



**Children & Young People's
Mental Health Coalition**

Overlooked and forgotten

A review of how well children and young people's mental health is being prioritised in the current commissioning landscape

**Laurie Oliva & Paula Lavis, 2013
Children and Young People's Mental Health Coalition**

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Foreword

Barbara Rayment, Chair of the Children & Young People’s Mental Health Coalition

“A leading priority for the Children and Young People’s Mental Health Coalition is ensuring children and young people’s mental health stays high on the health agenda. Earlier this year, we set out to discover the extent to which the new health and social care commissioning structures, introduced in April 2013, shared our concern. It proved a challenging task; requiring the Coalition’s staff of Laurie Oliva and Paula Lavis to review the inclusion of children and young people’s mental health across 145 joint strategic needs

assessments and 142 joint health and wellbeing strategies. Our findings provide a mixed picture - with some promising practice, as well as areas which are worrying. Sadly, the majority of JSNAs did not include children and young people’s mental health, and where it was included, too often the data was out of date and inconsistent. Good quality data is vital when it comes to understanding local needs and commissioning well to meet those needs. We know from the evidence that providing good

prevention and early intervention services can have a significant impact in reducing the human cost of mental health problems amongst children and young people. In an era of tight financial expenditure, better assessment and understanding of need to drive effective commissioning also makes good economic sense. The steps that could be taken to improve the situation are simple and alongside our findings, also included in this report are a number of recommendations that could make all the difference.”



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Executive Summary

Under the Health and Social Care Act 2012 local authorities and clinical commissioning groups (CCGs) are, through their health and wellbeing boards (HWBs), required to undertake a joint strategic needs assessment (JSNA) to assess the current and future social care and mental and physical health needs and assets of the local population and a joint health and wellbeing strategy (JHWS) which sets out the health priorities and how these will be met. Clinical commissioning groups and local authorities have a statutory requirement to take account of the JHWS in their commissioning plans.

Every child and young person, regardless of their circumstances,

deserves the right to be mentally healthy. Mental health problems often have their roots in childhood, so tackling problems when they first emerge is both morally right and cost effective (Department of Health, 2011a). Mental health problems in childhood are associated with poor outcomes in adulthood. For instance, people who had severe conduct problems in childhood are more likely to: have no educational qualifications, be economically inactive and be arrested (Richards et al, 2009).

Supporting the mental health of children and young people is not just a task for specialist child and adolescent mental health services. Early intervention is vital and building resilience in children and

young people is something that many universal services, such as schools can help do. Health and wellbeing boards have a good opportunity to bring together relevant agencies and create a shared vision that will influence local commissioning plans.

This review, carried out by the Children and Young People's Mental Health Coalition, seeks to assess the extent to which children and young people's mental health has been prioritised in the new commissioning landscape. To measure this we have reviewed the 145 JSNAs and 142 JHWSs that were in the public domain in early 2013, from the total 151 HWBs.

Key Findings

- Two thirds of JSNAs did not have a section that specifically addressed children and young people's mental health needs- where there was a section it was sometimes limited to a paragraph and where there wasn't a section relevant data was placed throughout the document rather than grouped together as a comprehensive needs assessment making it difficult to find and more likely to be overlooked by professionals consulting the document
- One third of JSNAs did not include an estimated or actual level of need for children and young people's mental health services in their area
- Where levels of need were estimated there were three types of data commonly used: hospital admissions data; rates of referral to child and adolescent mental health services (CAMHS) and calculating local prevalence rates for children and young people's mental disorders by extrapolating from national data
- Hospital admissions data and CAMHS referral rates only provide information about children and young people who have reached a critical stage and don't provide a full picture of need
- The most commonly used data for generating an estimate of prevalence of need was from the study of children and young people's mental health conducted by Green et al at the Office for National Statistics in 2004. This study was undertaken almost

ten years ago and prior to the recession and other significant social and cultural changes which are likely to have had an impact on children and young people's mental health

- Despite the transition from child to adult services being repeatedly highlighted by a range of agencies as in need of improvement, data about the mental health needs of young people aged 16-25 was especially limited in the JSNAs. The tool for assessing child and adolescent mental health needs provided by the child and maternal health intelligence network only provides data about 5-16 year olds and this may have contributed to the lack of data about young people in this older age band.
- There are certain risk factors that are known to put children and young people at greater risk of experiencing mental health problems. Whilst almost all JSNAs included numbers of children and young people experiencing some of these risks, only one fifth of those JSNAs highlighted the link between these risk factors and mental

health. In the majority of cases, data about risk factors was not included in a section about children and young people's mental health- meaning its relevance to assessing this need may be overlooked

- Many JSNAs and JHWSs were difficult to access and the information relevant to children and young people's mental health difficult to find
- One third of JHWSs did not prioritise children and young people's mental health
- Nearly all JHWSs included priorities related to risk factors that research shows can lead to an increased likelihood of a young person experiencing mental health problems, such as not being in employment, education or training; living in poverty; having a learning disability etc. though the majority did not explicitly link these priorities with children and young people's mental health



Recommendations

Health and Wellbeing Boards

Alongside the recommendations outlined in the Children and Young People's Mental Health Coalition's 2012 briefing paper *What Health and Wellbeing Boards Can Do to Help Children and Young People with Mental Health Problems* the following recommendations are added:

1. That all local areas sign the Department of Health's pledge (DH, 2013) to show their commitment to improving the health of children and young people. Among other things, the pledge states that those who sign it are determined to:

improve the mental health of our children and young people by promoting resilience and mental wellbeing and providing early and effective evidence-based treatment for those who need it

support and protect the most vulnerable by focusing on the social determinants of health and providing better support to the groups that have the worst health outcomes

2. That all JSNAs include a section specifically about children and young people's mental health needs which use a comprehensive range of data to estimate local levels of need for children and young people's mental health services and involve a wide range of partners in the needs assessment. Additionally, that the needs assessment be kept accessible and up to date.

3. That all JHWSs include children and young people's mental health as a priority and that specific

actions are included for addressing local children and young people's mental health needs which are based on evidence of need in the JSNA and that a wide range of local partners have been involved in determining. Additionally, that JHWSs include outcomes to measure the impact of proposed actions.

Department of Health

4. That a national survey of child and adolescent mental health is commissioned to establish the prevalence of mental health needs in this group. This is important as the last national survey of child and adolescent mental health was in 2004. Commissioners need to have access to up-to-date information that they can use to better understand local need.

