An introduction to
Children and Young People’s
Emotional Wellbeing and
Mental Health in Plymouth

Needs Analysis

November 2008

PREPARED TO SUPPORT THE DEVELOPMENT OF THE JOINT
COMMISSIONING STRATEGY (2009-2014) FOR THE EMOTIONAL WELLBEING
AND MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE IN PLYMOUTH
1. Introduction

‘I know there are no magical answers. What I am looking for is a practical solution!’ Parent

This needs analysis has been undertaken with the explicit aim of enabling any practitioner, parent or carer to understand current needs around the mental health and emotional wellbeing of children, young people and families in Plymouth. With such a broad audience, attempts have been made to present the information in such a way to minimise the use of technical jargon and enable it to be accessible to everyone.

This needs analysis belongs to all of us striving to improve the mental health and emotional wellbeing of our children and young people in Plymouth.

1.1 The Government’s Vision – what are we aiming for?

The national vision for mental health and psychological well-being in England is set out in the Children’s National Service Framework, Standard 9, as follows:

- An improvement in the mental health of all children and young people;
- Multi-agency services, working in partnership, to promote the mental health of all children and young people, and provide early intervention, and also meet the needs of children and young people with established or complex problems;
- Ensuring that all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

This is reflected in the strategic intent of Every Child Matters1, and subsequent legislative programmes and guidance. The underpinning principles of prevention and early intervention through integrated services support this further.

Achieving the Governments’ vision is a requirement for all Children’s Trusts, Local Authorities and Primary Care Trusts. Evidence of delivery is required by regular reporting against Every Child Matters and the National Service Framework and through the monitoring of specific targets, previously known as PSA’s and now more detailed within the National Indicator set.

Bearing this vision in mind, this analysis takes advantage of the findings from the national CAMHS Review Interim Report (2008) ‘Improving the mental health and psychological well-being of children and young people’. This report looks at how services can be improved further to meet the educational, health and social care needs of all children and young people at risk of, or experiencing, mental health problems, and is referred to where appropriate within this analysis.

1.2 Objectives of Needs Analysis

The purpose of this needs analysis is to introduce all stakeholders, including young people and parents to the emotional wellbeing and mental health needs of children and young people in Plymouth. This analysis will feed directly into the process of developing the new five-year strategy for 2009-2013.

Specifically, this needs analysis will;

- Present the views of stakeholders, including young people, parents and professionals around their perceptions of service provision across the spectrum of needs, and in relation to vulnerable groups of children and young people;
- Provide information on the prevalence of CYP mental health problems in Plymouth, reflecting the diversity of the city’s population and local demographic circumstances;
- Provide an assessment of the needs of particular groups of CYP who are vulnerable, at risk, or who might ordinarily find it hard to access services.
This analysis does not feature service mapping or review service utilisation figures, as this is an identified next step in the commissioning process once needs have been identified and priority areas established. In this sense, it is expected that service provision can then be reviewed based on identified and agreed need.

1.3 Methodology
This needs analysis has been put together by looking at:
- Views of local stakeholders (practitioners, young people and parents);
- Demographic and deprivation data;
- Estimated prevalence rates;
- Risk and resilience factors;
- Needs of vulnerable groups.

1.4 Definitions

1.4.1 Mental health
“...every individual realises his or her own potential, 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”\(^2\). The term ‘mental health’ is used in a positive sense and does not mean to imply the absence of mental illness.

Mental health in young people is indicated by\(^3\):
- A capacity to enter and sustain mutually satisfying personal relationships.
- Continuing progression of psychological development.
- An ability to play and to learn so that attainments are appropriate for age and intellectual level.
- A developing moral sense of right and wrong.
- The degree of psychosocial distress and maladaptive behaviour being within normal limits for the child’s age and context

1.4.2 Emotional wellbeing
...enables an individual to be able to function in society and meet the demands of everyday life; people in good mental health have the ability to recover effectively from illness, change or misfortune.\(^4\)

1.4.3 What is the difference between a mental health disorder and a mental health problem?
A useful distinction is often drawn between mental health problems which indicate a disturbance of mood or behaviour in only one functional area, and mental health disorders defined as either a severe and/or persistent problem or the co-occurrence of multiple problems\(^5\).

Mental health problems (e.g. sleep or feeding difficulties, abdominal pain without organic cause, severe tantrums, tic disorders, educational difficulty and simple phobias) are more prevalent than disorders (e.g. major depression, obsessive compulsive disorder, bulimia nervosa and attempted suicide). Table 1 below explains disorders in more detail.

<table>
<thead>
<tr>
<th>Table 1: Classification of mental disorders(^6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional disorders</strong></td>
</tr>
<tr>
<td><strong>Conduct Disorders</strong></td>
</tr>
<tr>
<td><strong>Hyperkinetic Disorders</strong></td>
</tr>
<tr>
<td><strong>Development Disorders</strong></td>
</tr>
<tr>
<td><strong>Eating Disorders</strong></td>
</tr>
<tr>
<td><strong>Habit Disorders</strong></td>
</tr>
<tr>
<td><strong>Post Traumatic Syndromes</strong></td>
</tr>
</tbody>
</table>

\(^1\) [Source: Abnormal Psychology]
\(^2\) [Source: WHO]
\(^3\) [Source: Dadds, 1988]
\(^4\) [Source: World Health Organization]
\(^5\) [Source: World Health Organization]
\(^6\) [Source: World Health Organization]
<table>
<thead>
<tr>
<th>Somatic disorders</th>
<th>Chronic fatigue syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic disorders</td>
<td>Schizophrenia, manic depressive disorder or drug-induced psychoses</td>
</tr>
</tbody>
</table>

Source: Audit Commission 1999.
Source: NHS Health Advisory Service, Together We Stand: The commissioning, role and management of child and adolescent mental health services, HMSO, 1995

1.4.4 What is Child and Adolescent Mental Health Services (CAMHS)?

In Plymouth, it is acknowledged that ‘CAMHS’ is often used to refer to the child and adolescent mental health services provided by the Primary Care Trust (and formerly by the Plymouth Hospitals Trust) and operating at targeted and specialist levels of response (see table below).

Within this analysis and strategy development process however, ‘CAMHS’ is defined in its broadest sense to include all services that promote emotional well-being and mental health, or which respond to and meet the mental health needs of children and young people. This includes universal services (such as GPs, early years settings and schools), targeted services (such as social care) as well as specialist services (such as community mental health clinics and hospitals)†.
Table 2 below illustrates the implementation of CAMHS, and how all professionals can and will be involved in providing some degree of emotional wellbeing and/or mental health service based on the needs of the child or young person at any one time.

| PRACTITIONERS & PARENTS CAN WORK ACROSS ALL LEVELS ACCORDING TO THE NEED OF THE CHILD AT ANY ONE TIME A CHILD OR YOUNG PERSON CAN MOVE ACROSS SERVICES AS REQUIRED |
|---|---|---|
| UNIVERSAL SERVICES | TARGETED SERVICES | SPECIALIST SERVICES |
| Mild emotional and behavioural difficulties | Emerging problems and/or the early stages of a disorder. Services should offer CAF assessment to identify needs. Problems at this level are not usually complicated by serious risk factors and can be managed by multi-agency practitioners with the relevant skills and experience. | Less common problems indicating a more severe, complex and persistent condition. Services at these levels offer: |
| Many conditions here will be self-limiting, but may cause considerable distress in the child and family, disruption in the classroom and child’s learning. Practitioners at this level: | Practitioners at this level enable: | Multi-professional assessment & management of mental health disorders; |
| o Pursue opportunities to promote the 5 outcomes and emotional wellbeing; | o Training & consultation for professionals and families; | Provision of specialist interventions; |
| o Identify problems early in their development; | o Assessment and strategies; | Support to staff in other services. |
| o Offer general advice and signposting | o Young people and their families to cope with life experiences; | |
| | o Outreach to identify needs that require more specialist interventions. | |

PREVENTION

Main audience is whole population or groups
- Before onset of problems, no identified risk factors;
- Main focus to prevent problems occurring - enhance capacity & protective factors;
- Awareness of risk factors to signpost if problems arise or are identified.

EARLY INTERVENTION

Main audience is individual children and young people
- **Risk factors identified and problems emerging:**
  - Combination of prevention and intervention approaches.

SPECIALIST INTERVENTION

Main audience is individual children and young people
- Problems are well developed and established;
- Main focus to intervene to minimize negative impact of the problem;
- Enhance protective factors by signposting to prevention-focused services.

PREVENTION REMAINS AN ELEMENT OF ANY SERVICE INTERVENTION

A CHILD OR YOUNG PERSON WITH

NO ADDITIONAL NEEDS SOME ADDITIONAL NEEDS COMPLEX NEEDS

Adapted from HAS, Wallace & Kurtz
2. Demography and Deprivation

2.1 Population

The total number of children and young people aged 18 years and younger in Plymouth is 56,150. This represents around 20% of the total population. Of these, 21,073 (37.5%) live in the most deprived neighbourhoods compared to 28.9% in the least deprived.

