Children and Young People's Mental Health

Joint Strategic Needs Assessment 2018

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“For too long mental illness has been something of a hidden injustice in our country, shrouded in a completely unacceptable stigma and dangerously disregarded as a secondary issue to physical health. Yet left unaddressed, it destroys lives, it separates people from each other and deepens the divisions within our society. Changing this goes right to the heart of our humanity; to the heart of the kind of country we are, the values we share, the attitudes we hold and our determination to come together and support each other.”

Prime Minister Theresa May, 2017

1. Background and narrative

The mental health of children and young people (CYP) has become a national priority in recent times with the Prime Minister describing the unequal chances faced by young people with mental health problems as one of the burning injustices of our time (Department of Health, Department of Education, 2017). One in ten young people has some form of diagnosable mental health condition and, for many of them, their mental health problems will continue into adulthood (DoH & DfE, 2017). Estimates suggest that between a quarter and half of mental health issues experienced in adulthood could be averted with effective early interventions in childhood (Kim-Cohen, Caspi, Moffitt, Harrinton, Milne, & Poulton, 2003). This document is intended to contribute to the goal of improving the mental health of children and young people in Thurrock.

1.1 Purpose and focus of this report

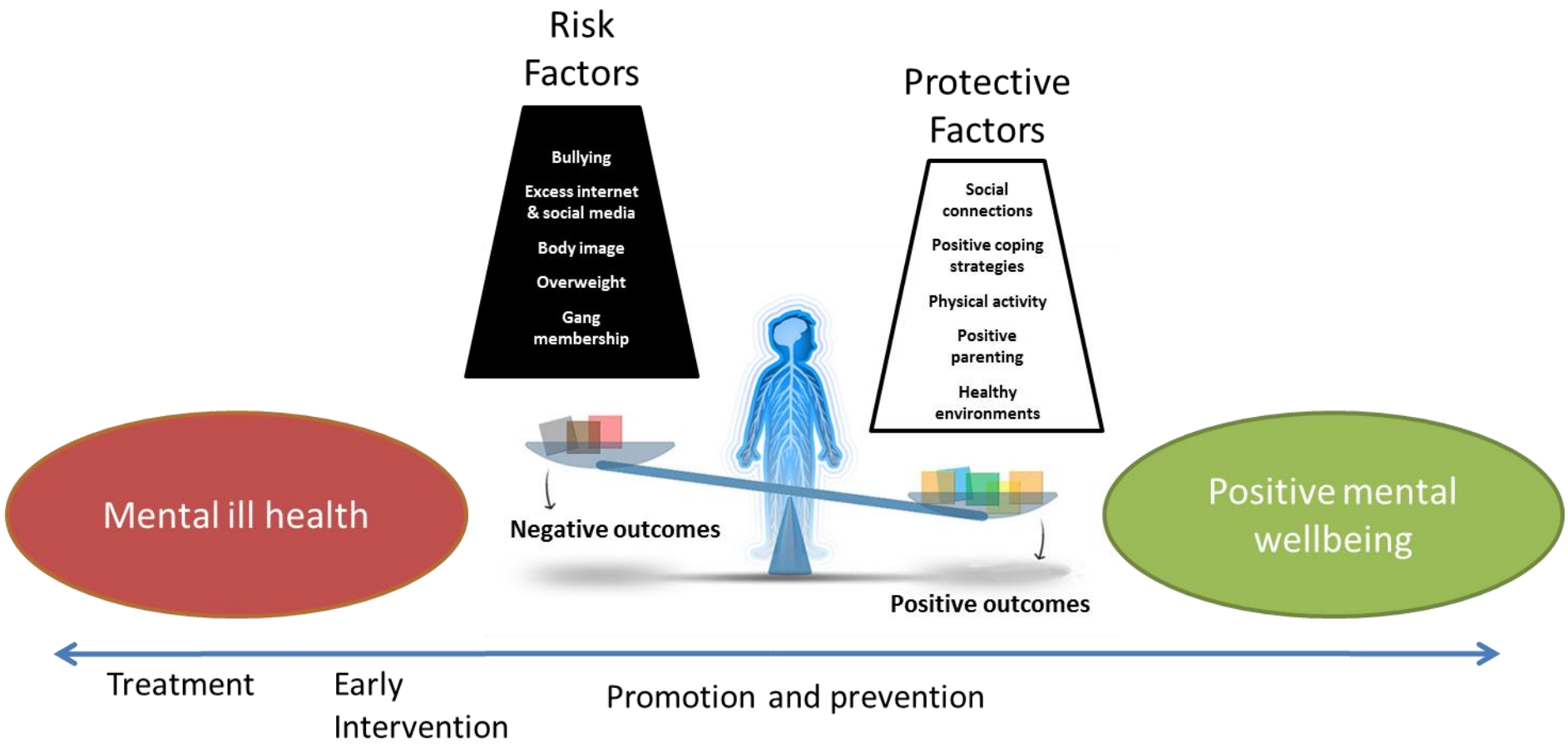
One of the main reasons for writing this needs assessment was the mounting concern in schools, colleges, community organisations, and among young people themselves about mental health issues. This report presents the data and evidence what we currently have about mental health in Thurrock, but it is also designed to start a new conversation about the topic. Throughout the document, therefore, key questions are raised about what the needs of our young people are, what is already being done to meet them, and what more we could do in future.

Until now, much of the conversation (locally and nationally) has been focussed on treatment services which help those who already have a mental health problem. This is clearly an issue of vital importance to those young people who need help and the adults who care for them. Whilst acknowledging the huge importance of treatment, this document intentionally takes a public health approach, focussing on some of the underlying causes of poor mental health and how these can be addressed. The reason for this is that we believe prevention is better than cure, and that the growing pressure on treatment services (nationally and locally) is unsustainable. Unless we address some of the underlying factors, treatment services will become increasingly stretched in future.

Much of this report, therefore, is focused not on medically diagnosed mental health conditions but on the positive, protective factors which promote positive mental wellbeing, and the risk factors which can lead to mental health problems. This is illustrated in Figure 1 below. Whereas a traditional approach may emphasise the need to treat those who are unwell and intervene early when problems start occurring, our focus has been to consider how we can build on existing strengths and minimise risks which tip young people away from positive mental wellbeing and towards mental ill health. We focused, in particular, on particular protective and risk factors where the evidence suggests that:

- they have a strong impact on children and young people's mental health;
- they are a significant local issues in Thurrock;
- it is possible to improve them through targeted action.

Figure 1. Tipping the balance towards positive mental wellbeing and away from mental ill health



* Graphic adapted from: Resilience Scale, Center on the Developing Child, Harvard University

1.2 National Policy Context

Over the past three years, two key government reports on young people's mental health have been published: Future in Mind in 2015 (Department of Health, NHS England, 2015) and the Five Year Forward View (FYFV) for Mental Health in 2016 (Department of Health, NHS England, 2016). Both set out proposals to transform the design and delivery of treatment services for CYP with mental health needs, to make it easier for children, young people, parents and carers to access help and support when needed and to improve how services are organised, commissioned and provided. There is also an emphasis in these documents on working towards preventative, integrated provision of services. The FYFV report made recommendations grouped around five themes:

1. Promoting resilience, prevention and early intervention
2. Improving access to effective support – a system without tiers
3. Care of the most vulnerable
4. Accountability and transparency
5. Developing the workforce

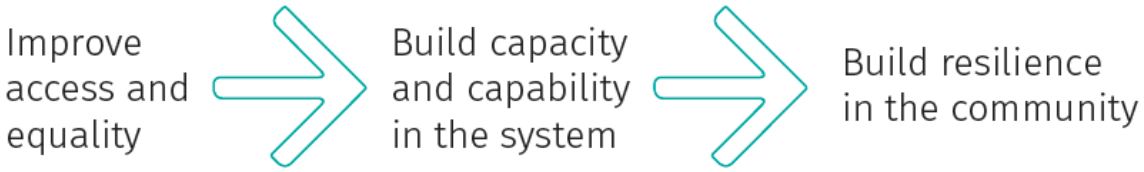
Following on from these reports, the Government published a Green Paper in 2017, *Transforming Children and Young People's Mental Health Provision*, which reviews the evidence of what works in the treatment and prevention of ill mental health in young people (DoH & DfE, 2017) and makes specific proposals for how to improve services in future. The three main elements of the approach proposed by the Green Paper are: having a designated mental health lead in all schools by 2025, creating mental health support teams working with schools and colleges, and reducing the waiting time standard for access to mental health services for children and young people. More detail on these proposed changes is given in the section covering existing and future services (Section 4.4.1).

1.3 The Regional Policy Context

In 2015, a programme of service transformation was launched across Southend, Essex and Thurrock. The transformation plan is set out in the *Open Up, Reach Out 2015 – 2020* strategy. In the first year, this led to the launch of a new integrated service (the Emotional Wellbeing and Mental Health Service (EWMHS)) operating across seven Clinical Commissioning Groups and three local authorities (including Thurrock CCG and Council).This change included a 25% increase in annual investment and an expansion of coverage: the previous service was working with around 3,200 children whereas there are now more than 6,000 being supported by EWMHS across the Southend, Essex and Thurrock. The EWMHS service is provided by NELFT (the North East London Foundation Trust) and more information on the service in Thurrock can be found in Section 3.4.

The *Open Up, Reach Out* strategy focuses on the three high level goals and priorities for action set out below. More information on the implementation of these priorities is given in Section 4.1 below. A Joint Strategic Needs Assessment for Southend, Essex and Thurrock has also been completed to support the regional strategy.

Figure 2. Open Up, Reach Out Goals



1.4 Conclusion

The mental health of CYP has become a high priority nationally and locally. This document is designed to support the development of local action to improve the mental health of CYP. Local action needs to take account of the national and regional policy context, given above. The emphasis of this document is on the protective and risk factors shown in Figure 1.

2. Protective and risk factors for mental health in children and young people

2.1 Protective Factors

A range of positive factors are known to keep children and young people mentally well. These factors (listed below in Table 1) not only build positive mental wellbeing but also help people to cope with stress or adverse events effectively and without becoming mentally unwell. This ability to cope with adversity is also known as **resilience**. Resilience is not just about having the ability to 'bounce back', but also having the capacity to adapt in the face of challenging circumstances, whilst maintaining good mental wellbeing (MIND, 2018). Importantly, a person's resilience can change over time and will be enhanced by the protective factors listed below.

In this section we outline the key protective factors for CYP mental health and present local data on them.

Table 1. Protective factors which enhance mental health in children and young people

Protective Factor	Description
Social connections	Good social networks of friends and family are vital for positive mental wellbeing. By contrast, we know that loneliness and isolation are associated with mental ill health.
Positive coping strategies	When faced by stress or adverse circumstances some ways of coping are highly effective, while others can be destructive. Positive strategies can include, for example, talking to a trusted adult, while negative strategies include drug taking or self-harm.
Physical exercise	Exercise is known to promote good mental health as well as to help in recovery from poor mental health. It promotes positive attitudes and protects again low mood/depression.
Supportive parenting	Parents' mental health has a strong influence on their children's mental wellbeing so that there are intergenerational patterns of mental health. In additional, a stable home and absence of conflict with parents are strong protective factors for children's mental wellbeing.
Healthy environment	The physical environments CYP live in have a strong influence on their mental health. Good quality housing and access to outdoor, green spaces all promote mental wellbeing.

Brighter Futures Survey

Much of the local data on protective and risk factors in this report comes from the Brighter Futures Survey (BFS). The BFS was carried out for the first time in Thurrock in 2016/17. It is a survey focused on pupils in academic Years 6, 8 and 10. The report provides quantitative data and insight into child and adolescent experiences, attitudes and development including issues related to mental health.

During the 2016/17 academic year 1,010 children and young people from 4 secondary schools and 8 primary schools in Thurrock completed the survey which included questions related to all aspects of young people's lives, including their experiences, their engagement in risk-taking behaviours, their relationships and how happy they are with their lives.

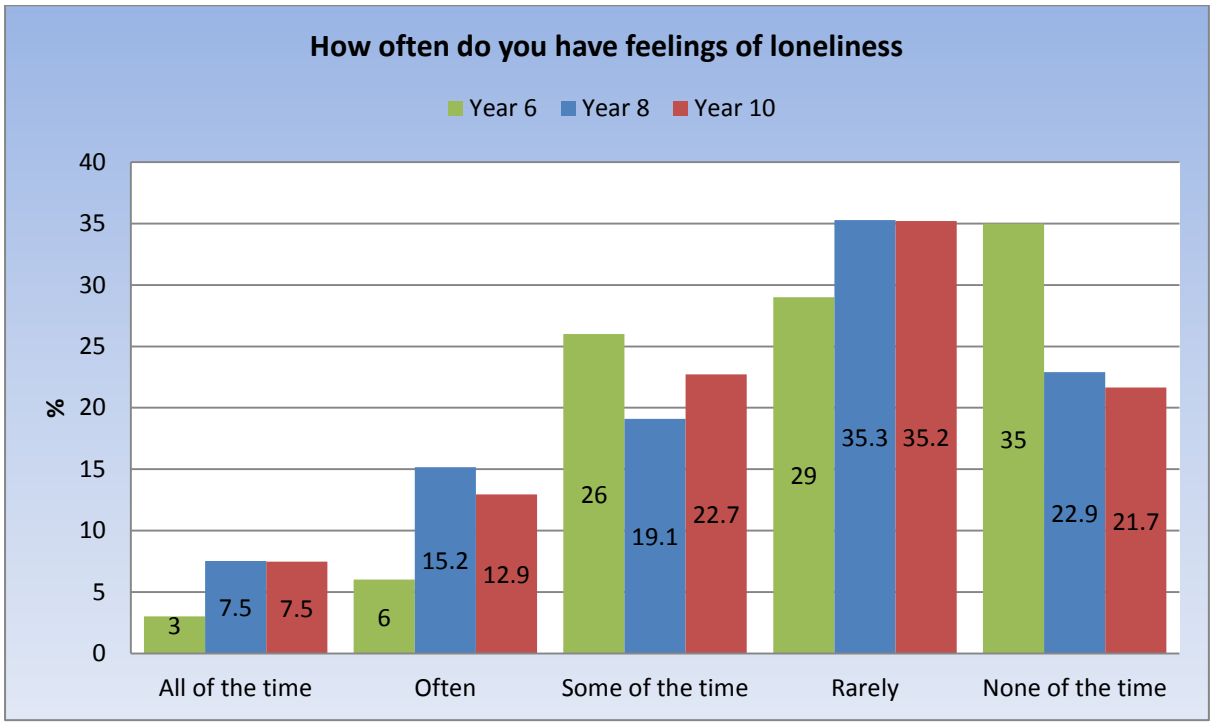
2.1.1 Good social connections

Having positive friendships is an important part of children's social and emotional development. Good social connections (with adults and other children) play an important part in keeping CYP mentally well. Conversely, social isolation and loneliness are associated with poor mental health.

We have local information about this from the BFS, which asked pupils about loneliness. As shown in Figure 3, the proportion of pupils feeling lonely varies and was more common in the older age groups. Whilst most pupils reported that they rarely or never felt lonely, more than 20% of pupils in Years 8 and 10 said they felt lonely often or all of the time. Loneliness appears to be less common in the younger age group (Year 6).

In addition, Figure 4 below shows that a large minority of pupils in years 8 and 10 do not talk to anyone about things which bother them and instead, keep it to themselves. Taken together this suggests that while many CYP in Thurrock do have strong relationships and social connections which would help them to cope in difficult times, many do not putting them at greater risk of developing mental ill health.

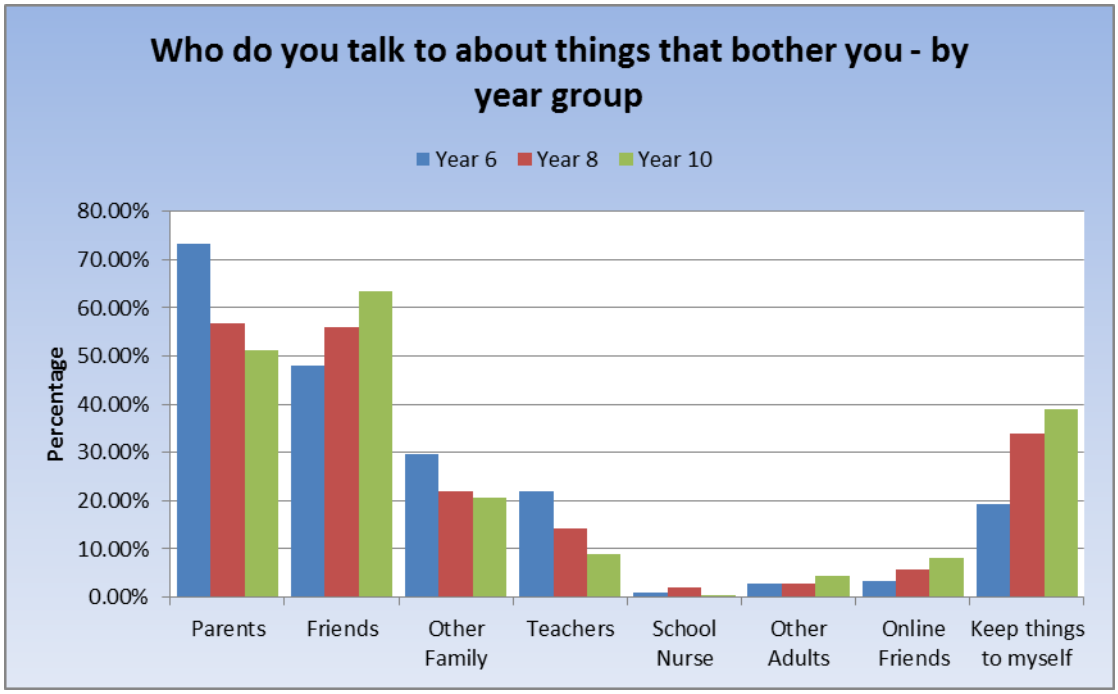
Figure 3: Feeling Lonely Years 6, 8, 10 Pupils



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

The survey also explored who CYP were likely to talk to about things that bothered them. It found that parents were the most common source of support in years 6 and 8, but that friends became a more common support source in year 10. The proportion of children and young people who relied on online friends or kept things to themselves increased with age, with 39% of year 10 pupils saying they kept things to themselves.

Figure 4. Talking about problems, Years 6, 8 and 10 pupils[1]

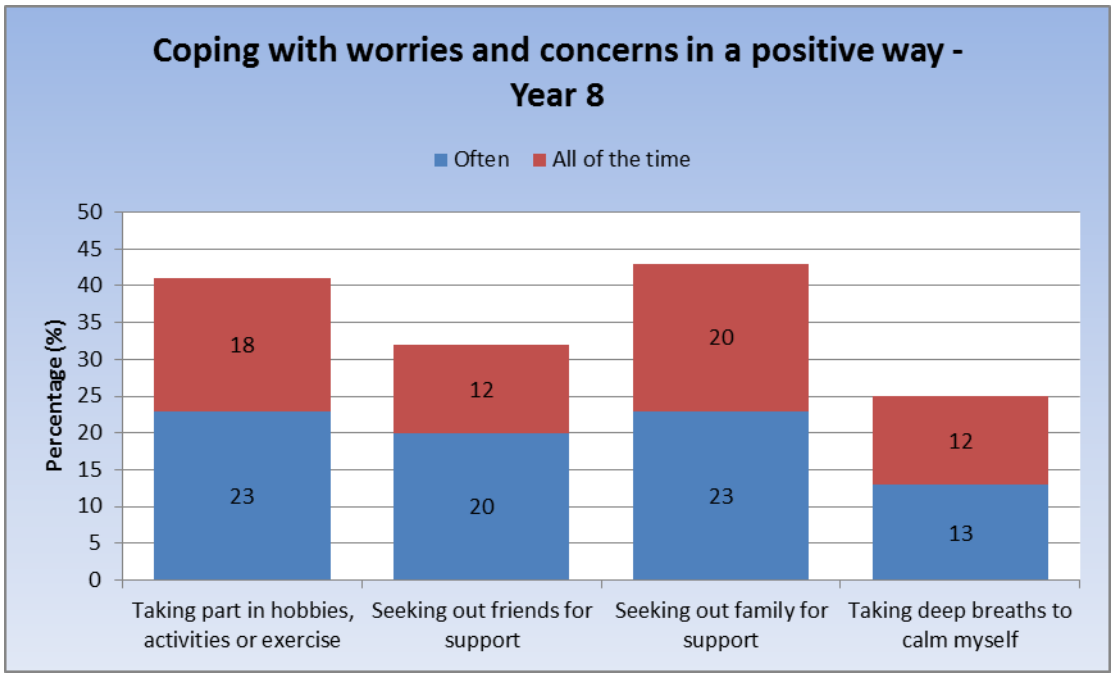


Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

2.1.2 Positive Coping Strategies

Positive coping strategies can help CYP to be resilient at difficult times. The BFS found that the most common positive coping strategies used by year 8 pupils were seeking out family (43% said they did this often or all the time) and taking part in hobbies, activities or exercise (41% did this often or all the time).

Figure 5: Coping positively in Year 8

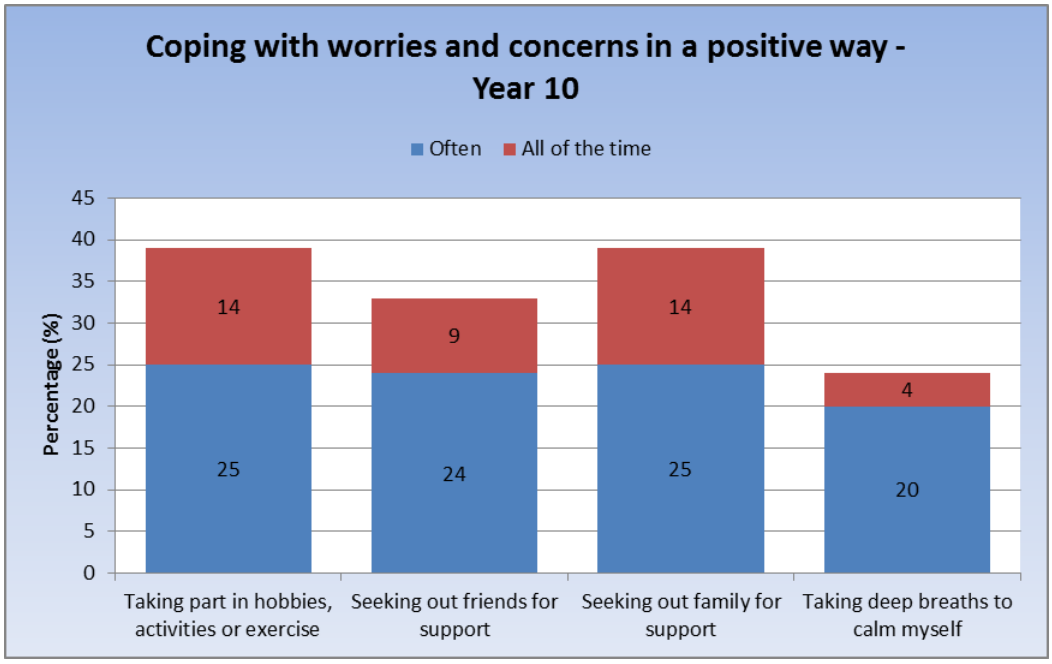


Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

[1] Pupils could select more than one response to this question

The same two strategies were most commonly used by year 10 pupils, with 39% of pupils saying they took part in hobbies, activities or exercise often or all the time, and the same proportion sought out family for support.