5. That data from this updated study and all other data about children and young people's mental health be divided into five-year age bands as recommended in the Report of the Children and Young People's Health Outcomes Forum. This will ensure that data is available in a useful form, allowing services to be commissioned based on the distinct needs of children and young people at different stages of their development. Additionally, data about young people's health up to the age of 25 should continue to be presented in five-year age bands, including data from adult data sets.

6. That the recommendation in the Report of the Children and Young People's Health Outcomes Forum to "adapt and extend the existing outcomes within the NHS outcomes framework" be followed to make sure that outcomes adequately cover mental health. As outlined in the forum report, the outcomes particularly pertinent to children

and young people's mental health are: time to diagnosis/start of treatment, effective transition from child to adult health services and age-appropriate healthcare.

Public Health England

7. That existing guidance and tools on how to assess children and young people's mental health needs and commission children and young people's mental health services are updated to ensure they are in line with current government guidance, refer to the most recent data available and incorporate how to assess the needs of and commission services for children and young people up to age 25.

8. That such guidance and tools are made easily accessible to health and wellbeing boards and commissioners through Public Health England's child and maternal health intelligence network. Also, that such materials be promoted to them through relevant networks such as the Public Health England's regional offices, Local Government Association (LGA) regional networks and health and wellbeing board chair networks.

9. That an evidence review is commissioned into existing research on risk factors related to children and young people's mental health. This review should be made easily accessible to health and wellbeing boards and clinical commissioning groups to enable a better understanding of the links between some wider determinants of health and children and young people's mental health.

Introduction

Children and young people's mental health

What is Children and Young People's Mental Health?

People often confuse the term mental health with mental health problems. The World Health Organisation (WHO) define mental health as being 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2011). This definition illustrates that mental health is a positive term and a key component of health; and is similar to other terms you may have heard of, such as emotional wellbeing, or psychological wellbeing.

Mental health problems refer to a wide range of difficulties, which vary in their persistence and severity. Mild problems are at one end of the spectrum and severe mental illness at the other. It is well established that children and young people who experience certain risk factors are at greater risk of developing mental health problems. These risk factors can be within the child, within the family and within their environment (Department of Health, 2008). The more risk factors experienced, the greater the chance they will develop mental health problems. Conversely, there are well known protective factors, which help build resilience in the child and reduce the risk of mental health problems developing.

Health and wellbeing boards need to understand the distinction between mental health and mental illness and appreciate that the support needed is not only going to be specialist child and adolescent mental health services. Children at risk of, or who have mental health issues will need a wide range of support that is provided by a range of agencies. Building resilience is something that many universal services, such as schools can do. Health and wellbeing boards are in a good position to bring together relevant agencies and create a shared vision that will influence local commissioning plans.

Why children and young people's mental health is important

Every child and young person, regardless of their circumstances, deserves the right to be mentally healthy. Mental health problems often have their roots in childhood, so tackling problems when they first emerge is both morally right and cost effective (Department of Health, 2011a). Mental health problems in childhood are associated with poor outcomes in adulthood. For instance, people who had severe conduct problems in childhood are more likely to: have no educational qualifications, be economically inactive and be arrested (Richards et al, 2009).

A key objective of the Mental Health Strategy is that 'more people will have good mental health' (Department of Health, 2011a); and early identification and intervention was identified in support of the economic case for the Mental Health Strategy (Department of Health, 2011b). Article 24 of the UN Convention on the Rights of the Child states that

Children have the right to good quality health care (Office of the UN High Commissioner for Human Rights, 1989).

1 in 10 children and young people are known to have a mental disorder, and many more are likely to have emerging mental health problems that haven't yet reached the clinical threshold of a disorder (Green, et al. 2004).

Despite the high level of need, children and young people's mental health is often low on the list of local priorities and is often sidelined. Health and wellbeing boards are in an ideal position to act as local champions for children and young people's mental health and ensure that their area is doing all it can to help them.

The Economic Case for Investing in Children and Young People's Mental Health

- Mental illness during childhood and adolescence results in UK costs of £11,030 to £59,130 annually per child (Department of Health, 2011b).
- It is estimated that the 45% of children who have mild or moderate conduct problems go on to commit half of all crime at an annual cost of some £37 billion (Sainsbury Centre for Mental Health, 2009).
- The economic burden of mental health falls on all statutory services (Romeo, et al., 2006), so investing in children and young people's mental health will help partner organisations represented on the H&WBBs save money in the longer term.



Policy Context

Health and Wellbeing Boards

Under the Health and Social Care Act 2012 unitary and upper tier local authorities have a statutory duty to set up a health and wellbeing board (HWB). Local authorities and clinical commissioning groups (CCGs) are, through the HWB, required to undertake a joint strategic needs assessment (JSNA) to assess the current and future social care and mental and physical health needs and assets of the local population and a joint health and wellbeing strategy (JHWS) which sets out the health priorities and how these will be met. Clinical commissioning groups and local authorities have a statutory requirement to take account of the JSNA and JHWS in their commissioning plans.

JSNAs

The completion of JSNAs has been a statutory requirement for local authorities and the NHS since 2007. The Health and Social Care Act 2012 transferred the responsibility for the completion of JSNAs to health and wellbeing boards. The Department of Health's Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (2013) states that the JSNA should include an overview of the physical and mental health and social care needs of their population; the local assets that could be used to meet those needs and a consideration of the wider factors that affect local health such as employment; the environment and levels of deprivation.

They should include both quantitative and qualitative data and might also be informed by

detailed needs assessments of specific aspects of their community or of specific aspects of health or care.

The Department of Health guidance gives a clear explanation of what JSNAs are:

"JSNAs are assessments of the current and future health and social care needs of the local community. – These are needs that could be met by the local authority, CCGs, or the NHS CB. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities." (Department of Health, 2013)

Why they are important

The evidence in JSNAs is used to inform the development of the priorities in the JHWS that the health and wellbeing board must produce. Together these two documents should influence the commissioning plans for the CCG and local authority. A comprehensive understanding of local needs can ensure that the right services are commissioned to improve local health and wellbeing, which could improve both the value for money and the impact of services. Establishing needs and priorities with clarity could also help ensure that clear outcomes are set for commissioned services.