Map 1: Number of children aged 0-19 by locality

Table 3: Profile of age groups across Plymouth

<table>
<thead>
<tr>
<th>Age profile</th>
<th>Total Population</th>
<th>As a % of 0-18 yr olds</th>
<th>As a % of total population</th>
<th>% living in most deprived areas</th>
<th>% living in middle deprived areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 year olds</td>
<td>13,543</td>
<td>24.1</td>
<td>5.2</td>
<td>39.2</td>
<td>33.7</td>
</tr>
<tr>
<td>5-10 year olds</td>
<td>16,555</td>
<td>29.5</td>
<td>6.4</td>
<td>36.3</td>
<td>34</td>
</tr>
<tr>
<td>11-16 year olds</td>
<td>18,862</td>
<td>33.6</td>
<td>7.3</td>
<td>35.4</td>
<td>34.3</td>
</tr>
<tr>
<td>17-18 year olds</td>
<td>7,195</td>
<td>12.8</td>
<td>2.8</td>
<td>42.9</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>56,150</td>
<td>100</td>
<td>20</td>
<td>37.5</td>
<td>33.6</td>
</tr>
</tbody>
</table>

Source: Population by age and neighbourhood PHDU 2006

2.1.2 Population Projections

The ONS data estimates that overall the population of England will increase by 5.2% over the next twenty years, whilst the population of the Southwest is expected to increase faster by ~9.5%. However, this is expected to be more prominent amongst older age groups. Thus the relative proportion of children and young people is expected to fall in the Southwest. Estimated population changes for Plymouth are shown in Table 4.

Table 4: ONS estimated population changes

<table>
<thead>
<tr>
<th>Age bands</th>
<th>2001 census data</th>
<th>2021 projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 years</td>
<td>13,211</td>
<td>12,900</td>
</tr>
<tr>
<td>5-9 years</td>
<td>14,618</td>
<td>13,200</td>
</tr>
<tr>
<td>10-14 years</td>
<td>16,077</td>
<td>13,200</td>
</tr>
<tr>
<td>15-19 years</td>
<td>16,569</td>
<td>15,100</td>
</tr>
<tr>
<td>0-19 years</td>
<td>60,569</td>
<td>54,400</td>
</tr>
</tbody>
</table>

Source: Population by age and neighbourhood PHDU 2006
Key factors influencing these population projections include migration, lower fertility rates and local policy to increase housing capacity.

### 2.1.3 Population by ethnic group

Black and minority ethnic groups make up about 9% of the total England population. However the South West as a region has the lowest percentage of all the regions at 2.3%. BME groups make up 1.6% of the Plymouth population, and 6.5% of the population in schools[^9]. Further breakdown of specific groups is shown in Table 5.

#### Table 5: Population by ethnic group in Plymouth Local Authority

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Plymouth LA Number</th>
<th>(Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>236,763</td>
<td>98.36%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1,556</td>
<td>0.65%</td>
</tr>
<tr>
<td>Asian</td>
<td>741</td>
<td>0.31%</td>
</tr>
<tr>
<td>Black</td>
<td>455</td>
<td>0.22%</td>
</tr>
<tr>
<td>Chinese</td>
<td>690</td>
<td>0.50%</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>515</td>
<td>0.65%</td>
</tr>
<tr>
<td><strong>Total ethnic minority</strong></td>
<td><strong>3956</strong></td>
<td><strong>1.6%</strong></td>
</tr>
</tbody>
</table>

Base population: 240,719

[^9]: ONS Census 2001

### 2.2 Deprivation

The Deprivation Affecting Children Index combines a number of indicators including income; employment; health, deprivation, and disability; education, skills and training; access to housing and services; crime and disorder; and living environments into a single deprivation score. Table 6 below uses this index to calculate the estimated number of children defined as deprived by area;

#### Table 6: Percentage of children defined as deprived by area

<table>
<thead>
<tr>
<th>Area</th>
<th>% 0-15 year olds who are deprived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth PCT</td>
<td>24.1%</td>
</tr>
<tr>
<td>South West region</td>
<td>16.1%</td>
</tr>
<tr>
<td>England</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

On this basis, 11,333 (24.1%) of 0-15 years olds are defined as deprived by this measure, and Plymouth ranks third of the 32 South West PCTs.

Deprivation varies widely across Plymouth City itself. Deprivation measured using the Townsend material deprivation score, which reflects unemployment, car ownership, home ownership and overcrowding has been calculated for the 43 neighbourhoods within Plymouth. These scores can be used to group the neighbourhoods into groups representing the most deprived, the least deprived and a middle group, which are shown in Map 2. These groupings will be used to examine the distribution of children and young people who are deprived across the City, and also to examine how risk factors for mental health problems are distributed.
Examining 2003 “workless benefits” data for children aged 0-15 years in Plymouth shows that about 1 in 5 (n=9915) children aged 0-15 are in families reliant on ‘workless benefits’. Table 7 shows how they are distributed across the City. More than 1 in 3 children in the third most deprived neighbourhoods are living in families reliant on workless benefits. This falls to just 1 in 14 for the most affluent areas.

Table 7: Number and percentage of children (aged 0-15 years) in families on “workless benefits” in 2003 by deprivation group and sub-locality

<table>
<thead>
<tr>
<th>Deprivation group</th>
<th>Number living in families reliant on workless benefits</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived</td>
<td>6,245</td>
<td>36.4</td>
</tr>
<tr>
<td>Middle group</td>
<td>2,660</td>
<td>16.5</td>
</tr>
<tr>
<td>Least deprived</td>
<td>1,010</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>Sub-locality</strong></td>
<td><strong>Number</strong></td>
<td><strong>Percentage</strong></td>
</tr>
<tr>
<td>Central/North East</td>
<td>1,250</td>
<td>11.2</td>
</tr>
<tr>
<td>North West</td>
<td>2,970</td>
<td>29.5</td>
</tr>
<tr>
<td>Plympton</td>
<td>470</td>
<td>7.8</td>
</tr>
<tr>
<td>Plymstock</td>
<td>290</td>
<td>6.4</td>
</tr>
<tr>
<td>South East</td>
<td>1,580</td>
<td>25.8</td>
</tr>
<tr>
<td>South West</td>
<td>3,355</td>
<td>36.9</td>
</tr>
<tr>
<td><strong>Plymouth total</strong></td>
<td><strong>9,915</strong></td>
<td><strong>21.1</strong></td>
</tr>
</tbody>
</table>
3. Prevalence of Mental Health Disorders

The 2004 survey of the mental health of children and young people in Great Britain undertaken by the Office for National Statistics provided a solid body of evidence to demonstrate that 10% of children and young people aged 5-16 have a mental disorder that is associated with ‘considerable distress and substantial interference with personal functions’, such as family and social relationships, their capacity to cope with day to day stresses and life challenges and their learning\(^\text{11}\).

The term ‘disorder’ is used to indicate that these children and young people had a clinically recognised set of symptoms or behaviours that fulfilled the strict criteria required by the survey. The majority of these fell into the categories of emotional, conduct or hyperkinetic disorder. 1% have a variety of less common disorders such as autistic spectrum disorder or an eating disorder. Many of the children and young people with an established disorder - and some 2% have more than one - will continue to have difficulties well into adult life.

A greater number will have mental health problems that are less severe, and which are more likely to be short-lived, but which may nonetheless affect their psychological well-being and be of concern both to themselves, their families and their friends.

Mental disorders are more common in older than younger children and in boys than girls. In 2004, 10% of boys and 5% of girls aged 5-10 were found to have a disorder compared with 13% and 10% of those aged 11-16\(^\text{12}\).

3.1 What is the situation in Plymouth\(^\text{13}\)?

Across Plymouth, it is estimated that Child and Adolescent Mental Health Services in their broadest sense (from universal through to specialist services), should reach out to and serve around 13,850 children and young people.

### Table 8: Service response and estimated need in Plymouth

<table>
<thead>
<tr>
<th>Service Response</th>
<th>% all CYP</th>
<th>Plymouth Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>15%</td>
<td>8,100</td>
</tr>
<tr>
<td>Mild emotional and behavioural difficulties or the early stages of disorders.</td>
<td>15%</td>
<td>8,100</td>
</tr>
<tr>
<td>Targeted</td>
<td>7.5%</td>
<td>4,100</td>
</tr>
<tr>
<td>Services offer CAF assessment to identify needs. Problems at this level are not usually complicated by serious risk factors and can be managed by multi agency professionals with the relevant skills and experience.</td>
<td>7.5%</td>
<td>4,100</td>
</tr>
<tr>
<td>Specialist</td>
<td>2.5%</td>
<td>1,400</td>
</tr>
<tr>
<td>Less common problems indicating a more severe, complex and persistent condition.</td>
<td>2.5%</td>
<td>1,400</td>
</tr>
<tr>
<td>Intensive and highly specialised care</td>
<td>0.47%</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>25.47%</td>
<td>13,850</td>
</tr>
</tbody>
</table>

Plymouth can expect in the region of 3460 children aged between 5-15 years to have a mental health disorder at any one time, with nearly 700 of these having more than one disorder. The extrapolated Plymouth prevalences are shown in the Table 9.

