

Unlocking our children and young people’s future

**Dudley Mental Health Needs Assessment**



Centre for Mental Health has been commissioned by Dudley Metropolitan Council to complete an assessment of the social, emotional and mental health and wellbeing needs of local children and young people.

The needs assessment brings together and analyses a range of quantitative and qualitative data and will consider the implications for future whole-system joint commissioning, service development and self-help.

**Why child social, emotional, mental health and wellbeing is important**

One in ten children and young people and one in five young adults will have a diagnosable mental health difficulty. Many more children will be struggling to thrive or will have difficulties just below the threshold for ‘diagnosis’ placing them on a trajectory toward poor mental health without early good quality help.

Good child mental health and emotional wellbeing starts well before a child is born, for example through reducing foetal exposure to the detrimental effects of excessive maternal stress, untreated maternal mental illness and poverty. Social, emotional and mental health is built through the development of good attachments, reciprocal and empathetic communication between carers and children and through positive parenting approaches; it is strengthened in families and in schools through minimising exposure to prolonged and multiple risk factors and through supporting children and young people to develop coping skills and resilience in the face of a manageable level of setbacks. Risk factors that predispose a child to poor social, emotional and mental health and which lead to mental health crises are similar to those undermining their safety and educational achievement. This highlights the central importance of joined up commissioning and working together to build assets and reduce environmental risks in local areas.

We know that most parents approach either their own families or schools and GPs for advice if they have a child who has a mental health difficulty. However, we also know that only a quarter of children get the support they need to help them recover. We also know that young people suffering from mental illness wait an average of 10 years between experiencing first signs of poor mental health and getting treatment. We have a system at present that tends towards responding to mental health crises rather than being preventative in focus. This is of considerable concern in the light of well-established evidence that late intervention undermines the chances of a young person’s recovery from mental health difficulties, increasing the chances of multiple poor life chances and imposes a heavy financial burden on society.

In September 2014, a national CAMHS Taskforce was established to consider ways to help children, young people, parents and carers to get more accessible help and to support whole system improvements to the way that services were responding to need (DH, 2015). In 2015, a cross Government response to the Taskforce’s report committed to a number of recommendations for improving local provision.

**New money**

As part of the Government response to Future in Mind, the Department of Health allocated £30 million for investment in eating disorders and self-harm services with further investment up to £250 million recurrent annual increase in funding for five years from 1st April 2015[[1]](#footnote-1). Increases are expected to:

* improve access to perinatal mental health services
* improve access to mental health care for children and young people
* help implement new waiting time standards
* extend delivery to an additional 70,000 children and young people per annum over the next five years.
* expand nationally the Children and Young People’s workforce transformation programme (and include those working with children with learning disabilities and enhance the quality of provision for under-fives).

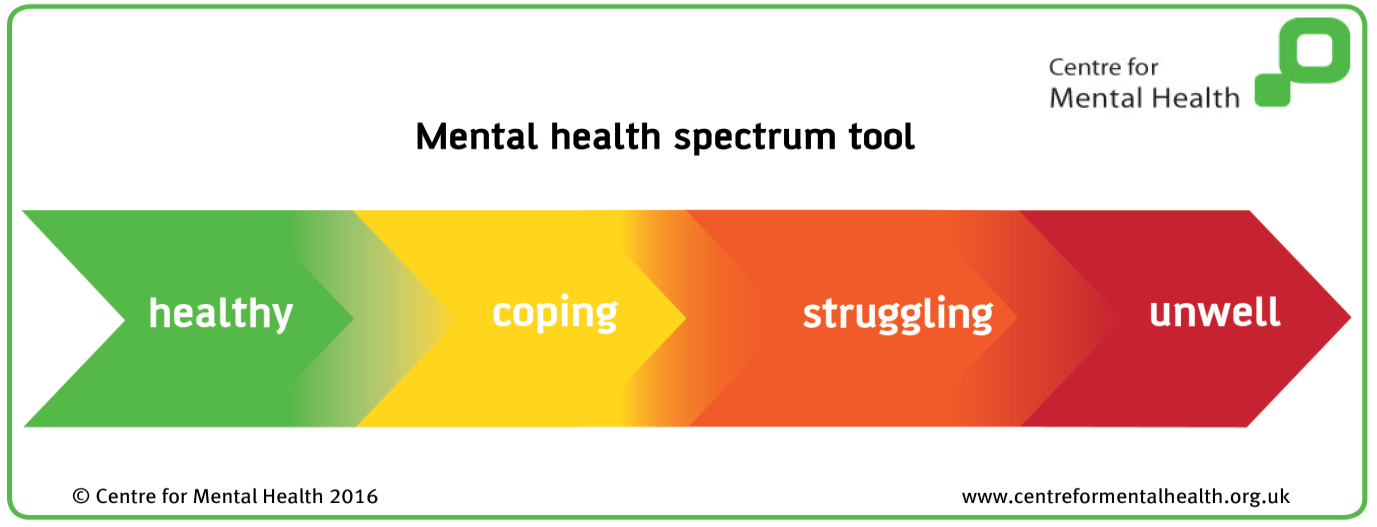
Last year, each local area was tasked with producing a CAMHS Transformation Plan. Subsequently to this, NHS England required these plans to be refreshed and integrated into NHS Sustainability and Transformation Plans. The release of new money will be tightly monitored by NHS England to ensure that it has the greatest chance of achieving transformative ambitions.

**Establishing benchmarks: what does good look like?**

**What we mean by mental health?**

Good mental health is not just about being free from illness. It is ‘a state of complete physical, mental and social wellbeing…in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community’ (WHO, 2015). It involves social, emotional and mental wellbeing and recognises that children often communicate distress or developmental problems through their behaviour.

Good mental health is ‘the foundation of healthy development and mental health problems at this life stage and can have adverse and long-lasting effects’ (Fonagy and Murphy, 2012).

****Figure 1: mental health spectrum of need**

Positive mental health is determined by a complex interplay between biological, socioeconomic and environmental factors (e.g. temperament, poverty, exposure to abuse, experiences of discrimination etc.) which combine to promote or undermine wellbeing. Any child’s wellbeing can move outside healthy ranges leading them to need a bit of extra help; but some children are at greater risk than others. Exposure to early adverse events such as untreated maternal mental illness or prolonged exposure to cumulative risks can significantly undermine children’s potential and wellbeing (Murphy & Fonaghy, 2012). Strengthening protective factors in children and young people or in the families and environments around them is critical to providing the best start, helping them achieve their potential, stay healthy and develop resilience (The Centre for Community Child Health, 2000).

**Whose business is social, emotional and mental health and wellbeing?**

Good child mental health and wellbeing benefits everyone. Without good mental health and emotional wellbeing children face poorer life chances and do not achieve their potential. They do poorly in school, face higher levels of damaging distress, have higher rates of poor physical health over their lifetime, may cause difficulties for local communities and have a range of other poor outcomes (Green, et al., 2005) (Fergusson, et al., 2005) (Department of Health, 2015).

When children’s mental health and wellbeing deteriorates, it not only damages their life chances, it also places pressure on and imposes considerable additional costs on many public services such as schools, the justice system, social care and health services (Knapp, 2010) (Centre for Mental Health, 2014) WSIPP, 2016). Right from the first spark of life, all sectors can play a part in supporting children, young people and their families to adopt and maintain behaviours supporting good mental health. And they can be alert to children’s emotional and behavioural wellbeing, providing compassionate support and helping them get extra help if they need it (Department of Health, 2015).

Promoting, preserving and restoring children’s mental health (like safeguarding) must be the responsibility of all those in contact with infants, children young people and families – not just the duty of those whose core expertise lies in the mental health field (Department of Health, 2015). Communities, families, young people and children themselves can be supported to maximise and preserve child and youth wellbeing (Department of Health, 2015).

*Future in Mind* outlined ‘a vision for our country in which child mental health and wellbeing is everybody’s business, where our collective resilience and mental strength is regarded as an asset to the nation in the same way as we prize our levels of attainment, creativity and innovation’ (Department of Health, 2015).

## An effective system promoting robust child mental health and wellbeing: vision and key features

An effective system supporting the mental health of children is one that:

1. Puts at its heart the strengths and needs of children and young people and families;
2. Prevents problems, helps children get back on track or facilitates early help to de-escalate, manage and prevent the re-occurrence of a crisis;
3. Has a child/youth/family/carer friendly service design - providing ‘the right help at the right time in the right place’
4. Draws together the activity of a confident and skilled whole system and multi sector workforce (including early years, schools and colleges, voluntary sector providers and statutory health and children’s services) supporting children’s social, emotional and mental health. Activity should:
   1. promotes mental health in children, young people and families right from the first spark of life
   2. strengthens protective factors and assets that build strong child and youth mental health and reducing influences that compromise a child’s healthy social and emotional development (e.g. exposure to maltreatment)
   3. helps children and families build resilience to cope with and manage inevitable setbacks;
   4. gives extra help to children struggling developmentally, socially or emotionally de-escalating difficulties early
   5. intervenes as early as possible to support those presenting with diagnosable difficulties
   6. provides continuity and eradicates gaps affecting age-related transitions
5. Recognises the important role that maternity services, primary care and early years support plays in building strong family mental health and emotional wellbeing –helping early maternal/infant communication, promoting healthy attachment and child development and supporting early identification and treatment for parents, infants and children with poor mental health;
6. Builds capacity in parents, carers, children and young people themselves so that they can strengthen and preserve wellbeing and so they know how to help themselves or where to go if they need extra help (Department of Health, 2015)
7. Recognises the important role that schools and whole-school approaches play in supporting children and young people’s social, emotional, mental health and attainment
8. Provides a clear gateway with trouble-free access to an easy to understand offer of help for all children, young people,carers and families. The offer should be:
   1. developed in collaboration with parents, carers, children and young people and backed up by a single gateway to get help
   2. needs-led rather than diagnosis-led or merely focused on what services or alternatively what funding is available
9. Commits to an ‘invest to save’ approach: recognising that inadequate early investment stores up problems for all sectors later on, damaging children’s outcomes, reducing quality of life and building up later crisis costs (Knapp, et al., 2011)
10. Ensures equal parity of esteem for mental and physical health (Department of Health, 2015)
11. Minimises the chances of children falling between the gaps of systems of care – particularly during adolescence which is the peak age for escalating mental illness
12. Works together to achieve best outcomes for *all* children - regardless of gender, sexuality, ethnicity, religion, class and disability (recognising that some families, children and young people face greater risk adversity and need more help)
13. Recognises that some children have poorer chances of escalating mental health than others. This includes:
    1. children exposed to maltreatment, neglect and/or family violence
    2. children whose parents experience poor mental health themselves or whose parents are reliant on substances
    3. looked after children and care leavers and children
    4. children with learning, neuro disabilities and long term physical health conditions
    5. children who are at risk of or victims of sexual exploitation
    6. children from some BME communities as well as those from some migrant communities
    7. children who go missing, are homeless, are involved in gangs (or have families involved in gang activity)
    8. children on the edge of or in the youth justice system – particularly those with severe and persistent early starting behavioural problems
    9. Lesbian, gay, bi-sexual and transgender children and young people
    10. children who are excluded from school, who are bullied or who are both bullies and are themselves victimised
    11. children reliant on alcohol or substances

Whole system activity should be guided by best quality evidence to ensure what is offered has the best chance of making a difference to children, young people’s and families. *Future in Mind* highlighted that:

*Although lack of evidence should not be used as an excuse for lack of care, it is unethical and a waste of taxpayers’ money to invest in interventions that have no evidence base – unless they are subject to rigorous evaluation…* *There is good evidence that well-meaning interventions, with the best of intentions, can do more harm than good*.(Department of Health, 2015)*.*

**What do children and young people want?**

As well as taking into account research evidence, we must listen to and prioritise children, young people’s, families’ and carers’ views of what they want based on their lived experience of what helps. Children and families who formed part of the national Taskforce said they wanted services:

* That were easy to access, understand and navigate;
* That felt ‘non-clinical’;
* Delivered by empathetic, compassionate and caring practitioners;
* Delivered flexibly in a range of welcoming or familiar settings;
* That allowed them choice and flexibility in terms of the variety of services/interventions on offer, who provided them, the timing and location of contact and which involved informal and formal as well as good quality online support.

Most young people also felt that teachers and schools could play a bigger role in recognising when pupils are struggling and helping them access appropriate support.

The report emphasised that children and young people and their parents/carers need clearer awareness of how to recognise when they might have a mental health problem as well as where and how to get help, what help is available, what might happen when they access it, and what to do while they are waiting (Department of Health, 2015).

Dudley’s needs assessment will add further to our knowledge through drawing together key findings from recent local surveys and consultations with Dudley’s children, young people and families.

**Young people in Dudley**

The following findings are collated from:

* nationally available data designed to help commissioners benchmark children’s needs and local performance against national and regional comparators. This includes Public Health England Fingertips data (PHE, 2016), ONS data (ONS, 2016), Chimat Child, school aged children, youth justice and maternity profiles (Chimat, 2016)
* analysis of local Health Behaviour In School-Aged Children Survey data for Dudley for 2014 and 2016 (where available)
* local strategic or service data
* other data of particular relevance to children’s mental health, either as proxies for local risk or indicators of local service usage.

It will also provide an estimate of likely prevalence rates for poor child mental health as well as identifying Dudley’s priority high risk vulnerable children based on local data[[2]](#footnote-2). All data will be considered in the context of feedback from consultation with local children, young people, parent/carers, practitioners and commissioners.

*Dudley child and youth demographics*

|  |  |
| --- | --- |
| Child population by age band in Dudley based on mid 2014 estimates | |
| 0-4 year olds | 19,652 |
| 5-10 year olds | 22,524 |
| 11-15 year olds | 17,896 |
| 16 to 25 year olds | 33,219 |
| Total child and youth population | 93,291 |

Table 1: Population estimates for Dudley children and young people based on mid-year 2016 ONS data.

Office for National Statistics data (ONS, 2016) estimates that there are:

* 93,291 children and young people aged 0-25 years living in Dudley making up 30% of the local population.
* 75,300 children aged 0 to 19 years (making up 23.8% of the local population)
* 60,072 children and young people aged 0-16

The proportions of girls/young women and boys/young men are roughly equal in Dudley. 21.4% of the school-aged population are from ethnic minority communities. Those identifying themselves as being of ‘Asian/Asian Pakistani’ heritage form the second biggest ethnic community in Dudley (after White British) making up 3% of the local population.

People aged 0-19 years make up 23.8% of the local population. A very small projected decrease (under 1%) is currently anticipated in the numbers of 0-19 year olds living in Dudley by 2025. This contrasts with some other localities in England where the youth population is significantly increasing.

**Poverty**

Poor mental health usually has multiple and complex interlinking causes and it is important not to oversimplify drivers. However, prolonged exposure to family poverty and to a lesser extent neighbourhood poverty can play an important role in worsening child and youth mental health (Akee, et al., 2010; Yoshikawa, et al., 2012). Relative poverty (how poor you feel compared to others around you) has been noted to be as important an influence on child mental health as absolute poverty (Yoshikawa, et al., 2012). The most recent ‘sweep’ of Millennium Cohort longitudinal data revealed that 11 year olds in the lowest social economic band were at least 4 times more likely to have a diagnosable level condition compared to those in the highest income band. This study also suggested that the impact on child mental health of living in a low income family was worsening over time (Morrison Gutman, et al., 2015).

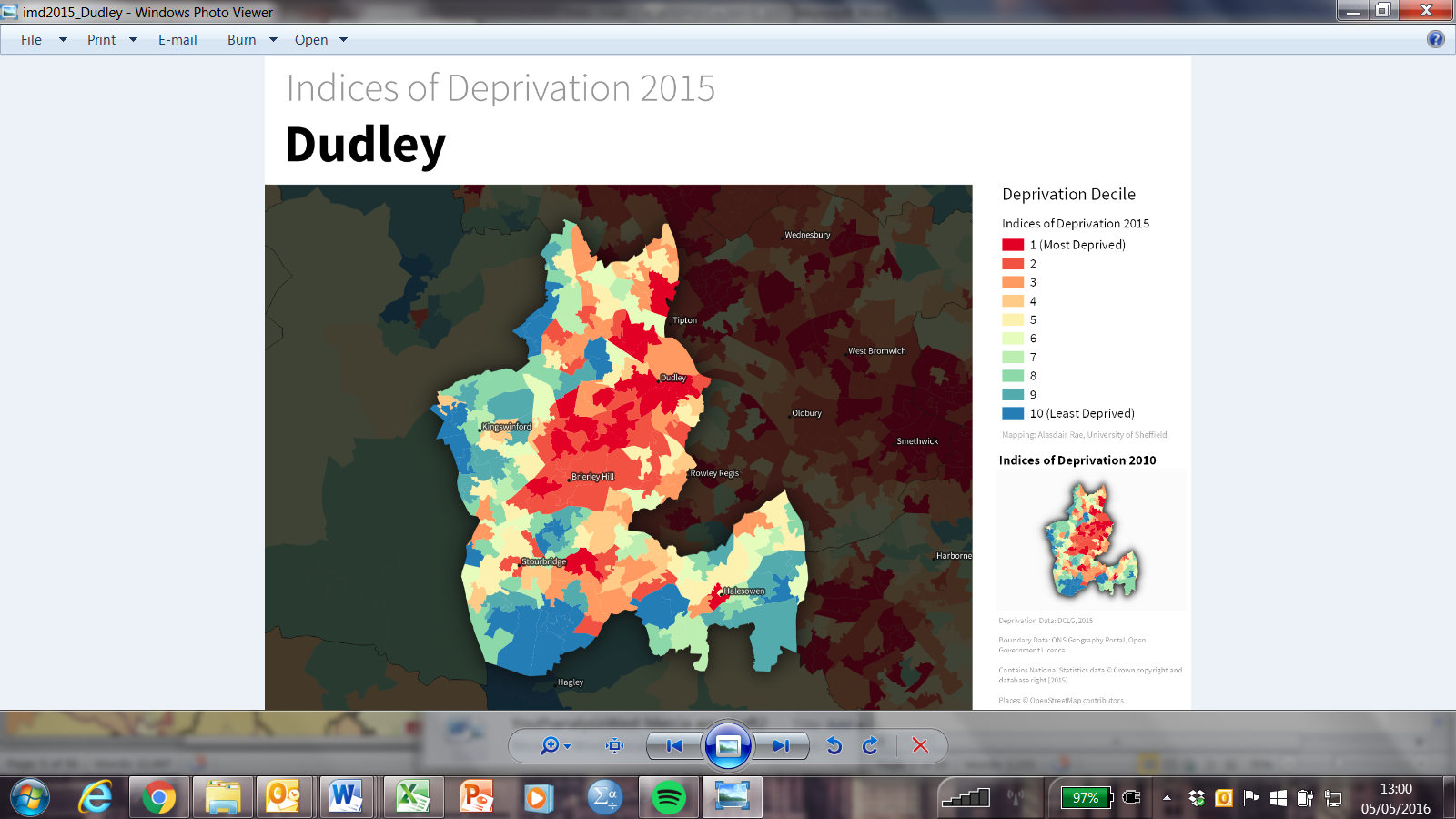
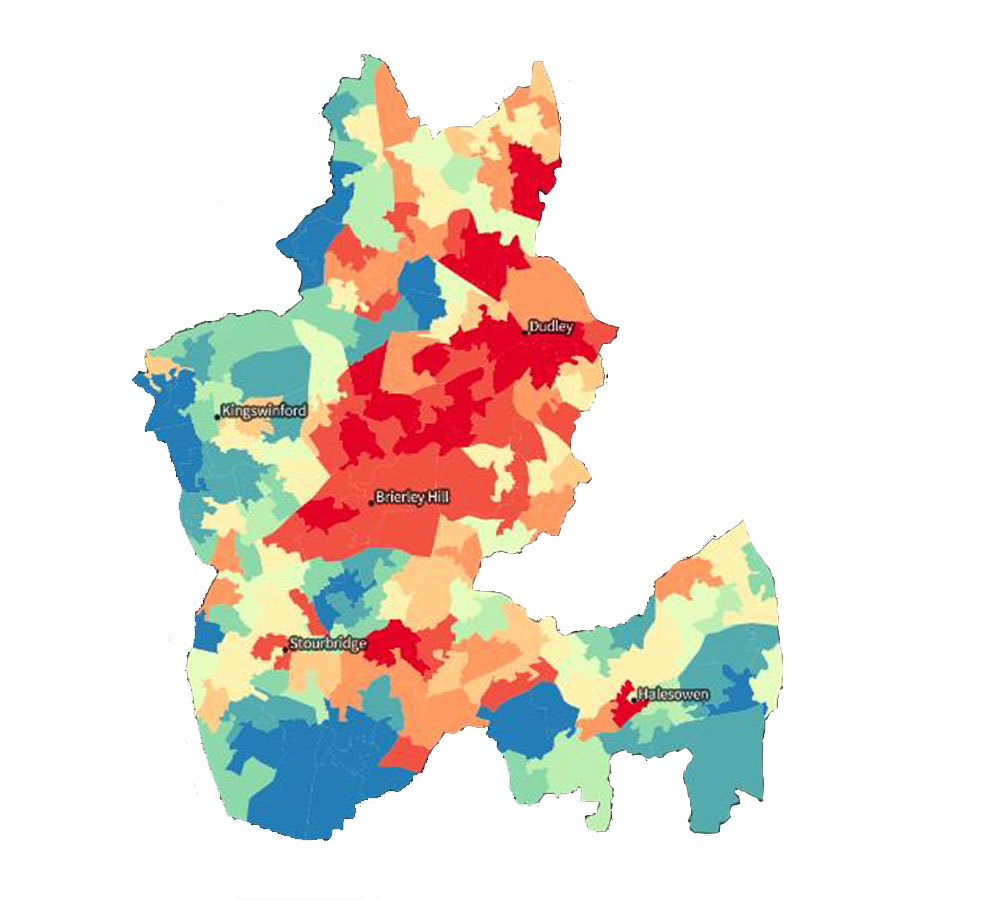
Out of 326 local authorities, people in Dudley live in the 118th most deprived local authority area in England, suggesting the borough lies roughly in the mid-range for deprivation compared with other localities. However, across the Metropolitan Borough there are significant variations and inequalities in the distribution of deprivation (Office of National Statistics, 2016). For example Gornal and St. James wards in Dudley contain areas within their boundary which fall both within the 10% least deprived and 10% most deprived in Dudley.

Broadly speaking the most deprived areas fall in the centre of Dudley (see Figure 1)

In Dudley, 12,795 (21.3%) children under the age of 16 years live in poverty. Although this is similar to the regional average (21.5%), it is higher than the national average (18.6%) (CHIMAT, 2014).

Table 2: Number of children under the age of 16 living in poverty in Dudley

|  |  |  |
| --- | --- | --- |
|  | No. of children in poverty | Those likely to have diagnosable mental health problems |
| Number of children under the age of 16 living in poverty in Dudley | 12,795 | 2060 |

Figure 2: map illustrating indices of deprivation in Dudley Metropolitan Borough Council

**Child and youth wellbeing**

|  |  |  |
| --- | --- | --- |
| Numbers of children with poor well-being (based on a breakdown of WEMWEBS measure) | | |
| Percentage of children… | Based on Dudley school-age children (2016 responses) | Based on Dudley college survey returns (2014 responses) |
| Never or rarely feeling optimistic | 25% | 24% |
| Never or rarely feeling relaxed | 22% | 32% |
| Never or rarely able to deal with problems | 22% | 26% |
| Never or rarely thinking clearly | 20% | 22% |
| Never or rarely feeling close to other people | 20% | 20% |
| Never or rarely able to make up their own mind about things | 14% | 22% |
| Never or rarely feeling useful | 26% | 29% |
| Never or rarely interested in other people | No data | 25% |
| Never or rarely feeling good about myself | 20% | 28% |

**Table 3: scores for a range of wellbeing domains (WEMWEBS) for secondary (2016) and college (2014)**

The Warwick-Edinburgh Mental Wellbeing scale (WEMWEBS) measures wellbeing using responses to14 positive statements and gives score between 14 and 70 where positive answers lead to higher scores. The mean WEMWEBS score for 15 year olds in Dudley (based on Public Health England data) was 48.3 which is slightly higher than the national average score of 47.6. The mean score for 16-24 year olds in 2012 was 52.4.

Data from the most recent Healthy Behaviour in School-Aged Children Survey (HBSCS, 2016) indicated that for primary school children in Dudley, there were no significant differences in wellbeing between 2014 and 2016. Only two elements of wellbeing (optimism and problem solving) for secondary school children showed a weak but significant increase since 2014. However, for those attending colleges, there had been a statistically significant (although again weak) deterioration in overall WEMWEBS scores between 2012 and their 2014 survey.

In primary school 6% of children said they never or rarely felt happy and 7% said they felt sad either all or most of the time.

In college and secondary school, Table 3 sets out the percentages of young people with poor wellbeing.

**Childhood exposure to broader risks**

Poor mental health results from a complex interplay between risk and protective factors over time. The more risk factors a child faces and the longer the period of exposure, the more it undermines social functioning and mental health and emotional wellbeing (Kessler, et al., 2010). The following section in this assessment outlines both key risk factors noted to impact on child mental health and wellbeing and also proxies that indicate that children may not be thriving. Where possible, we have identified likely numbers of children and families affected in Dudley Metropolitan Borough.

**Family risk factors**

**Maternal mental health difficulties**

There is a strong link between poor maternal mental health during pregnancy and during the first year after birth and the development later of child mental health problems (Bauer, et al., 2014). Taken together, a one year cohort of mothers with perinatal depression, anxiety and psychosis would carry lifetime costs to Dudley of around £37,500,000 with around £7,889,700 falling on the public sector. The largest proportion of public sector costs falls on the NHS and social services. Nearly three quarters of costs relate to negative social and emotional impacts on the child rather than the mother (Bauer, et al., 2014).

Diagnosable perinatal mental health difficulties affect between 10-20% of women at some point during pregnancy and for the first year after birth. Roughly 13%-15% of women experience common mental health problems such as anxiety and depression (O’Hara & Swain, 1996; Heron et al., 2004). Despite this, only 40% of mothers are identified and of those only 60% get any treatment, of whom only 40% are given interventions with the best chance of promoting recovery (Bauer, et al., 2014). This means that just one woman in ten gets effective help for perinatal depression or anxiety.

Reducing the risk of poor later child mental health relies on strong partnership between parents/carers, midwives, health visitors, GPs to ensure early identification, swift access to Improving Access to Psychological Therapies (IAPT) and specialist perinatal mental health services.

In 2014 there were 3,758 live births in Dudley (Public Health England, 2016).

Table 4: summary of key data relevant to maternal and child mental health during the perinatal period

|  |  |
| --- | --- |
|  | Number of women in Dudley |
| Live births in Dudley per annum (based on 2014 figures) | 3,758 |
| Women likely to experience poor perinatal mental health per annum (using 15% the mid-point between 10-20%) | 564 |
| Women likely to be experiencing common mental health problems per annum (using the midpoint of 14%) | 526 |
| Mothers with poor perinatal mental health likely to be identified (40%) | 225 |
| Of those identified, mothers likely to be receiving treatment (60%) | 135 |
| Of those treated, those likely to be treated *effectively* (40%) | 54 |

A further 18 mothers in Dudley gave birth to a stillborn infant in the last year of data collection (ONS, 2016). These mothers are at greater risk of poor subsequent mental health. (NICE, 2014).

**Maternal smoking**

Table 5: smoking during pregnancy in Dudley

|  |  |
| --- | --- |
| Number of mothers smoking during pregnancy in Dudley | 590 |

Exposure to tobacco in the womb has been linked to greater risk of conduct disorder later on (even after controlling for other high risk factors affecting poor child mental health such as socio-economic status, parenting quality etc.) (Zeanah, 2012). There is also believed to be a link between maternal perinatal smoking and ADHD and hyperkinetic conditions (Linnet et al.,2005, Mick et al., 2002). Reducing the numbers of mothers smoking during pregnancy is an important preventative activity.

In Dudley, 16% of mothers were noted with smoking status at the time of delivery compared with 12% in England making Dudley mothers roughly thirty percent more likely to smoke during this critical period (PHE, 2016).

