within routine practice and used to select, guide and evaluate treatment interventions and support collaborative shared decision-making.

In order to achieve this services are developing and where necessary redesigned to ensure they achieve the aims of IAPT. Services are adapting their delivery so that children and young people are offered the right interventions by the right people, with the right skills at the right time and in the right location. Halton is also looking to providers to work collaboratively to provide clearer and
more cohesive pathways of support for families.

In 2017 Halton mental health providers worked collaboratively and in consultation with the public to develop a new model of care based on the Thrive model (see section 5 for more details). This has entailed developing a single point of access, the hub, for all emotional health and wellbeing referrals, working towards pathway integration (and the removal of the tiered model of care). The single point of access that has been developed will act as a hub where families can access information, help and support and access to specialists as needed. A referral pathway has been developed that provides information in relation to interventions that can be carried out through universal services as well as more specialist services.

New developments as a result of the development of a thrive model have included providing a named mental health professional who with schools and a mental health link worker for Young Offenders.

4.6.1 Eating disorders service

Eating disorders are serious mental health problems that can lead to serious psychological, physical and social consequences. Children and young people with eating disorders often have other mental health problems, which need treatment. It is vital that children and young people with eating disorders are able to access effective and timely treatment.

Specific commissioning guidance was published in July 2015 for specialist Eating Disorder Services. The aims of this guidance was to improve the access and quality of eating disorder services, moving to cover a population footprint of 500k and with monitored waiting lists of one week for urgent cases and four weeks for non-urgent. Consequently NHS Halton CCG worked with St Helens CCG, Warrington CCG and Knowsley CCG to commission a specialised service that meets guidance requirements. The eating disorder services is now extended and is available for children and young people up to 18 years of age and the new services started in Spring 2017.

4.6.2. Children in care

A targeted emotional health and wellbeing service is available for all Children in Care, to reduce waiting times and ensure they have access to appropriate support in a timely manner. Children in care also receive a health assessment on an annual basis.

4.6.3. Carers

The definition of a young carer is someone who, unpaid, helps to look after a friend or family member due to an illness, disability, mental health difficulties or addiction.

The Care Act (2014) and Children and Families Act (2014) specify that carers have an entitlement to information and support in their own right. Carers may be caring for a child or young person accessing mental health services or they may themselves be in need of or eligible to use mental health services.

Young carers often get forgotten when addressing local need as there are no accurate figures of the number of children or young people with caring responsibilities. It is essential that the specific needs of this often hidden group are considered. Within the development of the Thrive model, young carers are identified as a group that will require targeted and tailored provision to ensure their
emotional mental health and support needs are met.

4.7. Third Sector Provision

Good emotional health and wellbeing is something that is supported across by a wide array of public, private and third sector organisations. Third sector organisations in particular work to engage the community, often working with groups that may find it harder to engage in mainstream provision and do excellent work in building community cohesion, self-esteem, engagement and resilience. Below is a list of the some of the local services that work with children and young people and their families and have a positive effect on emotional health and wellbeing. Due to the wide ranging nature of the work this is not an exhaustive list.

- Young Addaction (LA commission)
- Catch 22 (LA commission)
- Scope
- Wellbeing Enterprises
- Canal Boat
- Training Attention via the 14 – 19 service
- Venus – parent to parent volunteering project
- Schools – internal support, wishes and feelings, nurture groups, 1-2-1 support
- Family Support via our internal locality teams
- Engage – Youth Federation (other projects with support re employment)
- Child Bereavement UK
- Riverside College – 1-2-1 work
- RU different mindfulness
- Health improvement team, wellbeing promotion
- Parenting sessions – Triple p
- National Child birth trust peer support for parents with depression and anxiety

