Children and Young People's Emotional Health and Wellbeing

ISNA Lite

Children's wellbeing is central to that of society as a whole. Promoting children's wellbeing is not only important in order for children to have a good childhood, but also as a solid foundation for their future wellbeing as adults. In order to achieve this goal it is vital that we understand the key factors that affect children's lives.

Children's Society 2012[1]

Specialist Public Health Directorate

6th Floor

10 Duke Street

Blackburn BB2 1DH

Integrated Strategic Needs Assessment (ISNA)

the

answer to

Joint Strategic Needs Assessment (JSNA)

Contents - click to go to page

Defining the issue

Emotional health and wellbeing

For the purposes of this ISNA, the term **emotional health and wellbeing** will be used to refer generally to all aspects of mental health. The Mental Health Foundation has described **emotional health** in the following terms:

> *"A positive sense of wellbeing which enables an individual to be able to function in society and meet demands of everyday life; people in good mental health have the ability to recover effectively from illness, change or misfortune."*
>
> *"Being able to develop psychologically, emotionally, intellectually and spiritually; initiate, develop and sustain mutually satisfying personal relationships; use and enjoy solitude; become aware of others and empathise with them; play and learn; develop a sense of right and wrong; resolve (face) problems and setbacks and learn from them."*
>
> **Mental Health Foundation, 1999[2]**

As part of the engagement work for this ISNA, children and young people living in Blackburn with Darwen were asked what emotional health and wellbeing means to them:

> *'Emotional health and wellbeing means being safe, having good physical health, being active, having close bonds with family and pets and strong social connections with friends and community. It also includes having positive behaviours and emotions, having confidence, attaining personal goals and having a faith.'*
>
> **Report of primary and secondary school aged children**

The focus on **wellbeing** offers a fresh perspective, emphasising the value of positive emotional health, and the fact that it is more than just the absence of mental ill-health.

Mental health problems

Mental health problems range from day-to-day worries to serious long-term conditions. At the more severe end of the spectrum are **mental disorders**. Common mental disorders in children and young people include: conduct disorder, depression, eating disorders (anorexia/bulimia nervosa), anxiety disorders and hyperkinetic disorders. Young people with a mental disorder are much more likely than average to suffer from related problems such as self-harm.[3]

Self-harm

Self-harm is when an individual intentionally injures or damages their body. It is a way of coping with or expressing overwhelming emotional or psychological distress.

Young people

In keeping with the Chief Medical Officer's report[3], this ISNA encompasses children and young people's emotional health and wellbeing from **0 to 24 years**. This takes it beyond the age of 16 or 18 at which young people's specialist services may typically cease. Within this age-range, important age-bands are as follows:

- 0-4 years (early years)
- 5-11 years (primary school aged children)
- 12-16 years (secondary school aged children)
- 16-24 years (further education, employment)

In view of its importance for babies and the early years agenda, the emotional health and wellbeing of mothers is also considered.

Why is this issue highlighted?

The best start in life

The Marmot Review (*Fair Society, Healthy Lives*[4]) outlines the need to '**give every child the best start in life**' to reduce health inequalities across the life course. As it states:

> *"The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status ….Later interventions, although important, are considerably less effective if they have not had good early foundations."*

This principle is particularly important where emotional health and wellbeing is concerned, as we know that 50% of mental illness in adult life starts before age 15, and 75% before age 25[5] (or, by some accounts, age 18[3]). It is reinforced by the Royal College of Psychiatrists in their position statement, *No health without public mental health*[6]:

> *"Most mental illness begins before adulthood and often continues through life. Improving mental health early in life will reduce inequalities, improve physical health, reduce health-risk behaviour and increase life expectancy, economic productivity, social functioning and quality of life. The benefits of protecting and promoting mental health are felt across generations and accrue over many years."*

Mental health disorders - scale

Maternal

In approximately 10-15% of maternities, the mother will experience mild to moderate depressive illness and/or anxiety. Much more rarely, pregnancy can lead to more severe forms of mental illness, such as postpartum psychosis, or precipitate an episode of chronic underlying mental illness.[7]

Children and young people

Survey data about the prevalence of mental health disorders in children and young people is both scarce and out-of-date.[8] For early years, the most widely-quoted estimate comes from an American study of 2-5 year-olds.[9,10]

British survey estimates for ages 5-16 are shown broken down by age and sex in Table 1. These use different criteria, whereby the disorder must be causing distress to the child or having a considerable impact on day-to-day life.[3,10] Overall, approximately 10% of 5-16 year-olds are affected at any given time, but it is estimated that nearer 20% have such a problem in any one *year*.[11]

The estimates for young people aged 16-24 come from the ONS survey of adult psychiatric morbidity, which uses different methods and definitions.[3,12]

Group	Condition	% affected	
		M	F
Pregnant women/new mothers[7]	Mostly anxiety and/or depression		10-15%
Early years (2-5 years)[9,10]	Any mental health disorder	19.6%	
Primary School Aged Children (5-10 years)[3,10]	Any mental health disorder	10.2%	5.1%
	Conduct Disorder	6.9%	2.8%
	Emotional Disorder	2.2%	2.5%
	Hyperkinetic disorder	2.7%	0.4%
	Less Common Disorder	2.2%	0.4%
Secondary School Aged Children (11-16 years)[3,10]	Any mental health disorder	12.6%	10.3%
	Conduct Disorder	8.1%	5.1%
	Emotional Disorder	4.0%	6.1%
	Hyperkinetic disorder	2.4%	0.4%
	Less Common Disorder	1.6%	1.1%
Young adults (16-24 years)[3,12]	Depressive Disorder	2.2%	
	Post traumatic stress disorder	4.7%	
	Anxiety disorder	16.4%	
	Personality Disorder	1.9%	
	Psychotic Disorder	0.2%	