**Maltreatment and exposure to violence**

Child maltreatment (including abuse, neglect and exposure to violence in the home through witnessing or experiencing domestic violence) has lifelong consequences; it represents a significant environmental risk for normal psychological and biological development often affecting children’s ability to control their emotions and behaviour (Cichetti, 2013). The longer experiences persist and the later risk is escaped, the worse the outcome for children’s mental health (Kumsta, et al., 2015). Studies have shown strong associations between all forms of maltreatment in childhood and a range of poorer child outcomes including depression, anxiety, post-traumatic stress, suicide, self-injury, severe and persistent behavioural problems, school failure, increased risk taking i.e. use of drugs and alcohol, sexual exploitation and crime (Lanktree et al., 2008; Gilbert et al., 2009; NSPCC, 2011). In 2006, the World Health Organisation (WHO) called for greater public health prominence to be given to this important risk factor affecting children’s outcomes (Gilbert, et al., 2009).

It is generally difficult to source accurate data on the prevalence of maltreatment due to low disclosure and identification. For every child formally identified as having experienced these difficulties, many more remain unidentified (MacMillan, et al., 2003).

A variety of data provides insight into the scale of maltreatment in Dudley. Children and young people in Dudley are more likely than other children nationally to be identified as a Looked After Child (Public Health England, 2016). In Dudley, they are also more likely to be taken into care due to abuse and neglect compared with the national average. For example:

* Rates of **Children in Need** were 27% higher than national averages (although children were marginally less likely to become a Child in Need due to abuse, neglect or family dysfunction)
* In Dudley, the rate of ‘**Children in Need for more than 2 years’** was roughly 40% higher than national averages (CHIMAT, 2016).
* Rates of children subject to a **Child Protection Plan** were broadly similar to national averages. The recent Ofsted Inspectorate Review of the Local Safeguarding Board (2016) noted that neglect was a risk factor in 40% of these plans, emotional abuse in 43%, physical abuse in 14% and sexual abuse in 2% of cases.
* Rates of **Looked after Children** under the age of 18 years were 82% higher than national averages.
* Dudley also had more than double the number of **Looked After Children per 10,000 under the age of five years** (97.8) compared to national averages (44.9 per 10,000). This rate was also 60% higher than West Midlands average (60.5 per 10,000).
* A recent Ofsted Inspection noted that 62% of **new admissions to care** during 2014/15 were for reasons of abuse and neglect, compared to 56% nationally.

Evidence from Gilbert *et al* (2009) suggested that around 16% (10,000) of infants and children under the age of 16 may be affected by maltreatment. This is a cautious estimate given historically low rates of disclosure.

**Family structure and other family risk factors**

There are associations in research between family structure, family working patterns and family physical and mental health and child mental health and emotional wellbeing. The most recent child mental health survey revealed that those with lone parents – particularly where lone parenting was the result of divorce, separation or bereavement were nearly twice as likely to have a diagnosable mental health problem than other families (Green, 2005). In families where no parent was working (including lone parents), children were twice as likely to have a diagnosable mental health problem. Children living in a household where a parent was drawing any disability benefit in 2004 were around 3 times more likely to develop a diagnosable mental health difficulty. Children in families in insecure accommodation were also roughly twice as likely to present with diagnosable difficulties. Children living in families with these characteristics and facing these challenges are likely to benefit from additional support (Green, 2005).

Dudley presents with a mixed picture in terms of these family risk factors. For example, on a positive note Dudley Metropolitan Borough has:

* slightly lower numbers of lone parents with dependent children
* markedly lower levels of family homelessness than the national average
* slightly lower numbers of parents in drug treatment than the national average
* fewer adults in the local population whose current marital status is separated or divorced (11%) compared with the national average (12%).

However, Dudley also had:

* a marginally higher percentage of children in households where no adult was working
* a much higher percentage of children in households where at least one parent has a long term disability
* higher than the national average rate (27 versus 22.25)[[3]](#footnote-3) of teenage conceptions for 15-17 year olds (although this rate has been falling and is now comparable to broader West Midlands rates which are 27.5 per 1,000). Teenage parents and their children are known to face higher levels of multiple challenges and undermined life chances including poorer educational achievement, social isolation and poverty (Swann et al, 2003).

No figures appear to have been collected on the numbers of parents in alcohol treatment in Dudley although this data is available for other localities nationally. This is an important gap in local information.

Table 6: Summary table for family risk factors and number of children affected in Dudley

|  |  |  |
| --- | --- | --- |
| Summary table for family risk factors and number of children affected in Dudley | | |
|  | Estimated percentage | Estimated number of children affected |
| Lone parents with dependent children | 6.7% | 4550 |
| Family homelessness | 0.6 per 1000 households | NK |
| Children in a household where no adult is in employment | 4.6% | 3120 |
| Children in households where at least one parent has a long term disability | 5.03% | 3415 |
| Estimated number of children (aged 0-15) with parents in drug treatment | 90.8 per 100K | 50 |
| Under 18 conceptions per 1000 | 27 per 1000 of 15-17 | 150 |

These challenges can in some instances expose children to prolonged stress which can be toxic to their wellbeing and can undermine parental energy to adopt positive parenting approaches which we know are critical for supporting good child mental health (Shonkoff & Garner, 2012; Khan, 2016).

**Early development and pre-school years**

School readiness is a measure of how prepared a child is to succeed in school, cognitively, socially and emotionally. Just as there is an achievement gap in school performance, there is a school readiness gap that separates disadvantaged children from their more affluent peers. School readiness can be seen therefore as a useful proxy for healthy child social, emotional and mental health development.

Children at the end of reception in Dudley were less likely than national and regional averages to have a good level of development at the end of the reception year (60.6% versus 66.3% and 64.3% respectively).

|  |  |
| --- | --- |
| Number of children in Dudley with poor school readiness | 7743 |

**Table 7: Number of children with poor school readiness in Dudley**

**School-age risk factors**

School environments provide additional or compensatory support to help children thrive emotionally and socially; they also expose children to additional environmental risks which can undermine their mental health and wellbeing (EIF, 2015; Khan, 2016).

**Bullying**

**The Health Behaviour in Schools survey and bullying (2016)**

*Primary schools*

In Dudley, 24% of primary school children (5,279) said they had been bullied in or near school in the last year in 2016.

Among bullied children:

* 62% had received nasty or threatening messages a few times, daily or often with text or instant messaging; 18% received such messages daily or often.
* around 10% were teased or called nasty names often or every day (38% if you include ‘a few times’)
* around 25% of primary school children were pushed or hit for no reason on a daily, frequent basis or a few times.

The most common reason for bullying was the way a child looked (14%) with race, colour and religion being the second most common reason for bullying (4%).

*Secondary schools*

In secondary schools, 23% of secondary school children (3,887) said they had been bullied at or near school in 2016. There had been a statistically significant (but weak) increase in the rate of bullying at or near school between 2014 and 2016.

Of those bullied in secondary school:

* around a third had been called nasty names with a weak but significant increase since 2014
* 21% had been hit for no reason with once again an increase since 2014
* 13% had been ganged up on (and this had increased by roughly a third compared with 2014)
* 12% had had something taken or broken – with an increase since 2014
* 11% had received nasty or threatening texts or instant messages (with a rise of just over a third since 2014)
* 11% had seen something nasty written about them online (again with a significant increase since 2014)

For those secondary school students who disclosed bullying, 20% were bullied about the way they looked with a (weak) statistically significant increase in the percentage citing this as the driver for bullying in Dudley schools between 2014 and 2016. There had also been statistically significant increases in bullying in secondary schools:

* because of size and weight (increasing from 10% to 13%)
* because of race, colour and religion (increasing from 3% to 5%)
* because of the clothes they wore (from 4% to 7%)
* due to sexuality (around 3%)
* and due to their disability (3%)

**Schools taking bullying seriously:** a third of secondary school students and three quarters of primary school children felt that their school took bullying seriously. There had been a statistically significant increase in the number of secondary school children feeling that concerns were taken seriously since 2014.

National comparative data on Dudley’s children suggests that they are less likely to report ever having been bullied (49.6%) than national and regional averages (55% and 54% respectively).

Evidence increasingly confirms that being a target of bullying in childhood, and particularly frequent bullying, has pervasive negative effects on children's mental and physical health, and social, educational and economic development which seem to persist for at least four decades (Takizawa et al, 2014).

In the US, based on these findings, calculations suggest that prevention of bullying could result in lifetime savings of over 1.4 million dollars per person (Masiello, et al., 2012; Wolke & Lereya, 2015). Those who are bullied and who also bully others face the poorest social, emotional and mental health outcomes - including a higher risk of suicide and imprisonment.

**Special educational needs**

Children with a diagnosable mental health difficulty are between two and ten times as likely as other children to fall behind in their intellectual development, have unauthorised absences from school, be excluded and have special educational needs (Green, 2004).

Based on Public Health England comparative data:

* 7,572 children in Dudley are estimated to have special educational needs.
* Dudley has a higher percentage of children identified with special educational needs than national and regional averages (17.1% versus 15.4% and 16%).
* However, Dudley has roughly comparable rates of young people with a special educational need statement.

**School exclusions**

Primary school exclusions are a useful proxy for early starting behavioural problems which we know are a marker for multiple poor and distressing life chances including poor mental health, increased risky behaviour, increased chance of entry into care and into the justice system etc (Parsonage, et al., 2014). On average, these early starters impose costs on society of approximately £260,000 per capita across their life course affecting many public sector budgets.

On a positive note, Dudley has largely similar rates of fixed period primary school exclusions as the national average; however rates of secondary school fixed period exclusions are higher (8.7% versus national rates of 6.6% and regional average rates of 6.3%).

**Disabilities and neuro disabilities**

Dudley has a higher percentage of children with learning disabilities than the national average although rates are only slightly higher than the regional average. It also has a much higher percentage of school age children with speech and language difficulties than national and regional averages (3.5% versus 2.26% and 2.19%).

On the other hand, it has a slightly lower percentage (0.87%) of school age children with autistic spectrum disorder than English and regional averages.

|  |  |  |  |
| --- | --- | --- | --- |
| Summary table for school based risk factors for children’s social, emotional and mental health and well being[[4]](#footnote-4) | | | |
|  | Estimated percentage | Estimated number of children affected in Dudley | Higher or lower than national average |
| Primary school children bullied in or near school | 24% | 5279[[5]](#footnote-5) | Lower |
| Secondary school pupils bullied in or near school | 23% | 3887[[6]](#footnote-6) | Lower |
| Pupils identified with SEN | 17.1% | 7572 | Higher |
| Pupils with a SEN statement | 2.92% | 1293 | Lower |
| Primary school fixed exclusions | 0.98% | 220 | Lower |
| Secondary school fixed exclusions | 8.7% | 1893 | Higher |
| Pupils with a learning disability | 6.54% | 2895 | Higher |
| Pupils with speech and language difficulties | 3.50% | 1550 | Higher |
| Pupils with autism | 0.87 | 385 | Lower |

Table 8: Summary table for school based risk factors for children’s social, emotional and mental health and wellbeing

**Safety**

78% of secondary school students had been the victim of violence or aggression in the area they live in Dudley in 2016. There had been a weak but significant decrease (from 80%) since 2014.

When secondary school students were asked about intimate partner violence:

* 4% of students said they had been in a relationship where a partner had made them feel scared
* 3% had been in a relationship where a partner had physically hurt them and 8% had been in a relationship where they had been emotionally hurt
* 3% had been in a relationship with a partner who had made them do things they did not want to do.

In all three instances there was a weak but significant increase in the occurrence of these events since 2014.

7% of secondary school students carried a weapon for protection ‘sometimes’, ‘usually’ (0.8%) or ‘all the time’ (1.6%) in 2016 with no difference in prevalence since 2014.

In 2014, young people at college were marginally more likely to worry about risk taking than in 2012 and fewer in 2014 said they sought out risk because they enjoyed the danger (6%) or when they were drunk (15%).

**Vulnerable and high risk groups in Dudley**

A number of young people have been noted in evidence reviews to present with higher risk of poorer social, emotional and mental health than other young people (Khan, 2016). Many children and young people from vulnerable groups have multiple needs and are often under served by statutory services. *Future in Mind* reinforces that these children need greater local focus and more engaging services (DH, 2015). This section will explore which groups appear to be over represented in Dudley.

**Looked After Children**

As outlined earlier, Dudley has a higher percentage of Looked after Children in its local population than regional and national averages.

They are likely to experience poorer social, emotional and mental health due to unhelpful attachments, higher exposure to risk factors and sub optimal experiences of family life undermining their ability to develop good mental health and well-being (Khan, 2016). To thrive and to avoid deteriorating mental health, these children need interventions which build assets and resilience and which address traumatic and attachment-related difficulties.

Because of experiences of abuse, many more of these children will also go on to experience diagnosable mental health difficulties. At least 45% of Looked after Children are likely to meet the criteria for having a mental illness - mostly conduct disorder (38%). Many have more than one mental health diagnosis (Ford et al. 2007).

Approximately 10% of young people enter group homes and their outcomes are the worst of all those in the care system. Children living in residential homes have very high rates of mental health problems with just under three quarters meeting criteria for a psychiatric diagnosis (Luke et al, 2004).

**Table 9: Likely numbers of LAC with diagnosable difficulties in Dudley based on Ofsted figures**

|  |  |  |
| --- | --- | --- |
| Likely numbers of LAC with diagnosable difficulties in Dudley based on Ofsted figures | | |
| Number of looked after children | Number of Looked After Children | Likely numbers of these children with diagnosable mental health condition |
| Number of Looked after Children from Dudley in community placements[[7]](#footnote-7) | 653[[8]](#footnote-8) | 261 |
| Number of LAC from Dudley in residential children’s homes | 55 (34 outside borough) | 41 (26 outside borough) |
| Of those looked after, number in foster placements | 529 | 212 |
| Of those looked after, number of children who reside in Dudley | 347 | 125 |
| Of those looked after, number of Dudley LAC who live outside borough | 361 | 130 |

In Dudley, 80% of children and young people had initial health assessments completed within timescales. This is below the England average of 90% and below the local authority target of 95%. The recent Ofsted report notes that performance has not improved since 2013/14 (Ofsted, 2016). However, there are 7% more looked after children being assessed for emotional and behavioural health assessments in Dudley compared to the national average and 24% more than the regional average.

Of the total number of children in care in Dudley (708), 478 are of school-age and 53% of these are taught in the borough. Attainment for children looked after at Key Stage 1 is below the national average in reading, writing and mathematics. This gap in attainment remains wide at 19 percentage points lower in reading, 25 percentage points lower in writing and 21 percentage points lower in mathematics.

**Care leavers**

Care leavers have poorer mental health and wellbeing than other young people. They are:

* 5 times more likely to self-harm as young people and adults
* Only half have normal range of emotional well being
* 22% become teenage parents
* 41% are not in education, employment or training (compared with 15% of other young people).

(Khan, 2016)

The most recent Ofsted report into children in the care system in Dudley noted that:

* there were 177 care leavers being supported by the 14 plus Looked After Children’s team
* 123 additional 16 and 17 year olds were eligible by age for care leaving services.

The rate of children under 18 leaving care (per 10,000) in Dudley in 2015 was 28.7 of the local child and youth population. As such, this is 7% more than the national average but broadly comparable with the regional average (PHE, 2016).

**Young carers**

Young carers provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, misuses substances or who suffers from a disability. An estimated 10% of young carers care for more than one person (The Children's Society, 2013) and 30% of young carers support parents with mental health problems (Dearden & Becker, 1998). More girls and young women are young carers than boys and young men – and the care provided increases as young people grow older.

When the level of care-giving becomes excessive or inappropriate, young carers can become vulnerable, risking their own physical and emotional wellbeing or educational achievement and life chances (ADASS and ADCS, 2009). Evidence suggests that they experience higher levels of stress, anxiety, low self-esteem and depression, eating and sleeping problems and self-harm than other children (SCIE, 2005). Around 5% reported missing school.

The percentage of children aged below 15 years, providing unpaid care in Dudley is roughly comparable with national averages (1.03% versus 1.11%). The number of young people aged between 16-24 years who provide unpaid care *was higher* in Dudley (5.8% versus 4.8%) compared with the national average.

In the Health Behaviour in School Survey in 2016, 10% of young people in secondary school said they had missed school due to caring responsibilities. There had been a weak but significant decrease in the number of young people missing school for this reason compared with 2014.

**Table 10: Summary data: broad estimates of number of young carers in Dudley**

|  |  |
| --- | --- |
| Summary data: broad estimates of number of young carers in Dudley | |
|  | Likely number of young carers by age band |
| Young carers < 16 years providing care | 380 |
| Numbers of secondary school children missing school due to caring responsibilities | 1780 |
| Young carers > 16 -24 | 1,700 |

**Young people in the Youth Justice System**

Children on the edge of or in the youth justice system have multiple health and social vulnerabilities (many below the threshold for specialist help at earlier ages) with trauma, multiple bereavements and poor attachment commonly forming part of their developmental experiences. Young women in the system have been noted to have particularly high levels of vulnerability – particularly those disclosing gang involvement (Khan, 2013). Other vulnerable populations frequently end up in the youth justice system including those at risk of or victims of sexual exploitation, Looked after Children, those with mild to moderate learning disabilities (Khan, 2010), young people reliant on substances, those with learning and neuro disabilities and children with speech and language difficulties (Bryan, 2007).

Children under the age of 18 in the youth justice system are at least three times more likely than average to have a diagnosable mental health difficulty. Within this age group symptoms can sometimes be masked by non-clear-cut presentations and aggressive behaviour. By late adolescence, 90% of 16 to 20 year olds in custody were noted with a diagnosable mental health difficulty with almost all having more than one diagnosable condition (Singleton et al., 1998).

Every local authority collects information on the number of first time entrants to the Youth Justice System. First time entrants are defined as young people (aged 10 to 17) who receive their first substantive outcome (relating to a warning, caution, conditional caution or a court disposal for those who go directly to court without an out of court disposal).

In 2015, Dudley had largely similar rates of first time entrants into the youth justice system per 100,000 compared with English averages (460 per 100,000 versus 409 per 100,000) (PHE, 2016). Rates of first time entrants appeared higher than the national average for younger age groups but seemed to improve (or decrease) in comparison to national averages between 15 and 18 years – with particular improvements noted among 17-18 year olds in the locality (Public Health England, 2016).

Based on 2015 First Time Entrant rates, this suggests that roughly 135 young people a year aged 10 to 17 years enter the youth justice system for the first time with approximately 45 to 70 of these children likely to have a diagnosable level difficulty (most likely conduct disorder) (Chitsabesan et al, 2006) (Stallard, et al., 2003). Many more will have generally poorer mental health and wellbeing than other children in Dudley requiring input to build assets and resilience and to reduce risk factors preventing further escalation.

The published reoffending rate for young people on the YOT caseload in Dudley was 32.6%. This was a slight deterioration compared to the previous year but much better than the England and Wales average of 37.8% (HM Inspectorate of Probation, 2016).

**Children with chronic or long term conditions**

Somewhere between 10-15% of children under the age of 16 will have a chronic physical health condition (Weiland *et al,* 1992). Studies indicate that these children have at least a twofold greater chance of developing a psychiatric condition. For some physical health conditions (e.g. those affecting the central nervous system) the risk increases to approximately fivefold.

Taking a midpoint in cited prevalence rates, this means that around 7500 children and young people under the age of 16 in Dudley will have a diagnosable mental health condition.

Table 11: Number of Under 16 year olds with a chronic physical health condition in Dudley

|  |  |  |
| --- | --- | --- |
|  | Number of young people | Those likely to have a diagnosable mental health condition |
| Under 16 year olds with a chronic physical health condition in Dudley | 7500 | At least 1500 |

**Children with learning disabilities**

Children with learning disabilities face higher levels of mental health difficulties compared with those without such disabilities. They are:

* 33 times more likely to have an autistic spectrum condition;
* Eight times more likely to have attention deficit and hyperactivity condition;
* Six times more likely to have a conduct disorder;
* Four times more likely to have a diagnosable emotional mental health problem;
* Three times more likely to have psychosis as they move into adolescence/early adult years;
* Nearly two times more likely to have a depressive disorder.

(Emerson and Hatton, 2007)

In 2015, 6.54% of the school-age population in Dudley were identified with a learning disability; this is significantly higher than the English average.

**Table 12: Summary data: number of school-age children with learning disabilities with broad estimates of likelihood of diagnosable mental health difficulties**

|  |  |  |
| --- | --- | --- |
| Summary data: number of school-age children with learning disabilities with broad estimates of likelihood of diagnosable mental health difficulties | | |
| Likely number of school-age children with learning disabilities | 6.5% | 2,627 |
| Of these, children, estimate of numbers likely to have a diagnosable mental health difficulty | 36% | 850 |
| Of these, children with a learning disability, estimate of number likely to have an autistic spectrum condition | 8% | 210 |
| Of these, children, estimate of numbers likely to have a ADHD | 8% | 210 |
| Of these children, estimate of numbers likely to have three coexisting diagnosable difficulties | 3% | 80 |

**Children and young people with substance misuse needs**

Alcohol is the most common substance used by 11-15 year olds and has been linked to a range of poorer mental health outcomes for teenagers. For example:

* Pupils with low wellbeing and taking other risks were more likely to have drunk alcohol in the last week (Fuller, et al., 2015)
* Alcohol may increase symptoms of depression and the likelihood of other mental health difficulties emerging (Newbury-Birch et al, 2008)
* Drinking as a result of stress or anxiety has been associated with long term and more negative consequences (Institute of Alcohol Studies, 2013).

Nationally, alcohol consumption among this age group has been reducing in recent years with one of the highest rises in teetotalism among 16 to 25 year olds (ONS, 2015). However, for those who have continued to drink, binge drinking has continued to rise. There is also a suggestion that patterns of use are worsening among vulnerable children.

Nationally available figures suggested that Dudley had a marginally higher percentage of children and young people who said that they were drinking alcohol compared with national averages (18% compared with 15%[[9]](#footnote-9)). Dudley also had relatively higher rates of child inpatient admissions per 100,000 for alcohol admission in 2013-14 for under-18 year olds (51.8 versus 41.7) compared to other areas.

**The Health Behaviour in School Survey revealed that:**

* 6% of primary school children had consumed more than just a sip of alcohol in the last seven days. This had not changed from 2014.
* 6% of secondary school children drank alcohol about once a week or at least once a week. 9% drank about once a month. There had been no significant change in consumptions patterns since 2014.
* around 12% of college students drank alcohol in 2014 about twice a week or every day. There had been a (weak but) significant decrease since 2012 in these rates of consumption.

The last national survey of child and adolescent mental health (Green 2005) revealed that young people with a diagnosable mental health difficulty were between two and eight times as likely to be using illegal substances. Furthermore, although drivers for poor mental health are multiple and complex, there is increasing evidence that use of some drugs can worsen mental health and wellbeing particularly during critical periods of adolescent brain development, the earlier a young person starts using, the more often they use drugs, if they have histories of trauma or abuse and if a family member has been predisposed to cannabis-related psychosis (Di Forti, et al., 2012; Chadwick, et al., 2013; Radhakrishnan, et al., 2014; National Institute on Drug Abuse, 2015).

Rates of children who said that they used drugs in Dudley were broadly comparable to national averages (5% compared with 4%[[10]](#footnote-10)) as were most recent reports of child hospital admissions due to substance misuse between the age of 15-24 years compared to the national average (92.6 per 100,000 compared to 81.3 per 100,000).

The Dudley Health Behaviour in Schools Survey indicated that:

* around 2% of secondary school children used drugs almost daily, twice a week, about once a week and monthly; there had been no significant increase since 2014 in these rates.
* 6% of college students used drugs sometimes, often or most days.

**Table 13: Summary data: broad estimates of number of children misusing substances in Dudley**

|  |  |  |
| --- | --- | --- |
| Summary data: broad estimates of number of children misusing substances in Dudley | | |
|  | % | Likely number of children and young people affected in Dudley |
| Primary school children who had had more than a sip of alcohol in the last 7 days (2016) | 6% | 1,351 |
| Secondary school children who drank alcohol about once a week or at least once a week (2016) | 6% | 1,074 |
| College students drinking alcohol ‘often’ or ‘most days’ | 12% | 3,986 |
| Secondary school students using drugs almost daily, twice a week, about once a week and monthly (2016) | 2% | 358 |
| College students using drugs sometimes, often or most days (2014) | 6% | 1,993 |
| Estimate of annual child inpatient admission rate for alcohol specific conditions in 2013-14 for under 18 year olds per 100,000 of population (2010-14) | 51.8% | 35 |
| Estimate of annual youth inpatient admission rate for substance misuse specific conditions for the 15 to 24 year age band per 100, 000 of population[[11]](#footnote-11)(2010-14) | 92.6 per 100,000 | 30 |

**16-18 year olds not in education employment or training**

Young people not in education, employment or training have poorer wellbeing, less hope about the future, feel more socially excluded and have poorer mental health than other young people (The Prince’s Trust, 2015; Simmons et al, 2014).

As of January 2016, at 3.8%, Dudley had slightly lower rates of young people aged 16 to 18 years of age not in education, employment and training compared to national and local averages (5.7% versus 4.3% respectively)[[12]](#footnote-12). This means that around 430 young people aged 16 to 18 years will face such challenges at the current time.

**Children at risk of or who are victims of sexual exploitation**

There is currently poor national data on numbers of children and young people at risk of or who are victims of child sexual exploitation. Best estimates are that between 6% and 15% of under 16 year olds are known to be victims of sexual abuse (Cawson, et al., 2000; Radford, et al., 2013) although low levels of disclosure (only 2 out of 3 disclosed when an adult was the perpetrator and only 1 in 5 where a peer was involved) are also noted in studies suggesting actual levels may be higher (Radford et al, 2013). Almost all victims are young women (9 out of 10) and the average age of identification is 15 years although abuse had often taken place for a prolonged period before disclosure (Health Working Group Report on Child Sexual Exploitation, 2014).

Many sexually exploited young people, like those in the justice system and those in care, have multiple risk factors for poor outcomes and overlap with other higher risk groups (half were children who had gone missing, a quarter were in care, two thirds were not attending school).

In addition:

* 41% had substance misuse problems;
* 32% were self-harming;
* 39% had suspected sexual health problems;
* 73% suffered with some PTSD symptoms;
* 57% were identified as suffering with depression;
* Over half presented with separation and anxiety disorder.

(Health Working Group Report on Child Sexual Exploitation, 2014).

In 2015/16, Dudley began to collect quarterly data on victims or potential victims of child sexual exploitation. Victims ranged from 13 to 17 years of age.

Table 14: Summary data: Children identified during quarter 3 of data collection as being at risk of, or victims of, child sexual exploitation.

|  |  |
| --- | --- |
| Summary data: Children identified during quarter 3 of data collection as being at risk of, or victims of, child sexual exploitation (March 2016). | |
|  | No of children |
| Number of new children identified over the last year | 80 (7 per month) |
| Total CSE caseload during last quarter | 94 |
| Percentage of children assessed as currently being exploited and at ‘serious risk’ | 14% |
| Percentage of children assessed as actively being targeted | 14% |
| Of these children, estimate of number likely to suffer from depression or anxiety related conditions | 50 |
| Of these children, estimate of number likely to have substance misuse difficulties | 25 |
| Of those identified, estimate of number likely to have diagnosable depressive | 30 |
| Of those identified, estimate of number likely to have *some* symptoms of PTSD | 69 |

**Lesbian, gay, bisexual and transgender (LGBT) children and young people**

LGBT children and young people are at higher risk of:

* being bullied (55%)
* poorer mental health
* self-harming compared to other young people (more than half).

Seven out of ten LGBT girls and six out of ten LGBT boys had experienced suicidal thoughts; boys from BME communities had the highest rate of suicidal thoughts affecting nearly eight out of ten (Statham, et al., 2012).

**Children with a parent in prison**

Studies suggest that children of prisoners are twice as likely to have mental health problems during their life course (Nacro, 2005; SCIE, 2008). These children also face poorer social, educational and mental health outcomes. There is currently poor national data on the numbers of children with a parent in prison.

**Assessing social, emotional and mental health need in Dudley**

In order to thrive, all children need positive and mental health promoting family, school and community environments from the first spark of life. They also benefit from being helped to develop coping skills and resilience to deal with adversity. Some children, who experience a deterioration in their mental health and wellbeing, need early help to promote protective factors supporting positive mental health thereby reducing further escalation; if they become unwell, they need prompt NICE guidance recommended help which has the best chance of facilitating swift recovery. In the case of children and young people, such interventions are less likely to be medical interventions and more likely to be talking therapies, psychosocial and family based interventions.