During 2015/16 a small grants were awarded to 18 local third sector and statutory organisations for projects which support improving the emotional wellbeing and resilience of young people locally (Table 9)
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Runcorn Amateur Boxing</td>
<td>Boxing club/community hub that will provide an outlet to youngsters who may become bored and engage in criminal activity, giving them something of substance to focus on, not only as a sport but as a career option in the future.</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>A roll out to schools’/alternative education providers’ staff of: “Your Voice Counts Teachers’ Resource Pack”. Healthwatch Halton in conjunction with Halton Healthy Schools Standard (HHSS) 2015, for Key Stages 1–4 pupils, linking into Personal Development/Citizenship. Support schools to plan and implement health and wellbeing improvements for pupils. Healthy schools promote physical and emotional health by providing accessible, relevant information, equipping pupils and staff with the understanding, skills and attitudes to make informed decisions.</td>
</tr>
<tr>
<td>Canal Boat</td>
<td>A hub for isolated young people, that will promote employment and job aspirations, enrichment and experience, housing and upkeep</td>
</tr>
<tr>
<td>Child Bereavement</td>
<td>Two Bereavement Awareness Half-Day Training Courses for school staff and an E-Learning Programme ‘supporting bereaved pupils’ to be embedded in all schools in Halton. Aims to increase confidence and offer practical advice and skills for educational professionals by receiving online bereavement training, access to an interactive forum and a resource bank of lesson plans.</td>
</tr>
<tr>
<td>Citizens Advice Bureau</td>
<td>Provide an advocacy service for young people as they transition into independent adulthood so that they have a trusted community champion to turn to if they have a problem.</td>
</tr>
<tr>
<td>Wellbeing Enterprises</td>
<td>Train a member of our staff in the Mental Health First Aid youth programme which will enable staff to train the local CYP workforce, volunteers and parents in spotting signs and symptoms of mental health problems and develop mental health awareness</td>
</tr>
<tr>
<td>Cancer Support</td>
<td>6 month pilot project to work with at least one local school or youth organisation to create a readable resource for local schools, which informs the reader about Cancer and its implications, processes and possible outcomes.</td>
</tr>
<tr>
<td>Children’s Centre Incredible</td>
<td>The Health Visiting Service, Children Centre staff and early intervention support workers to work in partnership to deliver the Incredible baby Programme in Halton.</td>
</tr>
<tr>
<td>Organisation</td>
<td>Project</td>
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<td>--------------------------------------</td>
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</tr>
<tr>
<td>Children’s Centre Solihull</td>
<td>To train all the children centre early years team, Early Help officers, locality teams, midwives, breastfeeding support workers and mental health support workers in the use of the Solihull approach</td>
</tr>
<tr>
<td>Perinatal mental health Bridgewater</td>
<td>The Health Visiting Service would like to provide all parents to be with a Building a Happy baby leaflet. The leaflet will support the Health Visitors discussion with parents in relation to transition to parenthood, bonding and attachment. The service would like to purchase the Getting it right from the start DVD. Used in the antenatal transition to parenthood groups, it supports parents in understanding their baby and in developing a good relationship with their baby.</td>
</tr>
<tr>
<td>Health Improvement Team-Peer led campaign</td>
<td>Peer led campaign, utilising the skills of the Youth Health Champions (YHC) to lead a peer led campaign across Halton schools. The themes will be driven by local need (drawn out via YHC and local CYP focus groups). This model fits with existing evidence that children and young people seek information predominantly from their peers and enables consistent reinforcement of key messages. This campaign will complement the training programmes for the workforce to ensure consistency of message.</td>
</tr>
<tr>
<td>Halton Community Radio</td>
<td>HCR will work in partnership with NCS (National Citizens Service) Halton to provide Broadcast Training for groups of young people. Each group would be trained once a week over a 6 week period as well as being supported to broadcast live on HCR as part of the NCS Show. Each weekly session would be run by a youth worker</td>
</tr>
<tr>
<td>Children In Care</td>
<td>Children in Care and care leavers to be given free gym passes and swimming passes.</td>
</tr>
<tr>
<td>Young Addaction</td>
<td>Digital app that can be installed on tablets/computers etc. to be utilised within the young carer’s cohort that would allow portable access to their data that could be used when engaged in multiple services.</td>
</tr>
<tr>
<td>CHAPS (Autism)</td>
<td>Continue to offer a variety of children and young people’s activities and events to support the whole family in a range of community settings. For children with autism we offer youth and junior youth clubs, sensory circuit training, swimming sessions, pony riding, trampolining, a Kids Club, Crazy Club, gaming nights and much more.</td>
</tr>
<tr>
<td>Organisation</td>
<td>Project</td>
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<tr>
<td>----------------------------</td>
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</tr>
<tr>
<td>HIT Youth Health Champion</td>
<td>Implement Youth Health Champions within schools or organisations to enthuse, encourage and motivate those within the school community to improve health. The Youth Health champion model is designed to give young people the skills, knowledge and confidence to act as peer mentors, increasing awareness of healthy lifestyles and encouraging involvement in activities to promote good health.</td>
</tr>
<tr>
<td>HIT Peer led evaluation app</td>
<td>A new, innovative app ‘Panda’ that provides Psycho-education and interventions aimed at reducing anxiety, which combines emotion sensing, fitness and health monitoring devices with specific anxiety reduction exercises, using responsive and engaging avatars. The app provides mindfulness, relaxation distraction and facilitation of self-soothing skills.</td>
</tr>
<tr>
<td>Body Image Project</td>
<td>Work with young people to produce set of dramatic narrative, tableaux style photographs, based on the participants ideas around body image. Images will be exhibited at the Brindley, along with a celebration event.</td>
</tr>
</tbody>
</table>
5. Service redesign