JHWSs

JHWSs are strategies for meeting the needs identified in JSNAs. The Department of Health's Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies gives a clear explanation of the purpose of JHWSs:

"They should explain what priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. Again, it would not be appropriate to specify or dictate issues which should be prioritised. This is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives. JHWSs should translate JSNA findings into clear outcomes the board wants to achieve, which will inform local commissioning – leading to locally led initiatives that meet those outcomes and address the needs." (Department of Health, 2013)

Why they are important

"CCGs, the NHS CB, and local authorities' plans for commissioning services will be expected to be informed by relevant JSNAs and JHWSs. Where plans are not in line with JSNAs and JHWSs, CCGs, the NHS CB and local authorities must be able to explain why." (Department of Health, 2013)

Along with the JSNA, the JHWS should guide commissioning plans in the local area across both the CCG and the local authority. Whilst both the local authority and the CCG will have to take into account additional considerations beyond the priorities in the JHWS when determining their commissioning plans, the JHWS should play a key role in shaping the commissioning agenda. The JHWS is also important as it empowers the HWB to challenge the CCG and the local authority if commissioning plans are not in line with the JHWS. If something is not included in the JHWS, it may be less likely to be prioritised in commissioning plans.



Objectives

The objectives of this review were to:

- understand how health and wellbeing boards assessed children and young people's mental health needs locally
- find out whether children and young people's mental health was considered a priority by health and wellbeing boards
- determine to what extent health and wellbeing boards made links between wider determinants of mental health such as poverty, youth offending and employment and children and young people's mental health
- identify good practice
- assess if health and wellbeing boards would benefit from support or guidance in relation to understanding children and young people's mental health and establish what that support would look like and who would need to provide it

Methodology

To achieve these objectives a review of all JSNAs and JHWSs that were in the public domain was carried out. This amounted to 145 JSNAs and 142 JHWSs. Health and wellbeing boards that were identified as being exemplars of good practice (good practice criteria is outlined on page 17 of this report) were contacted for further information about their local approach to children and young people's mental health.

The data recorded about the JSNAs was:

- when the JSNA was last updated
- whether it included a section on children and young people's mental health

- whether it included an estimated or actual local level of prevalence of children and young people's mental health needs
- where a local prevalence level was given, what data was used to measure this and what year this data was from
- whether data was included about the following groups who are known to be more vulnerable to mental disorders: children eligible for free schools meals, young offenders, NEET young people, children living in poverty, children subject to a child protection plan, looked after children, children and young people using alcohol and drugs, teenage conceptions, pupils with an SEN statement
- where data was included about these groups, we recorded where it was from and what year it was from

The data recorded about the JHWSs was:

- whether they were in draft or final form
- whether children and young people's mental health was included as a priority
- if it was a priority, whether it was included as a lead priority or as a sub-priority
- which lead priority it was included in, if relevant

When determining whether children and young people's mental health had been prioritised within the strategy, we considered that it had been given priority according to the following criteria.

1. Children and young people's mental health was a lead priority.

For example, one area's JHWS included a priority to address '*Increasing Volumes and Complexity of Need: Children with Mental and Emotional Health*

Problems' and included extensive information on the mental health needs of children and young people in the area and how these would be addressed.

2. Mental health was a priority and it included children and young people's mental health as a sub-priority.

For example, one area listed the priority '*Better mental health and wellbeing*', and included the specific actions '*1. Ensure early intervention with children at risk of developing emotional and/or mental health issues,*' and '*2. Develop and improve access to psychological therapies for children and young people.*'

3. Children and young people's mental health was included as a sub-priority within broader priorities relating to children and young people.

For example, one area listed the priority '*Learning and skills across the life course*' which included the sub-priority '*Increase support to enable young people and adults to improve resilience / mental toughness and key life skills*'.

Strategies that mentioned children and young people's mental health but did not outline a clear intention to put measures in place to address it were not considered to be prioritising children and young people's mental health. For example, some strategies had a priority of reducing child poverty, stating this would improve the mental health of children and young people, but they included no specific actions addressing children and young people's mental health.



Challenges in conducting this review

Determining the number of health and wellbeing boards

There is a lack of clarity about the number of health and wellbeing boards. We referred to two lists: one produced by the King's Fund and the other by the Local Government Association. As the King's Fund lists includes some district councils that have chosen to set up a health and wellbeing board without a statutory obligation to do so, we decided to use the LGA list and so reviewed the JSNAs and JHWSs for the 151 boards on that list.

Availability of JSNAs and JHWSs

It was not possible to locate both of these documents for every health and wellbeing board. Of the 151 health and wellbeing boards, we were able to review 145 JSNAs and 142 JHWSs. The others could not be found through an online search.

Almost half of the JSNAs we found had not been updated since 2012, when the Health and Social Care Act 2012 transferred responsibility for their completion to the health and wellbeing boards. However, the legislation did not specify a timeframe in which they should be updated. It is possible that some of the JSNAs have been updated more recently than we recorded but are not in the public domain.

Of the 142 JHWSs reviewed, 71 were published as final documents, 67 were published as drafts and 4 were published as early stage 'in development' documents. Some of the drafts and 'in development' documents were found among the minutes from health and wellbeing board meetings, rather than as final published documents. This means that a substantial number of the strategies reviewed were not completed and might be subject to future changes as they progress through further consultation stages.

Format

The format of the JSNAs varies extensively, so whilst some JSNAs are very accessible, others are not. This is not surprising as guidance from the Department of Health states that:

"As with JSNAs, they (JHWSs) are produced by health and wellbeing boards, are unique to each local area, and there is no mandated standard format." (Department of Health, 2013)

Some areas approach the JSNA as an on-going process with a continual update of different chapters of the document, whilst others approach it as a complete project which is reviewed in full periodically. Some of the formats were very hard to use without encountering further barriers such as dead links to documents and pages that no longer exist, or incomplete sections. This means that in a small number of cases, data may potentially have been included, but because we couldn't find it, we were unable to record it. In all cases, considerable effort was made to locate data. The inaccessible nature of some of the documents is a key finding in itself. The supposed importance of the JSNA may be undermined by the fact that some of them are so inaccessible, both to the public and to professionals commissioning local services.

Similarly, the layouts of the joint health and wellbeing strategies varied substantially. Generally strategies had a small number of lead priorities, typically between five and ten and each of these had several sub-priorities. In some cases each priority had as many as twenty or more sub-priorities.

Findings

Joint Strategic Needs Assessments

- Almost two thirds (63 per cent) of JSNAs did not have a section that specifically addressed children and young people's mental health.
- Amongst the third that did, there was substantial variation in the amount of information included, with many not including more than a short paragraph.
- Amongst the two thirds that did not have a section about children and young people's mental health needs, relevant information was either not included at all or was placed throughout the document or website and often no link was made to mental health making the information difficult to find.
- Whilst almost half (47 per cent) of JSNAs had been updated in 2012 or later, the data used in the majority of documents was not as recent- this is detailed further below. Twenty per cent of JSNAs did not have a date that showed when they were last updated.

