

Bristol JSNA Chapter 2017-18

Children and Young People Emotional and Mental Health and Wellbeing

Chapter information

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Executive summary

Introduction

This Joint Strategic Needs Assessment (JSNA) chapter considers the mental health and emotional wellbeing of children and young people aged 0 – 17 and the risks factors for developing mental health and poor emotional wellbeing. The JSNA also considers the mental health and wellbeing of perinatal women, given the strong links to children’s wellbeing.

1 in 10 children aged 5 – 15 have a diagnosable mental health problem and this rises to 1 in 5 for young people aged 16 and 17. The term “mental health” is used to describe a spectrum, from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health. The World Health Organisation (WHO) definition of mental health is a “state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”. (WHO, 1948) This definition focuses on positive health, rather than illness.

Emotional wellbeing has no single agreed definition. This needs assessment uses the Mental Health Foundation’s definition of emotional wellbeing: “A positive sense of wellbeing which enables an individual to be able to function in society and meet the demands of everyday life.” (Mental Health Foundation, 2015) Mental health problems cover a large range of different conditions from short term difficulties in coping with day to day to severe and enduring illness. Common mental health problems in children and young people include: conduct disorder, depression, eating disorders, anxiety disorders and hyperkinetic disorders. At the more severe end of the spectrum are mental disorders, also called a mental illness or psychiatric disorders, which is a diagnosis by a mental health professional of a behavioural or mental pattern that may cause suffering or a poor ability to function in life. Such features may be persistent, relapsing and remitting, or occur as a single episode.

Mental ill-health impacts upon the people themselves, their families, friends and communities. Good mental health is vital for children and young people to develop the resilience they need to face life as adults and to grow, learn and achieve throughout childhood and adolescence.

The risk of developing a mental health problem increases if a person is looked after by a local authority, a young offender, has a disability or long term condition, is a young carer or has a parent who uses substances. Children who are well-attached to their care-givers, have a stable home life, attend school regularly and are engaged in meaningful activities have a reduced risk of developing mental health problems.

In Bristol it is estimated that at least **2500** children aged 2-5, **5100** children aged 5 – 16 and **1700** 16 and 17 year olds have a diagnosable mental health problem. A further **1000** women will develop mild to moderate depression in the perinatal period.

There are also children and young people in Bristol who do not have a diagnosable mental health problem yet do not have a good emotional health. This could be described as not flourishing or thriving and struggling to cope with the everyday stresses and strains of life. This, in itself is a problem, but it also puts them at risk of developing further mental health problems. The Public Health England survey “What About YOUth?” reported that in Bristol 55% of children had been bullied, 16.5% reported low life satisfaction and 47.3% regarded themselves to be the right size. (PHE, 2015)

Young people’s mental health and emotional wellbeing has risen up the political agenda in recent times. The Government published *Future in Mind* (DH, 2015) and the *5 Year Forward View for Mental Health* (DH,

2016) which made a series of recommendations including a requirement for local areas to produce an annual transformation plan with the aim of prioritising areas for action and reducing waiting times. In Bristol, young people's mental health and wellbeing has been identified as a priority for the Mayor, the Children and Families Partnership Board and by the Health and Wellbeing Board. The Clinical Commissioning Group and Local Authority have recently recommissioned the CAMHS service and are continuing to develop mental health services for children and young people.

Public health, within the local authority, also provides preventative services for children and young people; producing resources for women in pregnancy, supporting the Bristol Standard for Health in early years and the Healthy Schools programme which have specific elements for mental health and wellbeing. There has been lots of activity in building capacity throughout the system through training and support for professionals working with children and families.

Key issues and gaps (summary of section 8)

Key Issues

The responsibility of commissioners, service providers of all types, the council and NHS together is to help children and young people facing risks to their mental health. This must be both a whole systems and a life course approach.

There are high levels of risk factors for poor mental health in Bristol and it is vital that services reach out to young people affected by these risk factors early on and in partnership with the important people in a young person's life. The evidence points to the effectiveness of supporting parents as early as possible, even before birth. Through the life course there are opportunities to intervene with children and their carers, through their contact with children's centres, schools and further education as well as the other services that may be involved in a child's life.

However, to be truly preventative, it is all of our responsibilities to think about those risk factors and how we can work to reduce them. Child poverty, on the rise in Bristol and across the country, and its associated problems with unemployment, poor housing and family stress put children at risk of developing poor emotional wellbeing and mental illness and this places children under real jeopardy. This needs a assessment needs to be read outside of the usual children and mental health stakeholders and widely considered as a call to action. Preventing the risk factors will reduce the burden of mental health problems, rather than merely mitigating the damage that has already been done.

Gaps

Strategic

There is currently no all-age mental health and emotional wellbeing strategy.

Wellbeing

There is more that can be done to work collaboratively to promote wellbeing in the city. Adopting a mental health in all policies approach to all work with children and young people will enable wellbeing to achieve a higher profile and ensure that wellbeing is put at the heart of the work that is done with children and young people.

There is evidence that an approach such as the 5 ways to wellbeing (adapted for young people) is effective in promoting resilience in young people. This does not appear to be widely adopted by agencies

working with children and young people. This could be promoted by people working with children and parents should be given information on how to work with their children to promote mental wellbeing.

The offer of support made to schools and children's centres is not routinely offered to other services that may be able to also promote children's mental health and wellbeing, and that of their families. These other services include the voluntary sector and organisations such as faith groups, youth clubs, sports and arts clubs and any group which works with children and young people, regardless of their funding source.

Risk Groups

Preventing the risk factors occurring is to look at poverty, stigma, racism, homophobia and gender inequalities. It is to think about the culture and society we live in, the opportunities that each young person has, the environment in which they grow and to think creatively about the way that the City Council, with its partners, can address these problems. This must be addressed within any strategic approach to mental health and emotional wellbeing.

The Adverse Childhood Experiences (ACEs) work shows that ACEs are common in childhood and are a major predictor of future mental health problems. This model could be applied, possibly in partnership with the Early Help Team/Think Family service to identify young people who perhaps do not reach the threshold for a referral from the Think Family service and offer them targeted support. This is particularly important for children who do not obviously display behavioural problems and may be under the radar of other services.

Parenting

Bristol City Council offers a range of parenting courses, some general and some more targeted. There are also other parenting programmes being delivered by other groups such as churches. Whilst some parents do attend parenting courses most parents do not. We do not know how many parents would like to attend parenting courses, what kind of support they would like or need or what are the barriers to attending. It would be useful to understand the situation in Bristol in more depth and understand how we can ensure that we are making the best use of resources.

Services

About 70% of the estimated number of children with a diagnosable mental health problem do not access services. For many, this may be entirely appropriate but we also need to understand who does not access services and ensure that they are adequately supported.

Services for children aged 5-11 are variable with some schools buying in counselling services while other children struggle to access them. Children should have access to the same and appropriate level of support regardless of what school they attend.

There is no crisis service for young people over the weekend. Whilst children who self-harm are admitted, the lack of a weekend crisis team means that children and young people who do not self-harm have no access to emergency out of hours care. Children admitted for self-harm at a weekend are deemed serious enough for an admission but not for any specialist crisis intervention. This leaves children unsupported in a crisis if the crisis occurs out of hours.

There is a great deal of activity in Bristol for children and young people in both the voluntary as well as statutory sector. It can be difficult for parents and young people to find out what services they can access and what is the most suitable. Now a searchable directory has been developed it should be extensively promoted, made widely available and kept up to date.