5.1 Best practice interventions

Up until recently Child and Adolescent Mental Health Services (CAMHS) in England were provided through a four tier framework described as a stepped model of care. This model was developed in 1995 and is based upon the concept of the child or young person stepping up or down a tier according to the complexity of their mental health needs. The four tiers span from the promotion of good emotional health, to early identification and low level support, to specialist support for mental illness and, to specialist inpatient care.

The Future in Mind (2015) report proposed a move away from the tiers model of CAMHS towards local models of seamless care pathways and support. This is because children and young people and professionals who engaged in the discussions with the taskforce did not feel the tiers model put the child at the heart of the service. The tiers acted as barriers between services with young people falling through the gaps, or having to fit the service, rather than the service adapting to meet their changing needs. An alternative model that is highlighted is the Thrive Model. This seeks to replace an escalator model of increasing severity or complexity with one that works to keep children thriving, by a combined support system, where children and their families can access information, support, treatment and advice as needed, not as a result of their diagnosis as was previously the case.

Figure 9: THRIVE model

The image describes the input offered for each group and the one on the right describes the state of being of people in that group. Each of the four groupings is distinct in terms of needs and/or choices of the individuals within each group:

- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group
The groups are not distinguished by severity of need or type of problem. The middle designation of “thriving” is included to indicate the wider community needs of the population supported by the prevention and promotion initiatives.

**Coping** – This group would include children, young people and families adjusting to life circumstances with mild or temporary difficulties. Provision would be interventions to support resilience provided within an educational or community setting. Education would be likely to be the key provider but with input from the most experienced health staff, to provide decision making about how to help people in this group and to help determine whose needs can be met by this approach.

**Getting Help** – This group would include children, young people and families who would benefit from focused evidence based treatment with clear aims and criteria for assessing whether aims have been achieved. This would include children and young people who fell under the NICE guidance remit. The NHS would lead on provision bring in specialists in different treatments. At the outset an explicit agreement would be made of what a successful outcome looked like, a timeframe for achievement and what would happen if this was not achieved.

**Getting More Help** - This group would include children, young people and families who would benefit from extensive long term or intensive treatment, which may include inpatient care and outpatient provision. Young people with psychosis, eating disorders and emerging personality disorders are likely to require significant input. This provision will be health led with input from specialised health workers for different treatments.