Table 1 – Prevalence of mental health disorders (national & international estimates)

Mental health disorders - impacts

Impacts

Maternal mental health problems

Maternal mental health problems during or after pregnancy can have significant long-term effects on children's mental health and wellbeing. Antenatal depression and anxiety are linked to to higher levels of emotional and behavioural problems in children aged 3-5, as is maternal depression in the nine months after the birth.[13]

Childhood mental health problems

Once childhood mental health problems have developed, this can further exacerbate underlying inequalities. Children and young people with a conduct disorder are almost 17 times more likely to be excluded from school than those with no mental health problems, and 11-16 year-olds with emotional, conduct or hyperkinetic disorders are anything from 1.4 times to 6 times as likely to engage in a range of risk-taking behaviours such as smoking, drinking, drug-taking and self-harm.

Mental health problems during childhood and adolescence are also associated with a wide range of adverse outcomes in later life, including higher rates of adult mental health problems, poor educational outcomes, unemployment, low earnings, teenage parenthood, marital problems and criminal activity.[21]

Self-harm

Self-harm is indicative of overwhelming emotional or psychological distress.[14] A survey in 2002 of English schoolchildren aged 15-16 found that just over 13% reported having self-harmed ever, and 6.9% had self-harmed within the past year.[15] Self-harm thus affects large numbers of children and young people, and amounts to a serious public mental health issue.

Current rates may be even higher, as there is evidence that self-harm is on the increase. Hospital admission rates show a gradual rising trend (Figure 1), although It should be noted that only a fraction of cases are ever seen in hospital settings.[16] Childline has reported a 41% rise in contacts about self-harm in a single year (2011/12-2012/13).[17]

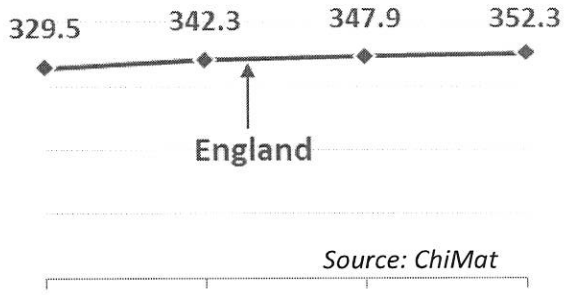


Figure 1 - Hospital admissions for self-harm age 10-24 (England, directly-standardised rate per 100,000)

Costs

For children and young people with mental health problems, estimated costs are between £11,030 and £59,130 annually per child. These costs include service provision (education, social services and youth justice) and direct costs to the family in terms of the child's illness.[8]

Given that three-quarters of enduring mental health problems are diagosed during adolescence, the lifetime costs associated with failing to offer appropriate services are immense. For instance, the annual cost of crime in England and Wales committed by adults who had conduct disorder in childhood or adolescence has been estimated at £22.5 billion.[18] The lifetime costs of a one-year cohort of children with conduct disorder (6% of the child population) has been put at £5.2 billion.[18] One study found that by the age of 28, the cumulative cost of public services for individuals diagnosed with conduct disorder as a child was ten times higher than for those with no problems.[19]

The Royal College of Psychiatrists considers that mental health services for children are grossly underfunded relative to need, and that this represents a missed opportunity to prevent considerable suffering and expense in the future.[20]

Who is at risk and why?

Miscellaneous risk factors

Children and young people exposed to certain risk factors are more likely than average to experience negative emotional health and wellbeing outcomes (Figure 2):

Figure 2 - Risk groups and factors for emotional wellbeing in children and young people[21] **E.g. x 3 = 3-fold increased risk, ↑ = increased risk** *(unquantified)*

RISK GROUP OR FACTOR / OUTCOME	Use of alcohol/ drugs/ tobacco in pregnancy	Maternal stress during pregnancy	Low birthweight	Unemployed parent	Poor parenting skills	Parents with no qualifications	Deprivation (highest v. lowest group)	Child abuse	Children with learning disability	Children with Special Educational Needs	Children with physical illness	Homeless young people (in B&B or hostel)	Young LGBT	Young offenders	Young people in custody	Looked-after children	Children of prisoners
Child behavioural problems		↑															
Common mental disorders			↑			x 4.25	x 3		x 6.5			x 8		x 3		x 5	
Emotional/conduct disorder			x 4-5	x 2-3							x 2						
Conduct disorder					x 4-5					x 3						x 6-7	
Anti-social / delinquent outcomes																	x 3
Depression								x 15.5						x 4			
Anxiety								x 8.1						x 4			
Attempted suicide (as young person)													x 7 (F) x 18 (M)				
Attempted suicide (as adult)																x 4-5	
Suicide															x 18 (M) x 40 (F)		
Multiple poor outcomes	↑							↑									

Age

The highest overall prevalence estimates for mental disorder in Table 1 are for the pre-school age-group, but these are from an American study and cannot necessarily be directly compared with the British estimates for ages 5-16. If we confine our attention to the 5-10 and 11-16 age-groups, it can be seen that the estimated prevalence rises with age for both boys and girls (Figure 3).