Figure 6: Coping positively in Year 10

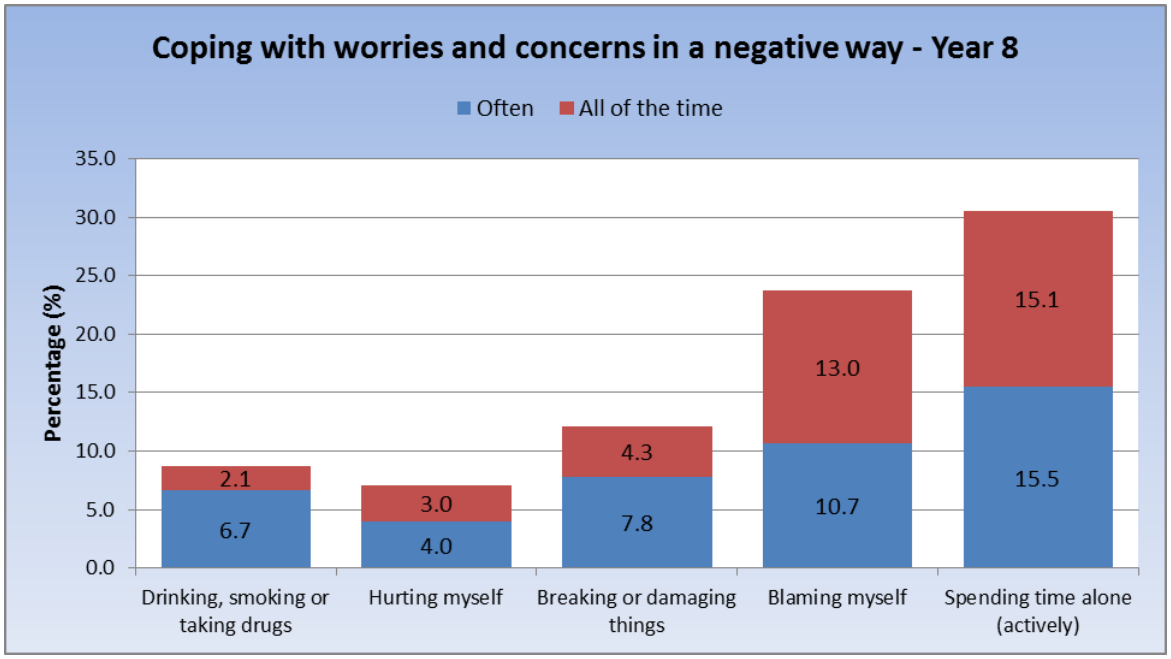


Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

Using negative coping strategies can increase the risk for developing a mental health condition as CYP grow older. The BFS showed that in Year 8, almost 12% of pupils said they would not be able to cope if they had a problem and in Year 10, 8% of pupils said they wouldn't be able to cope.

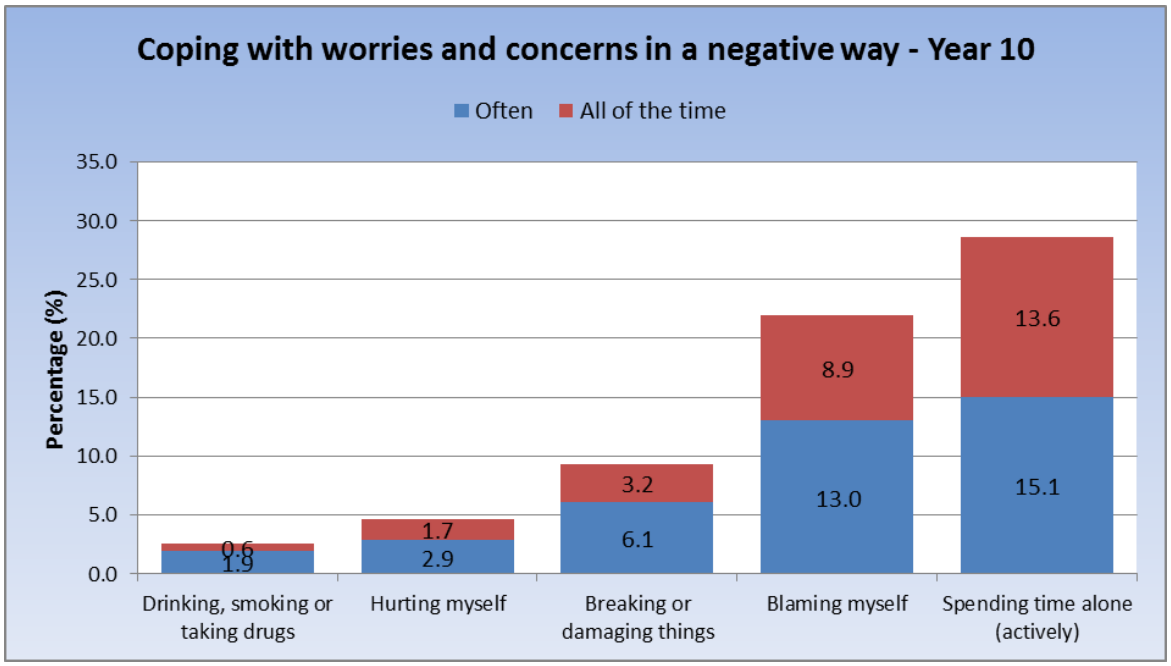
Figure 7 demonstrates the negative coping strategies identified by the BFS in Years 8 and 10: spending time alone, followed by blaming myself, were the most common options for coping with worries and concerns. The most damaging coping strategies (substance use and self-harm) were identified as common coping strategies by 8.8 and 7% of pupils respectively in Year 8 though interestingly these were much less common in Year 10. It will be important to see whether this pattern persists in future years. The seriousness of self-harm as an issue is further emphasised by the fact that it is one of the most common reasons for CYP to access the EWMHS service accounting for 11% of cases in Thurrock (see Section 3.4 for more details).

Figure 7: Coping negatively in Year 8



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

Figure 8: Coping negatively in Year 10



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

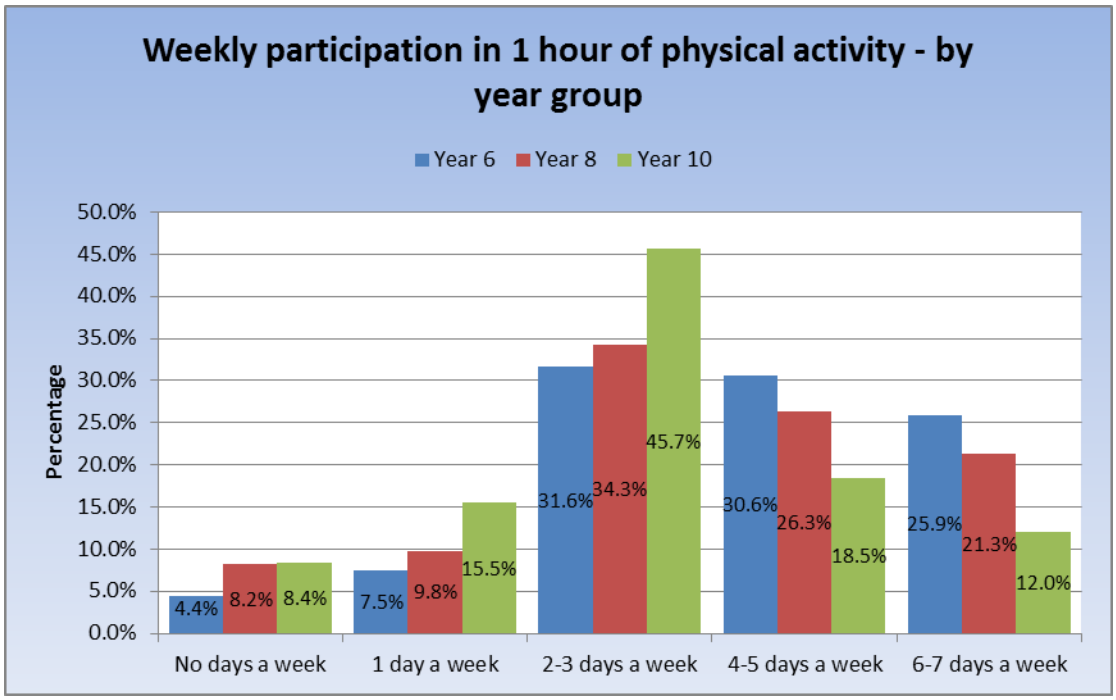
Overall this suggests that whilst many CYP in Thurrock use positive coping strategies to deal with worries and concerns, there are significant numbers turning to negative strategies which are likely to have a bad effect on their mental health. This is an area where there appears to be room for improvement if young people can be supported to find positive ways of coping with stress.

2.1.3 Physical activity

There is strong evidence to show that physical activity can enhance psychological well-being in children (Lagerberg D, 2005). Conversely, studies have consistently shown that sedentary behaviour is associated with poorer mental health.

The BFS asked Thurrock pupils about how much physical activity they do (see Figure 9 below). It found that younger pupils generally do more physical activity than older pupils. For example, 56.5% of year 6 pupils reported being physically active for more than an hour 4+ days per week, compared to 30.5% of year 10 pupils.

Figure 9: Weekly participation in physical activity

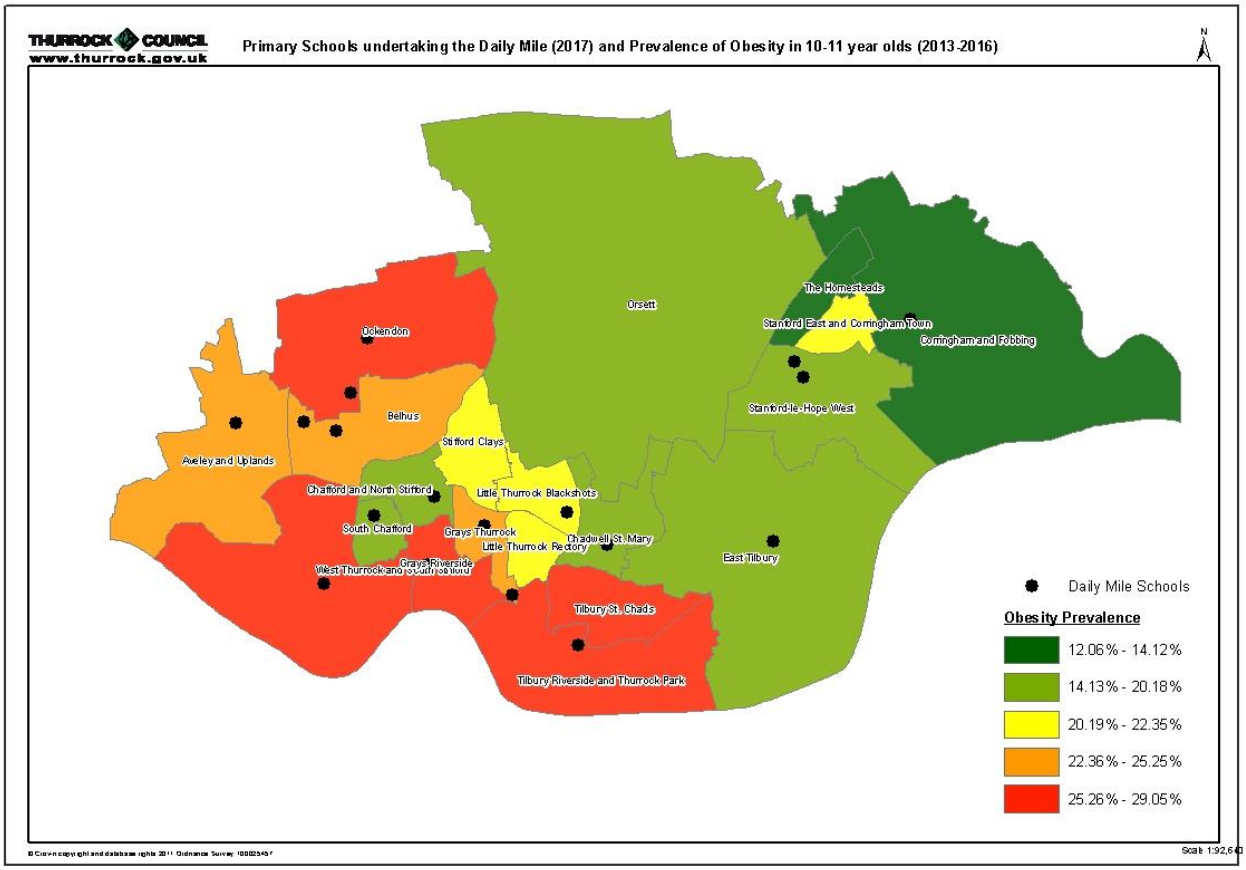


Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

One initiative which has proved to be successful elsewhere in improving the amount of physical activity which CYP do in primary school is the Daily Mile. This is a short (15 minute) Daily Exercise time implemented in many primary schools across the UK. Thurrock Council has been promoting the uptake of the Daily Mile in schools in 2015. In May 2017, 50% of primary schools were taking part in the Daily Mile. However, the latest data (Feb-March 2018), shows that 37% of primary schools were actively taking part in the Daily Mile. It is possible that fewer schools have taken part during the winter months and this may account for the fall in participation. This needs to be investigated further. It should also be noted that no information was available for 6 schools.

Figure 10 below shows the schools participation in the Daily Mile (May 2017) overlaid with the NCMP data for year 6 (age 10/11) in Thurrock. Whilst there is a good geographical spread of schools undertaking this, it would be beneficial to promote this initiative further, particularly in areas of high obesity prevalence, and Thurrock's public health team is working with partners to promote the scheme.

Figure 10. Schools undertaking the Daily Mile and Obesity prevalence in Year 6, 2013-16



Source: Thurrock Council and National Child Measurement Programme.

Given the fall in the number of schools implementing the Daily Mile and the fact that levels of physical activity appear to be lower in secondary school age-groups than in primary, there is clearly scope for significantly increasing the amount of physical activity which CYP do in Thurrock.

2.1.4 Positive Parenting

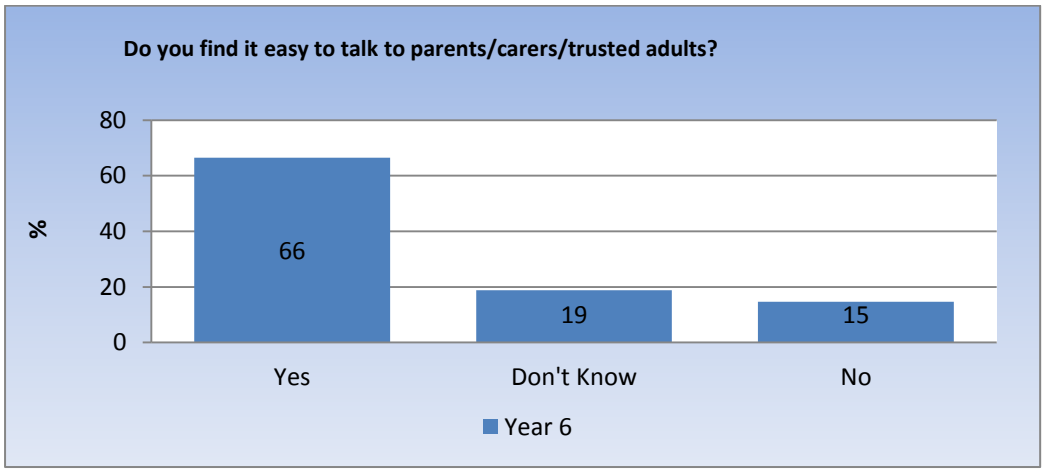
There is strong evidence to show that parental mental health, particularly maternal mental health, influences children's mental health (Goodman, Rouse, Connell, Broth, Hall, & Heyward, 2011a) (Laucht, Esser, & Schmidt, 1994). This means that there are intergenerational patterns of poor mental with children whose parents have mental ill health more likely to suffer poor mental health themselves. Untreated perinatal mental health problems have particularly been associated with later conduct problems in children (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014).

It is also known that CYP's overall wellbeing is affected by their relationship with their parents of caregivers (Children's Society, 2013). Moreover, a poor relationship with parents may exacerbate mental health issues and result in adverse behaviour or inappropriate emotional responses.

The BFS asks about being able to talk to a parent or trusted adult. Year 6 pupils were asked whether they find it easy to talk to parents/carers/trusted adults. As shown in Figure 11, 66%

of Year 6 pupils said it was easy to talk to a parent, carer and/ or a trusted adult, however 15% said it was not easy and 18% said they didn't know.

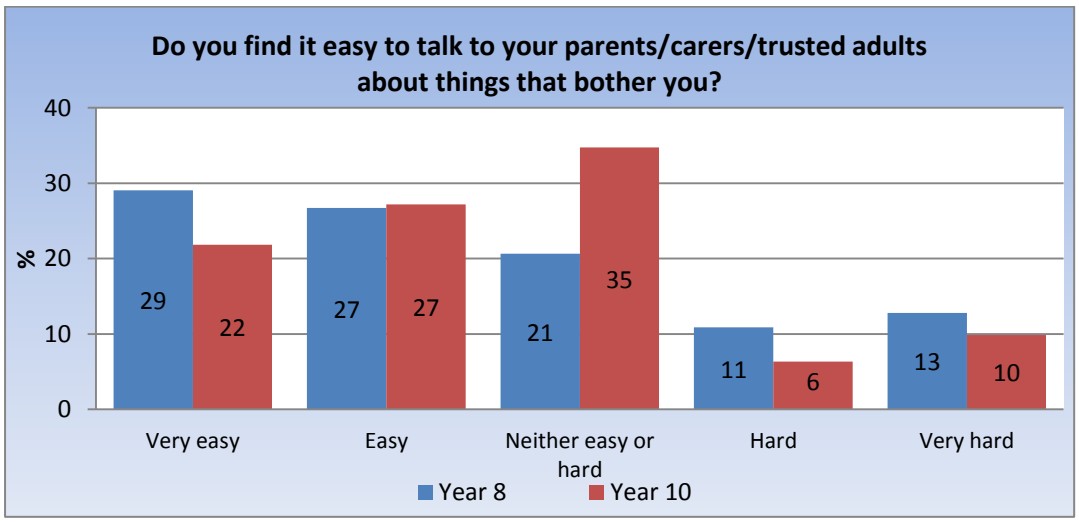
Figure 11: Being able to talk to a trusted adult in Year 6



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

In Figure 12, there is a similar trend with the majority of Year 8 and 10 pupils stating they find it very easy or easy to talk to a trusted adult about the things that bother them. However, a considerable proportion in all age groups said that they would find it hard or very hard to talk to a trusted adult about things which bother them. This suggests that there is considerable room for improvement in ensuring that all children and young people have trust adults who they are able to talk to about worries and concerns.

Figure 12: Easiness to talk to adults in Years 8 and 10



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

2.1.5 Summary of protective factors

The information presented above highlights some key factors which promote positive mental wellbeing for children and young people in Thurrock and help them to be resilient when they experience difficulties in life. Local data suggests that, while many CYP do have strong protective factors in place, there is significant room for improvement. In particular, responses to the Brighter Futures Survey suggest that older age groups (years 8 and 10) may not have as much support as they need. For example:

- More than 20% of Year 8 and Year 10 pupils say they feel lonely often or all the time and 39% of Year 10s say they keep worries to themselves;
- Whilst most young people do report using positive coping strategies to deal with difficulties, a worrying number also resort to negative and risky strategies such as the use alcohol, smoking or drugs to cope (8.8% in Year 8) hurting themselves (7% in Year 8);
- Nearly 26% of Year 6s report doing the recommended amount of physical activity but that drops to just 12% in Year 10;
- Positive relationships with parents and a willingness to talk to parents about concerns also appear to be less common in older age groups.

This local information fits with other research about the prevalence of many mental health disorders which shows that, in general, they are more common in adolescents. The lack of protective factors means that adolescents may be particularly vulnerable to developing mental ill health. It also means, however, that there are significant opportunities to improve mental wellbeing by addressing some of these known protective factors in Thurrock. In particular promoting good social connections (reducing social isolation and loneliness), providing CYP with positive coping strategies, and promoting physical activity are areas where there are clear opportunities to promote positive mental wellbeing for children and young people in Thurrock.

2.2 Risk Factors

2.2.1 Being bullied

Being a victim of bullying is one of the most common reasons for children and young people experiencing mental ill health. The Antibullying Alliance defines bullying as:

> *"the repetitive, intentional hurting of one person or group by another person or group, where the relationship involves an imbalance of power."*

Bullying can take many forms including: physical assault; verbal bullying (such as teasing, making threats and name calling); cyberbullying bullying via platforms such as email, social networks and instant messaging; and indirect bullying, when an individual creates and spread rumours or other gossip within their social group. All types of bullying can have a negative impact to wellbeing, affecting mental health, social status and educational achievement.

Evidence shows that children bullied at age 13 were more than twice as likely to have depression at age 18 and approximately 29% of the burden of depression at age 18 years can be attributed to victimisation by peers in adolescence if this relation were causal (Bowes, Joinson, Wolke, & Lewis, 2015). Moreover, bullies themselves are at greater risk of substance abuse, antisocial behaviour, poorer classroom performance, and may develop unhealthy social perceptions such as an overreliance for aggressive behaviour for problem-solving (Merrell, Gueldner, Ross, & Isava, 2008).

The 2016 Annual Bullying Survey is carried out by an anti-bullying charity in partnership with secondary schools and colleges across the UK (Ditch the Label, 2016). A total of 8,850 respondents aged 12-20 were included in the analysis and it was found that 1 in 2 young people have at some point experienced bullying, with 1 in 4 being bullied at least once within the past year. The survey showed that as a result of bullying, 31% have self-harmed and 44% developed depression.

The potential for cyberbullying has grown with the increased access to internet platforms through use of computers, tablets and mobile phones among young people. There is also a strong link between experiencing cyberbullying and poor mental health in young people (Brooks, Magnusson, Klemera, Chester, Spencer, & Smeeton, 2014; Smith, Mahdavi, Carvalho, Fisher, Russell, & Tippett, 2008). Findings from the Health Behaviour in School-aged Children (HBSC) study for England 2014, drawing on the responses from 5,335 students aged 11-15 years illustrated associations between cyberbullying with demographics and social context (PHE, 2014). The main findings were:

- 17.9% of 11-15 year olds reported being cyberbullied in the two months prior to being surveyed, while 32% reported being bullied face to face
- Girls were twice as likely as boys to report being cyberbullied
- Cyberbullying increased with age for both boys and girls; the reported prevalence rates of cyberbullying at age 15 were almost double those for 11 year olds
- Cyberbullying is associated with socioeconomic status - young people from more affluent families were more likely to report being victims of cyberbullying
- Young people who reported positive family communication, especially with a father, were less likely to experience cyberbullying

Local data

What About YOUth? (WAY) is a survey carried out in 2014, designed to collect robust local authority level data on a range of health behaviours amongst 15 year-olds (Health & Social Care Information Centre; Ipsos Mori, 2015). The report found that the percentage of 15 year olds in Thurrock who reported being bullied at least once in the past two months was 53.7%; Figure 13 below shows this is similar to our statistical neighbours (also known as CIPFA comparators[2]) and the England average of 55%.