### Table 9: Expected number of common mental health disorders in Plymouth for children aged 5-15 years (n=36,039)

<table>
<thead>
<tr>
<th></th>
<th>Percentage prevalence 5-16 yrs</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>3.7</td>
<td>1333</td>
</tr>
<tr>
<td>Conduct</td>
<td>5.8</td>
<td>2090</td>
</tr>
<tr>
<td>Hyperkinetic</td>
<td>1.5</td>
<td>541</td>
</tr>
<tr>
<td>Less common</td>
<td>1.3</td>
<td>469</td>
</tr>
<tr>
<td>More than one disorder</td>
<td>1.9</td>
<td>685</td>
</tr>
<tr>
<td>Overall</td>
<td>9.6</td>
<td>3460</td>
</tr>
</tbody>
</table>

Child and Maternal Intelligence Unit
Table 10: Estimated numbers of children in Plymouth with specific mental disorders, split by gender.

When looking at these figures, we need to place them within the context of significant amounts of deprivation compared to the South West and England. Based on this it would be anticipated that these expected numbers could be an underestimate. Also these estimates only cover the 5-15yr child population.

The health visitor survey\textsuperscript{14} identified directly the numbers of families on health visitor caseloads where there was a child with behavioural problems, special needs, developmental delay or issues around parenting problems. These data cannot be used to give direct prevalence estimates as they do not cover the whole child population, but they do give an indication of potential proportions of families who might be experiencing these problems and where these children can be found.

The results show that developmental delay, behaviour problems and parenting problems are found in markedly greater percentages of caseloads in the more deprived neighbourhoods.

For younger children, behaviour problems and parenting problems affect approximately 12% of the case load families in Plymouth, with greater prevalence’s (17%) being seen amongst families from the most deprived neighbourhoods.

**16-18 year olds**

Further work will be required to determine the actual numbers of this group of young people within Plymouth in relation to prevalence.
4. Risk and Resilience

4.1 What are risk factors?

It is recognized that certain groups of children and those living in certain conditions are at greater risk of developing mental health problems. Certain factors may predispose the development of emotional and behavioural disorders in young people or may act to perpetuate existing problems.

These risk factors fall into three groups as seen below:

<table>
<thead>
<tr>
<th>In the child</th>
<th>In the family</th>
<th>In the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Specific learning difficulty</td>
<td>o Overt parental conflict</td>
<td>o Socio-economic disadvantage / deprivation</td>
</tr>
<tr>
<td>o Communication difficulties</td>
<td>o Family breakdown</td>
<td>o Homelessness</td>
</tr>
<tr>
<td>o Specific developmental delay</td>
<td>o Inconsistent or unclear discipline</td>
<td>o Disaster</td>
</tr>
<tr>
<td>o Genetic influence</td>
<td>o Hostile or rejecting relationships</td>
<td>o Discrimination</td>
</tr>
<tr>
<td>o Difficult temperament</td>
<td>o Failure to adapt to a child’s changing needs</td>
<td>o Other significant life events</td>
</tr>
<tr>
<td>o Physical illness especially if chronic &amp;/or neurological</td>
<td>o Physical, sexual or emotional abuse</td>
<td></td>
</tr>
<tr>
<td>o Academic failure</td>
<td>o Parental mental illness</td>
<td></td>
</tr>
<tr>
<td>o Low self-esteem</td>
<td>o Parental criminality, alcoholism or personality disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Death and loss – including loss of friendship</td>
<td></td>
</tr>
</tbody>
</table>

An analysis of risk factors as part of this analysis is useful to generate more insight into potential areas of need, especially in understanding the various factors that influence a child throughout their early years\(^\text{15}\), as can be seen by the table below which highlights how certain groups or characteristics are disproportionately affected with regards to poor mental health.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Expected prevalence of mental disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked after children</td>
<td>45%</td>
</tr>
<tr>
<td>Children with Special Educational Need requiring statutory assessment</td>
<td>44%</td>
</tr>
<tr>
<td>Child with learning disability</td>
<td>22%</td>
</tr>
<tr>
<td>Households with no working parent</td>
<td>20%</td>
</tr>
<tr>
<td>Child absent from school more than 11 days in a year</td>
<td>19%</td>
</tr>
<tr>
<td>Parental mental illness</td>
<td>18%</td>
</tr>
<tr>
<td>5 or more children in household</td>
<td>18%</td>
</tr>
<tr>
<td>Lone parent families</td>
<td>16%</td>
</tr>
<tr>
<td>Children living in less prosperous/mixed areas</td>
<td>16%</td>
</tr>
<tr>
<td>Parents with no educational qualifications</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: ONS 2002 Follow Up Survey

Children and young people who are helped to overcome difficulties and challenges have a better quality of life, can build on their strengths and reduce the chances of other problems developing or persisting into adult life. Promotion of emotional wellbeing and mental health is also important for children and young people who have severe difficulties, including the less common disorders such as schizophrenia, major depression or anorexia nervosa. An emphasis on prevention should aim to reduce the associated harmful impact of more severe problems on the life chances of children and young people with severe difficulties as well as to reduce the likelihood of difficulties arising in the first place\(^\text{16}\).
### 4.2 Child’s social functioning

Children with mental health disorder find it much harder to make and keep friends and are more likely to engage in risk taking behaviours. This difficulty in establishing supportive peer relations may further impact on mental health difficulties.

#### Table 13: Percentage of children and young people with mental health disorder who have difficulties in social functioning

<table>
<thead>
<tr>
<th></th>
<th>Hard than average to make friends</th>
<th>Harder than average to keep friends</th>
<th>Current smoker</th>
<th>Alcohol-regular drinkers</th>
<th>Has used drugs</th>
<th>Tried to harm of kill themselves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorder</td>
<td>35%</td>
<td>22%</td>
<td>23%</td>
<td>13%</td>
<td>20%</td>
<td>28%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>25%</td>
<td>33%</td>
<td>34%</td>
<td>19%</td>
<td>28%</td>
<td>21%</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>32%</td>
<td>44%</td>
<td>21%</td>
<td>13%</td>
<td>23%</td>
<td>18%</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td>71%</td>
<td>73%</td>
<td></td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Other children</td>
<td>9-10%</td>
<td>4-5%</td>
<td>8-9%</td>
<td>9%</td>
<td>8%</td>
<td>6.7%*</td>
</tr>
</tbody>
</table>

*taken from 1999 ONS report 11-15 years olds

### 4.3 Effects of mental health problems in childhood and later life

Research undertaken by Young Minds (1999) showed the links between mental health problems in children and young people and;

- Poor behaviour in schools
- Low school achievement
- School exclusion
- Poor social relationships
- Involvement in crime
- Self injury
- Drug and alcohol abuse
- Homelessness
- Breakdown in family relationships
- Teenage pregnancy
- Truanting
- Attempted suicide and suicide

Later in this analysis, we look in more detail about how we apply this information to specific groups of children, young people and families in Plymouth.
4.5 Building Resilience

There are some children and young people who are more resilient than others in the face of certain life events.

While we may all strive to minimize the risks that children will inevitably encounter, building up children’s resilience can increase the child’s chances of growing up healthy. An important key to promoting children’s mental health is to build on the protective factors which enable children to become more resilient. These are illustrated in Table 14.

<table>
<thead>
<tr>
<th>Resilience factors</th>
<th>In the Child</th>
<th>In the Family</th>
<th>In the Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being female</td>
<td></td>
<td>At least one good parent-child relationship</td>
<td>Wider supportive network</td>
</tr>
<tr>
<td>More intelligent</td>
<td></td>
<td>Affection</td>
<td>Good housing</td>
</tr>
<tr>
<td>Easy temperament when an infant</td>
<td>Clear, firm and consistent discipline</td>
<td>High standard of living</td>
<td></td>
</tr>
<tr>
<td>Secure early relationships</td>
<td>Support for education</td>
<td>High morale school with positive policies for behaviour, attitudes and anti-bullying</td>
<td></td>
</tr>
<tr>
<td>Positive attitude, problem solving approach</td>
<td>Supportive long-term relationship/absence of severe discord</td>
<td>Schools with strong academic and non-academic opportunities</td>
<td></td>
</tr>
<tr>
<td>Good communication skills</td>
<td></td>
<td>Range of sport and leisure opportunities</td>
<td></td>
</tr>
<tr>
<td>Planner, belief in control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humour/religious faith</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity to reflect</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*From: www.teachernet.gov.uk/_doc/4619/mentalhealth.pdf*
5. Stakeholder Consultation

Consultation with frontline practitioners, parents and young people was undertaken to provide greater insight around needs and the way that services are currently responding to them. A great range of comments and information was generated during this process, and the key messages and themes consistently raised have been collated for use within this needs analysis.

While key messages applied to all service areas, examples around specific service areas may be provided to illustrate the stakeholder message.

5.1 Key messages

5.1.1 Holistic Support for Children, Young People and Families
Stakeholders agreed that a holistic, family approach to children and young people’s emotional wellbeing is essential to effectively tackle emerging problems. Children cannot be assessed and supported in isolation from their normal environment and influences, and must be seen in their home, family and school context to reach a deeper understanding of the issues facing that young person and family.