Recommendations (summary of section 10)

The main recommendations are:

General

There should be an all-age mental health and emotional wellbeing strategy/programme that should be co-designed with all the stakeholders, including young people, children, parents, carers, and professionals. It must take into account the views and needs of multiple stakeholders and ensure that it delivers an all-age strategic vision for Bristol which has the active participation of Bristol's citizens. The strategy needs political leadership from leaders across the system in Bristol and must work to address inequality as one of the drivers of poor mental wellbeing.

Wellbeing

Mental health and emotional wellbeing should be considered in all policies in the local authority and Clinical Commissioning Group (CCG).

Whole Setting Approach

The whole setting approach of both the Healthy Schools programme and the Bristol Standard in early years is the key delivery mechanism of mental health promotion and prevention. This approach should be widely promoted and settings that have not previously engaged should be strongly encouraged to.

Risk Groups

Influence across the local authority and CCG the policies which can affect the wider determinants such as child poverty, poor housing, and unemployment. The whole system should consider the impact of its policies and actions on the mental and emotional health and wellbeing of children.

Prioritise areas for action where Bristol has a high level of risk factors (for e.g. 1st time entrants to the youth justice system)

Consider commissioning some resilience promotion for identified young people such as the programmes run by Young Minds. Consider using the ACE framework to target those at the greatest risk.

Parenting and family support

Ensure that parents are able to take up the offer of attending parenting support through a review of the provision and work with parents to identify barriers to accessing support and ensure that the offer meets the needs of parents in Bristol, especially those in most need. Parenting and family support also needs to help parents with their relationship with each other (whether together or not) as this may be a driver for anxiety in children and young people.

Services

Continue to develop whole school approach to address the variation in provision for primary school children as recommended by NICE

Support schools by ensuring that they know what interventions have an evidence base for effectiveness.

Develop a crisis service for weekends so young people have access to interventions when they need them.

Accessibility

Ensure all places/professionals have access to an up to date searchable directory of mental health services for young people.

JSNA chapter report

A: What do we know?

1) Who is at risk and why?

There is not a single, direct cause of mental health problems in children and young people; it is more helpful to think about a range of risk factors which can increase an individual's chances of developing a mental health problem. There are also a range of protective factors which can help build resilience and prevent mental health problems developing. The presence of risk factors does not guarantee the development of mental health problems but increases the risk. (Hobcraft & Kiernan, 2014)

The risk factors for developing mental health problems are interrelated. Children whose parents misuse drugs and alcohol are also more likely to be living in poverty and poor housing, are more likely than other children to be in care and are more likely to have parents with poor mental health. So whilst risk factors can be listed, the lived experience of children and young people will show that they are connected. In the same way protective factors are interlinked. Children who are well attached to their care givers, live in stable environments, are also likely to go on and do well at school and the protective factors begin to stack up and reinforce one another.

Risk factors are listed here but they must be considered as the whole lived experience of a child and how we respond to these risk factors will be to build up the protective factors, acknowledging that they are very much a by-product of the direct environment a child is raised in.

Risk Factors

- Looked after children
- Unaccompanied asylum seekers
- Young Offenders
- Gypsy and Travellers
- Young Carers
- Young People Not in Education, Employment or Training (NEETS)
- Children and young people with a long term illness and physical or learning disability
- Children with SEND
- Teenage parents
- Children exposed to inter-parental conflict
- Domestic Violence
- Child abuse/neglect
- Parental substance misuse

Protective factors (JCPMH, 2013)

- Good Attachment to care givers
- Genetic and early environmental factors
- Socioeconomic factors including higher income and socio-economic status
- Living environment
- Good general health
- Education
- Employment including autonomy, support, security and control in an individual's job
- Activities such as socialising, working towards goals, exercising and engaging in meaningful activities
- Social engagement and strong personal, social and community networks
- Altruism (doing things for others)

- Emotional and social literacy life skills, social competencies and attributes such as communication skills, cognitive capacity, problem-solving, relationship and coping skills, resilience and sense of control
- Spirituality is associated with improved well-being, self-esteem, personal development and control
- Positive self-esteem
- Values
- Resilience

Wellbeing of Children and Young People

Public Health England conducted a survey, What about YOUth with 15 year olds in 2014. (PHE, 2015) This survey found that:

- 52.4% regarded themselves as the right size
- 13.7% reported low-life satisfaction
- 63.1% were bullied in the past couple of months
- 10.1% had bullied others in the last couple of months

National prevalence of mental health problems

Perinatal mental health

NB: For a fuller explanation please see a future JSNA chapter on perinatal mental health, which will be published [here](#).

Perinatal mental health problems are those which occur either during pregnancy or in the year following childbirth. The following table shows the rates of mental health problems nationally, per thousand pregnancies. It shows that severe mental health problems are relatively rare but at least 10% of pregnancies result in an episode of mild-moderate depression and up to 30% of women suffer from adjustment disorders and distress. (Royal College of Psychiatrists, 2015)

Table 1: Rates of perinatal psychiatric disorder per thousand maternities

| Illness | Rate |
|---|--------------|
| Postpartum psychosis | 2/1000 |
| Chronic serious mental illness | 2/1000 |
| Severe depressive illness | 30/1000 |
| Mild-moderate depressive illness and anxiety states | 100-150/1000 |
| Post-traumatic stress disorder | 30/1000 |
| Adjustment disorders and distress | 150-300/1000 |

Source: Joint Commissioning Panel for Mental Health (JCPMH, 2013)

Pre-School Children

Few studies have been carried out to assess the prevalence of mental health problems among pre-school children. Currently there are no large UK studies. There are also a number of recognised challenges in assessing the prevalence of mental health problems among pre-school children. In particular, between the ages of 0 and 5, children undergo rapid developmental changes which makes it difficult to distinguish normal from abnormal emotions or behaviour. This leads to a debate about the appropriateness of traditional diagnostic categories for this age group. (Gardener & Shaw, 2016) The estimates of prevalence discussed below therefore need to be treated with some caution.

In order to make an estimate of the number of preschool children who may have a mental health problem,

the evidence is drawn from the literature as well as what we know the prevalence is in school age children. It is reasonable to estimate that prevalence in younger children will not exceed the prevalence in school age children. We can therefore make an estimate that 10% of children under 5 may have a mental health problem.

School-Aged Children

In 1999 the Office of National Statistics (ONS) carried out a large survey of 10,500 children and young people aged 5-15 years old living in private households, which was repeated in 2004. These surveys provide the most robust and comprehensive data on the prevalence of mental disorders among children in the UK. It is currently being updated and a new report is expected to be published in 2018

The key findings were:

- 1 in 10 children had a diagnosable mental disorder associated with distress and interference with personal functions such as social and family relationships.
- 4% of children had an emotional disorder such as anxiety or depression.
- 2% had a hyperkinetic disorder.
- 1% had a less common disorder (e.g. autism, tics, eating disorders).
- 6% had a conduct disorder
- 2% had more than one type of disorder.
- More boys than girls had a diagnosable mental disorder.
- Mental disorders were more common among children aged 11-15 than children aged 5-10.

Young People Aged 16 and 17

The Survey of Psychiatric Morbidity Among Adults Living in Private Households was updated in 2014 included people aged 16-74 living in Great Britain. (National Centre for Social Research, 2014) This survey estimates the prevalence of mental health disorders for 16–24 year olds.

10% of men aged 16–24 (the age group reported on in the survey) and 28% of women reported having symptoms of a common mental disorder in the previous week. The table below shows the prevalence by gender of a range of disorders.