Figure 13: What About Youth Survey 2014/15 responses to bullying

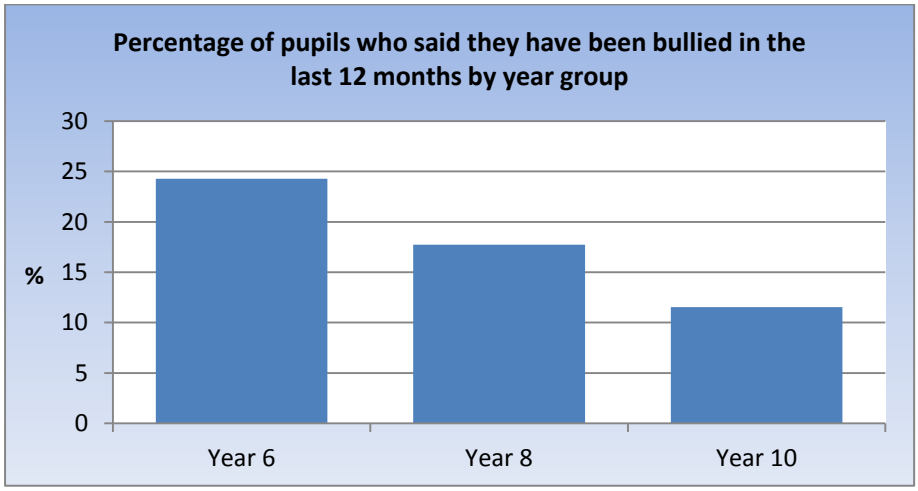
Area	Value	Lower CI	Upper CI
England	55.0	54.7	55.3
Thurrock	53.7	50.2	57.2
Milton Keynes	59.4	56.5	62.2
Swindon	53.3	50.3	56.2
Peterborough	54.6	51.6	57.5
Reading	55.8	52.4	59.1
Warrington	56.4	53.4	59.4
Trafford	53.0	50.1	55.8
Telford and Wrekin	59.3	56.4	62.2
Medway	57.1	54.2	59.9
Bolton	56.0	53.1	58.9
Stockton-on-Tees	57.1	54.0	60.2
Bedford	52.3	49.2	55.4
Derby	55.3	52.2	58.3
Coventry	58.4	55.4	61.4
Rochdale	53.0	50.1	55.8
Calderdale	55.7	52.8	58.7

Source: What About YOUth (WAY) survey 2014/15

The BFS asks a number of questions about bullying in Thurrock: Figure 14 shows that bullying is less common in older age groups. In Year 6, 24% of pupils reported being bullied in the past 12 months, 18% in Year 8 and 12% in Year 10, although even the 12% who report having been bullied in Year 10 is a cause for serious concern, especially given what is known about the higher risk of mental ill health in adolescents.

[2] Statistical neighbours (also known as CIPFA comparators) were developed by the Chartered Institute of Public Finance and Accountancy to aid local authorities in comparative and benchmarking exercises. They are groups of local authorities with similar demographic and socioeconomic profiles. Source: CIPFA Stats Publisher: IPF Geographic coverage: England. www.data.gov.uk/dataset/cipfa_-_nearest_neighbours

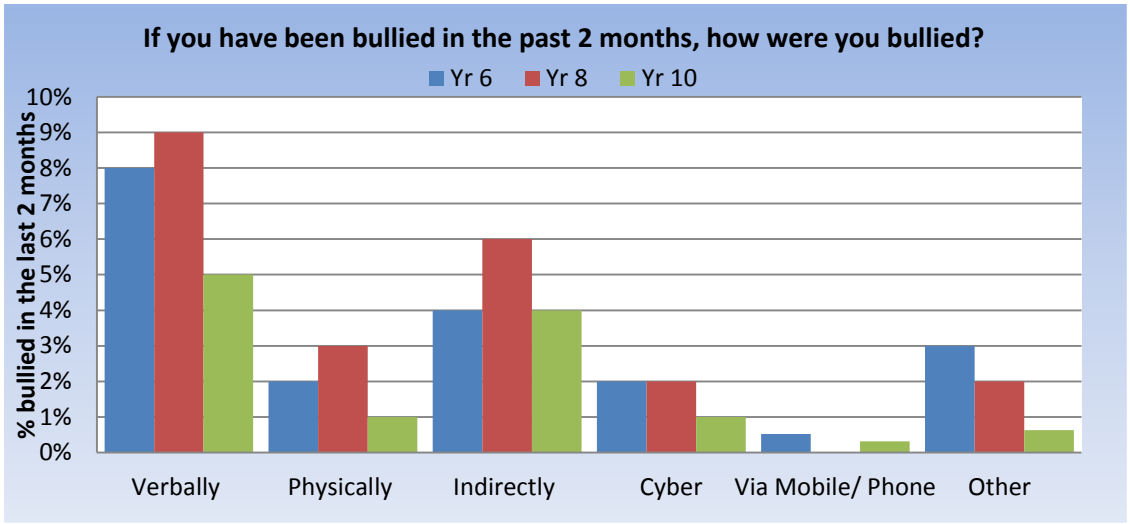
Figure 14: Proportion of respondents that reported ever being bullied in the past 12 months



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

Figure 15 shows that the most common form of bullying reported in the two months previous to the survey was verbal bullying, followed by indirect and then physical.

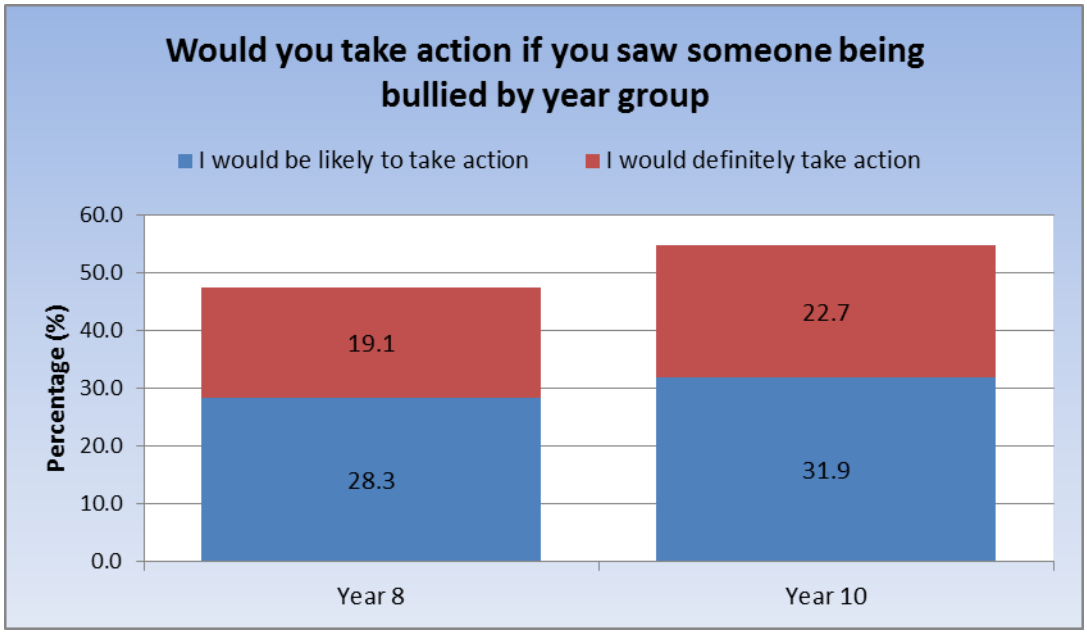
Figure 15: Type of bullying in schools



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

A positive finding shown in Figure 16, is that a majority of Year 8 and 10 pupils (49%) would 'likely' or 'definitely' take action if they saw someone was being bullied. Only 15% of young people felt they were unlikely take action.

Figure 16: Taking action against bullying



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

Bullying is clearly a national issue and the available data does not suggest that Thurrock is worse than other comparable areas. However, it is clear that it is still a very significant issue for Thurrock's CYP and is, therefore, likely to be having a very significant impact on their mental health.

2.2.2 Excessive Internet and Social Media Use

Internet use and social media are common features in young people's lives. There is now a large body of research showing that excessive screen time (including watching television, DVDs and videos) has a negative impact on mental well-being. Children who spend more time on computers, watching TV and playing video games tend to experience higher levels of emotional distress, anxiety and depression and this is particularly the case for those children spending more than four hours a day engaged in those activities. In 2012 to 2013, around 8% of children spent over three hours on social networking websites on a typical school day. Girls were far more likely than boys to spend over three hours on social networking websites. In 2012 to 2013, around one in 10 girls (11%) spent over three hours on social networking websites compared with just 5% of boys (Public Health England and Liverpool John Moores University, 2015).

An ONS study in 2015 found that while 12% of children who spend no time on social networking websites have symptoms of mental ill health, the figure more than doubles to 27% for those who are on the sites for three or more hours a day (Office for National Statistics, 2015). Other research has shown links with excessive internet use with depression and social media use with poor quality sleep and other social and emotional problems (Frith, 2017).

There is also evidence that the use of mobile technologies such as smartphones is linked to anxieties about conforming to social norms and the need for "likes": external validation from friends for personal content posted online. Time spent online has also been associated with a decline in academic achievement and participation in offline social interactions (Rosen, 2011).

Young people are spending more time using the internet; Ofcom reported that 59% of 16-24 year olds in the UK agreed that they spent too much time online (Ofcom, 2015). A quarter (25%) said that they feel nervous and/or anxious when they are offline (this phenomenon is sometimes described as FOMO or 'fear of missing out'). Nearly 4 in 10 (37 %) of 16-24s said that they had neglected their work or job. Teenagers were found to be less likely to think they spent too much time online. Nevertheless, their other responses provided evidence to the contrary:

- Nearly 8 in 10 (78%) had been told off by their parents for spending too much time on the internet.
- 72% said they had missed out on sleep because of their online habits.
- 60% agreed that they had neglected their schoolwork or studies.

Access to the internet and use of social media was explored within the BFS. Table 2 below demonstrates how the majority of respondents in youngest age group of the BFS (Year 6 group) are using the internet freely on their own devices and without adult supervision. The pupils were asked whether they had a social network profile and the majority at 76% of respondents said yes.

Table 2: Internet and social media usage Year 6s

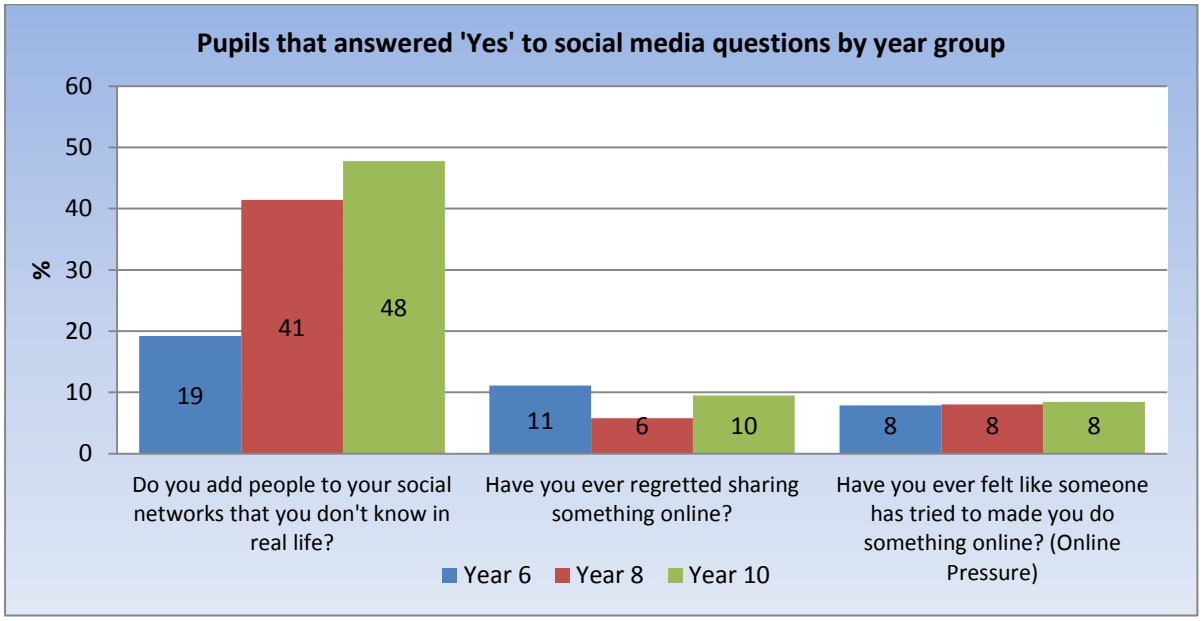
Question	Yes	No
Do you own a device that can access the internet?	99%	1%
Are you allowed to use the internet on your own?	96%	4%
Have you had lessons in school about internet safety?	99%	1%
Do you have a social network profile?	76%	24%

Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

The BFS asked whether they had ever "added"[3] someone on social media that they did not know in real life. As shown in Figure 17, an unexpected proportion of children said they had added someone on social media that they don't know in real life ranging from 19% in Year 6 to 49% in Year 10. Almost 10% said they had regretted sharing something online and 7% said they had at some point felt pressured to do something online.

[3] Adding someone on social media means to share access to your personal social media profile with someone, for example on Facebook, Twitter and Instagram; a person's social media profile will often have content visible such pictures, written posts and personal interests.

Figure 17: Social Media Usage



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

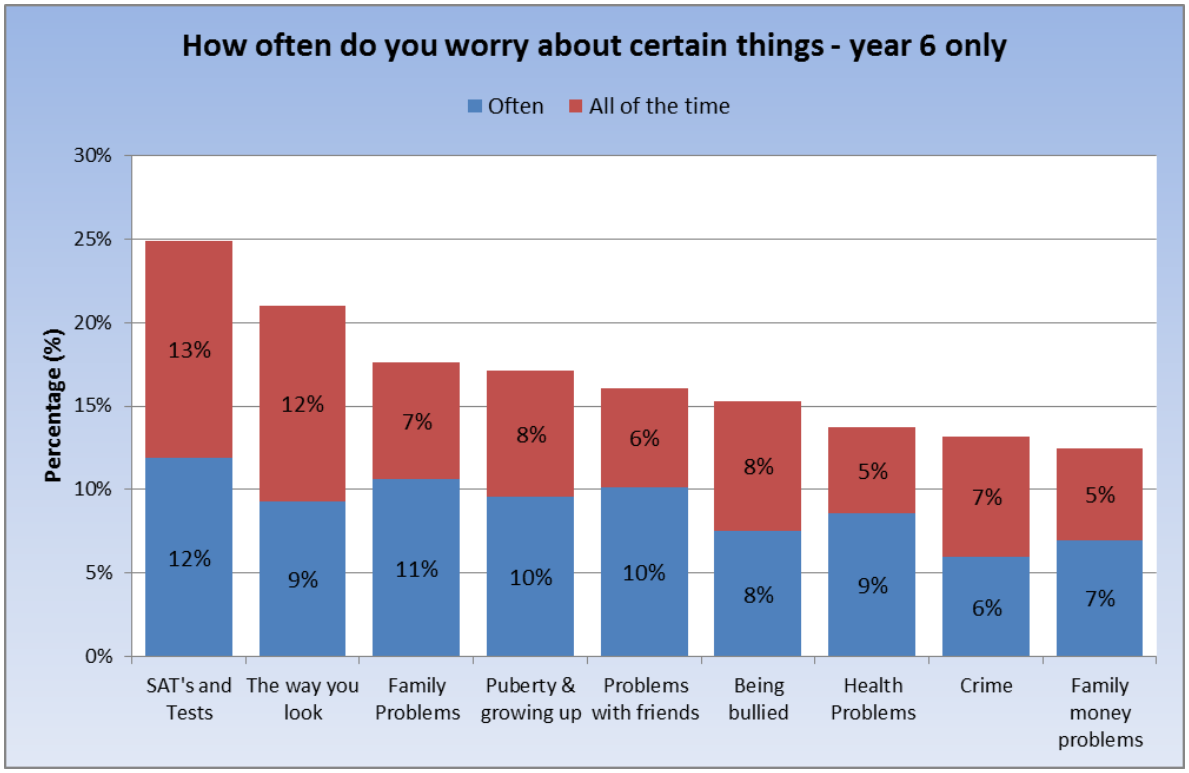
2.2.3 Body Image

There are cultural, social, physical, and psychological changes that occur in adolescents during puberty that can affect their self-perception of body image. Having a poor body image has been found to be negatively associated with self-esteem and depression, particularly amongst teenage girls and may account for the higher prevalence of depression and low self-esteem amongst girls (ONS, 2015). A large study in the UK (around 40,000 households take part each year) showed that around 1 in 10 children aged 10 to 15 years old were unhappy with their appearance (11% in 2011 to 2012 and 10% in 2012 to 2013). The proportion of girls reporting that they are unhappy with their appearance is around double that of boys (14% of girls compared with 7% of boys in 2012 to 2013) (Understanding Society, 2012).

Constant negative feelings about body image can not only affect emotional health, leading to depression, but can also be the strongest predictor of disordered eating behaviours and clinical eating disorders across psychosocial variables, such as perfectionism and locus of control (Wertheim E, Koerner, & Paxton S, 2001).

Pupils in the BFS were asked what they thought was the most common focus of bullying within their schools: 58% reported that appearance was the most common focus of bullying. Appearance was also reported by Year 6 pupils (ages 10-11) to be one of the things they most often felt worried about (Figure 18)

Figure 18: Percentage of children in Year 6 (ages 11-12) who are worried about something



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

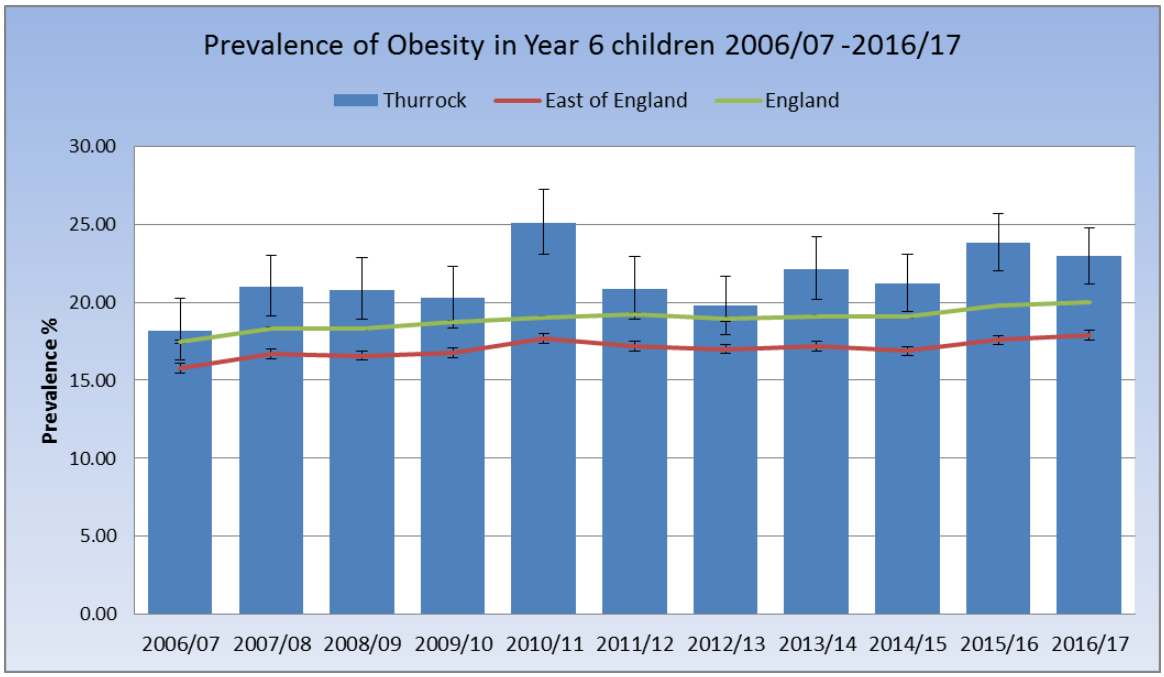
It is clear that body image has close and complex links with some of the other risk factors explored in this section including use of social media, bullying, overweight/obesity (below) and mental ill health. It is an issue which could be address directly as part of a strategy to improve mental wellbeing.

2.2.4 Overweight and obesity

Childhood obesity is associated with emotional and behavioural problems from a very young age (age 3 upwards). Obese boys have been found to be at particular risk (Griffiths, Dezateux, & Hill, 2011). Further studies have demonstrated that obesity can be both a cause and a consequence of common mental health disorders and obesity in adults (Luppino, de Wit, Bouvy, Stijnin, Cuijpers, & Penninx, 2010).

In Thurrock we know that obesity in children is a problem. The obesity rate in Reception pupils in Thurrock was 10.2% and for Year 6 pupils was 23.0% in 2016/17. Figure 19 shows the trend in obesity rates for Thurrock compared to national and regional data and it can be seen that the Thurrock prevalence remains significantly higher than the regional and national averages. This has many implications for the health and wellbeing of CYP in Thurrock including a higher risk of mental ill health.

Figure 19. Prevalence of Obesity in Year 6 Children 2006/07 – 2016/17



Source: National Child Measurement Programme

2.2.5 Being involved with a gang and crime

Research shows that children and young people in the youth justice system have higher than normal levels of depression (18%), anxiety disorders (10%) and psychotic-like symptoms (5%) (Berelowitz, 2011). Being involved with a gang has been strongly linked to greater levels of poor mental health in young people; the relationship operates in both directions as young people with poor mental wellbeing can be drawn to gang-affiliation, while involvement in gang-related activities can damage mental health (Public Health England and Liverpool John Moores University, 2015).

One study showed that 40% of young gang members (of both sexes), aged 10 to 18 years, at point of arrest had signs of severe behavioural problems before the age of 12, compared with 13% of the general youth justice entrants. On average a quarter had a suspected mental health diagnosis and over a quarter were suffering sleeping or eating problems, compared with less than 10% for general entrants. One in three female and one in ten male gang members were considered at risk of suicide or self-harm (Khan, Brice, Saunders, & Plumtree, 2013).

It is hard to be sure how many CYP in Thurrock may be involved in gangs currently but it is known that gang membership is an issue in the borough and that efforts to combat gangs may have a positive impact on mental health.

2.2.6 Adverse childhood experiences

There is a growing body of evidence showing how Adverse Childhood Experiences (ACEs) can affect long-term health and wellbeing. ACEs are intense sources of stress that children may suffer early in life. Such experiences include: abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence (World Health Organisation). Experiencing an adverse life event may affect any child at some point in their lifetime,

however there are particular groups of children who have significantly worse health outcomes linked, for example to being a looked after child, being in the youth justice system or having a disability. These children have an increased chance of developing mental ill health. Children who have been physically and sexually abused are at particular risk. Asylum seeker and refugee children have consistently been shown to have higher levels of mental health problems, including post-traumatic stress, anxiety and depression (British Medical Association, 2006).

Multiple ACEs and resultant prolonged stress in childhood has life-long consequences for a person's health and well-being. ACEs can have a strong influence on the chances of developing mental health problems in adulthood including depression, post-traumatic stress disorder, and attention deficit and hyperactivity disorder. As well as the direct effects of ACEs on mental health, they can also lead to an increased risk associated with negative coping mechanisms such as including alcoholism and eating disorders (Lessof, Ross, Brind, Bell, & Newton, 2016; Hughes, et al., 2017).