As such, when planning to meet children’s needs effectively, rather than an approach which merely responds to diagnosable needs, there is a need for a whole life and whole system strategy to build, promote, preserve and restore mental health and emotional wellbeing.

There is no clear-cut and simple formula for working out how many infants, children and young people require what range of services across this whole spectrum of need. Many methodologies used previously to plan services are not sufficiently focused on mental health promotion and early intervention and are more focused on diagnostic presentations and the largely out of favour tiered system. In order to assess the scale of likely need and the extent to which this is met through current investment and resources, the Centre has adapted and updated Kurtz’s (1998) service planning methodology (an explanation of adaptations follows in Appendix 1). In the interests of simplicity, the Centre will consider need across three different age bands to facilitate planning, commissioning and providing services at these different stages of need.

**0-5 year olds**

There are around 19,652 infants and children aged 0 to 5 in Dudley based on recent population estimates. During routine contact with universal primary care, maternity services and the Healthy Child Programme, families benefit from help that focuses both on the physical *and* emotional wellbeing of their child and of the broader family. This can include the role played in an infant’s development by positive attunement, which ‘jump starts’ infant’s cognitive and emotional health, sensitive and positive parenting and of attachment which helps children to self soothe and regulate emotions and behaviour over time.

Infants and toddlers frequently pass through transient socially and emotionally challenging ‘phases’ during early years which subsequently resolve as part of normal child development (Olds, et al., 1997). However, some children, exposed to high and ongoing levels of environmental and family risk, get stuck in negative patterns of relating to the world around them which can be distressing and damaging for both child and parent/carer.

In terms of what we know about families at risk during early years, based on locally available data:

* Around 500 mothers a year in Dudley will have diagnosable mental health difficulties ideally needing fast track access to Improving Access to Psychological Therapies or to specialist perinatal/secondary mental health care
* Around 3,000 mothers will smoke during pregnancy
* Around 150 parents will have under age conceptions
* Around 3,000 children in this age group in Dudley may experience maltreatment (Gilbert et al 2009)
* Around 4,000 children in this age band may also be living in poverty in Dudley
* Some will experience many or all of these challenges at once.

**Prevalence of severe mental health problems among preschool children**

We currently lack good quality UK data on the prevalence of pre-school diagnosable level social, emotional and mental health difficulties. The new child psychiatric morbidity survey will for the first time include under-fives in its survey reporting back in 2018. In the absence of good data, our best indicator of the scale of need comes from international evidence reviewed by Eggar and Angold, 2006 who note a mid-point of around 20% for the prevalence of these more severe social, emotional or mental health difficulties during early years. Table 15, estimates the number of under five year olds likely to present with diagnosable level difficulties in Dudley.

Table 15: Pre-school prevalence rates for diagnosable disorders

|  |  |  |
| --- | --- | --- |
| Pre-school prevalence rates for diagnosable disorders[[13]](#footnote-13) |  | Estimated numbers of children in Dudley aged 2-5 years with diagnosable difficulties |
| Any diagnosable mental health condition | 20%[[14]](#footnote-14) | 2,357 |
| Hyperactivity conditions | 4% [[15]](#footnote-15) | 472 |
| Any diagnosable severe behavioural difficulty | 9% | 1,061 |
| Any diagnosable emotional difficulty | 13%[[16]](#footnote-16) | 1,532 |

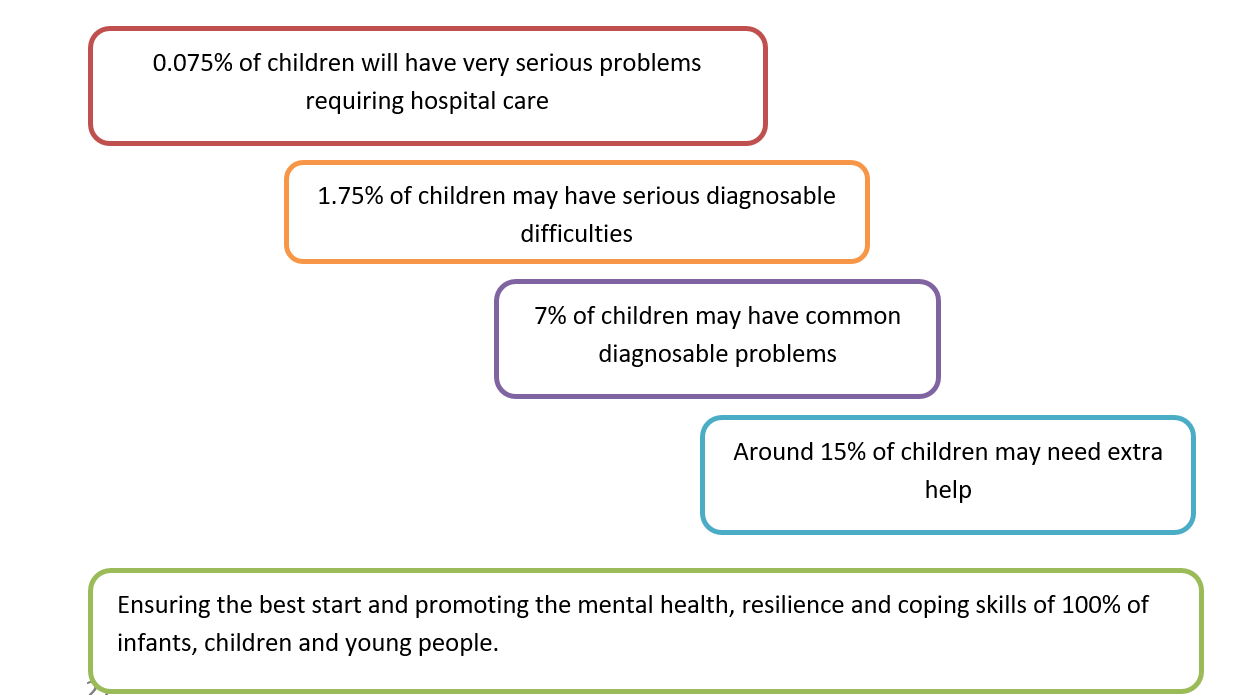
Taking all of these factors into account, The Centre provides the following very broad estimates of likely need based on 2015 estimates of the 0-5 child population.

**Figure 3: assessing scale of social, emotional and mental health needs among 0 to 4 in Dudley**

**5 to 10-year-old children in Dudley**

Between the ages of 5 to 10 years, around 8% of children will have a diagnosable mental health difficulty (Green, 2005). Many will also have emerging or escalating problems benefitting from early help to reduce environmental risk factors and strengthen assets undermining children’s mental health. Going to school is often the most important environmental change for children at this age, bringing with it challenges that may undermine social, emotional and mental health as well as opportunities to strengthen and preserve wellbeing. There is strong evidence that good quality school based whole-population programmes (e.g. The Good Behaviour Programme and to a lesser extent PATHS) help children at this age develop social and emotional skills and coping abilities. They help strengthen mental health and prevent later poor social and emotional outcomes and costly crises (Durlak, 2010; WSIPP, 2016). There is evidence that use of these programmes benefits a range of local commissioners/stakeholders including schools, social care, justice and health (Knapp, 2010; WSIPP, 2016). To be effective, programmes need to be delivered within the context of a whole school culture promoting children’s social, emotional and mental health (Durlak, 2010).

**Assessing the scale of mental health need for 5 to 10-year-old children in Dudley**

Kurtz (1996) created a methodology for establishing how many young people might present with varying levels of need requiring different levels of ‘stepped’ support. This methodology is linked to the out of favour tiered system. It also fails to reflect evidence reinforcing the importance of all children and young people needing mental health promotion to develop resilience and coping skills as they face adversity. On the plus side, based on available evidence it provides a formula which local areas can use to calculate how many children might have health compromising risk factors or need help *before* they become unwell. It also divides those children who are unwell into those with common mental health problems (which can be met by a range of Nice guidance compliant school, health, voluntary sector and parenting services) and those with less common and serious mental illnesses who are more likely to need more specialised mental health services.

**Figure 4: Centre for Mental Health’s adaptation of Kurtz’s methodology (1996) for evaluating the local scale of mental health need**

We have used an adapted version of Kurtz’ CAMHS planning formula (see figure 4) to assess need in Dudley for 5 to 10 year olds.

Figure 5: numbers of children in Dudley aged between 5 and 10 years of age needing support to promote, preserve and restore good mental health using adapted model of need set out by Kurtz, 2001.

**Detailed breakdown of prevalence**

About 8% of children in this age group will have a diagnosable level mental health need (Green, 2005). Most needs should be met through NICE guidance compliant parenting support or primary care/targeted therapeutic services.

The following table provides a rough breakdown of how many children aged 5-10 are likely to have different types of diagnosable needs in Dudley.

Table 16: Likely prevalence of diagnosable conditions in Dudley’s primary school age children

|  |  |  |
| --- | --- | --- |
| Likely prevalence of diagnosable conditions in Dudley’s primary school age children[[17]](#footnote-17) | Number of children aged 5-10 based on current population | Number of children based on anticipated reduction of 1% in 2020 population |
| Diagnosable level conduct problem | 1,126 | 1,115 |
| Diagnosable level emotional problems | 541 | 536 |
| Diagnosable level hyperkinetic conditions (e.g. ADHD) | 360 | 356 |
| Likely to meet threshold for diagnosis with autism | 225 | 223 |
| Likely to have other diagnosable conditions | 90 | 89 |
| Total number of 5-10 year olds in Dudley with a diagnosable level need[[18]](#footnote-18) | 1,734 | 1,717 |

Around 3400 more children will also have subthreshold needs or face risk factors undermining their resilience requiring early multi sector targeted help.

**Gender**

At this age, boys are twice as likely as girls to have poor social, emotional and mental health which generally manifests as severe and persistent challenging behaviour.

**Children from BAME communities**

There is poor national data from previous surveys on the extent to which children from BAME communities differ in terms of their mental health and well-being at this age. However, the most recent sweep of the millennium longitudinal study cohort indicated that children of mixed heritage had a higher chance of suffering diagnosable difficulties at age 11. Children from families identifying themselves as ‘Indian’ generally had much better mental health than their peers and had less chance of having a diagnosable difficulty (Morrison Gutman, et al., 2015). It should be noted, however, that despite being on a generally level playing field as children, Black boys and South Asian girls experience worse mental health outcomes as they transition into adult years.

**Young people aged 11-15 years**

Children and young people in secondary school can benefit from:

* whole school approaches and whole school population social and emotional learning and skills programmes building resilience and preventing the escalation of problems
* access to early help to de-escalate mounting problems
* a range of accessible NICE guidance recommended interventions – which have the best chance of promoting recovery. The majority can be delivered by a range of providers at targeted/primary mental health care level; some more serious mental health issues will require specialist support. However, help should feel relevant and be focused on the goals and aspirations which are important to children and young people.

Children who are more vulnerable to poor mental health (and their parents or carers) need more targeted and outreaching support to strengthen resilience and address risks to their mental health and emotional wellbeing (DH, 2015) (Young Minds, 2016).

Using Kurtz’ adapted formula (1996), Figure 7 assesses the likely scale of social, emotional and mental health needs among 11-16 year olds in Dudley.

Figure 7: numbers of young people in Dudley aged between 11to 16 years of age needing support to promote, preserve and restore good mental health using adapted model of need set out by Kurtz, 2001.

Table 17: Likely prevalence of diagnosable conditions among Dudley’s 11-16-year-old school age population

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Likely prevalence of diagnosable conditions among Dudley’s 11-16-year-old school age population. [[19]](#footnote-19) | | Numbers based on current population projections | | Numbers based on 2020 population projection (-1%) |
| Diagnosable level conduct problem | 1,181 | | 1,169 | |
| Diagnosable level emotional problem | 895 | | 886 | |
| * and who meet the criteria for PTSD | 54 | | 53 | |
| Diagnosable level hyperkinetic conditions (e.g. ADHD) | 251 | | 248 | |
| Likely to meet threshold for diagnosis with autism | 143 | | 142 | |
| Likely to have an eating disorder | 72 | | 71 | |
| Likely to have any other diagnosable condition | 54 | | 53 | |
| Any diagnosable difficulty[[20]](#footnote-20) | 2,058 | | 2,037 | |

At this age, young men have poorer mental health than young women – although the gender gap begins to narrow. Young men are more likely to present with behavioural difficulties; girls are more likely to experience emotional difficulties.

We generally lack up to date information on prevalence; however, based on data from recent UK longitudinal studies, there is some suggestion that despite suspected improvements of late in rates of conduct disorder, emotional problems at this age (and therefore girls’ mental health) may be getting worse (Collishaw, 2015). The most recent psychiatric survey completed for young people aged 16 to 24-years has indeed revealed a relative stabilisation in young males’ mental health but a deterioration in young women’s mental health (McManus, 2016). However, we will not achieve greater certainty about time trends for the school-age cohort until after the child and adolescent national survey is completed in 2018.

In 2016, The Health Behaviour in Schools Survey for Dudley noted that 16% of students in this age group self-harmed, with 5% harming themselves often or always. This rate was weakly but significantly higher than in 2014. We know that young women and LGBT young people are much more likely to report self-harming than other young people. Self-harming is also much more common among young people with diagnosable level mental health difficulties.

Table 18: Self-harming rates among secondary school children based on the HBSC survey (2016)

|  |  |  |
| --- | --- | --- |
| Secondary school students… | Percentage | Likely number of students affected in Dudley in secondary school |
| Self-harming often and always in 2016 | 5% | 895 |
| Self-harming rarely, sometimes, often, always in 2016 | 16% | 2,863 |

**Suicide**

There is no reliable data on the number of young people with suicidal thoughts or who have attempted suicide in this age band. Overall in England in 2014, there were 4 deaths by suicide among 10 to 14 year olds and 40 deaths for 15 to 19 year olds (a rate calculated as 2.5 per 100,000 young people).

**Young people aged 16 to 24 years**

The most recent national adult psychiatric morbidity survey (McManus, 2007) revealed that at least a quarter of young adults aged 16-24 years suffered with a diagnosable level mental health difficulty (not including substance misuse reliance and self-harming behaviour or those diagnosed with developmental difficulties such as autism). There had been a 6% increase overall in common mental health conditions among this age group since 2007. For young women, there had been a 19% increase in such conditions since 2007 whereas for young men there had been a 23% decrease over the same period. These surveys also provide some information on the scale of sub threshold social, emotional and mental health need for some but not all conditions (e.g. this information is available for eating disorders and adult ADHD). Understanding how many young people might have rising or sub threshold needs is important as there should still be a focus at this age on supporting those with escalating difficulties. Some of these sub threshold problems will resolve themselves naturally but for others such deteriorations in mental health may be a sign that they need help to prevent distressing and damaging crisis.

Adolescent years are the peak age for the first emergence of serious mental illness with three quarters of psychiatric conditions starting by age 24 (Kessler et al, 2005). There is good evidence that intervening early is important, having potentially long term benefits to the young person, to the public purse and to society more broadly (Knapp,2010; (Patel, et al., 2007). There is also evidence that limiting the length and recurrence of diagnosable level conditions during teenage years reduces the chances of such episodes repeating during adult years (Patton, 2014).

As with earlier stages in a child and young person’s life, for those with diagnosable level conditions, there are a range of NICE recommended interventions which can improve the chances of a young person’s recovery. However, good youth mental health needs to sit on a firm foundation of activity in college (or in the workplace) to support strong social and emotional skills and coping mechanisms as young people continue to negotiate challenges and setbacks. At this age, in the workplace or in college/university, there is less opportunity to draw young people into universal programmes to develop social, emotional and mental health skills but there may be opportunities to support self-care, develop universal mental health awareness raising, skills building and signposting through whole college/workplace mental health and wellbeing initiatives; through developing peer champions and through use of social media and websites.

Extent of social, emotional and mental health need among Dudley young adults

Table 18:

|  |  |  |
| --- | --- | --- |
| Likely numbers of 16-24 year olds in Dudley with diagnosable level and sub threshold mental health difficulties based on 2016 population estimates. | | |
|  | Likely diagnosable level rates (based on 2016 population estimate) | Estimate of lower level difficulties/symptoms who may need some support (based on 2016 population estimate)[[21]](#footnote-21) |
| Common mental health difficulties (e.g. anxiety and depression) | 5,747 | 5,149[[22]](#footnote-22) |
| PTSD – current positive screen | 2,658 | NA |
| Eating disorders | *1,163[[23]](#footnote-23)* | *4,352* |
| ADHD | 4,850 | NA |
| Psychosis | 166 | NA |
| Bi Polar symptoms (7+ characteristics with impairment and several at a time) | 1129 | 7507 |
| Anti-social personality disorder | 1628[[24]](#footnote-24) | NA |
| Borderline personality disorder | 1893 | NA |

**Suicide and self-harm**

In 2014, The Health Behaviour in College-aged students Survey for Dudley noted that 18% of students in this age groups acknowledged self-harming with 3% harming themselves often or always. This was a weak but significant decrease from 2012.

|  |  |  |
| --- | --- | --- |
| College students… | Percentage | This rate applied to 16-24 age band |
| Self-harming often or always in 2014 | 3% | 991 |
| Self-harming rarely, sometimes, often, always in 2014 | 18% | 5,979 |

Based on 2007 data, about 1,462 young people aged 16 to 24 years in Dudley would have made a suicide attempt at some point in their life(McManus et al, 2007). Young men are more likely to complete a suicide attempt.

Based on 2014 national suicide rate data, there is a very low risk that any young person aged 15 to 18 years would commit suicide (2.5 per 100,000); in the 19 to 25 age group around 1 young person would be projected to commit suicide in the borough.

**Views on what undermines child mental health in Dudley**

During consultations for this needs assessment, parents, carers and young people identified a number of factors which they saw undermining children and young people’s social, emotional and mental health in Dudley. These included:

* ‘you get judged all the time’: children and young people report feeling that they were increasingly being ‘judged’ from a young age by parents (sometimes), peers, and academically. They felt that this was detrimental to their well-being.
* Judgement in the form of academic pressure – seen as sometimes detrimental to good mental health
* parents/carers and young people mentioning bullying as a factor that undermined children and young people’s mental health.
* That ‘people like to put you down’ – a tendency on social media and in schools to turn on others and put someone down if they looked happy, did well or achieved something.
* maltreatment (often unidentified and persisting over time), trauma (violent attacks) and bereavements were cited in discussions as events undermining children and young people’s mental health and wellbeing
* transitions between primary and secondary schools and then later between school and college were seen as critical points of difficulty emotionally
* social media: ‘access to the internet’ and ‘easy access to social media, pornography, violence’ - raised by both parents/carers and young people and with young people feeling that their parents needed help becoming wiser about the impact of social media on their lives.
* Not being able to get trusted help when they needed it.

|  |  |  |  |
| --- | --- | --- | --- |
| **Summary of services raised through this consultation to support children and young people’s social, emotional, mental health and well-being in Dudley[[25]](#footnote-25)** | | | |
| **Stage 1: UNIVERSAL**  **Screening, promotional, preventative work in universal services** | **Stage 2: VULNERABLE**  **Targeted services enhancing work of universal services** | **Stage 3: COMPLEX**  **Multi-disciplinary specialist services** | **Stage 4: ACUTE/CRISIS**  **Specialist services for highest levels of need** |
| **Early Help universal offer including Healthy Child Programme**   * Ante-natal & post-natal services (Midwifery & Health Visiting) * Maternal mental health (Midwifery & Health visiting)   + *‘listening visits’ to track mother’s mental health* * Family Centres and health visiting   + Solihull parenting approach   + Child health & development reviews (Health Visiting) * Family support workers * School Nursing (Healthy Child Programme 5-19)   **Primary care services – GPs**  **A&E**  **Schools**   * Some Whole School/College approaches (including anti-bullying approaches) - patchy * Pastoral Care & nurture groups– *valuing more support* * Personal, Social and Health Education *(gap in colleges & few SEL programmes mentioned)* * Healthy Schools support programme & school nursing * Head Teachers Fora and networks– support work * Kooth online counselling * The What?Centre school drop-in   **Family Information Service directory of help** | **Early Help universal plus offer**   * Midwifery and Health Visiting ‘listening visits’ & targeted work * Family Centres – targeted work * School Nursing * Triple P parenting support for CYP with conduct problems * Connexions * Improving Access to Psychological Therapies service (16+) * Mellow Babies   **Counselling and targeted mental health support**   * School Counselling service – traded service via Education Psychology * Other counselling commissioned directly by schools; * Nurture groups and mentoring commissioned only by some schools * Kooth online counselling (available only in some schools) * The What?Centre (not commissioned for 18+) * Special Educational Needs provision and Education psychology service (half LA commissioned/half traded service)   **Vulnerable groups**   * The Phase Trust * Switch substance misuse service * Community Paediatricians * Social care and looked after children teams * Alternative education provision * CSE team * Teenage outreach nurse * NHS all age health point of arrest Liaison and Diversion screening (10+) * Youth offending service * Top Church Training (homeless young people) * Dudley Foster Carers * The What?Centre’s LGBT support group * Families First/ Troubled Families | **Specialist & targeted services (assessment, intervention & treatment)**   * Child & Adolescent Specialist Service Team * CAMHS Learning disability team * Deaf CAMHS team (0-18 years) * MDT neuro-developmental panel and Team * The What?Centre * Multi Systemic Therapy (for small group on edges of or in care) * Flipside   + (Multi-dimensional treatment fostering)   + KEEP * Barnardo’s sexual abuse counselling * Young Offenders CAMHS * ***Children Looked After specialist CAMHS (depleted resources and soon will no longer exist)*** * Families First/Troubled Families (for families facing multiple and complex challenges) * CSE team – ***lacking specialist mental health support*** * Family Nurse Partnership * Multi-Agency Safeguarding Hubs (MASH) * Mellow parenting | **Highly specialist and resource intensive services**   * Tier 4 in-patient CAMHS services * Special school provision for children with social, emotional and behavioural needs * Social Care – Stage 4 Child Protection Services * Continuing Care for those in OoB Placements including those sentenced to custody in the youth justice secure estate |

**Workforce consultation on social, emotional and mental health needs of children and young people aged 0-20 in Dudley**

In Dudley, 195 strategic and clinical leads, managers, service providers, practitioners, teachers and foster carers were consulted as part of this assessment of social, emotional and mental health need. A list of local stakeholders was developed in consultation with Dudley Public Health with contacts added as a result of local intelligence built up during the course of this consultation. The majority of respondents were from the general child, youth, family/social care or educational workforce.

Consultation took place through:

* Four focus groups reaching 106 members of the Dudley workforce
* 57 survey responses (many surveys were ‘snowballed out’ via key contacts so it is difficult to comment on percentage response rates)
* 29 telephone or face to face interviews with key practitioners/providers (with a small minority also attending focus groups and thus counted twice)
* Focus group with eight parents and carers
* Focus group with 15 young people.

Qualitative and quantitative findings from the consultation were triangulated creating a hierarchical framework of key themes and priorities.

**Key findings**

Most of the workforce responding to the survey (83%) agreed that children’s mental health and wellbeing was the responsibility of everyone in contact with children, young people, families and carers in Dudley. A strength identified through the workforce consultation was the passion and the commitment of frontline staff in Dudley to try and get it right and improve children and young people’s mental health, wellbeing and life chances.

**A lack of mental health promotion, preventative activity and early intervention**

There were widespread concerns about inadequate early intervention and preventative work in Dudley to build strong child and youth mental health and to reduce the impact of cascading risk factors as a child grew. A lack of integration across different child developmental stages and across different sectors who might potentially support children’s mental health was also seen to hinder the development of strong child and adolescent mental health and wellbeing.

For example around three quarters of the workforce felt that Dudley services were ill equipped:

* to prevent child and youth mental health problems
* to identify and support children at an early stage
* to prevent the escalation of mental health crises.

Nearly 9 out of 10 respondents felt that services were not doing enough to promote and strengthen the wellbeing and mental health of children in Dudley and only 18% felt that Dudley’s parents, young people and children were adequately helped to look after their mental health. The need to improve the quality and consistency of support to strengthen children and young people’s resilience and coping skills and to build strong self-esteem was a recurrent theme during focus groups and among qualitative survey comments.

Responses also highlighted key ‘missed opportunities’ for early intervention as children began to accumulate risk factors. These included:

* a relatively high degree of confidence (72%) in the workforce’s ability to *identify* maternal mental health difficulties during the critical perinatal period but split views on how easy it was to access timely help to promote recovery and thus reduce impact on a child’s mental health;
* a lack of systematic focus on the family and its resilience;
* A lack of attention to family-based drivers for poor child mental health particularly to children’s accumulation of ‘emotional damage’ as a result of parents facing difficulties such as mental health problems (including trauma), learning disabilities/difficulties or substance misuse or for those children exposed to family violence and volatility;
* a lack of attention to Adverse Childhood Experiences – particularly where difficulties fell below the threshold for support from statutory agencies;
* Insufficient support for parents and foster carers to address early issues;
* only 4 out of 10 respondents feeling that they had good access to interventions for children with early starting behavioural problems;
* inadequate focus on the social, emotional and mental health development of 3-5 year olds which was resulting in schools seeing more children with emerging difficulties as they started their education.

Indeed, parental difficulties were identified by the workforce as one of the main factors undermining children and young people’s mental health and wellbeing in Dudley.

GPs and schools particularly described a child mental health system in Dudley that was poorly focused on prevention and intervening early. Teachers asked ‘where’s the family and social support’ and were concerned at the ‘lack of an early intervention strategy’ and at the fact that ‘prevention is missing’. Primary schools felt that they had fewer resources to devote to building strong mental health in children at this earlier stage. And when teachers saw children struggling and needed to secure additional help, they described a system which required a child’s mental health to have escalated to crisis before help was available.

**Accessing timely help**

A further key theme from this workforce consultation was the accessibility of help. Practitioners, children, young people and families described difficulty getting timely access to help before children and young people became unwell or drifted into crisis.

*Having to wait is a big challenge to children after they have plucked up the courage to talk to someone (Survey respondent)*

*It feels like there are a lot of frustrated people hitting their heads against a wall [when they try to get help] (Survey respondent)*

For example:

* two thirds of the workforce in Dudley felt that they were not able to organise timely mental health support for children and young people in need; some were undecided about this issue and only 15% felt that could get help for children and young people easily;
* Three quarters felt that even when a child presented with a diagnosable level need, Dudley services were poorly equipped to respond promptly;
* More worryingly, although most people felt that they knew who to contact if a child needed *urgent* mental health care, only 4% of respondents felt they could secure help quickly. Half were undecided about this issue and just under half felt unable to organise urgent help in a timely manner. This is despite the fact that specialist CAMHS were confident of being able to respond quickly to urgent child and adolescent mental health needs with a turnaround cited of 2 days for urgent cases and 7 days for young people with priority needs (between referral and first specialist CAMHS contact).

Increasing budget pressures and incrementally dwindling resources affecting all locality budgets coupled with what were seen as increasing levels of need for support were perceived as contributing to this deterioration in available help to respond to children and young people’s mental health:

*As this agenda [children’s mental health and wellbeing] is coming to the fore, support mechanisms seem to be diminishing (Survey respondent)*

Many of those consulted talked of a system which gravitated towards crisis and crisis management rather than prevention and early help. Respondents particularly identified gaps in the current system of support in Dudley at Tier 2 (or targeted or primary mental health practitioner level) which meant that children’s problems were left to fester with ‘watch and wait tactics adopted rather than early help’ or prompt action to de-escalate. Respondents felt this led to unmanageable later demands on specialist CAMHS, schools, primary care and online and voluntary sector counselling providers. Specialist CAMHS was described as ‘an overloaded service’. CAMHS managers described working hard to stabilise and minimise waiting lists (a recent CQC inspectorate report commented that they did not compare unfavourably with other localities) but there was concern from others consulted that this had resulted in a now very restrictive gateway to get help and rising thresholds for acceptance making ‘the criteria to fit more extreme’.

Parents/carers and a number of professionals seeking help did not recognise the quoted timescales for accessing help by specialist CAMHS – timescales which did not reflect their own experiences of attempting to access help on behalf of children in Dudley.

*‘6 to 8 weeks doesn’t feel like what actually happens’ (Survey respondent).*

*‘6-8 weeks? 6 months more like it’ (Survey respondent).*

Many schools and other universal and targeted services felt they were left to deal with the full impact of parental and child frustration unsupported as families and practitioners tried without success to get the help they needed at the right time. Others raised concerns about the lack of crisis care – lack of 24 hour CAMHS support, lack of urgent support for foster carers in crisis and lack of availability of a Home Treatment Team in Dudley as factors which compromised crisis responses and de-escalation.