Prevalence of children and young people's mental health needs

- One third of the documents did not include an estimated or actual level of need for children and young people's mental health services in their area.
- Of the two thirds that did estimate a level of need for services, there were three types of data predominantly used to make the estimate:
 - hospital admissions data (for



suicide, self-harm, mental disorder- different documents used from none to all three types of hospital admissions data)

- referral rates to child and adolescent mental health services (CAMHS)
- Calculating local prevalence rates for children and young people's mental disorders by extrapolating from national data – this is the approach used by the Child and Maternal Health Intelligence Network (ChiMat) needs assessment tool: Child and adolescent mental health (CAMHS for local authorities and CCGs).

• Using a range of relevant data provides a comprehensive picture of local need, however over two fifths of JSNAs used only one type of data to estimate levels of need.

- Both hospital admissions data (which two fifths of JSNAs that estimated need for services used) and CAMHS referrals data (which half of JSNAs that estimated need for services used) only provide information about children and young people who have reached a critical level of ill mental health and who have reached the threshold for intervention. CAMHS referral data provides no information about children and young people who have not been referred to CAMHS so cannot provide evidence of the overall need for mental health services.

- Additionally, as funding to CAMHS services is cut (YoungMinds, 2013) it is possible that the threshold for referral will be raised, meaning that increasing numbers of children and young people who have mental health problems will no longer be able to access support from CAMHS, and so their needs will no longer be reflected in the rates of referral.

- A third of those who estimated the need for children and young people’s mental health services relied on data from the survey conducted by the Office of National Statistics in 2004. This was the last national epidemiological survey and is now almost a decade old. This is the data used in the ChiMat needs assessment tool which may be why so many areas are using it. Figure 3 below shows the high amount of JSNAs which are relying on this data to estimate current need for services.

- Data about the mental health needs of young people aged 16-25 was especially limited in the JSNAs. This may be because much adult health data is presented in wide age bands that make it difficult to extrapolate information about younger adults. For example, the data for adults accessing NHS specialist mental health services is presented in an age band of 18-35. Where data is available in narrower age bands, for example in the Adult Psychiatric Morbidity Survey, each age band has a relatively small sample size. This makes it more difficult to generalise from this data and estimate local

need. Additionally, the ChiMat tool only includes data about children and young people aged 5-16 and this may also contribute to the paucity of data about young people outside of this age range.

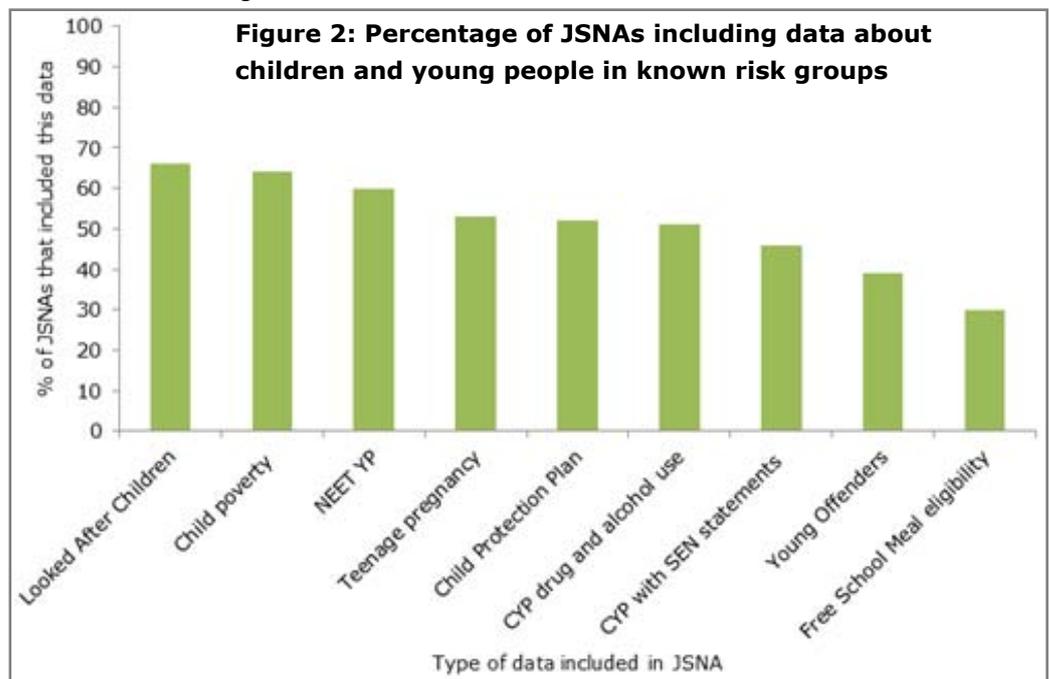
Children and young people at greater risk of mental health problems

- It is well established that children and young people who experience certain risk factors are at greater risk of developing mental health problems (see appendix 1). Including information about numbers of children and young people experiencing these known risk factors in a JSNA would provide a more comprehensive analysis of local need and a clearer understanding of what factors and services, besides CAMHS, could help improve children and young people’s mental health and emotional wellbeing in both the immediate and longer term. The ChiMat commissioning guidance Better Mental Health Outcomes for Children and Young People: A resource directory for commissioners recommends including data about vulnerable

children and young people in a needs assessment and lists some of these vulnerable groups.

- Almost all (94 per cent) of JSNAs included some data about numbers of children and young people experiencing risk factors that are known to contribute to a higher chance of mental health problems. The majority of JSNAs however (78 per cent) did not make a link between these risk factors and the mental health of children and young people experiencing them. In over two thirds of JSNAs such information was not included in a section about children and young people’s mental health even where such a section existed, meaning its relevance to understanding local levels of need may be overlooked.