‘If it is happening to one child, no one considers what else is happening to the other kids – there is no family approach’  Parent

‘Information about a child needs to be contextualized’

5.1.2 Intervening Early to Prevent a Crisis Later On
There is a common perception among practitioners and parents that many services are provided only once a child or family has reached crisis point. Stakeholders identified a large gap in the provision of targeted support and advice to universal services, especially for those children with multiple needs that may not yet have reached the threshold for any specialist service.

‘The help is never there when you need it’  Parent

‘No one wants to do anything about it now – there is always the need to wait, and no support in the meantime. There is no prevention, only crisis, and at that time it is too late to make a difference’  Stakeholder

‘Because parents or children do not meet thresholds for specialist services, no one is picking them up’  Health/Secondary School stakeholder

‘Where do I get family support? I never reach the thresholds for social care’  Parent

‘Bottom line in terms of who gets attention is who is most in crisis. There are not enough resources to prevent them from getting to this crisis level’  Teacher

‘No one wants to do anything about it now – there is always the need to wait. There is no prevention, only crisis, and at that time it is too late to make a difference’  Stakeholder
There is a real willingness within universal services to engage with the emotional wellbeing agenda, but practitioners are struggling to deal with emerging problems of young people, and are hindered by time, a lack of support and advice about what to do, and a lack of understanding of what to look for and where to refer to when problems start to emerge.

‘Primary mental health workers provide advice, but the problem is that I do not have the time or opportunity to carry out longer term pieces of work’

School stakeholder

‘Sometimes you need short term therapeutic interventions – this does not exist in Plymouth’

Voluntary sector practitioner

5.1.3 Accessing Information, Signposting and Service Navigation

Practitioners and parents felt that unless one knew how to navigate the system and individual services, it was common to face real and significant blockages at each step of the way to addressing a child’s identified needs.

‘I want to have a solution without having to beg for it’

Teacher

‘I often go home and cry because I cannot get help the help and support I know that this child needs’

Stakeholder

‘Unless you are kicking and screaming, you do not get anywhere’

‘In the end you give up – there are too many blocks’

Parent

‘There are more obstacles than doors opened when trying to access any CAMH service’

‘I know parents who suspect their child is ASD but who refuse to get a diagnosis because of how difficult it is. They have already experienced it with another of their children and will not do that again’

Parent

‘You get worried about rubbing people up the wrong way because you come up against so many brick walls’

Parent

Stakeholders are frustrated because they do not know what services were available and how to access them. This echoed concerns about the lack of active signposting when a child’s needs do not meet their service’s thresholds.

‘There is the continuing issue of staff knowing who to refer to. Even when they signpost, parents themselves may not be able to respond’

School stakeholder

‘We need to know what services are available – too often we are only told what is not available. Professionals often have no idea of what other services are out there’

Stakeholder

‘I call social services because I don’t know where else to turn to but I am always turned away’

Parent

‘Swift referrals and joined up thinking do not exist’

Stakeholder
5.1.4 Magic Solutions or Practical Support?
Stakeholders acknowledged that while there may not be any effective intervention or service to meet a child’s identified needs, practical support for the child and their family should be provided to enable them to cope with everyday life as best as possible, and facilitating that child to live life to its fullest.

| ‘Sometimes a diagnosis doesn’t help because the behaviour still exists’ | Parent |
| ‘Sometimes they know what the problem is, but the service does not exist. If someone could just sit with parents and explain to them how to live with it a bit better, that would be better than what we get now’ | Parent |
| ‘There doesn’t seem to be a focus on understanding the problem and looking for a practical solution that tries to help them’ | Parent |
| ‘Parents across Plymouth are feeling like they are being let down’ | Parent |
| ‘You put all your trust in them because there is no where else to go. So you come away disappointed’ | Parent |

5.1.5 The Role of Parents in Meeting the Needs of Children and Young People
Parents often feel judged, isolated and blamed for what is wrong with their child.

| ‘She is the way she is because of the parent’s fault’ *(said to a parent)*. They have no idea what impact they have with their words’ | |
| ‘You people think you can do no harm with your words’ | Parent |
| ‘It always feels like people are on the fence – they don’t live with our kids, but they blame us for making the child anxious’ | Parent |
| ‘Regardless of mind or body, it is the isolation you feel that hurts the most’ | Parent |

Parents often had no idea what a care plan was and what type of support/intervention their child was receiving

| ‘I have no idea what they are doing with my child. He has gone for 6 sessions now and all he says they do is talk. He hasn’t improved. I thought it would get better but his behaviour hasn’t changed and he is still so angry’ | Parent |
| ‘I was never given a care plan or told what to expect’ | Parent |
| ‘Children and parents are not told what to expect before the process starts – sessions are not explained well to the client group’ | Stakeholder |
Parents feel that their views and opinions of what is best for their child is ignored when deciding what services and support to provide/not provide for a child/young person – with a mismatch between what a parent and what a practitioner believes the holistic needs of a child are. This includes issues around parents not being involved in the assessment and subsequent care planning process, the way they feel they are treated, and the use of professional languages and terminology that is alien to parents and young people.

‘Parents are like mushrooms – keep them in the dark and feed them crap’  
Parent

‘If I can’t help my child, and no one else is helping me to help them, what else is there might as well let them get on with it – parents need support to help their children’  
Parent

‘Many parents have learning difficulties themselves so we need to engage with them on their own terms and pace’  
Teacher

5.1.6 Professional responsibility, ownership and multi agency partnership
Stakeholders reported professional differences getting in the way of providing the best possible response to a child’s needs. The result is that the child can often be bounced from one service to another, with no service being provided in the meantime. Stakeholders felt a real need for services and practitioners to own responsibility to meet the needs of a child, and for someone to lead this process throughout.

‘There is a lack of care coordination around mental health - you don't need 20 different professionals coming into a child’s life’

‘There are differences in understanding of what constitutes need across most services (social care, CAMHS, educational psychologists)’

‘Much of the time, it is left to education to sort out’  
Parent

There was a common perception that practitioners often disagree or do not communicate together about the best possible solution to addressing a child/young person’s needs. This is compounded by different services’ understanding of risk. As a result, the professional’s opinion becomes the focus of discussions and the child gets forgotten. Stakeholders wanted more collaboration between agencies with a real commitment to compromising and coming up with the best plan possible to help a child or young person.

‘Collaboration is good, as long as it coincides with the view of the professional involved’

‘Many of our children with mental health issues also have other social problems, but social work is a specialist service now so who can we refer to if there is no immediate risk around child protection?’  
Teacher
5.1.7 Consistency in Service Provision
Stakeholders believe that it makes a difference which individual is assigned to work with a family or child, implying a limited consistency across services in response to need.

‘If you get the right person around the table, something gets done. But you don’t know who that person is, so it’s pot luck for the child and parents’ Parent

‘I like the lady who works with me, she’s helped me learn what to do when I get really angry, when the teachers wind me up. I try and walk away now and it really helps. I hope she stays with me because I wouldn’t talk to anybody else. I wish sometimes that we could go somewhere quiet to talk – it’s really noisy in the school and if I could go anywhere, I would love to go somewhere like a park or in town somewhere. That would be good’ Service User, 10yrs

5.1.8 Supporting Team Around The Child
Frontline practitioners feel their ability to really help families is limited by an institutionalized inability to deliver the team around the child (tight budgets, bureaucracy, governance arrangements, risk assessments). The concept of team around the child cannot work unless frontline services are supported to do so and current barriers are removed.

‘There are good people who are locked into a sick system’ Social Worker

5.2 Comparing data with the Interim National CAMHS Review
Information from parents, children and young people collected within the national CAMHS review process revealed that they value an approach where they feel listened to and involved in the actions taken.

The report noted that whilst this information is unsurprising, this is not always the case in the services which they receive. Particular emphasis is placed by families on the need for:

1. Continuity of staff and professionals: Families find it particularly difficult when they are passed between different services, or where staff change regularly. They want to build trusting relationships with staff.

2. Involvement in deciding on services and interventions and getting some choice in this.

3. Easier access to information on what is available to help and what different services can offer. There is a particular need to understand referral procedures and contact arrangements for specialist services.

4. Earlier intervention to avoid crises and better aftercare support.

5. Services provided in places which are convenient and at times which make sense for people.

6. Young people in particular are very concerned that their need for confidentiality is respected.

7. It has been a marked feature of the responses to date that families highlight the important role which schools and colleges play in promoting mental health and psychological well-being amongst children and young people. A question which has arisen is why there is not a more consistent standard between educational institutions given the importance of this work.
8. Given the importance of the role that parents and carers play in children’s lives, support for parents particularly during the referral processes, which can be lengthy, is seen as particularly important.

9. Too often at present, mental health and psychological well-being is still seen as somebody else’s problem to address. Families and universal services often feel they are left to deal with a problem rather than helped to resolve it.

Many of these factors are consistent with the original messages laid out within Every Child Matters and its value led framework that brings ‘working together’ (partnership), developing new ways of working (innovation) and focus on needs of children and young people (culture) together as the basis of local success.