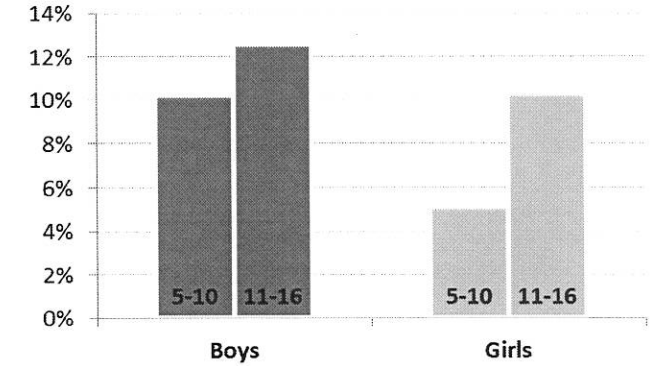


Figure 3 - Estimated prevalence of mental disorder (GB, 2004)

More recent survey work carried out by the Children's Society[22] paints a similar picture of declining wellbeing as children enter their teens, reaching a low point around 14-15 years before starting to recover (Figure 4).

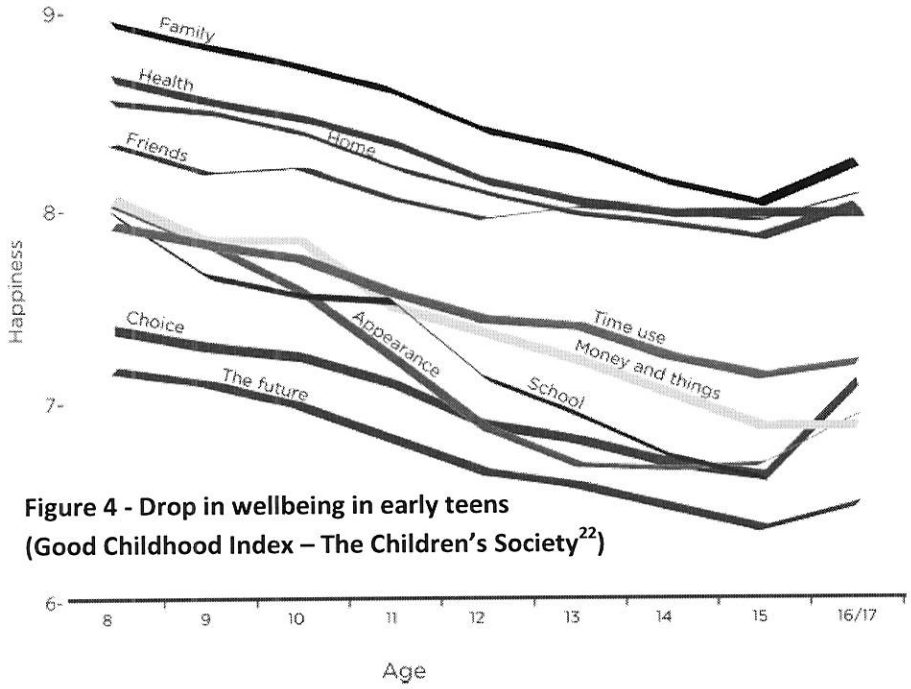


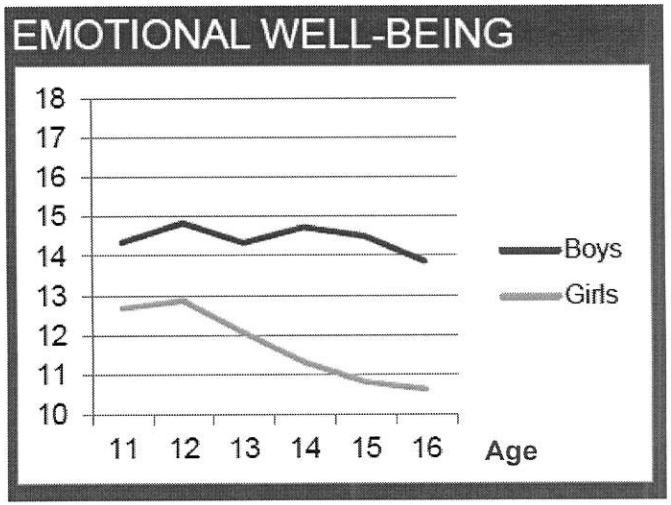
Figure 4 - Drop in wellbeing in early teens (Good Childhood Index – The Children's Society[22])

Another charity, NPC, has devised its own multi-dimensional Well-being Measure. This has been tested on over 6000 young people, and appears to confirm the general picture of declining levels of happiness as young people go through adolescence (see e.g. Figure 5).[23]

Gender

Boys have a higher overall prevalence of clinically diagnosable mental disorder than girls at both age 5-10 and age 11-16 (Figure 3), and are much more likely to have conduct disorders and hyperkinetic disorders (Table 1). However, by the age of 11-16, girls are more likely than boys to have an emotional disorder.

Findings from national wellbeing studies appear to show that sub-clinical emotional problems also become more prevalent in girls than boys as they enter their teens.



NPC cautions that its results are not generalisable to the general population because of the sample design. However, it is notable that almost every aspect they measured (including self-esteem, overall life satisfaction, and satisfaction with family, school and friends) shows this same pattern. The most striking example is for "Emotional Wellbeing":

Figure 5 - Drop in emotional wellbeing in early teens, Male v. Female (Well-being Measure, NPC[23])

Eating disorders are also more common among young women than their male counterparts[21], and rates of hospital admission for self-harm are much higher among teenage girls than teenage boys.[24]