Targeted voluntary sector counselling providers reported being oversubscribed and facing rising demand and waiting lists with ‘agencies stretched to the maximum’. There was evidence that GPs (and sometimes Accident and Emergency departments) were referring directly to community counselling organisations such as The What?Centre instead of specialist CAMHS teams due to widening awareness of this voluntary sector service but also because they believed that CAMHS was difficult to access and oversubscribed. This had then led to the What?Centre being oversubscribed.

A common theme was that children needed ‘holding’ help whilst they waited to access CAMHS or other services.

**The referral process**

Referral systems to get help emerged as a particularly confusing and challenging issue in Dudley. A recurrent frustration on the part of the broader workforce was that there had been a change in the system of referral to specialist CAMHS with ‘fierce protection of CAMHS by GPs’. For example, educational psychologists and other primary mental health practitioners described how they were no longer able to refer directly to specialist CAMHS having instead to refer parents via GPs. This change in access was seen as a major barrier to children, young people and families accessing help. For example:

* it increased the need for children and young people to re-tell distressing stories on multiple occasions
* it meant that services in contact with parents had to prepare and encourage parents to make sure that they said the right things to ensure accurate GP identification
* GPs themselves were described as having variable knowledge of child and young people’s mental health and wellbeing; educational psychologists and primary mental health workers felt that this increased the chance of either ‘dead ends’ when seeking help or of inappropriate referrals.
* Some teachers said that after encouraging parents to attend GP appointments, some GPs then referred children back to schools creating a situation where parents felt ‘passed from pillar to post’
* and most importantly, because those parents with the greatest risk factors were less likely to proactively seek help, the Dudley system was seen by some as building in unnecessary ‘hoops to jump through’ making the process of getting help like a ‘snakes and ladders game’ and significantly disadvantaging higher risk groups with low trust in formal services and with more fragile motivation to engage.

*‘Schools [have difficulty engaging parents to contact GP[s] – particularly hard to reach parents.’ (Survey respondent)*

*Trust can be a barrier for young people, children and families with mental health [problems] if they are going to get the help that they need (Survey respondent)*

However, discussions with specialist CAMHS managers suggested that broader workforce beliefs that there was a ‘GP only’ referral system were not accurate. It is once again difficult to understand how this widespread misconception had occurred and this suggests an urgent need for greater integration and clearer communication between specialist CAMHS and broader stakeholders with a clearer access pathway co-produced and understood by all stakeholders.

Additionally, although representatives for specialist CAMHS felt that criteria for accessing support were clear, many of those in the broader workforce (and parents/carers – see page 15) said they were confused about who was accepted and who was not accepted by specialist CAMHS.

**Confusing service landscape**

Many of those consulted as part of the workforce consultation (particularly schools and a very small number of GPs) talked about the confusing nature of support available for children’s social, emotional and mental health in Dudley.

*‘How do we know which agency or intervention to use?’ (Survey respondent)*

*‘Need signposting to services available’ (Survey respondent)*

*‘What do we try first in early intervention and how do we know what service to access?’ (Survey respondent)*

*‘We don’t know what the options are for support – what effective services are available...it’s guesswork’ (Survey respondent)*

*‘Who are the voluntary sector services and what do they offer?’ (Survey respondent)*

*‘If not CAMHS, where do they go?’ (Survey respondent)*

*‘[There is] a lack of awareness of what CAMHS can provide and what is outside CAMHS.’ (Survey respondent)*

Many were confused about thresholds for access to these broader services supporting children’s mental health.

Those consulted similarly felt that they lacked advice and a clear gateway to get help for children, young people and families.

For example:

* two thirds of survey respondents felt that they lacked a clear reference point for advice when identifying a social, emotional or mental health concern or were faced with worried or frustrated parents who needed help
* 80% of the workforce also did not feel that there was a single clear gateway for children and families to get help in Dudley.

Although we were told that clinical pathways had been developed for difficulties such as ADHD, these were not well understood by those in broader day to day contact with children. Many talked of the need for moving beyond ‘clinical pathways’ and having more multi sector integrated pathway development supporting children’s broader mental health:

*‘[We] need to know what we all can offer and how we all fit in’. (Survey respondent)*

**Schools and colleges**

Some specific issues emerged from schools. Two thirds of school survey respondents (n=25) felt that they had seen an increase in social, emotional and mental health issues in recent years. This perception is not entirely borne out by broader local evidence – but there is now some national evidence that the mental health of young women aged over 16 is significantly deteriorating over time (McManus *et al*., 2016).

The most recent Health Behaviour in School-aged Children Survey for Dudley suggested relatively stable wellbeing rates locally between 2014 and 2016 except for college students (between 2012 and 2014). Even for college students, increases were only weakly significant. The young people consulted during this needs assessment were also split on whether their peers’ mental health was deteriorating with some arguing that mental health problems were now more commonly disclosed, discussed and ‘stressed about’ by children and young people and that young people possibly had lower resilience and fewer coping skills.

Schools felt very much at the frontline of dealing with children, young people and particularly parents’ frustration at not being able to get the right help at the right time when their child’s mental health was deteriorating. Schools felt that they had accumulated more commissioning responsibilities for children’s mental health often in the context of dwindling resources and poorer knowledge/understanding of their options locally or of what effective responses looks like. Colleges were particularly concerned at the lack of support and consultancy for the development of their services and about the ‘cliff edge’ in mental health support that occurred in Dudley for those in middle adolescence to young adult years. Schools explained that they valued Educational Psychology input and counselling but saw these as expensive when they had increasingly limited resources to invest. During the school workforce focus group, participants talked of a postcode lottery in what could be offered dependent on the size and resources available to the school.

Schools also felt that over time there had been increasing pressure on them to fund ‘almost all support in schools (educational psychology, mentoring, counselling) except school nurses’. One respondent felt that this may have a knock on effect in that it was now ‘easier not to support excluded pupils’.

A number of school respondents said they very much valued the support of the Dudley Public Health Healthy School Initiative. However, they felt poorly integrated with specialist CAMHS and were frustrated at the lack of feedback from social care, CAMHS or other services feeling isolated when trying to support vulnerable young people with progress on a day to day basis. This same issue of feeling left alone managing very complex behaviours and difficulties was raised by foster carers in Dudley.

**Fragmentation of provision**

82% of survey respondents felt that services did not work in a coherent and integrated manner to support and promote the mental health and wellbeing of children in Dudley. Many felt that lack of integration had been exacerbated by:

* budget cuts with organisations described as becoming ‘more protectionist’ and retreating into silos, delegating responsibility for mental health support to other agencies and dealing only with core activities
* the complexity of the service landscape supporting children’s mental health and wellbeing
* a lack of shared outcomes (only 11% of survey respondents felt that there were cross sector shared outcomes in relation to children’s mental health and emotional wellbeing)
* underdeveloped leadership for whole system social, emotional and mental health provision for children, young people and young adults in Dudley:
  + - *‘Overall control needed to pull everything together (e.g. NHS/LA)’. (Survey respondent)*
* poor inter agency collaboration and information sharing (fewer than 10% of those completing surveys felt that there was good multi-agency information sharing about children’s social, emotional and mental health)
* in focus groups it was also felt that there was poor feedback for parents, children and young people while they were waiting explaining ‘where they are on the pathway of waiting’:

*‘You need to know where you stand when waiting’ (Survey respondent)*

When asked about the extent of integrated working across different sectors to support children’s mental health, most survey respondents reported higher integration on mental health issues with:

* schools and school nurses (around two thirds)
* social care, speech and language workers and early years workers (just under two thirds)
* the voluntary sector (with around a half saying they worked in an integrated way).

Respondents were less likely to feel that they were working in an integrated way on this agenda with specialist CAMHS (24%), paediatricians (24%), parenting providers (30%) and special educational needs teams (30%).

Many identified *‘more multi-agency working with clarity of roles’* as a key aspiration for work on children’s social, emotional and mental health in Dudley:

*‘We need more [multi-disciplinary team]… work and meeting including GPs, school staff counsellors modelling the MASH approach’ (Survey respondent)*

*‘We need to get together more regularly’ (Survey respondent)*

Some also felt that there was a need for more joined up commissioning plans with ‘more of an outcome focus’.

When asked how they would know if things had improved in Dudley, those consulted identified some of the following key performance indicators:

* Dudley would have happier children
* Children in Dudley would be more resilient
* Young people would talk more openly about their mental health
* Dudley’s children would have better educational attainment
* Fewer children would become looked after
* There would be fewer school exclusions
* There would be improved school attendance
* There would be fewer referrals to specialist and highly specialist CAMHS and to the What?Centre
* Children would have access to the right help at the right time and in the right place.

There was some support for using universal resilience screening measures in schools to raise the profile of wellbeing in a non-stigmatising way and to track when children might need a little more early support. There was also a belief that a new impact measurement approach being developed in Dudley (PSIAM) might help improve tracking of children’s social, emotional and mental health.

**Information sharing**

Only 9% of survey respondents felt that effective multi-agency arrangements were in place for children’s mental health and emotional wellbeing. This was also a recurrent theme during focus groups and interviews with particular concerns about ‘one way communication’ and the lack of feedback between broader services who had mental health as their core focus (but especially specialist CAMHS) and schools. Schools felt that they were left to manage a child and young person’s day to day progress without additional guidance:

*‘After a CAMHS diagnosis it would be useful for school staff to be given recommendations to aid support.’ (Survey respondent).*

Some school respondents said that messages from specialist CAMHS were only ever passed via parents/carers – sometimes losing accuracy as they were shared second hand.

Foster parents raised a similar frustration about the lack of guidance from CAMHS (but also from other therapeutic providers) as they sought to support a vulnerable child receiving therapy in their broader day to day life. (See page 15).

However, it should also be noted that there were mixed views on information sharing. Some agencies sought greater transparency in information on local children between agencies and others reinforced firmly the importance of protecting children’s rights to confidentiality. These same issues emerged during discussions with foster carers. The management of these tensions requires some problem solving (including children and young people and parent/carers being at the centre of discussions in Dudley).

**Service design**

A number of respondents commented on the service design of the majority of mental health support in Dudley and again particularly of specialist CAMHS provision.

There was a request for more home visits and assessments to take place and comparisons were made with specialist learning disability CAMHS services for whom such practices were more commonplace. Some felt that a lack of outreach ‘favoured supportive parents’ and disadvantaged families and children facing greater challenges and with trust issues. Specialist CAMHS service user non-attendance data (DNAs) suggested that rates compared favourably with national comparators and managers talked about having tried hard to use text and other reminders to improve engagement. Again, this data was not always consistent with the anecdotal reports of local stakeholders who talked of CAMHS ‘giving up after a couple of no shows/failure to appears’ and a frustrating experience of ‘snakes and ladders’ for broader professionals seeking to encourage people to engage.

Once again, these different perceptions of children’s experiences across the system are perplexing. One possible hypothesis may be that many ‘harder to reach’ children and young people get filtered out naturally through the general misconception that parents need to approach GPs before CAMHS referral leading to only the most motivated families eventually getting successfully referred to specialist CAMHS.

A common theme during qualitative discussion was a need for specialist CAMHS and all services in Dudley to identify more creative ways to motivate, engage and sustain contact with harder to reach families and young people needing help.

**A system that has children, young people and parents/carers needs at its heart**

* only 4% of survey respondents felt that the Dudley child and young people’s mental health offer had been shaped in collaboration with parents, children and young people – with just under half of the workforce being undecided about this issue and just over half believing that it had not.
* a third of the workforce in Dudley thought that the current mental health system had children and young people’s and families’ needs at its heart – with most survey respondents being undecided on this issue
* only 2% thought that children’s mental health outcomes in Dudley made sense to children.

Comments from this workforce consultation stressed the need for more attention to children, young people’s and parents’ voices in future developments:

*‘Could more be done with the children saying what their needs are and how to improve their needs?’ (Survey respondent)*

There was also a call for more routine collection and publication of ‘family and friend’ test feedback from parents/carers, children and young people by all agencies so that the system could assess the extent to which it satisfied families, carers and young people.

**Transitions to adult years**

A common challenge identified in the system was the lack of continuity in social, emotional and mental health care for young people between mid adolescence and early adult years. Continuity at this age is critical as these are the peak years for the first emergence of poor mental health and this period offers a key opportunity to reduce life course impact (Patton, 2014).

Mental health promotion and supporting resilience at this age was also seen as more challenging as young people were either in employment or in colleges where mental health promotion messages and whole college timetabled activities were much more limited. It was felt that some creative problem solving was required to enhance mental health promotion for this age group.

College representatives and those attending focus groups also referenced a lack of adequate mental health support. One college was trying to skill up in-house staff to support students’ needs but needed support with this endeavour and access to specialist consultancy/supervision to promote effective and safe practice.

The What?Centre community counselling service also said that it was increasingly receiving referrals from GPs for young people over 18 years of age even though it was not commissioned to provide services for this age group. Adult Improving Access to Psychological Therapies (IAPT) services were commonly used by specialist CAMHS as part of the transitional care plan for those with anxiety and depression. Indeed, specialist CAMHS wondered how widely known this service was to the broader workforce and to schools. IAPT services confirmed that they provided a time limited evidence based service for young people with anxiety and depression in Dudley in this age group and subsequently provided information on their reach.

A number of specialist CAMHS practitioners felt that an area of strength in their service was their ability to facilitate handover to appropriate adult mental health support where someone was already on their caseload and further support was needed. This may mean that transitions to adult services may be more of an issue for those who are not already in contact with specialist CAMHS in Dudley.

Only 5% of the workforce felt that care leavers had adequate mental health support and most did not know whether their needs were likely to be met. The newly rolled out NHS England commissioned Black Country Partnership Liaison and Diversion service (providing health screening at an early point of arrest for young people on the edges of the formal Youth Offending team caseload) covers Dudley young people and adults and involves both an all-age model of screening as well as help with bridging to local support for those at an early stage of offending. This service will be gaining expertise in the landscape of services available at critical transitions in Dudley (and any gaps) and intelligence should be feeding into local planning and commissioning.

**Workforce and community confidence and skills**

* Eight out of ten survey respondents felt confident that they were able to identify children needing additional help with their mental health and wellbeing;
* Around three quarters said that they felt able to offer preliminary help to children, young people and families;
* Two thirds felt confident that they had the skills to promote most children’s and families’ resilience and lower level mental health needs.

However, a number of those consulted raised the need for further investment in the Dudley workforce to help develop skills to promote good mental health, build assets and de-escalate early stage difficulties. Practitioners also mentioned the potential benefits of coordinated multi-agency training and support for children, young people and families in mental health awareness and promotion.

Some specialists working in highly intensive services for the most vulnerable looked after children in Dudley felt that the wider social care workforce could do more, in very simple ways, to build the resilience of these children and strengthen their social, emotional and mental health. One worker believed that there was scope for promoting simple resilience boosting skills. Some of those involved in this consultation talked positively about attachment-based training delivered by the former Looked After Children specialist CAMHS team and many wanted more training in this area and in understanding the impact of trauma. Some also felt there was a need for broader training of the Dudley workforce to partner in Triple P parenting group delivery to help parents support children with diagnosable level conduct problems.

Foster carers in Dudley felt very strongly that they were lacking practical advice and strategies to support the social and emotional wellbeing of sometimes very vulnerable children in their care. They also felt that, at times of (usually) behavioural crisis, they were left on their own (sometimes for hours) trying to manage highly volatile situations unsupported. They did not currently feel well supported in the challenging work they were attempting to do.

Schools wanted free whole school training of staff so that they could support children at a universal and targeted level. Some wished to train learning mentors in targeted support and in resilience/emotional coaching (similar to an approach being rolled out by the University of Bath and through the Big Lottery HeadStart resilience funding in Birmingham and Wolverhampton).

Various Dudley-based training initiatives were mentioned during the consultation. However, training appeared piecemeal, not always coordinated and reducing in scale and reach.

Practitioners, school staff (and foster carers) identified need for more ‘informal contact’ or ‘someone to pick up the phone to’. Getting advice and consultancy on children’s mental health and well-being was seen as generally challenging in Dudley:

* Only 13% felt that they were able to get advice easily if a specialist referral was not possible and talked of ‘a lack of support from broader professionals’ for those in day to day contact with children who were struggling or unwell.
* The workforce was very much split in terms of knowledge of the broader systems of support for children and young people with social, emotional and mental health needs (and their families).

**The scale of provision for vulnerable groups**

Those completing surveys felt that the following groups were least likely to have their mental health and emotional needs met in school:

* Children from BAME and migrant communities (only 11% of the workforce agreed/strongly agreed that their needs were adequately met and two thirds didn’t know). Others during the consultation emphasised the need for a different and more proactive engagement and qualitatively different communication strategy concerning mental health for BAME communities due to higher levels of stigma and fear.
* Those at risk of school exclusion (only 15% of the workforce felt that their needs were adequately met)
* Children with substance misuse difficulties (with only 16% of the workforce feeling that their needs were sufficiently met and concerns emerging about how effectively ‘dual diagnosis’ was managed)
* Children who are victims of child exploitation and homeless young people (only 18% of the workforce felt that their needs were met adequately)
* Looked After Children (only 22% of the workforce felt that their needs were adequately met)
* Children with neuro disabilities (only 21% of the workforce felt that their needs were adequately met)

Respondents were least knowledgeable about how adequately the mental health needs of LGBT children and young people, homeless young people, children and young people with long term physical health conditions and young carers were met in the borough.

During focus groups and broader consultation, the needs of looked after children (including adopted and fostered children) emerged consistently as an area of concern in terms of the adequacy of social, emotional and mental health provision. The inadequacy of services for these children had been highlighted in previous Ofsted inspections. It was explained that at one point there had been a team of psychologists working with Looked After Children, their parent/carers and social work teams in Dudley. Those consulted felt that this team had provided effective support for this group of children who it was recognised had higher needs. They had also provided training and advice on attachment difficulties and trauma following experiences of maltreatment. However, we were advised by interviewees that following the transfer of funding to the local authority, incremental cuts had resulted in an increasingly limited service. Specialist CAMHS said they still attempted to provide limited consultation for parents/carers but were conscious of the insufficiency of this approach as children and young people could not directly access specialist interventions.

Other groups identified with largely unmet needs in Dudley included:

* children with sub-threshold social or health needs or who went under the radar in other ways (for example they were withdrawn but not causing problems in schools)
* children with parents in crisis (e.g. with mental health difficulties, substance misuse difficulties or victims/perpetrators of domestic violence)
* those less likely to engage with formal services or who had parents who were unable to fight for services.

A lot of feedback highlighted the particular impact on joint working of recent challenges following negative looked after children Ofsted Inspections and talked of ongoing reorganisation, instability, ‘changing cultures’ and cuts in the system. Short term contracts (particularly affecting the voluntary sector) were felt to lead to ongoing organisation instability. There was a degree of anxiety among the workforce about ongoing instability and change.

**What is working well?**

Those consulted felt that there was learning that could be capitalised on from existing multi-agency initiatives either developed or developing in Dudley. For example promising examples of integrated working included:

* the joint working intrinsic to Troubled Families (Family Intervention Project), multi-agency safeguarding hubs, children’s centres and the evolving early help offer
* the developing mental health Vanguard approach seeking to draw social care and health more closely together
* the multi-agency forum to support diagnosis of neuro disabilities

There was praise for the voluntary sector in Dudley and the drive behind the coordination of and integration of this provision.

Schools said that they valued the increased visibility of school nurses, having a named Educational Psychologist, school-to-school support networks sharing best practice (although recognising that this only worked up to a point) and the Healthy Schools training initiative.

***Parent and carer feedback***

This needs assessment draws together the views of nine parents/carers from Dudley. One parent also completed a parent survey distributed to parents through voluntary sector contacts. Five parents and three foster carers attended focus groups. When asked about low numbers completing surveys, they explained that most parents/carers have to fill out many forms and write many emails so tend to be put off by surveys. This should be noted for future reference.

Around half of parents/carers attending focus groups had children with neuro disabilities (autism and ADHD); two parents’ children had sought help and accessed specialist CAMHS as a result of emotional difficulties; one had eventually secured private therapy for her child. Two of the foster carers had decades of experience of supporting children with a range of behavioural and emotional difficulties as well as with backgrounds of maltreatment, poor attachment and trauma. They had an overview of many attempts of linking up with schools, special schools, social care, emergency services and specialist CAMHS.

The key themes from their feedback are discussed below.

**Access**

Getting access to help and being listened to were key themes during this consultation. The majority of parents and carers described being involved in ‘a constant battle’ requiring dogged persistence to get help for their children. Foster carers who had needed to link closely with these services over time also described what felt like a randomness in the system in terms of what was available from school to school, from special educational needs provision and from specialist CAMHS. One mother described her own mental health being undermined by constant battles to get help for her child and talked of the ‘many individuals who have fought against us’ saying:

*‘The time I spend on letters, emails, meetings just to get my child’s needs met is phenomenal…it means I am now unable to work for more than a few hours a week… my stress levels have been severely affected.’ (Survey respondent)*

Foster carers and parents were concerned about the resilience needed by parents and carers to engage with this ‘constant struggle’ and were concerned about all those children and parents who lacked resilience to engage with the ‘fight’ described:

*‘And what strikes me is that you’re really able to fight for your kids, and so are you and you…and yeah that’s really brilliant…but what happens to the kids that haven’t got parents [like you]…they’re out there with all of these complex needs, they haven’t got parents who are able to fight …never mind willing…and they’re getting diddley squat’ …(Focus group attendee)*

Like professionals, these parents/carers described a system where preventative work and family resilience-building support were disappearing, that was insufficiently focused on early help, that sometimes didn’t feel like it valued or listened to parents/carers resulting in the escalation of children’s problems.

One fairly experienced carer still was unclear how the system ‘is supposed to work’ and others described a system which felt random in terms of who got help and who didn’t. They explained that by the time parents/carers approached specialist CAMHS, it was a last resort and children, young people and families/carers were under great stress and in significant need and crisis:

*‘When you get to CAMHS you are not at a healthy stage, you’re already in crisis, your child’s unwell and the waiting times make it worse…you are at the end of your tether and if you don’t get help, things get even worse…’(Focus group attendee)*

Parents described very long waiting periods at this stage (involving many months) between the point of referral and getting their first appointment with specialist CAMHS. Like some practitioners, they did not recognise official specialist CAMHS waiting targets.

At the stage of their first meeting, some described initial meetings which did not feel as if they were sufficiently focused on the child’s or family’s needs but instead seemed to them to place an onus either for the child to ‘act out and perform’ on the day or placing responsibility on parents/carers to go away and produce further evidence to prove that children ‘fitted the criteria’ for their service (this probably relates to the need to demonstrate that lower level support has been engaged with before CAMHS is approached – but as practitioners have already highlighted, there are gaps in this lower tier level of support).

Carers also explained how they had been told that specialist CAMHS could not support fostered children until they were in a stable placement; ironically this placed them in a ‘Catch 22’ as carers said that until these children had support with their social, emotional and mental health needs, they couldn’t stabilise.

Parents/carers felt that the system was a long way from feeling like it was child and young people centred; rather ‘it’s all red tape and criteria’. They also highlighted that as you transition to adult years, these criteria shift again:

*‘When you get to eighteen, you may have been receiving some form of service and at eighteen the criteria changes and you get nothing.’ (Focus group attendee)*

Many parents/carers also described their child’s mental health deteriorating during delays as they ‘battled’ to get the help they felt their child needed sometimes leading to damaging and high cost outcomes:

*My son saw CAMHS years ago; they did not ‘help’ him despite my pleas for help as he was getting worse (Parent survey)*

*They didn’t listen to me…things got worse, now there’s been an incident and he’s got into lots of trouble …but this is now a serious incident and he won’t come back home (Focus group attendee)*

Access to crisis support for foster carers was worryingly poor. They described many incidents over time when they had very vulnerable and volatile children in their care and when children’s behaviour had escalated into significant crisis where either the child or foster carer’s safety was felt to be compromised:

*‘We do have an out of hours’ service but last time I rang them they didn’t respond*

*…and it’s difficult because [the duty social workers] could be dealing with so many other things’*

*‘I needed someone now and they have arrived one and a half hours after…I could have been killed by then….My husband left work and my family came straight away…That’s the first time I needed someone because I knew I couldn’t keep the child safe…’*

*‘He said “I am going to knock you down and you will never get up” and I rang for help and I got help the next day…and the next day he locked me in the kitchen being really aggressive and he screamed at social services to ‘move him’. He was really escalating.’*

Incidents included threatening violence in the home, very bizarre and troubling behaviours or immediate threats by children to self-harm. These incidents were in some ways described as part of what foster carers had come to expect from their roles and from their responsibilities caring for very vulnerable children; however, what troubled them was the lack of 24 hour professional crisis support and back up on the very few occasions that they needed it.

The emergency duty team and broader services were often their first port of call in an emergency but even then it was not uncommon for more than an hour to pass before anyone arrived and in the interim they and their families were trying to ‘talk down’ and manage a young person in some significant distress unaided.

Another parent said that there needed to be more parity between physical health and mental health crises with a 24 hour response system for children whose mental health was rapidly escalating:

*‘I think mental health should be recognised as a 24 hour health issue, everything is 9-5 and anything outside that is even more difficult to access’*

One parent had experienced a predominantly positive experience as a result of his child’s contact with CAMHS for anxiety related problems. Another had encountered some problems but also said that ‘what CAMHS can do is amazing’. The majority, however, talked about negative experiences and ‘randomness’ in the system (depending on who you contacted, whether they had a professional advocate who could help them fight, if they were pre-armed with the right knowledge etc).

Finally, carers with extensive experience of fostering also felt that children in their care were presenting with more complex and severe needs over time.

**Working with and listening to parents/carers**

A significant complaint voiced by parents/carers was that ‘nobody seems to work with us’ and they were not generally considered partners in the package of care being offered by specialist CAMHS or counselling services.

This was considered problematic in a number of ways. For example when children and young people were unlocking very distressing past experiences, there was frequently a knock on effect on the child afterwards and parents/carers were often left managing this alone and with no warning.

Many examples were given of the challenges faced by parent/carers through not being seen as part of care packages. Two carers were able, in contrast, to give an example of how on occasions this process had felt more collaborative as if they were ‘working together’ with local support services. One had experienced this care through being part of the Flipside multi-dimensional treatment fostering scheme which she recognised needed to be restricted for the most needy but which she described in glowing terms – particularly the partnership with and support offered to foster carers. Another described one example, from a chequered history of foster care placements, that had worked very differently to the others:

*I was included in the sessions and the psychologist and I worked together to support him and that was great because all the things she was saying, I could also do at home and then when he was in the sessions I was able to say ‘What she means is this’ and explain a bit more to him. (Focus group attendee)*

*‘Listen to us we know our children’ (Focus group attendee)*

Many parents/carers also did not feel that mental health and educational services were ‘taking parents’ views into account’.

*They need to listen to us as well – we have a lot of collective information and they need to listen to what we have to say… and it may help costs as well as they may be doing things that aren’t needed. (Focus group attendee)*

This was seen as a difficulty because parents/carers felt they often held critical pieces of the jigsaw puzzle. For example, parents described children as putting on a ‘coping front’ with professionals so that they could feel good and avoid making difficult changes. Some parents/carers felt that this ‘coping front’ had sometimes been accepted without further cross referencing with parents/carers. In one instance, this had led to reassurance from the therapist to the parent about progress which did not tally with what was going on at home and which led to later dramatic escalation into crisis. This lack of collaborative working with parents/carers was described as worsening as vulnerable young people entered adult services.

**The perceived quality and usefulness of the help offered through mental health services**

Although a minority of parents/carers who had accessed therapeutic care had been happy with their child’s care, the majority were unhappy with what had been provided. A particular concern was the lack of pragmatic help for children. Parents/carers also said they wanted practical strategies to support and manage their child’s behaviour and emotional wellbeing. Carers talked of interventions being used that felt like a ‘waste of money’ and that were not future focused, ‘goal orientated’, ‘helping young people understand the choices they can make’ or ‘linked to reality’ – in one instance with interventions continuing for 18 months when the carer felt this was intuitively not helping and there had been no evidence of progress. Help was also described as too rigid, adopting a ‘one size fits all’ approach.