5.3 Questions arising from stakeholder consultation that should influence commissioning

5.3.1 Holistic Support for Children, Young People and Families
- How can services ensure that the right people, including parents, are around the table when looking to support a child’s needs?
- How will services respond to the need for community based, family oriented responses around emotional well-being?

5.3.2 Intervening Early to Prevent a Crisis Later On
- Are services really aligned to only respond to those in crisis?
- Is the current totality of current service provision adequate to meet need?
- Are adequate resources allocated to respond across the spectrum of need, specifically prevention and early intervention/targeted services?
- How can we better support universal services to build the resilience of children, young people and families?
- Are universal services aware of and responsive to their role to build resilience in relation to emotional well-being (e.g. in their allocation of time and resources)
- How can we stop children and young people falling through the gaps of service provision once needs start to emerge?
- How can we learn from and build on good practice examples of early intervention/targeted work within the city?

5.3.3 Accessing Information, Signposting and Service Navigation
- How can we ensure that the first contact is a good one?
- Do we know what services are out there to support the emotional wellbeing and mental health needs of young people and their families?
- What steps do we need to facilitate easier signposting and referrals between agencies?
- How can we ensure a shared understanding around the emotional wellbeing needs of children and young people?

5.3.4 Magic Solutions or Practical Support?
- What are the characteristics of our services that we should aspire to? Are they set up to only try and solve the problem, or do they seek also to enable the child and family to cope and live with life challenges.

5.3.5 The Role of Parents in Meeting the Needs of Children and Young People
- Do services understand the role that parents have in emotional wellbeing?
- What can services do to reflect on the way they communicate with parents – language, approach etc
- How can parents become a key partner when understanding and responding to a child’s needs?
- How can services support parents better when working to support a child’s needs?
5.3.6 Professional responsibility, ownership and multi agency partnership
  o Whose role is it to coordinate care around the needs of a young person at any level? Whose role is it to coordinate and lead around EWB/MH?
  o How can we acknowledge and overcome professional differences in a way that benefits the child?
  o How can we best implement the lead professional concept within the emotional wellbeing agenda?
  o Is emotional wellbeing included in the initial training of practitioners working with children and young people?
  o How can we facilitate faster and more systematic communication between practitioners to ensure that agreements about the best course of support for any child or young person are reached as soon as possible?

5.3.7 Consistency in Service Provision
  o How can we ensure that services provide consistently good quality support, where clients and other stakeholders know what to expect and how to respond when expectations and quality are not met?

5.3.8 Supporting Team Around The Child
  o How can we unblock the institutional and cultural barriers that are preventing practitioners from implementing the concept of team around the child? Do we fully understand what these barriers are, and what we need to do to unblock them?
  o Is the strategic vision around needs based commissioning in line with the corporate and strategic priorities of all agencies involved?
  o What role do strategic leaders have in facilitating cultural change around emotional wellbeing across the Children’s Trust?
  o How can we overcome the difficulties raised by service specific governance arrangements, languages used, perceptions of risk and cultural differences in order to respond effectively to the needs of children, young people and their families?
6. Vulnerable Groups

Children and young people who may be vulnerable around the issue of emotional wellbeing and mental health include those;

- whose problems are hidden from the system e.g. asylum seekers;
- whose problems are not recognised or addressed due to discrimination, lack of awareness or the overshadowing of other diagnoses – e.g. children from black and minority ethic communities, or children with learning disabilities;
- who are known from research evidence to be more vulnerable – e.g. children with learning disabilities;
- who have a number of vulnerabilities, and who are at risk of falling between services e.g. children in care or those with complex needs.

This section takes a look at some of these vulnerable groups in more detail, and what we know about them in Plymouth. These include:

- Families affected by deprivation
- Young offenders
- Living with a parent with a mental health problem
- Children in care
- Children and young people with a learning disability
- Children and young people with special educational needs
- Black and ethnic minority groups / asylum seeking children

Children and Young People affected by;

- Substance misuse
- Homelessness
- Domestic abuse
- Bullying
6.1 FAMILIES AFFECTED BY DEPRIVATION

While there are many factors that affect prevalence of mental health problems in children and young people, socio economic situation plays a major part. Children who grow up in low income families are less likely to stay on at school and gain qualifications; they are more likely to experience unemployment and poverty during adulthood and are at increased risk of experiencing health problems and dying younger than their better off peers. Specifically, these children are prone to develop mental health problems such as unstable tempers, insomnia and obsessive and depressive disorders.¹⁹

The 2004 ONS survey found that:

- Prevalence of mental health problems was higher among children in families where neither parent worked (20 %) compared to those in which both parents worked (8 %), and one parent worked (9 %).

- Sixteen per cent of children from families with a weekly household income of under £100 suffered from mental health problems, compared to 5 per cent with a weekly household income of more than £600.²

- The link between childhood mental health problems and familial affluence is again highlighted by type of accommodation. Children living in rented accommodation, either social sector (17 %) or private sector (14 %), were twice as likely to suffer from a mental health problem than those in owned accommodation (7 %).

- Educational qualifications of the parent, especially the mother, have a strong impact on prevalence of mental health problems. The ONS survey showed a rate of 17 per cent among children whose parent had no educational qualification, as opposed to 4 per cent among those with parents educated to degree level.

- Family make-up can also impact on the mental health of children and young people. Prevalence rates of mental health problems were higher in children from single parent families (16 %) compared to married couple families (7 %). Nearly one fifth (18 %) of boys living in single parent families suffered from a mental health problem, as opposed to 13 per cent of girls. Reconstituted families, i.e. those where stepchildren are present, also increased the prevalence of mental health problem: 14 per cent compared to 9 per cent without stepchildren.

What is the situation in Plymouth?

In Plymouth, families living in the most deprived neighbourhoods are 7 times more likely to have the wage earner unemployed compared to the least deprived neighbourhoods.

Compared to both regional and national statistics, Plymouth has a greater proportion of children living in deprivation, with nearly 1 in 4 of 0-15 years defined as deprived by the Deprivation Affecting Children Index. Deprivation also varies widely across the city. In the most deprived third of neighbourhoods over 1 in 3 children aged 0-15 years live in families dependent on workless benefits. This compares with only 1 in 14 in the least deprived third of neighbourhoods. Based on this information, the expected numbers of children and young people with a mental health disorder using estimated prevalence figures could be an under estimate.
6.2 SUBSTANCE MISUSE

Why is this an issue?21?
Alcohol misuse can have serious physical and medical consequences and often leads to psychological
dependence. The taking of illegal and legal drugs can be physically addictive, and may be taken by young
people to escape from emotional problems. Certain drugs such as cannabis have been linked with
depression and psychosis in some susceptible young people.

There is growing evidence that young people with a conduct disorder / emotional disorder / hyperkinetic
disorder have high prevalence levels of drug and alcohol use.

It is estimated that:
- 31% of young people (aged 14-16) with any emotional disorder had used illegal drugs;
- 43% of young people (aged 14-16) with a conduct disorder had used illegal drugs;
- 45% of young people (aged 14-16) with any hyperkinetic disorder had used illegal drugs. (ONS 2004)

In addition, the National Treatment Agency have found that service users in specialist substance misuse
treatment who have longer-term needs (around 20% of those in treatment) may require specialist mental
health input.

What is the situation in Plymouth?
Research by Ofsted shows that young people in Plymouth are more likely to have smoked a cigarette or had
an alcoholic drink than the national average. 28% have ever smoked a cigarette. 56% have had an alcoholic
drink. 25% of young people have been drunk at least once in the last four weeks. 9% state they’ve been
drunk three or more times.

Ofsted found that 79% of young people state they have never taken drugs. In line with the national averages,
9% have taken cannabis in the last four weeks, 4% have taken other drugs such as ecstasy, cocaine, heroin
or LSD.

In a 3 month period between July and September 2007, 90 Plymouth young people under 18 were admitted
to A&E for psychiatric disorder / drug overdose. There were 6 admissions of young people who had self-
harmed involving the use of substances.

The number of admissions to hospital of under 20 year olds with mental and behavioural disorders due to
substance misuse or with poisoning by narcotics and psychodysleptics is higher than expected for a city this
size and slightly higher than the statistical neighbour average. Once every ten days a young person is
admitted to hospital for this reason.

An analysis of 112 young people using the Hamoaze House youth programme service in 2006 found that
86% were experiencing health/behaviour problems. 80% of those aged 11-16yrs had also been excluded
from school.

The young people’s specialist substance misuse service is reporting increased numbers of young people
entering the service with a history of being prescribed methylphenidate (Ritalin). Methylphenidate is
prescribed as part of the treatment for Attention Deficit Hyperactivity Disorder (ADHD). Recent work by the
Plymouth Public Health Development Unit demonstrates that Primary Health Care Practices with the highest
level of methylphenidate (Ritalin) prescribing are situated or serve the most deprived neighbourhoods in the
City.
6.3 YOUNG OFFENDERS

Why is this an issue?
Young people who offend are much more likely to have mental health problems; these problems are likely to be similar to those of the general adolescent population but ‘more so’ (conduct disorder, emotional disturbance, hyperactivity and attentional problems). Estimates show that rates of mental illness in these young people is three times as high as that for their peers.