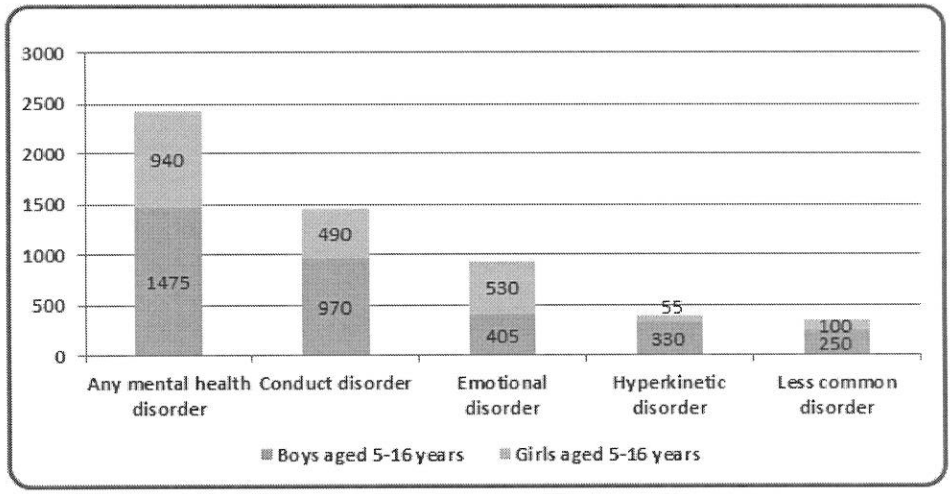
Level of need in the population

Prevalence estimates

Mental health disorders

To estimate the numbers of children and young people affected by mental health disorders in Blackburn with Darwen, we can apply the rates in Table 1 to the population estimates for the relevant age-group. If we do this for children aged 5-16, we obtain the totals shown in Figure 6:

Figure 6 - Estimated numbers of children aged 5-16 with mental health disorders (Blackburn with Darwen, mid-2012)*



It must be stressed that the estimated rates, as well as being old, are a national average. Given its high levels of deprivation, it is reasonable to suppose that the prevalence rates, and resulting numbers, in Blackburn with Darwen may be somewhat higher.[25]

Tier	Description of Tier[26]	Estimated Prevalence	Estimated numbers
Tier 4	Highly specialist/ inpatient	0.075%	29
Tier 3	Require involvement of specialist support	1.85%	715
Tier 2	Require consultation, targeted or individual support	7%	2704
Tier 1	Universally encountered and can be addressed in everyday settings	15%	5795

Need for CAMHS services

The numbers of young people locally who may be expected to require CAMHS services at different levels of need are conventionally calculated using prevalence rates published in 1996.[27] In Table 2, these rates are applied to the mid-2012 under-18 population of Blackburn with Darwen, on the assumption that CAMHS services cater for young people up to age 17.

Table 2 - Estimated service demand at CAMHS Tiers 1-4 (Blackburn with Darwen, age 0-17, mid-2012)

* *NB - Number affected by 'any' mental health disorder will not equal the sum of the remaining four columns, as some children may be affected by more than one disorder.*

At-risk groups

Looked-after children

As at 31 March 2013, there were 345 children looked after by Blackburn with Darwen council, which equates to a rate of 89 per 10,000 children aged under 18 years. This is higher than both the England average rate (60 per 10,000) and the North West average (79 per 10,000).[28] Recent NICE guidance estimates that approximately 60% of children looked after in England have emotional and mental health problems, which would amount to 207 young people in Blackburn with Darwen.[29]

All local authorities are required to provide data on the emotional and behavioural health of children in their care using the Strengths and Difficulties Questionnaire (SDQ). A score of 17 or above is considered 'cause for concern'. In 2013, 44% of looked-after children in Blackburn with Darwen had an SDQ score in this range.[30]

Even after leaving care, a high proportion of looked-after children experience poor health, educational and social outcomes. As shown in Figure 2, they are between four and five times more likely than average to attempt suicide in adulthood.

Children with Special Educational Needs

It is estimated that mental health disorders affect 44% of children with special educational needs (SEN) who require statutory assessment.[25] In 2013, out of 27,587 pupils in Blackburn with Darwen schools, 523 had a statement of special educational needs.[31] This suggests that approximately 230 such children may have mental health disorders.

Young offenders

In 2012-13 there were 177 children and young people aged 10-17 years in Blackburn with Darwen known to the Youth Justice system.[32] Prevalence estimates of mental health problems for young offenders vary hugely, from 25% to 81% or even above, with rates highest for young people in custody.[33,36]

NEETs

Young people who are *Not in Employment Education or Training* (NEET) are one of the groups particularly prone to mental health disorders.[34] A survey of 1000 UK NEETs in 2013 found that a third were depressed, 39% suffered stress and anxiety, 37% rarely left the house, and 15% described themselves as having a mental health condition.[35] It is highly likely that for many young people, becoming NEET is at least partly *attributable* to childhood mental health problems, particularly conduct disorder.[36]

In Blackburn with Darwen in 2013, 370 young people aged 16-18 were known to be NEET, or 6.2% of the age-group (NW average 5.6%).[37] This represents a fall from 460 (or 7.5%) in 2012, but is still too high in view of the damaging consequences of becoming NEET – which include an estimated £97,000 lifetime cost to the public purse.[36]

Wellbeing

The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) assesses mental wellbeing according to the following seven dimensions:

- I've been feeling optimistic about the future
- I've been feeling useful
- I've been feeling relaxed
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling close to other people
- I've been able to make up my own mind about things

The scale was used in the 2012 North West Mental Wellbeing Survey[38] to measure the wellbeing of 11,500 people across the region, aged 16 or over, including 500 from Blackburn with Darwen. The borough's mean WEMWBS score of 25.3 was the lowest of all the participating authorities (NW mean 27.7).

