LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE CHAPTER

AUGUST 2018

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FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.

- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester, District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined.

The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs

2. An online infographic summary of each chapter available on the internet

3. An online data dashboard that is updated on a quarterly basis to allow users to self-serve

high level data requests

This JSNA chapter has reviewed the population health needs of the people of Leicestershire in relation to Mental Health in Children and Young People. This has involved looking at the determinants of the Mental Health, the health needs of the population in Leicestershire, the impact of the Mental Health, the policy and guidance supporting Mental Health, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

Please note, the majority of indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals.

EXECUTIVE SUMMARY

Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by age 18. The life chances of those individuals are significantly reduced in terms of their physical health, their educational and work prospects, their chances of committing a crime and even the length of their life.

In an average class of 30 15-year-old pupils:

- three could have a mental disorder

- ten are likely to have witnessed their parents separate

- one could have experienced the death of a parent

- seven are likely to have been bullied

- six may be self-harming

In 2015, an estimated 8.7%, of children and young people aged 5-16 had a mental health disorder in Leicestershire. This equates to nearly 8,000 children. A very small proportion of children with a mental health condition require psychiatric hospital admission. Between 2011 and 2017, the rates for hospital admissions for self-harm for children and young adults, aged 10-24 years has been increasing, both nationally and locally. Leicestershire's rate remains below lower than the England average. Young women are more likely to self-harm than young men. Although there is a strong link between self-harm and suicide there is no local data to report this.

Less than 25% to 35% of children and young people with a diagnosable mental health condition access support. Action is needed across a child and young person's life course and within the wider context of their lives. There needs to be a greater emphasis on mental health promotion, prevention of mental health problems and early intervention. Identifying emotional and mental health problems early will also help to 'break the cycle'. Broadly speaking our approach needs to incorporate both interventions to promote and protect mental health, wellbeing and resilience and interventions to reduce the risk factors for mental illness.

Preventative interventions and strategies must address adversity and trauma and particularly prioritise those who have Adverse Childhood Experiences (ACEs). ACEs include: parental separation, domestic violence, sexual assault, mental illness, alcohol abuse/ drug use.

For those children who end up requiring support for emotional and mental health issues we need good systems of early identification plus coherent referral pathways into support. A cross-system single point of access for referral is required. Other priorities across our local pathways include

strengthening the Future in Mind programmes, including Kooth (on-line counselling), Early Intervention, Crisis support and Eating Disorders services.

Overall, support needs to be targeted and prioritised to ensure we reach those in greatest need. For example groups at increased risk and those who have specific mental health and wellbeing needs e.g. Looked After Children (LAC) need particular approaches e.g. we should undertake a Strengths and Difficulties Questionnaire (SDQ) every 6 months as part of their LAC review, to monitor changes in emotional and mental health state and trigger timely interventions when required.

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Poor mental health can cause suffering and anguish to individuals, families, carers and people who have contact with persons who have a mental health condition. Mental health problems cover a multitude of areas from emotional disorders such as anxiety and depression through to severe conditions such as schizophrenia and bipolar disorder. One in ten children are recognised to need help, care and support for mental health problems.   Yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age.[1]

Mental health conditions in children and young people can result in many years of psychiatric disorder and can lead to further health problems as they reach adulthood. Research has shown that 50% of long term mental health disorders in adults will present by the age of 14, this increases to 75% by the age of 24 (excluding dementia). This underlines the importance of prevention, early detection and treatment at an early stage in the life course.[2]

It is recognised that children and young people with a mental health disorder may not reach their full potential in life; they may suffer from poor education, which could lead on to poor employment prospects. They may experience poor physical health and find it difficult to form relationships which in turn can lead to social isolation. Young people with poor mental health also have an increased risk of smoking, drinking and drug misuse.[2]

1.1.   Protected characteristics and individual factors.

1.1.1. Poor physical health

It is recognised that poor physical health can impact and worsen mental health and poor mental health can impact and worsen physical health. A physical illness or disability can affect people's emotional and mental health in everyday living. This may be due to mobility problems, the debilitating effect and weariness of a physical disability, not having the opportunity to join in physical activities with family and friends, lack of confidence or difficulties in building relationships.[2]

In 2014/15, from the 'What about YOUth survey', 14.5% of 15 year olds in Leicestershire stated they had have a long-term illness, disability or medical condition (like diabetes, arthritis, allergy or cerebral palsy. This percentage is similar to 14.1% reported nationally.[3]

1.1.2. Learning disability

In 2017 the count of primary, secondary and special school pupils who were identified as having a learning disability in Leicestershire was 6,655, this is the fourth consecutive year that the number

of pupils with a learning disability has risen. This equates to 6.9% of all pupils attending Leicestershire schools which is significantly higher than 5.6% for England.[3]

1.1.3. Sexual orientation

Research indicates the increased likelihood of certain mental health problems occurring in the lesbian, gay, bisexual, transgender/transsexual and other (LGBT+) population.[4] Over half (55%) of young LGBT+ people experience homophobic, bi-phobic or transphobic bullying in schools in Britain. Gay pupils who have been bullied are most at risk of depression, self-harm and even suicide, with 23% reporting they have tried to commit suicide at some point in their life. The research shows girls are more likely to attempt suicide (29%) than boys (16%).[5]

1.1.4. Race

Although mental health is known to affect children and young people from all races, there is very little evidence to prove if any race is affected more than the other. One report by the NCBI in 2001 suggests, common mental health disorders in white British children were higher or similar to the main minority ethnic groups. It is suggested there is a higher rate of psychosis in black children, eating disorders in South Asians and an unmet need for mental health services in Pakistani and Bangladeshi children.[6]

It is known BME children and young people are over-represented in the youth justice system, looked after children/children in care provision and school exclusions, all of which have links to poor mental health.

As research shows that 50% of long term mental health disorders in adults will present by the age of 14 then by definition the breakdown of mental health by BME in adults could apply to children. Research for adults indicates mental health problems are more prevalent in BME populations. For example, rates of schizophrenia are 5.6 times higher in the black Caribbean population, 4.7 times higher in the black African population and 2.4 times higher in Asian groups.[7] Black populations have the highest rates of posttraumatic stress disorder (PTSD), suicide attempt, psychotic disorder and any drug use/dependence while white populations have highest rates for suicidal thoughts, self-harm and alcohol dependence.[8] Those from minority ethnic backgrounds are also less likely to access mental health services; hence these may underestimate the true prevalence in the population, with pockets of the population remaining undiagnosed.[8]

1.1.5. Teenage pregnancy and young mothers

1.1.5.1. Under 18 conceptions

The National Institute of Health and Care Excellence (NICE) guidance on social and emotional

wellbeing in the early years report being born to parents aged under 18 years as a factor that can lead to children being vulnerable to poor wellbeing, including poor health and social outcomes for both the mother and child.[9] NICE guidance states "...resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, illness, accidents and injuries."[10] Young mothers are three times more at risk of developing postnatal depression and poor mental health, feeling isolated and having low self-esteem, which in turn can have an effect on their child's physiological and emotional development. [11,12]

In Leicestershire, the rate of under 18 conceptions has decreased for nine consecutive years between 2007 and 2016. The latest data in 2016 shows there were 155 conceptions to females under the age of 18 years, this equates to a rate of 13.7 per 1,000 females aged 15-17. This is significantly lower than the national rate of 18.8 per 1,000 females aged 15-17.[13]

It is important to note, not all teenage parents will suffer from mental health issues.

1.1.5.2.   *Young mothers*

Mothers who give birth under the age of 20 have a 30% higher risk of poor mental health for up to two years after giving birth than mothers over the age of 20.[14] This can affect their own wellbeing, and their ability to form a secure attachment with their baby, attachment that is recognised as a key basis for positive child outcomes allowing the baby to grow and develop physically, emotionally and intellectually.[15] Young mothers under the age of 20 have a 13% higher risk of stillbirth and a 75% higher risk of infant mortality than mothers over the age of 20.

In Leicestershire 212 live births took place in 2015 to mothers under the age of 20, this equates to 3.0% of total births in Leicestershire. This is similar to the national average of 3.4%.[16]

1.2.   Low income households

Low income is recognised as a significant risk factor for developing mental illness. Children and families from the lowest 20% income households are three times more likely to suffer from mental health disorders compared to those living in the highest 20%.[17]

Mental health problems in turn may affect people's education and employment opportunities and therefore increase the risk of poverty. In 2014, 12.4% of children under the age of 16 and 12.0% of children under the age of 20 were known to be living in low income families in Leicestershire. Both indicators are significantly lower than the England average of 20.1% and 19.9% respectively. This equates to 14,050 children aged under 16 years and 16,060 children aged under 20 years in Leicestershire living in low income families.[18]

Figure 1 highlights the difference in the percentage of children aged 0 – 15 years living in income

deprived families in Leicestershire wards based on national quintiles. The darkest coloured area highlights the wards with the highest percentage of children living in income deprivation.

In 2015, 14 wards in Leicestershire reported a higher percentage of children living in income deprived families than the national average, five of these wards were in the top quintile of deprivation. These five wards are Loughborough Ashby (46.7%), Loughborough Storer (34.2%) and Loughborough Hastings (29.4%) in the Charnwood district and Castle Rock (42.7%) and Greenhill (40.6%) in the North West Leicestershire district. These are all significantly higher than the national average of 19.9%.[19] It is important to note that not every person living in a highly deprived area will themselves be deprived. Likewise, there will be some deprived people living in the least deprived areas.

Figure 1 - Children aged 0-15 years living in income deprived families in Leicestershire by ward 2015
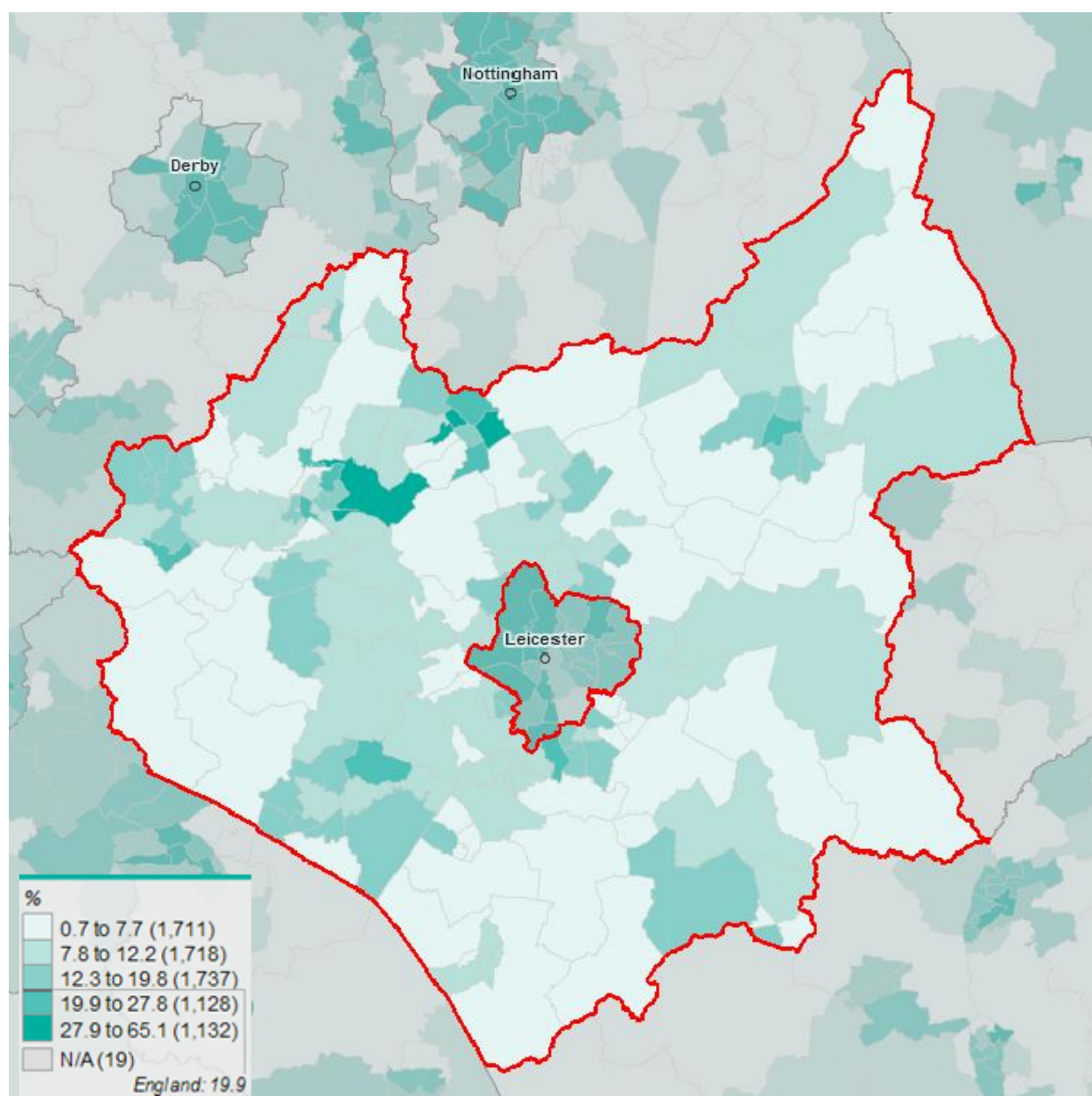
1.2.1. Free school meals

Eligibility for free school meals is a marker of relative poverty. Free school meals are a vital provision for children in low income families as this meal may be the child's main meal of the day and in some cases is their only suitable meal. In 2017 in Leicestershire, 7,266 pupils were known to be eligible and claiming free school meals who attended state funded nursery, primary, secondary or special schools. This equates to 7.5% of all children on the school census roll which is significantly lower than 13.9% nationally.[3]

1.3. Children in care

The term 'children in care' is defined as a child or young person who is being looked after by the local authority, including children who may be living with foster parents or in a residential children's home. Parents who are struggling may have voluntarily placed their child in care, or social services may have intervened because a child may be at significant risk of harm.[20]

Approximately 50% of children who are cared for by the Local Authority between the age of 5 and 17 will suffer some form of mental health problems; this rises to 60% if the children are living in a residential home.[21,22] Children who have been in care are more likely to go on to suffer from mental health problems including antisocial behaviour, emotional instability and psychosis in adult life.[3] In 2017 the number of children in care in Leicestershire was 510, this equates to a rate of 37.0 per 10,000 population aged 0-17 years, this is significantly better than the national average of 62.0 per 10,000 population aged 0-17 years.[23] In 2015/16 the number of children under 18 leaving care in Leicestershire was 255, this equates to a rate of 18.8 per 10,000 aged 0-17 years which is significantly lower than the national rate of 27.2 per 10,000 aged 0-17 years.[3]

1.3.1. Looked After Children

The term 'looked after children' is defined as when a child or young person is looked after by the local authority and has been provided accommodation for more than 24 hours.[20]

It is recognised that looked after children are a vulnerable group and are at significantly increased risk of developing a high level of mental and emotional health disorders. Nationally, it is estimated that 46% of looked after children have mental health problems, this is over four times higher than children in the general population.[2]

Children who are neglected are more likely to suffer from anxiety and depression and experience mental health problems, including emotional attachment issues.[3] In 2017/18, in Leicestershire 155 children under the age of 18 were looked after by the local authority due to abuse or neglect. This equates to a rate of 11.3 per 10,000 children aged 0-17 years in Leicestershire, this is significantly lower than the national rate of 16.2 per 10,000 children aged 0-17 years. These figures have remained constant both nationally and locally for the past two years.[3]

In 2016, 80 children aged under 18 started to be looked after due to family stress, dysfunction or absent parenting in Leicestershire, this equates to a rate of 5.9 per 10,000 children aged 0-17 years. This is significantly lower than the national rate of 10.1 per 10,000 children aged 0-17 years.[3]

1.3.2. Children in need

The term 'children in need' is defined as a child or young person who has been referred to children's social care services and to be in need of social care services from the local authority to achieve and maintain a reasonable standard of health and development. [24]