Young offenders are at risk of having higher than usual rates of mental health problems for three main reasons:

- Because the original risk factors that led to their offending also predict, in the general population, to mental health problems. These factors include inconsistent or erratic parenting, over-harsh discipline, hyperactivity as a child, and various other types of stressors on families and neighbourhoods.
- Because various aspects of offending itself may cause mental health problems. The characteristically risky behaviour of young offenders may itself cause stresses.
- Because interactions with the criminal justice system are stressful and may on their own lead to anxiety and depression, particularly those associated with custody.

What is the situation in Plymouth?
In 1997, the ONS carried out a study looking at the levels of mental illness in prisoners in England and Wales. In 2000, the ONS published an analysis of this data for young offenders aged 16 to 20 years. The main findings were:

- Over 80% had a diagnosable personality disorder (the vast majority had antisocial personality disorder).
- 4% of young males who were sentenced had a psychotic illness compared with 9% of women.
- 42% of sentenced young males and 68% of sentenced young females had a neurotic disorder (including anxiety, depression and phobias).
- 38% of young males reported having had suicidal thoughts at any stage of their life; 30% in the past year and 10% in the past week. The figures for young females are higher.

The Youth Offending Service sees young people aged 10 to 18 (and up to 20 years if the order started when they were eighteen). All new cases undergo an ASSET assessment which includes an emotional and mental health section. An individual may have more than one ASSET assessment undertaken. A score of two or more on this scale precipitates the requirement to undertake a more detailed mental health assessment using a specifically designed questionnaire. A score above threshold precipitates a detailed assessment by the health worker contained within the youth offending service.

Of the 474 ASSET assessments undertaken during 2007/8, 212 (44.7%) scored two or above and so were assessed further. 89 (42%) of these 212 individuals subsequently underwent an assessment by the youth offending service health worker.
6.4 LIVING WITH A PARENT WITH A MENTAL HEALTH PROBLEM

Why is this an issue?
Some children and young people live with a parent that have a mental health problem or illness, such as depression (including post natal) or a personality disorder. Parents with enduring mental health difficulties are often able to be effective and loving parents with additional support appropriate to their circumstances. In many cases parents have strong relationships with their children and they may feel anxious, uncertain and unconfident about caring for them.

Mental health problems invariably make a parent's job more difficult. A child can be affected by their parent’s often reduced capacity to cope as a parent, and also by the parent’s illness directly. Both parents and children may feel isolated and unsupported, which can lead to distress. Furthermore, living with a parent with a significant mental illness increases the chances of a young person developing mental health problems themselves.24

Research findings suggest that in the UK about 4% of all parents with dependant children have mental health problems, with lone parents being particularly vulnerable and women being more vulnerable than men.25

Families affected by parental mental health difficulties are at increased risk of poverty; adults with enduring mental health problems are unlikely to be in work – only 24 per cent are in paid employment – and are more likely to live in deprived neighbourhoods.

What is the situation in Plymouth?
Table 15: Percentage of children with mental health disorder whose parents have a mental illness

<table>
<thead>
<tr>
<th></th>
<th>Parents with CHQ-12 indicative of emotional disorder</th>
<th>Parents with CHQ-12 indicative of emotional disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorder</td>
<td>51%</td>
<td>44%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>48%</td>
<td>23-24%</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>43%</td>
<td></td>
</tr>
</tbody>
</table>

(PDHU 2007)

Local data is available from health visitor data that shows the percentage of their caseloads with a parent who is depressed or has a mental health problem. Once again this shows that households in the most deprived neighbourhoods are almost twice as likely to experience this than households in the least deprived neighbourhoods.

Table 16: Percentage of health visitor caseloads with a parent with depression or other mental health problem by deprivation group

<table>
<thead>
<tr>
<th>Deprivation group</th>
<th>Parent depressed / mental health problem Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived</td>
<td>21.1</td>
</tr>
<tr>
<td>Middle group</td>
<td>13.8</td>
</tr>
<tr>
<td>Least deprived</td>
<td>11.8</td>
</tr>
</tbody>
</table>

(PDHU 2007)
6.5 CHILDREN IN CARE

Why is this an issue?
Children find themselves in care for a variety of reasons: they may have experienced abuse or neglect, or a parent may be unable to care for them for a variety of reasons, or may have died. Clearly, a child taken into care has to establish new relationships with peers and care workers or foster parents. Such children are more likely to come from disadvantaged homes where there has already been additional risk.

By definition, children in care have often already experienced traumatic events in their lives, so it is not surprising that they are more likely to develop mental health problems than those in stable family environments. Sometimes the experience of care can contribute to a child’s already fragile self.

What is the situation in Plymouth?
In 2003, the ONS carried out a survey of mental health problems in young people aged 5 to 17 years looked after by local authorities in England. Overall 37% of children had a clinically significant conduct disorder; 12% were assessed as having emotional disorders (anxiety and depression) and 7% were hyperactive. The prevalence of less common disorders was 4%. Among 5 to 10 year olds the overall prevalence was 42% and for young people aged 11 to 15 it was 49%. This is 4-5 times greater than the general UK prevalence determined by the ONS study.

Table 17: Mental health disorders among children looked after by the local authority compared to children living in a private household (England, 2002)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>5-10 year olds (%)</th>
<th>11-15 year olds (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Looked after</td>
<td>Private household</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>11 3</td>
<td>12 6</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>36 5</td>
<td>40 6</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>11 2</td>
<td>7 1</td>
</tr>
<tr>
<td>Any disorder</td>
<td>42 8</td>
<td>49 11</td>
</tr>
</tbody>
</table>


The prevalence of mental health disorders in children living in residential care, with foster carers or birth parents was 68%, 39% or 42% respectively. The prevalence of childhood mental disorders tended to decrease with the length of time in their current placement. The overall rate fell from 49% of those in their current placement for less than a year to 31% of children in their current placement for at least five years.

Currently Plymouth LA has around 92 per 100,000 population under 18 accommodated under a care order or section 20.26. This is significantly more than the national figure of around 66 per 100,000 population under 18. As a broad estimate, half of these children will have a mental health problem and a high proportion of these will be of a conduct disorder. This threatens placements and may lead to breakdown of care arrangements, multiple moves amongst foster carers and if special accommodation is required creates high costs. Placement breakdown can often present with crisis and access to a timely response is required.

Data shows that looked after children have poor educational attainment, are disproportionately represented amongst young offenders, the homeless, self-harm, substance misuse, teenage pregnancy and long term mental disorders that extend into adulthood. Looked after children therefore form highly an excluded group with high mental health needs and incur significant health costs to themselves and service providers.

In addition looked after children often experience greater difficulty in accessing health care which is compounded by multiple moves, failure of letters and notes to be available and a higher level of failure to attend.


6.6 HOMELESSNESS

**Why is this an issue?**

Homeless families are defined as all adults with dependent children who are statutorily accepted by local authorities (housing departments) in the UK, and are usually accommodated for a brief period in voluntary agency, local authority or housing association hostels. This definition does not include those children and their carers who have lost their homes and live with friends or relatives, on the streets, in squats or as travellers.

The impact of homelessness on families with children includes:
- No consistency in accommodation, schools, GPs, area, community, friends;
- Lack of identity, lack of autonomy;
- Lack of safe play opportunities, lack of homework space;
- Poor parenting skills and parental lack of self esteem;
- Impact of shared hostels/accommodation.

Research has found high prevalence rates for a number of emotional and behavioural problems and disorders\(^{27}\). In children of pre-school and primary school age, behavioural problems include sleep disturbance, feeding problems, aggression and hyperactivity. These often occur alongside emotional or developmental disorders. Anxiety and post-traumatic stress disorder (PTSD) are often precipitated by life events such as witnessing domestic violence\(^{28}\).

Homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and vulnerability to sexually transmitted diseases. A high proportion of homeless mothers also have similar psychiatric disorders, again primarily depression and substance misuse\(^{29}\).

**What is the situation in Plymouth?**

During 2007-8, 239 families were accepted as ‘Statutory’ homeless, of which:
- 125 had one child (125 children in total)
- 80 had two children (160 children in total)
- 34 had three or more children (at least 102 children).

The average number of families accommodated by the Local Authority at any one time is 46. An average of 179 children/expected children are homeless at any one time, being accommodated in various forms of accommodation in Table 18 below:

<table>
<thead>
<tr>
<th>Accommodation Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>B &amp; B</td>
<td>4%</td>
</tr>
<tr>
<td>Private Sector Leased</td>
<td>24%</td>
</tr>
<tr>
<td>Own Stock</td>
<td>28%</td>
</tr>
<tr>
<td>Private Rented Sector</td>
<td>1%</td>
</tr>
<tr>
<td>Homeless at home (i.e. able to stay at home temporarily to await settled accommodation)</td>
<td>43%</td>
</tr>
</tbody>
</table>

About half of all families accommodated are ‘intentionally’ homeless – and accommodated for a ‘reasonable’ amount of time in order to enable them to access accommodation for themselves. Most families are able to stay in their own homes, at least temporarily, while waiting for other accommodation – this may be because they have received an eviction notice that allows them to remain until a specified date; they are staying with family who are prepared to house them in the short term; or they are awaiting court eviction proceedings and can remain in the accommodation in the interim.