At the individual level, low mental wellbeing is defined as a score of 21 or less. 26.7% of Blackburn with Darwen respondents came into this category, compared with 16.1% across the North West. The percentage among young Blackburn with Darwen participants (aged 16-24) was 30.5%, but this is not significantly different from the all-age borough average.[39] The WEMWBS scale has now been validated for use with 13-15 year-olds, so it may be possible to extend a future survey to include this age-group.

Hospital admissions

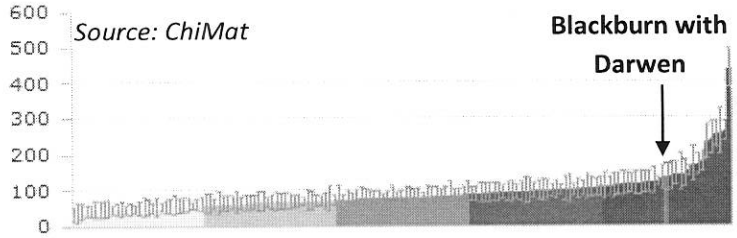


Figure 7 – Hospital admissions for mental health disorders, 2012/13, age 0-17 years (crude rate per 100,000)

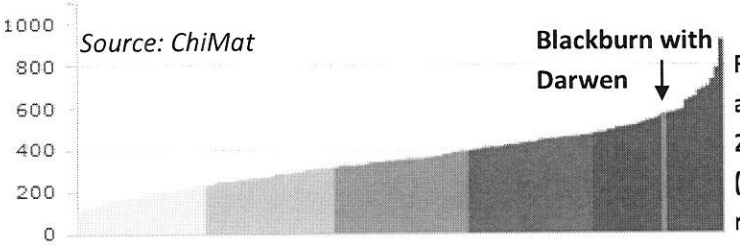


Figure 8 - Hospital admissions for self-harm, 2010/11-2012/13, age 10-24 (directly age standardised rate per 100,000)

Mental health disorders

In Blackburn with Darwen in 2012/13, there were 50 hospital admissions of children and young people aged 0-17 for mental health disorders, which equates to 129.4 per 100,000. This was the 15th highest rate of any upper-tier local authority (Figure 7), and significantly higher than the England average of 87.6 per 100,000.

Self-harm

For the three-year period 2010/11-2012/13, the rate of self-harm hospital admissions for Blackburn with Darwen residents aged 10-24 was 561.9 per 100,000. This rate has been fairly stable in recent years, but is the 14th highest in England (national average 352.3 per 100,000).

Suicide

Child suicides

When analysing suicide statistics for those aged 15 or over, it is usual to include deaths by injury or poisoning where the person's intent to kill themselves is less than certain ('undetermined'). However, it is considered inappropriate to make any such assumptions in the case of a child under 15, so the suicide figures for this age-group only include those cases where intent has been firmly established.[40,41] According to this strict definition, there were only six such deaths in children under 15 in 2012 in the whole of England and Wales, and figures for individual local authorities are not in the public domain.

Young people aged 15+

The youngest age-group for which suicide statistics are routinely published at the local authority level is 15-34, which goes well beyond our definition of 'young people'. The rules on disclosure have recently been relaxed, and annual counts at the local authority level can now be found in the public version of the HSCIC Indicator Portal (https://indicators.ic.nhs.uk/webview/). By either definition, there was one (male) suicide in the 15-34 age-group in Blackburn with Darwen in 2012.

For 2010-2012 as a whole, the rate of suicide or injury undetermined in Blackburn with Darwen was 9.0 per 100,000 persons aged 15-34, which compares with an England average of 7.8 per 100,000. However, the local rate is clearly based on very small numbers, and this difference is not statistically significant.

Good Practice

Preventative approach

Amid the pressures on mental health spending, there is growing evidence that shifting the focus towards prevention and early intervention can improve societal outcomes and be cost-effective. NICE has issued a local government briefing on *Social and emotional wellbeing for children and young people*, which stresses the importance of building self-esteem and self-efficacy, reducing bullying behaviour, reducing risk-taking behaviours and supporting the development of social and emotional skills.[42]The ChiMat 'Resource Directory' for commissioners of children's mental health and wellbeing services presents a strong case for prevention and early intervention on both moral and economic grounds, and devotes a full chapter to the evidence, issues and challenges surrounding this approach.

Key elements of the NICE guidance include:

Ante-natal and post-natal home visiting

NICE advises that health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support. [42] This initiative aims to assist vulnerable families and children with issues such as the mother-child relationship, home learning and parenting skills and practice, and is particularly pertinent as responsibilities for health visiting will transfer to local authorities in 2015.

School health promotion programmes

NICE advocates taking a 'whole school approach' to pupils' social and emotional wellbeing, which means embedding the appropriate support and values into the ethos of the school.[42] The Faculty of Public Health endorses the view that school-based programmes to promote mental health can be among the most effective of all school health promotion programmes.[43] Both organisations agree that the optimum approach is to combine universal programmes with specific help for those children most at risk.