When a child is thought to be in need, children's social care will be involved and carry out an assessment to identify if the child is in need of services. Children in need are known to have a significantly increased risk of developing mental illness. Support services include supporting families who are experiencing difficulties, helping young people who have been living in care, supporting disabled children through social care, education and health provision.[25] In 2017 the main reason children under the age of 18 who were 'in need' in Leicestershire was due to abuse or neglect. The number of children under the age of 18 who were identified as 'in need' due to abuse or neglect in Leicestershire was 1,519, this equates to a rate of 110.9 per 10,000 children aged 0-17 years. This is significantly lower than the national rate of 172.9 per 10,000 children aged 0-17 years.[3]

In 2017, the number of children under the age of 18, 'in need' due to family stress, dysfunction or absent parenting in Leicestershire was 686 children. This equates to a rate of 50.1 per 10,000 children aged 0-17 years. This is significantly lower than the national rate of 93.8 per 10,000 children aged 0-17 years.[3]

In 2017, the number of children 'in need' due to a child disability or illness in Leicestershire was 350, this equates to a rate of 25.6 per 10,000 children aged 0-17 years. This is significantly better than the national rate of 31.2 per 10,000 children aged 0-17 years.[3]

 In 2017, the number of children 'in need' due to a parents disability or illness is 138, this equates to a rate of 10.1 per 10,000 children aged 0-17 years. This is similar to the national rate of 9.2 per 10,000 children aged 0-17 years.[3]

In 2017, the number of children under 18 years identified as being 'in need' due to socially unacceptable behaviour is 36, this equates to a rate of 2.6 per 10,000 children aged 0-17 years. This is significantly lower than the national rate of 6.7 per 10,000 children aged 0-17 years.[3]

1.3.3. Child protection plan

Child abuse can have a negative effect on children which can lead on to serious mental health illnesses like personality, psychiatric, conduct disorders, high risk lifestyles, aggression, violent and anti-social behaviours, relationships and parenting, as well as physical illness. Child protection plans (CPP) have been put in place for children who have been identified as being at risk of abuse and/or neglect which may have a detrimental effect on the mental health and wellbeing of

children.[3]

In 2014/15, there were 393 children in Leicestershire under the age of 18 who were the subject of a child protection plan at the end of the financial year. This equates to a rate of 29.2 per 10,000 children aged 0-17 years in Leicestershire which is significantly better than the England rate of 42.9 per 10,000 children aged 0-17 years.[3]

 In 2016, there were 117 children in Leicestershire under the age of 18 who were the subject of a child protection plan with an initial category of abuse. This equates to a rate of 8.6 per 10,000 children aged 0-17 years in Leicestershire which is significantly lower than the England rate of 20.8 per 10,000 children aged 0-17 years.[3] In the same period, there were 129 children in Leicestershire under the age of 18, who were the subject of a child protection plan with an initial category of neglect. This equates to a rate of 9.5 per 10,000 children aged 0-17 years in Leicestershire which is significantly lower than the England rate of 19.8 per 10,000 children aged 0-17 years.[3]

In 2016, there were 131 children in Leicestershire under the age of 18 who became the subject of a protection plan for a second or subsequent time, this equates to 30.5% of all CPP children in 2016. This is significantly higher than the national average of 17.9%.[3] This is the fourth consecutive year the number of cases has increased in Leicestershire and England.[3]

1.4. Education

1.4.1. Special Educational Needs (SEN)

The term Special Educational Needs (SEN) is a legal definition that refers to children and young people who have learning difficulties and/or disabilities and can affect their ability to learn.[26] Children and young people with SEN may have a wide range of complex needs both socially and emotionally. These children and young people may suffer from a medical condition such as Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Autism. Others may become withdrawn, feel isolated, be disruptive or have behavioural problems. Any of these problems may suggest there is an underlying mental health issue such as anxiety and depression, self-harming or substance abuse for example.[27] In 2016, the number of school aged pupils who were identified as having SEN in Leicestershire was 11,525, this equates to 12.1% of the total number of pupils registered in Leicestershire schools. This is significantly lower than the national average of 12.3% of the total number of registered pupils. Since 2014 there has been a year on year decrease both nationally and locally in the number of pupils with SEN.[3]

In 2016, the number of primary school ages children with SEN attending schools in Leicestershire was 5,845, this equates to 11.3% of school age pupils identified as having SEN. This is significantly

lower than 13.4% nationally. The numbers decrease for children with SEN at secondary school age to 4,604 which equates to 10.8% in Leicestershire; this is significantly lower than 12.7% for England.[3]

1.4.2. School exclusion

Exclusion from schools and education is a risk factor for mental health problems. The Department of Education's Guidance on Mental Health and Behaviour in School (2016) identifies that disruptive behaviour may be a sign of an underlying mental health problem.[28] As is well known, education is important in engaging children in fulfilling and worthwhile opportunities to support their mental wellbeing.

In 2015/16, Leicestershire had 336 primary school pupils and 2,351 secondary school pupils with fixed periods of exclusions. This equates to 0.7% of all primary school pupils and 5.5% of all secondary school pupils respectively in Leicestershire. Both percentages are significantly lower than the England average of 1.21% and 8.5%.[3] Since 2013/14 both primary and secondary school exclusions in Leicestershire have remained constant whereas the national rate of exclusions has risen by 2 percentage points. In 2015/16, 563 school aged children had a fixed period of exclusion due to persistent disruptive behaviour in Leicestershire. This equates to 0.6% of school age children in Leicestershire, this is significantly lower than the England average of 1.2% of school aged children.[3]

1.4.3. Educational attainment

There is a strong association between educational attainment and mental health and wellbeing. Education in children develops their knowledge and understanding, skills and abilities that are required to build their mental, emotional, social and physical wellbeing for now and the future.[3] In 2015/16, in Leicestershire 58.9% of children aged 15-16 years attained 5 or more GCSEs at grade A*-C. This is similar to the national percentage of 57.8%.[18]

Children in care have poorer educational outcomes than children who are not in care. A high percentage of children in care have special education needs and suffer from emotional, behavioural and mental health issues.[29] In 2015 in Leicestershire, 10.2% of children in care aged 15-16 years attained 5 or more GCSEs at grade A*-C. This is similar to 13.8% reported nationally.[18] Nationally, it is reported that children not in care who are living at home tend to average grades B and C in their core subjects where as children in care and looked after by the local authority generally average grade E in their core subjects.[30]

1.4.4. Academic pressure/pressure to succeed

Academic pressure and the pressure to succeed are often driven by fear of failure and letting

others and themselves down. This can be driven from parents' expectations and the belief that the better you do in school and university the better employment options and better future you will have.[31] Too much academic pressure can lead to mental health conditions, such as anxiety and depression. This in turn can lead to becoming withdrawn to the point of not wanting to attend an education establishment, and with it, lose the benefits that education offers children.[31]

1.4.5. Home schooling

Home schooling in the UK has increased 40% over 3 years. Mental health issues such as ADHD and anxiety and avoiding exclusion are two reasons parents give for removing children from classrooms. However, there is no evidence to suggest that home schooling is better than traditional schooling for children with anxiety or ADHD.[32]

Home educated children can be essentially 'invisible' to Children Services which can make it difficult to make timely and appropriate contact with these families to provide support that may be needed.[32]

1.4.6. Not in education employment or training

Young people over the age of 15 who are not in full time education, employment or training have a greater risk of developing poor health, depression and other mental health issues. Young school leavers are likely to leave school with no qualifications which in turn can lead to poor employment opportunities.[18] In 2016, the number of 16-17 year olds in Leicestershire who were not in education, employment or training (NEET) or whose activity is not known was 700, this equates to 5.1% of the total number of 16-17 year olds in Leicestershire. This is significantly lower than the national average of 6.0%.[18]

1.5. Bullying

Bullying can have a negative effect on people's physical and mental health. Nearly half of the UK's 12 to 15 year olds have faced some form of bullying, including cyber-bullying over the last year.[33] Research by the National Centre for Social Research found that nationally 16,000 11-15 year olds are absent from school at any one time due to bullying. It is recognised that bullying in schools can significantly impact on young people's mental health and for some people this can pose a suicide risk. Almost half (47%) of young people reported being bullied by the age of 14 and the same study showed that girls are more likely to be bullied than boys. Cyber-bullying via mobile or tablet and the use of social media is on the increase.[34]

In 2014/15 in Leicestershire, of the 15 year olds who responded to the YOUth survey question "how often have you been bullied in the past couple of month?" 56.2% said they had been bullied, compared to 55.0% nationally. Of the 15 year olds who responded to the question "how often

have you taken part in bullying another person in the past couple of months?" 9.1% said they had bullied others, compared to 10.1% nationally.[3]

1.6. Crime

Children and young people who commit crime and are a part of the youth justice system, have a higher risk of mental health problems. Mental health problems can occur from issues such as problematic parenting and stressful life experiences. Interacting and being part of the criminal justice system, including those who are in custody can be very stressful.[35] In 2016, there were 105 10-17 years olds receiving their first reprimand, warning or conviction in Leicestershire and Rutland combined. This equates to 163.4 per 100,000 children aged 10-17 years and is significantly lower than the national rate of 327.1 per 100,000 children aged 10-17 years.[3] Leicestershire and Rutland figures have been combined for the first time in 2016 due to Rutland's value being suppressed due to small numbers.[3]

1.7. Quality of parenting

1.7.1. Drug and alcohol abuse

Drug and alcohol abuse can have severe long term effects on an individual's mental health; conversely the state of a person's mental health can cause people to abuse drugs and alcohol. Research has shown that parents misusing substances are at risk of a range of difficulties in their role as a parent. These may include a lack of understanding about child development issues, ambivalent feelings about having and keeping children and lower capacities to reflect on their children's emotional and cognitive experience.[36] Drug and alcohol abuse can also affect how the family functions; it may mean a child has to look after themselves or for older children to take on adult responsibilities like caring for their siblings. Some adults under the influence of drugs and alcohol may abuse their children, either physically or emotionally, which could impact the child's mental health.[37]

In 2011/12, in Leicestershire 164 parents who lived with their children (aged 0-15 years) attended treatment for alcohol abuse. This equates to a rate of 139.9 per 100,000 population, this is similar to the national rate of 147.2 per 100,000 population.[3] In 2011/12, in Leicestershire 73 parents who lived with their children (aged 0-15 years) attended treatment for substance misuse. This is a rate of 62.3 per 100,000 population which is significantly lower than the national rate of 110.4 per 100,000 population.[3] Please note, these figures are the number of parents in treatment, not the number of parents who are misusing drugs or alcohol.[3]

1.7.2. Domestic violence

Domestic violence within the household can have a major impact on the mental health of

children, including babies and toddlers. NICE guidance states "*the impact of living in a household where there is a regime of intimidation, control and violence differs by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development.*"[38] Whether the violence is in a controlling and intimidating manner, either physically or mentally, this can impact on the emotional and psychological health of the child.[38]

The rate of domestic abuse related incidents and crime recorded by the police in Leicestershire, Leicester and Rutland has increased from 14.7 per 1,000 population in 2015/16 to 18.7 per 1,000 population in 2016/17. This increase is not reflected nationally where there has only been a small increase in rate from 22.1 per 1,000 population in 2015/16 to 22.5 per 1,000 population in 2016/17. Although Leicester, Leicestershire and Rutland has a lower rate of domestic abuse related incidents when compared to England this gap is now closing.[18] It is important to remember that this indicator only examines the rate of domestic abuse incidents and crime recorded by the police and that there will be levels of abuse in the population that is not reported.

1.8. Other subgroups

Other subgroups of the population can be missed in overarching statistics, such as asylum seekers, and the homeless. These subgroups, who have not been mentioned in key statistics above, are more exposed and vulnerable to the unfavourable social, economic, and environmental circumstances encompassed in the above risk factors. They are therefore at a higher risk of mental health problems than the general population. Rural isolation may also pose an additional risk factor for people living in more isolated rural parts of the country.

1.8.1. Homelessness

Children and families who are homeless or live in poor quality housing are considered to be at increased risk of common mental health problems. Children who experience homelessness and mothers and children who have been re-homed can suffer from significant mental health problems. It is important to note that people may become homeless due to many different factors, including domestic abuse and violence which can also contribute to high levels of mental health conditions. [39]

In 2016/17, the rate of family homelessness in Leicestershire was 1.0 per 1,000 population, this equates to 272 families being homeless. This is significantly lower than the national rate of 1.9 per 1,000 population.[3] The rate of homelessness in 2016/17 in Leicestershire and Rutland is 0.32 per 1,000 young people aged 16-24 years, this is significantly better than the England rate of 0.56 per 1,000 population aged 16-24 years.[39] Please note, these indicators measure only those homeless children and families who are known to local authorities and accepted as being unintentionally

homeless and in priority need. The number of those experiencing homelessness is likely to be much higher.

1.8.2. Child sexual exploitation

Child sexual exploitation (CSE) is a form of sexual abuse and violence including rape. It happens when a child or young person is persuaded, encouraged or tricked in to performing sexual activities or having sexual activities performed on them, sometimes this can be in return for receiving gifts like money or invited to parties etc.[40] CSE can have a detrimental effect in the child's mental, emotional and psychological health and their social and educational development.[40]

CSE can happen to boys and girls of any age however children between the ages of 13 to 15 are most vulnerable. Children may not understand they are being abused and therefore can often trust and believe their abuser.[40]

1.8.3. Adverse childhood experiences

Adverse childhood experiences (ACEs) are very traumatic and stressful experiences that occur in childhood and can lead on to suffering from physical and mental health conditions in adulthood. ACEs can cover a multitude of events (many described earlier in this chapter) from maltreatment, violence (including sexual assault and domestic violence), coercion and prejudice through to inhumane treatment, adult responsibilities (being a young carer), bereavement and surviving an accident or illness. They can impact a child's development and their relationships with others which could result in social isolation and mental health problems.[41]

There are many protective factors to assist in keeping children safe and well. This includes having positive and supporting family environments, safe and mutual relationships with peers and compassionate and supportive responses from professionals including early intervention and support from safeguarding services.[41] Evidence also indicates that having one positiEs

People with four or more ACEs are more likely to engage in risky behaviour. They are twice as likely to binge drink, five time more likely to have under age sex, and 11 times more likely to have been incarcerated and/or to have used illicit drugs.[41]

1.8.4. Unaccompanied children asylum seekers

Being alone and unaccompanied can have a severe effect on the children's mental health and wellbeing, as can children seeking asylum.[3] In 2017, there were 30 unaccompanied asylum seeking, looked after children in Leicestershire, that equates to 0.7% of the total number of unaccompanied asylum seeking children in England. This is the third consecutive year that the

number of unaccompanied asylum seeking looked after children has risen both locally and nationally.

1.8.5. Travelling families

Gypsy and Traveller children will often be seen as young adults by the time they reach the age of 14 when this is the case they will be expected to take on an adult role within the family unit. Taking on such responsibilities at a young age can have a significant impact upon the young person's mental health.

A number of children from the Gypsy and traveller community will have the opportunity to attend school mostly up until year 6. School can be a challenging experience for gypsy and traveller children, there is a lack of support specifically designed to target the cultural needs of these children meaning that they can at times have difficulties adjusting to a school environment. Children from the community live such contrasting lives to their peer's school can feel isolating and can cause anxiety and feelings of not fitting in.

The community have limited access to healthcare services and lack of knowledge surrounding children's mental health and without the appropriate healthcare there is a high possibility that it could lead to more significant mental health problems as the child develops into adulthood.

1.8.6. Young carer

Many children care for the parent, siblings and relatives. This can have a detrimental effect on the young carers' mental health.

The proportion of children aged 0-15 years in Leicestershire in 2011 that provided one or more hours of unpaid care per week was 0.94%, this equates to 1,109 children providing unpaid work. This is significantly better than the England average of 1.11%.[3]

The proportion of children aged 0-15 years in Leicestershire in 2011 that provide 20 or more hours of unpaid care per week was 0.17%, this equates to 199 children providing unpaid work. This is significantly better than the England average of 0.21%.[3]

1.9. Lifestyle behaviours in young people

The "What about YOUth survey" collected information at local authority level on young people's health and lifestyles covering the period of January-December 2014. The survey included their health, diet, bullying, smoking, taking drugs and drinking alcohol. The survey was sent to around 300,000 fifteen year olds across England who were randomly selected to take part.