**Homeless 16/17 year olds during 2007-8**

54 young people aged 16/17 were accepted as being ‘statutory homeless’ during 07/08. Around 200 young people approached the Local Authority with a housing need during 2007/8, and homelessness is prevented in most cases\(^{30}\).
6.7 SPECIAL EDUCATION NEEDS (SEN)

Why is this an issue?
The term SEN encompasses children with a wide range of difficulties including dyslexia, visual impairment, learning difficulties, physical disabilities and communication difficulties. It also includes children with autism and Aspergers syndrome as well as those with emotional and behavioural difficulties, such as ADHD. Children with SEN all have learning difficulties, or disabilities that make it harder for them to learn than most children of the same age. These children need extra or different help from that given to other children of the same age.

Children with SEN exhibit higher levels of mental health problems than the general population. The 1999 ONS survey found the chance of a child having any mental health disorder increased through the various stages of the statementing process. Just over 5% of children without any special educational needs had a mental health disorder compared to over 40% of children with a statement.

Mental health problems experienced by children with SEN include all those exhibited by any other child. Difficulties that occur more frequently however include conduct disorder, depression and suicide, ADHD, soiling and wetting, obsessive-compulsive disorder and schizophrenia.

The incidence of mental health problems varies between the different types of SEN. For example a significant proportion of children with EBD are considered to have mental health problems, while around half of children with severe learning difficulties show evidence of having mental health problems.

What is the situation in Plymouth?
The percentage of pupils with a statement of special educational needs in Plymouth is currently 3.2%. The percentage of pupils with a statement of special education need has been steadily reducing over time, but it remains higher than the national average of 2.8%.

56% of pupils with statements attend a mainstream school. This is roughly in line with the National average but higher than other authorities. The percentage of pupils with special educational needs, that is, those with a statement of educational need and those with school action plus is higher than average in primary schools, and average in secondary schools.

<table>
<thead>
<tr>
<th>Table 19: Numbers of pupils with SEN by need and age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>Behaviour, Emotional and Social Difficulties</td>
</tr>
<tr>
<td>Hearing Impairment</td>
</tr>
<tr>
<td>Moderate Learning Difficulty</td>
</tr>
<tr>
<td>Multi-Sensory Impairment</td>
</tr>
<tr>
<td>Other Difficulty/Disability</td>
</tr>
<tr>
<td>Physical Disability</td>
</tr>
<tr>
<td>Profound and Multiple Learning Difficulty</td>
</tr>
<tr>
<td>Speech, Language and Communication Needs</td>
</tr>
<tr>
<td>Severe Learning Difficulty</td>
</tr>
<tr>
<td>Specific Learning Difficulty</td>
</tr>
<tr>
<td>Visual Impairment</td>
</tr>
<tr>
<td>Other Difficulty/Disability</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*(CYPP needs analysis 2008)*
In primary schools, those children with speech, language and communication needs (36%) and behavioural, emotional and social difficulties (23%) make up the majority of children with special needs. Both categories are significantly higher in Plymouth than in the typical authority. Conversely, the number of children with moderate learning difficulty is significantly lower than expected in a city of this size.

In secondary schools, behavioural, emotional and social difficulties or BESD (31% of pupils with special needs) and moderate learning difficulties (21%) are the highest presenting need. Compared with the typical authority Plymouth has a slightly lower number of young people with learning difficulties, but has a higher number of young people with speech, language and communication needs, and with autistic spectrum disorder (ASD).

Across both phases, the number of children with BESD has risen by 24% in two years particularly with the use of School Action Plus. Increases have been most marked in Reception Year and with Years 6 and above, and more marked among girls than boys. The number of pupils with ASD has risen by 21% over the same period.

Whilst the number of young people with special needs has remained static over the last three years there have been considerable rises in Years 8 to 10. SEN pupils are less likely to hold a level 3 qualification than the national average. SEN pupils without a statement do better at GCSE level than the national average (5 or more GCSE A* - C, Any passes)\textsuperscript{35}.

**SEN and SCHOOL ATTENDANCE**

Children and young people with mental health disorders also have increased difficulties with social functioning, scholastic ability and school attendance compared with other children. Significant numbers of children with mental health disorders have special educational needs and higher levels of absenteeism and truancy. Children who had played truant in the last year were more likely to have a mental health disorder than those who had not (15% versus 2%). Almost 1/3 of children with conduct disorder or ASD have been excluded.

**Table 20: Percentage of children and young people with mental health disorder who have difficulties in scholastic ability and school attendance**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Considered by teachers to be behind scholastically</th>
<th>Considered by teachers to be 2 or more years behind scholastically</th>
<th>Considered by teachers to have SEN</th>
<th>&gt;15 days absence in previous term</th>
<th>Possibly / certainly truanted</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorder</td>
<td>44%</td>
<td>23%</td>
<td>35%</td>
<td>17%</td>
<td>16%</td>
<td>-</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>59%</td>
<td>36%</td>
<td>52%</td>
<td>14%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Hyperkinetic disorder</td>
<td>65%</td>
<td>36%</td>
<td>71%</td>
<td>11%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td>72%</td>
<td>40%</td>
<td>97%</td>
<td>-</td>
<td>-</td>
<td>27%</td>
</tr>
<tr>
<td>Other children</td>
<td>24%</td>
<td>9%</td>
<td>16%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

In 2007, the percentage of fixed term exclusions for pupils with statements in mainstream secondary schools was 31%, compared to 17% in 2005. This reflects the national increase in exclusion rates for these young people. For primary schools, we remain under the 10% national average at just under 4%.
**6.8 CHILDREN AND YOUNG PEOPLE WITH LEARNING DIFFICULTIES**

**Why is this an issue?**

It is useful to understand the difference between learning disability and learning difficulty. A term used mostly within health services, a child with a ‘learning disability’ finds it difficult to learn, understand and do things compared to other children of the same age. It entails a significantly reduced ability to understand new or complex information or learn new skills, and a reduced ability to cope independently.

Children with a learning difficulty, a term used mostly within education, have significantly greater difficulty in learning than the majority of children of the same age, or have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local education authority.36

Both terms can cause confusion, as a child with a mild learning disability in health terms could probably be described as having a moderate learning difficulty in the education system.

It has been estimated that between a third to two-thirds of children and young people with learning disability have a mental health problem. Children and young people with a learning difficulty/disability are more likely to have behavioural and mental health problems for the following reasons:

- **Communication difficulties**: these children may find it hard to understand what is asked of them and even to communicate their basic needs
- **Poor coping mechanisms**: A lack of coping strategies can lead to reliance on aberrant behaviours when things go wrong (screaming, shouting, becoming aggressive)
- **Low self esteem**: no matter how supportive their families are, the children know they cannot do things as well as others (e.g. clumsy or poorly coordinated)

It is reported that children with a learning disability are over twice as likely to experience anxiety disorders 8.7% v 3.6%, and approximately six times as likely to experience conduct disorders 25% v 4.2% 37.

Some parents themselves also have learning difficulties and have trouble nurturing their children, who also have learning difficulties.

**What is the situation in Plymouth?**

Prevalence estimates from several sources are shown in the following table and have been extrapolated to the 0-18 years population figures for the “PHDU Children’s Atlas 2006”

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated prevalence per 1000 whole population</th>
<th>Applied to Plymouth 0-18 years population (based on 56,542)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profound and Multiple Learning Disabilities</td>
<td>3-4 per 1000</td>
<td>170-226</td>
</tr>
<tr>
<td>Mild / moderate learning disability</td>
<td>20 per 1000</td>
<td>1131</td>
</tr>
<tr>
<td>Down’s syndrome</td>
<td>1 in 700</td>
<td>81</td>
</tr>
<tr>
<td>Autism</td>
<td>1.68 per 1000</td>
<td>95</td>
</tr>
<tr>
<td>Other autistic spectrum disorder</td>
<td>4.45 per 1000</td>
<td>252</td>
</tr>
</tbody>
</table>
6.9 BULLYING

Why is this an issue?
A national study of bullying reported that “it could include verbal and physical abuse, theft, threatening behaviour, and coercion. Bullying was also understood as behaviour intended to cause distress or harm”. It is important to note that perceptions and definitions of what constitutes bullying vary from child to child. Children's Fund research shows that children and young people are unclear of what bullying is, often reporting a one off incident of name calling as bullying.

For most young people, being bullied is a transient experience; however, severe or persistent bullying can seriously affect a child's emotional wellbeing mental health, particularly as there is a tendency for those who are bullied to suffer in silence and internalize the problem. As well as lacking confidence, having poor self-esteem, a sense of inferiority and being isolated and lonely, they may develop insecurity and anxiety arising from continually feeling under threat. Some may experience sleep problems, eating disorders, phobias, depression, suicidal thoughts or even post-traumatic stress.