Looked after children are a particularly high risk group and have consistently been found to have high rates of mental health difficulties, with almost half meeting criteria for a psychiatric disorder at a rate many times higher than for children raised in birth families and even those in birth families at elevated social risk (Ford, Vostanis, Meltzer, & Goodman, 2007; Meltzer, Corbin, Gatward, Goodman, & Ford, 2003).

There are 5% of households with dependent children who are families out of work and 3.1 children per 1,000 households are experiencing family homelessness. The most recent monitoring data from March 2018 shows that there are 308 looked after children in Thurrock.

Figure 20 illustrates some of the ACE statistics in Thurrock. It is clear that a significant number of children in Thurrock will be affected by ACEs at some point and this puts them at high risk of poor mental health. Strategies to improve mental health, therefore, need to take account of the groups of children who are at particularly high risk.

Figure 20: Adverse Childhood Experiences in Thurrock

2.2.7 Not being in employment, education or training (NEET)

NEET refers to not being in employment, education or training at the age of 16-24 years. Being in employment and/or education provides both material and social benefits (Creed & Macintyre, 2001). Having a mental health disorder has been associated with an increased risk of disruption to education and school absence (Green, McGinnity, Meltzer, Ford, & Goodman, 2004). Evidence shows that young people who are NEET are more likely to experience poorer overall health including mental health, demonstrating a relationship in both directions (UCL Institute of Health Equity and PHE, 2014). There is, therefore, a two-way relationship between being NEET and mental ill health since poor mental health can

result in CYP dropping out of education or employment and lack of those things can result in mental ill health.

In 2015, in Thurrock there were an estimated 4.8% of 16-18 year olds NEET, a statistically higher proportion than the CIPFA comparator averages. Since 2015, the methodology changed and Local Authorities are only required to record NEETs up to the end of the school year excluding 18 year olds who have left school or college. In 2016, it appeared Thurrock's proportion of NEET population (aged 16-17) was statistically similar to the regional partners at 2.5% and statistically lower than many of the CIPFA comparator, see Figure 21.

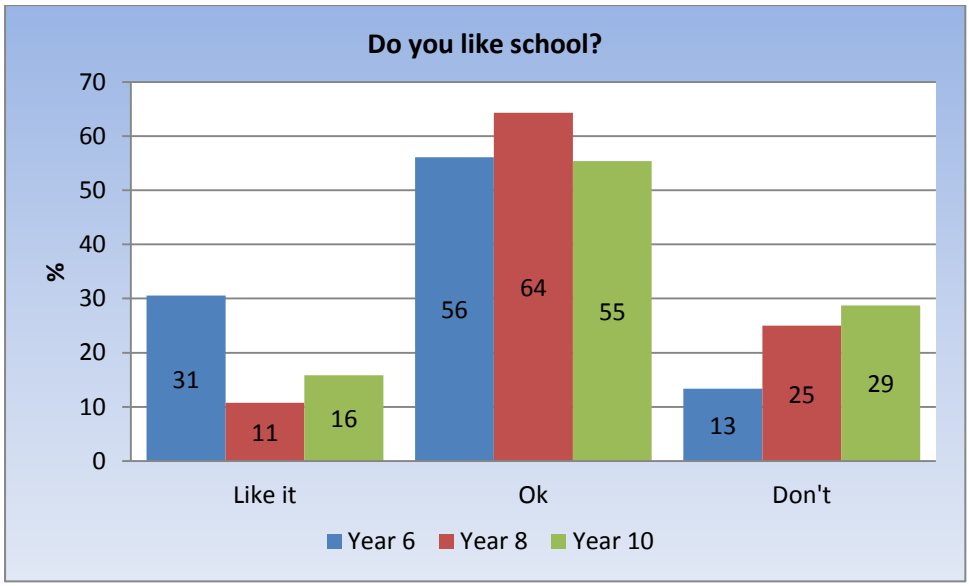
Figure 21: % of NEET in Thurrock and CIPFA comparators

Indicator	Period	England	Thurrock	1 - Milton Keynes	2 - Swindon	3 - Peterborough	4 - Reading	5 - Warrington	6 - Trafford	7 - Telford and Wrekin	8 - Medway	9 - Bolton	10 - Stockton-on-Tees	11 - Bedford	12 - Derby	13 - Coventry	14 - Rochdale	15 - Calderdale
1.05 - 16-18 year olds not in education employment or training - historical method	2015	4.2	4.8	3.8*	4.0	5.3	4.6	3.2	3.9*	7.9*	7.4	4.8	6.6	5.4	4.8	4.7	4.2	4.4
1.05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known - current method	2016	6.0	2.5	5.6	6.1	6.6	5.4	2.3	6.1	9.2	9.8	6.8	4.4	5.1	8.4	6.8	6.7	4.1

Source: PHE Fingertips

Happiness with school can be linked to prevention of NEET and is an important protective factor as the majority of CYPs time is spent within schools or college. School happiness is linked to many other factors in the short and the long term such as school attendance and educational attainment. Figure 22, below shows that the majority of pupils in Years 6, 8 and 10 feel they like school or think it is "ok". There appears to be an upward trend with 13% in Year 6, 25% in Year 8 and 29% in Year 10 reporting that they don't like school.

Figure 22: Percentage of children who are happy with school year 6, 8 and 10



Source: Thurrock Brighter Futures Children and Young People's Survey, 2017

2.2.8 Non-modifiable risk factors

The risk factors below are ones which are impossible (or difficult) to modify directly though they are relevant when developing strategies to tackle mental ill health since they may help to target services or interventions designed to improve mental health.

Age

As children grow older and become young adults their risk of a mental health disorder starts to increase (Green, McGinnity, Meltzer, Ford, & Goodman, 2004), most likely linked to changes that occur as children grow older physiologically and environmentally. For example, changes in friendships and greater pressures when children reach secondary school can strain young people's mental wellbeing.

Adolescence is a critical life point and at this age mental health disorders are more likely to develop or become apparent. There are a number of risks that are specific to this life stage including risk taking behaviours (e.g. smoking, alcohol and drug use), experiencing peer pressure and greater media influence. In addition to these risks to health, substance use in adolescence is linked to lowered educational outcomes, more risky sexual behaviour and heightened violence (Fisher, Cabral de Mello, Izutsu, Vijayakumar, Belfer, & Omigbodun, 2011; Sawyer, et al., 2012). Substance use is particularly hazardous and harmful for adolescents because the brain and body are still developing at this age.

Data from the EWMHS service data (see Section 3.4) shows that the greatest proportion of referrals comes from the age group 10-15 years (56%) and 16-18 years (34%).

Gender

Recent evidence in the UK has shown that both genders are likely to experience similar levels of ill mental health but there is variation in the type of disorder. Conduct problems tend to be more common among boys (24% in boys, 15% in girls in 2014) and emotional problems more common in girls (7% in boys, 20% in girls in 2014) (Fink, Patalay, Sharpe, Holley, Deighton, & Wolpert, 2015).

Ethnicity

Ethnicity is also significant, though more evidence exists for adults than for children. There is evidence that in adulthood, black and minority ethnic (BME) groups have greater mental health hospital admission rates, around three times higher than average. The evidence also suggests that mental health services do not always meet the of BME communities effectively (Department of Health, 2011). However, the evidence of the impact of ethnicity on children's mental in the UK is weak. The main source of evidence, the ONS survey in 2004 of the mental health of CYP in the UK, includes less than 10% minority ethnic groups in the whole sample, which is a representative sample of the general population; however, as no oversampling techniques for minority groups were used, the data lacks power and reliability (Dogra, Singh, Svirydzenka, & Vostanis, 2012).

A study looking at access to online counselling in England found that, 81.8% of Kooth clients gave their background as White and 17.6% had a BME background (median age of clients was 15 years). This was compared this to the rate of BME groups in the general population of the same local authorities. Overall in these areas 90% of the population was white and 10% were BME. This suggests that Kooth has attracted a high rate of clients with a BME

background – higher than the overall proportion within the local populations (Frith, Online Mental Health Support for Young People, 2017). Thurrock's local service data (see Section 3.4) showed that the ethnicity of EWMHS users is predominantly White British at 90.28%, compared to 66% of White British in the Thurrock general population aged 0–19 years suggesting that BME groups appear to be under-represented in the current service.

Sexuality

Lesbian, gay, bisexual and transsexual (LGBT) young people are known to be at significantly higher risk of having poor mental health (Metro Charity, 2016). An analysis of The Adult Psychiatric Morbidity Survey 2007 (n=7403), a representative sample of the population living in private UK households, highlighted that self-reported identification as non-heterosexual was associated with increased risk of poor mental health (Chakraborty, McManus, Brugha, Bebbington, & King, 2011). This study also showed that mental health-related GP consultations and community care service use over the previous year was elevated in non-heterosexual groups. The study is in line with international findings that people of non-heterosexual orientation report elevated levels of mental health problems and service usage, potentially linked to the social stressor of discrimination.

Local data

At school age young people may not yet have identified their sexuality. The BFS (2017) found that a small proportion of pupils identified as transsexual (0.63% in Year 8 and 1.3% in Year 10) while others recorded their gender as 'other' (3.87% in Year 8 and 0.63% in Year 10). The 2016 ONS annual survey, 1.7% of 16-24 year olds identified their sexuality as either gay or lesbian and 2.4% as bisexual.

Genetic Factors

There is evidence to show that some mental health conditions can be related to a person's genetics. A genome-wide association study of more than 30,000 people with autism, ADHD, depression, bipolar disorder or schizophrenia, compared genetic sequences with more than 27,000 people who did not have these conditions. The findings suggested that these conditions may have common genetic risk factors. These variations cannot, on their own, predict or explain particular mental health conditions. However, the researchers report that evidence from a variety of research, "including that from clinical, epidemiological and molecular genetic studies, suggests that some genetic risk factors are shared between neuropsychiatric disorders." Mental health conditions such as depression or schizophrenia cannot be explained only genetic factors; environmental factors are also thought to play a part (Cross-Disorder Group of the Psychiatric Genomics Consortium., 2013). Local data would not be possible on these factors.

2.2.9 Summary of risk factors

There is good evidence that the risk factors discussed above have a negative impact on CYP mental health. These risk factors range from the individual-level (e.g. genetics, gender, overweight and body image), through family and friends (e.g. bullying or abuse), to wider social and economic factors such (e.g. deprivation). Intervening at each of these levels has different implications and requires a different approach. Moreover, some of these risk factors are more easily modified than others.

Our focus has been on those factors which are modifiable and could, therefore, be a target for intervention. Bullying stands out as a risk factor which a large proportion of children

experience at some point and which also has a strong negative impact on mental health. This also appears to be more common in younger children with 24% of Year 6s in the Brighter Futures Survey reporting having been bullied in the past 12 months, compared to 12% in of Year 10s.

There also appears to be a cluster of risk factors around the internet and body image. This includes: bullying, with evidence that cyberbullying is on the rise and Thurrock pupils reporting that appearance is the most common target for bullying; evidence that excessive use of internet and social media (more than 3 hours per day) increases the risk of anxiety and depression; body image, with images seen on social media thought to have a negative effect on body image for many adolescents; and overweight, which has increased significantly over the years, as the amount of time CYP spend using screens has increased. All this suggests that there are particular risks associated with modern life, which are having an impact on the mental health of children and young people. This also suggests that interventions addressing one or more of this cluster of risk factors successfully could have wide-ranging positive impacts on mental health affecting a number of risk factors. Strategies for combatting these risks are explored below in Section 5.

3. Mental Health Disorders

Where the risk factors affecting mental health outweigh protective factors, children and young people may develop medically recognised mental health disorders ranging from mild to severe conditions which require support or treatment of some kind. At every stage of severity, reducing risk factors and strengthening protective factors can have a positive impact on mental health so that treatment and prevention work can complement one another. This section outlines the information available on the number of children affected by recognised mental health disorders nationally and locally. It also gives information on the most common forms of mental health disorder and how these are changing over time.

3.1 The Scale of the Problem Nationally

The best available national data on the prevalence of mental health disorders in children dates back to 2004 (Office for National Statistics) though new data is being collected through a national survey. The 2004 survey found that 1 in 10 young people (under 18) will have a clinically diagnosable mental health disorder at some point during childhood. The most common forms of mental health disorder are shown in Table 3.

Table 3. Prevalence of major mental health disorders in young people in England

Condition	Percentage (and approximate number) of young people experience it*
Conduct disorder	5.8% (510,000)
Anxiety	3.3% (290,000)
ADHD	1.5% (132,000) (2.6% in boys, 0.3% in girls)
Depression	0.9% (80,000)
Autism Spectrum Disorder	0.9% (80,000)
Eating disorder	0.3% (26,500)
Selective mutism	0.1% (26,500)

* The prevalence of severe but rare disorders (such as psychosis) in young people is unknown

There are clear links between child and adult mental health with 50% of all mental health disorders emerging before the age of 14 and 75% before the age of 25.

3.2 National Trends

Long term trends in CYP's mental health are not easy to understand, partly because there is a lack of data and partly because definitions and categories of mental ill health change over time. There is evidence of increasing demand for treatment services and a perception among many that mental ill health is increasingly common in adolescence. However, there are also concerns about the medicalization of (and growing use of medication for) behaviour and experiences which would once have been treated as a normal part of growing up (Conrad, 1975) (Conrad & Bergey, 2014) . Finding objective evidence to support or refute these perceptions is not easy. Below is a summary of some of the best available evidence relevant to these questions.

3.2.1 Mood (emotional) disorders

There is strong evidence of increases in diagnosis and treatment of depression and anxiety, particularly amongst teenagers in the UK. Moreover, a number of cohort studies also suggest that there have been real increases in the underlying prevalence of anxiety and depression in both self-reported and parent-reported studies amongst adolescents. For example, the number of children reporting five or more symptoms of anxiety or depression

rose from 7% in 1986 to 15% in 2006 in comparable studies (Collinshaw, 2015). Studies from other high-income countries show similar increases in prevalence, diagnosis and treatment.

Definitions of Common Mental Health Disorders in Children

Conduct disorders is the term used to describe persistent defiant, anti-social behaviour where a child or young person repeatedly carries out aggressive acts that upset other people.

Mood/emotional disorders

Anxiety typically includes disproportionate, pervasive, uncontrollable, and widespread worry (Hoge, 2012). *Selective mutism* is a severe anxiety disorder where a person is unable to speak in certain social situations, such as with classmates, at school or to relatives they don't see very often. It usually starts during childhood and, left untreated, can persist into adulthood.

Depression is characterised by persistent low mood and/or loss of pleasure in most activities. It can be defined by the presence of defining symptoms which are severe enough to cause significant distress or impairment (American Psychiatric Association, 2013).

Eating disorders are characterized by a persistent disturbance of eating or eating related behaviour that results in altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning. Eating disorders include bulimia nervosa, anorexia nervosa and binge eating disorder.

Neurodevelopmental disorders

Strictly speaking neurodevelopmental disorders are not classified as mental health conditions. However, there are strong interactions with mental health conditions (such as those listed above) and some overlap in services. They have, therefore, been included in this report.

*Austin Spectrum Disorder (ASD***)** is the name for a group of developmental disorders. ASD includes a wide range, “a spectrum,” of symptoms, skills, and levels of disability. ASD is often characterised by ongoing social problems that include difficulty communicating and interacting with others, repetitive behaviours as well as limited interests or activities.

Hyperkinetic Disorder (HKD) and *Attention Deficit Hyperactivity Disorder (ADHD)* are characterised by poor attention, hyperactivity and impulsivity. The core symptoms have a significant impact on a child’s development, including social, emotional and cognitive functioning.

3.2.2 Conduct disorders and self-harm

In the UK and other high-income countries, the available evidence suggests that there was a significant increase in conduct disorders (particularly non-aggressive conduct issues) from the 1970s until the 1990s. After that, the trends appear to have levelled off (Collinshaw, 2015).

There are no reliable data showing trends in self-harm and suicide amongst CYP. Under-reporting is very common and is likely to change as social attitudes change. Community studies show that around 10% of adolescents report some self-harm or injury (with or without suicidal intent) and there is evidence that presentations to hospital have increased but this cannot be taken as evidence of a rising underlying trend (Collinshaw, 2015).

3.2.3 Trends in Neurodevelopmental Disorders

There is clear evidence of a significant increase in diagnoses (and in the use of drugs to treat) ADHD. However, studies which use consistent methods of assessment over time suggest that the underlying prevalence has actually stayed stable or even decreased slightly over the last 20 – 30 years. The rise in diagnosis and treatment, therefore, appears to be largely due to, "broadening diagnostic definitions and better recognition by professionals," (Collinshaw, 2015).

For ASD, there have also been significant increases in rates of diagnosis from around 0.4 per 1000 children in the 1960s to around 9 per 1000 in 2004. There are no studies using consistent methods of assessment of ASD over time making it impossible to tell whether increased diagnosis is due purely to changes in diagnostic criteria and greater recognition of the condition, or whether there has been a true increase in prevalence.

3.3 Prevalence of Mental Health Conditions in Thurrock

Thurrock's child population has grown at roughly twice the national average rate over the past 10 years and this growth is likely to continue into the future. Between 2014 and 2037 it is estimated that Thurrock's child population will grow by 35.4%. This means that even if the prevalence of mental health disorders remains steady in future years, the absolute number of children affected will rise significantly. A detailed overview of the demography of Thurrock child and adolescent population is given in Appendix A.

3.3.1 Prevalence of Mental Health Disorders

Although local prevalence surveys have not been carried out it, it is possible to make estimates of the prevalence of mental health disorders by applying national data to the Thurrock school-age population (5-16 years). This takes into account the age, sex and socioeconomic status of the child population in Thurrock[4]. Using this method, it is estimated that **9.5%** of CYP in Thurrock were affected by mental health disorders in 2015.

Table 4 below gives more detailed estimates. These figures indicate that conduct disorders are likely to be the most common mental health disorder in our population, this is not what is shown in the service data from the EWMHS which shows that emotional disorders are the most reported reason for referral. There is evidence that conduct disorder varies by gender, affecting more boys, whilst emotional disorders, such as anxiety, are more likely to affect girls (Fink, Patalay, Sharpe, Holley, Deighton, & Wolpert, 2015).

[4] http://www.hscic.gov.uk/pubs/mentalhealth04

Table 4. Prevalence of common mental health disorders in school-age children and young people (aged 5 – 16)

Indicator	Data year	England	East Of England	Thurrock
All mental health disorders	2015	9.20%	8.80%	9.50%
Emotional disorders:	2015	3.60%	3.40%	3.63%
Conduct disorders	2015	5.60%	5.30%	5.81%
Hyperkinetic disorders	2015	1.50%	1.40%	1.59%

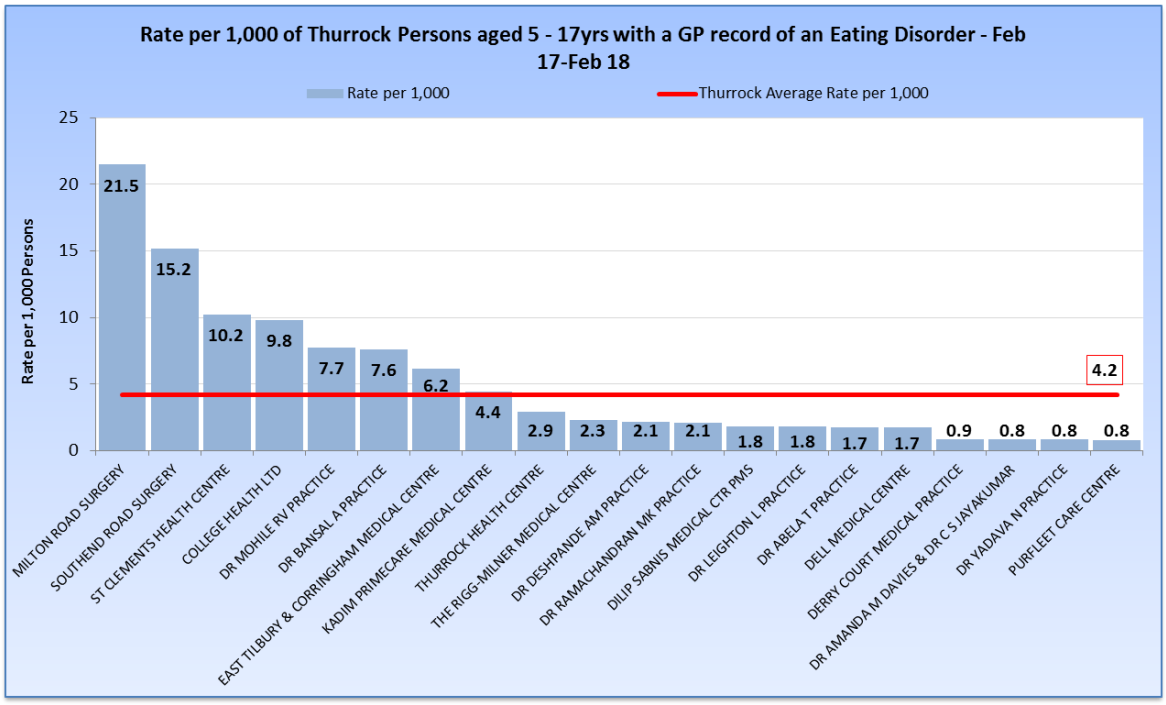
Source: PHE Fingertips

Eating disorders

National data from the Adult Psychiatric Morbidity Survey (APMS) indicates that there are 6.1% males and 20.3% females aged 16-24 with an eating disorder[5]. In Thurrock, this equates to around 2,269 young people aged 16-24 years with an eating disorder though this is a crude estimate which does not take into account local population characteristics.

Looking at local data from primary care, 94 children aged 5-17 years are recorded as having an eating disorder by their GP, which equates to a rate of 4.2 children per 1000[6]. Figure 23 below shows there is wide variation in the rates between practices in the rates of children aged 5-17 years diagnosed with an eating disorder.