Assets-based approach

Social capital

More emphasis is also now being placed on the importance of involving individuals, groups and communities in promoting wellbeing, and acknowledging the strengths, resilience, knowledge and social capital of the local community. A systematic review of the research literature has found evidence of a strong link between family and community social capital and the health and wellbeing of children and adolescents.[44] The elements most closely associated with mental health and problem behaviours are illustrated in Figure 9:

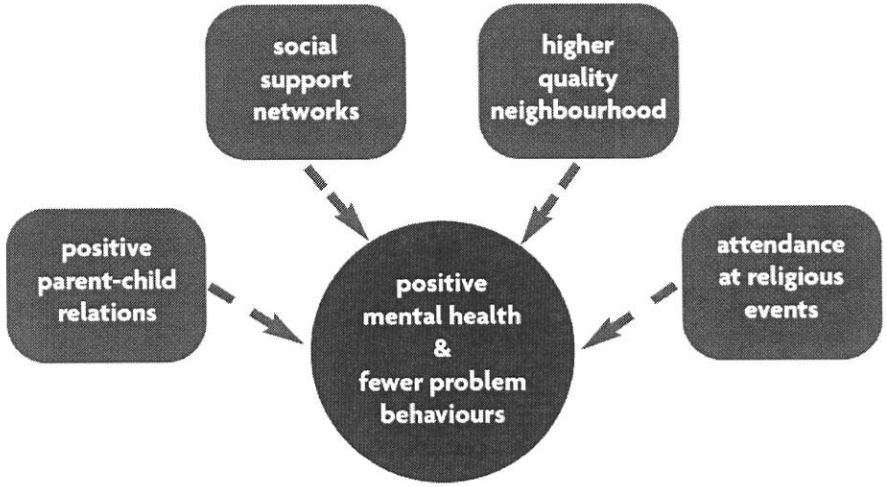


Figure 9 - Elements of family and community social capital having the strongest association with mental health and problem behaviours

Source: Glasgow Centre for Population Health[44]

Five ways to wellbeing[45]

The five ways to wellbeing were developed by nef (the New Economics Foundation) based on evidence from the government's 2008 Foresight project on Mental Capital and Wellbeing. They have since been used by schools, local councils, health organisations and community projects across the UK and beyond to help people take action to improve their wellbeing.

Figure 10 - Five ways to wellbeing logo devised by Tameside Council

The Children's Society has been working with nef to find out whether the five ways to wellbeing are beneficial to children as well as adults.[46] They have found good evidence that the first four ways – Connect, Be active, Take notice and Keep learning – do work for children. The evidence for the fifth way – Give – was more mixed, although many children may help others without perhaps realising it. The Society favours replacing it with a fifth concept related to creativity, imagination and play. They are about to publish their findings in a joint report with nef, along with a guide for professionals.

Five Ways to Wellbeing

Connect...
With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Be active...
Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice...
Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Keep learning...
Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give...
Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Gaps

At the time of writing, the House of Commons Health Committee is conducting an inquiry into children's and adolescent mental health and CAMHS, prompted by ***"concerns that have been expressed by the Chief Medical Officer and others about both the extent to which children and adolescents are affected by mental health problems and difficulties with gaining access to appropriate treatment"***.[47] Two of the main issues it is considering are the lack of data on children's and young people's mental health, and the transition to adult mental health services.

Shortage of data

Mental health

The prevalence estimatesfor mental health disorders in Figure 3 and Figure 6, and most of those in Table 1, rely on a national survey which is now more than a decade old. In her latest annual public health report, the Chief Medical Officer draws attention to the lack of up-to-date data, and calls for this to be remedied. She has recommended that a regular survey should be commissioned to establish the prevalence of mental health problems in children and young people, and that it should be extended to provide information on 0-5 year-olds, ethnic minorities, those in the youth justice system, and children with underlying neurodevelopmental issues.[48]

Wellbeing

It is also difficult to find consistent national data on the wellbeing of children and young people, as various voluntary sector organisations have devised their own measures. This may be about to change, however, because as part of its Measuring National Wellbeing programme, the Office for National Statistics has proposed a draft set of wellbeing indicators for children aged 0-15[49], and another for young people aged 16-24.[50]

Transition to adult services

Young people's mental health services may typically cease at 16 or 18 years of age, but this means that the transition to adult services takes place at a time of high risk to wellbeing and mental health, and susceptibility to risk-taking and offending behaviour.[51] In the first study to follow a cohort of young people crossing the boundary from child to adult mental health services, a third were not referred on to adult services, and a fifth of those who were referred were never seen. Fewer than 4% were reported to have experienced an optimal transition.[52]According to ChiMat, the reason some teenagers may not be referred to adult mental health services, or may be turned away, is that they have a problem which is not catered for by adult services, or does not meet their thresholds.[5]

Value for money

A study by the London School of Economics (LSE) presents compelling evidence of the cost-effectiveness of mental health promotion and mental illness prevention, including where children and young people are concerned.[53] Parenting interventions for parents of children with, or at risk of developing, conduct disorders are a case in point. Such interventions cost about £1200 per child, but produce savings of £9300 gross (i.e. £8100 net) over a 25-year period. This includes not only savings to the public sector (principally NHS and criminal justice system), but the avoidance of costs incurred by victims of crime and of lost output due to crime.

The LSE report also confirms that school-based social and emotional learning programmes are cost-saving for the public sector, and that school-based anti-bullying initiatives offer good value for money on a long-term perspective. NICE acknowledges that the upfront costs of preventative interventions will sometimes not be recouped for a number of years, but states that they will often be far outweighed by the future health benefits and long-term cost savings achieved.[42]

Involvement

In her Annual Report 2012, focusing on child health, the Chief Medical Officer emphasises the importance of listening to the voices of children and young people, learning from their suggestions, and feeding back to them the changes that have been made as a result.[3] Engaging directly with children, young people and their parents and carers was particularly important in this ISNA because of the shortage of hard data available from other sources.

Engagement programme

Between November 2013 and April 2014, a series of engagement activities was carried out to gain insight into the knowledge, attitudes and behaviours of local children and young people on the subject of emotional health and wellbeing. Some of this work was commissioned, and the remainder was carried out by researchers from the Specialist Public Health Directorate at Blackburn with Darwen Council. Altogether, over 200 children and young people were involved.