Table 2: Estimated number of 16 and 17 year olds in Bristol with Common Mental Disorders by gender, 2016 population estimate

| | Men | Women | Persons |
|--------------------------------------|-----|-------|---------|
| Generalised anxiety disorder | 175 | 394 | 569 |
| Depressive episode | 41 | 166 | 207 |
| Phobias | 60 | 237 | 297 |
| Obsessive compulsive disorder | 55 | 105 | 160 |
| Panic disorder | 18 | 96 | 114 |
| CMD-NOS* | 258 | 495 | 753 |
| Any CMD** | 460 | 1235 | 1695 |

* Common Mental Disorders – Not Otherwise Specified

** Common Mental Disorder

Source: Adult Psychiatric Survey applied to Bristol mid-year population estimates. (National Centre for Social Research, 2014)

2) What is the size of the issue in Bristol?

Demographic information about Bristol

The latest estimate of the total number of people living in Bristol (2015 mid-year population estimate) is 449,328. Bristol has 83,751 children under 16 (18.6% of the population). The current estimate of children under 18 is 91,859 and for children 5-16 years old is 56,316.

Table 3: Mid-2015 Population estimates by age and sex for Bristol

| | Males | Females | Total |
|----------------|--------|---------|--------|
| 0-4 | 15,701 | 15,086 | 30,787 |
| 5-10 | 16,128 | 15,533 | 31,661 |
| 11-15 | 10,771 | 10,532 | 21,303 |
| 16 - 17 | 4,600 | 4,383 | 8,983 |
| Total | 53,857 | 52,292 | 92,734 |

Source ONS Mid-year population estimates 2015

High Risk groups

Some groups of people reported higher levels of mental health problems and have reported poor mental and emotional wellbeing.

Table 4 Selected Risk factors and numbers/rates in Bristol

| Risk Factor/Group | Source of data | Number in Bristol | Rate |
|---|--|--|------------------|
| Looked after Children | Public Health Outcomes Framework, March 2017 | 700 | 76.2 per 100,000 |
| Unaccompanied asylum seekers | ONS Children looked after in England Including Adoption 2015-to-2016 (ONS, 2016) | 30 | N/A |
| Young Offenders – 1st time entrants to the criminal justice system | Fingertips indicators: 'First time entrants to the youth justice system' & Children in the youth justice system: rate per 1,000 aged 10-18 (PHE, 2017) | 235 | 675 per 100,000 |
| Gypsies, Travellers and Roma | Fingertips indicator: "Traveller children: % school children who are Gypsy/Roma" (PHE, 2017) | 500 | |
| Young Carers | ONS 2011 Census | 860 under 16 year olds 2,7000 16 – 24 year olds | |
| Young People 16 and 17 not in Education, Employment and Training | PHE Fingertips 2016 (PHE, 2015) | 690 | 5.8% |

| | | | |
|---|--|---|------------------------------------|
| Children and young people with a physical or learning disability | <i>PHE Fingertips</i> (PHE, 2017) | 4,441 | 1.7% |
| Children with SEND | School Census 2016 (Dep of Education, 2016) | 8,800 | 15.2% of pupils |
| Teenage Parents aged 17 and under | Office for National Statistics (ONS) - 'Births by area of usual residence of mother, UK' (ONS, 2016) | 113 | 22 per 1000 teenage girls |
| Domestic Abuse | ONS, Domestic Abuse in England and Wales (ONS, 2016) | | 17.3 incidents per 1000 population |
| Parental Substance Misuse | PHE Fingertips (PHE, 2017) | 190 parents of young people in drug treatment and 66 in alcohol treatment | |

Protective Factors

There are a collection of factors which provide protection against developing mental health problems. For many of these we do not have data, for example, how many children are securely attached to a caregiver. The table below list some protective factors for which we have some data.

Table 5: Protective Factors and Performance in Bristol

| Protective factor | Source of data | Performance in Bristol |
|--------------------------------|---------------------------------------|---|
| Breastfeeding | PHE Child Health Profiles (PHE, 2017) | 82.2% of mothers use breastmilk as first food |
| School readiness | PHE Child Health Profiles (PHE, 2017) | 66.3% of children achieving a good level of development at the end of reception For children receiving free school meals this is 49.6% |
| GCSE achieved: 5 A* - C | PHE Child Health Profiles (PHE, 2017) | 54% of pupils attained 5 or more GCSEs A* - C |
| Unauthorised Absence | PHE Child Health Profiles (PHE, 2017) | 5.1% of school time missed by Bristol Pupils |

Emotional Wellbeing

The table below compares the wellbeing of young people in Bristol with the England average. For all indicators, Bristol is worse than the England average.

Table 6: PHE Wellbeing indicators for young people aged 15

| Indicator | Period | Bristol Value | England Average | Range |
|---|---------|---------------|-----------------|-------------|
| Percentage who think they are the right size | 2014/15 | 47.3% | 52.4 | 46.5-57.1 |
| Mean score of the 14 WEMWBS* statement | 2014/15 | 46.9% | 47.6 | 45.4 – 48.9 |
| Percentage reporting low life satisfaction | 2014/15 | 16.7% | 13.7 | 9.5 – 19.1 |
| Percentage who were bullied in the last couple of months | 2014/15 | 55.2% | 55 | 42.6 – 63.1 |
| Percentage who had bullied others in the last couple of months | 2014/15 | 12.6% | 10.1 | 5.5 – 14.1 |

*Warwick Edinburgh Mental Wellbeing Score

Source: PHE What About YOUth survey 2015 (PHE, 2015)

Local data is collected in the form of the Pupil Voice survey. The survey is done at years 4 and 6 in primary school and years 8 and 10 in secondary school. The survey is not a statistically representative sample so the results must be treated with caution. However, 3233 primary school pupils and 2301 secondary school pupils took part. In relation to emotional wellbeing:

In primary schools

- 79% of pupils responded that they worry about at least one of the issues listed a lot or quite a lot.
- 47% of pupils said they worried about family matters a lot or quite a lot.
- About 50% of pupils said they could speak to their parents about their worries
- 10% said there was no one they could talk to
- 60% of boys and 54% of girls said they had experienced at least one type of bullying in the previous month.

In secondary schools pupils reported

- 18% said they didn't enjoy any lessons at school
- 40% said they slept for less than 8 hours the night before
- 49% said they felt their views were never listened to
- 55% said they spent at least 3 hours looking at a screen
- 55% said they had experienced some bullying in the previous month

Incidence and Prevalence of Mental Health Problems.

Perinatal Mental Health

The table below shows the estimated numbers of women in Bristol with a various mental health problems based on national prevalence data.

Table 7: Estimates of numbers of women with mental health problems during pregnancy and after childbirth

| Condition | Number |
|---|--------|
| Estimated number of women with postpartum psychosis (2013/14) | 15 |
| Estimated number of women with chronic SMI *(2013/14) | 15 |
| Estimated number of women with severe depressive illness (2013/14) | 195 |
| Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate) (2013/14) | 650 |
| Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate) (2013/14) | 975 |
| Estimated number of women with PTSD*8 (2013/14) | 195 |
| Estimated number of women with adjustment disorders and distress (lower estimate) (2013/14) | 975 |
| Estimated number of women with adjustment disorders and distress (upper estimate) (2013/14) | 1,950 |

Source of deliveries Hospital Episode Statistics

Source of rates of illness – Joint commissioning panel for mental health (JCPMH, 2012)

* SMI is serious mental illness, illness characterised by its duration, level of disability it produces and can produce psychotic symptoms

** PTSD is Post Traumatic Stress Disorder, a mental health condition triggered by a traumatic event which

sometimes occurs following childbirth.