Figure 23: GP Practice Level Records of 5-17 years with recorded Eating Disorder



Source: SystmOne

[5] http://www.ic.nhs.uk/pubs/psychiatricmorbidity07

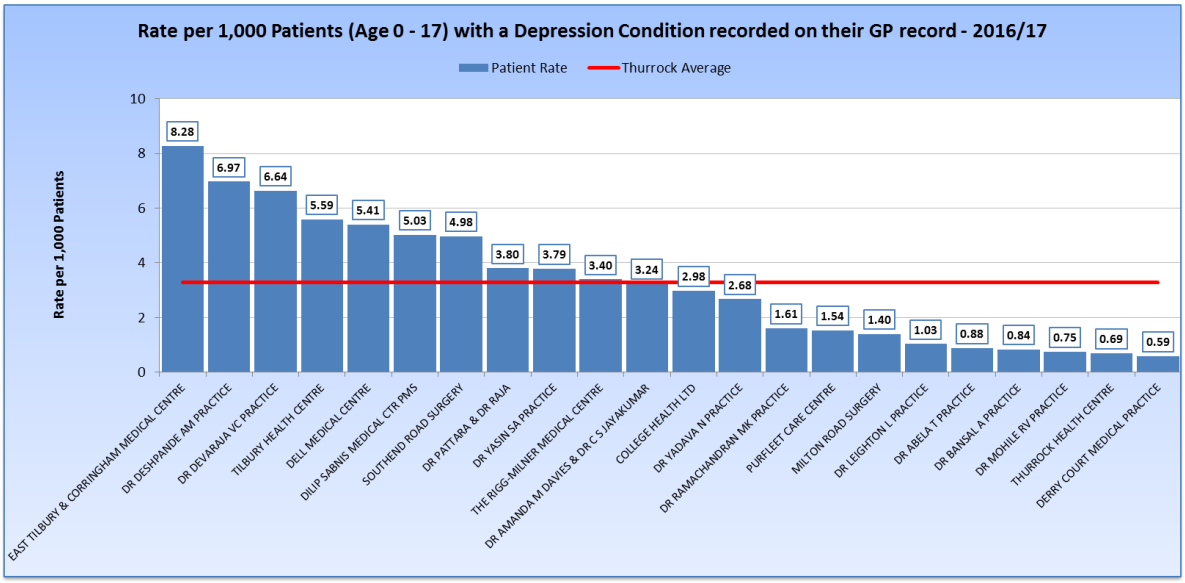
[6] We excluded the 0-4 age range as there were many coded to an eating disorder but for reasons such as lack of appetite. These data also exclude four GP practices in Thurrock that do not use SystmOne.

3.3.2 Primary care registers

Depression

GP records also indicate that 3.2 per 1,000 patients aged 0-17 in Thurrock have been diagnosed with depression. Again, this varies significantly between practices, ranging from 0.59 to 8.28 per 1,000 patients as shown in Figure 24. Recording of anxiety or depression will vary for a number of reasons including having the condition recognised by the GP; variation in recording practices; and the demographics of practice populations.

Figure 24: Rate of Children and Young People with Depression Condition Recorded

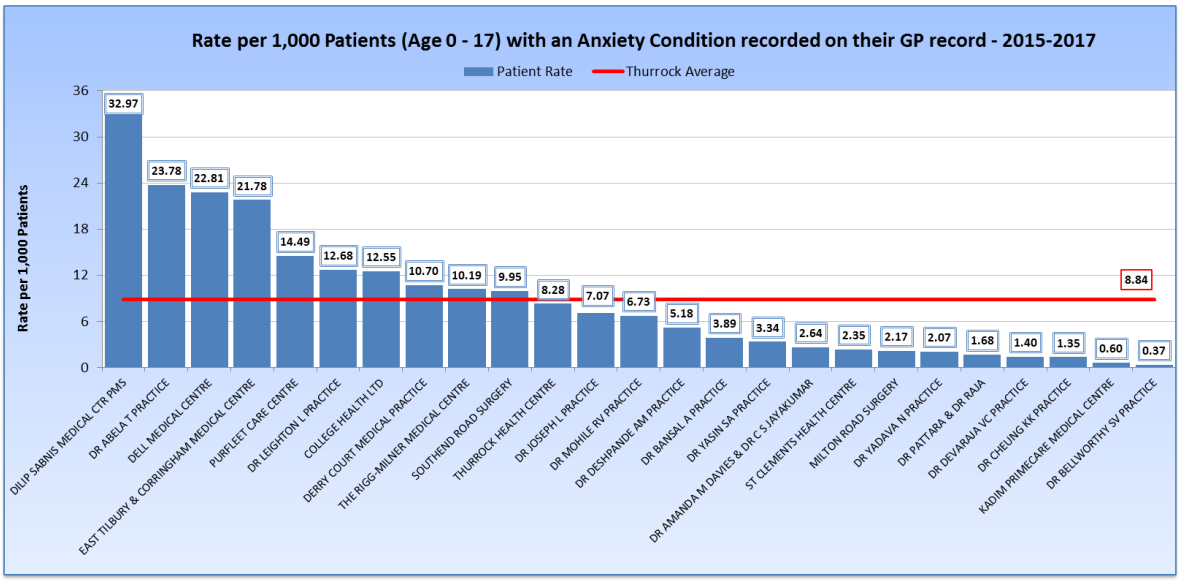


Source: SystmOne

Anxiety

The rate of children in Thurrock aged between 0-17 years with an anxiety condition recorded on their GP record is 8.84 children per 1,000. This varies from 0.37 to 32.97 children per 1,000 between practices.

Figure 25: Rate of Children and Young People with Anxiety Condition Recorded



Source: SystmOne

3.3.3 School pupils with social, emotional and mental health needs

For pupils identified as having Special Educational Needs (SEN), a primary reason for this is given as part of the SEN statement. In 2017, 2.2% of all school-age (5 – 16) children in Thurrock had an SEN with their primary need identified as being social, emotional and mental health. This figure is similar to that of Thurrock's statistical neighbours as shown in Figure 26. It does highlight, however, the overlap between SEN and mental health and the need address both issues together.

Figure 26: Thurrock and CIPFA comparators for SEN needs, where need is social, emotional and mental health

Area	Value	Lower CI	Upper CI
England	2.33	2.32	2.34
Thurrock	2.17	2.00	2.35
Milton Keynes	2.02	1.89	2.15
Swindon	3.10	2.92	3.29
Peterborough	1.84	1.71	1.99
Reading	3.00	2.78	3.24
Warrington	1.99	1.84	2.15
Trafford	1.80	1.68	1.94
Telford and Wrekin	2.66	2.48	2.85
Medway	3.02	2.87	3.18
Bolton	2.35	2.22	2.49
Stockton-on-Tees	2.41	2.24	2.58
Bedford	2.03	1.87	2.20
Derby	2.68	2.53	2.84
Coventry	2.38	2.25	2.51
Rochdale	1.74	1.61	1.89
Calderdale	2.20	2.06	2.36

Source: Department for Education special educational needs statistics
https://www.gov.uk/government/collections/statistics-special-educational-needs-sen

Source: PHE Fingertips

3.3.4 Exclusions from school and mental health

Mental health is likely to be a factor in many cases where children and young people are excluded from school. Indeed, some professionals see exclusion as being inherently a mental health issue (Cole, 2015) since the behavioural, emotional and social difficulties which lead to exclusion can be regarded as mental health problem even when they are not part of a diagnosable mental health disorder. Exclusion from school may also be a risk factor for poor mental health potentially creating a vicious cycle.

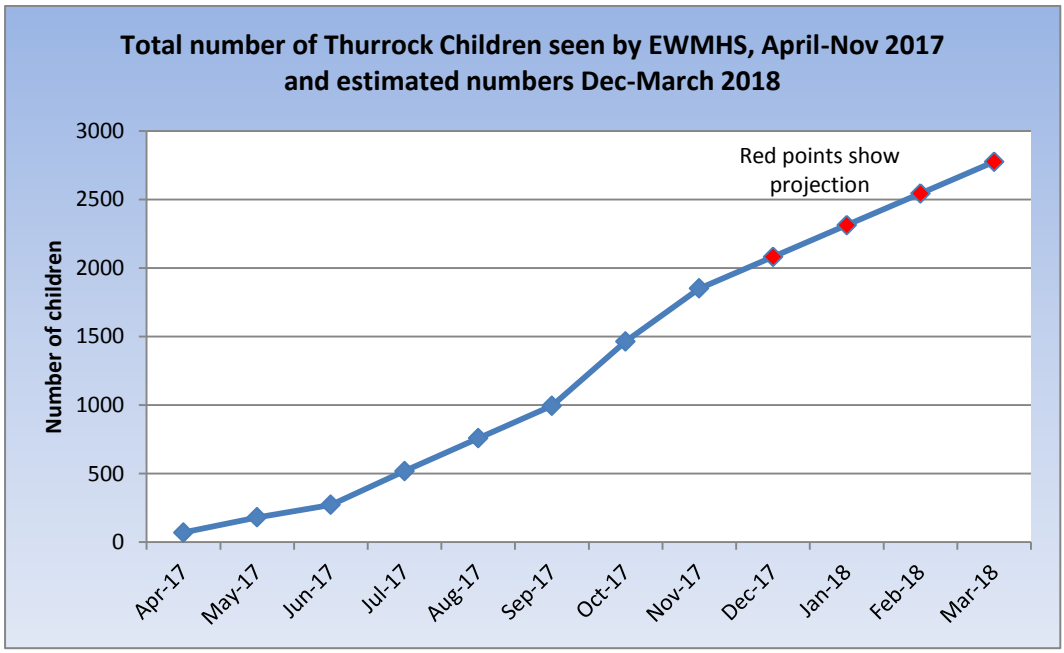
No data are available on the number of school exclusions in Thurrock which are linked to mental ill health though there is some anecdotal evidence suggesting that mental ill health plays a part in many exclusions locally.

3.4 Service Data: Emotional Wellbeing Mental Health Service

The Emotional Wellbeing and Mental Health Service (EWMHS) was launched in November 2015 taking over from the old Child and Adolescent Mental Health Service (CAMHS) with the aim of providing a most integrated and accessible service to children and young people. At its launch 225 cases were transferred to the new service in Thurrock. By November 2017, the number of cases open to the EWMHS service was 600. The increase in caseload of more than 260% over two years, is a strong indication of the growing demand for mental health treatment in Thurrock.

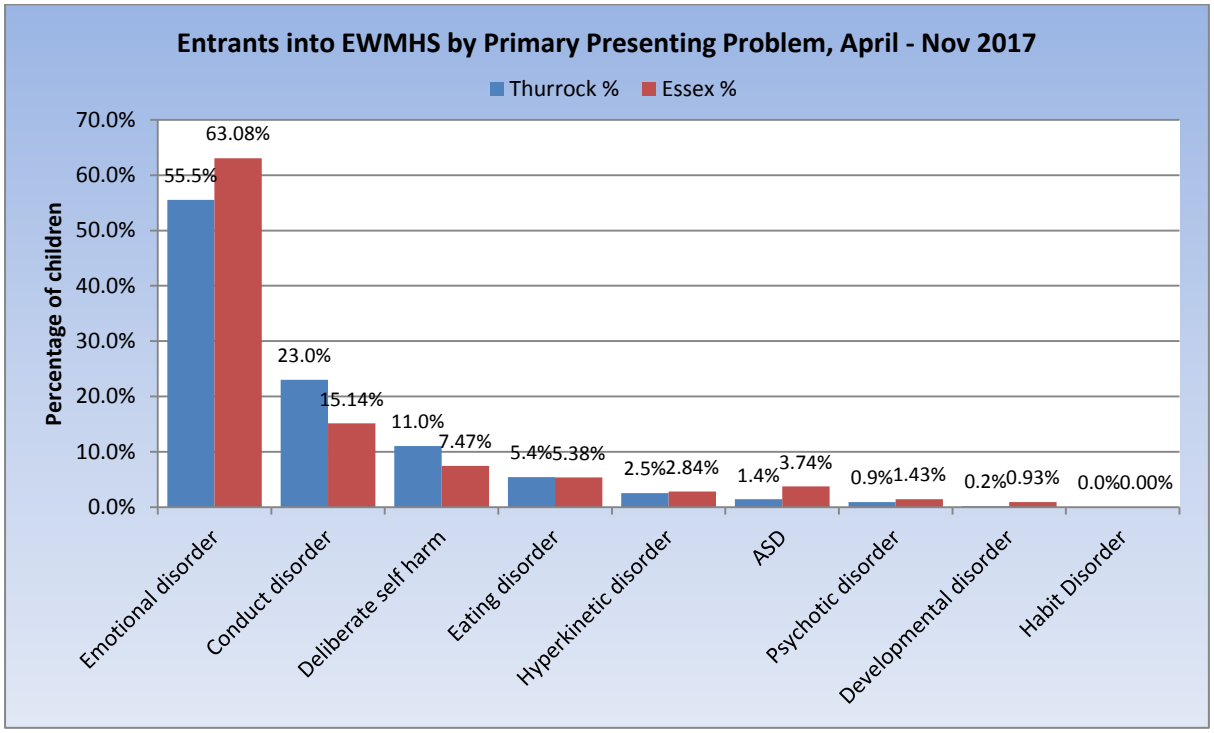
The information presented below comes from the EWMHS over the 7-month period between April and November 2017, which was the latest data available at the time of writing. During this period the service carried out 1850 appointments with Thurrock children (see also Figure 27 below). Projecting this forward for the full year, the service could carry out appointments with 2775 children by March 2018. This data set is not unique children seen and should not be used to infer caseloads; however it does provide a reflection of the activity undertaken by the service.

Figure 27: Cumulative Number of Thurrock children seen by EWMHS in an appointment setting, April to November 2017



The main presenting reasons for Thurrock children were Emotional Disorder (55.5%), Conduct Disorder (23.0%) and Deliberate Self Harm (11.0%). These were also the top three reasons pan-Essex (Figure 28). As mentioned above, this is different to the estimated prevalence of these conditions in Thurrock (with conduct disorders estimated to be more prevalent in the population than emotional disorders).

Figure 28: Primary Presenting Problem to Entering EWMHS 0-18 years



As shown in Figure 29, the ethnicity of EWMHS users is predominantly White British at 90.28%, compared to 66% of White British in the Thurrock general population aged 0–19 years. This population appear to be over-represented in this sample of service users. Black and minority ethnic (BME) groups, appear to be under-represented in the service, therefore. There is evidence to suggest that BME groups are more likely to access online counselling services such as Kooth (Frith, Online Mental Health Support for Young People, 2017).The reasons for these disparities are unclear and require further investigation.

Figure 29: Ethnicity of EWMHS Service Users

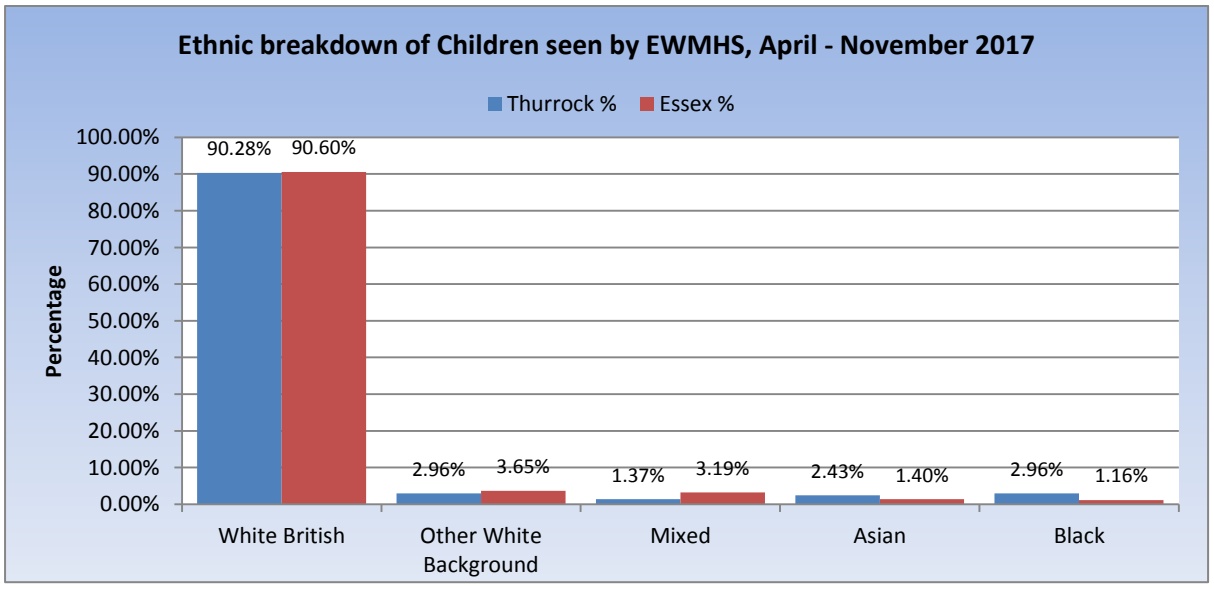
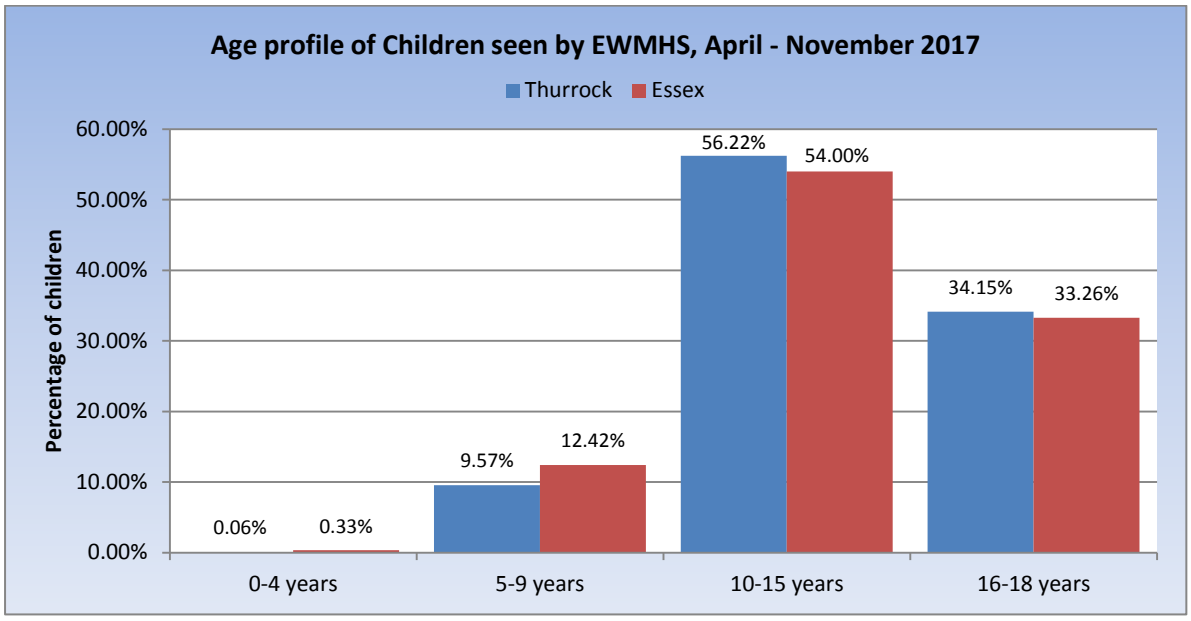


Figure 30 shows the age profile of children seen by EWMHS. The bulk of referrals appear to be of the age group 10-15 years at 56.22% and 16-18 years at 34.15%. The age profile of

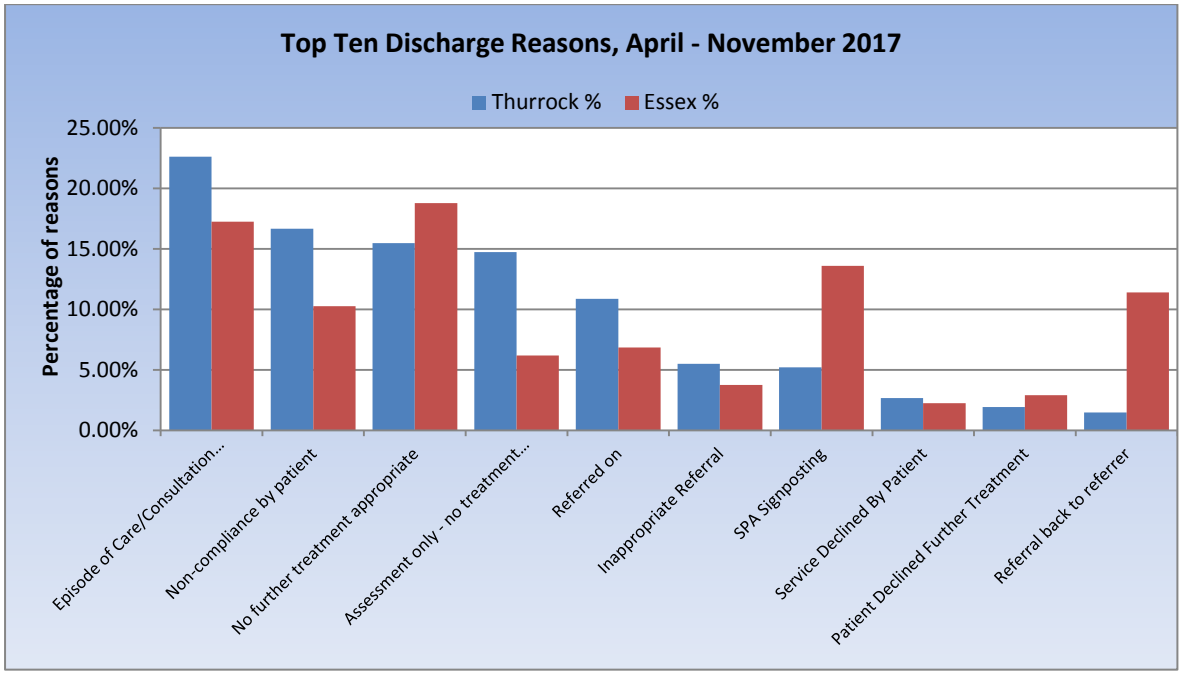
the referrals is what we would expect to see as we know that as children grow older and reach adolescence their risk of developing mental health condition increases.

Figure 30: Age Profile of EWMHS Service Users



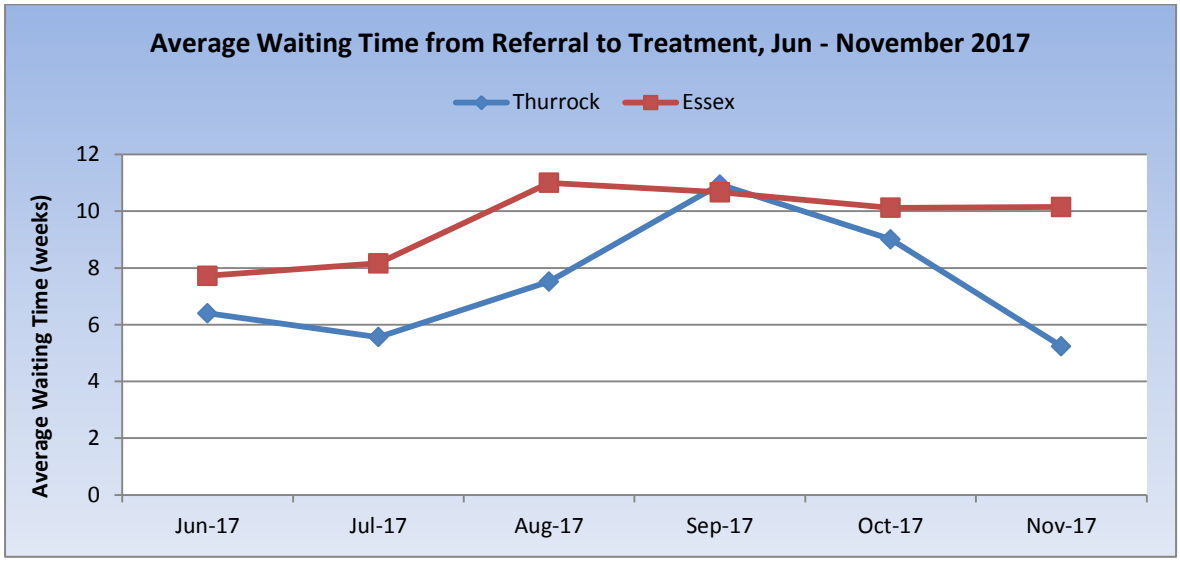
A wide range of reasons are recorded for discharge. Figure 31 gives an indication of the most common reasons for discharge.