**Getting risk support** - This group would include children, young people and families who are currently unable to benefit from evidence based treatment but remain a significant concern and risk. This group may routinely have crises but are not able to make use of help offered, or where it has been offered it has not made a difference. These people may self-harm or have emerging personality disorders or ongoing issues that have not yet responded to treatment. This group will require significant input. Services will need to collaborate closely and be clear who the lead is. This may often be social care. Health input should be from staff trained to work with this group and skilled in shared thinking with colleagues in social care but with explicit understanding that it is not a health treatment that is being offered.

**Thriving** – Services should aim to help everyone thrive by helping with prevention, promotion and awareness raising work in the community, including consultation and training.

One of the main areas of weakness in the current four tier model is the period of Transition from child to adult mental health services when a young person reaches 18 years. This can be a time when young people fall out of engagement with services due to lack of joined up care pathways, lack of flexibility and young people not meeting thresholds for adult services. The Joint Commissioning Panel for Mental Health 2012[^96] investigated what a good Transition would look like from child to adult mental health services. It stated that there is no prescribed best practice model to meet the needs of young people in Transition and that services need to relate to local need and circumstances. It recommends three main service models either working singly or in combination:

- A designated standalone transition service e.g. The Wirral 16-19 Transition Service
• A designated Transitions team within an existing Adult Mental Health Service or CAMHS e.g. Northamptonshire Dedicated Transitions Service Team (For 15-18 years with developmental conditions)
• Designated staff trained in working with young people seconded to Adult Mental Health Services e.g. Leeds CAMHS service

The National Institute for Health Care Excellence (NICE) provides guidelines on effective interventions for managing emotional and behavioural issues and mental health problems in relation to children and young people. Current guidance and quality standards are shown in Table 10.

Table 10: NICE guidelines and quality standards

<table>
<thead>
<tr>
<th>NICE guidelines</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG158 Antisocial behaviour and conduct disorders in children and young people:</td>
<td>2013</td>
</tr>
<tr>
<td>recognition and management</td>
<td></td>
</tr>
<tr>
<td>CG72 Attention deficit hyperactivity disorder: diagnosis and management (update</td>
<td>2008</td>
</tr>
<tr>
<td>due Feb 2018</td>
<td></td>
</tr>
<tr>
<td>CG28 Depression in children and young people: identification and management</td>
<td>2005</td>
</tr>
<tr>
<td>CG155 Psychosis and schizophrenia in children and young people: recognition and</td>
<td>2016</td>
</tr>
<tr>
<td>management</td>
<td></td>
</tr>
<tr>
<td>PH20 Social and emotional wellbeing in secondary education</td>
<td>2009</td>
</tr>
<tr>
<td>PH40 Social and emotional wellbeing: early years</td>
<td>2012</td>
</tr>
<tr>
<td>PH12 Social and emotional wellbeing in primary education</td>
<td>2008</td>
</tr>
<tr>
<td>NG43 Transition from children’s to adults’ services for young people using health</td>
<td>2016</td>
</tr>
<tr>
<td>or social care</td>
<td></td>
</tr>
<tr>
<td>NG6 Eating disorders: recognition and treatment</td>
<td>2017</td>
</tr>
<tr>
<td>NG7 Child abuse and neglect</td>
<td>2017</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NICE Quality Standards</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS115 Antenatal and postnatal mental health</td>
<td>2016</td>
</tr>
<tr>
<td>QS59 Antisocial behaviour and conduct disorders in children and young people</td>
<td>2014</td>
</tr>
<tr>
<td>QS133 Attachment difficulties in children and young people</td>
<td>2016</td>
</tr>
<tr>
<td>QS39 Attention deficit hyperactivity disorder</td>
<td>2013</td>
</tr>
<tr>
<td>QS48 Depression</td>
<td>2013</td>
</tr>
<tr>
<td>QS102 Bipolar, Psychosis and Schizophrenia</td>
<td>2015</td>
</tr>
<tr>
<td>QS34 Self-harm</td>
<td>2013</td>
</tr>
<tr>
<td>QS128 Early years: promoting health and wellbeing in under 5s</td>
<td>2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NICE Pathways - mapping guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial behaviour and conduct disorders in children and young people</td>
</tr>
<tr>
<td>Attachment difficulties in children and young people</td>
</tr>
<tr>
<td>Attention deficit hyperactivity disorder</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
</tr>
<tr>
<td>Child abuse and neglect</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Eating disorders</td>
</tr>
<tr>
<td>Looked-after babies, children and young people</td>
</tr>
<tr>
<td>Postnatal care</td>
</tr>
<tr>
<td>Psychosis and schizophrenia</td>
</tr>
<tr>
<td>Social and emotional wellbeing for children and young people</td>
</tr>
<tr>
<td>Transition from children’s to adults’ services</td>
</tr>
</tbody>
</table>