Early Years

It is difficult to get accurate estimates of mental health problems in children under 5. There are relatively little data about prevalence rates for mental health disorders in pre-school age children. The Report of the Children and Young People's Health Outcomes Forum (Children and Young People's Health Outcomes Forum, 2012) "recommends a new survey to support measurement of outcomes for children with mental health problems. In particular, we recommend a survey on a three-yearly basis to look at prevalence of mental health problems in children and young people. This could build on the work of the survey, 'Mental health of children and young people in Great Britain, 2004'." A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger & Angold, 2006). However, the paper reflects on the difficulty of measuring the mental health and well-being of children under 5. The survey data we have for school age children suggest that 1 in 10 children have a diagnosable mental health problem and there is no evidence to suggest that it would be twice this in the younger age group. It is important to remember that at this age, family interventions and risk factors are key and that thinking about strengthening parents' mental well-being and capacity to be well-attached is likely to have the biggest impact on children.

School Age children

In 2004 the Office of National Statistics conducted a survey of 7977 parents of 5-15 year olds living in England, Scotland and Wales. This is the best national estimate of mental health problems we have and the rates have been applied to the Bristol population and to estimate the number of people in Bristol with a diagnosable mental health problem.

Table 8: Estimated number of children in Bristol with mental health disorders, 2016

| Condition | 5 to 10 year Olds | | | 11 to 16 year olds | | | All children (5-16) | | |
|--|-------------------|------------|-------------|--------------------|-------------|-------------|---------------------|-------------|-------------|
| | Boys | Girls | All | Boys | Girls | All | Boys | Girls | All |
| Conduct disorders | 1113 | 434 | 1548 | 872 | 536 | 1408 | 1985 | 970 | 2955 |
| Emotional Disorders | 355 | 388 | 743 | 430 | 641 | 1071 | 785 | 1029 | 1814 |
| Hyperkinetic Disorders | 435 | 62 | 497 | 258 | 42 | 300 | 693 | 104 | 797 |
| Autistic Spectrum Disorders, eating disorders, tics, mutism | 306 | 16 | 322 | 108 | 53 | 161 | 414 | 69 | 483 |
| Anxiety Disorders | 339 | 373 | 712 | 388 | 547 | 935 | 727 | 920 | 1647 |
| Depression | 32 | 47 | 79 | 108 | 200 | 308 | 140 | 247 | 387 |
| Less Common mental health problems | 355 | 62 | 417 | 172 | 115 | 287 | 527 | 177 | 704 |
| Any mental health Problem | 1645 | 792 | 2437 | 1357 | 1083 | 2440 | 3066 | 2033 | 5099 |

Common Mental disorders in Young people aged 16 and 17

The Adult Psychiatric Morbidity Survey 2014 has the most recent estimates of the prevalence of mental health problems in adults from the age of 16.

Table 9: Estimated number of 16 and 17 year olds in Bristol with Common Mental Disorders by gender

| | Men | Women | Persons | |
|-------------------------------------|-----|-------|---------|-----|
| Generalised anxiety disorder | | 175 | 394 | 569 |
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| | | | |
|--------------------------------------|-----|------|------|
| Phobias | 60 | 237 | 297 |
| Obsessive compulsive disorder | 55 | 105 | 160 |
| Panic disorder | 18 | 96 | 114 |
| CMD-NOSb* | 258 | 495 | 753 |
| Any CMD* | 460 | 1235 | 1695 |

* Common Mental Disorders – Not Otherwise Specified
** Common Mental Disorder

3) What are the relevant national outcome frameworks indicators and how do we perform?

Public Health Outcomes Framework

The Public Health Outcomes Framework provides strategic direction and a range of indicators which Health and Wellbeing Boards can use to benchmark progress. The framework has 4 domains: improving the wider determinants of health; health improvement; health protection and health care and preventing premature mortality. Under the health improvement domain there are several indicators relating to subjective well being, although these are restricted to individuals aged 16 years and above and therefore provide only part of the overall picture.

PHE produce a series of profiles for children and young people’s mental health, listing a range of indicators for Identification of need, Protective factors, Primary prevention: Adversity, Primary prevention: Vulnerability and Finance. These indicators benchmark Bristol’s performance and population against the National average and provide comparisons to similar areas.

The full list of indicators can be found [here](#).

The specific PHOF outcomes which relate to children and young people’s mental health are:

School Readiness: The percentage of children achieving a good level of development at the end of reception
School readiness; the percentage of children with free school meal status achieving a good level of development at the end of reception

Pupil Absence

First Time entrants to the youth justice system

16-18 year olds not in education employment or training

Breastfeeding initiation

Breastfeeding prevalence at 6-8 week after birth

Under 18 conceptions

Average difficulties score for all looked after children aged 5 – 16 who have been in care for at least 12 months on March 3st

NHS Outcomes Framework

The NHS Outcomes framework sets out the framework and indicators that will be used to hold NHS England to account for improvements in health outcomes. The framework provides an overview of how the NHS is performing. The CCG Outcomes Indicator Set provides comparative information for CCGs, the Health and Wellbeing Board, local authorities, patients and the public about the quality of health services commissioned by the CCGs and provide useful information for identifying local priorities for quality improvements and to demonstrate progress that local systems are making on outcomes.

The full set can be found [here](#)

The specific outcomes related to children and young people's mental health are:

Breastfeeding Prevalence at 6 -8 weeks

Improving children and young people's experience of healthcare*
Delivering safe care to children in acute settings*

* No CCG measure at present

4) What is the evidence of what works (including cost effectiveness)?

Prevention

Prevention of mental ill health and poor emotional wellbeing predominantly works at three different levels:

Primary prevention - Stopping mental health problems from occurring in the first place.

Secondary prevention – Identifying the earliest signs that mental health is being undermined and ensuring early intervention is available to minimise progression into a more serious mental health problem.

Tertiary prevention - Working with people with established mental health problems to ensure the earliest path to sustainable recovery and to reduce the social, economic and health losses often resulting from living with a mental health problem.

The Mental Health Foundation suggests that an additional dimension should be built into this to allow for a progressive focus on those at highest risk: (Mental Health Foundation, 2015)

Universal: seeking to influence a whole population or groups within settings such as schools or colleges

Selective: seeking to reach individuals or subgroups based on known areas of generally higher risk, including those who may not be showing signs of developing a mental health problem but live in circumstances known to be at increased risk of poor mental health such as those with learning disabilities or LGBT people

Indicated: targeting people at the highest risk of mental health problems and potentially showing early indications such as children whose parents have a serious mental health problem.

It is important that professionals who work with children are alert to emerging difficulties and are able to respond early and in addition are listening closely to concerns raised by parents and those raised by the child.

Effective Interventions

Early Intervention and Diagnosis

Intervening early can reduce both the risk of the development of a disorder and the risk of persistence into adult life leading to improved outcomes and generating potential savings for services and society. In conduct disorders the potential savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct disorders and £75,000 for moderate conduct disorders. (Friedli & Parsonage, 2007)

Despite the clear need for early intervention, evidence suggests that 60-70% of young people are not offered evidenced based interventions at the earliest opportunity (Royal College of Psychs, 2017).