Figure 31: Reasons for Discharge from EWMHS 2017



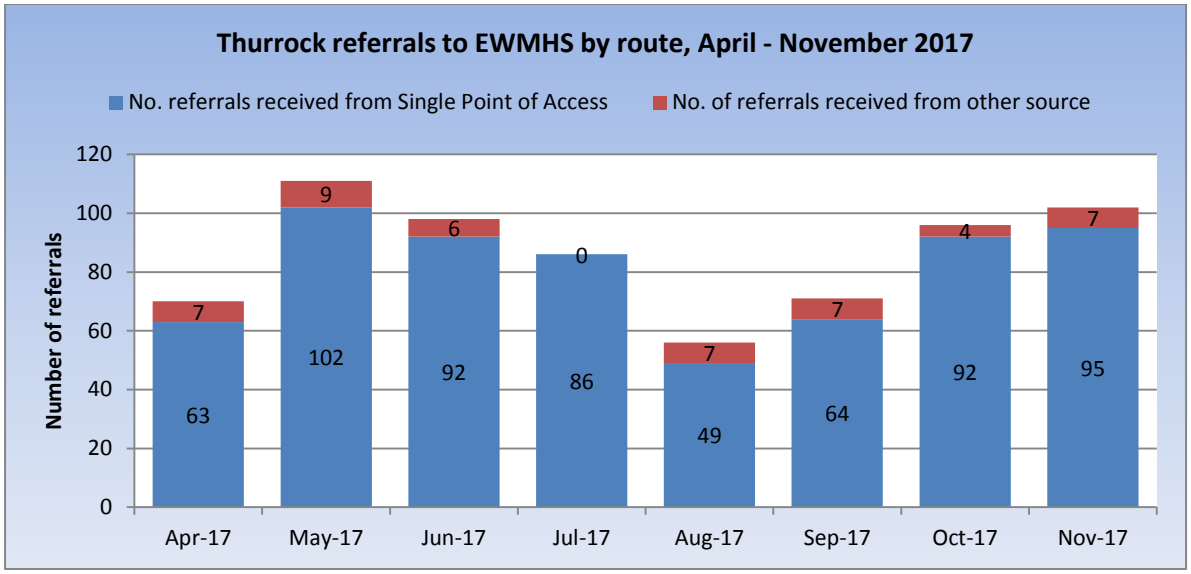
EWMHS is performance-managed against the national Referral to Treatment Target of 18 weeks, see Figure 32 below. Looking at data for June to November 2017, it can be seen that the average waiting time in Thurrock was 7.45 weeks, which is below the Essex average of 9.63 weeks.

Figure 32: Average Waiting Time Referral to Treatment (EWMHS)



There were 351 initial assessments completed between April and November 2017. Of these, 43 were for vulnerable children (looked after child, learning disability, or on child protection plan) equating to 12.25%. There were 690 referrals (excluding crises) for Thurrock children between April and November 2017. The majority of these (643) came through the Single Point of Access (see Figure 33). Projecting forward, it is expected that, based on the last 8 months, there could be up to 1,035 referrals for the financial year 2017/18.

Figure 33: Number and Route of Referral into EWMHS



3.5 Conclusions on Mental Health Disorders

With an estimated 10% of CYP having a diagnosable mental health condition, it is clear that far too many CYP are being allowed to get to the point where they have an established mental health disorder. There has been a very steep rise in the number of CYP in treatment services in recent years, rising from 225 at the launch of the EWMHS service in November 2015 to 600 by November 2017. This is an indication of the rising demand for treatment in Thurrock and the pressure faced by treatment services.

The EWMHS service works to a national target waiting time (from referral to treatment) of 18 weeks. Data from the service shows that, in the vast majority of cases, the service meets that target and average waiting times have reduced over time in Thurrock. Nevertheless, it is clear that many CYP have to wait long periods for treatment and that this is a major concern for parents, teachers and others working with CYP. Reducing waiting times is clearly desirable and should continue to be pursued by commissioners and providers of treatment services. However, there has been a steep rise in demand for treatment in recent years and it is clear that if that continues into the future treatment services will continue to be under pressure and waiting times are unlikely to fall significantly. Reducing demand for treatment is crucial, therefore, for ensuring that those who need specialist help the most can access it quickly.

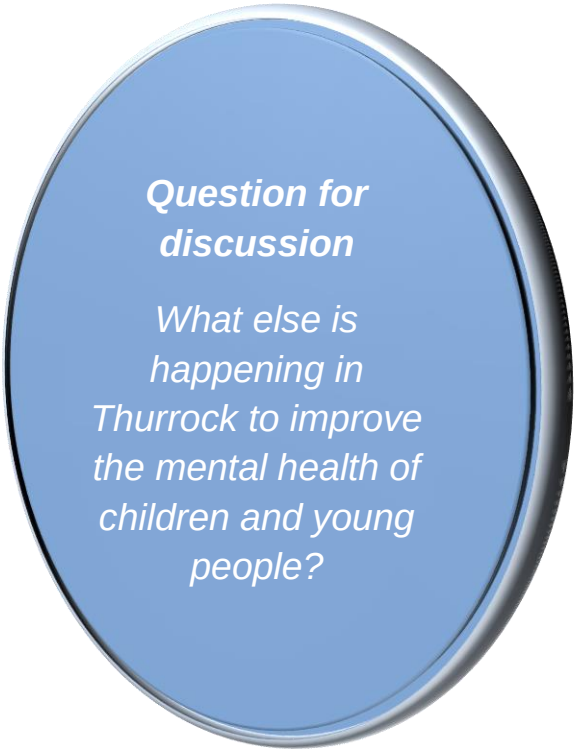
Our analysis shows that conduct disorders and mood disorders (mainly anxiety and depression) are the most common forms of mental ill health for CYP in Thurrock. Together these account for 78.5% of all those presenting to the EWMHS treatment service. Strategies which prevent these disorders from developing are, therefore, vital for improving children's mental wellbeing and also for relieving pressure on treatment services.

The prevalence of self-harm is an area of particular concern. It is the third most common reason for CYP presenting to EWMHS and 7% of Year 8 and 4.6% of Year 10 coped negatively by hurting themselves. Action is needed to address the use of self-harm as a coping strategy before it gets to the point of needing specialist treatment in EWMHS. Eating disorders are another area for concern though local data on this are scarce. It would be helpful to gather more information on this in the Brighter Futures Survey in future.

Finally, there are wide variations between GP practices in the registration of mental health disorders (including eating disorders, depression and anxiety). It is unclear at present what causes this wide variation. It may be due to differences between GPs in how they recognise, diagnose and record mental ill health in CYP or it could be due largely to demographic variation between practices. The role of primary care in CYP mental health should be considered as part of the on-going development of new models of care in Thurrock.

4. Review of Services

At present, a wide range of services are available to support and improve mental health for CYP in Thurrock. Here we give a summary of some of the major services available and show how they operate at different levels, addressing different needs. This summary is not comprehensive. There are, undoubtedly, initiatives happening in schools, colleges and through community groups which are not listed here. Improving our knowledge of what is already happening will help to improve services in future by allowing us to avoid duplication and through sharing learning about what has been effective locally.



4.1 Open Up Reach Out

The Open Up Reach Out strategy is a programme of service transformation across Southend, Essex and Thurrock[7]. The delivery of the strategy is managed by a Collaborative Commissioning Forum which includes three local authorities and seven Clinical Commissioning Groups (CCGs) including Thurrock Council and CCG. This group is responsible for the commissioning of the EWMHS service which is the major vehicle used to deliver the Open Up Reach Out strategy. The three main priorities for action set out in the strategy are to:

1. Improve access and equality by continuing to develop and improve the new single integrated service (EWMHS) across Southend, Essex and Thurrock;
2. Build capacity and capability in the system – with additional resources, staff development and a unified, coherent network of services;
3. Build resilience in the community – through support for self-help, strong partnerships, agreed protocols and a rolling training programme for those involved in protecting children and young people.

Examples of the type of work being undertaken to deliver these priorities is given in Table 5 below. Whilst much of this is delivered by the EWMHS service there is a strong need for wider community and partnership engagement, particularly to achieve the goal of building resilience in the community. Action at within Thurrock to develop strong partnership working on building resilience could make a major contribution to achieving this goal.

[7] The strategy is available here: https://www.essex.gov.uk/Documents/Full_version_Open_up_Reach_out_v17.pdf

Table 5. Open Up, Reach Out priorities for action

Improve Access and Equality	Build Capacity and Capability in the System	Build Resilience in the Community
For example: • Establishing single points of access • Improving crisis services • Increasing IAPT coverage for children and young people • Creating a community service for eating disorders • Early intervention in psychosis • Support children and young people who move between services	For example: • Workforce strengthening • Improving data and IT • Governance and performance framework	For example: • Engagement • A clear role for schools • Suicide prevention and support for children who harm themselves
Further needs assessment		
Investment		

4.2 Services currently available in Thurrock

There are a large number of existing services relevant to, or specifically focused on, the mental health of children and young people as illustrated by the service map below (Figure 34), which maps many existing services against the THRIVE framework for mental health services. As stated above, this is not a comprehensive list and more information is needed about what is already being done in the community.

Figure 34. Current children and young people's mental health services in Thurrock, 2018

- **Personal Social and Health Education** classes in schools
- **Brighter Futures Healthy Families:** service delivered by NELFT: health visitors, school nurses and other health professionals working in schools
- **Brighter Futures Survey**: annual survey in schools giving information on mental health and risk factors such as bullying
- **Brighter Futures Children's Centres**: offering education and parenting support to families
- **Risk Avert**: survey and follow-up classes in schools addressing risk-taking behaviours
- **Recovery College** offering recovery-focused education to help people (including young people mentally well.

- **School-based** pastoral care and counselling services.
- **Brighter Futures Prevention and Support Service**: children's social care service delivering support to families including targeted interventions such as domestic violence and parenting support.
- **Inclusion IAPT** Increasing Access Psychological (talking) Therapies for CYP is an objective of the Open Up Reach Out Strategy.
- **Kooth**: online counselling service available for ages 11 – 25
- **Reprezent**: Media channel (radio station, app, and website) championing young people's mental health issues
- **Suicide and self-harm toolkit** resource for schools
- Emotional Wellbeing and Mental Health Information portal for schools
- **MyMind**: Online directory of mental health services
- **Big White Wall**: safe, online community for people who are feeling anxious or down available for ages 16 to 18.

- **EWMHS** (Emotional Wellbeing and Mental Health Service). The main integrated treatment service providing a wide range of interventions including:
  - Assessment and treatment, brief interventions
  - Support to schools including training and a telephone helpline
- **SERICC** (South Essex Rape and Incest Crisis Centre): support services to children and young people who have experienced child abuse or child sexual exploitation
- **MIND**: Counselling support and Mental Health First Aid Training
- **Open Door**: Counselling, therapeutic workshops, play therapy, drop-in sessions for primary and secondary schools, mentoring and advocacy.
- **Wize Up:** Drug and alcohol service for young people
- **Crisis support**
- **Early Intervention in Psychosis**

- **EWMHS:** Longer interventions with one-to-one and group therapy

- **Specialist treatment**: Day and inpatient services and some highly specialist outpatient services e.g. CYP with gender dysphoria; highly specialist autism spectrum disorder/OCD services

Source: The framework used here to map CYP mental health services in Thurrock is the THRIVE framework developed by the *Anna Freud National Centre for Children and Families* and *The Tavistock and Portman NHS Foundation Trust*

4.3 Services addressing protective and risk factors

As this report focusses on the risk and protective factors which underlie mental ill health, it is useful to consider how well existing services address the factors which have been identified as being important in Thurrock. Table 6 below shows which services currently address key protective and risk factors.

Whilst this list is not comprehensive, it does seem clear that much more could be done to address some of the key protective and risk factors. For example, although the Daily Mile is operating in a number of primary schools, there are currently no major physical activity interventions targeting secondary schools, although we know that physical activity levels are lower in secondary age groups than in primary. Although we know that treatment services are under pressure (see above), a relatively wide range of services exist for early intervention and treatment does exist compared to the services addressing protective and risk factors.

Table 6. Existing services addressing protective factors, risk factors, early intervention and treatment

Protective Factor	Existing Preventative Interventions
Social connections	• Personal Social and Health Education (PHSE) lessons
Positive coping strategies	• Reprezent media channel • Open Door therapeutic workshops, mentoring etc.
Physical exercise	• Daily Mile in primary schools • Active Essex/Active Thurrock
Supportive parenting	• Healthy Families Service (health visiting and school nursing) • Prevention And Support Service (PASS) parenting programmes for those known to social care
Risk Factors	
Bullying	• Individual school policies and programmes
Body image	• None identified
Use of internet and social media	• PHSE • Walk online
Overweight and obesity	• Daily Mile in primary schools
ACEs	• Children's social care Prevention and Support Service (PASS)
Substance misuse	• Risk Avert • Wize Up
Early intervention and treatment services for those with mental health difficulties.	
• Kooth online counselling • EWMHS assessment and treatment service • Big White Wall online community • School-based pastoral care and counselling services • Open Door Counselling and therapeutic workshops • SERICC support and counselling services • Mind counselling support	

4.4 Planned Service Developments

The service landscape rarely stands still and services for CYP mental health are always evolving, particularly because of there is recognition nationally that more support is needed to address the issue of mental health in CYP. This section outlines some of the major service developments which are known to be in the pipeline.

4.4.1 Green paper proposals

Published in 2017 jointly by the Department for Education and the Department for Health, the Green Paper recognises the need for more to be done to support children and young people's mental health and sets a strategy containing three key elements to achieve this. They are:

1. **A Designated Senior Lead for Mental Health in every school**
   Schools will be incentivised to have someone in this role to oversee the approach to mental health and wellbeing. This person would provide rapid advice, consultation and signposting. It is suggested that this be in place in all schools by 2025.

2. **Mental Health Support Teams**
   The government would provide funding for these teams which would be supervised by NHS children and young people's mental health staff and provide extra capacity for early intervention and ongoing help. The teams would be linked to groups to primary and secondary schools and to colleges, providing interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing. For example, they could provide school-based cognitive behavioural therapy, group interventions on eating disorders, and training for teachers and early help workers. They would work closely with the designated mental health lead to provide a better link with specialist mental health services. This proposal is based on pilot studies which have already been carried out. The proposal is to extend the piloting to some trailblazer areas by 2019.

3. **Reduced waiting time standard**
   The latest data indicates an average 12-week waiting time for treatment in specialist NHS children and young people's mental health services. The paper proposing trialling and then rolling out a 4-week waiting standard beginning in trailblazer areas. The work of Mental Health Support Teams (above) would help to reduce the number of referrals into treatment services.

The timetable for implementation of these proposals, however, is long. The proposal is to have trailblazer areas beginning in 2019 and all three elements implemented in 20% – 25% of schools by 2022/23.

4.4.2 Transforming Care

Building the Right Support (2015) was a report published jointly by NHS England, the Local Government Association and the Association of Directors of Adult Social Services. It outlined a national plan to develop community services and reduce the dependence on hospital care for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition. It set out the vision to ensure all children

should have the opportunity to live satisfying and valued lives, and be treated with dignity and respect. This is to be delivered through local 'Transforming Care' partnerships.

A minority of CYP with severe learning disabilities and /or autism, including those with mental health problems, rely heavily on in-patient services which are often provided a long way from their home. Building the Right Support recognises the need to develop health and care services locally that can provide the right support for children to remain at home, close to their community and families. This work is being led by the Essex Transforming Care Partnership consisting of clinical commissioning groups, NHS England specialist commissioners and local authorities.

4.5 Conclusions

The plethora of services which currently exists may make it difficult for young people, professionals and parents to know where to go for help. This was reflected in feedback from young people given to a regional survey carried out as part of the regional JSNA carried out to support the *Open Up, Reach Out* strategy (Smith W. , 2015). In a survey of young people they found that 8 in 10 reported that they did not know how to access support for mental health. The schools information portal is an important initiative addressing the need for information but it remains to be seen whether this will be successful in significantly improving the ability of teachers and young people to know how to access help.

Current regional and local commissioned services are, to a large extent, focussed on treating established mental health problems in CYP. Future plans, including national strategy as outlined in the Green paper, are also focussed to a significant extent on treatment or on improving connections between schools and treatment services. Services promoting positive mental health through strengthening protective factors are relatively under-developed at present, though more information is needed about the work being undertaken by individual schools, colleges or community groups.

Priority 3 of the *Open Up, Reach Out* strategy is about building resilience in the community. This is the area where there is currently the biggest gap and where local action, at Thurrock level, to build strong partnerships between community organisations, educational institutions and mental health professionals is likely to yield the greatest benefit.

5. Interventions for Prevention of Mental Health Disorders

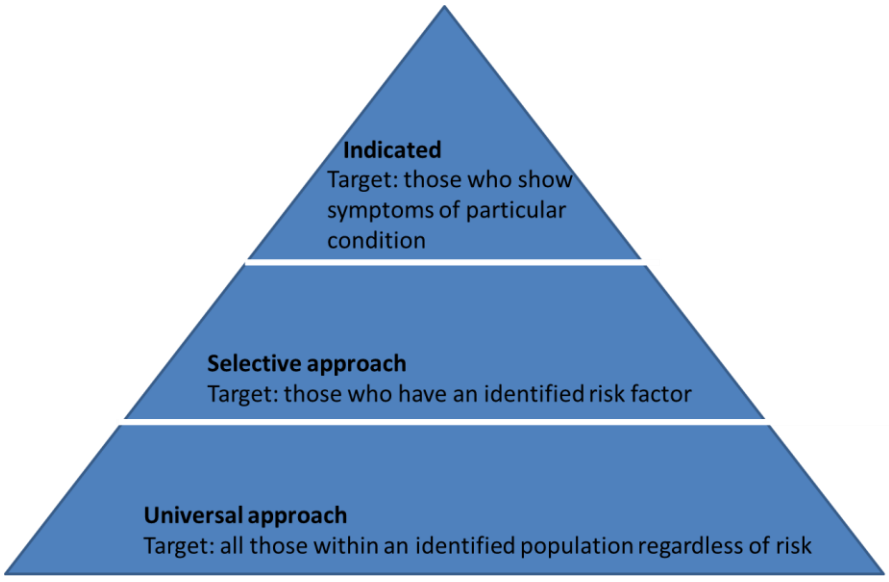
Having considered the services and initiatives which currently exist, we considered what more could be done to prevent[8] CYP in Thurrock from developing mental ill health. The evidence of what works to prevent mental ill health is vast so our review is not comprehensive. It does, however, give a clear basis for future action.

Many of the interventions we discovered not only prevent mental illness but have other desirable outcomes such as improving happiness with school, preventing and tackling bullying, and improving educational attainment. The education system as the setting for implementing prevention programs provides a natural and accessible way to reach CYP. Being a place of learning, schools and colleges provide an opportunity to give CYP the skills and methods that may protect against, or delay the onset of emotional difficulties (Werner-Seidler, Perry, Calear, Newby, & Christensen, 2017). School environments can be considered less stigmatising than traditional mental health services meaning that CYP and parents may be more willing to accept support through these routes (DoH & DfE, 2017). Moreover, NICE guidelines state that schools and local authority children's services should work closely with child and adolescent mental health and other services to develop and agree local protocols.

5.1 What works in prevention: general principles

There are two broad approaches to the prevention of mental ill health. A universal approach is delivered to everyone in a given population regardless of risk. For example, universal prevention programs for CYP are typically delivered on a large scale in the school environment to every child in a year group. Targeted prevention is directed towards those who have an increased risk of mental ill health, such as victims of bullying, (selective prevention) or who have specific symptoms of mental health disorder (indicated prevention) such as persistent low mood. This is illustrated by Figure 35 below.

Figure 35. Approaches to prevention



Source: Thurrock Public Health Team

[8] NB. The most effective forms of clinical treatment for mental health disorders was outside the scope of this report.

Advantages of the universal approach is that interventions of this kind may be less intrusive, potentially lower cost, easier to incorporate into the school structure than other approaches, and they do not exclude any students who may benefit from what is offered. Universal promotion of mental health programmes is often focused on social and emotional skills, positive behaviours, social inclusion and effective problem solving (Fazel, Hoagwood, Stephan, & Ford, 2014). Targeted approaches on the other hand, can focus resources on those with the greatest needs, can be more intensive and may have a bigger impact on the individuals taking part.

The national framework by the National Children's Bureau (NCB) suggests utilising both universal approaches that promote social and emotional health and targeted approaches that reduces symptoms of mental health disorders. The framework also stresses the importance of school staff wellbeing (National Children's Bureau, 2015).

5.2 Interventions addressing protective factors

5.2.1 Good Social Connections

One programme targeted at improving the social networks which CYP have is the German programme: Ease of Handling Social Aspects in Everyday Life Training (**LISA-T**). The programme is based on cognitive behavioural therapy (CBT) and has a social focus which targets students' ability to develop and maintain friendships with peers. It comprises of ten sessions of 1.5 hours in the regular school setting. LISA-T has been shown to be an effective school-based prevention program for 13-14 year olds with minimal to mild depressive symptoms, though more research is needed to establish its long-term impact (Pössel, Horn, Groen, & Hautzinger, 2004).

Mentoring interventions have been shown to have positive outcomes in relation to general mental health promotion and peer support for specific issues (for example, social media and eating disorders) (DoH & DfE, 2017). Some Secondary Schools in London, for example Westminster Academy, have adopted the **Mosaic Mentoring Programme**; the programme uses positive role models to improve students' confidence, self-efficacy and employability. It targets students with low or limited aspirations, low confidence and a weak sense of personal agency. The package of mentoring support for young people can be tailored to students' needs including group mentoring, workplace visits, inspirational speeches and competitions. The programme aims to enhance participants' 'soft skills' which are increasingly important for success at school and in the current job market (Mosaic Network, 2018)

5.2.2 Positive Coping Strategies

Social and emotional aspects of learning (SEAL) was rolled out in the UK 2005 and is aimed at children aged 3-16 years. It is a comprehensive, whole-school approach embedded within the school curriculum and aims to develop the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools. A national evaluation of the pilot showed that SEAL programmes were difficult to implement and were found to have little impact on young people's social and emotional health (DfE, 2010). This was also the finding in the more recent government review, with SEAL programmes having limited long term effects that may not be maintained at follow up (DoH & DfE, 2017).

One programme that was found to be effective in terms of developing positive coping strategies is the **FRIENDS for Life** programme, which incorporates building resilience through group CBT and practicing mindfulness. It is delivered over 10 sessions within the school setting and can be targeted to particular age groups. The programme has been endorsed by the World Health Organisation as "efficacious across the entire spectrum, as a universal prevention program, as a targeted prevention program and as a treatment." (World Health Organization, 2004)

Research on the programme shows reduced anxiety and depression, increased coping skills and self-esteem, with improvements maintained up to 6 years after the completion of the programme (Barrett, Farrell, Ollendick, & Dadds, 2006; Stallard, Simpson, Anderson, Hibbert, & Osborn, 2007; The National Behaviour Support Service, 2013). The programme enables children to learn a range of skills, including how to:

- identify 'anxiety-increasing' thoughts and to replace them with more helpful thoughts;
- identify anxious (and other difficult) feelings and learn to manage them;
- learn to overcome problems rather than avoid them.