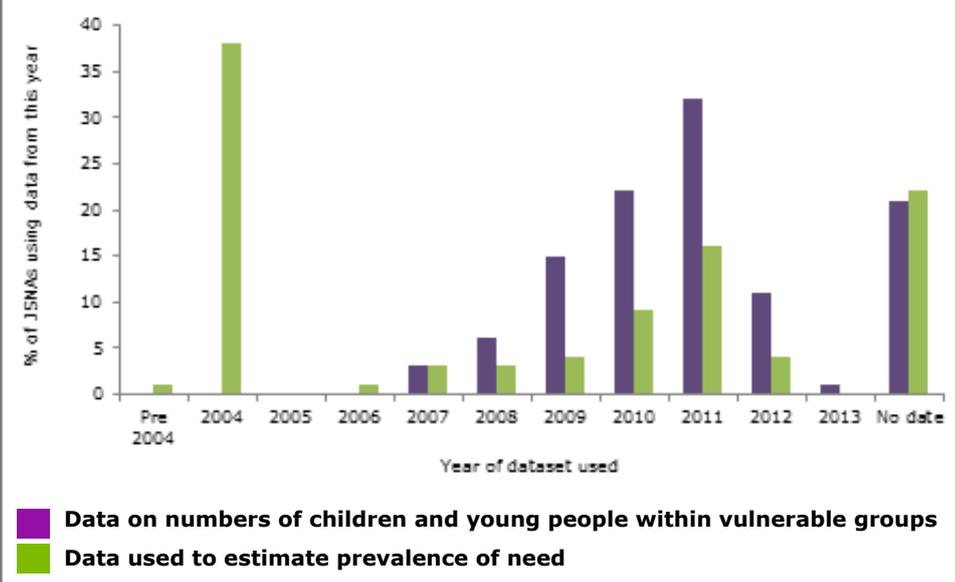
Figure 2 shows the percentage of JSNAs that included data on the numbers of children and/or young people within each of the groups listed. Appendix 1 gives details of research about known risk factors that could make children and young people more vulnerable to mental health problems- including research about all the groups included in Figure 2.





- Taking into account the delay in availability of some datasets, not all JSNAs used the most up-to-date available information about levels of children and young people’s mental health needs or the numbers of children and young people within vulnerable groups. Figure 3 shows the year of the data included in JSNAs about the prevalence of children and young people’s mental health needs and about children and young people in vulnerable groups.

Figure 3: Date of data used in JSNAs to estimate prevalence of need and about risk groups



Joint Health and Wellbeing Strategies

One third of JHWSs did not prioritise children and young people’s mental health.

There was also significant regional variation in prioritisation. Using the nine regions defined by the LGA list of HWBs, the following table sets out the extent to which boards in different regions prioritised children and young people’s mental health:

Region	Number of HWBs in the region	Number of strategies we reviewed in region*	Number of strategies that prioritised CYPMH	Percentage of strategies that prioritised CYPMH
East	11	11	5	45%
East Midlands	10	10	6	60%
London	33	29	21	72%
North East	12	9	7	78%
North West	23	21	15	71%
South East	18	18	14	78%
South West	15	15	9	60%
West Midlands	14	14	7	50%
Yorkshire & Humber	15	15	10	67%

* It was only possible to review strategies that were publicly available

Of the 94 (66%) of JHWSs that did prioritise children and young people’s mental health:

- 6 had children and young people’s mental health as a lead priority
- 19 had a mental health priority within which they included children and young people’s mental health as a sub-priority
- 69 included children and young people’s mental health as a sub-priority within a broader children’s health priority such as ‘Giving every child the best start in life’ and outlined specific actions they would take to address it

That 66% of boards are prioritising children and young people’s mental health is promising, and it could be positive that 88 of the 94 JHWSs

embed children and young people’s mental health as a sub-priority within a wider mental health or children’s health priority, as this could be indicative of a holistic approach to children’s health.

However, there may be a risk that where children and young people’s mental health is included alongside tens of other sub-priorities the focus on mental health could be diluted, and that commissioners might not accord it the attention it deserves. However,

it is not possible to draw any firm conclusions about this without analysing commissioning plans. It is also concerning one third of the JHWSs reviewed did not include any reference to children and young people’s mental health. This is despite the government’s commitment to early intervention, research evidencing the importance of addressing mental health problems early, and the strong links between children and young people’s mental health and other important factors such as their physical health and educational attainment (see appendix 1).

Good Practice

Whilst reviewing the JSNAs and

JHWSs we identified areas that had conducted thorough assessments of children and young people’s mental health needs in their area and had also prioritised children and young people’s mental health within their joint health and wellbeing strategies. We contacted these areas for further information about their approach and how their needs assessment and JHWSs had affected their commissioning plans for children and young people’s mental health. This section outlines the key commonalities in the

approach of four of these good practice areas.

Two of those areas are London boroughs- Area A and Area B. Area A has high levels of economic deprivation and ethnic diversity. Area B has areas of both high prosperity and high economic deprivation -it also has high numbers of looked after children. Area C is a historic city in the north of England which has relatively low levels of unemployment compared to the national average. Area D is a town within a rural county in the east of England, which is prosperous and displays good levels of education and unemployment compared to national averages.

JSNAs

The JSNAs which demonstrated good practice:

1. Had a section that specifically addressed children and young people's mental health.

It is important that commissioners have access to data and other information about children and young people's mental health, so that they can commission relevant services to meet the needs of their local population.

2. Used a comprehensive range of data to estimate local levels of need.

Triangulation of a range of data sources about children and young people's mental health, including data about wider determinants of health such as numbers of children in poverty, numbers of looked after children etc. will give the most comprehensive assessment of need in the local area and could also be helpful in determining how to deliver early intervention.

Area A is a borough with high rates of deprivation and many vulnerable families. When commissioning services, the impact of deprivation on emotional wellbeing is taken into account, as is the impact of mental health on things like employment and community resilience, and there is an understanding that improving emotional wellbeing is a key part of solving other challenges related to deprivation. Area A has recently completed a far-reaching needs assessment, both looking at those currently accessing mental health services, and at the needs of families who didn't meet the threshold for specialist mental

health services but were still in need of targeted interventions to maintain stability. It was with the emerging and escalating needs of these vulnerable families in mind that Area A developed its new enhanced mental health service.

To obtain as comprehensive a picture of children and young people's mental health needs as possible, Area B looks at many wider determinants of health known to affect emotional wellbeing, such as levels of children in poverty and numbers of young people not in education, education or training. Area B also looks at incidents of mental health needs amongst its adult population because it is aware of the impact that parental mental health can have on children's mental health and emotional wellbeing.

3. Involved a wide range of partners in the needs assessment.

Beyond statutory health services, a wide range of other partners have a vital role to play in providing support to children and young people with their mental health, including voluntary organisations and schools. Many of these services are well placed to conduct early interventions and offer children and young people support before their problems escalate. Involving such partners in the needs assessment will help provide a holistic picture of the full range of children and young people's mental health needs, including those who have not engaged with statutory services like CAMHS.

In Area C, alongside the statutory members of the health and wellbeing board, the local community and voluntary sector is represented, as is a range of

local delivery partners including the police and private health care providers. The board is particularly keen to ensure that the needs of more vulnerable and hidden groups like carers are considered and they outreach to relevant organisations to make sure they are represented.