Maternal Health and the Early Years

The Chief Medical Officer's report *Our Children Deserve Better, 2012* includes a number of intervention programmes as identified by the Evidence2Success project for the NICE Public Health Intervention Advisory Committee on the social and emotional wellbeing of vulnerable children aged 0–5 years. (Chief Medical

Officer, 2012)

Recommended cost effective interventions fell into the following categories:

- Pre-school curriculum interventions to enhance children's readiness for school, in particular skills in language and literacy.
- Parenting group programmes to improve children's behaviour.
- Parent and child therapy programmes to improve children's relationships with their parents/carers.
- Health visiting programmes which visit families at home to improve children's relationships with their parents/carers

Intensive child and family support programmes to improve behaviour and children's relationships with their parents/carers.

Parenting Support

Parenting education is an important intervention for the promotion of mental health in children. The parent or caregiver/child relationship is vital to a child's development and future psychological wellbeing. (Caestecker & Killoran-Ross, 2010)

The Healthy Child Programme led by the health visiting service is an evidence based programme that includes information and guidance to support parenting as part of its universal component.

There are many evidence based targeted parenting programmes such as Triple P, Incredible Yearsⁱ and Family Links. In an Australian trial the Triple P Programme was reported to demonstrate a 22% reduction in mental health problems in children and a 22% reduction in emotional distress in parents in less than three years (Saunders, et al., 2005).

School Based Programmes

Schools have an important role to play in enabling our young people to grow into functional adults; part of this is through promoting mental health and wellbeing.

Effective school based programmes should be implemented consistently, over a long period of time, with sustained investment and should:

- Start early – the most effective programmes are those targeting the youngest children.
- Adopt a whole school approach where mental health work is integrated across a whole range of school activity, including the curriculum.
- Include explicit work on the development of mental health skills in students, staff and sometimes parents.
- The effectiveness and implementation of mental health interventions for primary school aged children

A variety of effective, evidence-based mental health interventions exist for primary school aged children, most commonly these are either parenting programmes or school-based approaches

Whole school approaches are widely recommended, but are more difficult to evaluate, so literature largely concentrates on assessing the effectiveness of particular programmes or programme types

As many children with mild/moderate mental health issues will not be formally diagnosed, universally delivered interventions provide a way of reaching more children who can benefit from them, however it may be important to combine these with targeted services.

There is good evidence of effectiveness e.g. for cognitive behavioural therapy for anxiety, parenting programmes for conduct disorders, and many specific manualised programmes such as triple P parenting programme and incredible years. These programmes can be purchased and practitioners trained to deliver the programmes in their communities.

Summary of NICE Guidance for Mental Health and Emotional Wellbeing Programmes for Children and Young

People

Social and emotional wellbeing: Early Years (PH40) (NICE, 2012)

A complex range of factors have an impact on social and emotional development, and knowledge of these factors may help encourage investment at a population level in early interventions to support health and wellbeing. This would ensure children (and families) who are most likely to experience the poorest outcomes get the help they need early on in their lives.

The recommendations:

- Adopt a 'life course perspective', recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing.
- Focus on the social and emotional wellbeing of vulnerable children as the foundation for their healthy development and to offset the risks relating to disadvantage. This is in line with the overarching goal of children's services, that is, to ensure all children have the best start in life.
- Aim to ensure universal, as well as more targeted services, provide the additional support all vulnerable children need to ensure their mental and physical health and wellbeing. (Key services include maternity, child health, social care, early education and family welfare.)
- The recommendations should be used in conjunction with local child safeguarding policies.

Social and emotional wellbeing: Primary Education (PH12) (NICE, 2008)

This public health guidance provides a framework for primary schools. It promotes the whole school approach and recognises that emotional health and wellbeing underpins children physical and mental health and is the basis for educational achievement and provides protection from social harms.

Below is summarised some of the key specific recommendations

- Develop and agree arrangements as part of the 'Children and young people's plan' (and joint commissioning activities) to ensure all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing.
- Provide a comprehensive programme to help develop children's social and emotional skills and wellbeing.
- Training and development to ensure teachers and practitioners have the knowledge, understanding and skills to deliver this curriculum effectively.
- Support to help parents or carers develop their parenting skills.
- Ensure teachers and practitioners are trained to identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary school children.

Social and emotional wellbeing in secondary education (PH20) (NICE, 2009)

This guidance focusses on helping and supporting secondary schools meet their duties in relation to PSHE. It recognises that emotional wellbeing is an underpinning factor for physical and mental health as well as educational achievement and protects against drug and alcohol misuse, teenage pregnancy and emotional and behavioural problems.

Below is summarised some of the key specific recommendations

- Enable all secondary education establishments to adopt an organisation-wide approach to promoting the social and emotional wellbeing of young people, a whole school approach.
- Head teachers, governors and teachers should demonstrate a commitment to the social and emotional wellbeing of young people. They should provide leadership in this area by ensuring social and emotional wellbeing features within improvement plans, policies, systems and activities. These should all be monitored and evaluated.
- Provide a safe environment which nurtures and encourages young people's sense of self-worth and self-efficacy, reduces the threat of bullying and violence and promotes positive behaviours.
- Ensure young people have access to pastoral care and support, as well as specialist services, so that

emotional, social and behavioural problems can be dealt with as soon as they occur. (Specialist services include Child and Adolescent Mental Health Services.)

- Provide a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying. This can be achieved by integrating social and emotional skills development within all areas of the curriculum.
- Work in partnership with parents, carers and other family members to promote young people's social and emotional wellbeing.
- To help reinforce young people's learning from the curriculum, help parents and carers develop their parenting skills.
- Develop partnerships between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing.
- Integrate social and emotional wellbeing within the training and continuing professional development of practitioners and governors involved in secondary education.

Other relevant Guidance

- Antenatal and postnatal mental health: clinical management and service guidance (CG192) (NICE, 2014)
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. (NICE Guideline 26) (NICE, 2015)
- Self-harm in over 8s: long-term management (CG133) (NICE, 2004)
- Self-harm in over 8s: short-term management and prevention of recurrence (CG16) (NICE, 2004)
- Eating Disorders in over 8's (CG 8) (NICE, 2017)
- Management of depression in young people (CG28) (NICE, 2017)

5) What services / assets do we have to prevent and meet this need?

Within Bristol there are many services which have been commissioned by the Clinical Commissioning Group and the Local Authority to address emotional and mental health and wellbeing. In addition, there are services which, whilst not having the primary aim of working with children and young people on the emotional health and wellbeing, do in practice support young people. There are also a range of services, in the form of charities, faith groups, youth, sports and arts clubs and societies which work with children, young people, their friends and families to support and promote mental and emotional good health. In this section the focus is on services which are a) commissioned by either Bristol City Council or the CCG and b) have mental and emotional wellbeing as their primary focus. This is not to ignore the range of service provision made available by other groups, voluntary sector, schools but ensure the focus remains on the provision made by the statutory organisations.

Future in Mind (DH, 2015) recommends a move away from the tiered model of service provision. In the sections below, the services have been categorised into:

- Prevention and promotion of positive mental health
- Identification and early intervention services
- Treatment services

Some of the services and programmes may cut across the different categories.

Prevention and promotion of positive mental health

Services at this level focus primarily on a settings approach and through the building of capacity throughout the system through training and support for staff working with perinatal women, children and young people.

Training

There are a range of training programmes for people working in all different settings with children and young people to help them understand emotional health and wellbeing and to promote good emotional health and wellbeing in children and young people. Training programmes include:

- UNICEF baby friendly training which promotes breastfeeding and good attachment
- training in the Solihull approach, which promotes emotional well-being on young children and
- CAMHS training for universal staff such as health visitors, school staff and early years workers.