In 2014/15, as part of the 'What about YOUth survey', 15.8% of 15 year olds in Leicestershire

reported to having undertaken at least three unhealthy/illegal behaviours, (including smoking, drinking, drugs, cannabis, poor diet and poor physical activity). This is similar to the England average of 15.9%.[3]

The 'What about YOUth survey' asked if an individual had ever tried cannabis (even if only once). In Leicestershire 9.5% of 15 year olds who responded to the question responded by saying they had tried it, this is similar to the England average of 10.7%.[3]

When the same 15 year olds in Leicestershire were asked "How often do you usually have an alcoholic drink?" 7.2% of 15 year olds responded with the answer being "At least once a week." This is similar to the England average of 6.2%.[3]

In Leicestershire 6.9% of 15 year olds responded to the question about smoking stating they were current smokers, this is similar to the England average of 8.2%.[3]

2. Level of need in Leicestershire

2.1. Perinatal mental health

It is believed that between 10% and 20% of women will be affected by mental health problems at some point during their pregnancy or the first year after childbirth.[42] Perinatal mental health is defined as the antenatal period (during pregnancy) and the postnatal period (up to one year after childbirth). Mental health issues that arise during the perinatal period can vary in severity from anxiety and depression through to post traumatic stress disorder (PTSD) and postpartum psychosis. For women who have had a history of bipolar disorder, there is an increased risk of a relapse at this time. Although these conditions can affect anyone with mental health problems, the concern with mental health problems in perinatal women is that it can affect the foetus, baby, family and the mother's physical health.[42]

Table 1 shows in 2015/16, the most prevalent disorder affecting postpartum women in Leicestershire was adjustment disorders and distress, affecting between 15.1% - 30.0% of mothers in Leicestershire. This equates to between 955 and 1905 mothers in the county. Mild-moderate depressive illness and anxiety was the second most prevalent condition affecting between 10.0% - 15.1% of mothers in Leicestershire. It is estimated that severe depressive illness affected 3.1% of postpartum woman (195) in Leicestershire. It is important to remember that failure to treat perinatal depression can result in a prolonged and harmful effect on the relationship between the mother and baby. Evidence suggests that postnatal depression "may be associated with lower cognitive and language achievements" in young children.[43]

Table 1 – Estimated number and percentage of mental health conditions of postpartum women in Leicestershire in 2015/16[44]

In Leicestershire, 6,344 women gave birth in 2015/16: [45]

	*Count	*Percentage
Estimated number of women with adjustment disorders and distress (upper estimate)	1905	30.0%
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	955	15.1%
Estimated number of women with adjustment disorders and distress (lower estimate)	955	15.1%
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	635	10.0%
Estimated number of women with severe depressive illness	195	3.1%
Estimated number of women with PTSD	195	3.1%
Estimated number of women with postpartum psychosis	15	0.2%
Estimated number of women with chronic SMI	15	0.2%

Please note, figures are based on national estimates and must not be added together to give an overall estimate as some women may suffer from more than one condition.

Post-traumatic stress disorder is a mental health disorder that can occur after birth related traumas, stillbirth, the death of a baby or sometimes from an uncomplicated delivery.[14] It is estimated there are 195 women in Leicestershire (3.1%) who suffered from PTSD in the perinatal period in 2015/16.[46]

It is recognised that some fathers may also suffer from mental health issues over this period however there is very little data available to examine this.

2.2. Prevalence in Early Years /pre-school years

Early years and school readiness play a vast part in being able to learn, participate and contribute to schooling, all of which are associated with mental health benefits. Both formal learning and informal learning such as playing and interaction impact on mental wellbeing, it helps to build resilience and guards against mental illness

In 2016/17 the number of children achieving school readiness (all children at age 5 achieving a good level of development at the end of reception as a percentage of all eligible children) in Leicestershire is 5,548 children. This equates to 70.1% which is statistically similar to the England average of 70.7%.[3] The number of children achieving school readiness that are eligible for free school meal status in Leicestershire is 245 children, this equates to 46.4% of children eligible for free school meals which is significantly worse than the England average of 56.0%, this is the fourth consecutive year Leicestershire has been significantly worse than the England average.[3] A higher percentage of people who live in low income households are at a greater risk of suffering from mental health disorders.[3]

2.3. Prevalence in school years

2.3.1. School digital health contact

The school digital health contact (previously known as SHINT) is a questionnaire completed by parents and carers of children commencing Reception year of school in September 2017, relating to their child's health and wellbeing. The tool is underpinned by the principle of 'Every Child Matters' and is used to ensure activities and services designed for children and young people are focussed on local needs and the local environment.

Of the parents/guardians in Leicestershire who completed the SHINT questionnaire, 188 out of 5866 responded by saying their child had behaviour issues, this equates to 3.2% of the total responses in Leicestershire. In Melton 3.7% of the responses by the parent/guardian reported their child had behavioural issues, this is the highest percentage out of all areas in Leicestershire. North West Leicestershire had the lowest percentage of the responses of parents/guardians reporting their child had behavioural issues at 2.6%. Behavioural problems can be a form of mental health and could lead on the more severe mental health issues. Please note, the sample size of this questionnaire is small so please treat this data with caution.

Figure 2 - Percentage of children with behavioural issues by area in Leicestershire
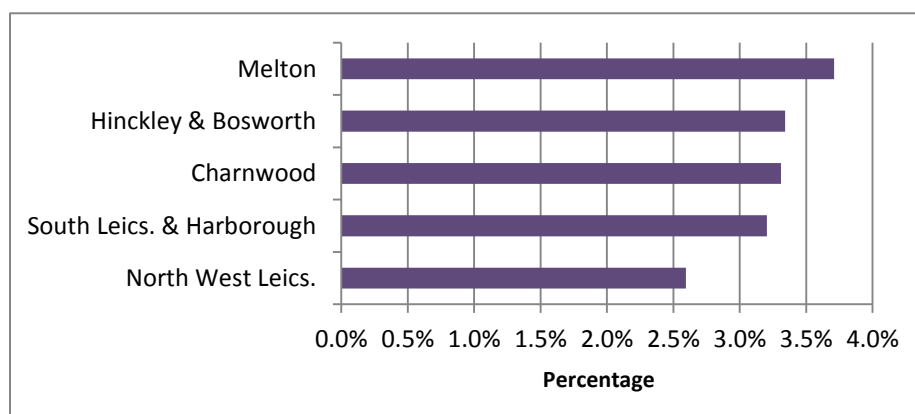
The parents/guardians in Leicestershire were asked if the child or any household member had a long-term condition or health need which might affect the child's education, 233 responded by saying there was, this equates to 4.0% of the total responses in Leicestershire. North West Leicestershire has the highest percentage of responses reporting a long term health condition that may affect the child's education at 4.9%, whereas South Leicestershire and Harborough has the lowest percentage at 3.5%.

Figure 3 - Percentage of pupils with a long term health condition or a household member with a long term health condition
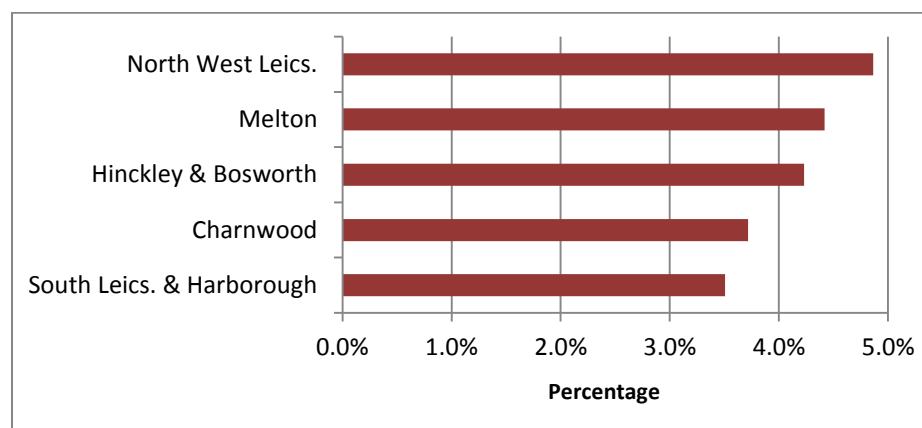
2.3.2. Social, emotional and mental health needs

The term Special Educational Needs (SEN) is a legal definition that refers to children and young people who have learning difficulties and/or disabilities and can affect their ability to learn.

In 2017, the percentage of pupils attending Leicestershire schools with statements of Special Education Needs (SEN) where primary need is social, emotional and mental health is 1.4%, this is significantly lower than the national percentage of 2.3%. This pattern is true in both in primary and secondary education.[3]

In primary schools, the percentage is 1.5% and in secondary schools the percentage is 1.3%, both significantly lower than the national percentage of 2.1% and 2.3% respectively. The latest data shows the percentage of pupils with an SEN statement where their primary need is social, emotional and mental health needs in Leicestershire decreases as pupils move into secondary education. [3]

2.3.2.1. Education and Health Care Plan (EHCP)

An Education and Health Care Plan (EHCP) is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs. These pupils have the highest level of need.

As of the spring term school census 2017, there are 174 children in Leicestershire schools with an EHCP with a primary need category of social, emotional and mental health.

Table 2 – The number of children with an EHCP with primary need category of social, emotional and mental health attending Leicestershire schools compared to England[46]

District of home address	Count on a EHCP with social, emotional and mental health issues	Total count on a EHC plan	Total no. of pupils	% on a EHCP with social, emotional and mental health issues	% on a EHC plan
Blaby	19	329	13,746	5.8%	2.4%
Charnwood	34	571	21,257	6.0%	2.7%
Harborough	15	219	11,896	6.8%	1.8%
Hinckley and Bosworth	28	478	14,807	5.9%	3.2%
Melton	18	207	6,169	8.7%	3.4%
North West Leics	22	368	13,760	6.0%	2.7%
Oadby and Wigston	18	215	7,676	8.4%	2.8%
Out of area	20	153	7,956	13.1%	1.9%
Total attending Leicestershire Schools	174	2,540	97,267	6.9%	2.6%
England	28,007	225,953	8,669,080	12.4%	2.6%

Table 2 shows for all pupils attending Leicestershire schools, 6.9% of pupils with an EHCP had a primary need of social, emotional and mental health needs. Those who live out of the county and attend Leicestershire schools have the highest proportion of pupils with an EHCP plan by primary need of social, emotional and mental health needs (13.1%). The district with the highest proportion of pupils with an EHCP by primary need of social, emotional and mental health needs is Melton at 8.7%; this is closely followed by Oadby and Wigston (8.4%). No district within Leicestershire has a higher percentage than England (12.4%) of children on an EHCP with a primary need of social, emotional and mental health conditions.

Table 3 shows social, emotional and mental health is the fifth highest primary need category of thirteen for EHCP pupils. Severe learning difficulty followed by moderate learning difficulty is the primary and secondary reasons for being on an EHCP for children who attend Leicestershire schools.

Table 3 – Percentage of Education and Health Care Plan by primary need category for pupils attending Leicestershire schools compared to England.[46]

	Autistic Spectrum Disorder	Hearing Impairment	Moderate Learning Difficulty	Multi-Sensory Impairment	Other Difficulty/ Disability	Physical Disability	Profound & Multiple Learning Difficulty	SEN support but no specialist	Severe Learning Difficulty	Social, Emotional and Mental Health	Specific Learning Difficulty	Speech, Language and Communications Needs	Visual Impairment
Blaby	18.5%	1.8%	17.6%	0.0%	4.6%	4.3%	5.8%	0.0%	23.4%	5.8%	4.0%	12.5%	1.8%
Charnwood	14.5%	1.2%	17.7%	0.9%	3.5%	5.3%	3.3%	0.0%	25.0%	6.0%	5.3%	15.1%	2.3%
Harborough	15.5%	1.8%	14.2%	0.5%	6.4%	6.4%	8.2%	0.5%	26.0%	6.8%	4.1%	8.7%	0.9%
Hinckley and Bosworth	14.6%	2.1%	29.9%	0.6%	3.8%	2.1%	4.4%	0.0%	18.8%	5.9%	4.8%	11.5%	1.5%
Melton	14.5%	1.4%	21.7%	0.0%	6.3%	4.8%	3.9%	0.5%	16.4%	8.7%	4.3%	15.5%	1.9%
North West Leicestershire	15.2%	0.8%	15.5%	0.0%	1.4%	3.5%	9.0%	0.3%	28.5%	6.0%	7.9%	10.3%	1.6%
Oadby and Wigston	15.3%	3.3%	18.1%	0.0%	2.3%	4.2%	2.8%	0.0%	24.2%	8.4%	9.3%	11.2%	0.9%
Out of County	17.0%	4.6%	13.7%	0.7%	2.6%	5.2%	8.5%	0.0%	18.3%	13.1%	5.2%	9.2%	2.0%
Total attending Leicestershire Schools	15.5%	1.9%	19.5%	0.4%	3.7%	4.3%	5.4%	0.1%	23.1%	6.9%	5.6%	12.2%	1.7%
England	26.9%	2.7%	12.6%	0.3%	2.5%	5.6%	4.4%	0.2%	12.9%	12.4%	3.7%	14.3%	1.4%

2.3.2.2.   Special Educational Need (SEN) support

SEN support is a level of support for pupils with special educational needs who do not reach the threshold of an EHCP.[46] In Leicestershire, the percentage of pupils on SEN support attending Leicestershire schools is 9.4%. Of those who receive SEN support, 1,220 pupils in Leicestershire schools have a recorded primary need category of Social, Emotional and Mental Health. This equates to 13.3% of the total number of pupils on SEN support or to 1.3% of the total number of pupils attending Leicestershire schools.

Table 4 shows throughout the districts, the percentage of pupils with SEN support with primary need category of social, emotional and mental health varies considerably. Oadby and Wigston has the highest percentage of 16.9% of pupils with SEN support with primary need category of social, emotional and mental health whereas Melton has the lowest at 11.3% of pupils with SEN support with primary need category of social, emotional and mental health. All Leicestershire districts have a lower percentage than England (17.3%) of pupils with SEN support with primary need category of social, emotional and mental health.

Table 4 – The number of children with SEN support with Primary Need category of Social, Emotional and Mental Health attending Leicestershire schools compared to England.[46]

District of home address	Count of SEN support with social, emotional and mental health issues	Total count on SEN support	Total no. of pupils	% of SEN support with social, emotional and mental health issues	% on SEN support
Blaby	146	1,107	13,746	13.2%	8.1%
Charnwood	356	2,463	21,257	14.5%	11.6%
Harborough	106	819	11,896	12.9%	6.9%
Hinckley and Bosworth	178	1,425	14,807	12.5%	9.6%
Melton	64	567	6,169	11.3%	9.2%
North West Leics	187	1,622	13,760	11.5%	11.8%
Oadby and Wigston	79	468	7,676	16.9%	6.1%
Out of area	104	707	7,956	14.7%	8.9%
Total attending Leicestershire Schools	1220	9,178	97,267	13.3%	9.4%
England	158,786	918,271	8,669,080	17.3%	10.6%

Table 5 shows in 2017, 39.5% of pupils with SEN support had a moderate learning difficulty; this is the highest primary need of SEN pupils in Leicestershire. This is followed by a specific learning difficulty (18.5%) and by speech, language and communications needs (14.0%). Social, emotional and mental health needs account the fourth highest primary need of SEN pupils in Leicestershire, compared to the third highest primary need nationally (17.3%).[46][47]

Table 5 - Percentage of SEN Support by primary need category for pupils attending Leicestershire schools compared to England 2017[46]

	Autistic Spectrum Disorder	Hearing Impairment	Moderate Learning Difficulty	Multi-Sensory Impairment	Other Difficulty/ Disability	Physical Disability	Profound & Multiple Learning Difficulty	SEN support but no specialist	Severe Learning Difficulty	Social, Emotional and Mental Health	Specific Learning Difficulty	Speech, Language and Communications Needs	Visual Impairment
Leicestershire	4.2%	1.8%	39.5%	0.0%	2.5%	2.0%	0.0%	2.3%	0.5%	13.3%	18.5%	14.0%	1.0%
England	5.2%	1.7%	25.2%	0.2%	5.3%	2.3%	0.1%	4.5%	0.4%	17.3%	15.1%	22.0%	0.9%

When examining by school category, Figure 4 shows for the last two years, the percentage of pupils with a primary SEN need of social, emotional and mental health needs increases from primary to secondary school. The percentage of SEN pupils with a primary need of social, emotional and mental health needs increased from 2014 to 2015 but decreased in 2016. This pattern was reversed in special schools.