Accessed from NICE website 7 December 2017
5.2 Service remodelling – Halton’s vision for mental health services

The ambition for Halton is to ‘wrap’ the care around the child in the most appropriate setting, and to maintain young people in education or an environment that best meets their needs.

The key objectives that will underpin our ambition are:

- Improve the mental health of the young people in Halton through prevention and early detection
- Increase early detection and intervention of mental health issues leading to an improved mental wellbeing for the population
- Improve outcomes through high quality accessible services
- Broaden the approach to tackle wider social determinants and consequences of mental health in young people, their families and their communities
- Optimise value for money by developing quality services with measurable outcomes that demonstrates a shift to a more positive mental wellbeing culture in the borough

We are aiming to build upon our existing Emotional Health and Wellbeing Plan by:

- Embracing the aspirations set out in ‘Future in Mind’
- Building capability and capacity in universal and targeted services to recognise emotional and wellbeing issues in our young people
- Equipping staff to deal with the low level issues and know when to refer to more specialist services

The local offer for young people in Halton will be a blended model with access to a range of services; schools and universal services feeling equipped to deal with the low to moderate emotional wellbeing issues, receiving training, support and supervision to feel confident to manage young people safely and have speedy access to more specialist services when required. Young people tell us that they want their schools/colleges to be better equipped to deal with the issues that they are facing and that they can talk to a professional who understands their situation and is empathetic to their needs.
6. Impacts of mental illness

The costs incurred to the public purse of not preventing, identifying and treating emotional health needs in children and young people early are considerable and result in an increased cost to the public purse and to wider society.

For example:

- A study[^97] estimated additional lifetime costs of around £260,000 per case – or around £5.3bn for a single cohort of children in the UK. These costs include those relating to crime (71%), mental health disorders in adulthood (13%) and differences in lifetime earnings (7%).

- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.[^98]

- The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.

- In 2012/13, it was estimated the total NHS expenditure on dedicated children’s mental health services was £0.70bn.

The impact of mental health disorders extends beyond the use of public services and incorporates the impact of antisocial behaviour and crime on communities etc. Taking this wider societal viewpoint, it has been estimated that the overall lifetime costs associated with a moderate behavioural problem amount to £85,000 per child and with a severe behavioural problem £260,000 per child[^99]. For certain young people with very individualized needs this can cost significantly more.

Caring for a child or young person with mental health issues has a negative impact on the physical and mental health of the carer. Carers save the public purse a significant amount of money. Whilst there is no information on carers of children and young people, Carers UK have shown that carers save the UK economy £132 billion per year and the damaging effect caring has on health[^1]:

7. User views

The importance of children's social and emotional wellbeing is being increasingly emphasised. In particular, there is a need to support the social and emotional wellbeing of the wider population of children and young people.