For people working with school age children there is 4YP training which aims to increase workers' confidence and skills to respond appropriately to young people's queries around sex, relationships and substance misuse and how to point them in the direction of specialist help and support which and resilience for teachers training which promotes positive mental wellbeing.

Settings approach

There are 2 programmes that provide a framework for promoting positive mental health in children and young people which create capacity through the system. In early years there is the [Bristol Standard for Health](#), a series of quality standards which are applicable for any early year's settings. These standards explore 10 relevant public health priorities, including emotional health and wellbeing as well as related topics such as working with young parents and risky behaviours and provide a model for practitioners to work from.

In schools there is the [Bristol Healthy Schools](#) programme. This is being revised to allow schools to apply for specific badges such as mental health. There are standards that must be reached and the healthy schools teams provide support to help schools achieve the standards within the framework. The standards are based on the NICE guidance and are a whole schools approach to mental health and wellbeing (as well as other health issues). Working alongside healthy schools is the [Bristol Ideal](#), an award scheme for secondary schools with standards around sexual health, domestic violence, healthy relationships and mental health.

Designed to complement the healthy schools approach, there are a variety of resources such as Jigsaw, a PSHE resource with an emphasis on mental health and wellbeing. There are programmes that schools can purchase such as the **Thrive** programme and the **Nurture** groups which provide specialist support to schools.

Resources and campaigns

Within Bristol there are resources produced by public health, mental health commissioning, local providers and national organisations. They promote positive mental health and tackle stigma. These change in response to the demand. In development is a searchable directory of services for professionals to use to find the most appropriate service. Also in development is the schools Mental Health Network which is being led by Heads of Mental Wellbeing which are being established in the schools in the most deprived areas of Bristol. This network is self-directed but supported by the city council and will help promote good practice within schools.

Parenting

Good parenting underpins the development of emotional health. There is a variety of parenting support and education on offer across Bristol. Bristol has a network of Children's Centres which provide a universal and targeted offer to parents and children. These centres provide a community hub for parents and children's, supporting development of children and supporting parents to give their children a good start in life. Family and parenting support is provided as part of the interaction that the staff have with parents on a daily basis.

Early Help commission a range of parenting support programmes, some targeted and some universal to support parents whilst their children grow up.

The Nurturing Programme aims to help adults understand and manage feelings and behaviour and become more positive and nurturing in their relationships with children and each other. It encourages an approach to relationships that gives children and adults an emotionally healthy start for their lives and learning.

Incredible Years is designed to promote emotional, social, and academic competence and to prevent, reduce, and treat behavioural and emotional problems in young children

Strengthening families, Strengthening Communities Parenting Programme is an inclusive evidence-based parenting programme, designed to promote protective factors which are associated with good parenting and

better outcomes for children.

Rock-a-bye is a group for mothers to help them attach and bond with their babies. The groups are run in Children's Centres for parents with babies aged 2-8 months. These are especially suitable for mothers who have anxiety or depression or experienced a difficult or premature birth and are finding their baby difficult to understand.

Welcome to the world is an 8-week group for parents expecting a baby. Parents attend the group from approximately 22 weeks of pregnancy. The aim of the programme is to build and strengthen a parent's attachment to the child.

Early Identification and Intervention

Services at this level focus on ensuring there is infrastructure in place to support the wider workforce identify people at risk and either providing interventions themselves or referring to specialist early intervention services.

Training

There is a range of training for professionals working with children, young people and their families to help them identify children at risk of mental health problems and to provide a low-level intervention where appropriate. Children's centre staff, midwives and health visitors are trained in **Mental Health First Aid** which enables them to know what to do if their patient seems to have a mental health problem. Some school staff will be trained in this and this training is further planned for the future.

School staff have also attended **CASCADE training** which helps them identify mental health problems in young people and what to do and when to refer to other services.

Identification and early intervention services

Screening

Midwives screen for mental health problems when women are 36 weeks pregnant and ask about mental health routinely throughout their antenatal care. At 36 weeks they use the **Whooley questionnaire**, a screening tool to detect mild to moderate depression, as recommended by NICE. Women continue to be screened by trained health visitors on first and subsequent contacts. Health visitors and staff from early years settings are able to either offer interventions (such as mental health first aid) or refer to other services.

Early Intervention

The **Family Nurse Partnership** is a home visiting service for young mums under 19 and their partners. The family nurse maintains contact with the mother from early stages of pregnancy until the child is 2. They support all aspects of the child and parents physical and emotional health.

Antenatal and post-natal rock-a-bye are specialist groups for mothers, fathers and babies where there is a history of pregnancy loss or child loss, anxiety or depression to help them feel less isolated and promote attachment.

Primary Infant Mental Health Service (PIMHS) consists of trained staff with a variety of backgrounds such as health visiting, based within CAMHS but working in other settings who work with children aged 0-4 where carers or others have concerns about their mental health and wellbeing. **Primary Mental Health Specialists (PMHS)** provide similar interventions for children of school age. School children are also supported by the **school nursing service**. School nurses are being trained in mental health first aid and can offer limited mental health support but can access support from the PMHS.

Individual schools purchase **counselling** for their students. This offer is variable in schools and some children are more easily able to access this than others.

Treatment services

New Horizons mother and baby unit is a specialist inpatient unit for women suffering mental illness after 36 weeks of pregnancy, especially when the illness impacts on the mother's ability to look after her child and

there are issues related to attachment.

Improving access to Psychological therapies (IAPT) is a national initiative, available locally. There is also a specific IAPT programme for children and young people which embeds the principles of IAPT into existing services. Parents and parents to be can self-refer. Perinatal women are fast-tracked too for Cognitive Behavioural Therapy (CBT) and group work

KOOTH is an online counselling service for children aged over 11. This is currently (June 2017) a pilot.

Off the Record is a service commissioned by the CCG and BCC to provide counselling and group work interventions for young people over 11. People can self-refer and access a range of different types of treatment such as art therapy and individual counselling. In 2016 they received **1,339** referrals and **836** received a service.

Children and Adolescent Mental Health Services (CAMHS) are commissioned by the CCG and BCC and are delivered as part of the Children's Community Health Partnerships by Avon and Wiltshire partnership Trust. Their website describes the services they provide: <http://cchp.nhs.uk/cchp/explore-cchp/child-family-consultation-services-camhs-0>.

An important component of the CAMHS service is the specialist services they provide in a number of settings. There are primary mental health specialists and primary infant mental health specialists, embedded within Early Help and Children's Centres. They provide early support to children, young people and their families and work holistically with other services. In addition, there are specialist services such as Thinking Allowed, a service for looked after children and Be Safe, a service for children displaying risky sexual behaviour.

6) What is on the horizon?

There has been an increase in the number of young people in Bristol. The increase is particularly marked in the under 5s as there has been both a "baby boom" as well as an increase in the number of young families moving to the city. There is an increase already seen across the 5 – 9 age group and this is expected to continue. These children will grow up to be teenagers and we can expect the youth population of Bristol to rise. This has had an impact on services already, with an increase made in the provision of primary school places. If the proportion of young people experiencing mental health problems remains the same, we should expect to see an increase in the numbers of people needing services.