Figure 4 - Percentage of pupils with a primary SEN need of social, emotional and mental health needs by schooling category.[47]
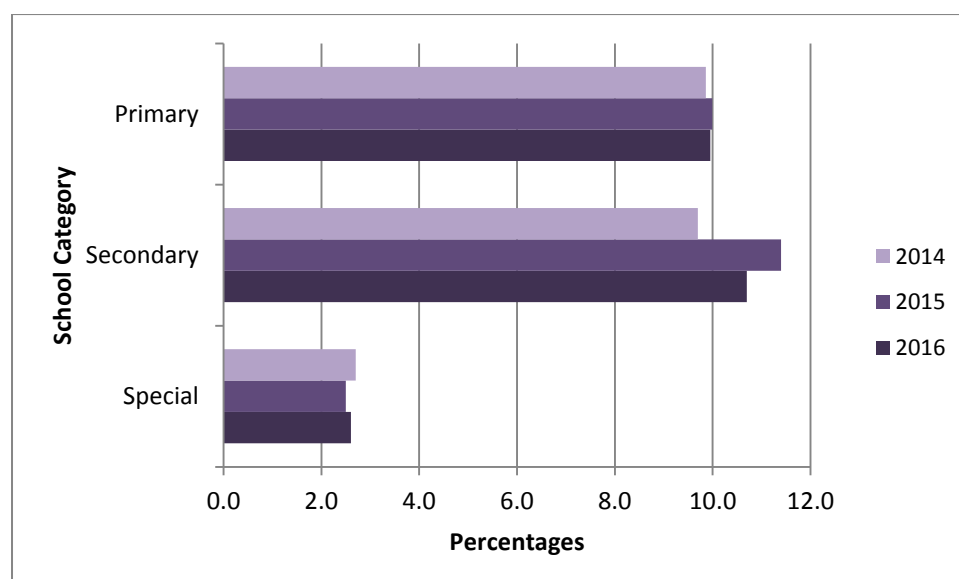
2.3.3. Youth health improvement

The "What about YOUth survey" collected information at local authority level on young people's health and lifestyles covering the period of January-December 2014. The survey included their health, mental wellbeing, life satisfaction etc. The survey was sent to approximately 300,000 fifteen year olds across England who were randomly selected to take part.

As part of the 'What about YOUth survey', 14 statements set by Warwick-Edinburgh Mental Well-being Scale (WEMWBS) covering a range of feelings and attitudes towards life were asked. The 15 year olds were asked to rate how often they felt like each of these statement. In Leicestershire, the mean wellbeing score response to these statements was 47.8. This is similar to the national score of 47.6.[3]

As part of the 'What about YOUth survey', one of the questions examines life satisfaction. In Leicestershire, 69.7% of 15 year olds reported having a positive life satisfaction, this is similar to the England average of 63.8%.[3] In contrast to having a positive life satisfaction, 12.5% of 15 year olds in Leicestershire reported having a low life satisfaction, this is similar to the England average of 13.7%.[3]

2.4. Vulnerable children

2.4.1. Strengths and Difficulties Questionnaire for Looked After Children[48]

The Strengths and Difficulties Questionnaire (SDQ) is a tool which is used to identify Looked After Children (LAC) who are at risk of developing emotional and behavioural difficulties. An estimated 45% of Looked After Children have mental health problems, over four times higher than all children.[22] If the total score is within the high risk category of 17 and above, a referral to CAMHS (Children and Adolescents Mental Health Service) will be discussed and made as necessary. Leicestershire's average score was 16 in quarter 1 2017/18 (April to June), although this score is not yet considered reliable. SDQ scores have been difficult to report over recent years due to inconsistency of the available data which includes low completion rates of the questionnaires in the first instance. The Children in Care service in Leicestershire County Council is focussed on improving the quantity and quality of returns and a briefing was issued to staff. The briefing was also placed on the Senior Management Team action log and circulated to all staff within the Children and Families Department of Leicestershire County Council.[46]

Statutory guidance advocates that both local authorities and health trusts ensure that SDQ's are built into the annual health assessments for Looked after Children. At quarter 1 in 2017/18, Leicestershire County Council had a 55% completion rate of SDQs. Whilst this is an improvement on the 2016/17 completion rate of 17.5%, it was not yet thought to be a sufficiently large sample size to use the average score to inform service provision and commissioning (data taken social care quarterly data).[46]

Leicestershire was in the lowest quartile of all local authorities for Emotional and Behavioural Health of Looked after Children in 2017, with an average figure of 16.9. This was above the national average of 14.1 and above the statistical neighbour average of 15.6.[48] Leicestershire has been above comparative levels (i.e. worse performing) for the previous three years, as shown in Table 6. The measure is calculated by the increase in the total difficulties score corresponding to an increase in the risk of developing a mental health disorder.[49]

Table 6 – Average difficulty scores of emotional and behavioural health of Looked after Children

Area	2015	2016	2017
Leicestershire	16.5	16.6	16.9
Statistical Neighbours	14.4	14.6	15.6
England	13.9	14	14.1

2.5.   Mental health

The figures discussed below are estimates of children aged between 5-16 years who have mental health disorders based on the age, sex and socio-economic classification (social class) of children resident in Leicestershire taken from the survey of Mental Health of Children and Young People in Great Britain (2004). The survey used to derive the estimates was carried out in 2004 and no adjustment has been made for possible change in prevalence over time.[3] An updated survey took place in 2017 with the results due to being published in 2018.[50]

In 2015 it is estimated that nearly one in ten (8.7%) of children aged between 5-16 have a mental health disorder in Leicestershire. This equates to nearly 8,000 children in the county affected by these disorders. Nationally, the average is 9.2%.[3]

One in twenty children (5.1%) in the county are estimated to have a conduct disorder. This is estimated to affect nearly 5,000 children aged 5-16 years. This percentage is lower than the national percentage of 5.6%. Conduct disorders in children lead to poorer health outcomes and lower life expectancy.[3]

Approximately 3,000 children aged between 5-16 have an emotional disorder in the county. This equated to 3.4% of the local population, lower than the national average of 3.6%.[3] Hyperkinetic disorders are estimated to affect 1.4% of the 5-16 years old in Leicestershire. This is lower than the national average of 1.5%.[3]

2.6.   Self-harm

Self-harm, including intentional self-poisoning or self-injury is widespread in children and young adults and strongly associated with suicide. Nationally, children's admissions to hospital for self-harm has increased in recent years, with young women having a much higher admission rate than young men.[2]

In 2016/17, the crude rate of hospital admissions as a result of self-harm in Leicestershire was 139.5 per 100,000 population aged 10-14 years, this represents 52 finished admission episodes per year. The national crude rate was 230.0 per 100,000 population. In the same time period the crude rate of hospital admissions as a result of self-harm for 15-19 years olds in Leicestershire was 535.3 per 100,000 population, this represents 220 finished admission episodes per year. The national crude rate was 658.0 per 100,000 population.[3] This shows that young people in Leicestershire between the ages of 15-19 are four times more likely to self-harm compared to younger people between the ages of 10-14. This may be due to exam stress and peer pressures at schools and university.

In 2016/17, the directly standardised rate of finished admission episodes for self-harm for children

and young adults aged 10-24 years in Leicestershire was 348.7 per 100,000 population, this was significantly lower than the directly standardised rate for England of 404.6 per 100,000 population aged 10-24 years.[3]

It is important to remember that not all episodes of self harm in children result in hospital attendance.

2.7. Undetermined deaths, including suicide

Suicide is a significant cause of death in young adults. In the last 10 years (2008 – 2017), Leicestershire recorded 18 deaths from suicide and injury of undetermined intent for young people aged 12-19 years. Of the 18 deaths from suicide in Leicestershire, 13 deaths have been male and 5 deaths have been female. The average age of suicide deaths in Leicestershire between the age range of 12-19 years is 17.2 years.

In 2017 The LLR Child Death Overview Panel (CDOP) undertook an themed review of suicides reviewed by CDOP and then more in-depth audit of four additional deaths. The Panel discussed action that may be taken locally to address the identified risk factors and which may reduce the risk of future suicides.

3.   How does this impact?

Early intervention can help children and young people from falling in to crisis and help stop then declining further or leading in to long term interventions in adulthood. The estimated annual cost of mental health issues in children and young people is estimated to be between £11,030 and £59,130 per child.[51] A good example of where early intervention is paramount is where children with conduct disorders, including aggression and anti-social behaviour, the estimated lifetime cost of a one year cohort is £5.2 billion. The annual cost of crime in England and Wales by adults who had conduct disorders in childhood costs an estimated £60 billion.[51]

Over 150,000 attendances to Accident and Emergency was due to self-harm in children and young people. In 2014-15, the annual cost to the NHS in England and Wales for admissions for children and young people who self harmed was £40 million.[51]

4.   Policy and Guidance

4.1.   Future in Mind (2015)

The Department of Health and NHS England published 'Future in Mind: Promoting, protecting and improving children and young people's mental health and wellbeing' in 2015. Future in Mind sets out the Government's vision for children and young people's mental health.[52]

The themes of Future in Mind include:

- Promoting resilience, prevention and early intervention

- Improving access to effective support – a system without tiers

- Care for the most vulnerable

- Accountability and transparency

- Developing the workforce

4.2.   The Green Paper [53]

A Green Paper 'Transforming Children and Young People's Mental Health Provision': was published in December 2017.

The Green Paper builds on the government's vision for children and young people's mental health set out in Future in Mind in 2015, the Green Paper provides the joint response of the Department for Health and Social Care (DHSC) and the Department for Education (DfE).

The Paper contains three key announcements:

- To provide an incentive for every school and college to have a designated senior lead for mental health. All children and young people's mental health services should have a link for schools and colleges to better support them in delivering on child and young people mental health and wellbeing needs. They will do this through advice, consultation and signposting for children who need it.

- Funding for new mental health support teams, which will be supervised by NHS children and young people's mental health staff, to provide extra capacity for early intervention and ongoing help. These teams will be linked to groups of primary and secondary schools and to colleges, providing support to those with mild to moderate needs and promoting good mental health and wellbeing. Their work will be managed jointly by schools, colleges and the NHS.

- A four week waiting time for access to specialist NHS children and young people's mental health services will be trialled. This builds on the expansion of specialist NHS services already underway.

4.3.   The Five Year Forward View for Mental Health (2016)[54]

In order to deliver on the vision set out in 2015's Future in Mind and 2016's Five Year Forward

View for Mental Health, the government have:

- Legislated for parity of esteem between physical and mental health.

- Committed to make an additional £1.4 billion available for children and young people's mental health over five years.

- Committed to recruit 1,700 more therapists and supervisors, and to train 3,400 staff already working in services to deliver evidence-based treatments by 2020/21.

- Committed to ensure that an additional 70,000 children and young people per year will obtain support from mental health services by 2020/21.

- Improved services for eating disorders, with an additional £30 million of investment, 70 new or enhanced Community Eating Disorder Teams, and the first ever waiting times for eating disorders and psychosis.

- Funded eight areas to test different crisis approaches for children and young people's mental health and testing New Care Models for Mental Health.

- Published: cross-agency Local Transformation Plans for children and young people's mental health for every area of the country.

4.4.   Prevention Concordat for Better Mental Health[55]

The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost effectiveness of this approach is enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing.

The concordat is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across: local authorities, the NHS, public, private and voluntary, community and social enterprise (VCSE) sector organisations, educational settings, employers.

It represents a public mental health informed approach to prevention, as outlined in the NHS Five Year forward view and promotes relevant NICE guidance and existing evidence based interventions and delivery approaches, such as 'making every contact count'.

The Prevention Concordat for Better Mental Health seeks to prevent mental health problems from

developing and to promote good health through local and national action including addressing the wider determinants of mental health and focusing on prevention. It recognises the need to build capacity and capability of the workforce to prevent mental health problems and promote good mental health. A Prevention Concordant has been adopted for the East Midlands and local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers. The voluntary and community sector within Leicestershire have signed up to this approach.

4.5. Suicide Prevention: Policy and Strategy (2018)[56]

The Five Year Forward View for Mental Health recommends that all local authorities have multi-agency suicide prevention plans in place in 2017. These plans should target high-risk locations and support high-risk groups, including men and people in contact with mental health services. The local plans should be reviewed annually and supported by new investment.

The All Party Parliamentary Group on Suicide and Self-Harm Prevention (2013) recommended that Health and Wellbeing Boards

I.   Ensure that suicide and self-harm are addressed in the Joint Strategic Needs Assessment beyond being a measure.

II.   Ensure that the local suicide prevention plan is written into the local health and wellbeing strategy and includes provision for bereaved families.

       Investigate opportunities for developing links with neighbouring local authorities to co-ordinate work through a regional group that could pool resources and expertise.

III.   The LLR Suicide Audit and Prevention Group (LLR SAPG) has been brought together to tackle the cause and the impact of suicide across Leicestershire. The LLR SAPG is a sub-group of the LLR Better Care Together Mental Health Partnership Group and it also feeds into the LLR Crisis Concordat. In addition it reports into local authority Health and Wellbeing Boards and Health Scrutiny Committees.

The LLR SAPG has developed the Leicester, Leicestershire and Rutland Suicide Prevention Strategy and Plan 2017-20 is in place, this plan includes the STOP Suicide Prevention Campaign, which is being developed amongst key partners across Leicester, Leicestershire and Rutland. The campaign includes the development of a Suicide Prevention website.

4.6. NICE Guidance

4.6.1. Social and Emotional Wellbeing in Primary Education PH 12

This guideline covers approaches to promoting social and emotional wellbeing in children aged 4 to 11 years in primary education. It includes planning and delivering programmes and activities to help children develop social and emotional skills and wellbeing. It also covers identifying signs of anxiety or social and emotional problems in children and how to address them.[57]

4.6.2. Social and Emotional Wellbeing in Secondary Education PH20

This guideline covers interventions to support social and emotional wellbeing among young people aged 11–19 years who are in full-time education. It aims to promote good social, emotional and psychological health to protect young people against behavioural and health problems.[58]

4.6.3. Social and emotional Wellbeing Early years PH40

This guideline covers supporting the social and emotional wellbeing of vulnerable children under 5 through home visiting, childcare and early education. It aims to optimise care for young children who need extra support because they have or are at risk of social or emotional problems.[59]

4.7. Young People's Mental Health coalition Guidance[60]

PHE and the Children and Young People's Mental Health coalition in 2015 published guidance 'Promoting Children and Young People's emotional health and wellbeing: a Whole School and College Approach.

The figure below illustrates the principles that make up the Whole School Approach to promoting children and young people's emotional health and wellbeing

The Whole School Approach is also included in the green paper, with the designated lead for mental health in a school or college will have oversight of the whole school approach.

Figure 5 - Principles of the whole school approach

An **ethos and environment** that promotes respect and values diversity

Curriculum, teaching and learning to promote resilience and support social and emotional learning

Targeted support and appropriate referral

Enabling **student voice** to influence decisions

Leadership and management that supports and champions efforts to promote emotional health and wellbeing

Working with parents/carers

Staff development to support their own wellbeing and that of students

Identifying need and monitoring impact of interventions

5. Current Services

Services to promote mental health and wellbeing and to identify and support those who are experiencing mental health problems need to be co-ordinated and integrated. Locally this has been described as a whole system pathway across Leicester, Leicestershire and Rutland, called the Social, Emotional, Mental Health and Wellbeing pathway.

5.1. Workforce across the emotional mental health and wellbeing services

We recognise that one of the ways we can achieve improved outcomes for children and young people with emotional, mental health and wellbeing is by developing the capacity and capability of our workforce. One of the main aims of the Future in Mind Programme is to increase the number of staff across the partnership by 2020 to meet the additional demand for services.