Carers talked about ‘consultation’ meetings with CAMHS which did not feel helpful and were not focused on providing them with practical strategies for supporting or managing the needs of fostered children; and neither in these instances was any direct help offered to the child. Discussion with CAMHS later on clarified that these experiences were due to the current diminishing specialist mental health support available for Looked After Children. Specialist CAMHS were attempting to provide a skeleton service but the previous team of workers no longer existed who were specialists in working with parents/carers and children and young people.

One parent also felt that where their child had complex needs, their recovery was treated in a very narrow way (particularly by adult mental health services) ignoring the ‘complex range of needs which have led him into trouble’.

Parents/carers also said that services’ and workers’ responses did not always feel compassionate and caring which they felt was essential for effective support; neither did they feel help was child, young person or parent/carer centred in design, emphasising that ‘they have to start consulting with the people who use the services’.

One respondent talked of a model for service development in a local college which had involved parents/carers and young people being part of task and finish groups focused on specific areas of service improvements. This, in her view, had led to some practical improvements and she wanted to see a similar methodology being used in Dudley to shift the system of mental health care for children and young people.

They were interested in tentative proposals to improve social, emotional and mental health support at a pre specialist CAMHS stage (e.g. through introducing targeted/Tier 2 level emotional health and wellbeing teams linking to schools) but felt firmly that the success of this initiative would depend on the extent to which the right workers with the right ‘caring and compassionate’ approach were recruited and also the extent to which what was on offer felt less like a system and more focused on children, young people and parent/carers’ needs.

*[At the moment], there’s a lack of compassion in the system and empathy for what parents/carers are managing and how young people feel.*

*‘[in Dudley] there’s not child centeredness…just criteria centeredness’.*

*Lack of early intervention and whole system responses*

Parent/carers raised concerns about incremental cuts affecting children’s centres and universal provision which in their view had undermined family and child resilience in Dudley:

*‘All that stuff put into [children’s centres] meant that there was less problems later on…but ‘cos it’s not measurable and we can’t see it, then that’s an awful lot of money, let’s close them all’.*

They also noted very variable provision supporting children’s social, emotional and mental health across schools in Dudley:

*‘There’s some schools that will go above and beyond for these children and there are others that do the bare minimum to get them through.*

*There’s some excellent schools…one girl had a real issue with her cognitive and emotional ability and the school bought in a service. A one to one session and practical stuff as well, it was private sessions through the school counselling service. They gave me a report and met with me, and said “this is what we’ve been doing, this is the progress she has made” plus they worked with me and I could make suggestions and say “Can you add in this now? Can we change it now?”… and it worked’.*

*‘If you don’t have a designated teacher…then you are not going to get very far.’*

*‘There are some A\* designated teachers who go above and beyond... and nobody was a number and everyone was a name and especially, for her, Looked After Children.’*

Nurture groups were also valued by a foster carer for the children in her care.

But parents/carers also acknowledged the pressures that schools were under to meet social, emotional and mental health needs with increasing responsibility for an ever expanding set of complex issues such as internet safety and anti-radicalism:

*The schools do try very hard. The problem is there’s so much. There’s a lot of government initiatives, all this anti-bullying, child sexual exploitation, anti-radicalisation, social media and internet safety, drug and alcohol… They’ve got so much now on their plate…it’s really hard for schools to do all of those things and at the end of the day yes kids have to come home and read and write… but they also have to be a fully functioning adult.*

Some parents/carers with children with complex needs also talked of the difficulty of getting the right needs led care in the borough to help them thrive emotionally and socially, particularly if they were functioning adequately academically in mainstream education. Two parent/carers felt that it was those children who functioned adequately and didn’t cause huge problems who would often fail to thrive and slip under everyone’s radar

They felt that there was a specific need for a social and emotional support service for foster carers and the children they looked after offering practical strategies and support. They also felt that there was real potential to re-establish and strengthen a foster carer ‘buddy’ system as long as this was ‘as well as’ and not instead of wider professional consultation, practical advice and support. One carer described how previously, all new foster carers had a buddy. They all had a list with phone numbers and buddies ‘knew someone’ who might have the answer for a particularly challenging situation. On some occasions, in an emergency, foster carers had been able to provide practical support over the phone and by getting to a location quickly to help talk down a young person in distress. However, for buddy systems to work effectively, they said some resources needed to be invested in facilitating and sustaining links (such as crèches, coordination, coffee mornings, things that built and valued their expertise etc). These were the things that most ensured that carers attended buddy meetings but were also the most likely to be cut in the current climate.

Overall, parents/carers described a whole system from their experience which undervalued building resilience and preventing or de-escalating problems and that largely delayed helping until crisis points through being overly focused on restrictive criteria to access help and through failing to value or work in partnership with parents and carers. Two carers talked of a short term perspective in Dudley which in the longer run cost local services more:

*‘I still maintain that it’s cheaper at the end of the day, cos what we end up with is a lot of adults that are [unwell and] off the end of the scale ...where huge amounts of money are having to be put into prisons and also into their kids… when they have kids - cos those kids then go into care. I know loads of carers who say ‘I had their mum; I had their grandmother with me’.*

**Children an d young people’s views**

In completing this needs assessment, information from children and young people has been drawn from three main sources:

* a survey completed with around 1,200 young people in Dudley borough by Dudley Youth Health Researchers supported by Healthwatch Dudley and by Dudley Youth Service;
* findings from the Health Behaviour in School-aged Children Survey (HBSCS) completed by Dudley primary schools (2014 and 2016), secondary schools (2014 and 2016), and college students (2012 and 2014);
* focus groups held with 15 young people from Dudley organised with the support of Healthwatch Dudley and the Phase Trust. Focus groups included young people with a range of experiences of local social, emotional and mental health services including no support, school based support, helplines, specialist CAMHS, voluntary sector support and inpatient experiences. It also included young people who had faced mild as well as significant mental health challenges who had not sought help.

**Mixed views on whether social, emotional or mental health difficulties were increasing**

There were mixed views in focus groups on whether social, emotional and mental health issues were increasing in Dudley. Almost all youth focus group participants felt that mental health problems were certainly more talked about among their peer group (and more talked about than in their parents’ and grandparents’ generations). There was also a perception that ‘being stressed’ was now somewhat of a cultural norm among young people compared with previous generations both in school and even in work settings – some felt that there was a degree of ‘one-upmanship’ with stress with those unaffected being made to feel bad because they ‘didn’t care enough’.

The HBSC Survey 2014 did indeed reveal a weakly significant increase in stress levels at college level between 2012 and 2014. However, there were no such differences at secondary school level between 2014 and 2016. Some young people in the focus groups felt that higher experiences of stress were in part the result of young people facing increasing and more complex pressures but also due to under developed coping skills and resilience.

**Seeking help**

The HBSC Survey indicated that:

* most children in primary school felt that if they needed help in school or outside it they were able to get help in 2016 (96% and 95% respectively). These rates had remained stable since 2014;
* most children in secondary school felt that if they needed help in school or outside they were able to get help (84% and 77% respectively). However, between 2014 and 2016 there was a weak but significant decrease in the number of children who felt they were able to ask for help either in school or outside school (a shift from 82% to 77% for in-school help and from 87% to 84% for help outside school);
* in 2014, young people in colleges were significantly more likely to know about and to have accessed counselling services (shifting from 7% in 2012 to 12% in 2014). Use of school nurses had also more than doubled with 7% using this service. Use of Connexions was most common among this age group (used by 18%) but had fallen since 2012. Use of SEN tutors had more than halved and use of personal tutors in college had also fallen.

In focus groups, stigma, lack of awareness of what was happening when wellbeing was deteriorating, a lack of knowledge of who to turn to and a lack of trust in services and a lack of person centred choice were all seen as deterrents to seeking help when young people were struggling with distress and poor mental health.

*‘And it’s that stiff upper lip and male mind-set thing – you feel [that mental health difficulties are] incompatible with what you were meant to be as a male…and that’s why I didn’t seek out any help and I wasn’t prepared’.*

*‘I think people feel a failure, like mental health is something you don’t want to admit to if you’re working class but also if you come from families with good degrees then you’re going to feel more pressure cos you feel you have to carry all that on.’*

A number of young people talked about not knowing that their mental health and wellbeing were deteriorating until there was a crisis or until there was some other outward sign (e.g. persistent headaches, family conflict and anger, schoolwork suddenly deteriorating). Some felt that there should be more education both for young people and for parents/carers about the importance of good mental health with the development of ‘coping skills’ and promotion of trusted brands of help in schools:

*I think there needs to be more educating young people about what mental health is – the younger the better - knowledge is power…*

*Peer education is the best way forward. You’ve got to learn from your peers.*

Many focus group members felt that peers were the best disseminators of mental health awareness and of local support options on mental health issues, although there were mixed views on whether peers could provide brief interventions. The Dudley Youth Health Researcher survey indicated that friends were the second most likely confidante when a young person had health or emotional issues (between 6% for eating disorders and 28% for health issues). One female in the focus group also felt that she had an opportunity to support friends more effectively:

*[they should] try to tell friends how to help their friends cos I know at this age especially you have so many friends coming to you telling you but then it puts you in a situation and you don’t know what to do…you’ve got all of their problems but you don’t know what to do with it.*

Others expressed a strong reluctance to engage with peer-led support because of low levels of trust and high levels of ‘gossip’ and systematic processes of ‘putting people down’ in school.

The Dudley Youth Health Researcher survey (2016) indicated that young people aged 11-19 were by far most likely to turn to their parents/carers when they had health or emotional problems with:

* 82% saying they would talk to parents/carers about a health issue
* 68% saying they had talked to parents/carers about emotional issues
* 45% saying they would talk to parents/carers about self-harming
* 48% saying they would talk to parents/carers if they had an eating disorder

Many young people in the focus groups saw most parents/carers as a real potential asset and ‘an opportunity’ in terms of helping children access the help they need. However, in focus groups young people felt that their parents’ generation were not always adequately aware of mental health issues and of where to seek help themselves and needed some support to help children effectively:

*‘[We should] educate parents – my parents had no education.’*

*‘You’ve almost got to get the kids educating the parents, I feel. I suppose using examples that people can relate to, and people in the public eye and bringing it more under their nose…’*

*‘We need some way to reach out to parents to give them the signs to look out for, so if their child is wanting to spend more time alone, or not eating like they used general change in schools behaviour .’*

However, they also felt that young people increasingly spent time in their room and away from parents/carers making it more difficult for parents to know what was going on for their child:

*‘When I come home, I don’t spend time with my mum and dad. And it’s increasingly difficult to identify when your child has a mental health problem cos I know what I’m like - I go straight to my room when I come in.’*

There was also a feeling that parents were reluctant to take action because they ‘feel they have failed’ when children’s mental health deteriorates.

Finally, the Dudley Youth Health Survey indicated that with serious issues and self-harming young people were much less likely to approach parents/carers and many more (around 20%) didn’t know who to approach.

**Educational settings and mental health support**

We know from national surveys that *parents* are most likely to turn to schools for help (Green, 2005). On the other hand, the Dudley Youth Health Survey suggested that children and young people in the area were currently unlikely to disclose proactively to teachers (around 5%) or school nurses (between 4% and 6%) compared with nearly three quarters who would talk to their parents/carers.

Focus group participants felt that teachers and lecturers were not generally skilled at identifying underlying mental health issues (despite the fact that most of the school workforce felt relatively confident that they could do this). Focus group participants also felt that the availability and quality of mental health promotion and resources had been variable, based on young people’s experiences, over time, from educational setting to educational setting and particularly as young people transitioned to secondary school or college.

Young people described patchy experiences of mental health input including poor and ‘inaccurate’ PSHE sessions, a lack of general confidentiality when children were accessing counselling (‘everyone knows about it and where you have been’). A lack of confidentiality was also sometimes described among the staff group following a disclosure by a child, and sometimes a lack of awareness of what deterioration looked like and how it presented in young people:

*‘The teachers didn’t really help at college; they didn’t know what I needed[…] I always got really good grades and then suddenly things dropped and I wasn’t doing the work and it was more like they were chastising me for not doing the work rather than trying to understand what was going on under the surface… They could have just asked me how I was doing. I was really sharp in the lessons, I looked ok but I couldn’t keep up with it…nobody asked me why or how I was’.*

*In colleges, it tends to be ignored; they don’t know how to handle these things.*

One young woman recovering from a serious mental illness talked of adjustments being made to her daily routine in secondary school (a mentor who accompanied her everywhere) without any discussion and collaboration with her about this decision. This had resulted in high levels of embarrassment as the mentor sat in at break times with her and her friends. It felt to her as if there was a high level of fear about her illness which undermined her own confidence in her recovery:

*It felt like they were really scared of my diagnosis and they went completely over the top. I had someone who was sitting in and watching me all the time in school, it I was chatting to friends, whatever I was doing. It made me worse. It felt like a barrier so I ended up walking out.*

On the other hand, well informed and confidential pastoral care was seen as helpful. Another girl talked about moving from a school where there was little mention of mental health to a school where mental health, discussion of it and seeking support was a cultural norm; she had no doubt that in this second school girls felt much easier about seeking help early and moving on quickly if they were experiencing stress or distress; whereas in the first school this was not the norm.

This same young woman had also noted a deterioration, based on her younger cousins’ experiences, in the promotion of low level support services in schools – she felt that when her cousins experienced troubles and family conflict, they didn’t know where to turn. On the other hand, when she had been at primary school, there had been routine promotion of Childline. Indeed, it was clear that Childline was particularly well known among these focus group members and it had been used by a few of them at earlier points of crisis or distress (including by males). Many focus group members saw it as a ‘trusted brand’ where workers didn’t make them feel that any issue was too trivial, allowed them to dictate the level and length of help they needed, which was anonymous and which helped them deal with and often de-escalate emotionally distressing issues. It appeared that school (and perhaps media) awareness-raising had not only led young people to know about this specific service but also to use it at points of general emotional distress.

**Things that would improve awareness and provision in school**

Young people described a range of actions they felt would improve awareness and provision for mental health and wellbeing in schools:

* Training for teachers
* Open dialogue on mental health which forms part of the culture and fabric of the school and daily routines
* More mental health promotion (knowledge of what good and poor mental health looks and feels like, what types of support exist and how and where to get help)
* More help to build coping skills and resilience in the face of pressures and adversity
* Greater awareness of the struggles and risks faced by students and looking beneath the surface when changes in behaviour/performance occur
* Asking young people whether they are alright
* Not making assumptions about children – bright children can experience a deterioration in their mental health; and that just because you are ill doesn’t mean you can’t achieve or be trusted
* Co-produce solutions with children; and use the expertise of those with lived experience to support other children
* Confidentiality (and not sharing issues unnecessarily with broader staff groups) is important to young people particularly in schools where they describe an increasingly stressful volume of ‘being judged’ in social and academic settings.

**Seeking broader help**

Young people described a variety of experiences of getting help (ranging from voluntary sector non-specialists in emotional well-being to statutory and voluntary sector specialists and inpatient support). Their experiences had been very variable. A service with a trustworthy brand was a priority for them if they were going to approach an organisation with emotional or mental health concerns. The Dudley Youth Health Researcher’s Survey also indicated that almost three quarters of young people preferred face to face support (although those in focus groups also pointed out that *they* had talked most positively about a child telephone helpline).

Like parents, some young people talked with some frustration about ‘delays’ to getting help. Many young people had very strong opinions about a system of care which they experienced as being led by trying to ‘group young people’ and assess whether children met suitability criteria.

*‘They say ‘no you’ve got to wait until you are bad enough to get help or counselling they deal with the people who have the highest needs first rather than the people who are just coping because that’s the way services have to be because of the funding…’*

*‘Someone who goes through the system, they’re ill and they maybe get help and then things get worse again and then they can’t see their health professional cos they’re not bad enough…you have to wait.’*

Some felt that turning people away because they weren’t a ‘serious enough’ case was short sighted as it led to later escalation; they felt that everyone who wanted support should be able to get help and often small amount of help could make a difference and stop things escalating requiring more help down the line.

Many also talked of the need for a more person-led and individualised approach where help was negotiated much more collaboratively with young people.

Two young people who had experienced severe episodes of mental illness during adolescence felt that the statutory health care they had received had been largely unhelpful. It focused too much on their illness and not enough on their strengths and abilities, what recovery might look like and on promoting hopefulness. They expressed disappointment that statutory services had not been able to think more creatively and work in partnership to find things that would promote their progress.

*‘They showed they cared…they were doing a good job but I felt like they were smothering me[…]They didn’t listen, I felt they didn’t take me or my views seriously… They treated me as if I wasn’t a normal person and it made me believe I was iller than I was …Not believing in me and seeing beyond my illness made it worse …’*

All three young people were now in contact with the Phase Trust and described their episode of mental illness as having made them lose hope and disengage from life. At this point, these young people said that outreach approaches and persistent and patient relationship and trust-building by the Phase Trust had slowly re-engaged them.

*‘Coming here [Phase Trust] was different, it was giving me a purpose, it’s not too stressful and not too heavy.’*

Their recovery was associated with positive reinforcement of their strengths and of the steps they were taking forward, reconnecting with life and routines through attending activities at the Phase Trust (they had some ideas of how to improve these activities), exploring aspirations with staff, developing practical plans as they moved forward, receiving help to achieve these goals and feeling capable and purposeful again:

*‘The Phase Trust is helping me apply for college – it helps me look forward and keeps me going. I was very nervous. But it has helped my confidence the most; it boosted my confidence.’*

This young woman, who had had a very serious episode of mental illness and had previously experienced multiple inpatient placements which ‘made me worse’ and who said she ‘rebelled’ against more clinical approaches, described also how things had turned around when she felt she was ‘treated as a person instead of an illness’ and felt trusted with responsibility by her new employer in a voluntary role accessed through the Phase Trust:

*‘She trusted me, she gave me real experience, and was really boosting my confidence. She treated me as a person.’*

Another young man explained:

*‘They got me to change from just staying in my own room for three months all the time… I wasn’t sure when I first met them but they still continued and they moulded it round what I needed. And first of all it was once a week and then 2 then 3 times a week and I didn’t want to leave at that time and then I started volunteering 6 months ago.’*

He eventually sourced a high quality home study system which was allowing him to achieve again academically in manageable chunks of time; he was disappointed that SEN advisers had previously been unable to help him find more stimulating academic programmes. Another young man had re-engaged successfully with college after his mental health crisis. All elements described by these young people are consistent with Recovery approaches (Shepherd *et al*, 2008) placing emphasis on increasing young people hopefulness, sense of agency and control. Recovery emphasises not only clinical recovery but ‘social’ and ‘personal’ recovery – the importance of ‘building a life beyond illness’. It also focuses on the goals and outcomes that matter to the young person and their family (Boardman *et al,* 2010).

These young people also felt that having access to young people who had ‘been in the same boat’ who had recovered and could give them hope that recovery was possible would have helped their progress and should be considered as part of any system transformation in Dudley:

*‘Hearing from those who have been in the same boat and recovered: Cos if you have been told by someone who has been in the same boat, you think if they can do it I can do it.’*

**Crisis**

One young woman, who had been taken on many occasions to A & E and then to paediatric wards when she was experiencing a mental health crisis, talked about the unsuitability of these settings and of what would have helped her:

*‘I’ve been in mental health A&E too many times. It isn’t the place to be when I am feeling unwell. After A&E I was taken to the children’s ward when I was unwell; and that was awful. It wasn’t the place to put me. I was really ill and running round the waiting rooms, screaming, in crisis and there were other children there. I can’t imagine what that must have been like for them. And I had to wait …in crisis; wait for camhs to come. There were no beds and I’d be there all night until the decision was made to get me into the adolescent unit. Why can’t there be a short term crisis place where you can be held and supported until you have cooled off and stabilised. Then when you have cooled off they can decide. Going into hospital for months I think made me worse.’*

**How much do Dudley’s services meet expected need?**

Securing activity and outcome data on the range of provision, outputs, outcomes and scale of investment by all sectors and services supporting children and young people’s social, emotional and mental health in Dudley has been challenging. This is not a problem unique to Dudley and was raised as a barrier to commissioning in *Future in Mind*. However, good quality whole system outcome data is essential for effective planning and ensuring that what is available is effective, child and youth friendly and adequately meeting need.

This chapter will attempt to make a very broad assessment of the extent to which current provision meets demand through assessing service data that has been supplied by key local services.

**Universal service provision in Dudley**

Ensuring the best start and promoting the mental health, resilience and coping skills of 100% of infants, children and young people.

At the present time, it is difficult to comment accurately on the adequacy of what is provided to support all families, children’s and young people’s mental health due to weakly integrated activity in this tier and poor information. Those consulted through this needs assessment felt that there was insufficient focus on mental health promotion and in building resilience in families, children and young people. They also felt that there was inadequate investment in preventative activity. In schools and colleges, universal mental health promotion support was patchy and variable. Young people themselves felt that growing stress levels were sometimes associated with lower resilience. They wanted more help developing resilience and coping skills.

The majority of stakeholders in this consultation were confused by the landscape of support for children and young people’s social, emotional and mental health needs. This, along with waiting lists for local services, also prevented universal services signposting successfully to get children and families the help they needed. The Family Information Service Website in Dudley appeared a useful resource for seeking out local services but very few stakeholders mentioned it during the consultation.

The needs assessment had limited access to data on the range of services supporting children’s emotional wellbeing, healthy behaviour and resilience at this universal level. However, interviews and focus groups with local practitioners highlighted that activity focused on supporting children’s resilience and mental health was taking place at this level.

Improving the availability of centralised data at this universal level on what is in place to promote children and young people’s mental health should be a priority for future commissioning. Data could capture:

* Activity, interventions and mental health training at this universal level
* The contribution of this support to children’s social, emotional and mental health outcomes identifying key indicators and outcomes of joint interest to local commissioners and tracking progress to demonstrate system transformation.

Better information should also be collected on the scale of whole sector financial investment in mental health promotion.

Around 15% of children may need extra help with social, emotional and mental health and well being

Kurtz (1996) identifies a number of young people who may need a bit of extra help to develop good mental health and coping skills. There are likely to be at least 6000 school aged children needing extra help in Dudley. These may be children who are in distress, whose wellbeing is beginning to deteriorate or from those groups identified earlier who are more at risk of poor mental health (e.g. including those children living in poverty, children with long term physical health problems, looked after children, children with learning disabilities). Many sectors and services are likely to be working with these children to strengthen their resilience. Best practice would suggest that every contact (with midwives, health visitors, social care, primary mental health, teachers etc) counts to build assets, reduce risk factors and identify if families and children need more help. Much of this activity in Dudley is not drawn together and transparently documented.

Consultation and analysis of local data suggests that some children (and families) needing extra help to support their wellbeing are accessing a range of providers including (but not limited to):

* The open access online counselling resource ‘kooth.com’
* The local traded School Counselling Service data (a small proportion of their caseload have sub threshold diagnosable level difficulties).
* The Phase Trust
* The What?Centre drop in being run at one Dudley school
* Top Church Training (for homeless young people)
* Social care teams
* Learning disability services
* Pastoral and school learning mentors
* School nurses
* Connexions
* Midwives and Health Visitors
* Children’s Centres

We have very limited data on how many children and young people are reached overall by services operating at this level. With the exception of kooth.com and some school counselling data, neither has information been provided on the quality of that support in terms of its ability to strengthen resilience and de-escalate deteriorating well-being.

Kooth.com supported around 789 children and young people aged 10 to 18 in the last year providing an average of 3 sessions – perhaps half to two thirds of whom are likely to be young people with sub threshold needs seeking a little extra help. 13% (27) of the Dudley Traded School Counselling Service also accessed young people with this level of need. Wider consultation during this needs assessment suggested that there was insufficient early help in Dudley when children were in distress and needed help. Young people favoured open access help with no waiting periods. Almost all children and young people using kooth.com expressed high levels of satisfaction with the service and stated a preference for online counselling. However, those not using kooth.com in Dudley said in a survey that they preferred face to face rather than online help (n=1260).

Dudley’s commissioners should identify and systematically track key indicators and outcomes which might act as a proxy for tracking how effectively services are working to:

* promote and improve good child and family resilience and mental health
* prevent poor child and adolescent mental health
* reduce priority risk factors for poor child mental health and wellbeing (e.g. improvements in two yearly WEMWEB scores, reductions in child maltreatment).

7% of children will have common diagnosable mental health problems

**Services for children and young people with lower level diagnosable needs**

Kurtz (1996) identifies around 7% of school aged children and young people (2830 young people in Dudley aged 5-16 years) as having less complex diagnosable level mental health difficulties (e.g. severe and persistent behavioural problems, anxiety and moderate depression).

The Centre has used locally supplied data to make a rough assessment of the extent to which the needs of these children and young people are being met in Dudley.

*The reach of school counselling*

It is currently difficult to assess accurately the scale of local coverage by school/college counselling as there is no centrally collected data comprehensively documenting the reach of these services across the 78 primary schools, 20 secondary schools, 5 colleges and alternative educational settings in Dudley. Discussion with providers and with schools indicates that resources for school and college counselling often vary significantly from setting to setting. The following organisations are the main providers of this support locally:

* The School Counselling Service – this service reaches 15 schools and around 140 children a year with some schools spot purchasing as and when needed; others buying places on an annual basis.
* The What?Centre appears to reach approximately 150 children with its school counselling in Dudley schools. They cover around 5 secondary schools.
* Kooth.com (online counselling); the regional manager explained that the service was limited primarily to key higher need areas/schools in Dudley. This service is also meeting a large number of young people needing support to strengthen their resilience (see page 3). For the purposes of this needs assessment, we have assumed that half of the children Kooth sees are likely to have low level diagnosable needs.

A small number of schools and colleges also commission their own counselling services; we were told that this was more common in secondary schools (in keeping with national evidence) (Centreforum, 2015). Some children with low level diagnosable needs will also be seen by other services such as SEN clinicians or by paediatricians. Better quality data should be centrally collected on the reach and outcomes of this provision.

**The reach of The What?Centre**

The What?Centre not only provides school counselling but also provides broader community counselling services for 13 to 25 year olds in Dudley (see Appendix 2 for fuller details on service activity and outcomes). In the last year, this service reached 328 13-17 year olds and anticipates, based on current referral rates, that it will reach a total of 389 in the coming year. The What?Centre has highlighted that current investment by the CCG covers only a third of the costs of its current projected delivery for this 13-17 age group (based on the unit price for its standard 12-session delivery model).

**The Phase Trust**

Information and data supplied by the Phase Trust (an outreach youth service providing health and well-being support to vulnerable children in the community and in schools) suggest that they may also be reaching some children (perhaps 100 children and young people) with this level of need.

**Parenting provision**

There is an active parenting team in Dudley who in January this year completed some work to map and integrate the broad range of parenting provision across the borough. It identified that Dudley has in place a range of parenting provision including:

* Level 4 Triple P parenting programme – NICE guidance compliant provision for children with diagnosable level early behavioural problems (the most common form of childhood mental health problem). This programme is available for 2-11 year olds.
* Triple P for teens
* Triple P standard Stepping Stones for parents of children with a disability (for 2-11 year olds)
* The Family Links nurturing programme (0-11 year olds) – delivered mainly via Children’s Centres
* Positive parenting programme (primary school)

Data was only available for a minority of this parenting provision (see Appendix 2). However, the Parenting Team is encouraging greater integration through supporting all local providers to draw data together to improve the overview of outcomes and activity. This would be a positive move and these data should form a routine part of whole system social, emotional and mental health service tracking and review.

Triple P activity should be considered an important resource locally for supporting children with early starting conduct problems. Left unsupported, these children face greater chance of multiple poor life chances across their lifetime causing them and their families distress and imposing a high burden of cost on a range of local commissioning budgets (Parsonage, 2014). The cost of early conduct problems on society has been assessed as £260,000 million over a child’s lifetime; and interventions are cost effective. Schools are the first beneficiaries of cost savings (in the form of reduced need for frontline staff) and the justice system is the biggest overall beneficiary later on. Social care and NHS budgets also benefit from savings as children are prevented from moving into later crisis affecting these services (Parsonage, 2014). NICE guidance compliant interventions such as Triple P are the most effective intervention for pre secondary school children struggling with severe and persistent behavioural difficulties. The programme also reduces family stress and improves parental mental health and wellbeing (which also benefits children) (NICE, 2013). Parents pick up strategies and approaches through these programmes to help their child learn greater self-regulation of their behaviour. NICE guidance indicates that these programmes should also be a key intervention for parents who have concerns about their child’s hyperactivity and possible ADHD (NICE, 2009). Some practitioners in Dudley said that parents concerned about their children’s behaviour should be prioritised for access to these programmes and see Triple as the first stage in a child’s ADHD assessment.