7) Local views

A children's mental health needs assessment was written in 2015 to inform the children's mental health services re-commissioning work. As part of that children and young people were consulted and, as this was fairly recent, this consultation has been used to inform this needs assessment. Their views have been summarised as:

- Mental health is everyone's business.
- Everyone needs to know how to support children and young people with mental health needs i.e. schools, GPs etc.
- Services need to communicate clearly how to access them and when they should be accessed
- Services need to be integrated and use technology
- Specialist services are only part of the answer; there should be capacity across the system to support young people and their families.
- Services need to be:
 - Be age and gender appropriate and understand issues related to diversity
 - Be child and family support-centred.
 - Be flexible - meeting the needs of children with complex needs and to include outreach and crisis services.
 - Address and challenge the stigma associated with mental health.
 - Have staff that are appropriately trained and to a high standard, are passionate, honest and non-judgemental and have the capacity ability to build trusting relationships and understand the pressures faced by young people in the 21st Century.

- Provide peer support.
- Account for children and young people as 'digital natives' (see note below) and address the positives and challenges related to this, including the provision of safe online services.
- Ensure the smooth, managed and timely transitions to adult services
- Ensure that young people have choice in relation to the interventions/support they receive (and provider)

In October 2016 there was The Freedom of Mind Festival. This came from young people on the Youth Council who made mental health and wellbeing a priority for action. This grew into a festival and conference. The conference made the following (summarised) recommendations:

- Schools should have the training and resources to support young people with mental health problems. There should be school mental health champions and good communication should be fostered between all parties.
- Services need to improve their communication with young people. Service users need to know what the service is, how would the young people expect to interact with that service and the benefit of that service to the young people. Young people want clear information on how to use a service and why they should use the service.
- Feedback needs to be heard and participation needs to be at the forefront of all interaction with young people
- There needs to be more support for parents/carers of young people going through mental health struggles and also for young people caring for a parent/carer of mental illness.
- GPs need to be trained in working with young people with a mental health need
- Community champions should be appointed and trained to breakdown stigma and help signpost people to help and support.

B: What does this tell us?

8) Key issues and gaps

Key Issues

There is not a single set of actions or interventions which will prevent mental health problems or ensure good emotional wellbeing. It is a complex interplay of factors, some modifiable and some not, that come together within individuals to produce mental health problems.

We know that each risk factor, for example poverty, exposes a young person to other risk factors, such as substance misuse or poor school attainment and these risks stack up. Mental health problems are result of these risk factors as well as becoming a risk factor in itself for other problems like poor school achievement and substance misuse. It can be a cycle which is hard for a young person to exit from. This must be both a whole systems approach.

Intervening early. Children are shaped by early life experiences. Evidence has shown that intervening early, e.g. from birth, during the early years and primary school can reduce emotional and behavioural problems. Early recognition and management of maternal mental health problems can help bonding and attachment.

Working collaboratively across agencies and services to prevent some of the drivers of child emotional and mental health problems. It is only collaboratively that issues such as parental unemployment, poverty and substance misuse can be reduced. Services to prevent mental health problems or promote emotional wellbeing are only part of what we can do. A truly preventative approach will work on those wider determinates which influence health and wellbeing.

Family-Focussed. Child and adolescent emotional and mental health problems do not happen in isolation from the wider family and community children live in. Parents and families often need support and advice to help their child with the problems they are facing. Children have been telling us that they worry about their parents and their relationships.

A life course approach. A life course approach recognises that there are crucial points in peoples' lives where interventions are potentially more effective or when people are more likely to respond.

Building resilience and emotional and mental wellbeing. Building resilience and teaching children and young people coping skills are an important part of preventing child and adolescent emotional and mental health problems.

Targeting to those most in need. "Proportionate universalism" is a term which describes how services and efforts to reduce the steepness of the social gradient in health, must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

Building Capacity. Young people in Bristol have contact with a huge range of groups, agencies and institutions such as faith groups, sports clubs, childcare providers, schools, voluntary work and youth clubs. Given the level of need identified in the population and given the financial environment we currently operate in, it is vital to use this work force, both paid and voluntary, to build resilience and promote mental wellbeing. It is also important that this does not widen inequalities with only families with the ability to source and pay for activities for their children given access to these protective activities.

Population based approaches. With 1 in 10 children and young people reporting mental health problems it is clear that commissioned services can only expect to reach a proportion of those affected. Services need to be able to respond appropriately to people in the most need but those with less severe problems also need those problems addressing.

Social Media. Social media has brought about huge changes to the way children, young people and their parents experience the world. Positive use of social media should be part of the way we interact with children and young people.

Gaps

Data

There is currently a lack of consistent data on wellbeing for children and young people nationally. The PHE survey is in its infancy and there is also a lack of hard data on measures of mental health disorders amongst children and young people. The prevalence data for children between age 5 and 15 is based on survey work that was undertaken over a decade ago and there is no robust prevalence data on children aged 2-5.

These estimates are in urgent need of updating, which is currently happening and due for publication in 2018. The Chief Medical Officer in 2012 draws attention to the lack of up-to-date data, and called for this to be remedied, recommending that a regular survey should be commissioned to establish the prevalence of mental health problems in children and young people, and that it should be extended to provide information on 0-5 year-olds, ethnic minorities, those in the youth justice system, and children with underlying neurodevelopmental issues. (Chief Medical Officer, 2012)

Wellbeing

In Bristol there have been efforts to work closer and in partnership across the Local Authority, CCG and other agencies. Adopting a mental health in all policies approach to all work with children and young people will enable wellbeing to achieve a higher profile and ensure that wellbeing is put at the heart of the work that is done with children and young people.

There is evidence that an approach such as the 5 ways to wellbeing (adapted for young people) is effective in promoting resilience in young people. This does not appear to be widely adopted by agencies working with children and young people. This could be promoted by people working with children and parents should be given information on how to work with their children to promote mental wellbeing (Children's Society, 2014).

Other services that work with young people have a vital role to play in helping promote wellbeing. They may be entirely voluntary like faith groups, or funded such as the youth service. Due to the volume of these services they have not been mapped in the services section.

Risk Groups

The causes and drivers of what puts children and young people at risk of mental health problems and poor emotional wellbeing is complex. There is sometimes intergenerational problems which are difficult to address and may seem intractable. But, mitigating the impact of risk factors is not to take a truly preventative approach. Preventing the risk factors occurring is to look at poverty, stigma, racism, homophobia and misogyny. It is to think about the culture and society we live in, the opportunities that each young person has, the environment in which they grow and to think creatively about the way that the City Council, with its partners can address these problems.

Children in risk groups are often in touch with a range of services which will be looking into the range of needs they may have. There are a range of programmes and services available which promote resilience such as those run by Young Minds. Commissioning one of these programmes could help prevent mental health problems in the future the most at-risk of young people

Schools and other groups could be supported in commissioning these types of programmes or using the toolkit from the Anna Freud Centre to use within their schools.

Bristol has a high rate of first time entrants to the youth justice system. The Public Health Team carried out a health survey in 2015 which suggested that there was within the cohort attending the Youth Offending Team (YOT) there was a high level of alcohol consumption, ADHD and cannabis use. However, the survey didn't do any more detailed questions about mental health and wellbeing. More information about the wellbeing of this group would help inform further actions in this area.

The Adverse Childhood Experiences (ACEs) work shows that ACEs are common in childhood and are a major predictor of future mental health problems. This model could be applied further, possibly in partnership with the early help team/think family service to identify young people who perhaps do not reach the threshold for a referral from the think family service and offer them targeted support. This is particularly important for children who do not obviously display behavioural problems and may not be engaged in other services.