5.2.3 Physical activity and exercise

According to Chief Medical Officer guidelines, all CYP aged 5 – 16 years should engage in moderate to vigorous intensity physical activity for at least 60 minutes every day. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week. All CYP should minimise the amount of time spent being sedentary (sitting) for extended periods.

The benefits of being active for at least 60 minutes each day in CYP aged 5-16 years:

- Improves cardiovascular health
- Maintains a healthy weight
- Improves bone health
- Improves self-confidence
- Develops new social skills
- Reduces anxiety and depression (Biddle & Asare, 2011).

The **Daily Mile intervention** which is currently implemented by a number of primary schools in Thurrock (see Section 2.1.3), has been evaluated in a number of schools around the UK and has showed positive effects on levels of physical activity and physical fitness. The intervention is currently the subject of a large, randomised controlled trial being carried out in Birmingham. This study is expected to report its findings in 2018 including evaluations of the impact of the intervention on Body Mass Index, wellbeing, academic attainment, physical fitness and staff wellbeing.

The **Child and Adolescent Trial for Cardiovascular Health (CATCH)** tested a school and family intervention carried in the USA. It demonstrated that school-level interventions could modify school lunch and school physical education programs as well as influence student behaviours. The physical education component focused on children's enjoyment of and participation in physical activity during physical education classes. Results indicated that physical activity during CATCH increased by 39% compared to a 23% increase for the controls (McKenzie, et al., 1996). A 3-year follow-up suggests that the behavioural changes

initiated during the elementary school years persisted to early adolescence for self-reported dietary and physical activity behaviours (Nader, et al., 1999).

The **GreatFun2Run programme (GF2R)**, a school-based healthy lifestyles intervention was delivered to 7-11 year olds in North East of England over a 10 month period. A 20 month follow-up evaluation of the GF2R program showed initial positive outcomes with increases in physical activity significantly greater in the intervention group. Unfortunately the positive changes in physical activity and body composition observed at the end of the intervention were not sustained. This was due to a number of factors including the fact that the intervention was short term (10 months) and potentially not intensive enough (Gorely, Morris, Musson, Brown, Nevil, & Nevil, 2011). Main findings from this study were that:

- Longer term interventions (as demonstrated in the CATCH study) are better-placed to make lasting changes and are important in CYP as the type and purpose of physical activity undertaken varies with age;
- Parents have an important role in promoting physical activity in children and maintaining change through the provision of ongoing encouragement and support for participation. Greater emphasis on engaging and supporting parents within school-based interventions may be required to facilitate long-term change;
- Teachers needed clearer guidance around the use of resources and required continued support;
- Other pressures can take priority and some of the intervention elements were not implemented due to time demands and responsibilities of teachers;

The **Switch-Play programme** was delivered over 12 months to 10 year olds and aimed to modify physical activity by raising awareness of the time children spent doing physical activity, the health benefits of physical activity, and things in the children's home and community environments that might influence their activity by, for example, identifying alternatives to screen time. Parents were sent newsletters and encouraged to support children with their goals. The most effective version of the programme incorporated movement skills, using games and activities to help children master a range of skills.

A12-month follow-up evaluation showed that children taking part in the intervention were less likely than controls to be overweight/obese immediately after the intervention and at 12-months follow-up. Compared with controls, intervention group children recorded higher levels and greater enjoyment of physical activity. This programme represents a promising approach to preventing excess weight gain and promoting participation in and enjoyment of physical activity (Salmon, Ball, Hume, Booth, & Crawford, 2008).

The **KISS programme,** was delivered to 6 years old and 11 years old as part of a trial in Switzerland, it is a multi-component physical activity that included structuring existing physical education lessons each week and adding two additional lessons a week, daily short activity breaks, and physical activity homework. At 3-month follow-up evaluation of the trial showed health improvements to body composition, fitness levels, and an overall increase in physical activity levels (Kriemler, et al., 2010). Unfortunately no long term follow-up has been published.

5.2.4 Positive parenting

Parenting programmes aimed at improving parent-child interactions and equipping parents parenting skills can be offered preventatively (universally) or when more serious difficulties have been identified. Parent training programmes have been shown to be effective in reducing child conduct problems and improving parental mental health and positive parenting skills (Buchanan-Pascall S, 2017). The National Institute for Health and Clinical Excellence (NICE, 2006) has published guidelines for parenting programmes for the treatment of conduct disorders. Only two programmes meet the NICE guidelines, one of which is the **Webster-Stratton Incredible Years Parenting Programme**. The programme is aimed at children aged 3 to 12 years and is founded on social learning theory. The programme consists of a minimum of 12 weekly, two-hour group sessions delivered by trained practitioners. The programme demonstrated significant improvement in parenting and problem behaviour in children (Hutchings, Bywater, Daley, Gardner, Whitaker, & Jones, 2007).

A Cochrane review demonstrated evidence of cost-effectiveness for parent training programmes, when compared to a waiting list control group, there was a cost of approximately £1712 per family to bring the average child with clinical levels of conduct problems into the non-clinical range. The costs of programme delivery are modest when compared with the long-term health, social, educational and legal costs associated with childhood conduct problems (Mairead, 2012).

The **Mosaic Primary School Mentoring Programme** has been running since 2008 and the aim is facilitate positive parenting and to raise aspirations in primary school aged boys and girls. The programme develops skills to connect education to work at an early age through mentors from professional backgrounds acting as role models, and to encourage CYP to aspire to careers in a range of different sectors. Mothers and fathers participate in lessons that raise their awareness of the importance of education and how to support their children through school and beyond. The programme is 10 weeks long, with a weekly hour-long session where the students cover themes such as confidence, communication, and role models, whilst parents look at themes such as citizenship and understanding the British education system. To complement the sessions, parents and students are provided with resource booklets which they can refer to throughout the course and beyond. Included in the programme is a special university visit to provide exposure to further education. Hosted by student ambassadors, parents and children attend a prominent university to participate in workshops, a tour of the campus and a presentation on university life (Mosaic Network).

5.3 Interventions addressing risk factors

5.3.1 Bullying

As discussed in Section 2.2.1 there are strong links between bullying and mental health problems, such as anxiety and depression. Because of this, bullying prevention should be an essential part of school/college ethos in order protect student wellbeing and mental health. For teachers and other school staff to effectively act and respond to issues around bullying and mental health requires the school or college to have appropriate policies in place to deal with bullying which are transparent to parents, pupils and staff. Every school in the UK must have an anti-bullying policy. As well as responding to bullying in a reactive way, a number of proactive preventative approaches to bullying have been shown to be effective.

KiVa is an evidence-based bullying prevention programme developed in Finland (Salmivalli, Kärnä, & Poskiparta, 2010). It is centred on the notion that bullying is a group process whereby bullies often behave aggressively to achieve higher peer-group status which is continually reinforced by the apathy/encouragement of onlookers. The programme works by encouraging constant monitoring of the situation in school and the changes taking place over time enabled by online tools. The KiVa Programme includes both universal and indicated actions. Universal actions, such as the KiVa curriculum (student lessons and online games), are for all students, focus mainly on preventing bullying. Indicated actions are to be used when a bullying case has emerged, targeted specifically to the CYP who have been involved in bullying as perpetrators or victims, as well as to classmates who are challenged to support the victim; the aim is to put an end to bullying.

The effects of the KiVa anti-bullying program have been evaluated in a number of well-designed studies (Kärnä, Voeten, Little, Poskiparta, Kaljonen, & Salmivalli, 2011). One study specifically looked at the effect of KiVa on mental health and found that the programme was effective for reducing students' internalizing problems, reducing anxiety and depression, and improving their peer group perceptions (Williford, Boulton, Noland, Little, Kärnä, & Salmivall, 2012).

Conduct disorders, such as consistent aggressive behaviour or bullying, have been shown to have a positive response to universal prevention mental health programmes. The literature demonstrates these types of interventions can have small effects on preventing conduct behaviours in schoolchildren for at least 12 months whilst also promoting positive wellbeing (Smedler, Hjern, Wiklund, Anttila, & Pettersson, 2015).

An example of a programme that can improve student behaviour and discourage bullying is **The Good Behaviour Game**. The programme is a two-year universal classroom based intervention that involves classroom management aiming to reduce disruptive behaviour problems and creating a safe and predictable environment (Vuijk, van Lier, Crijnen, & Huizink, 2007). The Game is based on 4 simple rules that encourage pupils to support one another as they complete classroom assignments.

Outcomes have included:

- Immediate improvements in pupil behaviour, particularly for disruptive boys
- Improved attainment and achievement
- Increased numbers of students continuing into further education
- Reduced substance abuse, mental health problems and criminal behaviour in later life (Kellam, et al., 2011)

5.3.2 Substance misuse

Research has demonstrated that universal drug education programmes in schools can reduce the use of alcohol, tobacco and cannabis (Foxcroft & Tsertsvadze, 2011).

Interactive learning approaches appear to be most effective for substance misuse and are based on understanding social influences and developing life skills. These include correcting misperceptions about how common and acceptable substance misuse is among the young people's peer group. They also teach interpersonal skills to help handle situations where alcohol or drugs are available. Examples with a strong evidence base include the **Life Skills Training programme**, developed in the United States and **Unplugged**, which was tested in

a large-scale evaluation across several European countries (James, 2011). As discussed above the Good Behaviour Game has also been evidenced to have a positive impact on substance misuse.

5.4 School-based multi-agency teams

The complexity of mental health issues and the services related to them means that no single organisation can address the issues alone though schools are generally acknowledged to be key settings for addressing CYP mental health issues. For this reason guidance from the National Institute of Clinical Excellence (NICE, 2013) recommends a range of interventions should be provided in schools, according to children's needs. Moreover, they also recommend that these should be part of a multi-agency approach to support the child and their family and may be offered in schools and other settings (NICE, 2013). In line with this recommendation, a number of multi-agency approaches have been trialled.

5.4.1 School Link Pilots to Mental Health Services

In 2015, the Department for Education (DfE) and NHS England (NHSE) sponsored a national pilot, the Mental Health Services and Schools Link Pilots, with the aim of improving communication and links between schools and Children and Young People's Mental Health Services (CYPMHS). It was trialled in 25 Clinical Commissioning Groups (CCGs) with funding provided to the CCGs of £50,000 which was expected to be matched. The overall aim was to test the extent to which joint professional working between schools and NHS CYPMHS can improve local knowledge and identification of mental health issues and improve the quality and timeliness referrals to specialist services. The types of programme were around three main models:

1. NHS CYPMHS named lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people
2. NHS CYPMHS named lead offering dedicated training and support time to school-based professionals
3. NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering a single point of access

The programme has been evaluated and the findings showed that schools and NHS CYPMHS had new opportunities to engage in joint planning and training activities, improving the clarity of local pathways to specialist mental health support, and establishing named points of contact in schools and NHS CYPMHS. No single model emerged as being the most effective, as pilots developed their approach to suit local circumstances, priorities and aims. However, a shared commitment from schools and NHS CYPMHS was an essential element for embedding the joint working arrangements, alongside backing from senior management teams across both sets of agencies to also ensure that staff had sufficient time to participate (DfE, 2017). These pilots have provided a foundation for the Green Paper plans (see Section 4.4.1).

5.4.2 Case Study: The York Model

York City Council developed a **School Wellbeing Servic**e (SWS) which is a school-based early intervention mental health (MH) support service, jointly funded by schools, York Clinical Commissioning Group, and Local Authority.

School Wellbeing Workers (SWW) are managed by the Local Authority (LA), clinically supervised by Child Adolescent Mental Health Service (CAMHS) and linked to a cluster of schools. The service is targeted at emerging and developing mental health need, especially CYP who are presenting with mental health issues and concerns, that are not severe enough to meet the threshold for an intervention from specialist CAMHS but more severe than can be handled by school pastoral structures.

The SWS has six School Wellbeing Workers (SWW) linked to the six geographical school clusters across the city. There is provision of: consultation, advice and support; training and continued professional development; pathways facilitated to different care and support-including specialist services; and an established partnership to deliver evidenced based direct work to CYP. Service access requests are made in collaboration with a pastoral lead for each school. CAMHS notify the SWW and the pastoral lead in the school of any children or young people who have attended an initial assessment and where they have not met CAMHS thresholds. The SWS provides support with a range of mental health conditions including: anxiety, emotional regulation, low mood, low self-esteem and poor resilience, trauma, loss and attachment difficulties, eating disorders, Autistic Spectrum Disorder, and ADHD.

The first year has made a positive impact ain three main areas:

- School staff knowledge and confidence in supporting children and young people with emotional and mental health issues: 70% of school staff (who completed the staff survey) said the service had increased their knowledge and confidence. Staff reported feeling more confident in supporting CYP on a range of mental health areas including self-esteem, attachment, bereavement, low mood, anxiety, depression and emotional regulation. Confidence had not increased significantly in other areas including; anger, social communication, self-harm, eating disorders, resilience and body confidence.
- CYP identified early and supported effectively within school to prevent needs increasing and the requirement for specialist intervention where appropriate. School staff rated 8/10 the support that the service has provided to schools in relation to referrals to CAMHS. When school staff were asked whether the support, information and intervention from the SWS had reduced the number of referrals made to CAMHS this academic year, 28% said yes, 15% no, 40% stated that it was too difficult to tell at this stage, 17% did not answer.
- Increasing the number of children and young people who feel more able to cope with mental health issues within a school setting: 82% of CYP achieved their specific goals as a result of direct work with SWS and 90% of CYP reported 8/10 or above service satisfaction evaluation feedback.

  'I put one of my sayings as 'I can do this!' because in a lot of situations I think 'I can't do this' and I would like to make myself believe 'I can'

  'I think this has really changed how I think about myself'
  Pupil Feedback

  'Thank you for helping me to get my little girl back'
  Parent Feedback

5.4.3 Case study: Hertfordshire School CAMHS: Link Work Stream

A review of the Herts Child and Adolescents Mental Health Service (CAMHS) identified the need for early intervention and prevention. A plan to improve communication with the Specialist CAMHS in a range of ways and ensuring the voices of schools were heard in the CAMHS Transformation was set out. The aim was to work towards better and consistent pastoral provision in school and to build capacity across the existing system.

The School Perspective

The views of school staff were gathered in a Transformation Survey. Overall schools felt they were expected to manage high levels of need and risk; they identified failures to utilise the knowledge and skills they have and they felt they were appropriately referring to early intervention and non-mental health specific services. Counselling was the most common school-funded external provision with schools reporting spending up to £30,000 per year with an average of £8,000 on average. Pressures on the schools were seen as resulting from long waiting times in CAMHS, high thresholds and poor communication.

Support for Schools and Training

Over 400 schools in Herts now have a Mental Health Lead and are able to access a one day training course to help them in their role. Quality guidance to support schools commissioning of emotional wellbeing provision is provided via the CAHMS and there is also a Mental Health Lead Toolkit[9]. A self-review tool has been developed to help schools consider their whole school approach. A kite mark will soon be launched to recognise schools with good practice. This will include an extension option to receive Suicide Aware School Status. Every area is hosting a funded course on anxiety, self-harm, Mental Health First Aid, staff sharing and a course for school mental health leads this year. Whole school mental health awareness training has been delivered in a number of schools. Training will have been delivered to over 2,500 professionals by the end of the financial year –approximately 2,000 of these have been school staff. Outcomes include increased knowledge and understanding, greater confidence, more awareness of key resources and where to find them. The training has also had a positive impact on participants' own sense of wellbeing.

Improving Communication

Pastoral network groups created for sharing of information and good practice and a termly mental health newsletter sent out to schools and other relevant stakeholders. An advice line has been set up for all schools. The School CAMHS Link Managers are working with specialist CAMHS to increase consent to share with schools and have developed templates to facilitate information sharing between agencies.

Future work plan

Future plans for the Link Project involve a new project to address teacher wellbeing; the development of an Attitudes and Perspectives Survey for school staff with a linked behaviour change index; enhance guidance for schools on self-harm; an expansion of Peer Supervision model to local network facilitators; refine outcome measures project for schools;

[9] www.healthyyoungmindsinherts.org.uk

project to support transition; join up SEMH and MH agendas and finally implement green paper recommendations.

5.5 Conclusions

The evidence review has identified a wide range of interventions which have been shown to be effective in addressing the protective and risk factors related to mental health in CYP. A summary of the most promising interventions is given in the tables below. Implementing a range of evidence-based, effective prevention interventions would allow more CYP to stay well and avoid the need for mental health treatment services. One general point to be taken from the evidence base is that many intervention are effective in the short-to-medium term but would require booster sessions to have a long-term impact. Moreover, it is important that the specific mix of interventions implemented in any particular setting is matched closely to the needs of that population. This makes it important, for example, for schools to understand the specific needs of their own pupil populations and tailor their approach accordingly.

As well as interventions which target specific protective and risk factors, a range of multi-agency approaches have been tested in recent years. The complex nature of CYP mental health issues makes a multi-agency approach appealing and this is the approach recommended by NICE best-practice guidelines. Multi-agency approaches offer a platform for delivering effective interventions. Many multi-agency teams have focused more on identifying those in need of treatment and improving links with treatment services. Others have focused more on early intervention and capacity building in schools. A multi-agency approach focused on promotion of protective factors and prevention of risk factors could be an effective vehicle for delivering the evidence-based interventions outlined in this report.

Table 7. Evidence-based interventions to improve mental health in children and young people

Protective factor	Intervention
Good social connections	PHSE LISA-T Mosaic Mentoring Programme
Positive coping strategies	FRIENDS for Life Penn Resilience Programme
Physical activity and exercise	CATCH Daily Mile (stronger evidence to be published in 2018) Switch-Play programme KISS
Positive parenting	Webster-Stratton Incredible Years Parenting Programme Mosaic Primary School Programme

Risk factors	Intervention
Bullying	Kiva The Good Behaviour Game
Excess internet & social media use	Evidence is lacking in this field.
Poor body image	Confident Body, Happy Being Me Confident Me BodyThink
Substance misuse	Life Skills Training programme Unplugged The Good Behaviour Game

School-based multi-agency models
School Link to Mental Health Services Pilots
York Model
Hertfordshire School CAMHS: Link Work Stream

6. Key findings and recommendations

Recommendation 1: Focus on building strengths and reducing risks not just treating illness.

Mental ill health can be seen as developing as a result of an imbalance between positive (protective) factors and risk factors. With an estimated 10% of CYP having a diagnosable mental health condition, it is clear that far too many CYP are being allowed to get to the point where they have an established mental health disorder and need specialist treatment.

Much of the focus of national and regional policy is on treatment and early intervention for children and young people who have established mental health problems. Given the large numbers of CYP affected by poor mental health at present, this focus is understandable. However, the rapid growth in demand for treatment services seen in recent years is unsustainable. From a caseload of 225 at the launch of the EWMHS service in November 2015 the number of CYP in the service had grown to 600 by November 2017. Whilst it is vital for CYP with serious mental ill health to be treated quickly, an ever-greater focus on treatment will not solve the underlying problem.

Focussing on prevention and promotion of mental wellbeing will not only prevent many young people from becoming unwell but will also reduce pressure on treatment services allowing those who do need specialist treatment to be access the support they need more quickly.

Recommendation 2: Promote the protective factors which keep CYP mentally well.

Based on what CYP in Thurrock have told us, it is clear that there are opportunities to build upon existing strengths. The three most promising areas identified by evidence are promoting good social connections, the use of positive coping strategies and physical activity. These are the areas where our analysis has identified a clear opportunity to improve based on local data, that existing services are not fully meeting the needs and that there is evidence of other interventions which can strengthen these factors.

Good social connections			
Opportunity	**Existing services**	**What works**	**Potential impact**
Strong relationships with friends and family help people to stay well and to cope during difficult times but last year, nearly a quarter of Year 8s we surveyed reported feeling lonely often or all of the time.	PHSE lessons in school can address relationship issues.	Mentoring schemes and the group intervention LISA-T can be effective in helping CYP to develop strong social connections.	Keeping more CYP mentally well and building resilience by giving them the social support they need to cope with difficulties.

Positive coping strategies			
Opportunity	**Existing services**	**What works**	**Potential impact**
Whilst many CYP in Thurrock report using positive strategies (such as seeking out friends or trusted adults) as a way of dealing with difficulties, many use negative strategies. Self-harm is the third most common reason for CYP presenting to EWMHS for treatment and 7% of Year 8 report hurting themselves as a coping strategy.	Reprezent media channel Open door therapeutic workshops	Interventions including the Friends for Life programme and the Penn Resilience Programme are effective.	Strengthening the ability of CYP to deal with stress in a positive way. Particularly useful for preventing depression and anxiety.

Physical activity			
Opportunity	**Existing services**	**What works**	**Potential impact**
Many CYP do not meet recommended guidelines on physical activity, particularly in secondary school. For example, in Year 6, 56% of pupils report doing an hour of physical activity on four or more days per week but the figure is only 30.5% in year 10.	School PE lessons. The Daily Mile is run by a minority of primary schools but there is nothing comparable for secondary schools.	The evidence base is not strong but some studies show a positive effect in the short-to-medium term. E.g. The Daily Mile, CATCH, Switch-Play, and the KISS programme. The programmes would need to be adapted to suit local conditions and strong evaluation plans would be needed.	Improved mood and reduced symptoms of depression and anxiety. Also improvements in fitness, physical health, and (potentially) educational attainment.

Recommendation 3: Tackle the risk factors which can push people into mental ill health.

Just as we have identified key protective factors which could be strengthened in order to keep CYP mentally well, there are a range of risk factors which could be address to prevent them slipping into mental ill health. The two most promising targets for intervention we have identified are: bullying and body image.

Bullying			
Opportunity	**Existing services**	**What works**	**Potential impact**
Young people say that **bullying** is a significant problem with 24% of Year 6 children in Thurrock reporting that they have been bullied in the past 12 months.	Individual school policies and programmes	KiVa anti-bullying programme and the Good Behaviour Game have been shown to be effective in reducing bullying in schools.	Reduction in bullying. Improved mental health for both victims and bullies including reduced anxiety and depression. Improvements in educational attainment.

Body image			
Opportunity	**Existing services**	**What works**	**Potential impact**
Body image is a source of dissatisfaction for many adolescents (including 14% of girls and 7% of boys aged 10 – 15). School pupils in Thurrock also report that appearance is the most common target for bullying and 21% of Year 6s report that they worry about the way the look often or all the time	No interventions specifically targeting body image in a preventative way were found.	A number of interventions have been trialled. One of the most effective for adolescents is *Happy Being Me*.	Reductions in negative body image, and thin ideals as well as improvements in self-esteem for both girls and boys. Potential to reduce the prevalence of eating disorders and self-harm.

Recommendation 4: Develop a new partnership model and implement school-based wellbeing teams

The complex nature of CYP mental health means that no single organisation can address it alone. Existing services are fragmented running the risk that young people, parents and teachers find it hard to get the right help at the right time. A new model for partnership working between key stakeholders could help to strengthen important connections between the many organisations with an interest in this topic to ensure that services are join-up and young people do not fall through gaps in the system.