Triple P programmes need to be well supervised, delivered as intended and highly engaging to ensure they have the best chance of helping families and children achieve and maintain healthy behaviours.

On the basis of the information provided to the Centre, we estimate that high quality parenting programmes reach at best between 200 to 400 children and teenagers a year with diagnosable level conduct difficulties. Some additional parenting services may also be reaching children and young people with conduct difficulties (e.g. Multi Systemic Therapy; Troubled Families; SEN support; Multi-Dimensional Treatment Fostering, other parenting support etc) but many of these will engage with limited numbers and data was not made available during this review. It is unclear whether Troubled Families provide NICE guidance compliant parenting provision as part of their core offer in Dudley. This should be an area for further exploration and consideration as evidence is now emerging from the US that even individually delivered Triple P can be cost effective with higher need families (WSIPP,2016).

In Dudley, at any one time, there will be around 1300 children with early diagnosable level conduct problems (e.g. aged 3 to 10 years) and around the same amount again aged 11 to 16 years.

Based on this analysis of the Dudley parenting data, the Centre anticipates that Triple P is currently covering:

* Just under 20% of diagnosable level need in primary school-aged children
* less than 10% of teenage diagnosable need

The parenting team described disinvestment in parenting provision in recent years. Attempts to train up practitioners in other agencies led to very few co-delivering Triple P programmes.

The total number of children reached through the services seeking to support children with lower level diagnosable mental health needs is as follows:

|  |  |
| --- | --- |
| Summary of service reach | Number of CYP aged 5 to 16 years accessed in 2015 |
| The What?Centre school-based counselling | 150 |
| The Traded School Counselling Service | 140 |
| Kooth.com | 400 |
| Triple P and the Positive Parenting programme | 285 |
| What?Centre community counselling[[26]](#footnote-26) | 328 |
| The Phase Trust | 100 |
| Total coverage | **1,403** |

**Estimated coverage versus likely demand**

The figures in this analysis should be approached with some caution as a great deal of data is missing[[27]](#footnote-27), some assumptions have had to be made and it has also been difficult to disaggregate data by age band and therefore some figures will include a small amount of provision for over 16 year olds. We may also be overestimating the reach of Kooth.com to those with diagnosable level needs (as much of its work may be with children and young people’s sub threshold needs). But it does provide a broad guide to the current scale of unmet need in Dudley. **It suggests that 1427 children and young people with lower level diagnosable needs (or common mental health conditions) may not be able to access effective therapeutic help.** Almost all providers of therapeutic services in Dudley at this level also reported being oversubscribed and having waiting lists for help.

*Primary care mental health service provision for 16 to 18 year olds*

|  |  |
| --- | --- |
| Summary of service reach | Number of CYP aged 16-18 years accessing help for common mental health difficulties in 2015 |
| Improving Access to Psychological Therapies provision | 215 |
| Kooth.com | Included in earlier data |
| What?Centre community counselling[[28]](#footnote-28) | Included in earlier data |
| Total coverage | **c215** |
| Scale of likely need | **1,351** |
| Likely unmet need | **1,136** |

Most data provided by therapeutic services in Dudley were not clearly disaggregated by age. The main service provider for 16 to 18 year olds in Dudley with common mental health difficulties will be the 16 plus Improving Access to Psychological Therapy (IAPT) Service. A Freedom of Information request return has indicated that this service delivered support to 215 young people with common mental health conditions in this age group in the last year. The What?Centre and Kooth.com also deliver services to this age group although their reach to this age group is likely to be far more limited (and their data has already been included in figures relating to secondary school children).

Based on data from the most recent Adult Psychiatric Morbidity Survey (McManus *et al.,* 2016), around 1,351 16 to 18 year olds at any one time in Dudley will have a common mental health condition. Presentations will be much higher in young women.

**Around 1,136 16 to 18 year olds with common diagnosable mental health conditions are currently unlikely to be getting their needs met in Dudley.**

*18 to 24 year olds*

Adult IAPT services indicated that they provided a service for 756 18 to 25 year olds in the last year. GPs also often make referrals to the The What?Centre for this age group. The What?Centre has provided a service for just over a hundred young people in this age group even though it is not formally commissioned to do so. Kooth.com and college-based counselling also provides a limited therapeutic service for young people.

Around 4,396 young people aged 18 to 24 will have diagnosable level common mental health condition which would benefit from early treatment. Patton’s (2014) research suggests that activity to reduce the length and re-occurrence of illness during adolescence is critical to improving recovery rates during adult years. There is, therefore, an argument for maximising reach during these important years.

Taking all of the findings of this needs assessment together, **around 3,459 young people with common mental health conditions in this 18 to 24 age group in Dudley appear not to be receiving any form of service.** The majority of young people presenting with these needs will be young women.

|  |  |
| --- | --- |
| Current services engaging with 18 years plus primary mental health needs | Numbers accessing services per annum |
| Kooth.com | 63 |
| The What?Centre (numbers reached | 118 |
| Improving Access to Psychological Therapies (for 18 to 24 year olds) | 756 |
| The Phase Trust (not possible to disaggregate data) | Not disaggregated |
| College counselling – directly commissioned | No data |
| Total | **937** |
| Current apparent shortfall in meeting diagnosable common mental health needs | **3,459[[29]](#footnote-29)** |

**Highly specialist services: children and young people with very complex diagnosable-level mental health needs**

1.75% of children and young people aged 5 to 16 will have complex and serious diagnosable difficulties

It is clear from data that some services operating at a primary mental health level of need in Dudley (e.g The What?Centre) are also working with some children and young people with higher level or specialist needs. This should be taken into account when considering the extent to which children and young people’s needs are currently met in Dudley at this higher level of mental health need.

Specialist CAMHS is the major provider for children and young people’s more complex mental health needs in Dudley.

The range of specialist CAMHS workers and teams include:

* a specialist multi-disciplinary CAMHS team with 32 WTE practitioners (including Early Intervention in Psychosis practitioners)
* a specialist learning disability CAMHS team (3.4 WTE practitioners)
* a part time mental practitioner working in the Youth Offending Team (no data available)
* A specialist CAMHS deaf team (no data available)

A specialist CAMHS Looked After Children team previously was commissioned but no longer exists in Dudley.

*What data tells us about the service and its reach*

* Data shows that the specialist CAMHS outpatient service receives around 1700 referrals a year on average for support. The Transformation Plan (2015) indicated that around 95% of referrals (around 1600) were accepted[[30]](#footnote-30). Current caseload for the whole team is around 1200.
* CAMHS had a 11% rate of non-attendance which compares favourably with national comparators.
* The team (with the exception of those not working in Early Intervention in Psychosis services) has an average caseload size of 35 (cited in the CQC inspection report). This is slightly below the Royal College of Psychiatrists’ recommended caseload level of 40.
* 88% of referrals in 2015 were for white British young people.
* No breakdown was available on age, type of presentation or complexity of needs. However, the Transformation Plan indicates that boys are more likely than girls to access the service and that of late activity has tended to concentrate more on those in their teens.
* The average length of intervention in 2015/16 from referral to closure was 99 days having reduced considerably from 176 days the preceding year.

CQC inspectorate evidence and consultation indicated that a range of interventions are reported to be available via CAMHS including:

* Cognitive Behavioural Therapy
* CBT trauma and Eye Movement Desensitisation Reprogramming Therapy for trauma
* Systemic family therapy
* Early Intervention in Psychosis approaches
* Psychotherapy

There is a limited eating disorder service in Dudley CAMHS. There is also no crisis Home Treatment Service to support diversion from inpatient settings and to facilitate swift step down following discharge. Neither is there bespoke CAMHS place of safety provision to support and help young people stabilise when they are very ill.

**Waiting periods**

The average wait between referral and assessment for a young person presenting:

* with non-urgent needs was reported as 7 weeks
* with ‘priority needs’ was two weeks
* with urgent needs was that all referrals would be seen within 2 days

It is not clear how long the wait is between assessment and the eventual commencement of an intervention/treatment. It would be helpful to monitor these patterns on a regular basis since many parents/carers, practitioners and young people described very lengthy waiting periods involving many months.

Specialist CAMHS are submitting data on a regular basis as part of the CAMHS minimum dataset. However, this data was not made available for this needs assessment.

**Outcome and satisfaction data**

Specialist CAMHS were not able to provide outcome or satisfaction data for the young people in touch with their services. It is therefore difficult to get a sense of the extent to which young people feel that the support they receive is relevant and how much they make progress. Many CAMHS subscribe to the CAMHS Outcome Research Consortium (CORC). A benefit of membership is that it provides regular analysis of caseload complexity, patterns of contact, types of presentations, range of interventions used, data on the usefulness and relevance of help (which was a criticism during the consultation) and outcome monitoring. In the Centre’s experience the sharing of this data helps local commissioners plan and helps the service monitor, review and adjust activity. Dudley CAMHS stated that they had ceased CORC membership as they felt they were able to analyse this data themselves. However, none of this data was made available on request.

CORC data also makes activity more transparent and helps communicate better what CAMHS do (this requires improvement in Dudley). Given the frustrations that emerged from broader Dudley practitioners and young people during the course of this consultation and needs assessment, it would be useful for CAMHS to be able to showcase more transparently their achievements, who they work with and who they make progress with. Most other providers were able provide some routine outcome data.

It was clear that there were close links with Cherry Trees School (a highly specialised resource for children and young people with emotional difficulties) and that joint work with CAMHS was highly valued by the school. In terms of wider survey feedback, CAMHS were seen as much less well integrated than most other services with wider children’s services activity and with schools.

**The Youth Offending mental health practitioner**

Dudley Youth Offending Service provides a service to all young people aged 10-17 years who come to the attention of the police or courts for criminal offences. It is a multi-agency team including 0.5 CAMHS Practitioner required to conduct mental health assessments and to sign-post young people with mental health needs to the most appropriate service. The CAMHS Practitioner is also involved in the direct provision of targeted services. Analysis of data provided in the Transformation Plan in 2015 suggested an average quarterly caseload of 14 (28 WTE) and completion of around 12 assessments of young people in contact with the YOT a quarter. There had been some fluctuation in caseload numbers over the 6 month period considered.

**The First Step Service for children and young people who have been sexually abused**

Barnardos provide specialist counselling for children and young people who are victims of sexual abuse. The service has one part-time counsellor offering an assessment and therapeutic intervention to around 30 young people a month. Based on an assumption that average intervention lengths are around 8 sessions, this service is likely to be reaching around 50 individual children and young people a year in Dudley.

**The CAMHS learning disability team**

Children with learning disabilities have higher risk of diagnosable mental health difficulties. The CAMHS Learning Disability team provides support to around 200 children at any one time. They receive about a 100 referrals a year. Given the high numbers of school aged children with learning disabilities in Dudley (2895), this service will only be able to meet a small proportion of likely need (947 children with likely diagnosable level mental health needs).

**The What?Centre**

It is clear from their data that The What?Centre also provides support for many young people in Dudley with this more complex level of need. It is not possible to disaggregate their data and assess what proportion of their work would have these more specialist needs. For the purposes of this needs assessment, we have added their data into the earlier section exploring current coverage for lower level diagnosable needs.

|  |  |
| --- | --- |
|  | Estimate of number of children reached |
| Specialist CAMHS outpatients | Around 1600 |
| Learning Disability CAMHS team | 192 |
| YOT mental health practitioner | Around 20 |
| First Step counselling for sexual abuse | Around 50 |
|  |  |
| Estimate of number of children and young people reached with complex specialist needs in Dudley | **1862** |

**The scale of need in Dudley and service reach**

Projections for estimated rates of specialist mental health need suggest that:

* 24 (or 1%) of under 5 year olds are likely to have needs requiring more specialist mental health interventions
* 748 children and young people aged 5-16 are likely to have these higher tier needs.
* 701 young people aged 16 and 17 years will have these higher tier needs (excluding those with emerging personality disorder)

220 16 to 18 year olds and around 895 11-15 year olds will also be self-harming ‘often’ or ‘always’ according to Dudley 2016 school survey data. Many of these will also have a complex diagnosable mental health or neuro developmental difficulties and will thus be double counted in the above figures. We have estimated that roughly half of these young people will not already be counted in the above groups with very serious diagnosable needs. This would therefore add around a further 500 young people who may need help from specialist CAMHS.

This suggests that just over 2000 young people are likely to have serious mental health needs meriting access to specialist CAMHS in Dudley. Many young people with these higher needs will be from vulnerable groups who consultation suggested found it difficult to ‘jump through the hoops’ required to access CAMHS.

**Based on the information provided, it looks as if at least 100 children and young people aged up to 18 years may have serious unmet mental health needs at any one time in Dudley.**

**Tier 4 or inpatient need**

0.075% of children will have very serious problems requiring hospital care

The main units being used in 2015/16 for inpatient placement were:

* Huntercombe Stafford
* Huntercombe Devon
* Woodbourne Priory
* Parkview Hotel

Kurtz’s methodology indicates that around 30 young people would be expected to have needs so severe that they require inpatient treatment. On the other hand, Dudley’s data indicates that only 21 young people entered inpatient settings in the last year which is lower than would be expected for the local population size. Over two thirds were females. The average length of stay in these settings was 77 days and the range was 2 to 232 days. Most were acute cases and the longest occupied bed days (OBD) were also for young patients with acute or medium secure needs (NHSE data, 2016).

Broader Public Health England data also confirmed that:

* child admissions for mental health in Dudley for 0 to 17 year olds are considerably lower than the national average
* hospital admissions for self-harm (10 to 24) are roughly in line with national averages
* child admissions for substance misuse and mental health problems are also roughly in line with national averages.

Given the lack of early intervention at earlier stages in the child and adolescent mental health pathway, it is to the credit of Dudley’s voluntary and statutory therapeutic services that they are generally able to prevent children and young people in crisis drifting further into these settings.

There was concern during the consultation that some children and young people were remaining for inappropriately lengthy periods in inpatient placements; additional concern was also expressed about children being placed some distance from home. One young woman talked about the inappropriateness of A& E settings and paediatric wards when she was in mental health crisis. She favoured a discrete place of safety where she could wait for assessment and slowly stabilise. This young woman was clear that repeat inpatient placements had exacerbated her mental illness and hampered her recovery. She also favoured the use of peers with lived experience to support young people, more listening and co-production and more of a focus on social recovery (which she eventually received through The Phase Trust). Another parent whose son had escalated into crisis talked about the lack of attention to her perspective as a parent when she continued to pick up worrying risks which eventually escalated.

**Meeting serious mental health needs of 18 to 24 year olds**

No data was available for young adults aged 18 to 24 years with more specialist and complex diagnosable needs accessing adult specialist mental health services in Dudley.

CAMHS practitioners reported effective transitions to adult mental health services for those requiring ongoing help and who were already on the CAMHS caseload. There were protocols in place with adult mental health services and if young people were not eligible for transfer, they were referred to primary mental health (IAPT) workers as part of ‘step down’ care. Work began many months before transfer and involved close working as part of the handover. It was CAMHS’ view that too little use was generally made of primary mental health (IAPT) workers for young people aged over 16 years.

However, anecdotal feedback suggested that support for this age group presenting with both common mental health problems and with more serious presentations was not sufficient and largely waited for young people to move into crisis before help was offered.

*Children and young people from vulnerable groups*

**Looked After Children**

There are no longer any specialist mental health resources devoted to supporting the mental health needs of children in care in Dudley. The needs assessment indicates that there will be just under 200 children and young people in care currently residing *in Dudley* (with around the same again outside the borough boundary) with a diagnosable level mental health need. Many more will have sub threshold and multiple emotional and social difficulties requiring resilience boosting interventions or will be on a trajectory towards poor adult mental health without appropriate early support.

These children require interventions to boost resilience and also attachment and trauma informed interventions. Those with the greatest needs will benefit most from interventions such as Flipside multi-dimensional supported fostering, and KEEP resources and multi systemic therapy (for those on the edge of care or at risk of persistent contact with the justice system). Support for children in care and particularly those in foster care was described as considerably lacking in Dudley. Foster carers wanted practical support with behaviour management strategies. They felt that the young people they had managed over the years required practical strategies with self-management and social recovery rather than long term psychotherapy. There was a need for improved emergency support for foster carers who were managing very challenging situations in their homes unassisted. There was also scope to invest in and support foster carer networks more proactively.

Given the numbers of children in care residing in Dudley (and based on a recommended average caseload of 40), this suggests that Dudley would require around 5 members of skilled therapeutic staff (this could be a mixture of primary and specialist mental health staff) to meet the needs of carers and young people. Staff would require excellent outreach and engagement skills as well as particular competencies in attachment related conditions and trauma CBT/EMDR.

Adjusting this shortfall is a priority. These workers should be closely integrated with the new local Early Help local clusters to improve integration between mental health activity in Dudley and the broader workforce. They should also have a virtual foot in the local specialist CAMHS team to support continual professional development (a model which would replicate the YOT mental health practitioner model and should support broader social, emotional and mental health work for vulnerable groups (as many of their children young people will also form part of wider vulnerable groups).

One potential model for consideration to meet the needs of Looked After Children might be the adolescent mentalisation-based integrative therapy (AMBIT) (Bevington *et al.;* 2012). This approach involves frontline support workers (skilled in engaging young people and carers) forming a team and being closely and very practically supported through close access to specialist clinical supervision (in this case experts in attachment and trauma based approaches). The approach could also be effectively used as a clinical model to support personal advisors working with care leavers who, given problems with age-transitional mental health provision in Dudley, are unlikely to be well served and require some additional resources.

In addition, 164 young people in care from Dudley will have diagnosable mental health difficulties and will reside *outside* Dudley MBC. Arrangements with partner counties should be in place to support the therapeutic needs of these children. It was not clear from the consultation how effectively arrangements were currently managed although some disputes between counties were referenced which led to unacceptable delays in treatment for young people in significant crisis at the centre of these financial discussions.

**Children with learning disabilities**

In Dudley, there is a specialist CAMHS team made up of 3.4 WTE clinicians. These clinicians work in collaboration with broader learning disability and children’s services support services to support the needs of these children and young people.

Of the 2,630 children and young people (across Tier 2, 3 and 4) who have a learning disability living in Dudley, 947 will have a diagnosable level mental health difficulty and 79 will have multiple diagnosable difficulties. The 3.4 clinicians currently in place are unlikely to be able to meet the entirety of this need and as indicated earlier, reach around 200 children and young people a year with more specialist needs. During the consultation, there was no feedback about the insufficiency of the CAMHS learning disability service. There was positive feedback about the service design model which was described as outreaching (completing home based assessments and interventions) and integrated with broader support activity.

**Youth Offending Service mental health resources**

It is difficult to assess the adequacy of YOT mental health resources due to a lack of information on the size of the current statutory YOT caseload. The Transformation Plan showed fluctuating caseloads and assessments over the last two years although activity had increased in more recent months with the mental health practitioner having a caseload of 18 (the equivalent of around 36 for a WTE). This may reflect the fact that most YOTs have witnessed reductions in the numbers ending up on the formal YOT caseload (although anecdotal reports of increasing complexity among these young people). In the last year, NHS England has also made some investment across the broader Black Country in health and mental health screening of young people who offend at the very first stage that young people have contact with the police. These services mainly assess and broker to local services. The service is new, and limited data is as yet available. Work is ongoing to dovetail the activity of this new service (a small proportion of which focuses on Dudley) and the broader YOT mental health practitioner role.

**Children at risk of or who are victims of child sexual exploitation**

There is an urgent lack of trauma based specialist support for young people identified as victims of or at risk of child exploitation. 80 young people have been identified as part of CSE monitoring over the last year and although good quality data on prevalence among this group is still lacking, there is evidence that the majority of these children (69) will have some symptoms of trauma and around 30 are likely to have diagnosable level depressive symptoms. There was evidence during the consultation that the mental health needs of these young people were not adequately supported even when they were in significant crisis and motivated to address trauma related issues. Meeting the needs of these young people is a priority.

**Other children**

The Family Intervention Team, who have a new priority to focus on ‘children who need help’, said that they experienced difficulties getting mental health care for the children and young people on their caseload. The needs assessment survey and consultation also noted other overlooked vulnerable groups including:

* children at risk of or excluded from school and who are unable access employment
* children with complex neuro disabilities
* children from some BME communities
* children who are homeless
* children who misuse substances
* pregnant teenagers under the age of 16

**Financial investment in mental health services in Dudley**

No data was provided on the current scale of investment in CAMHS. Although requested, the scale of expenditure on CAMHS related prescribing was also not available.

Public Health data (2016) on spending collated via the ‘Fingertip tool’ has been noted to be somewhat unreliable being dependent on what local areas provide. However, comparing Dudley’s expenditure with national comparators, this toll suggests:

* lower than national average expenditure that other regions on Children’s Centres, on Safeguarding services and on Pupil Referral Systems
* higher than national average expenditure on Looked After Children, on Local Authority Children and young people’s services (excluding educational services), on special school expenditure

The Transformation Plan identified the following expenditure supporting the social, emotional and mental health needs of children, young people and families in this area (although this may not be up to date and appears to be missing some of the key resources identified in this needs assessment). *We also note, that some of the key resources we have identified during this needs assessment (broader school counselling, sexual abuse counselling, IAPT, the Phase Trust, Specialist CAMHS LD team, MDTF and MST) are not included in this table.*

|  |  |  |  |
| --- | --- | --- | --- |
| Tier 1 | | | |
| DMBC | Family Information Service | Universal information directory to aid signposting | 139,000 |
| DMBC | Children’s Centres | Child Development and School readiness Parenting aspirations and parenting skills Child and family health and life chances | £3,000,000 |
| Tier 2 | | | |
| Dudley CCG | Kooth.com | An online counselling service for young people aged 11-25 living or receiving education in the Dudley Borough. | £62,000 |
| Dudley CCG | The What? Centre | A counselling service for young people, between the ages of 13-18 years old and young people with a disability up the age of 25, with a focus on young people who may be at risk. | £135,000 |
| Dudley CC | Children’s learning disability Team |  | £178,111 |
| DMBC | Education Psychology Team | Assessing children and young people so that education settings have a good understanding of how they can support children with additional needs.[[31]](#footnote-31) | £473,000 |
| DMBC | The Family and Adolescent Support Team (FAST) | Triple P Parenting Assessments Family Group Conferencing | £350,000 |
| DMBC | Common Assessment Framework Team Intervention | Completion of Early help Assessments | £107,000 |
| DMBC | Family Intervention Team | Troubled Families | £1,500,000 |
| DMBC | Connexions | Service supporting young people to enter Education, Employment and Training. | £500,000 |
| DMBC | Teenage Pregnancy Team | Supporting the reduction of conception rates | £134,000 |
| Tier 3 | | | |
| Dudley CCG | Specialist CAMHS | A mental health service for children and young people aged 0-16 years with identified or suspected emotional, behavioural or psychological/ psychiatric difficulties for which specialist intervention is required. | £2,774,780 |
| Dudley CCG | Looked After and Adoptive Psychology | Specialist psychologist service for children and young people who are looked after or adopted aged 0-25 years | No longer exists |
| Dudley CCG | Neurodevelopment Delay Service | An in depth and holistic medical and social assessment to support children, from birth up to 5 years of age, in need of additional support and input due to development delays and/or disability | £221,604 |
| Dudley CCG | Youth offending team | Specialist service to support youth offending team (no breakdown of mental health resources . | *Nb Figure in Transformation Plan looks inaccurate.* |
| DMBC | Switch: Young Person’s Tier 3 Substance Misuse Service | A Tier 3 Substance Misuse Service (drugs and alcohol) for young substance misusers that provides a range of specialist interventions that support a recovery focused treatment system. | £347,611 |
| Tier 4 | | | |
| NHS England | Highly specialist CAMHS | Day and inpatient services and some highly specialist outpatient services. | £810,000 |
| Total known expenditure (updated to reflect errors and discontinued services. | |  | 10,732,106 |

On the basis of this slightly incomplete, inaccurate and possibly outdated picture of expenditure, this amounts to spending of just under £11 million on children’s social, emotional and mental health needs.

We also note that the specialist CAMHS contract has reverted to a ‘block’ contract. The Centre notes that NHS England have specifically advised against block contracts for CAMHS services due to the difficulty of monitoring outcomes and performance (NHS England, 2016).

**Joint commissioning**

Those consulted said that joint commissioning in Dudley was under developed. This is particularly unhelpful in the field of child and adolescent mental health as all the evidence suggests that multi sector stakeholders (some of whom include adult and justice services) benefit from good quality commissioning to promote good child and youth mental health, from giving children the best start, from early intervention to de-escalate problems and from having the right interventions in place to restore good mental health in young people. We note the West Midlands Mental Health Commission is looking both at cost effectiveness, at promoting greater joint commissioning and at the most effective methods of delivering care in ways that maximise people’s outcomes and whole system cost effectiveness. However, we also note that at the moment it is not focusing on early intervention in life. The Centre would recommend greater focus be given to early intervention in life as the Commission moves forward.

## Appendix 1

**Establishing a formula for assessing extent of social, emotional and mental health need across the spectrum**

Previous methodologies for assessing mental health need (e.g Kurtz, 1996) have generally focused only on those with diagnosable level or sub threshold clinical need. However, the whole system approach advocated by Future in Mind requires a step change in the way we conceptualise and think about promoting children’s mental health and responding to need. We need a formula that helps us assess what *everyone* needs to develop or maintain good mental health. We also need a way of identifying emerging need (usually described as sub threshold clinical need) or those needing extra help to build resilience because they belong to a vulnerable group whose wellbeing is more likely to escalate. Of course, some children, when they begin to struggle emotionally and socially, will bounce back or find a resolution on their own or with minimal support. Others’ difficulties, if left, will escalate into crisis and worsen causing damage and distress to children and resulting in unnecessary costs for society.

What research tells us is that there are multiple opportunities across the life course and before diagnosable level crises occur to help de-escalate social, emotional and mental health crises. Children’s mental health difficulties are often non clearcut or hidden. Without whole system hypervigilance, young people can get missed. When early opportunities are not identified and seized or when a lack of resources are targeted early on, then there can be an overflow into more specialist or crisis settings.

In 1996, Kurtz developed a formula based on evidence of sub threshold and clinical need. She used this formula to estimate how many children would need responses to support their mental health across the tiered system. The formula assesses around 10% of children having diagnosable level difficulties. It also sub divides children with diagnosable level needs into those with common mental health needs (e.g. those with conduct problems and anxiety and depression) and those with more serious mental illnesses (e.g. psychosis, high risk and complex presentations).

Kurtz’ methodology is based on the Tiered model and sees the 10% of diagnosable need for children aged 5-10 falling across the 4 Tier model in the following proportions:

|  |  |  |
| --- | --- | --- |
| Tier 1 | 15% | Subthreshold need |
| Tier 2 | 7% | Common mental health problems |
| Tier 3 | 1.85% | More complex mental health problems |
| Tier 4 | 0.075 | Very complex or high risk presentations |
| **Total** | **31%** |  |

However, Kurtz’ model does not acknowledge the importance of activity *to promote* good mental health in children and young people (e.g. through school based programmes directed toward the entire population). Based on wider mental health promotion evidence, the Centre has adapted Kurtz’ formula to include this broader evidence. The adapted version of the formula is as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Children’s mental health needs | Proportion of children needing help | | Whose responsibility |
| Universal needs | 100% | All children and young people and families need resources and assistance to build strong mental health in children | Whole system |
| Targeted or early help needs | 15% | Some children and young people need extra help to build resilience because they face greater exposure to risk. Some children also have deteriorating mental health and need early help to deescalate and restore good wellbeing. | Whole system |
| Children less complex diagnosable needs | 7% | Some children will have less complex and risky diagnosable level needs | School counselling, voluntary sector high quality counselling, primary mental health support – using NICE guidance support |
| Children with complex and more risky needs | 1.85% | Very complex or high risk diagnosable mental health needs | Specialist CAMHS and services seeking to avoid further de-escalation – using Nice guidance support |
| Children with highly risky, complex or specialist needs | 0.075% | Some children will have highly complex, concerning and specialist diagnosable mental health needs | Inpatient settings, broader system ‘step down’ services – using Nice guidance support. |

The Centre will, therefore, use this adapted formula to consider children and young people’s and families’ needs across a spectrum in Dudley. The adapted formula aims to build strong mental health from the first spark of life, to de-escalate and restore good mental health early pending any deterioration and seeks to maximise chances of promoting improvement and recovery once children develop different severities of illness or diagnosable needs.