Whole School approach

No secondary school currently holds the healthy schools award which can help improve the mental wellbeing of pupils by adopting a range of policies which promote mental wellbeing, SRE, substance misuse and dealing with bullying for example. Amongst all schools the offer to children varies across the city. Some schools are very engaged in the emotional wellbeing agenda whilst others have not prioritised it in the same way. Work has already been carried out to address this, such as the development of a mental health network for school, the appointment of heads of mental wellbeing in some schools as a pilot scheme and changes to healthy schools which allows schools to prioritise particular areas of action. These should be continued and monitored for impact.

Parenting

Many parents express doubts in their ability to be good parents to their children. These doubts remain whatever the age of the child, or indeed, regardless of how well a child may be doing. Bristol offers a range of parenting courses, some general and some more targeted. There is evidence that parents find it difficult to access parenting programmes due to stigma and fear of being judged poor parents. Whilst there is lots of information available for parents to access on the web, much of it is not based on evidence of effectiveness. There are providers who provide evidence based on-line courses which could help parents to access evidence-based parenting support at a time that suits them and may encourage people to attend who may not otherwise.

Whilst some parents do attend parenting courses most parents do not. We do not know how many parents would like to attend parenting courses, what kind of support they would like or need or what are the barriers to attending. It would be useful to understand the situation in Bristol in more depth and understand how we can ensure that we are making the best use of resources.

Services

About 70% of the estimated number of children with a diagnosable mental health problem does not access services. For many, this may be entirely appropriate but we also need to understand who does not access services and ensure that they are adequately supported.

Services for children aged 5-11 are variable with some schools buying in counselling services while other children struggle to access them. NICE guidance recommends that the whole school approach is most suitable for this age group so commissioners should continue to work to ensure that schools have access to help in order to support children of this age.

There is no crisis service available for young people in crisis at the weekend. This means there is no specialist support available for children and young people in mental health crisis out of hours. This has an impact on the children themselves as well as their families and other agencies such as ED and the police.

There are a lot of services in Bristol for children and young people both in the voluntary and the statutory sector. It can be difficult for parents and YP to find out what services they can access and what is the most suitable. An online searchable directory has been developed. This needs to be widely promoted and kept up to date.

Self-harm rates are rising. There needs to be a focus on preventative work across the city to address this.

We do not fully understand the impact of screen time and the internet on children's emotional health and wellbeing. Pupil voice data suggest that many children are spending lots of time in front of screens (as no doubt are their carers). Screen time has been implicated in poor mental wellbeing and exposing children and young people to on-line bullying and harmful websites which have been implicated in self-harm and eating disorders. However, the link is not clear and this is an emerging area. Many young people report that being connected on-line is positive and connectivity is a feature of life for today's children and young people. This is an important area we need to understand further.

9) Knowledge gaps

The prevalence survey was last completed in 2004 for children age 5 – 15. When the new survey is published the estimates of local need should be revised and published as an addendum to this JSNA chapter.

There is a lack of accurate estimates for children aged under 5 with no reliable UK based data.

There is a great deal of activity and interventions going on in the community which has no evidence base. Services and providers should be supported to evaluate interventions against agreed criteria.

We do not know what impact the use of social media and the internet generally is having on young people's mental health.

We do not know what the impact of screen time is on young people's mental health. Further research is needed to understand this and how we can use it in a positive way for mental health and wellbeing. We need to understand what the risks may be and how to ameliorate them.

C: What should we do next?

10) Recommendations for consideration

General

There should be an all-age mental health and emotional wellbeing strategy/programme that should be co-designed with all the stakeholders, including young people, children, parents, carers, professionals and the general public. It must take into account the views and needs of multiple stakeholders and ensure that it delivers an all-age strategic vision for Bristol which has the active participation of Bristol's citizens. The strategy needs political leadership from the civic and political leaders in Bristol and must work to address inequality as one of the drivers of poor mental wellbeing.

Wellbeing

- Embed consideration of mental health and emotional wellbeing in all policies in the local authority and CCG.
- Promote 5 ways to wellbeing for CYP in services or a campaign
- Promote the mental wellbeing badge for healthy schools

Whole Setting Approach

- Use the new way of delivering healthy schools to encourage schools that have not previously engaged to get the healthy school award and specifically the emotional wellbeing badge.
- Encourage settings to take up the offer of mental health first aid training
- Use the different levers and forums of the Local Authority to develop relationships with schools which have not so far engaged in the mental health work.
- Review role of the school nurse to ensure they are able to support schools with emotional wellbeing, for example, are trained in Mental Health First Aid.
- Continue to embed emotional wellbeing in the perinatal period and early years, e.g. through Bristol Standard for Health

NICE Guidance

- Conduct an audit with action plan to identify where there are gaps and to plan for improvements of performance.

Risk Groups

- Influence across the local authority and CCG the policies which can affect the wider determinates such as child poverty, poor housing, unemployment, school achievement for example.
- Prioritise areas for action where Bristol has higher levels of risk factors (for e.g. 1st time entrants to the youth justice system)
- Consider commissioning some resilience promotion for identified young people. Consider using the ACE framework to target this correctly

Parenting and family support

- Undertake further work to identify barriers to attending parenting courses
- Ensure that parents have access to support with their relationship with each other to protect their child's mental health
- Use the settings approach, as used by the Children's Centres to offer families support

Services

- Support schools by ensuring that they know what interventions have an evidence base for effectiveness.
- Build capacity in the system to work with children and young people e.g. School nurses, teachers, other professionals through training and on-going supervision
- Support parents whose children may be experiencing mental health problems
- Identify any barriers to access services, including capacity and ensure that new provider improves accessibility.
- Ensure that there is a broad alternative provision (like Kooth) which is accessible to CYP who may not be able to attend CAMHs or Off The Record.
- Continue to develop data collection methods for CCHP so that we can get more information about children and young people accessing services and what the outcomes are.
- Develop an out of hours crisis service to meet the needs of children and young people experiencing a mental health crisis at the weekend.
- Ensure that there is a broad alternative provision which is accessible to so children and young people can access different services in different ways.

Accessibility

- Ensure the new searchable directory is promoted widely and kept up to date.

Self-Harm

- Ensure that self-harm is considered in the all-age mental health and emotional wellbeing strategy/programme.
- Support schools so they feel confident in supporting young people

Social media

- Ensure the impact of social media is considered in the mental health strategy.

11) Key contacts

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Glossary of terms

- ACE – Adverse Childhood Experiences
- ACMD – Advisory Council on the Misuse of Drugs
- ADHD – Attention deficit hyperactivity disorder
- ASD – Autistic Spectrum Disorder
- AWP – Avon Wiltshire Partnership
- BNSSG – Bristol, North Somerset and South Gloucestershire
- CBT – Cognitive Behavioural Therapy
- CCG – Clinical Commissioning Group
- CCHP – Children’s Community Health Partnership
- EHTP – Emotional Health Transformation Plan
- EIF – Early Intervention Foundation
- HSCIS – Health and Social Care Information Centre
- IAPT – Improved Access to Psychological Therapies
- JCPMH – Joint Council of Public Mental Health
- JSNA - Joint Strategic Needs Assessment
- NICE – National Institute for Clinical Excellence
- ONS – Office of National Statistics
- PCC – Police and Crime Commissioner
- PHOF – Public Health Outcomes Framework
- RCP - Royal College of Psychiatrists
- SCIE – Social Care Institute for Excellence
- STP – Sustainability and Transformation Plan
- WHO - World health Organisation

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