The Leicester, Leicestershire & Rutland Workforce Development Group has been established to work with a range of partners to ensure a whole system approach to increasing the skills of the workforce and to increase the number of staff working in children and young people's services. The group is developing a joint workforce strategy which will describe opportunities across our partnership to improve the skills, knowledge and competencies of our staff and to increase children and young people's access to evidence based practice to meet their different levels of need.

5.2. Future in Mind commissioned services

A number of services have been commissioned directly as part of the Future in Mind programme. These services have been designed to augment and improve pre-existing mainstream services. This is the list of the **Future in Mind commissioned services** (Commissioned by Leicester City Clinical commissioning Groups on behalf of all 3 CCGs across Leicester, Leicestershire and Rutland):

Figure 6 - System wide pathway of services
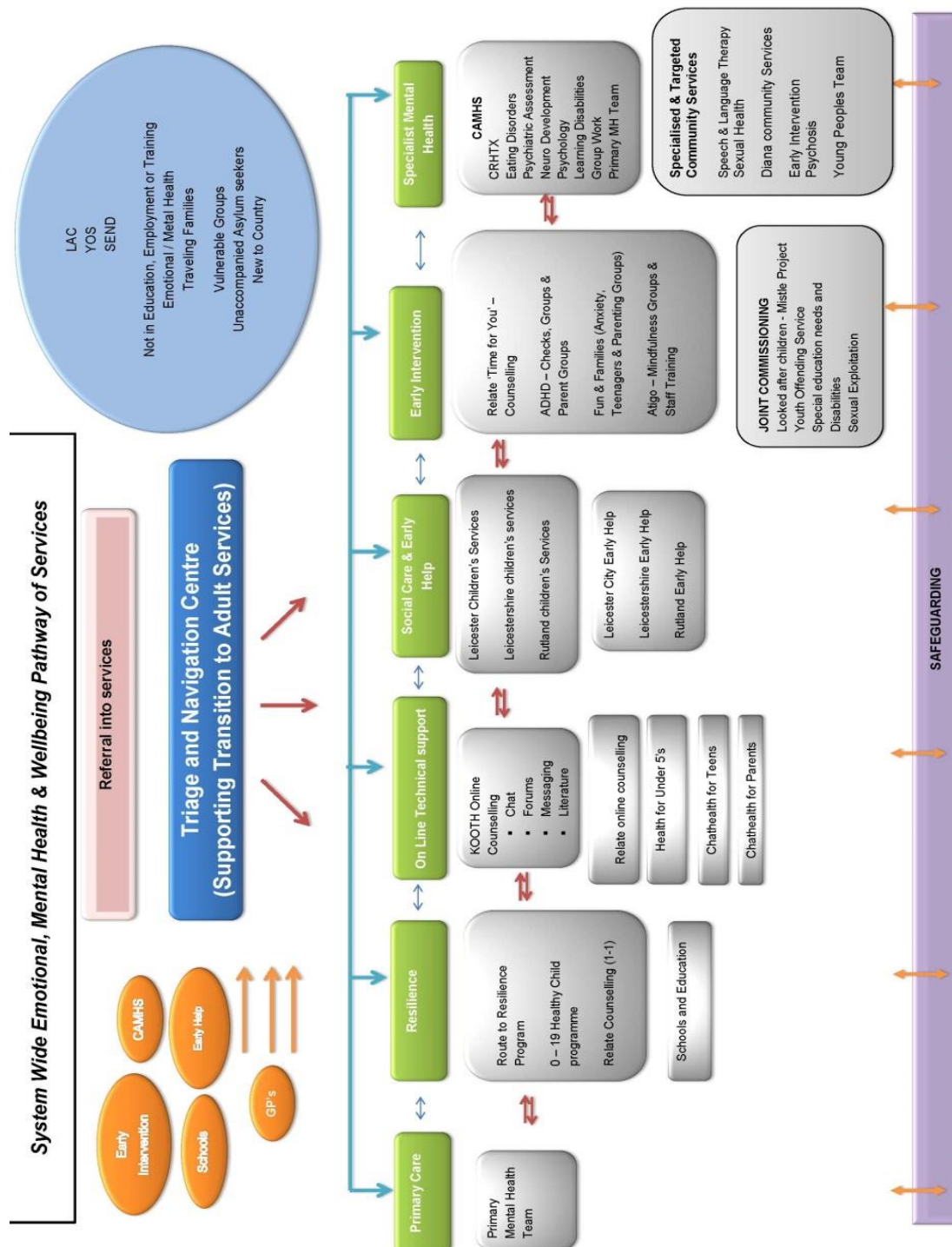
- Targeted Early Intervention Emotional health and wellbeing Service for LLR

- Route to Resilience in Schools - a whole school approach to resilience in schools programme

- Xenzone - Kooth deliver an Online Counselling service

- Enhanced Access to Childhood and Adolescent Mental Health Service (CAMHS)

- Eating Disorders Service

- Crisis and Home Treatment Service

- Place of safety

- CAMH Service

- Primary Mental Health Team

5.3. The Future in Mind programme overlaps with the local CAMHS service:

The Child and Adolescent Mental Health Service (CAMHS) help children and young people who have been referred by another healthcare professional. The CAMHS website is available at the following link: http://www.leicspart.nhs.uk/_OurServicesAZ-ChildandAdolescentMentalHealthServiceCAMHS.aspx)

Referrals are made if it's thought the child or young person has emotional and/or behavioural difficulties at a level which requires specialist support. We provide a range of services including initial assessments, therapy, group work, emergency assessments and in-patient care.

CAMHS sees young people from across Leicester, Leicestershire and Rutland. The service also links with other children's services to offer a multi-agency approach. The team is made up of doctors, nurses and therapists who specialise in child mental health. The support we provide varies according to need, from a one-off appointment to a programme of on-going care which lasts until the child or young person feels better and is felt to be safe.

- Most appointments are delivered in clinical bases.

- **CAMHS Crisis Resolution and Home Treatment team** provides rapid assessment and treatment at home for children and young people in mental health crisis and support for their families, providing no physical medical intervention is required. Once a referral is received, the team aims to make telephone contact with a family within two hours and to assess the child or young person within 24 hours. The service is operational from 8am until

10pm. Outside of these times, support is provided by the adult crisis team.

- The **Primary Mental Health Team** works between primary care - for example GPs and public health (school) nurses - and specialist CAMHS outpatient teams. The team treats young people having difficulties with their mental health or emotional wellbeing, and who may be at risk of developing a mental health disorder.

- The **Young Peoples Team** works particularly with vulnerable young people in care and those who are involved with the youth offending service.

- The **CAMHS Learning Disability Team** provide services for children with a moderate to profound learning disability as defined in ICD 10 presenting with mental health and or associated behavioural problems.

- The **CAMHS Eating Disorders Team**, based at Mawson House in Leicester, offers specialist outpatient assessment and treatment to young people and their parents affected by eating disorders, and manages around 100 new referrals each year. Treatment usually lasts between 12 and 18 months, though early intervention is crucial to recovery.

- The **Paediatric Psychology Team**, based at Artemis House, offers specialist psychological assessment and treatment to children, young people and their families who are psychologically affected by living with physical health conditions or disabilities. Referrals are from Consultant Paediatricians only

5.4.   Services provided by Leicestershire County Council

Services provided by the Leicestershire County Council's Children and Family Service include:

- **Early Help Wellbeing Practitioners -** Cognitive Behavioural Therapy informed brief interventions with children aged 7+ with low level mental health difficulties including anxiety, low mood. Part of national CYP Improving Access to Psychological Therapies (IAPT) programme. An evaluation of the Early Help Service has recently been completed by Leicestershire County Council. For further information of this evaluation relating to mental health of children, please see **Appendix 1**.

- **Targeted Youth Service provision** – mix of 1-1 and group work support for young people age 11+ covering a range of **issues which include anxiety, anger management, protective behaviours**. However, it should be noted that Leicestershire County Council no longer provides universal youth service provision.

- **Children's Centre programme** promoting infant mental health through parenting programmes, and a range of parent/care giver pathways including for example speech and

language based programmes; 1-1 support from Family Outreach Workers. Please see **Appendix 2** for further information and data relating to the Children's Centre programme.

Within the early help workforce there are a number of children and young people IAPT Enhanced Evidence Based Practitioners who are able to provide CBT informed interventions to children and young people

- **Feeling Safe programme** for children and young people who have experienced domestic abuse

5.4.1. Liaison and Diversion programme with Youth Offending Service

Liaison and Diversion (L and D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders.

The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

L and D services aim to improve overall health outcomes for people and to support people in the reduction of re-offending. It also aims to identify vulnerabilities in people earlier on which reduces the likelihood that people will reach a crisis-point and helps to ensure the right support can be put in place from initial police contact.

Within Leicestershire's Youth Offending Service the team is made up of a L and D lead, L and D project worker and L and D mental health practitioner, with oversight from both YOS and LPT management. Referrals are accepted to complete screening and L and D assessments to identify needs of young people who have been suspected or charged with a crime. There is liaison with agencies involved in the young person's care, onward referrals are made and information is provided to police decision makers to aid outcome and ensure decision makers are aware of the young person's health needs and vulnerabilities.

5.4.2. Leicestershire's Educational Psychologists (LEPs)

Leicestershire's Educational Psychologists (LEPs) promote learning, attainment, mental health and the emotional well-being of children and young people 0 – 25 years through the application of psychology at individual, group and organisational levels. They provide a problem-solving and solution- focused service which is most effective when working in partnership with others.

Additionally, LEPs work with early year's settings, schools, colleges and other education providers (commissioned offer) for children and their families to promote academic resilience – 'the

ordinary magic in the minds, brains and bodies of children, in their families and relationships and in their communities'.

Leicestershire County Council's Children and Family Service also commission the following services:

- CAMHS Post Sex Abuse Project

- CAMHS health posts

- MISTLE- Multidisciplinary Intensive Support Team – wrap around therapeutic support

5.4.3. Leicestershire County Council's Public Health Commissioned Services

5.4.3.1. 0-19 Healthy Child Programme

The programme helps to build resilience and support emotional health and wellbeing of children and young people and maternal mental health. Children's mental health has been included as high impact areas in the delivery of the 0-19 Healthy Child Programme. In this context, Public Health nurses (Health Visitors and School Nurses) provide brief interventions, advice, and support for children, young people and their families on emotional health and wellbeing.

The Healthy Together 0-19 Healthy Child Programme have also developed a number of packages of care and support and pathways in response to need including: anxiety, emotional health and self -harm, emotional health, behaviour management 0-5/ 5-19, domestic violence safeguarding, child sexual exploitation referral pathways.

Public health nurses provide face to face support through drop in clinics for young people in secondary schools and for parents in primary schools

Young people can also text a public health nurse to access confidential advice via a secure messaging service, ChatHealth. In Leicestershire and Rutland, young people can text
07520 615387

The ChatHealth service is also available for parents and carers if they have concerns about their child's health, and would like to contact a health professional. In Leicestershire and Rutland: 07520 615382

5.4.3.2. Early Start Programme

Public Health nurses (Health visitors) deliver the Early Start Programme throughout the county. The Early Start Programme (ESP) provides intensive early intervention and support for vulnerable first time parents with an infant 0-2 years living in Leicestershire. Informed by an outreach health

visiting model, ESP is delivered by health visitors, early childhood practitioners and family nursing support staff and provides families with bespoke support. Support can start from 16 weeks pregnancy until the child's second birthday.

The Aim of the Programme is to ensure all children in Leicestershire have the best start to life and prepare and equip vulnerable parents for parenthood. The objective of the programme is to ensure that participating parents and families have the skills, knowledge, confidence and capability to enable them to give their children the best possible physical, *emotional*, social and environmental outcomes

There is information on Emotional health and wellbeing and mental health issues on the 3 Healthy Together websites including:

Health for under 5's: https://healthforunder5s.co.uk/

Health For Kids: https://www.healthforkids.co.uk/

Health for Teens: https://www.healthforteens.co.uk/

5.4.3.3.   *Healthy Tots Programme and Healthy Schools Programme*

Emotional Health and wellbeing is one of the core themes of both the **Leicestershire Healthy Tots Programme (a healthy early years programme) and the Leicestershire Healthy Schools Programme.** Early year settings and schools have to fulfil criteria re emotional and wellbeing to achieve healthy tots status and to renew their healthy school status. Emotional health and wellbeing is one of the public health priorities that schools can work on to achieve enhanced healthy school status.

Early year settings and schools are supported by public health through the websites:

Leicestershire Healthy Tots: www.leicestershirehealthytots.org.uk

Leicestershire Healthy Schools: www.leicestershirehealthyschools.org.uk

And through free healthy school/tots training courses

5.4.3.4.   *Teenage Mediation*

Community mediation service aimed at young people aged 11-19 years old, their families and communities. Support for Children and Young People in danger of being excluded from school, home. Current work is progressing on the **'Think Family'** support for children of parents with mental health problems, to be delivered in the coming year.

5.5. Voluntary and Community sector

Despite a difficult funding climate with less voluntary and community based services being commissioned Leicestershire continues to be home for a number of innovative front services providing mental health support for children, young people and their parents and carers. Examples of a number of these services can be found below, but please note this is not an exhaustive list. There are many more local organisations and groups providing services and support for people with mental health problems. More information can be found at www.valonline.org.uk.

5.5.1. *Spirit at play and The Way of the Horse*

The Spirit at Play and The Way of the Horse both provide equine assisted learning for children with a variety of additional needs including learning difficulties, emotional & behavioural problems, mental & physical disabilities.

5.5.2. *ADHD Solutions*

ADHA Solutions work across Leicestershire and Rutland providing information, help and support for children, young people and adults with Attention Deficit Hyperactivity Disorder (ADHD) their families and anyone who supports them and/or works with them. http://cmsms.adhdsolutions.org/

5.5.3. *YES Project*

YES project is a partnership of nine organisations whose aims are to transform the futures of 400 young people between the ages of 15 and 24 who are currently the furthest from being able to move into employment. It offers a range of courses and support services that helps young people to overcome challenges and barriers that have prevented them from finding a job including low self-esteem and confidence and mental health issues https://www.yesproject.org/

5.5.4. *Future Minds:*

Offer a comprehensive service for emotional wellbeing and good mental health including specialist support for children & young people and their parents/carers http://www.futureminds.co.uk/index.php?subj=1

5.6. Services provided by the voluntary sector using public sector grants

• Bereavement Service

• Support for young carers

- Post Sexual Abuse

In addition, NHS England provide Youth Justice Project Funding for a Joint Youth Justice and Youth Offending Service programme to support children returning to the community from secure settings with a view to supporting all levels of emotional distress and / mental health needs related to physical and emotional trauma.

6. Unmet needs/Gaps

6.1. Needs of children and young people

The evidence of local needs, current and emerging indicates:

- There are increasing numbers of referrals to early intervention services and CAMHS for children and young people with mental health and emotional health and wellbeing problems e.g. self-harm, anxiety.

- There are an increasing number (approximately 1 in 5) children and young people who are exposed to domestic violence and other adverse childhood experiences. Research states that children who are exposed or experience domestic violence have a fourfold increased risk of experiencing behavioural and emotional health issues.[61] Therefore, there are a significant number of children in Leicestershire who may be experiencing and/or witnessing domestic violence; however their emotional and mental health needs are not necessarily being catered for.

- Public health nurses (school nurses) are seeing an increasing number of children and young people who are experiencing emotional and mental health problems. A recent pilot in three Leicestershire Secondary Schools of a new digital contact at year 7, 9 and 11 revealed that a significant proportion of young people completing the survey regularly experience feelings of anxiety.

- Public health nurses (school nurses) are also seeing an increasing number of children who are self-harming.

- The age at which children and young people are presenting to services with emotional and mental health problems has lowered to primary school age.

- A significant number of referrals to CAMHS are related to behaviour which is taking up significant time and resources. It is hoped that the new system wide emotional, mental health and wellbeing pathway will help to divert these referrals away from CAMHS, if appropriate. The care of children and young people with behavioural issues is better served if it is multidisciplinary and focused on the child's needs rather than a medical

diagnosis.