What is the situation in Plymouth?
Local data around bullying in Plymouth is limited, however national research does shed some light on the prevalence of bullying in schools;

- Research for ChildLine and the Department for Education and Skills (DfES) found that just over half (54%) of both primary and secondary school children thought that bullying was 'a big problem' or 'quite a big problem' in their school. Just over half (51%) of Year 5 students (aged 9-10) reported that they had been bullied during the preceding term compared with just over a quarter (28%) of Year 8 students (aged 12-13). 15% of primary school students, and 12% of secondary school students said that they had both bullied other children and been bullied themselves in the last year.

- Research with 11 to 19 year olds found that 1 in 5 young people (20%) had experienced bullying or threats via e-mail, internet chatroom or text message. Bullying using text messaging was the most common of these three forms of bullying, experienced by 14% of young people. Almost three quarters (73%) of young people who had been bullied by email, internet chatroom or text message said they knew the person who bullied or threatened them, while a quarter (26%) said it was done by a stranger.

- In 2005/6, 37,074 children called ChildLine and gave bullying as their main problem (of which 25,406 were girls and 11,668 were boys - i.e. 2 girls to every 1 boy). For 60% of these children, the bullying was categorised as name calling/teasing, for 55% the bullying was categorised as physical bullying, and for 11% the bullying was categorised as verbal or written threats.

- The 2006 Plymouth Children's Fund Big Consultation defined bullying as persistent abuse by an individual or group against another person or group. It found that 53.1% of the young people interviewed had ever been bullied and that the majority of those that had been bullied (75%) did report it. The consultation showed that verbal abuse was most common, and that physical abuse and being ignored were also high.

- The Tellus2 survey reported that 25% of young people in Plymouth worry about being bullied. A significant number reported being bullied in the last four weeks: 19% said a couple of times in the last four weeks, 4% about once a week, 4% two or three times a week, 6% most days. The Tellus3 survey reported that 50% of children and young people had been bullied at some point.
6.10 BLACK AND ETHNIC MINORITY GROUPS & ASYLUM SEEKING CHILDREN

Why is this an issue?
BME groups are amongst the most socially excluded people in society, being more likely than others to live in deprived neighbourhoods, be poor, be unemployed, experience ill health, and live in overcrowded and unpopular housing. Young people from black and minority ethnic communities experience the added jeopardy of widespread racial harassment and racist crime. Young people who experience racism or discrimination on account of their race, colour or religion are at increased risk of developing mental health problems. Black and minority ethnic young people are over-represented in the mental health system, and they may experience forms of institutional prejudice that affect their future life chances.

Asylum seekers form one part of BME communities. Many asylum seeking families leave their home countries because of war, instability or because their human rights have been abused. These families have often experienced trauma, multiple losses and transitions, all of which could potentially have a powerful impact on their children’s emotional and psychological well being and the family’s functioning. Once here, these families have to cope with new languages, new social and cultural experiences, racism and significant levels of deprivation. In addition, the asylum process creates an acutely oppressive climate of fear, anxiety and unpredictability that actively undermines the mental health of the women, children and young people subject to it.

What is the situation in Plymouth?
Annual audits by the local Ethnic Minority Achievement Service (EMAS) reveal some seventy languages being spoken in Plymouth schools and the growth (in size and international reputation) of the city’s University (which is the third largest in the UK with some 30,000 students) and other higher education institutes also indicates a growing diversity across educational sectors.

The city has seen a substantial rise in migrant workers from those countries (Poland and the Czech Republic in particular) that acceded to the EU in 2004 and has been a Home Office dispersal site for asylum seekers since 2000. The most salient aspect of Plymouth's BME population is that it represents a rapid growth area for the city that is driven particularly across younger age groups.

As of January 2008, figures from the Borders Agency indicated a total of 363 asylum seekers receiving Section 95 Support. Of these, 167 are single, with 196 families and 223 under 18s. In addition, in August 2008, there were 16 unaccompanied asylum-seeking children currently being cared for by Children’s Services.

A study of the mental health of asylum seeking and refugee women, children and young people, undertaken by the Devon and Cornwall Refugee Support Council (2008) found that;
- Asylum seeking women with young children (0-5) seem to find it especially difficult to cope and were more isolated than other women.
- School age children and young people from asylum seeking and refugee backgrounds appeared to be experiencing high levels of racist bullying and violence in and outside of school.
- Mothers of teenage children reported high levels of worry at the cultural influences and discrimination experienced by their children and found relating to their experiences difficult.
6.11 DOMESTIC ABUSE

Why is this an issue?
Most domestic abuse occurs in what should be a safe and supportive relationship, and often in the presence of children. This is an extreme violation of trust and causes immeasurable pain and suffering to victims and their children.

Children who witness domestic violence often find themselves in a state of constant fear and anxiety for the safety of a parent, or indeed their own wellbeing. They may experience a sense of loss for ‘normal’ family life. They may feel angry towards one or both parents and may be confused about where their loyalties lie. They may express anger through aggression towards peers and adults, although girls are more likely to ‘internalise’ their feelings. Relationships are inevitably affected and children may become withdrawn and isolated or try to dominate others in an attempt to control their world, which mostly feels out of control.

Children and adolescents living with domestic violence are at increased risk of experiencing emotional, physical and sexual abuse, of developing emotional and behavioural problems and of increased exposure to the presence of other adversities in their lives43.

What is the situation in Plymouth?
In 2007, 5390 incidents of domestic abuse were reported to the Police in Plymouth, 2523 of which had children resident. From April to September 2008, 2916 incidents of domestic abuse have been reported to the police in Plymouth, of which 1305 a child was resident44.

During 2006, Plymouth Women’s Aid received 2295 referrals (predominantly from the Police) and engaged with 837 women. 68 per cent of the women accommodated at the Refuge had one or more children with them45.

The Health Visitor survey identified 702 families with violence in the family. This is equivalent to 6.4% of the 2006 caseload. This figure rises in deprived areas. On average, one in nine families (11%) in the most deprived areas experienced violence. In Devonport this rises to one in five46.
### 7. Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit and Hyperactivity Disorder</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>ASR</td>
<td>Asylum Seekers and Refugees</td>
</tr>
<tr>
<td>BESD</td>
<td>Behavioural, Emotional and Social Difficulties</td>
</tr>
<tr>
<td>BA</td>
<td>Borders Agency</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>CYPP</td>
<td>Children and Young People’s Plan</td>
</tr>
<tr>
<td>DFES</td>
<td>Department for Education and Skills</td>
</tr>
<tr>
<td>DCSF</td>
<td>Department for Children, Schools and Families</td>
</tr>
<tr>
<td>EBD</td>
<td>Emotional and Behavioural Difficulty</td>
</tr>
<tr>
<td>EMAS</td>
<td>Ethnic Minority Achievement Service</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>EWB</td>
<td>Emotional Wellbeing</td>
</tr>
<tr>
<td>GCSE</td>
<td>General Certificate of Secondary Education</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework</td>
</tr>
<tr>
<td>Ofsted</td>
<td>Office for Standards in Education, Children’s</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PHDU</td>
<td>Public Health Development Unit</td>
</tr>
<tr>
<td>PSA</td>
<td>Parent Support Advisor</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>SEN</td>
<td>Special Educational Need</td>
</tr>
<tr>
<td>YOS</td>
<td>Youth Offending Service</td>
</tr>
</tbody>
</table>
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The National Service Framework for Children, Young People and Maternity Services, Department of Health & Department for Education and Skills, 2004

Risk and protective factors, Youth Justice Board, 2005

The Mental Health Needs of Young Offenders, Mental Health Foundation, May 2002
Following international classification of diseases ICD-10 - which implies a clinically recognisable set of symptoms or behaviours associated with considerable distress and interference with personal function

Interim National CAMHS Review 2008

Data in this section is sourced from 2007 report: Epidemiological Information on Children’s and Young People’s Mental Health Problems in Plymouth, Frier J, Public Health Development Unit, Plymouth PCT

Data taken from May 2008 School Census. BME includes all other ethnic codes other than White British.

Townsend 2001

Data taken and adapted from Interim CAMHS Report, 2008

Data in this section is sourced from 2007 report: Epidemiological Information on Children’s and Young People’s Mental Health Problems in Plymouth, Frier J, Public Health Development Unit, Plymouth PCT

Every 2 years since 2000 health visitors in Plymouth have completed a questionnaire for every family on their caseload. All children under the age of 5 should have a health visitor assigned to their care and so this data should capture all families with a child under the age of 5, plus others that are carried as part of health visitor’s caseload. Assuming that the issues in these families, in terms of risk factors and problems faced are broadly the same as families with children over 5, this survey can give good information on families in Plymouth. In 2006 11,382 records were returned.

Kurtz et al 1995

Interim CAMHS Review, 2008

‘Are we nearly there yet’, Audit Commission 2008

Interim National CAMHS Review 2008

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Parents from ethnic minorities with mental health problems and their children, Proven practice: More data needed on treatment of BME parents, Community Care, 2008

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Panos Vostanis, Mental health of homeless children and their families, 2002

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Meltzer H et al, the mental health of children and adolescents in Great Britain.

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Childline data 2007


The mental health of asylum seeking & refugee women, children and young people in Plymouth By Devon & Cornwall Refugee Support Council & Plymouth Teaching Primary Care Trust, February 2008

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Domestic abuse strategy data 2007

Domestic abuse strategy data 2007