Recognising the complexity of problem and the need for collaboration, multi-agency, school-based teams have been trialled successfully in a number of areas including York, Hertfordshire and as part of the national school link pilot schemes. Typically these teams are jointly funded and run by a range of partners including schools, the local authority and Clinical Commissioning Groups. They can act as a link between schools and specialist treatment services (EWMHS) but they can also directly deliver preventative interventions in schools, provide training for teachers to deliver preventative interventions and support pastoral care in schools. Since the evidence base suggests that many mental health promotion strategies have a short-to-medium term effect, having a team which can deliver on-going interventions as well as on-going training to school staff is potentially a powerful implementation mechanism.

Whilst schools are not the only setting where CYP mental health can be addressed, they are extremely important. Since teaching staff are unlikely to have either the skills or the capacity to implement many of the recommendations given above, significant progress in addressing protective and risk factors would require extra capacity. If implemented in Thurrock, it is strongly recommended that the primary focus of school-based wellbeing teams should be on the protective and risk factors highlighted though providing a link into treatment services could be a secondary benefit of such teams.

This proposal also fits well with the direction of national policy (as set out in the 2017 Green Paper) towards developing ‘mental health support teams’ for every school. However, the timetable for the national proposal is extremely long (to reach 20 – 25% of schools by 2022/23). A local partnership arrangement could speed this up, giving young people the

support they need as soon as possible and allowing the programme to be shaped by local priorities.

Recommendation 5: Gather and share information on what is already being done to improve CYP mental health

This report gives a summary of some of the work that is being done both on prevention and treatment of mental ill health. It is clear, however, that there is a lot of work happening in the community, in schools, and in colleges, which we are not currently aware of. Having a better understanding of what is already being done to address mental health issues will help to reduce overlap, identify gaps and share learning about what works. Further consultation with schools, colleges and community groups is needed to create a more comprehensive picture. Sharing this information will help to spread best practice and share learning.

Developing a self-assessment tool with schools to allow them to review their current mental-health related activities could help to identify gaps and shape future interventions supported by school-based wellbeing teams.

Recommendation 6: Improve mental health data and track progress by all schools participating in the Brighter Futures Survey

Understanding an issue as complex as CYP mental health requires good local data. This analysis has highlighted a number of areas where our understanding of the local situation is weak. This includes: eating disorders, sleep, self-harm and excessive social media use. The Brighter Futures Survey is a vital source of information about the health and wellbeing of children and young people in Thurrock. For the areas where we have identified a lack of data, new questions can be added to the BFS to fill the gaps.

For this to be of greatest use, it is important for all schools to participate. This will not only allow the development tailored strategies to improve mental health in each school but will also aid comparisons and benchmarking allowing schools to know how well they are doing relative to their peers. By carrying out the survey each year, it will be possible to track progress and evaluate the success of strategies to improve mental wellbeing. There is also a need to capture the views of young people who are not in school.

Data from the Brighter Futures survey should also be used to tailor the mental health strategy for each school and could be used to direct the work of wellbeing teams (see above) to ensure that work in each school is meeting the needs of that specific group.

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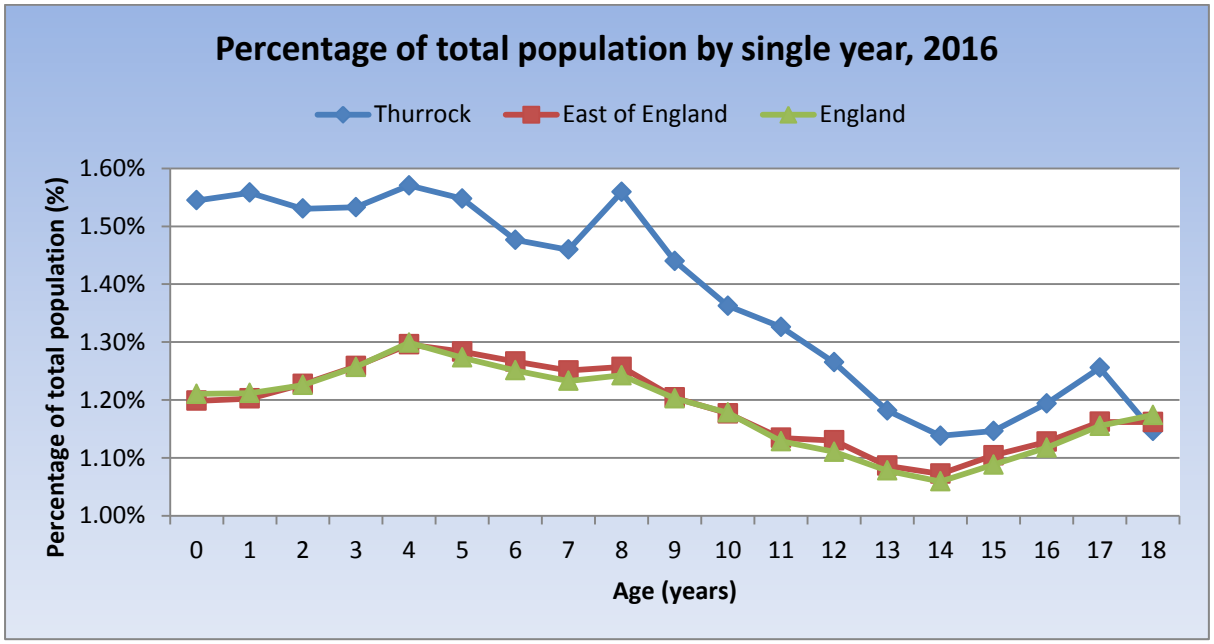
Appendix A: Demography of Children and Young People in Thurrock

It is estimated that there are 43,819 children aged 0-19 years (inclusive), of which 27,342 are of school age (aged 5-16years) (Office for National Statistics (ONS) 2016). Thurrock has a higher proportion of CYP than the national average, with 27.26% of the Thurrock population aged between 0-19 years, compared to 23.72% of the national population (see Figure 36).

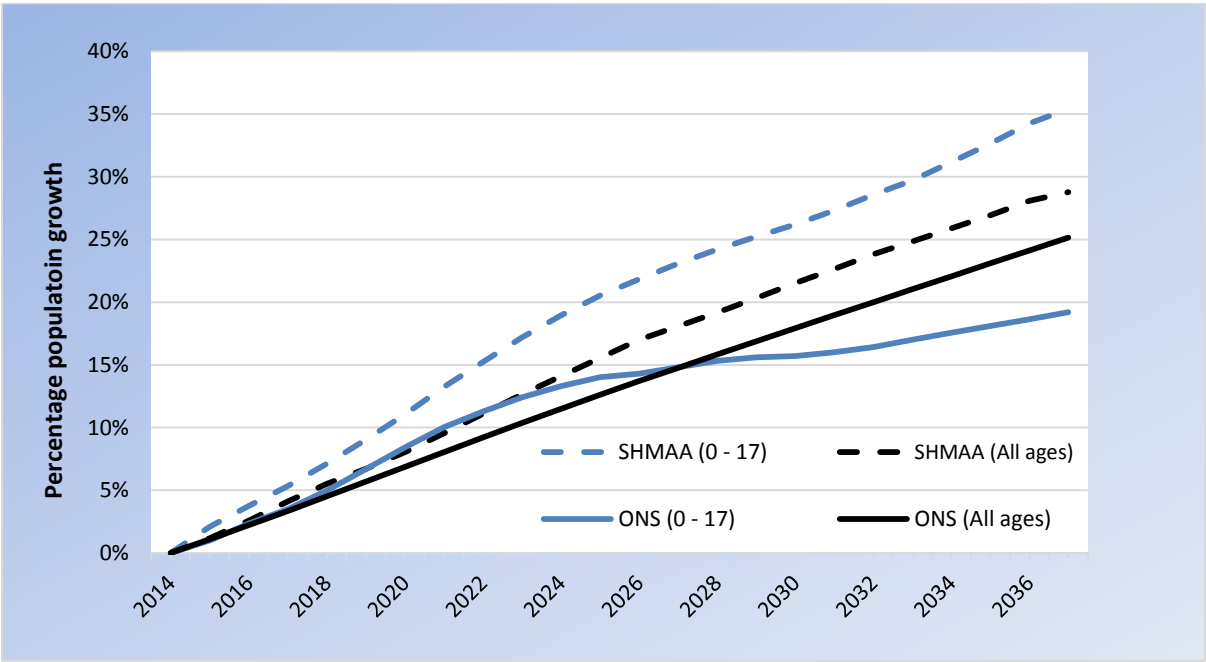
Figure 36: Percentage of total population by single year of age, 5-16 year olds



Source: ONS 2016

We have seen that Thurrock's child population has grown at more than twice the national average rate over the past ten years. Forecasts for the future suggest that this rapid pace of growth is likely to continue. Population projections made as part of Thurrock's Strategic Housing Market Assessment (SHMA) take into account the high levels of job and housing growth expected to take place in Thurrock in the coming years and provide a more realistic local forecast than standard ONS projections. From the baseline year of 2014, SHMA projections suggest that the child population (0-17 years) will grow by 19% by 2024 and 35.4% by 2037. By comparison, the child population of England is projected to grow by just 13.3% by 2024 and 19.2% by 2037 (Office for National Statistics, 2014); around half the rate of growth expected in Thurrock over the next 20 years as shown in Figure 37 below.

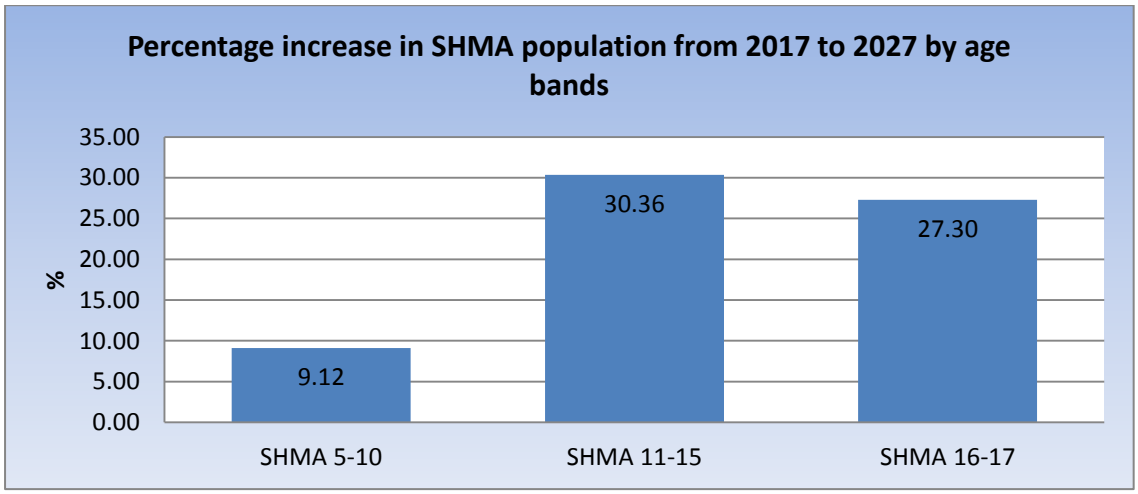
Figure 37: Projected population growth in Thurrock 2014 – 2037



Source: ONS and Strategic Housing Market Assessment (SHMA)

Figure 38 shows that all ages between 5-17 years will see an increase up to 2027, with the largest increase in the 11-15 year age group using the projections from the SHMA.

Figure 38: Population projections over 10 year period



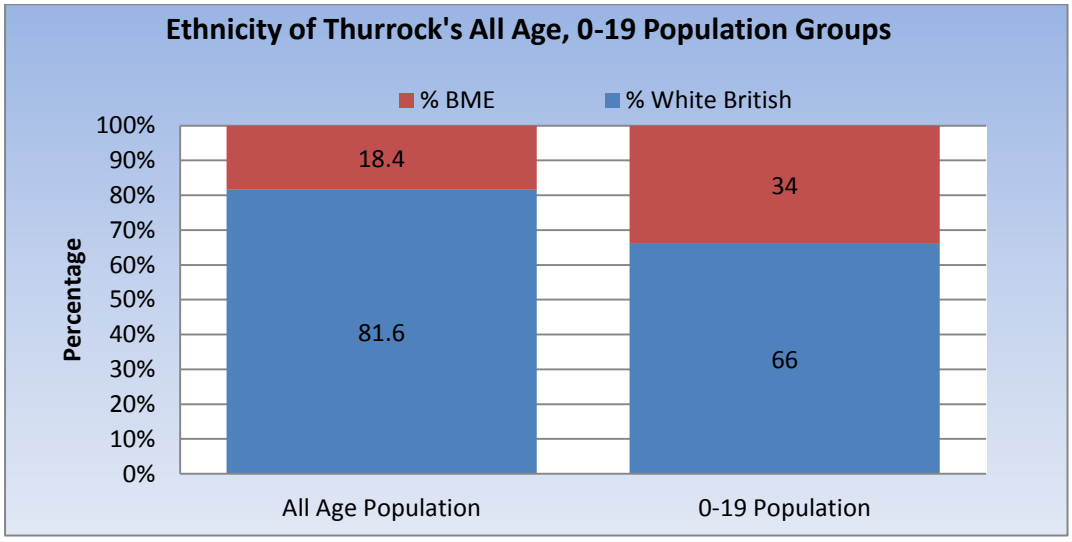
Source: SHMA 2017

Our child population in Thurrock is more ethnically diverse than the all-age population as shown in Figure 39 below. The ethnicity of our school aged population is captured within the School Census data which shows that the proportion of children from ethnic minority backgrounds in Thurrock is rising steadily at a faster rate than in England or Thurrock's statistical neighbours.

For some vulnerable groups such as those with Special Educational Needs and Disabilities (SEND), services are provided for children and young people up to the age of 25. Children and young people aged 0 - 25 make up 34.1% (56,959) of the population of Thurrock. The child population aged 0 – 25 in Thurrock has also been on the rise in the last decade (10.6%

from 2007) which is double the rate of increase in England, 5.9%. This trend is expected to continue over the next decade with the child population (0 – 25) projected to increase to 62,427 (9.2%) by 2027 from the 2016 mid-year estimate. Further details on the 0 - 25 child population in Thurrock can be found in the Special Educational Needs and Disability JSNA.

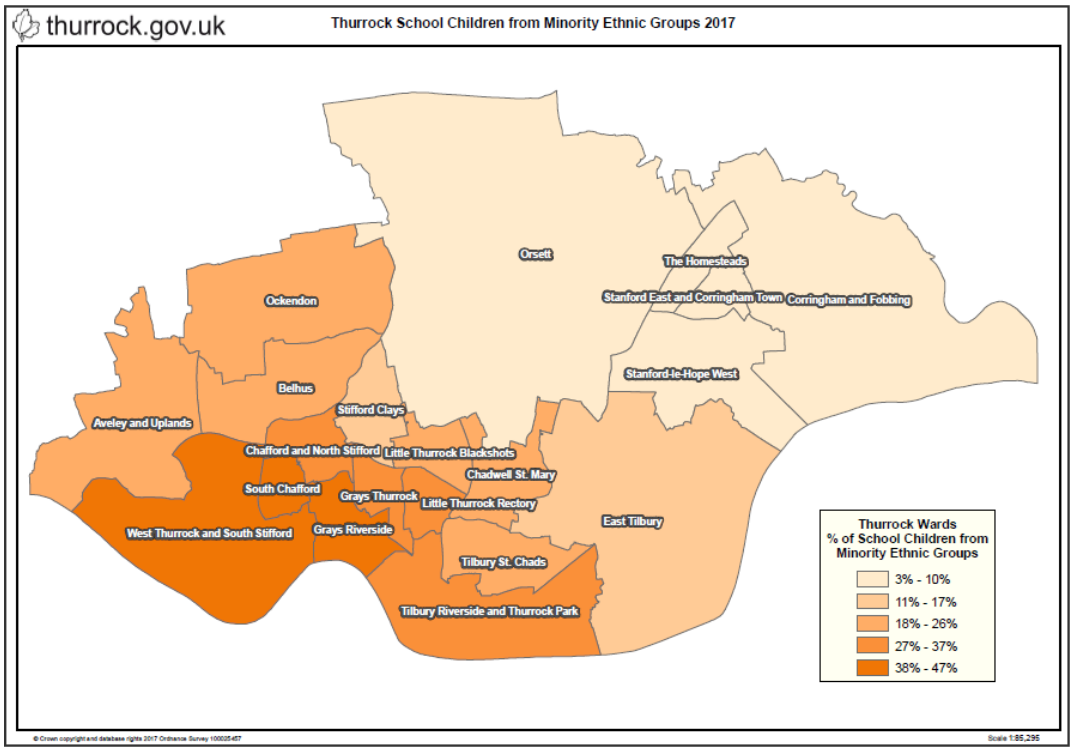
Figure 39: Ethnicity of Thurrock's all-age and 0–19



Sources: Census 2011, School Census 2017

As shown in Figure 40, wards in the west of Thurrock have the highest proportion of school children from minority ethnic groups, with the highest proportions residing in Grays Riverside (54.5% of their child population), and the lowest proportion of children from minority ethnic groups living in Corringham and Fobbing (5.1%).

Figure 40: Ethnicity of our school aged population by ward



Source: Spring School Census data, 2017

Appendix B: The Big Conversation – A Mental Health Summit

1.0 Consultation

On completion of the JSNA product in April 2018, a consultation period followed to establish the next steps and actions as a result of the outcomes within the JSNA and the views of professionals in our community of Thurrock.

On Friday 18th May 2018, the Big Conversation – A Mental Health Summit, was held. The summit was a joint event between Thurrock Public Health, Education and Thurrock CCG colleagues. The summit, which was chaired by the Portfolio Holder for Education and Health, included a range of presentations including the findings from the JSNA and the key recommendations; what services we currently have locally, and an inspiring talk from colleagues at Thurrock Mind representing the Young Person's Voice following their recent work.

The summit facilitated four workshops to gather important views and to understand what initiatives there are that promote positive wellbeing in CYP, what the barriers and gaps are, and what could be done to build a partnership school-based model for emotional wellbeing.

Section 3.0 summarises some of the main themes from the day.

2.0 Attendee List

2.1. Speakers:

Portfolio Holder for Education and Health Councillor James Halden
Ian Wake, Director of Public Health
Tim Elwell-Sutton, Consultant in Public Health
Rory Patterson, Corporate Director of Children's Services
Malcolm Taylor, Strategic Lead for Inclusion and Principal Education Psychologist
Paul Griffiths, Chair of the Schools Forum Chair
Thurrock Mind, Wendy Robertson Deputy Chief Executive Officer

2.2. Delegate organisations:

Thurrock Council
Thurrock Clinical Commissioning Group (CCG)
Thurrock Primary Schools
- Warren Primary School
- Bonnygate Primary School
- Benyon Primary School
- Chadwell St Mary Primary School
- Thameside Primary School
- Stifford Clays Primary School
- Abbotts Hall Primary Academy
- Aveley Primary School
- Kennington's Primary Academy
- Corringham Primary School
- Giffard's Primary School
- St Joseph's Primary

Belmont Castle Academy
Quarry Hill Academy
Thurrock Secondary Schools
Grays Covent High School
St Clere's School
Harris Academy Chafford Hundred
Gable Hall School
Osborne Co-operative Academy Trust
Seevic/ Palmers College
South Essex College
The Training Effect (TTE)
SERICC
Youth Cabinet
Mental Health services – NELFT
NELFT - Emotional Wellbeing Mental Health Service (EWMHS)
PASS- family support workers, Case Manager, Parental Outreach Workers
Local Area Coordination Team
Thurrock Mind
Online Mental Health Counselling Service KOOTH
Children and Young Person's Substance Misuse Service – CGL Wize Up
Thurrock Adult Community College

3.0 Feedback themes from the Workshops

3.1. Overall themes

Demand for treatment: as highlighted within the current JSNA findings, growing demand and severity of needs was recognised as a concerning trend among Thurrock Professionals. This comes with a general feeling that agencies are not always equipped to help CYP with some of the behaviours and experiences they are facing. Long waits and capacity limitations for accessing mental health treatment was recognised as a barrier along with limited flexibility in the approach for treatment.

Fragmented system: a key theme of the day was that the system is fragmented. Although there are many great programmes and initiatives, agencies are not particularly well linked up.

Support for collaboration with a prevention focus: there was a positive and encouraging level of support for a collaborative approach that takes a prevention focus using the recommendations for prevention interventions outlined within the JSNA.

3.2. What is working well

Communication and information sharing: was recognised as working well in some areas such as schools and colleges being able to develop relationships with CYP and parents/carers. There was also recognition for strong multiagency working around sharing appropriate information, shared responsibility, joint problem solving and joint reflection regarding effectiveness of current strategies and interventions. Transition planning, although

had been highlighted as having a number of limitations in some areas, is working well in others.

Community and family support: although it was felt more could be done, there was recognition that community and family support was strong in some places, for example the broad spectrum of support provided by the Thurrock Local Area Coordination Team. Schools identified they had a role and some capacity in providing additional support for families and felt that there were better outcomes when families are engaged. The Thurrock Adult Community College currently is providing a number of parenting courses that are free to access.

Signposting to support/ service: was discussed in terms of knowledge for a number of barriers but also recognising some good community support and alternate services for CYP. For example the use of peer mentor models, 'Open Door' to return to services once discharged, Young Carers Support Group and School based support. In the School/College setting there is often a designated Mental Health Champion role or lead for CYP to go to for advice and support.

Training, knowledge and understanding: is recognised as needing improvements and funding however a range of training programmes for staff and Governors was recognised. Shared team meetings and professional meetings facilitated the sharing of best practice and knowledge. Safeguarding training was useful, as was the offer of community and voluntary sector support and training, for example the Mental Health First Aid Training offered by Thurrock Mind.

3.3. Barriers

Communication and information sharing: is too often hindered for example where information was being withheld and gaining consent from families being difficult. In some cases information is not shared between professionals, schools and wider agencies effectively. There was a shared feeling that information on the range of services/support available locally was lacking. Services currently seem unable to respond in a holistic model that signpost to various points of contact.

Community and family support: were impeded by a lack of an information point for services and resources specific to mental health and a lack of outreach resources. There was discussion around limited resources for parent education/support and a felt lack of flexibility and resource within the system to invest in reaching families who need additional support.

Identification of concerns and referrals: colleagues discussed having a lack of capacity to respond to need in an appropriate time frame. Some agencies felt there was limited understanding of service eligibility/ criteria, again identifying the lack of flexibility in the system. In some cases there was felt to be a failure to engage with CYP and support is only available when a CYP is of a higher level of need or crisis point; therefore missing the opportunity to avoid escalation. Eligibility thresholds were felt to be too high with CYP then being passed from service to service. Gaining consent can also be a major barrier to referral.

Training, knowledge and understanding: was recognised by colleagues within schools or colleges to be limited in areas such as understanding around Eating disorders. There was

discussion around a lack of funding for training and limited awareness of support available and lack of capacity of staff to support early intervention. Whole system Training and awareness was something that would be useful.

4.0 Outcomes

The findings from the Mental Health Summit will help to shape the actions taken forward informing strategy of a new partnership school-based model for Thurrock. The aim is to support schools to cope with the growing demand and related signs and symptoms of mental health conditions in CYP. Taking a strong focus on the preventative factors and developing tailored action plans for individual schools to achieve emotionally healthy school environments is the objective.

Children and Young
People's Mental Health
Joint Strategic Needs Assessment
2018

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