- There is also emerging recognition that many of the referrals to services are caused by attachment issues, therefore there should be an increased focus on parenting programmes through the 0-19 healthy child programme the Children and Family Service's early help service and voluntary sector programmes.

- A recent national 'Time to change' survey[62] revealed that 90% of young people said that they have experienced stigma and discrimination as a result of their mental health issues. This has prevented them in some cases, from doing every day activities that they enjoy. Stigma and discrimination can also stop people from seeking help and socialising with friends and discussing their problems with family or friends because they fear a negative reaction.

6.2. Mental Health Promotion and Prevention of Mental Health problems and Early Intervention

- Across the system there is recognition that there needs to be a greater emphasis on mental health promotion, prevention of mental health problems and early intervention, identifying emotional and mental health problems early in order to 'break the cycle'.

- Resilience also needs to be systematically promoted within all schools through the route to resilience programme and the Leicestershire Healthy Schools Programme and through the delivery of personal social health education (PSHE) including how to build mental resilience and wellbeing. All schools will have to deliver compulsory health education from September 2020.

- Self Help: There may be scope and potential to help and support young people to manage emotional health and wellbeing issues themselves.

- There needs to be more emotional and mental health training and support provided to universal services (e.g. Schools, Primary Care (GPs), Health Visiting and School Nursing Services) due to sheer numbers of children and young people accessing these services.

- It is recognised that schools need to be helped to take on a greater role in promoting emotional health and wellbeing as well identifying children who are at risk of emotional and mental health problems. However, in order to do this they need training and support to feel competent and confident. Part of compulsory health education (from September 2020) will include the need to ensure that children and young people will know how to recognise when they and others are struggling with mental health issues and how to respond

6.3. Provision of CAMHS Services

- There are still significant blockages in terms of access to treatment at every level of CAMHS. However, it is also recognised that there have been recent improvements.

6.4. Emerging gap between children with ADHD and autism with mental health services

A gap in the current commissioned services around children and young people with a diagnosis of Autism has been identified. The gap focusses specifically on those children and young people with a diagnosis of Autism, but do not also have a diagnosis of a mild to moderate learning disability. The children with Autism with mild learning disability are not picked up until situations escalate i.e. in:

- Care and Treatment reviews

- Children with medical need (education meeting)

- NEET

- Youth offending Services

6.5. Children in Care (Looked after Children)

Children in care have particular emotional needs, related to their earlier experiences before they were looked after. These earlier experiences have an influence on brain development and attachment behaviour. Rates of: emotional, behavioural and mental health difficulties are at four to five times higher amongst children in care (looked after children) than the wider population.

A Whole System Approach to promoting good emotional health of children in care (looked after children) is needed (see NSPCC's 'Achieving Emotional Wellbeing for Looked after Children' (2015)[63] the priorities for change within the system should include:

- Embed an emphasis on emotional wellbeing throughout the system

- Take a proactive and preventative approach

- Give children and young people a voice and influence

- Support and sustaining children's relationships

- Support care leavers' emotional needs

6.6. Transition to Adult Services

There are mixed views about transitioning from child to adult mental health services. Nationally, many young people who present with emotional and mental health issues on the cusp of transition into adult services may not necessarily be placed with the most appropriate level of care.

7. Recommendations

- The importance of taking action right across a child and young person's life course needs to be recognised, within the wider context of their lives. (A life-course approach aims at increasing the effectiveness of interventions throughout a person's life. It focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime. It promotes timely interventions and support with an emphasis on addressing the causes, not the consequences, of ill health.)

- There needs to 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.

7.1. Wellbeing - wider determinates which influence health and wellbeing

- Build on the work of both the Healthy Schools programme and the Route to Resilience programme to fully embed interventions to enhance mental wellbeing and reduce the risk of mental illness in CYP in all schools and Further Education Colleges in Leicestershire.

- Continue to endorse the Whole School approach. All schools across Leicestershire should adopt the Whole School approach to promoting the emotional health and wellbeing of children and young people, including helping children and young people to build mental resilience and wellbeing (through participation in the Route to Resilience Programme).[60]

- Consider collecting bespoke data on wellbeing for children and young people locally.

- Increase in access to and provision of services such as debt counselling / welfare rights and legal support to address childhood poverty and homelessness

7.2. Early Years

- Utilise the Ages & Stages Questionnaire: ASQ SE (which includes Social and Emotional Development)   as part of the Healthy Child Programme 2 year review and Early Year Setting's 2 year progress checks to undertake an emotional and mental wellbeing check of the child and provide appropriate support based on the need identified including

signposting and referral to other services (including early help).

7.3. Parents/Family

- Systematic support should be provided to families with children and young people who are experiencing domestic violence at all risk levels. There needs to be recognition the impact of DV on children's emotional and mental health.

- All adult mental health services should have a Key Performance Indicator to support the emotional and mental health needs of children particularly when parents are diagnosed with a mental health condition. 'Think Family Approach'.

- All children and young people's services to consider: parental mental health, substance misuse and domestic violence as a factor affecting child emotional and mental health and to signpost/refer to appropriate services.

7.4. Training

- All primary care (GPs) Public health nurses (school nurses and health visitors) and schools (all teachers) should have comprehensive training in the skills and knowledge required to recognise children and families who may be experiencing emotional and mental health issues.

- A comprehensive self-harm training and suicide prevention training programme should be developed and delivered to all GPs, schools (both primary and secondary including teachers) and public health (school nurses.)

- Training should be available for school staff.

7.5. Risk Groups/ACEs

- **Adversity and trauma informed care** for children and young people in Leicestershire should be prioritised who have Adverse Childhood Experiences (ACEs). ACEs include: parental separation, domestic violence, sexual assault, mental illness, alcohol abuse/ drug use. The CDOP in their review of suicides recognises that their work could form part of an overarching Leicestershire Children's Partnership Strategy focussing on recognising and addressing Adverse Childhood Experiences.

  This adversity and trauma informed care should include:

  - o **Primary prevention**- developing a strategy to reduce primary exposure to adverse childhood experiences and

- o **Secondary prevention** and response including: building resilience individual/ family/ neighbourhood and the use of the 4Ps. The 4Ps include*: Parents* nurturing, caring, rule enforcing, relationship with a parent/ carer or adult figure. *Peers*: social connectedness with a supportive peer group. *Problem Solving*: ability to solve problems and communicate. *Passion:* an interest or hobby or skill that the child or young person highly values in themselves.

- o Work with front line staff, teaching staff and commissioners to highlight the potential impact on mental health of parental separation – particularly for those children with other risk factors

- Strengthen early recognition and management of maternal mental health problems to help bonding and attachment.

- Antenatal and perinatal health needs to focus more on emotional and mental health of mothers with the development of specialist mental health midwifery support for mothers with post-natal depression. This is due to the link between antenatal anxiety at 32 weeks and the link to behavioural and emotional problems in children.

- Continue the roll out the expansion of the Early Start Programme across the County which addresses how to parent effectively covering issues like attachment.

- Continue to signpost and refer to other services including early help

- Influence across the local authority and CCG and wider systems to develop policies which can affect the wider determinates e.g. child poverty, poor housing, unemployment, school achievement

- Use the Adverse Childhood Experiences (ACEs) model to identify young people and families who perhaps do not reach the threshold for a referral into statutory services

7.6.   Services

- Develop a cross-system single point of access for referral of patients with emotional and mental health issues

- Continue to strengthen and shape the mental health and wellbeing pathway by using data of need and service provision to understand current gaps and service delivery

- Further develop and support Future in Mind programmes including Kooth (on-line counselling), Early Intervention, Crisis support and Eating Disorders services

- Explore resourcing of support for patients with neuro-developmental disorders including ADHD, Autism Examine the potential to target resilience programmes on children and young people with diagnosed or suspected neurological developmental issues for example Asperger's / Autistic Spectrum disorders and ADHD.

7.7.   CAMHS

7.7.1. CAMHS Waiting times

- All referrals should work towards a standardised waiting times and all interventions should be standardised to ensure children and young people are at the heart of the service.

7.7.2. CAMHS specific services

- All looked after children in care /LAC should undertake a strengths and difficulties questionnaire (SDQ) every 6 months as part of their LAC review. This will hopefully ensure that all children in care will be monitored for changes in their emotional and mental health state and subsequently be swiftly referred into the CAMHS for appropriate interventions.

8.   APPENDIX 1 - Early Help Service

The Early Help Service is a non-statutory service which takes targeted action early and as soon as possible to tackle problems emerging for children, young people and their families, or with a population most at risk of developing problems. The service user population currently consists of families being supported by Supporting Leicestershire Families, Children's Centres and Youth Offending Services.

In 2017/18 a total of 26,543 individuals were provided with support from the Early Help Service. An individual may be supported by more than one of the Early Help services and during 2017/18, 4,408 were supported by Supporting Leicestershire Families, 22,171 by Children's Centre's and 405 by Youth Offending Services.

An evaluation of families with the highest needs i.e. supported by a caseworker in the Supporting Leicestershire Families and Children's Centre's took place. Below are further details of the context of those families and key evaluation findings in relation to mental health.

8.1.1. Families with the Highest Needs Supported By the Early Help Service

Between 2013 and 2017 there was a total of 5,486 casework families identified, of which 1,118 were used to define nine clusters of families grouped by need.

These nine clusters (A-I) group to four high level areas of need as shown below some of which have higher and lower levels of child mental health needs:

Table 7 is an extract from the evaluation and describes at a high level the type of families in each group and the number and percentage of families in each cluster from a subset of 787 families consisting of 4,564 individuals.

Table 7 - Number and Percentage of Families in the Early Help Evaluation Featuring in Each Cluster

High level Group	Predominantly Adults Requiring Support		Domestic Abuse Families		Lower Needs Families		SEND Families		
Group & level of need	A Low	B High	C Low	D High	E Low	F High	G Low	H Mid	I High
Number	134	141	104	42	107	73	68	65	53
%	17.0	17.9	13.2	5.3	13.6	9.3	8.6	8.3	6.7

8.1.2. Age of Children

The age range of children being supported by a case worker from Early Help is very similar to the demographic profile of Leicestershire, with a slightly lower proportion in the over five age ranges and a slightly higher proportion in the 0-4 age range.

Figure 7 - Extract from the Segmentation Dashboard
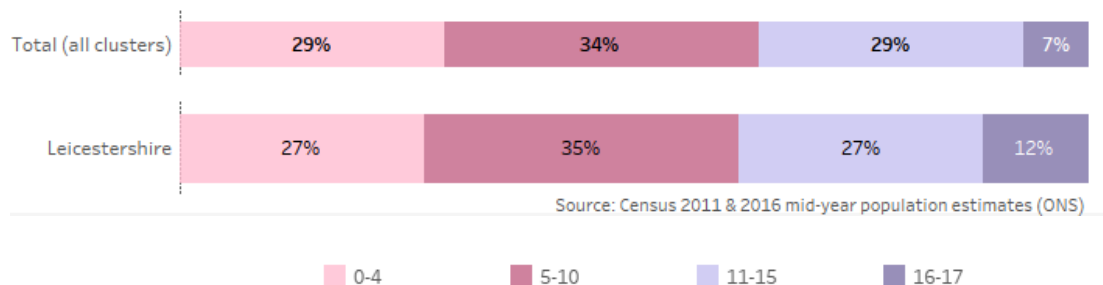
Low level mental health is the 5th biggest child need (40%) at the start of the Early Help intervention. The percentage of children with low level mental health issues varies by cluster. The lowest prevalence is in cluster A (Adults requiring support - low) at 6% and the highest prevalence is in cluster I (SEND families – high) at 73.6%. Clusters A, B and E have significantly lower levels than expected (i.e. compared to the overall) and Clusters C, D, F and I have significantly higher levels than expected. Clusters G and H are as expected.

Figure 8 – Percentage of children who have low level mental health issues for each cluster
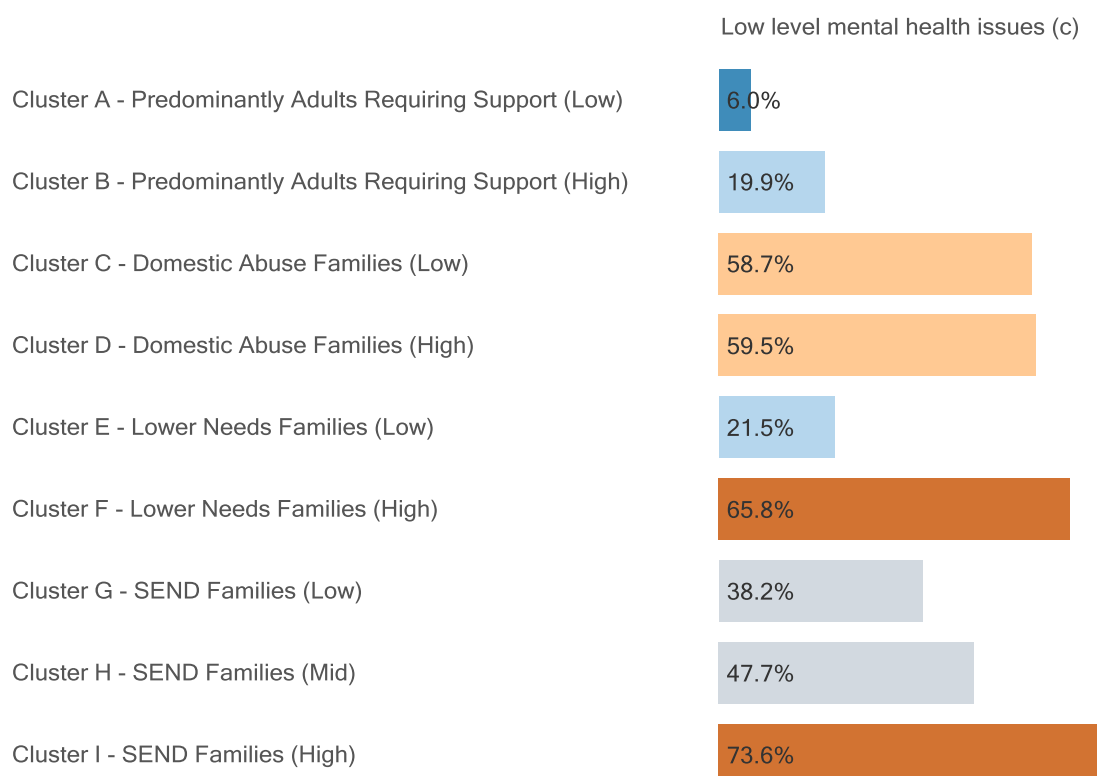
Other mental health issues are the 14th biggest child need (15%) at the start of the Early Help intervention. The percentage of children with other mental health issues varies by cluster. The lowest prevalence is in cluster A (Adults requiring support – low) at 2.2% and the highest prevalence is in cluster F (Lower needs families – high) at 35.6%. Clusters A, B and E have significantly lower levels than expected (i.e. compared to the overall) and Clusters F, G and H have significantly higher levels than expected. Clusters C, D and I are as expected

Figure 9 – Percentage of children who have other mental health issues for each cluster

Other mental health issues (c)

Cluster	Percentage
Cluster A - Predominantly Adults Requiring Support (Low)	2.2%
Cluster B - Predominantly Adults Requiring Support (High)	5.7%
Cluster C - Domestic Abuse Families (Low)	8.7%
Cluster D - Domestic Abuse Families (High)	11.9%
Cluster E - Lower Needs Families (Low)	2.8%
Cluster F - Lower Needs Families (High)	35.6%
Cluster G - SEND Families (Low)	25.0%
Cluster H - SEND Families (Mid)	35.4%
Cluster I - SEND Families (High)	20.8%

Figure 10 - Overall Profile of Needs and Vulnerabilities of Families Being Supported by a Caseworker in the Early Help Service