Partnership working is important in Area D, so as well as reviewing the need for statutory services, they looked at services that were being delivered by voluntary and community organisations, which hadn't been commissioned by the local authority. As a result, they are planning to pull together these services with statutory services in a consortium in order to look at how they can better promote all services to schools. This is to ensure that schools feel they have a wider range of options than counselling alone, and that children and young people get access to support as soon as possible.

4. Kept the needs assessment up to date and accessible.

The data that is pertinent to children and young people's mental health is updated at differing intervals; however most of it is refreshed within a two-year time frame. This would indicate that biennial updates would keep the needs assessment current. If a framework were adopted for the needs assessment, updating it would simply require importing any updated data. Related to this, ensuring that the data collected is accessible is another priority. Some areas displayed data in a table accompanied by explanatory text, which made the relevant information easy to find and understand.

In Area B the JSNA is project managed by the public health



directorates and comprises comprehensive needs assessments on a wide range of issues. They use the same needs assessment framework for every section to make assembling data as easy as possible and to make the document easy to use. As well as collating the information for the JSNA they are committed to ensuring that the information is accessible and usable and a clear and consistent layout helps achieve this.

JHWSs

The JHWSs which demonstrated good practice:

1. Included children and young people's mental health as a priority or included children and young people's mental health as a sub-priority with specific actions and outputs to be taken to address it.

Area B's JHWS included four sub-priorities that specially addressed children and young people's mental health and which clearly outlined the changes they expected to see: 1) Prioritise prevention and early intervention by working with schools, young people and families to provide accessible, non-stigmatising mental health services in local community based settings. 2) Ensure the universal services we commission are providing good outcomes in terms of wellbeing and early intervention for mental health problems, for example, the HCP, GPs, health visitors, Children Centres and schools. 3) Introduce children's Improving Access to Psychological Therapies (IAPT) service. 4) Reduce the use of the high cost Child and Adolescent Mental Health (CAMHS) services.

2. Linked priorities to the needs identified in the JSNA.

The areas identified as being exemplars of good practice provided evidence for the priorities they had put forward by including relevant parts of the JSNA in their so that a clear link was made between the evidence of need found and the priorities proposed.

3. Included outcomes to measure impact of proposed actions.

Whilst there are very few outcomes in the national outcomes frameworks that relate to children and young people's mental health, some areas have developed their own outcomes frameworks to measure the impact of their interventions around children and young people's mental health. Importantly, they have also rolled these out across all services, including voluntary organisations, to make sure outcomes measurement is consistent.

In Area D a commitment to evidence based working is reflected in the comprehensive children and young people outcomes framework that they have developed, which includes measures for mental health. Area D has also developed its own outcomes tool to measure the impact of interventions and this tool is being rolled out to all relevant services, including CAMHS, to ensure consistency in measuring impact.

4. Involved a range of partners in determining the priorities.

Those areas that have carried out the most comprehensive needs assessment have accumulated a

vast amount of evidence about local health. It is important that a wide range of partners, including service users, contribute to reviewing this evidence and determining which of the needs identified should be prioritised.

In Area C the adult, children and education directorates led the completion of the JSNA and identified 25 recommendations, which formed the basis of the priorities in the JHWS. To determine the final priorities in the JHWS, consultations were held with a wide range of stakeholders including staff from health and social care. Every organisation on the board was visited by policy officers working on the strategy and the voluntary sector was closely involved via the local voluntary sector forum. The board used the results of the consultation to ensure the final priorities in the strategy were right.

In Area A the health and wellbeing board held a workshop to allow all partners to collaboratively determine the health priorities for the area based on the evidence in the JSNA. The director of children's services, who has a statutory seat on the board, attended this workshop, as did other colleagues from children's services, including the lead commissioner for CAMHS, to contribute their knowledge and expertise. The broad evidence collected in the JSNA about children and young people's mental health and emotional wellbeing directly contributed to this being included as a priority in the strategy.

Implications of findings

- Evidence in the JSNAs is meant to guide the determining of priorities in the JHWSs and both should be considered in commissioning plans. The extremely limited local knowledge about children and young people's mental health needs and the use of data up to a decade old in certain cases has worrying implications both for effective commissioning and for services' ability to respond to need.
- The Department of Health's statutory guidance on JSNAs and JHWSs states that JSNAs should take into account the wider determinants of health and their impact on health and care needs of the population. However, only a fifth of JSNAs stated a link between the numbers of children and young people within vulnerable groups known to be at higher risk of mental disorders and the mental health of children and young people in these groups. This suggests that many are not aware of the impact of wider determinants of

health like poverty, employment, homelessness and youth offending on children and young people's mental health, so may not be able to effectively address them or fulfil this aspect of the guidance.

- Additionally, the apparent lack of awareness of the increased vulnerability of certain groups of children and young people to poor mental health has concerning implications for the potential to target early intervention where it may be most needed and make sure support is easily accessible to all who require it.
- Where health and wellbeing boards are estimating local levels of prevalence, the national data set being used for this is a decade old. Since it was undertaken in 2004, significant shifts have occurred including the economic crisis and changes in welfare, health and education policy which could have a substantial impact on children and young people's mental health. New technologies, including the huge growth of social media since 2004, have developed hugely in

the last decade and have both positive and negative impacts on children's lives and may affect their mental health. It is important that commissioners have new data about the current mental health needs of children and young people.

- The limited data about the mental health needs of 16-25 year olds is concerning, as the transition from child to adult mental health services has been repeatedly highlighted by a range of groups, including academic bodies, voluntary organisations and the government as in need of improvement. The ability to commission age-appropriate, accessible services for this group is likely to be limited by this relative lack of information.
- Despite a wide evidence base (see appendix 1), which highlights the importance of children and young people's emotional wellbeing for their educational attainment and their future lives and health, one third of the JHWSs reviewed have not prioritised it in any way.



Recommendations

Health and Wellbeing Boards

Alongside the recommendations outlined in the Children and Young People's Mental Health Coalition's 2012 briefing paper What Health and Wellbeing Boards Can Do to Help Children and Young People with Mental Health Problems the following recommendations are added:

1. That all local areas sign the Department of Health's pledge (DH, 2013) to show their commitment to improving the health of children and young people. Among other things, the pledge states that those who sign it are determined to:

- improve the mental health of our children and young people by promoting resilience and mental wellbeing and providing early and effective evidence-based treatment for those who need it
- support and protect the most vulnerable by focusing on the social determinants of health and providing better support to the groups that have the worst health outcomes

2. That all JSNAs include a section specifically about children and young people's mental health needs which use a comprehensive range of data to estimate local levels of need for children and young people's mental health services and involve a wide range of partners in the needs assessment. Additionally, that the needs assessment be kept accessible and up to date.