**Appendix 2**

Summary of activity and outcome data received for this needs assessment from services supporting children and young people’s mental health in Dudley.

**Kooth.com**

Kooth.com is currently an important local ‘open access’ (e.g. self-referral and open to everyone) online counselling service in Dudley and data was provided by this service for this needs assessment. The service is commissioned by the CCG for 10 to 26 year olds. Data suggested that the service was engaging with young people presenting with a range of mental health needs - mostly those needing help with social and emotional difficulties. Counselling takes place through online messaging and peer mediated fora. The service is available 24/7.

Discussion with the regional manager suggested that the service was performing above contract expectations in terms of its reach and this had led to the need to limit advertising the service as widely as they wished across the borough. This restriction on its promotion may hinder young people’s awareness of the service and possibly prevent it building up its reputation as a ‘trusted brand’ with local young people. The manager explained that the service was predominantly focused on certain schools in higher need areas. Data for 2015-16 indicated:

* 429 children and young people had been engaged during the last quarter of 2015/16 with an average contact rate of around three contacts per child. 357 children and young people were described as ‘active users’ of the service. The number of children and young people in touch with the service had doubled since the previous quarter. However, registrations had fluctuated considerably month by month over the last financial year.
* The average age of active users over the last year was 16 years of age with just under a quarter of young people being around 13 years of age. The ages of those contacting the service spanned 11-26 years.
* There had recently been an increase in the number of boys contacting the service. However, girls were still twice as likely to engage as boys.
* Two thirds of contact was out of office hours
* 12% of those contacting the service were from BME communities (a slight decrease compared with the previous quarter from 14%)
* 100% of those using the service would recommend the service to a friend and it scored an average satisfaction score of 4.38 out of 5.
* 82% of those using the service said that they preferred online to face to face contact; this needs to be cross referenced with the wider survey completed by Young Health Researchers in Dudley indicating that three quarters of their broader sample of young people in Dudley (n= 1160) preferred face to face contact.

The main presenting issues of young people approaching the service were anxiety, depression, self-worth, confidence and friendships. A small minority of young people had more serious mental health needs.

Overall, in terms of understanding where kooth.com fits in the Dudley system of support for children and young people, it would appear that the service is building resilience, addressing early stage social, emotional and mental health needs and risk factors for poor wellbeing and de-escalating emerging need. It is also picking up a very small number of young people with more serious mental health difficulties.

**School counselling**

The World Health Organisation Whole School Approach sees school counselling as an early stage in-school resource designed to support the majority of students with early stage needs (Wyn, 2010).

**The traded School Counselling Service**

The Schools Counselling Service is a traded service managed by the local Educational Psychology Service. It appears to provide counselling for around 140 children a school year and covers 15 local schools. Schools either purchase counselling places on an annual basis or sometimes spot purchase what they need. Interventions involve a 10 session change approach. Outcome data shows that half of those engaged started with scores of 17 or over on the Strengths and Difficulties Questionnaire. This means that half of their caseloads involve children likely to have diagnosable level mental health needs.

Based on an analysis of one quarter of outcome data, analysis shows around two thirds of these children make improvements compared with their starting points and 20% move out of damaging and distressing clinical (e.g. diagnosable level) ranges. Unusually, 64% of those engaging with the service are boys/males. There is no detail on age or ethnic background. Some counselling was delivered via group work. Data indicates that a small minority had issues which escalated very dramatically over a term resulting in scores suggesting a very high degree of concern and complexity. Some counselling supported safeguarding disclosures and link up to statutory services as follow-up. There were also many other referrals on to other services (Education Psychology and CAMHS) for children whose wellbeing escalated during the course of counselling. The manager explained that the service sought to advise schools on step down and provided ongoing advice on management. The service also sought to provide ‘talk to me’ times for parents and advice on strategies.

The service offered a range of skills including person-centred/integrative counselling, cognitive behavioural therapy, play therapy and drama therapy. Counsellers were qualified and routinely provided with clinical supervision.

**The What? Centre**

The What Centre counselling service has a 33 year history of providing counselling in Dudley. It is part commissioned by the CCG (for 13 to 17 year olds) and part commissioned by Children in Need (for the same age band). Traditionally half of its referrals (mostly from GPs) have been for the 18 to 25 age group although they are not commissioned to provide services for this age group.

The What?Centre has in place a qualified group of staff using a range of counselling approaches including:

* Integrative, psychodynamic and person centred counselling
* Cognitive behavioural approaches
* Play therapy

The What?Centre indicates that Counsellors have developed specialisms in eating disorders, working with suicidal young people and young people affected by trauma.

We would assess the What?Centre as providing both targeted (primary care or Tier 2) and specialist (secondary or Tier 3) services. Data suggests that 9 out of 10 young people have diagnosable level difficulties.

In 2015-16 the What?Centre received 444 referrals mainly from GPs. Referrals have been noted on average to increase by a third each year.

* 328 referrals were for 13 to 17 year olds
* 116 referrals were for 18 to 25 year olds.

**Referral criteria**

Children and young people must have a GP in the Dudley Borough and reside in the Borough. Eight out of 10 referrals are white British young people and three quarters are girls. The non-attendance rate (DNA) for the service is around 10% (which is similar to CAMHS) The service currently has 100 young people on their waiting list to be assessed with a waiting period of 10-12 weeks. Urgent presentations are prioritised although it is noted that urgent demand is also increasing. After assessment, there is a further 6 week wait to access a counsellor. 58 young people are waiting to access a counsellor. Various methods have been adopted to attempt to reduce this waiting period. The service also provides school counselling through a trading arm of its service and investment from this source currently supports work with young adults.

**Vulnerable groups**

The service provides bespoke support service for LGBT young people in the borough through Children in Need Funding. It also provides play therapy and counselling to two women’s refuges

**Outcomes**

The What?Centre uses Core and Outcomes Star measures to track progress for service users towards self-reliance and other goals. Data from use of Outcomes Star indicates that overall two thirds of young people achieve sizeable increases in pre and post scores for ten areas of their lives. Eight out of 10 particularly experience big improvements in mental health and in self-esteem and three quarters report big improvements in trust and hope. The What?Centre outcomes are noted to be consistently better than national outcome star average data.

**Triple P Parenting programme**

Data is available for Triple P programmes but not for broader parenting work in Dudley. Triple P parenting support is a stepped system of parenting support. The best evidence exists for Level 4 programmes (which are specifically effective for children with early behavioural problems helping parents develop approaches and techniques which help settle children’s behaviour) and level 5 programmes (for parents facing complex difficulties whose children have severe and persistent behavioural problems). However, shorter term Triple P seminars are developing a growing and promising evidence base for making a difference to children with behavioural difficulties. Although less proven, there are also Triple P programmes for parents with teenagers with behavioural difficulties.

To be effective, level 4 and 5 group programmes have to be well targeted towards those children already showing signs of behavioural difficulty. They must also be implemented as they were designed and should maximise recruitment and retention strategies.

In the last year:

* 380 referrals were made to Triple P
* around 200 parents completed the programme

Data was only available for one quarter of the year (and only for around 56 parents), but indicated the following findings:

* Average child and teenage Strength and Difficulty Questionnaire scores for those accessing the intervention suggested that parents of children with diagnosable level difficulties were indeed accessing these groups in Dudley.
* There were improvements in Strength and Difficulty Questionnaire scores after completion (although shifts with such a small sample are unlikely to be significant).
* There were larger improvements in parental depression rates, anxiety and stress following attendance (thus also promoting adult mental health outcomes). In almost all instances parents had started in the severe range for distress in terms of depression, anxiety and stress. After completion of the programme distress levels had reduced to moderate.

**The Phase Trust**

The Phase Trust delivers interventions which support the social, emotional and mental health of children and young people in Dudley. In the last year, it has provided 59 young people (aged 12-20) with intensive 1-2-1 sessions to help them overcome emotional and behavioural challenges. This will be at the very least six sessions of between 1 and 2 hours per session. Some support was more intensive extending to 2 to 3 days per week over a 10 week period.

The majority of these young people had complex difficulties, including low-level autism and Aspergers’ conditions, ADHD, high anxiety, eating disorders, and some with histories of suicidal tendencies. Some of these young people had experienced serious mental illness and had disengaged from formal mental health services. Many had huge gaps in their education due to mental ill health.

The Phase Trust uses an outreach approaches and gentle persistence to engage young people and focuses on social and service user led Recovery orientated approaches.

Young people have a personalised programme, which has some common content but is also tailored to their needs and aspirations.

A further 50 young people aged 16-17 received transitional support to enable them to carry on their educational journey, into college or some other form of further education (The Step Up service). All of these had learning difficulties or complex vulnerabilities impacting on their mental health and wellbeing. 90% of these were described as making ‘a successful transition’. The intervention took the form of an intensive three week programme over the summer break, intentionally focused on dealing with issues such as handling transition and change, dealing with potential conflict, being able to speak up if they were beginning to struggle and coping mechanisms for handling anxiety and stress.

**Work on risk factors**

The Phase Trust has also completed school based health promotion work with young women on sexual health and boundaries (n=170) as well as one to one sessions with at risk girls in schools (101).

**Summary of data from specialist CAMHS**

Activity data has been analysed in the main body of the Needs assessment. It indicates that specialist CAMHS receive around 2000 referrals a year and that around 9/10 of these referrals are accepted. The current caseload for the whole team is around 1200. The average length of intervention in 2015/16 from referral to closure was 99 days having reduced considerably from 176 days the preceding year.

The numbers of young people failing to attend appointments was around 11% which is roughly in keeping with national averages.

88% of referrals in 2015 were for White British young people. Boys were more likely than girls to access the service and of late activity has tended to concentrate more on those in their teens.

CQC inspectorate evidence along with our consultation findings indicated that a range of interventions are available via CAMHS including:

* Cognitive Behavioural Therapy
* CBT trauma and Eye Movement Desensitisation Reprogramming Therapy for trauma
* Systemic family therapy
* Early Intervention in Psychosis approaches
* Psychotherapy

Interventions and pathways are closely mapped against NICE guidance to ensure that they are evidence based.

There is a limited eating disorder service in Dudley CAMHS. There is also no crisis Home Treatment Service to support diversion from inpatient settings and to facilitate swift step down following discharge. Neither is there bespoke CAMHS place of safety provision to support and help young people stabilise when they are very ill.

The average wait between referral and assessment for a young person presenting:

* with non-urgent needs was reported as 7 weeks
* with ‘priority needs’ was two weeks
* with urgent needs was that all referrals would be seen within 2 days

No outcome data was available from specialist CAMHS.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Appendix 3:**  **Risk factors for poor mental health and higher risk groups**  (prepared August 2016) | **%/rate** | **Number of children affected in Dudley** | **Those likely to have diagnosable mental health needs** | **Higher or lower than national average** |
| **Family risk factors** | | | | |
| Children under 16 living in poverty | 21.3% | 12,795 | 2060 | Slightly worse than average |
| Children under 20 living in poverty | 20.4% | 15,358 | NK | Slightly worse than average |
| Child wellbeing average score (mean score for 15 year olds) | 48.3 | NA | NA | Slightly above national average |
| Low satisfaction with life (% of 15 year olds reporting low satisfaction) | 12.5% | Around 500 15 year olds | NA | Slightly above national average |
| Average health life expectancy at birth (83.2 and 79.3) | 81.25 years | NA | NA | Similar to national comparator |
| % of households with a lone parent with dependent children | 6.7 | N/K | NA | Better than national average |
| % of households with dependent children where no adult is in employment | 4.6 | N/K | NA | Worse than national average |
| % of households where at least one family member has a disability | 5.03 | N/K | NA | Worse than national average |
| Domestic abuse: incident rate per 1000 of population | 13.3 per 1000 | 4200 | NK | Better than national average |
| Parents in drug misuse treatment (for children >15) | 90.8 per 100,000 | 55 | NK | Similar to national comparator |
| Parents in alcohol treatment | No data for Dudley | No data | NK | No Dudley data |
| % of parents whose current relationship status is separated or divorced | 10.7 | NK | NK | Better than national average |
| **Early years data** | | | | |
| Live births in Dudley per annum (based on 2014 figures) | NA | 3758 | 564 | No data |
| Number of stillbirths | NA | 18 | NA | NA |
| Percentage of mothers smoking during pregnancy in Dudley | 15.7 | 590 |  | Worse than national average |
| % of children achieving a good level of development in good school readiness | 60.6 | 7743 | NA | Worse than national average |
| % of children on free school meals achieving a good level of development in school readiness | 43 |  |  | Worse than national average |
| Teenage conceptions for 15-17 year olds | 27 per 1000 |  |  | Worse than national average |
| School aged children and young people | | | | |
| Primary school children bullied in/near school in last year (2016) |  | 5279 |  | No data |
| of these, number receiving nasty or threatening messages a few times, daily or often with text or instant messaging; 18% received such messages daily or often. |  | 3273 |  | No data |
| Of these, number receiving nasty or threatening messages daily or often |  | 950 |  | No data |
| Number of secondary school children bullied in/near school |  | 3887 |  | Better than national average for 15 year olds based on PHE data |
| Of these, hit for no reason |  | 816 |  | No data |
| Of these, number receiving threatening texts or instant messages |  | 428 |  | No data |
| Children identified with special educational needs |  | 7572 |  | Worse than national average |
| Children with a statement of educational needs |  | 1293 |  | Better than national average |
| Primary school fixed exclusions |  | 220 |  | Better than national average |
| Secondary school fixed exclusions |  | 1893 |  | Worse than national average |
| Pupils with a learning disability |  | 2895 |  | Worse than national average |
| Pupils with speech and language difficulties |  | 1550 |  | Worse than national average |
| Pupils with autism |  | 385 |  | Better than national average |
| Secondary school children who were the victim of violence or aggression in the area they live | 78% | 3998 |  | No data |
| Had been in a relationship where a partner had physically hurt them | 3% |  |  |  |
| Secondary school children carrying a weapon sometimes, usually or all the time | 7% |  |  |  |
| Number of secondary school children missing school due to caring duties | 10% |  |  |  |
| **Vulnerable children** |  |  |  |  |
| Number of looked after children in Dudley |  | 708 | 333 | Worse than national average |
| Of those looked after, number of children who reside in Dudley |  | 368 | 171 |  |
| Number of LAC from Dudley in residential children’s homes in Dudley |  | 21 | 15 |  |
| Number of LAC from Dudley in residential homes outside Dudley |  | 34 | 24 |  |
| Of those looked after, number of Dudley LAC who live outside borough |  | 340 | 162 |  |
| Emotional wellbeing of looked after children: average score | 13.1 |  |  | Fractionally better than national average score |
| Rate of Children in Need during the year in Dudley | 859 per 10,000 < 18 |  |  | Worse than national average |
| % of Children in Need for more than 2 years | 43.7 |  |  | Worse than national average |
| **Other high risk groups** | | | | |
| % of children aged > 15 providing unpaid care | 1.03% | 380 |  | Similar to national average |
| % of children > 15 providing 20 hours plus care a week | 0.21% |  |  | Similar to national average |
| % of young people aged 16-24 years providing unpaid care | 5.8% | 1700 |  | Worse than national average |
| % of young people aged 16-24 providing 20 hours plus care a week | 1.7% |  |  | Worse than national average |
| Family homelessness | 0.6 per 1000 households | N/K | N/K | Better than national average |
| First Time Entrants | 460 per 100,000 |  |  | Similar to national comparator |
| Rate of children leaving care | 28.7 per 10,000 |  |  | Worse than national average |
| Children with a chronic health condition | 10% | 7,500 | At least 1500 |  |
| Number of school aged children with learning disability | 6.5% | 2627 | 850 |  |
| % of school aged children saying they drank alcohol (PHE, 2014 data) | 18% | 7276 |  | Worse than national average |
| Primary schoolchildren who had had more than a sip of alcohol (2016 data) | 6% | c 1351 |  |  |
| Secondary school children who drank alcohol once a week or at least once a week | 6% | c 1074 |  |  |
| College students who drank alcohol twice a week or every day | 12% | C 1415 16-18 year olds |  |  |
| Inpatient admissions per 100,000 for alcohol admission in 2013-14 for under-18 year olds | 51.8% | 35 |  | Worse than national average |
| Inpatient admissions per 100,000 for substance reliance in 2013-14 for under-18 year olds | 92.6 | 30 |  | Similar to national comparator |
| Young people not in education or employment | 3.8% | 430 |  | Better than national average |
| Children and young people at risk of or victims of child sexual exploitation |  | 80 children identified in last year | At least 50 |  |
| Lesbian, gay, bisexual and transgender young people | Not good data |  | Around half likely to self-harm, be bullied and have suicidal thoughts. |  |
| Children from BME communities | 21.4% |  | Prevalence varies among different communities and over time |  |
| Children with a parent in prison | Poor data on numbers affected in local areas |  | Higher likelihood of poor mental health but poor data |  |

**Appendix 4 Centre for Mental Health. Dudley Needs Assessment. 2016**

|  |  |  |  |
| --- | --- | --- | --- |
| **Dudley’s needs assessment: possible outcome measures or key performance indicators for priority areas of need** | | | |
| **Improvement target** | **Possible Key Performance Indicators/outcome measures** | **Measurement method** | **Comment** |
| **Improved early intervention and prevention to give children the best start in terms of their social, emotional and mental health skills** | At least 60% of mothers with maternal mental illnesses (60% of 564 mothers in Dudley) are identified in 2017/18.  Services should track numbers accessing Nice-guidance compliant mental health care. | Performance data from midwives/health visitors assessing how many of the anticipated 564 women are identified annually.  Data should start to be collected on how many mothers are accessing Nice guidance compliant care. This should be compared with national rates (which are poor). Dudley should aim for a 10% improvement on this rate each year. | Would require some new data to form part of the dashboard tracking early years SEMH. |
| 10% reduction in maternal smoking during pregnancy in (add year) | Compare with ONS/PHE Fingertip tool data |  |
| 10% improvement in school readiness of children in Dudley | PHE Fingertip tool data/DfE data |  |
| Increased number of parents of children aged 2-5 with clinical level behavioural problems accessing Nice guidance parenting support. | Analysis of annual performance data. This will require a performance reporting format that reports back by age of child. |  |
| **Nice guidance compliant parenting support will be extended to meet the needs of children with early starting behavioural problems** | The number of children currently being reached will be doubled in 2017/18. | Analysis of annual performance monitoring data. Parenting programmes should aim for 90% of children in clinical ranges reached. |  |
| **Improvement in availability of universal good quality school SEL programmes supporting children’s social, emotional and mental health skills** | Number of children who have received a whole school intervention to develop social and emotional skills in Dudley  Proxies for the effectiveness of such interventions might include:   * percentage reduction in secondary school exclusion rates * improved well-being (measured through biennial HBSCS) * reduced bullying (measured through biennial HBSCS) | Requires an audit to create a baseline. This will then allow measurement of improvement going forward. |  |
| **Improve children’s early access to SEMH help** | Kooth access rates per quarter  School counselling support for those below clinical level  What?Centre individual child drop in rates | Does Connexions input to SEMH (any other organisations contributing?) | Capture better quality information on who is contributing to this. |
| **Improve children’s access to good quality and relevant (CYP IAPT, care relevant to and valued by CYP and parents/carers) support for social, emotional and mental health difficulties for children and young people** | Percentage increase in number of children and young people accessing therapeutic support in Dudley | Accepted referral rates should act as a proxy.  Specialist CAMHS accepted referral rates should be compared with predicted rates in the needs assessment.  Accepted referral rates for those supporting children with less complex diagnosable difficulties should be compared with projected need. | Question: how might we get a better sense of those accessing |
| Time from referral to assessment | Compare with national benchmarks | NHS England expect that Dudley increases its reach to children and young people in Dudley by around 400 per annum until 2020. |
| Time from assessment to treatment | Create benchmark with first report and move towards a percentage improvement annually |  |
| 75% of children are happy with the care they receive | Track quarterly satisfaction rates |  |
| 75% of parents/carers are happy or very happy with the help their child receives | Track quarterly satisfaction rates |  |
| Percentage of children achieving progress or recovery | Using agreed outcome measure tools | There should be increased focus on outcome measurement reporting - in specialist CAMHS particularly. |
| Percentage of children achieving their therapeutic goals | Use Goal-Based Outcomes Measurement tool | All therapeutic services should also use the Goal-based outcomes measurement tool |
| Number of CYP IAPT trained staff in the workforce | Track numbers trained per annum and benchmark against expectations | NHS England expects that around 32 staff in Dudley are trained up by 2020 |
| **Improve available support for vulnerable children. Priority vulnerable groups in Dudley at the moment include Looked After Children, children affected by sexual exploitation and children with learning disabilities.** | In 2017/18, a therapeutic service should be provided for at least 150 LAC and CSE affected children and carers. Percentage increase in reach should be aspired toward during subsequent years. | Reach of social, emotional and mental health support in 2016/17 to LAC and CSE affected children should be recorded and form part of expected performance data from all therapeutic services.  Therapeutic support and advice to parents/carers should be recorded separately  Performance data for the first year should set a benchmark for improvement in the second year. | Current intelligence suggests that hardly any LAC and CSE affected children with diagnosable needs (333 and 50 respectively) are accessing mental health support. Minimal resources are currently in place to meet the social, emotional and mental health needs of the vulnerable children identified.  Carers are also unhappy with the lack of partnership working with them and the lack of pragmatic help for their children to promote social recovery.  These targets to prevent maltreatment in Dudley. Joint commissioning focus sho8ld consider the feasibility of implanting such programmes. |
|  | Number of individual children (LAC and CSE affected) receiving a therapeutic service in 2017 (compare with projected need from needs assessment). | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. Accepted referral rate could act as a proxy. |  |
| Number of individual carers receiving a therapeutic service/consultancy. | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
| Number of accepted referrals for therapeutic support for LAC and CSE affected children. | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
| Time between referral and assessment for LAC and CSE affected children | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
|  | Time between assessment and initiation of intervention for LAC and CSE affected children | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
| 75% of children are happy with the care they receive | Track quarterly satisfaction rates |  |
| 75% of parents/carers are happy or very happy with the help their child receives | Track quarterly satisfaction rates |  |
| Percentage of children achieving progress or recovery | Using agreed outcome measure tools | There should be increased focus on outcome measurement reporting - in specialist CAMHS particularly. |
| Percentage of children achieving their therapeutic goals | Use Goal-Based Outcomes Measurement tool |  |
| **Children with learning disabilities** | Number of individual children with learning disabilities receiving a therapeutic service. | Accepted referral rate can be a proxy | Dudley has higher than expected school age children identified with learning disabilities. |
| Time between referral and assessment for children with LD | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
| Time between assessment and initiation of intervention for LD affected children. | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
| 75% of children are happy with the care they receive | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
|  | 75% of parents/carers are happy or very happy with the help their child receives | This data would need to form part of expected performance monitoring data for all (VSO and statutory) therapeutic services in Dudley. |  |
| Percentage of children achieving progress or recovery | Using agreed outcome measure tools | There should be increased focus on outcome measurement reporting - in specialist CAMHS particularly. |
| Percentage of children achieving their recovery/therapeutic goals | Outcome tracking through **Goal Based Outcome measures**. | Requires audit of how many young people are reached by adult IAPT together with audit of satisfaction rates. Audit should split figures so that |
|  | Number of 16 to 24 year olds receiving a therapeutic service (compared with identified need in this age group of at least 3,000 young people). | Once benchmark is established, aim for percentage improvement. This must be through joint commissioning approach with adult services. |
| **Resources available for 16 to 24 year olds appear insufficient to meet the full extent of diagnosable need affecting this age group.** | Percentage increase in the number of 16 to 18 year olds accessing treatment.  Percentage increase in the number of 18 to 24 year olds accessing treatment | Annual breakdown by Adult IAPT of 16 to 18 year old sub group.  Annual breakdown of other organisations providing therapeutic support to this age group. This will need to become part of reporting data.  Services in Dudley should be reaching at least a third of 16 to 18 year old need (as set out in the Dudley needs assessment). | Moving forward, urgent attention is required to access and to outcomes of 18 to 24 year olds in Dudley. There is good evidence that limiting the length of exposure to mental illness and preventing its reoccurrence improves the chances of experiencing less illness as an adult.  This will require:  -an audit of the current scale of coverage by adult IAPT of this age group.  - an audit of the acceptability of the adult IAPT offer to this age group  -an assessment, based on this data, of the extent to which current need tis being met  -joint work with adult mental health commissioners to review access annually and to improve access for this age group |