The chart below displays the full range of 57 needs by percentages across three areas of child, adult and family for a representative sample of families being supported by a caseworker from Supporting Leicestershire Families and Children's Centres in the council's Early Help Service. This illustrates the context of child mental health for this population in relation to other needs at a child, adult and family level;
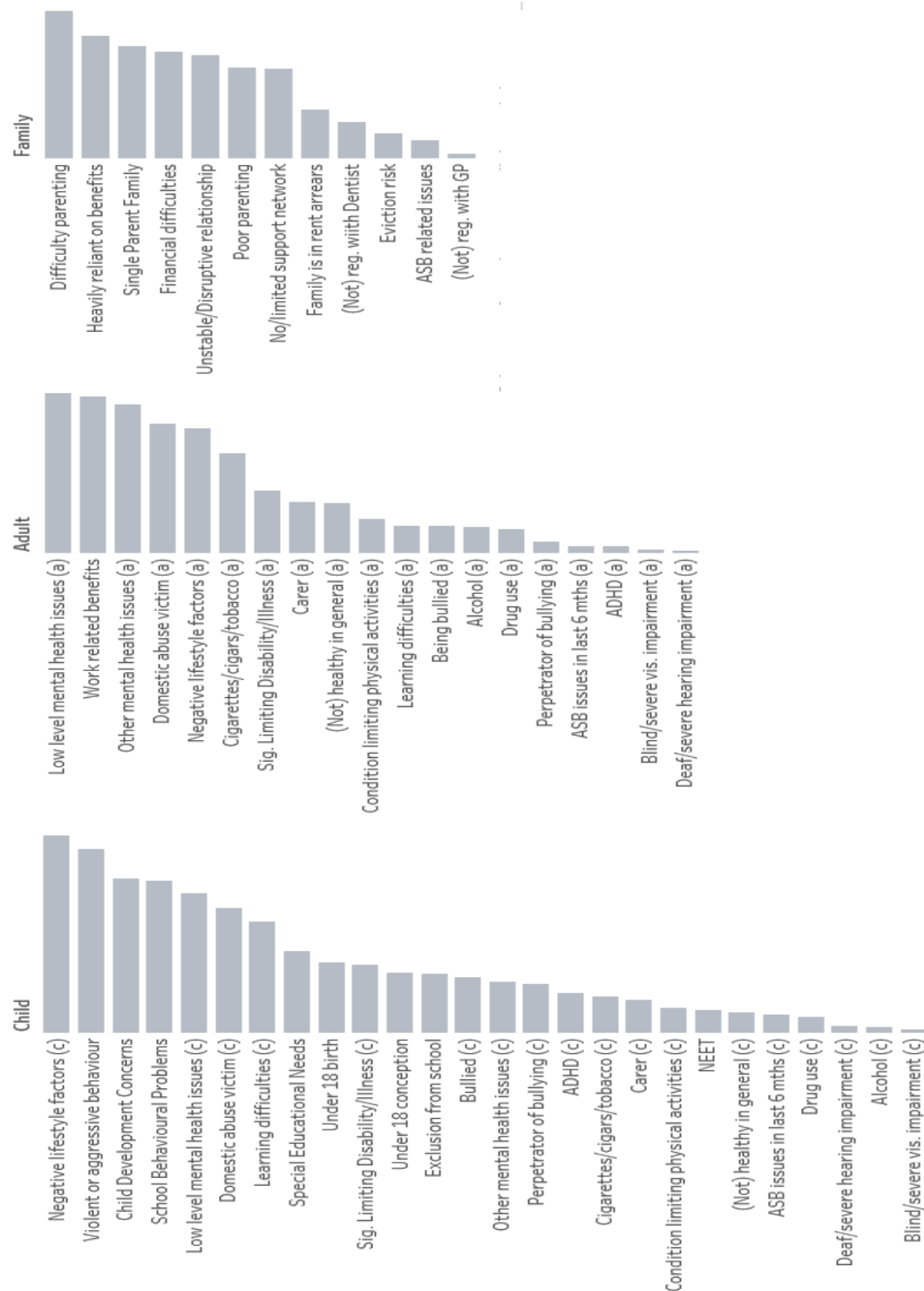
Family Star Progress: - Meeting Children's Emotional Needs

Family Star Plus is a practitioner based tool which enables conversation and family plans to be developed whereby workers and families agree a reading of between 1 and 10 against ten key domains at regular intervals to determine where families' progress is. The ten key domains of Family Star Plus are:

1. Positive experiences with Home and Money
2. Keeping Children Safe
3. Positive Boundaries and Behaviours
4. Positive Family Routines
5. Good or improved Physical Health
6. Positive Adult Wellbeing
7. Positive and supportive Social Networks
8. Meeting Children's Emotional Needs
9. Positive and appropriate Education and Learning
10. Achieving Progress to Work [64]

Figure 11 shows that 64% of families supported by an Early Help caseworker make progress overall around the Family Star domain of Meeting Children's Emotional Needs, (this domain is about meeting children's emotional needs, including the connection and relationship the parent has with them. It is about giving children the attention, positive feedback and encouragement that they need, being able to express love for them and ensuring they can grow up positive and able to deal with life's inevitable ups and downs). It also illustrates the variation in progress made in the Meeting Children's Emotional Needs domain across the nine different Clusters of families.

Most progress is made around Meeting Children's Emotional Needs by Cluster E (Less complex families - Low) (75%).

Least progress is made around Meeting Children's Emotional Needs by Cluster D (Domestic abuse families - High) (49%).

Figure 11 - Family Star Progress – Meeting Children's Emotional Needs

Overall

Meeting Children's Emotional Needs	64% Positive / 29% None / 7% Negative

Clusters

Cluster	Positive	None	Negative
Cluster E	75%	20%	5%
Cluster C	69%	23%	8%
Cluster F	66%	32%	
Cluster I	65%	20%	16%
Cluster H	63%	32%	5%
Cluster A	63%	27%	10%
Cluster B	63%	30%	7%
Cluster G	54%	42%	5%
Cluster D	49%	46%	5%

Legend: Positive / None / Negative

Figure 12 illustrates the differences in start readings against the nine different groups of families for the Family Star domain of Meeting Children's Emotional Needs.

Figure 12 - Start Reading: Meeting Children's Emotional Needs

Overall

Meeting Children's Emotional Needs	13% / 27% / 35% / 19% / 6%

Clusters

Cluster					
Cluster I	15%	45%	32%	4%	4%
Cluster C	18%	39%	32%	10%	
Cluster B	19%	33%	32%	12%	4%
Cluster D	24%	27%	39%	10%	
Cluster H	17%	17%	42%	22%	
Cluster A	5%	29%	30%	25%	11%
Cluster F	6%	21%	37%	29%	7%
Cluster G	7%	19%	44%	25%	4%
Cluster E	9%	11%	37%	28%	14%

Families in Cluster I (SEND families - High) on average have the lowest start readings, being most likely to start Stuck (15%) or Accepting Help Adults (45%) around Meeting Children's Emotional Needs. Families in Cluster E (Less complex families - Low) on average have the highest start readings, being most likely to start Finding what Works (28%) or Effective Parenting (14%) around Meeting Children's Emotional Needs
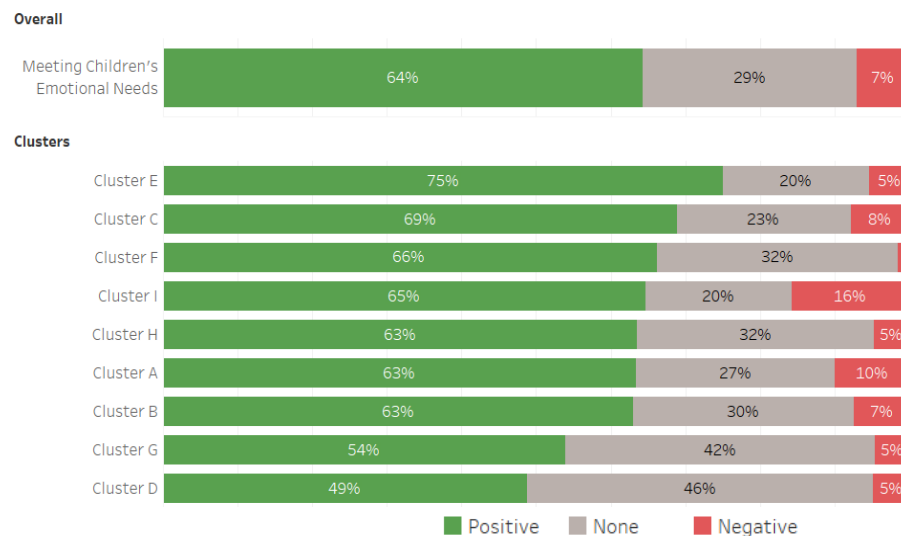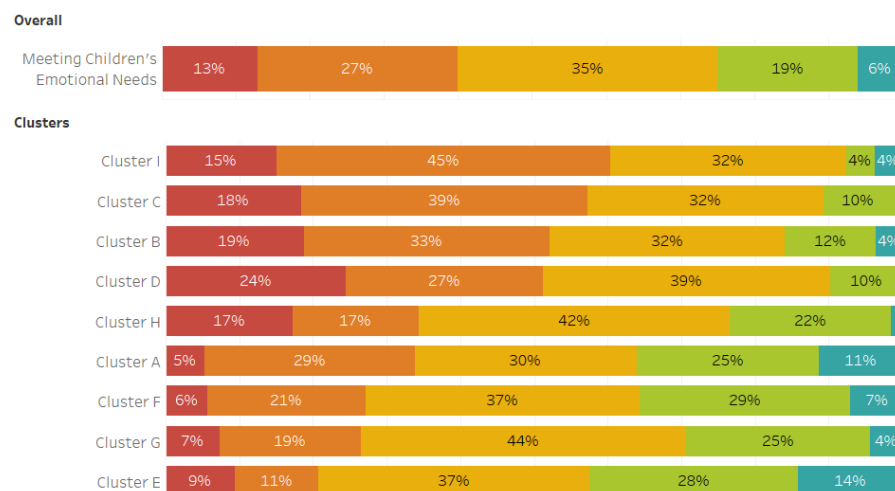
Figure 13 illustrates the differences in end readings against the nine different groups of families for the Family Star domain of Meeting Children's Emotional Needs.
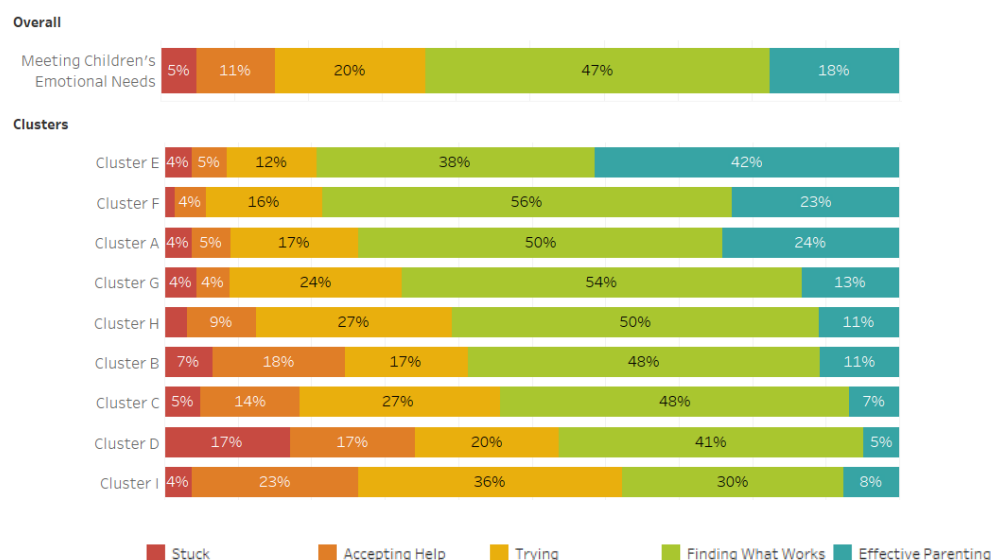
Figure 13 - End Reading : Meeting Children's Emotional Needs

Families in Cluster D (Domestic abuse families - High) on average have the lowest end readings, being most likely to end Stuck (17%) or Accepting Help (17%) around Meeting Children's Emotional Needs.

Families in Cluster E (Less complex families - Low) on average have the highest end readings, being most likely to end Finding what Works (38%) or Effective Parenting (42%) around Meeting Children's Emotional Needs.

8.1.3. Most Significant Change: Meeting Children's Emotional Needs

As part of the evaluation, staff presented 227 cases where they had seen the most significant change as a result of the Early Help casework.

Figure 14 and 15 below illustrates the top 5 activities/approaches and enablers for cases where Meeting Children's Emotional Needs was identified as relevant to change

Figure 14 - Top 5 Early Help Activities and Approaches

Workers providing practical support around behaviours, parenting, daily household tasks and routines	73 (36%)
Families relationship with worker	71 (35%)
Voice of child, young person	65 (32%)
Workers providing emotional support e.g. encouragement, praise and reassurance	65 (32%)
Other Early Help Groups	63 (31%)
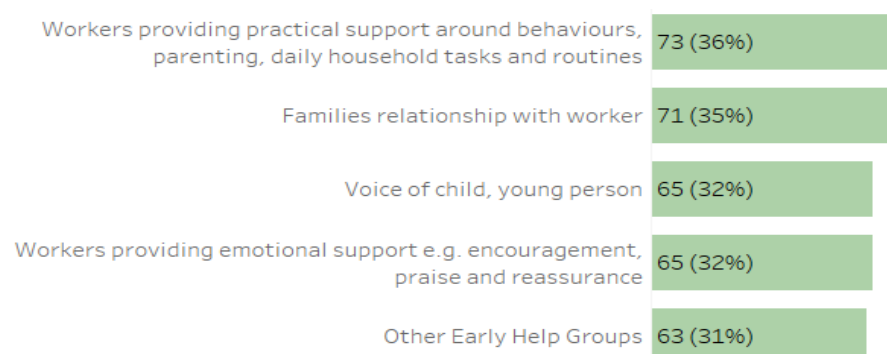
Early Help activities and approaches

Of the most significant change cases submitted by staff where Meeting Children's Emotional Needs outcomes were identified, the top five Early Help activities and approaches linked to these cases were: workers providing practical support around behaviours, parenting, daily household tasks and routines; families relationship with the worker; the voice of the child/ young person; workers providing emotional support e.g. encouragement, praise and reassurance; and Early Help groups.

Workers supporting parents to have a better understanding of children's needs, development and abilities, whole family working and the Solihull parenting programme also featured in these cases.

Figure 15 - Top 5 Enablers

Families want change, accept responsibility, support & take advice	141 (67%)
Multi agency working	102 (48%)
Improved parenting	84 (40%)
Family relationships improved	83 (39%)
Schools	67 (32%)
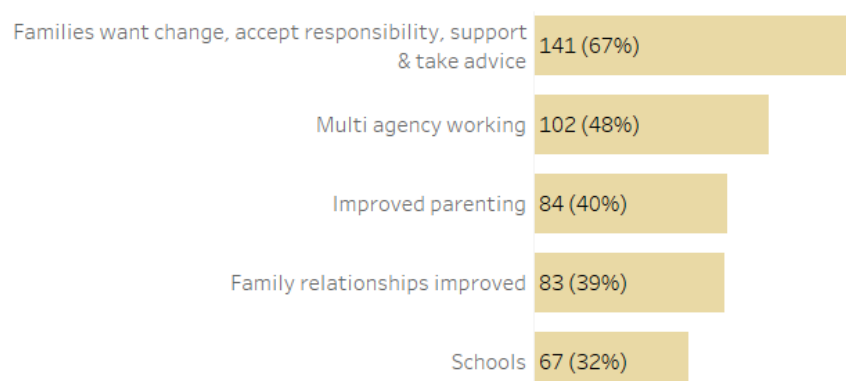
Enablers

The top five enablers linked to these cases were: families wanting change, accepting responsibility, support and taking advice; multi-agency working; improved parenting; improved family relationships and schools.

The following also featured in these cases: health services for children and young people;

leisure opportunities; health diagnosis for families; and parental changes in home environments e.g. children/ young people moving in with another parent/ family member.