3. That all JHWSs include children and young people's mental health as a priority and that specific actions are included for addressing local children and young people's

mental health needs which are based on evidence of need in the JSNA and that a wide range of local partners have been involved in determining. Additionally, that JHWSs include outcomes to measure the impact of proposed actions.

Department of Health

4. That a national survey of child and adolescent mental health is commissioned to establish the prevalence of mental health needs in this group. This is important as the last national survey of child and adolescent mental health was in 2004. Commissioners need to have access to up-to-date information that they can use to better understand local need.

5. That data from this updated study and all other data about children and young people's mental health be divided into five-year age bands through childhood and teenage years as recommended in the Report of the Children and Young People's Health Outcomes Forum. This will ensure that data is available in a useful form, allowing services to be commissioned based on the distinct needs of children and young people at different stages of their development. Additionally, data about young people's health up to the age of 25 should continue to be presented in five-year age bands, including data from adult data sets.

6. That the recommendation in the report of the Children and Young People's Health Outcomes Forum to "adapt and extend the existing outcomes within the NHS outcomes framework" be followed to make sure that outcomes adequately cover mental health. As outlined in the forum report, the outcomes

particularly pertinent to children and young people's mental health are: time to diagnosis/start of treatment, effective transition from child to adult health services and age-appropriate healthcare.

Public Health England

7. That existing guidance and tools on how to assess children and young people's mental health needs and commission children and young people's mental health services are updated to ensure they are in line with current government guidance, refer to the most recent data available and incorporate how to assess the needs of and commission services for children and young people up to age 25.

8. That such guidance and tools are made easily accessible to health and wellbeing boards and commissioners through Public Health England's child and maternal health intelligence network. Also, that such materials be promoted to them through relevant networks such as the Public Health England's regional offices, Local Government Association (LGA) regional networks and health and wellbeing board chair networks.

9. That an evidence review is commissioned into existing research on risk factors related to children and young people's mental health (see appendix 1). This review should be made easily accessible to health and wellbeing boards and clinical commissioning groups to enable a better understanding of the links between some wider determinants of health and children and young people's mental health.

References

Chevalier, A. & Feinstein, L. (2005), 'Sheepskin or Prozac: The Causal Effect of Education on Mental Health, Centre for the Economics of Education Discussion Paper 71', [online] Available at: <<http://cee.lse.ac.uk/ceedps/ceedp71.pdf>> [Accessed 12 Sept 2013].

Child and Maternal Health Intelligence Network (ChiMat), 'Child and adolescent mental health (CAMHS) for local authorities and CCGs needs assessment', [online] Available at: <<http://atlas.chimat.org.uk/IAS/profiles/needsassessments>> [Accessed 16 Sept 2013].

National CAMHS Support Service (2011), 'Better Mental Health Outcomes for Children and Young People: A resource directory for commissioners', [online] Available at: <<http://www.chimat.org.uk/camhs/commissioning>> [Accessed 16 Sept 2013].

Children and Young People's Mental Health Coalition (2010), 'Improving Children and Young People's Mental Health: The Business Case', [online] Available at: <http://cypmhc.org.uk/resources/improving_children_and_young_peoples_mental_health/> [Accessed 12 Sept 2013].

Children and Young People's Mental Health Coalition (2012), 'What Health and Wellbeing Boards Can Do to Help Children and Young People with Mental Health Problems', [online] Available at: <http://cypmhc.org.uk/resources/briefing_on_what_health_and_wellbeing_boards_can_d/> [Accessed 12 Sept 2013].

Children and Young People's Health Outcomes Forum (2012), 'Report of the Children and Young People's Health Outcomes Forum', [online] Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216852/CYP-report.pdf> [Accessed 12 Sept 2013].

Costello, E., Keeler, G. & Angold, A. (2001), 'Poverty, Race/Ethnicity, and Psychiatric Disorder: A Study of Rural Children', *American Journal of Public Health*: September 2001, Vol. 91, No. 9, pp. 1494-1498. Article DOI: 10.2105/AJPH.91.9.1494

Department of Health (2008) *Children and young people in mind: the final report of the National CAMHS Review*. London: Department of Health, [online] Available at: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_090398.pdf> [Accessed 16 Sept 2013].

Department of Health (2011a) *No health without mental health*. London: Department of Health, [online] Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf> [Accessed 16 Sept 2013].

Department of Health (2011b) *No health without mental health: supporting document- The economic case for improving efficiency and quality in mental health*. London: Department of Health, [online] Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf> [Accessed 16 Sept 2013].

Department of Health (2013), 'Better health outcomes for children and young people', London, [online] Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207391/better_health_outcomes_children_young_people_pledge.pdf> [Accessed 12 Sept 2013].

Department of Health (2013), 'Statutory Guidance on Strategic Needs Assessments and Joint Health and Wellbeing Strategies', London, [online] Available at:

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf> [Accessed 12 Sept 2013].

Emerson, E. & Hatton, C. (2007) The mental health of children and young people with learning disabilities in Britain. Lancaster University, [online] Available at: <http://www.lancs.ac.uk/staff/emersone/FASSWeb/Emerson_07_FPLD_MentalHealth.pdf> [Accessed 16 Sept 2013].

Gill, O. & Sharma, N. (2004), 'Food poverty in the school holidays', Bristol: Barnardo's South West, [online] Available at: <<http://www.barnardos.org.uk/foodpovertyreportv3.qxd-2.pdf>> [Accessed 12 Sept 2013].

Green, H., McGinnity, A., Meltzer, H., et al. (2005), 'Mental health of children and young people in Great Britain 2004', London: Palgrave, [online] Available at: <http://www.esds.ac.uk/doc/5269/mrdoc/pdf/5269technicalreport.pdf> [Accessed 16 September 2013].

Harrington, R. et al. (2005), 'Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community', Youth Justice Board, [online] Available at: <<http://www.yjb.gov.uk/publications/Resources/Downloads/MentalHealthNeedsfull.pdf>> [Accessed 12 Sept 2013].

Kings Fund (2013), 'Health and wellbeing boards directory', [online] Available at: <<http://www.kingsfund.org.uk/projects/health-and-wellbeing-boards/hwb-map>> [Accessed 12 Sept 2013].

Local Government Association (2013), Regional Map, [online] Available at: <http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3510973/ARTICLE-TEMPLATE> [Accessed 12 Sept 2013].

Meltzer, H. et al. (2000), 'The Mental Health of Children and Adolescents in Great Britain', London: The Stationery Office, [online] Available at: <http://www.dawba.info/abstracts/B-CAMHS99_original_survey_report.pdf> [Accessed 16 Sept 2013].