National information\(^{100}\) shows that children and young people want:

- To grow up confident and resilient
- To know how to find help easily
- Choice about where to get advice and support
- To have the opportunity to shape the services they receive
- To only tell their story once
- Not have to wait until they are unwell to get help

In order to develop a model that fits locally, a Thrive Joint Steering Group has been established. It holds overall accountability for the implementation of the new approach to delivering children and young people’s mental health and wellbeing services.

Halton and Warrington jointly facilitated a one off task and Finish Workshop in December 2016 with all key local stakeholders who worked closely with children and young people including; CAMHS, 3\(^{rd}\) Sector, Schools, School Nurses, Education and Social Care. The group were asked to start to think about how each of the 4 clusters may look, in line with the Thrive principles, based on their knowledge and expertise. The main occurring theme was the idea of a community hub/drop in centre for children and young people to access advice and information and one-two-one support if required. The feedback from this task and finish group was then collated and scribed into a visual artistic poster that was used as part of our engagement work with children and young people.

Figure 10: Draft Thrive Model designed by the Task and Finish Group
The engagement of the draft thrive model took place between 14 March and 4 July 2017 and a variety of methods were used for working with professionals, children and young people and parents and carers, to best suit their needs. This included an online survey, development of I statements and focus groups/events. A competition also took place to rename CAMHS. All audiences were shown the draft model that was developed by the stakeholder task and finish group and asked to share their views. They were also asked to complete a survey about the service provision of the new ‘Getting Advice Hubs’ and to choose the ‘I’ Statements that they felt were most important to them.

**Getting Advice Hubs Service Provision**

- Children and young people overall preferred to receive face to face and online support when accessing the hubs
- Information to also be accessible on mobile apps for busy people
- A variety of professionals to be available to offer support and signposting
- Children and young people would benefit more from a number of different venues in both Widnes and Runcorn to ensure a larger number of children and young people had access to support
- Support to be offered in schools during school hours
- Hours of provision to run in the evenings after school and Saturdays in the afternoon as children and young people like to have a lie in. It was felt on Sundays that the hubs would not be used as much.
- Hubs to be available on both sides of the Bridge, especially given that the toll will soon be in place.
- Promote the hubs through social media such as facebook and twitter, and various other routes to reach as many children and young people together with their families as possible. It was felt crucial to get the marketing right.

**‘I’ Statements**

The largest proportion of children and young people found the following ‘I’ Statements were most important to them:

- I will be given a choice of where and when I will be seen, who will see me, and what care I will receive. If this cannot happen I will be told why.
- I will be supported to carry on with my studies.
- I understand what my need is and why I need help.
- I will be supported and helped to speak up when I feel things are not working out.
- I will be involved in planning what care I receive and how it is provided to me.
- I will be supported to carry on doing the things that are important to me (seeing friends, playing hobbies, following my hobbies).

**Draft Thrive Model**

- Ensure vulnerable groups are supported equally and are able to access advice easily
- Less standardised approach to support for children and young people
- Consistency of staff and to see the same person throughout, where possible, in order to build a relationship and create stability
- Consider the use of a fidget cube for anxious children and young people

**Key Recommendations**

- To choose various locations across both Widnes and Runcorn for the establishment of the getting advice hubs, enabling more children and young people to access support
• Getting advice hubs to be accessible during evenings and weekends
• Ensure a suitable staffing structure is agreed and managed across the whole system so that children and young people receive the level of care and confidentiality they require
• Carefully consider the approach for the marketing and promotion of Thrive, in particular the getting advice hubs, as this is crucial to its success
• Development of an online directory of local services for children and young people Emotional Health and Wellbeing Support, which will be accessible in the getting advice hubs
• All vulnerable groups to be offered the same level of care and to be able to access advice and information easily
8. Projected levels of need

Population projections have an essential role in assessing the future need for services for children and young people in the borough. Data from ONS\(^1\) indicates:

- The resident population is projected to increase to 131,300 by 2039, a 3.5% increase compared to 2016; an increase of 4,200 people from 2016.
- The 0-19 population is predicted to reduce by 3.9% (1,204 more children and young people) between 2016 and 2024.
- There are only minor increases expected in two children and young people age groups; 15-19 year olds is expected to increase by 3.2% (or 233 in real terms) 10-14 year olds is expected to increase by 0.6% (or 49 in real terms). The 20-24 age group is projected to decrease by 6.9% (507 people).
- The number of births per year in Halton is projected to be approximately between 1,400 and 1,500 per year between 2016 to 2039.\(^2\)

### Table 11: Predicted population change in the 0-24 age groups 2016 to 2039

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2016*</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>2035</th>
<th>2039</th>
<th>% change 2016-2039</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>7,900</td>
<td>7,500</td>
<td>7,500</td>
<td>7,300</td>
<td>7,300</td>
<td>7,300</td>
<td>-7.6%</td>
</tr>
<tr>
<td>5-9</td>
<td>8,386</td>
<td>8,200</td>
<td>8,800</td>
<td>7,700</td>
<td>7,500</td>
<td>7,500</td>
<td>-10.6%</td>
</tr>
<tr>
<td>10-14</td>
<td>7,551</td>
<td>8,400</td>
<td>8,200</td>
<td>7,900</td>
<td>7,800</td>
<td>7,600</td>
<td>0.6%</td>
</tr>
<tr>
<td>15-19</td>
<td>7,267</td>
<td>6,900</td>
<td>8,000</td>
<td>7,800</td>
<td>7,600</td>
<td>7,500</td>
<td>3.2%</td>
</tr>
<tr>
<td>20-24</td>
<td>7,307</td>
<td>6,500</td>
<td>6,200</td>
<td>7,100</td>
<td>7,100</td>
<td>6,800</td>
<td>-6.9%</td>
</tr>
</tbody>
</table>

*Source: ONS 2014 projections except 2015 - mid-year estimate*

The make-up of various vulnerable groups identified as at higher risk of emotional and mental health problems is also changing. The number of young carers has risen sharply between the 2001 and 2011 censuses. The number of Children in Need and number of children subject to Child Protection Plans have risen in recent years but the number of children in care has remained stable. The number of young offenders has decreased in the last few years but this may reflect that they are being kept out of the youth justice system rather than being at lower risk. Nationally, there have recently been rises in the number of homeless families and in those placed.

If current trends continue there will be less young people requiring hospital admissions for reasons connected to alcohol but more because of self-harm. However, the data these trends are based on is fairly short-term and subject to service and coding influences and therefore may not accurately reflect underlying need.

The arrival of the digital age poses new threats to children and young people’s mental health or at least new manifestations of existing threats. Violent video games, the sharing of indecent images on mobile phones, cyber-bullying and websites advocating anorexia and self-harm all pose a danger to the mental wellbeing of children and young people, according to a Commons health select committee report.\(^3\) However, the internet can also be a valuable source of support for children and young people with mental health problems.

National trends include a drive to reduce the number of hospital admissions and provide more care closer to home in the community; promote parity of esteem between mental and physical health
and ensure the personalisation of services to ensure that the service meets the needs of the patient. This last issue was highlighted as a key priority by the children and young people’s consultation. The government has pledged to improve waiting times particularly for Early Intervention in Psychosis and also eating disorders.

Whilst there has been a national commitment to increased funding for CAMHS, local budgets continue to be strained and there is a need to make significant savings locally over the next five years, within both the local authority and NHS funding. A reduction in support services in one part of the health and care system may therefore increase demand in another part if underlying level of need remains the same or especially if it increases. The impact of this on service access will need to be considered carefully to ensure that needs continue to be met. Budget constraints and national policy are likely to result in increased joint working between the CCG and HBC in order to plan and deliver services in a more efficient manner.
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