8.1.4. Barriers and Other Outcomes for cases where Meeting Children's Emotional Needs was identified as Relevant to Change[65]

Figure 16 - Top 5 Barriers

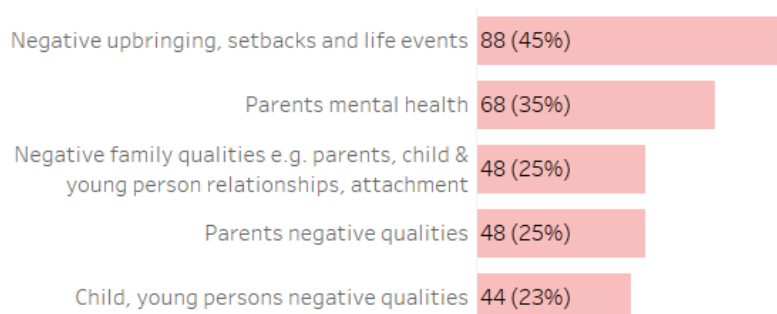| Barrier	Count (%)
Negative upbringing, setbacks and life events	88 (45%)
Parents mental health	68 (35%)
Negative family qualities e.g. parents, child & young person relationships, attachment	48 (25%)
Parents negative qualities	48 (25%)
Child, young persons negative qualities	44 (23%)

Barriers to change

The top five barriers to change linked to these cases were: negative upbringing, set-backs or life events; parent's mental health; family negative qualities e.g. family relationships and attachment; other parent's negative qualities; and children's negative qualities.

The following barriers also featured in these cases: children and young people's mental health; child/ young people's other issues; isolation; unstable home environments; parents lack of experience or understanding around parenting; and negative wider family, peers or communities.

Figure 17 - Top 5 Other Outcomes

Outcome	Count (%)
Improved wellbeing for families	84 (43%)
Improved mental health of parents	66 (34%)
Improved educational prospects	61 (31%)
Improved behaviour of child, young person	57 (29%)
Families are now significantly safer	51 (26%)
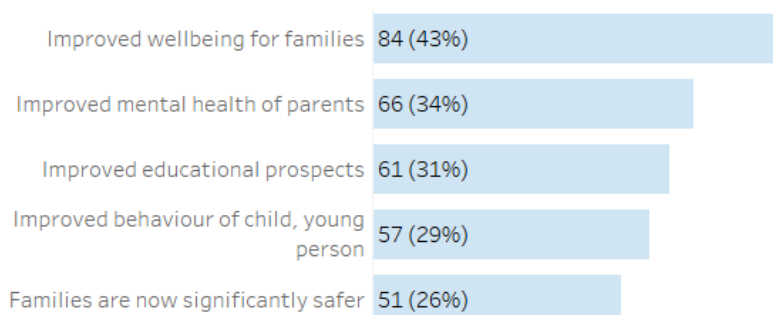
Other Outcomes Associated with Cases (where meeting children's emotional needs was identified as relevant to change)

The top three outcomes relating to these cases were: improved wellbeing for families; improved mental health of parents; and improved educational prospects. The following outcomes also featured in these cases: improved behaviour of children/ young people; families being significantly safer; improved mental health of children/ young people; improved health of children/ young people; improved child development; and parents able to control their anger.

8.1.5. CHAID (Statistically Significant Findings) around Progress: Meeting Children's Emotional Needs

Table 8 - Adults Requiring Support (Clusters A – Low and B – High), Domestic Abuse Families (Cluster D – High), Lower Needs Families (Clusters E – Low and F – High) and SEND Families (Clusters G – Low and H – Mid)

Predominantly Adults Requiring Support		Domestic Abuse Families		Lower Needs Families		SEND Families		
A	B	C	D	E	F	G	H	I
Low	High	Low	High	Low	High	Low	Mid	High

For these families where there is a child protection plan after early help intervention they are almost 4 times more likely to make lower progress around meeting children's emotional needs compared to the overall (25.7%:6.7%). Similarly, they are less likely to make higher progress compared to the overall (31.1%:60.8%).

For these families where there is no child protection plan or children's social care involvement after the Early Help intervention and the length of involvement is less than 9 months these families are less likely to make lower progress around meeting children's emotional needs compared to the overall (1.2%:6.7%).

Table 9 - Domestic Abuse Families (Cluster C – Low) and SEND Families (Cluster I - High)

Predominantly Adults Requiring Support		Domestic Abuse Families		Lower Needs Families		SEND Families		
A	B	C	D	E	F	G	H	I
Low	High	Low	High	Low	High	Low	Mid	High

For these families where there is no children social care involvement after the Early Help intervention they are more likely to make higher progress around meeting children's emotional needs compared to the overall (76.3%:60.8%).

8.1.6. What Factors are Worthy of Further Attention When Looking at Lower Progress around Meeting Children's Emotional Needs

- **Financial related benefits + difficulties parenting + children with significant limiting disability**
- **Families with low level mental health issues + adult domestic abuse victims**

Families in receipt of financial related benefits with difficulties parenting, where there are also children with a significant limiting disability are more likely to make lower progress around meeting children's emotional needs compared to the overall (9.9%:6.7%). Similarly, they are less likely to make higher progress around meeting children's emotional needs compared to the overall (43.7%:60.8%).

Families with low level mental health issues and where adults have been victims of domestic violence (but children have not been victims of domestic violence) are twice as likely to make lower progress around meeting children's emotional needs compared to the overall (13.0%:6.7%).

8.1.7. What Factors are Worthy of Further Attention When Looking at Higher Progress around Meeting Children's Needs

- **A lack of adult domestic abuse victims (even if low level mental health issues are present in families)**
- **A lack of financial related benefits + children with no mental health issues (even if there are difficulties parenting)**
- **Adult and child victims of domestic abuse combined with low level mental health issues**

Families with low level mental health issues (but not adult victims of domestic abuse victims) are less likely to make lower progress around meeting children's emotional needs compared to the overall (3.1%:6.7%).

Families where there are difficulties parenting (but they aren't in receipt of financial related

benefits and their children do not have mental health issues) are more likely to make higher progress around meeting children's emotional needs compared to the overall (74.4%:60.8%).

Families with low level mental health issues and where there are adult and child victims of domestic abuse victims are more likely to make higher progress around meeting children's emotional needs compared to the overall (69.7%:60.8%).

Table 10 illustrates some of the significant factors that were found in relation to each Family Star domain which may be worthy of further attention by the Early Help service:

Table 10 - A summary of statistically significant findings worthy of further attention around each Family Star Domain

Family Star Plus Domain	Families Making Lower Progress	Families Making Higher Progress
Meeting Children's Emotional Needs	• Financial related benefits combined with difficulties parenting and children with a significant limiting disability • Low level mental health combined with adult domestic abuse victim	• A lack of adult domestic abuse victims • A lack of financial related benefits combined with a lack of children with mental health issues • A lack of adult and child domestic abuse victims combined with a lack of low level family mental health

On the whole, families have a very positive experience of the Early Help service and recognise whole family working. Families mostly recognised support from their Early Help key worker but many also recognise support from multi-agencies

For more information on Family Star Plus see:
http://www.outcomesstar.org.uk/using-the-star/see-the-stars/family-star/

9.   APPENDIX 2 - Children Centres

In 2017/18 the Children's Centre programme worked with 21,017 individuals (includes all individuals with an active involvement, open at some point during 2017/18), 10,899 children under 5 years old, 666 children between the ages of 5 to 17 years, and 9,495 adults/parents in Leicestershire.

The Children's Centre programme offers a broad range of services, delivered through the Pathway, direct 1-2-1 work with a Family Outreach worker, group work and other drop-in services, including Health Visitor Checks. Each piece of work is recorded as an 'involvement'. A total of 23,775 involvements, including Pathway, Targeted 1-2-1, Targeted Group and Contact Involvements recorded on Capita, recorded in 2017/18, 5,495 being targeted involvements during 2017/18. Targeted involvements include; Pathway, Targeted 1-2-1 and/or targeted group involvements only, not Contact Involvements.

Figure 18 shows the reasons for these involvements, highlighting that the most likely reason for the Children's Centre programme to be involved with an individual is health (83% of targeted involvements), followed by parenting (64%).

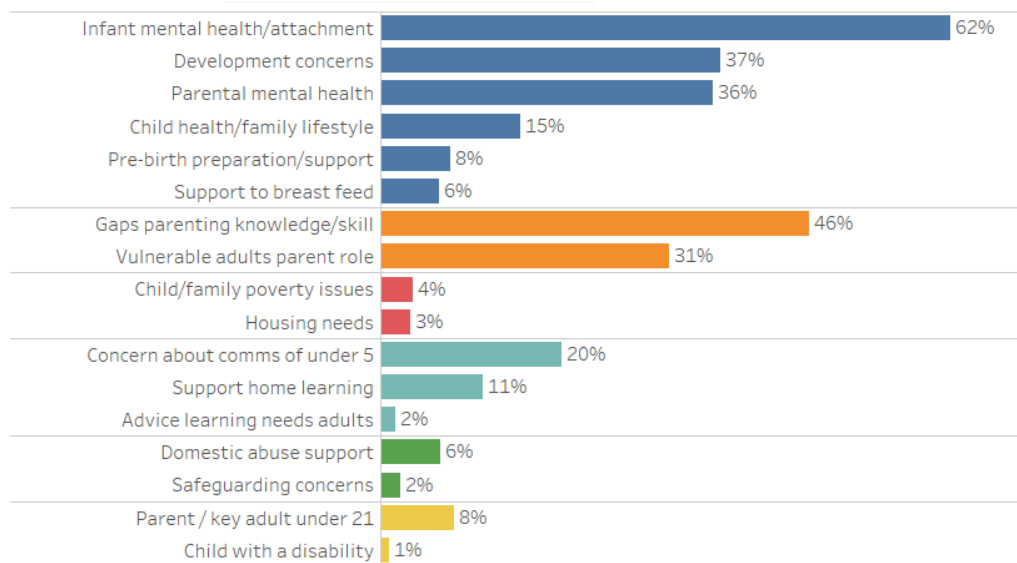**Figure 18 - High Level Reasons for Targeted Involvement**
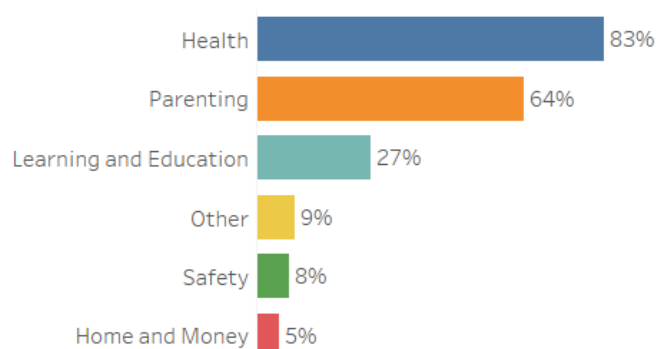
* Based on 4,569 1-2-1 and Group Involvements active in 2017/18 – Source Capita

Figure 19 provides more detailed reasons for involvement with the Children's centre programme. Infant Mental Health / Attachment is the most likely reason for a targeted involvement (62%), and Parent Mental Health being the fourth most likely reason (36%).

Figure 19 - Detailed Reasons for Targeted Involvement

Reason	Percentage
Infant mental health/attachment	62%
Development concerns	37%
Parental mental health	36%
Child health/family lifestyle	15%
Pre-birth preparation/support	8%
Support to breast feed	6%
Gaps parenting knowledge/skill	46%
Vulnerable adults parent role	31%
Child/family poverty issues	4%
Housing needs	3%
Concern about comms of under 5	20%
Support home learning	11%
Advice learning needs adults	2%
Domestic abuse support	6%
Safeguarding concerns	2%
Parent / key adult under 21	8%
Child with a disability	1%

Of the 5,085 individuals who were worked (targeted) with by the Children's Centre programme 3,908 (77%) had an identified Mental Health need (includes Involvement Reasons 'Infant mental health/attachment' and 'Parental mental health').

Figure 20, 21, 22 and 23 shows the proportion of targeted Children's Centre users with a mental health, split by age, district, deprivation and urban/rural, compared to overall proportion of service users with an identified mental health need (77%).
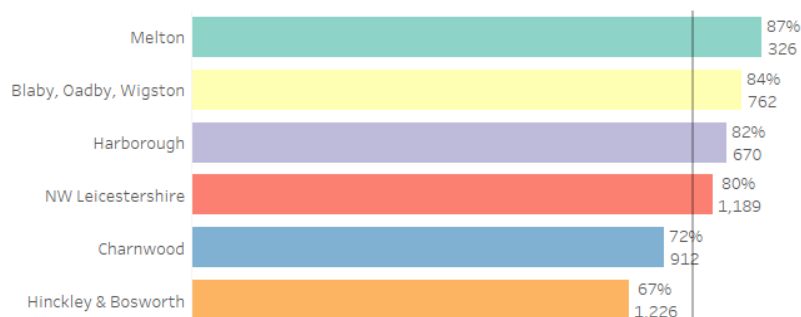
There is little variation in the proportion of service users identified with a mental health need by age.

Figure 20 - Proportion of Targeted Children's Centre Users Accessing Services with a Mental Health Need by Age

Age	Percentage	Number
0 -< 5 years	77%	2,519
5+ Years	72%	250
18+	77%	2,334

Melton has the highest proportion of targeted service users with an identified mental health need (87%), but the lowest number of targeted service users (326). Conversely, Hinckley and Bosworth has the lowest proportion of targeted service users with an identified mental health need (67%).

Figure 21 - Proportion of Targeted Children's Centre Users Accessing Services with a Mental Health Need by District

| District	%	Count
Melton	87%	326
Blaby, Oadby, Wigston	84%	762
Harborough	82%	670
NW Leicestershire	80%	1,189
Charnwood	72%	912
Hinckley & Bosworth	67%	1,226

The proportion of targeted service users with an identified mental health need living within the 10% most deprived areas of Leicestershire is slightly higher (80%) compared to the proportion in the rest of the county.

Figure 22 - Proportion of Targeted Children's Centre Users Accessing Services with a Mental Health Need by Deprivation [66]

	%	Count
10% Most Deprived	80%	1,074
Other	76%	4,011

The proportion of targeted service users with an identified mental health need is slightly higher in rural areas, Hamlets and Isolated dwellings (83%) and Villages (82%), compared to urban areas of the county (76%), although the number of targeted service users living in rural areas in relatively small in comparison

Figure 23 - Proportion of Targeted Children's Centre Users Accessing Services with a Mental Health Need by Urban /Rural [67]

	%	Count
City and Town	76%	3,662
Town and Fringe	77%	1,032
Village	82%	325
Hamlets & Isolated Dwellings	83%	66
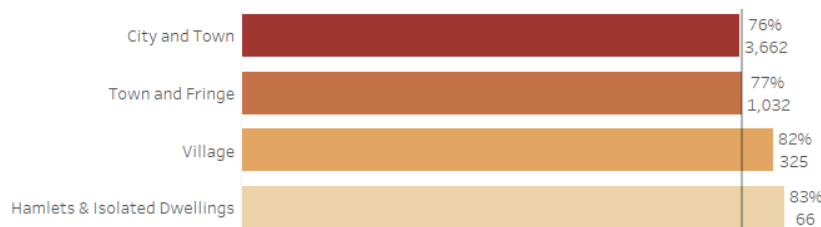
GLOSSARY OF TERMS

ACE	Adverse Childhood Experiences
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CPP	Child Protection Plan
CSE	Child Sexual Exploitation
DHSC	Department for Health and Social Care
DfE	Department of Education
DV	Domestic Violence
EHCP	Education and Health Care Plan
ESP	Early Start Programme
GCSE	General Certificate of Secondary Education
IAPT	Improving Access to Psychological Therapies
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LGBT+	Lesbian, Gay, Bisexual, Transgender/Transsexual, Other
LEP	Leicestershire's Educational Psychologists
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
PTSD	Post Traumatic Stress Disorder
SAPG	Suicide Audit and Prevention Group
SDQ	Strengths and Difficulties Questionnaire
SEN	Special Educational Needs
SEND	Special Educational Needs and Disabilities
SHINT	School Health Interview
VCSE	Voluntary, Community and Social Enterprise
WEMWBS	Warwick-Edinburgh Mental Well-Being Scale
YOS	Youth Offending Service

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