Ministry of Justice (2013), Youth Justice Statistics 2011/12 England and Wales Youth Justice Board / Ministry of Justice Statistics bulletin, [online] Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218552/yjb-stats-2011-12.pdf> [Accessed 12 Sept 2013].

Morrison, L. et al. (2012), 'The impact of pupil behaviour and wellbeing in educational outcomes', London: Department for Education, [online] Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/219638/DFE-RR253.pdf> [Accessed 12 Sept 2013].

National Institute of Clinical Excellence (2010), 'Promoting the quality of life of looked-after children and young people', London, [online] Available at: <<http://www.nice.org.uk/ph28>> [Accessed 12 Sept 2013].

Office for National Statistics (1997), 'Psychiatric morbidity among young offenders in England and Wales', London: Office for National Statistics, [online] Available at: <<http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&>> [Accessed 16 Sept 2013].

Pearce, A. et al. (2013), 'The role of poverty in explaining health variations in 7-year-old children from different family structures: findings from the UK Millennium Cohort Study', *Journal of Epidemiology & Community Health*, Vol. 67, No. 2, pp. 181-189.

Prince's Trust (2013), 'The Prince's Trust Youth Index 2013', [online] Available at: <<http://www.princes-trust.org.uk/pdf/youth-index-2013.pdf>> [Accessed 12 Sept 2013].

Richards, M. et al. (2009) Childhood mental health and life chances in post-war Britain. London: Sainsbury Centre for Mental Health, [online] Available at: <http://www.centreformentalhealth.org.uk/pdfs/life_chances_report.pdf> [Accessed 16 Sept 2013].

Romeo, R. et al. (2006) Economic cost of severe antisocial behaviour in children - and who pays it. *British Journal of Psychiatry*, 188, pp.547-553

Sabates, R. & Dex, S. (2013), 'The impact of multiple risk factors on young children's cognitive and behavioural development', *Children and Society*, [online] Available at: <<http://onlinelibrary.wiley.com/doi/10.1111/chso.12024/abstract>> [Accessed 12 Sept 2013].

Sainsbury Centre for Mental Health (2009) The chance of a lifetime: preventing early conduct problems and reducing crime. London: Sainsbury Centre for Mental Health, [online] Available at: <http://www.centreformentalhealth.org.uk/pdfs/chance_of_a_lifetime.pdf> [Accessed 16 Sept 2013].

Sempik, J. et al. (2008), 'Emotional and behavioural difficulties of children and young people at entry into care', *Clinical Child Psychology and Psychiatry*, Vol. 13, No. 2, pp. 221-233.

Sigle-Rushton, W., (2004), 'Intergenerational and Life-Course Transmission of Social Exclusion in the 1970 British Cohort Study', CASEpaper, No. 78., London: LSE [online] Available at: <<http://sticerd.lse.ac.uk/dps/case/cp/CASEpaper78.pdf>> [Accessed 12 Sept 2013].

World Health Organisation (WHO) (2011) Mental health: a state of wellbeing, [online] Available at: <http://www.who.int/features/factfiles/mental_health/en/> [Accessed at 16 Sept 2013].

YoungMinds (2013), 'Stop Cutting CAMHS', London: YoungMinds, [online] Available at: <http://www.youngminds.org.uk/about/our_campaigns/cuts_to_camhs_services> [Accessed 12 Sept 2013].

APPENDIX 1

Risk factors related to children and young people's mental health

This list is intended as an introduction to research in this area, further information can be found on the Mental Health Foundation and YoungMinds websites.

Child poverty and mental health

- Children living in disadvantaged families are over three times more likely to suffer from mental health disorders as those in well-off families (Meltzer et al., 2000).
- Children from low-income households are more likely to eat a poor, 'unhealthy' diet and this poor nutrition can have a negative influence on the mental wellbeing of children (Gill and Sharma, 2004).
- Homelessness, frequent moves and poor housing also contribute to poor mental health (Costello et al., 2001).
- Those growing up in the poorest households are more likely to suffer poor physical and mental health at the age of 33 (Sigle-Rushton, 2004).

Young offenders and mental health

- Self-harm amongst young offenders increased by 21% in 2011-12 (Ministry of Justice, 2013).
- 31% of young offenders have mental health problems (Harrington, 2005).

Mental health of looked after children

- 72% of children in residential care have some form of emotional and mental health problem (Sempik, J, et al, 2008).

Youth unemployment and mental health

- Young people not in employment, education or training (NEETs) are more than twice as likely to feel unable to cope as their peers. More than one in four believe their prospects have been permanently damaged by the recession (Princes Trust, 2013).

Exclusion and mental health

- There is a strong association between the education level of young people aged 23 and their probability of having depression (Chevalier and Feinstein, 2005).
- 'Children with higher levels of emotional, behavioural, social, and school wellbeing, on average, have higher levels of academic achievement and are more engaged in school, both concurrently and in later years' (Morrison, et al., 2012).

Substance use and mental health

- Smoking, drinking and drug use are more prevalent among 11-16 year olds with an emotional disorder (Green, et al., 2005).

Family Break-up

- The rate of possible mental health problems was 14% higher for children in reconstituted families, and 10% higher for those in lone-parent families, than the rate for children living in couple families (Pearce, et al., 2013).

Multiple Risks

- Some 28% of young children are growing up in households with more than one risk factor, and with some experiencing five or more risk factors (Sabates and Dex, 2013).
- Outcomes for cognitive, emotional and conduct developments and hyperactivity were all worse for children exposed to multiple risks by age five (Sabates and Dex, 2013).

The case for early intervention

The Children and Young People's Mental Health Coalition's publication *Improving Children and Young People's Mental Health: The Business Case* (CYPMHC, 2010) outlines the critical need for early intervention.

The Children and Young People's Mental Health Coalition

The Children and Young People's Mental Health Coalition (CYPMHC) brings together 14 leading children and young people and mental health charities to campaign with and on behalf of children and young people in relation to their mental health and wellbeing. With a unified voice, the CYPMHC aims to achieve policy changes at the highest level that will directly improve the mental health and wellbeing of children and young people across the UK. This is necessary because at any one time, one in ten children and young people have a diagnosed mental health problem and it is now well established that the antecedents of most adolescent and adult mental illness, with the exception of dementia, are in childhood. Addressing issues early will lead to better outcomes for individuals and for society.

Members

British Association for Counselling and Psychotherapy
Centre for Mental Health
Family Action
Mental Health Foundation
NSPCC
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Rethink Mental Illness
Right Here
Royal College of Psychiatrists
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YouthNet
Youth Access
YoungMinds
Zurich Community Trust