**Appendix 1 Strategic and commissioning action plan**

The Action plan is presented in two sections 1) Strategic priorities and 2) Commissioning priorities. We recommend that strategic priorities and commissioning priorities are the most significant areas that require development over the first six months, in order to create the necessary structural and governance framework upon which to base subsequent decisions relating to the priorities for operational delivery. The success of future operational adjustments is dependent upon a shared understanding and agreement about what is to be achieved and in what timeframe. Using the first six months to agree and embed strategic and commissioning decisions and governance will strengthen subsequent operational decisions.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DUDLEY – SOCIAL, EMOTIONAL AND MENTAL HEALTH**  **STRATEGIC PRIORITIES**  **NB First 100 days are quick-wins** | | | | | | | | |
| **PRIORITY** | | **FIRST 100 DAYS** | | **ACTION** | **INTENDED OUTCOME** | **IMPACT ON CHILDREN AND FAMILIES** | **MEASURE** | |
| 1 | |  | | Broaden membership of the current Transformation Board to include wider voluntary sector and school stakeholders. Refresh terms of reference for this Strategic Partnership; Agree how children and young people and parents/carers are represented.  Consider whether more strategic resources are required to lead transformation and implement improved Social, Emotional and Mental Health (SEMH) outcome monitoring. | * Clear signal of intention * Partnership statement * Line of governance to Children’s Alliance and HWB | * Clarity about who is responsible for what * Ability to contribute and receive regular feedback | * Written terms of reference with co-signatories at Executive Board Level | |
| 2 | |  | | Refresh and re-work the SEMH Governance structure and process to ensure more systematic participation by key partners and systematic participation on decisions from CYP and from parents/carers. | * Children, young people’s and parent’s/carers voices will be more centrally embedded in SEMH strategy decisions | * Ability to contribute and receive regular feedback | * Yearly short survey on the experience of participating in shaping the SEMH | |
| 3 | |  | | Analyse Needs Assessment and gaps; interrogate gaps; co-produce a 3 year Social, Emotional and Wellbeing strategy based on known needs | * A Social, Emotional and Wellbeing strategy for Dudley | * Clarity about what is provided for whom. The needs and voices of CYP and parents/carers should be at the Centre of this strategy. | * A written and published strategy available online to all who are interested | |
| 4 | |  | | Produce a simple Action Plan for Years 1, 2 and 3 and review dates. | * An Action Plan which sets out timeframes, development tasks, task owners | * Clarity about what priorities have been made and why | * A published Action Plan with review dates | |
| 5 | |  | | Agree standardised whole system key performance indicator/ outcome measure framework (see Appendix 4) and data collection methods for tracking progress.  Key indicators should prioritise early intervention, improvement in access and parent/CYP satisfaction. | * To collect the same and comparable data across similar service delivery models in Dudley | * This will include patient and service user satisfaction measures. Improvement in access to help should be prioritised as these are key concerns for CYP and parents/carers. | * 90% data collected | |
| 6 | |  | | Plan out how Dudley Transformation activity contributes to national NHS England ambitions to increase MH support and coverage to an additional 70,000 CYP per annum. | * Track access and outcome data to demonstrate improvement in CYP and parental access | * Easier access to help when needed | * Set out in Action Plan | |
| 7 | |  | | Commission a Children’s Workforce and Skills Audit and then write a workforce plan | * To better understand the type of skills available in the total children’s workforce | * Ensure the right staff are available at the right time with the right skills in the right place | * A published workforce skills audit | |
|  | | **6 MONTHS** | |  |  |  |  | |
| 1 | |  | | Liaise with commissioning leads and agree approach to commissioning and commissioning priorities for universal, targeted and specialist services | * To achieve 100% agreement on the commissioning priorities and how they link to the strategic priorities in the early Help and Social, Emotional and Mental Health strategy | * Services will be commissioned to service a coherent pathway of care | * Publish statement about approach to commissioning and spell out commissioning priorities for universal, targeted and specialist services | |
| 2 | |  | | Create multi-stakeholder task and finish group to develop a generic pathway supporting children’s social, emotional and mental health in Dudley. | * A pathway will be created with common language and understanding of everyone’s roles and responsibilities in promoting and restoring good mental health and de-escalating difficulties early. This pathway should make sense to CYP, parents/carers and non-health specialists. | * Clarity about who is doing what and how that will result in smooth pathways of care | * Pathway created and published | |
| 3 | |  | | Develop process and strategy for CYP IAPT workforce development locally (involving statutory and voluntary sector participants). This strategy will outline how Dudley MBC will meet NHS targets for IAPT training. | * More practitioners will be using interventions with the best chance of promoting CYP recovery | * Children and young people will have a better chance of receiving help that makes a difference to their outcomes. | * Track through analysis of outcome data | |
| 4 | |  | | Complete audit on reach of adult IAPT for 16 to 24 year olds in Dudley | * Evaluation of extent to which adolescent and young adult common mental health needs are met | * Evidence collected on the extent to which young adult common mental health needs are met – facilitating more effective pathways and commissioning. | * CYP IAPT data | |
| 5 | |  | | Create Task and Finish group with CYP to co-design an affordable and appropriate pathway to get open access early help | * To create an open access pathway more in keeping with the needs of Dudley’s young people | * Offer will be shaped by young people from Dudley. | * Satisfaction rates tracked for the open access service. | |
| 6 | |  | | Work with HealthWatch Youth Champions and School Forum to develop a script for school/college website with signposting links for help on SEMH | * Improve awareness and signposting | * CYP and parents have better information | * 70% of schools adapt website to include promotion of SEMH resources. | |
| 7 | |  | | Work with HealthWatch Youth Champions and a Parent/carer task and finish group to develop support plan for parents to respond more effectively to CYP SEMH needs in Dudley | * Parents/carers feel equipped to support CYP in Dudley | * Parents/carers feel equipped to support CYP in Dudley | * Resource produced | |
|  | | **1 YEAR** | |  |  |  |  | |
| 1 | |  | | Approaches that support positive outcomes for children and young people’s emotional health and wellbeing should be built into all contracts and service specifications. | * Greater integration | * CYP and parents and carers experience more joined up system | * Adjustments to all contracts | |
| 2 | |  | | Identify and respond to workforce training needs based on skills audit | * To match skills to need * To inform commissioning and budget planning | * Skills are available at the right level in the right place | * Publish a Training and Development Plan for the children’s workforce | |
| 3 | |  | | Review strategic priorities , data and information and consider necessary changes | * To adjust priorities and take account of data analysis, impact and outcomes | * Services received are regularly reviewed and adjusted, ensuring continuous improvement | * The SEMH Strategy and Action /Transformation Plan is formally reviewed and adjusted for the following year. | |
| 4 | |  | | Complete audit of universal school programmes in Dudley promoting social, emotional and mental health skills. | * to understand the scale of current CYP SEMH skill building in schools | * children want more focus on building SEMH skills in schools | * Report on availability of provision with recommendations for improvement | |
|  | | **2 YEAR** | |  |  |  |  | |
| 1 | |  | | Use data to review strategic priorities, data and information and consider necessary changes. | * To adjust priorities and take account of data analysis, impact and outcomes | * Services received are regularly reviewed and adjusted, ensuring continuous improvement | * The SEMH Strategy and Action /Transformation Plan is formally reviewed and adjusted for the following year. | |
| 2 | |  | | Review training and development plan | * To inform commissioning and budget planning | * Skills are available at the right level in the right place | * A repeat skills audit shows improved skills across the workforce. | |
| **2 DUDLEY CHILDREN AND YOUNG PEOPLE – SOCIAL, EMOTIONAL AND MENTAL HEALTH**  **COMMISSIONING PRIORITIES**  **NB FIRST 100 DAYS ARE QUICK-WINS** | | | | | | | | |
| **PRIORITY** | **FIRST 100 DAYS** | | **ACTION** | | **INTENDED OUTCOME** | **IMPACT ON CHILDREN AND FAMILIES** | **MEASURE** | |
| 1 |  | | * Commission multi-agency and multi stakeholder (parents and CYP) care pathway development task and finish groups to review and simultaneously co-produce easy to understand pathways required to support the implementation of the CAMHS Strategy, to ensure all children are able to access the right service at the right time. These pathways should be shaped by and make sense to non-health specialists. | | * Pathways of care for: * ***Early intervention, prevention and parenting support*** * Perinatal and infant mental health * Support and intervention in universal/targeted settings * ***Improving waiting experience and times initiatives*** * Simplifying and clarifying referral processes to specialist CAMHS. * Assessment and intervention by specialist CAMH clinicians and practitioners * Responses to self-harm * Responses to first episode of psychosis * Crisis intervention and home treatment * Inpatient care including Eating Disorders * ***Specialist mental health assessment and treatment for vulnerable children at risk of developing mental disorder including LAC, sexually exploited/abused, Youth offending, learning disability, ASD, ADHD, neuro developmental disorder, challenging behaviour, self-harm, suicidal ideation, A&E, transition, LGBT*** | * Services are available that respond to need | * Published pathways of care that are reviewed annually | |
| 2 |  | | * Agree transparent budgets and areas for co-commissioning | | * There is clarity about who is commissioning what, based on CAMHS strategy priorities | * As above | * Budgets agreed as early as possible and separate and co-commissioning areas confirmed | |
| 3 |  | | * Service specifications agreed against the areas prioritised for first 12 months | | * Providers are clear what is being commissioned, the review cycle, evidence base and outcomes measures to be used | * As above. Children, young people and families have regular opportunities to shape service design and review | * Service specifications are published | |
| 4 |  | | * Take steps to transfer specialist CAMHS back to a non-block contract as per NHS guidance. Ensure that there are sufficient resources in place to review contract progress (quality *and* quantity). | | * Easier to track activity and in keeping with NHS England guidance | * Greater transparency on what is expected of specialist CAMHS and what is being achieved | * Specialist CAMHS managed by non-block contract | |
| 5 |  | | * Consider contracting specialist CAMHS to re-establish membership of CORC. | | * Easier to track case complexity and outcomes | * Greater transparency in relation to who is accessing CAMHS and on outcomes achieved. | * CORC provides comprehensive overview of specialist CAMHS outcomes. | |
| 6 |  | | * Review current contract expectations and payment for The What?Centre and for kooth.com to ensure contracting adequately covers activity. | | * Contract more closely matches level of activity |  | * Contract more closely matches level of activity | |
| 7 |  | | * Initiate recruitment of staff to social, emotional and wellbeing teams in schools and colleges. Create structure and process for embedding these teams in Early Help settings, in schools, in colleges and with GPs. Embed the voluntary sector in this commissioning approach. | | * To increase availability of easily accessible non-stigmatising services enabling school, GP and self-referral, early intervention, consultation, training and professional support. | * More services are available in non clinical settings * A range of interventions is offered | * Increase in numbers of CYP seen in community settings; decrease in number of referrals to specialist CAMHS. * The voluntary sector is directly and consistently involved through clear commissioning model providing opportunities for mixed methods of accessible delivery. | |
| 8 |  | | * Initiate recruitment aiming to double current coverage of NICE compliant parenting provision for children with early starting behavioural difficulties. Parenting link workers should link with Early Help Hubs and social care teams. | | * Double number of children reached by NICE complaint parenting provision. This will reduce the number of | * reduce poor child and parental mental health | * Quarterly outcome monitoring via Transformation Board | |
| 9 |  | | * Promote DfE Promoting Wellbeing in Schools and WHO, 2015 what works in enhancing social and emotional skills in schools. Enhance support for delivering PSHE on mental health and emotional wellbeing | | * To take a more strategic approach in engaging and supporting individual schools’ approach and school clusters | * CYP experience improved responses to their needs in the school environment | * Schools report improved understanding of how to develop PHSE and promote wellbeing in schools | |
| 10 |  | | * Initiate recruitment of staff for vulnerable young people’s team (prioritising LAC, Care leavers and children at risk of or victims of CSE). Create a structure and process for embedding teams in Early Help settings, in schools, in colleges and with GPs. Practitioners should be highly outreaching in approach and skilled in trauma and attachment based approaches. | | * better met need for vulnerable CYP, more appropriate skills and better service design | * LAC/CIN/CSE affected children and carers are satisfied with their ability to access help and with quality of help offered. | * tracking access data and satisfaction data | |
|  | **6 MONTHS** | |  | |  |  |  | |
| 1 |  | | * Commissioners specify to statutory and non statutory service providers the evidence based interventions to be delivered against known need and its required outcome measures across the spectrum of need and point of delivery (in collaboration with providers) | | * All delivery is evidence-based and CYP, parent/carer & clinician reported outcomes measures are routinely collected | * Assurance that all interventions from parenting support to intense community based crisis work and inpatient care is evidence-based | * Audits and data demonstrate compliance with evidence based interventions and routine outcomes measurement including satisfaction with service delivery | |
| 2 |  | | * Commissioners consider jointly implementing a good quality universal programme to reduce maltreatment (e.g. Family Foundation) | | * Reduced maltreatment, CIN and maltreatment. | * proven to reduce maltreatment | * Track using key performance indicators. | |
| 3 |  | | * SEMH teams to support school Youth Champion system * resources provided to sustain initiative | | * Better promotion of early help | * CYP will shape promotion and how system works | * School Champion system set up | |
| 4 |  | | * Commissioners promote access to [*MindEd*](http://www.minded.org.uk)  and work with providers to develop support and education toolkits similar to the Toolkit for Social Care – for example a Toolkit for Primary Care, and a Toolkit for Schools | | * More staff in universal settings are educated and supported in recognising and responding to mental health needs of CYP | * CYP will experience staff who understand their needs and who can respond and refer appropriately | * Annual survey reveals improvements in basic knowledge of all staff about mental health | |
| 4 |  | | * Commissioners work with NHS England and begin Shadow Tier 4 commissioning planning | | * Planning for transition of Tier 4 commissioning responsibilities begins | * Patients experience is seamless and the local services are more responsive to need | * A written transition plan produced which sets out the arrangements for handing over commissioning responsibilities for specialist inpatient care | |
|  | **1 YEAR** | |  | |  |  |  |  |
| 1 |  | | * Commissioners work towards completing Tier 4 transition | | * A seamless transition with all risks managed | * As above | * As above | |
| 2 |  | | * Consider personalised budgets for LAC | | * More flexible provision | * Greater parent/carer and CYP choice | * Create plan for introduction of personalised SEMH budgets for LAC | |
| 3 |  | | * Commissioners consider Vanguard developments and how they might meet needs of children with complex physical, neurodevelopmental and mental health needs | | * develop a plan for increased holistic support for children with very complex needs | * parents and CYP more satisfied with support offer | * parent/carer and CYP satisfaction data | |
| 4 |  | | * Commissioners consider enhancement of crisis intervention and home treatment as *invest-to-save* in order to reduce the number of admissions to hospital. | | * No young person is admitted to hospital with highly specialist mental health condition because of lack of resource in community settings | * Young people experience the best possible care in least restrictive environment | * Further reductions in inpatient episodes and out of area treatments | |
| 5 |  | | * Service specifications, data and outcomes reviewed | | * Observations are fed back to the CAMHS Strategic Partnership, JCB and HWB; providers are engaged in co-producing new priorities and workforce development needs responding to the priorities set in CAMHS Strategy | * CYP and parents are engaged in the review and have the opportunity to contribute | * New specifications, data requirements and outcomes measures are published as necessary and built into the review cycle | |
|  | **YEAR 2** | |  | |  |  |  | |
| 1 |  | | Service specifications, data and outcomes are reviewed | | Observations are fed back to the CAMHS Strategic Partnership, JCB and HWB; providers are engaged in co-producing new priorities and workforce development needs responding to the priorities set in CAMHS Strategy | CYP and parents are engaged in the review and have the opportunity to contribute | New specifications, data requirements and outcomes measures are published as necessary and built into the review cycle | |
| 2 |  | | A full perinatal and infant mental health service is commissioned to allow early intervention and support, strengthen knowledge and practice | | Improve liaison between primary care, midwifery, adult 5mental health, CAMHS and children’s services; identify vulnerable families; reduce puerperal psychosis; reduce post-natal depression; improve | Improved antenatal and perinatal mortality; mothers vulnerable to mental health problems are identified and supported; vulnerable families receive support, are more resilient; infant attachment is promoted. Parents tell us they know about these services and can access them. | Perinatal and infant mental health is included in the CAMHS Strategy and in published commissioning priorities | |

**Appendix to CVO**

**Dudley workforce skills audit (outline specification )**

Centre for Mental Health is currently in the process of completing:

* a needs assessment
* and co-producing a strategic action plan

to help strengthen and transform whole system mental health promotion and support for social, emotional and mental health and wellbeing for 0-25 year olds in Dudley.

As part of local Transformation activity, Dudley Public Health have asked the Centre to investigate a methodology to assess whole-system workforce capabilities for supporting children both to thrive socially and emotionally as well as to maximise their chances of recovering swiftly from declining mental health in the borough. Workforce development in this field should not only be about building evidence-informed skills, competences and confidence; it should also be about creating a shared whole system understanding, vision and effective partnerships - creating a robust starting point for developing local pathways. It will help ensure that existing skills in the workforce are better identified and integrated across the local area and that any gaps are highlighted and addressed in strategic planning as Dudley moves forward. It will also ensure that the entire system (universal, targeted and specialist support) includes the necessary basic and specialist skills to help it move forward in a confident, evidence based and integrated way.

**Methodology**

The proposed skills audit would link closely with the current needs assessment and strategic planning already underway in Dudley. It would use the Child and Adolescent Mental Health Service (CAMHS) integrated workforce planning tool first developed as part of the CAMHS National Workforce Programme in 2011. It follows a recognised process set out in Figure 1:

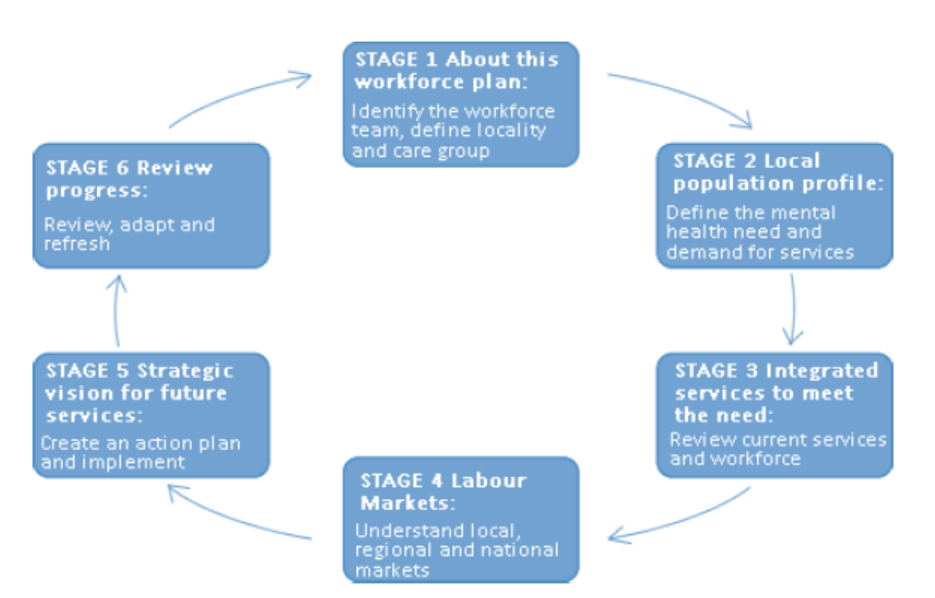


Figure 1: Stages of skills audit and workforce planning process

The workforce audit would prioritise social care teams, school workforce, GPs and Tier2/3 therapeutic services supporting children’s mental health for completion of the tool. Further teams could adopt the tool going forward. It would include a focus on four main areas:

1. As a starting point for any skills and training audit, it will be important to get a better sense of the case mix for each therapeutic service (e.g. targeted and specialist or Tier 2/3). The case mix, in combination with data forthcoming from the broader needs assessment, should provide a helpful proxy indicator of the mix of the specific skills needed locally. Detailed service data has not been readily available through the current needs assessment process for all services and ideally requires some short term multi-agency tracking to get a better idea of therapeutic caseload mix. This activity will involve a one month audit focused just on presenting needs for all organisations working in tier 2 and 3 during September.
2. During the same period, we would ask all of those operating in targeted and specialist (Tier 2/3) therapeutic services to complete the online **Self-Assessed Skills Audit Tool (SASAT).** The SASAT is a well-established integrated CAMHS workforce tool used for those working in Tier 2 and 3 clinical therapeutic settings. **This tool can be used to strengthen each practitioner’s continual professional development. It also provides an overview of workforce interests, confidence, strengths and training needs at team, organisational and system level in a local area. The effectiveness of the audit process relies on getting a good response rate from local teams and would require local implementation backing and support. At the start of the initiative, we would seek to identify workforce development ‘champions’ who can promote and support this audit locally. We would envisage the following teams/practitioners being asked to complete the online SASAT:**
   1. **the Dudley Specialist CAMHS team**
   2. **the Educational Psychology and school counselling team currently led by Dawn Goodall**
   3. **The YOS health practitioner**
   4. **The WhatCentre team**
   5. **kooth.com team**
   6. **School counsellors**
   7. **Barnardo’s counselling services for children affected by child sexual abuse**
   8. **Triple P/FAST parenting programme provider and team members**
   9. **Adult IAPT providers and teams (for 16 to 25 year olds)**
3. **Moving on to consider the skills and capabilities of the broader universal workforce, the Centre has identified a gap in the availability of an up-to-date and appropriate audit tool exploring skills, interest and confidence in social, emotional and mental health and wellbeing among those working in universal services. However, discussions with national CAMHS workforce development leads suggests scope to build further on the former Essential Capabilities developed as part of Children’s Workforce Development council in the mid-2000s and used as part of workforce development initiatives in areas such as Yorkshire and Humberside (Yorkshire and Humber Children’s Workforce leads group, 2013).** **We would therefore ask universal services and schools to complete an online audit exploring confidence and knowledge in respect of the following core capabilities which are deemed essential for supporting children’s social, emotional and mental health:**

* Recognition of the importance of social and emotional health and their own role in promoting this.
* Understanding the local landscape of targeted services supporting social, emotional and mental health, referral routes and how to access support
* Knowing how to communicate with children and young people including children with disabilities
* Knowing about and recognising the importance of risk, protective factors and resilience in the face of adversity
* Knowing about and recognising the impact of bullying
* Understanding infant, child and adolescent development
* Understanding the impact of parental mental health on children and young people
* Understanding the importance of building positive emotional health, self-esteem and demonstrating the ability to incorporate this into own work
* Ability to respond helpfully to a child or young person who is troubled, by listening appropriately
* Ability to provide practical advice and support to parents

1. **Finally, current needs assessment activity has identified a number of diverse training providers in Dudley. We would wish to map this provision more closely to support the creation of a more coordinated local training plan. This mapping will help identify what resources already exist but merely require better promotion in Dudley and which resources will need to be sought outside the borough.**
2. **Centre for Mental Health will then analyse returned data and compare findings with best practice benchmarks producing an integrated and updateable workforce plan and summary report:**
   * **identifying local strength in terms of current competencies, interests and confidence**
   * **identifying gaps or areas for development requiring further investment in training**
   * **pinpointing how competencies and expertise might link together to form clearer pathways for help benefitting local children, young people and families**
   * **analysing workforce demand and retention issues**
   * **highlighting local training needs and provision to support workforce development**

**Timing of the work**

Given that we are now approaching the summer leave period, it would not be helpful to start audit activity until September although we can fine tune tools during the summer. We would envisage the work taking place between September and the end of January 2017 with two months allocated for the completion of the skills audit with staff. Final recommendations would be made by the end of January 2017.

**The Centre’s team**

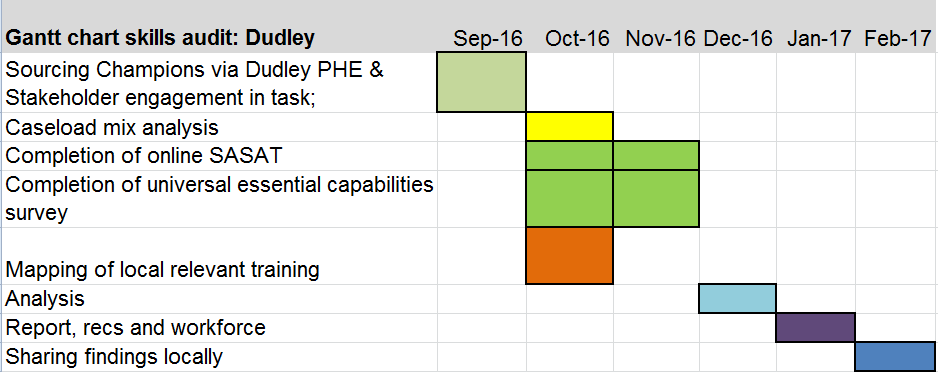
Lorraine Khan would lead the work, analysis and action planning and Geena Saini or Jessica Stubbs would complete statistical analysis of findings of returned data.

**Further advisable work**

Ideally, this type of skills, interest, confidence and knowledge audit would go hand in hand with work to find out what parents and young people might value to promote their mental health literacy (e.g. knowledge about how to promote and identify when a child or young person is struggling and ability to understand what services might be best placed to help locally). This developmental work could be usefully pursued through the HealthWatch-supported Youth Researcher initiave as a parallel piece of work.

**Budget and Gantt chart**

|  |  |  |
| --- | --- | --- |
| **Dudley workforce skills audit** | **Number of days** | **Costs** |
| Development/adaptation of tools and stakeholder engagement | 5 | 3750 |
| Meetings, admin and dealing with queries | 3 | 2250 |
| Analysis | 15 | 11250 |
| Report writing | 15 | 11250 |
| Feedback to teams/meetings | 5 | 3750 |
|  |  |  |
| **Sub total** |  | 32250 |
| VAT @20% |  | 6450 |
| Travel |  | 1000 |
|  |  |  |
| **Total (inclusive of VAT)** |  | **39700** |



LK/CMH/27/06/16

**Challenges and moving forward**

Centre for Mental Health spoke with 195 people, including service providers, practitioners, parents, carers and young people about children and young people’s mental health in Dudley.

The Dudley needs assessment identified insufficient early help for children’s mental health and wellbeing linked to schools and colleges. People seeking help found it difficult to find out about all the help available and referral systems were complicated and help did not always feel well integrated.

|  |  |
| --- | --- |
| **You said** | **We will…** |
| 1. Nine out of ten people consulted in Dudley felt that there was not enough focus on promoting children and young people’s resilience and mental health as they grow |  |
| 1. There is a lack of attention and coordinated action to address adverse childhood experiences and family-based risk factors for poor mental health   *‘[We] need to know what we all can offer and how we all fit in’.* |  |
| 1. Accessing help was frustrating for everyone in Dudley. There are insufficient therapeutic services for children with common mental health problems (for example open access help; school, online and community counselling; parenting interventions). This led to long delays for help and to children drifting into crisis   *‘When you get to CAMHS you are not at a healthy stage, you’re already in crisis, your child’s unwell and the waiting times make it worse…you are at the end of your tether and if you don’t get help, things get even worse…’(Parent/carer)* | A team of 7 school/college-based emotional health and wellbeing practitioners will be recruited in Dudley to work with school nurses, counselling providers, online counsellors, parenting teams, SEN teams and linking to specialist CAMHS. This will strengthen what is available in Dudley and provide children, young people and families with the right help in the right place at the right time. It will also help prevent CYP drifting into crisis and into specialist care. |
| 1. Referrals systems for getting specialist help are confusing and frustrating for parents, young people and schools. |  |
| 1. Young people said they want trusted open access help that doesn’t categorise them or hurry them, places their views and wishes centre stage and helps them quickly get back on track when their resilience or mental health was tested.   *There’s not child centeredness…just criteria centeredness’.* |  |
| 1. Parents/carers say they want support that listens to their perspective, is compassionate, that provides practical advice and that works in partnership with them to support the wellbeing of their children.   *They didn’t listen to me…things got worse*  *‘Listen to us we know our children’* |  |
| 1. Family difficulties were identified by the workforce as one of the main factors undermining children and young people’s mental health and wellbeing in Dudley – and family support was identified as missing by schools. |  |
| 1. Schools and colleges were seen to have important opportunities to promote children and young people’s mental health and wellbeing and to signpost children and young people to the help they needed; but schools often struggled to know what to do and to get children the help they needed.   *It’s hard for schools to do all those things [they have to do] but at the end of the day […] kids have to come home and read and write… but they also have to be a fully functioning adult.* |  |
| 1. Young people often turned to parents/carers in Dudley when they had mental health difficulties. They felt parents/carers could be better assisted to help young people.   *‘We need some way to reach out to parents to give them the signs to look out for, so if their child is wanting to spend more time alone, or not eating like they used general change in school behaviour.’* |  |
| 1. Practitioners felt concerned about fragmented service responses and a lack of integrated working. |  |

1. Although we note that in the first year only £143 million was actually spent. [↑](#footnote-ref-1)
2. NB prevalence data from the last child psychiatric morbidity survey is now potentially outdated. It will be updated in 2018. Most UK longitudinal data suggest that there has been no recent dramatic increase in poor mental health among young people although there may be a worsening in the prevalence of emotional problems for teenage girls. [↑](#footnote-ref-2)
3. Live update of ONS data provided by local worker and based on April 2015 to March 2016 figures. [↑](#footnote-ref-3)
4. Chimat Fingertip tool data based on 2015 data [↑](#footnote-ref-4)
5. Based on HBSC survey sample size [↑](#footnote-ref-5)
6. Based on HBSC survey sample size [↑](#footnote-ref-6)
7. Based on figures presented in recent Ofsted report [↑](#footnote-ref-7)
8. Total number of LAC in Dudley minus those in residential settings who have higher prevalence rates [↑](#footnote-ref-8)
9. Based on 2009 data XXXX our survey may be able to update this. [↑](#footnote-ref-9)
10. Based on 2009 data XXXX our survey may be able to update this. [↑](#footnote-ref-10)
11. based on an aggregate from 2012/2013/2014/2015 HSCIC data [↑](#footnote-ref-11)
12. https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training [↑](#footnote-ref-12)
13. Based on meta-analysis by Egger and Angold, 2006 [↑](#footnote-ref-13)
14. Midpoint [↑](#footnote-ref-14)
15. Midpoint [↑](#footnote-ref-15)
16. Midpoint [↑](#footnote-ref-16)
17. Based on outdated prevalence data which should ideally be updated with new rates in 2018 [↑](#footnote-ref-17)
18. Some children will have more than one condition [↑](#footnote-ref-18)
19. Based on outdated prevalence data which should ideally be updated with new rates in 2018 [↑](#footnote-ref-19)
20. Numbers will not add up as some children will have more than one co-existing condition. [↑](#footnote-ref-20)
21. Based on McManus et al, 2016 which sets out sub threshold symptoms for some diagnosable difficulties [↑](#footnote-ref-21)
22. Based on those with CIS-R score of 6-11 which is below clinical cut off. [↑](#footnote-ref-22)
23. Prevalence rates for eating disorders were missing from the most recent psychiatric morbidity survey. This figure is based on 2007 assessments of prevalence in this age group. [↑](#footnote-ref-23)
24. In the 2016 survey, the methodology for identification of young people screening positive for personality disorder changed to include just self-completion using the SCID-II questionnaire. During previous surveys, both self-completion and clinical assessment combined to identify those screening within clinical ranges. This has had the effect of increasing the numbers now identified with both ASPD and BPD in the 2016 survey in the 16 to 24 age group. [↑](#footnote-ref-24)
25. This summary is based on an analysis of local strategic documents and is limited to the information provided by those who engaged with this needs assessment [↑](#footnote-ref-25)
26. This data has not been disaggregated for 16 and 17 year olds. [↑](#footnote-ref-26)
27. There is not data available for the Positive Parenting Programme being run locally or for Family Links which runs mainly for under five year olds in Children’s Centres. [↑](#footnote-ref-27)
28. This data has not been disaggregated for 16 and 17 year olds. [↑](#footnote-ref-28)
29. This is based on 2016 prevalence rates for Common Mental Health conditions as set [↑](#footnote-ref-29)
30. There appeared to be some errors in the data forwarded for this needs assessment which prevented more accurate analysis of referral rates. [↑](#footnote-ref-30)
31. The school counselling service is a traded service which I understand sits outside this provision. [↑](#footnote-ref-31)