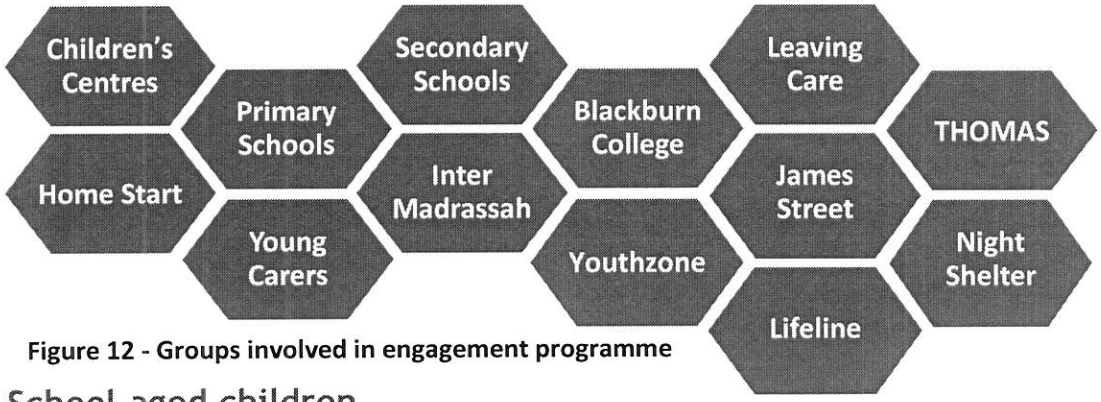


Figure 12 - Groups involved in engagement programme

Figure 11 - social media coverage of engagement programme

Early years (0-4)

Children aged under 5 years were considered too young to participate in the engagement work. Therefore, a total of 49 parents and carers were approached via Children's Centres and Home-Start (a voluntary organisation which supports parents with young children at home), and asked about their experiences of pregnancy and childcare.

School-aged children

A team of Educational Psychologists employed by Blackburn with Darwen Council were commissioned to conduct engagement work in local primary and secondary schools, involving 64 children and young people aged 6-15. Healthy Living Blackburn with Darwen was commissioned to undertake a Citizens Jury with twelve Year 10 pupils from Blackburn Central High School with Crosshills. The pupils worked intensively over several weeks to develop and produce a film called 'Emotions Matter'[54], which was premiered at a showcase event at Blackburn Youth Zone in March 2014.

Age 16-24

A wide range of groups was consulted in this age-band, including students at Blackburn College,young people not in education employment or training (NEET), care-leavers, homeless young people, young carers, and young substance-misusers. A team of Asian heritage young people affiliated to the Inter Madrassah Organisation were trained as engagement practitioners, and interviewed 25 other young people from their community or social networks.

Pre-school children

Figure 13 summarises what parents of 0-4 year-olds in Blackburn with Darwen told us had a positive or negative impact on their children's emotional health and wellbeing:

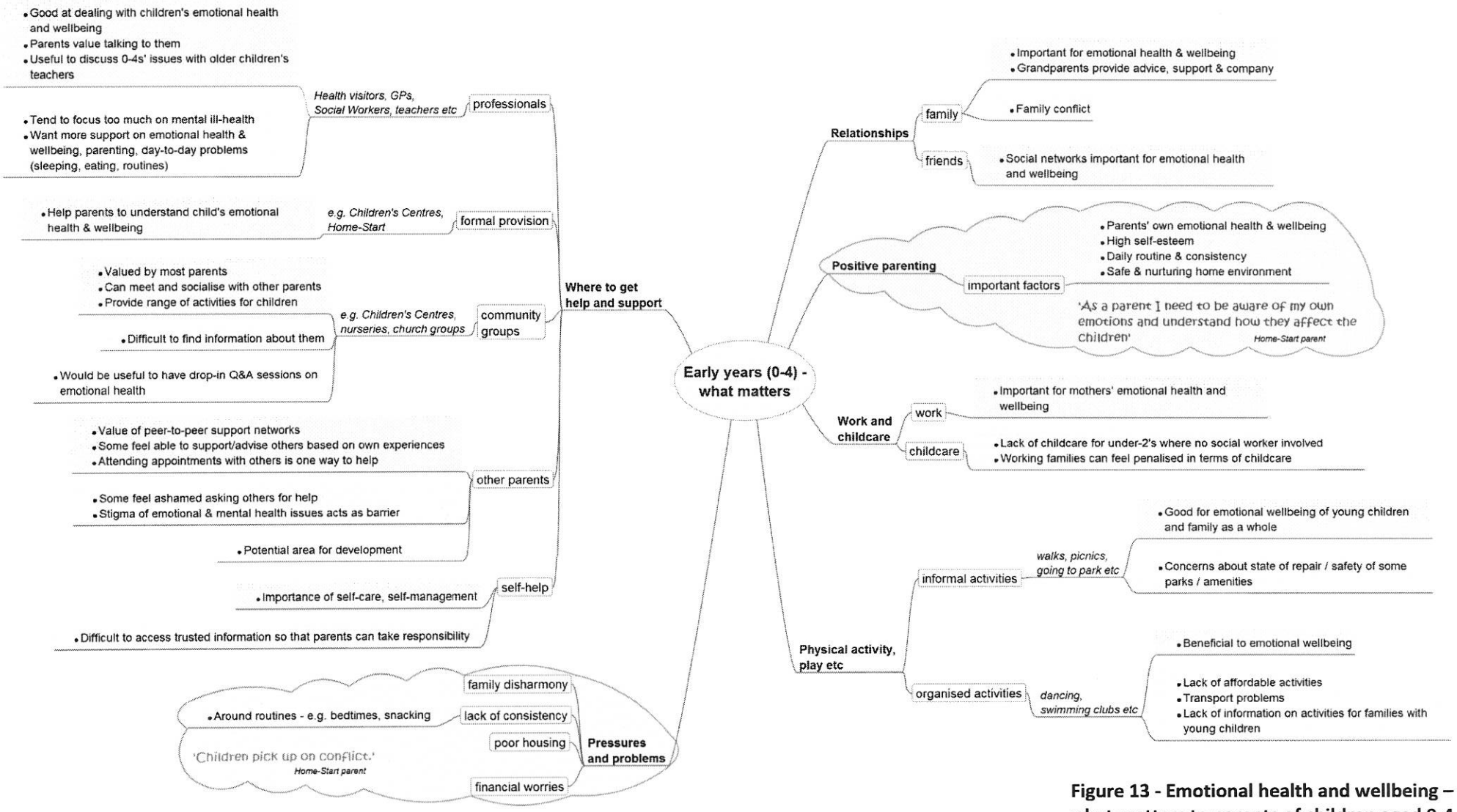


Figure 13 - Emotional health and wellbeing – what matters to parents of children aged 0-4

School-aged children

Figure 14 summarises what school-age children and young people in Blackburn with Darwen told us had a positive and negative impact on their emotional health and wellbeing:

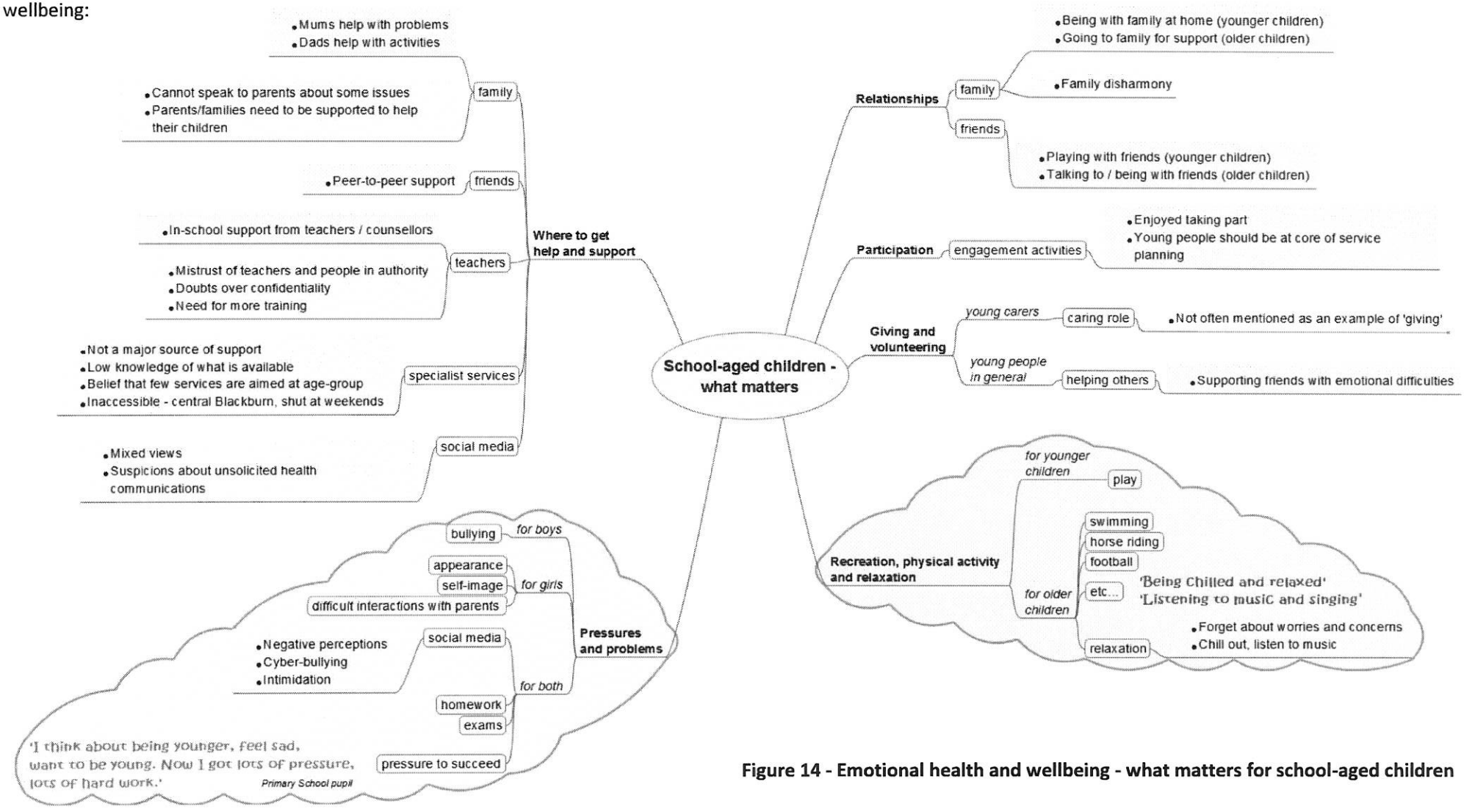


Figure 14 - Emotional health and wellbeing - what matters for school-aged children

Age 16-24

Engagement work with young people aged 16-24 took place in a wide range of settings, and included work with South Asian young people and those belonging to various vulnerable groups (e.g. homeless young people, care-leavers and substance misusers).

The diagram shows which issues young people told us had a positive or negative impact on their emotional health and wellbeing. Points which came across strongly in the engagement work with South Asian young people are marked Ⓐ, and points which relate particularly to young people in vulnerable groups are marked Ⓥ.

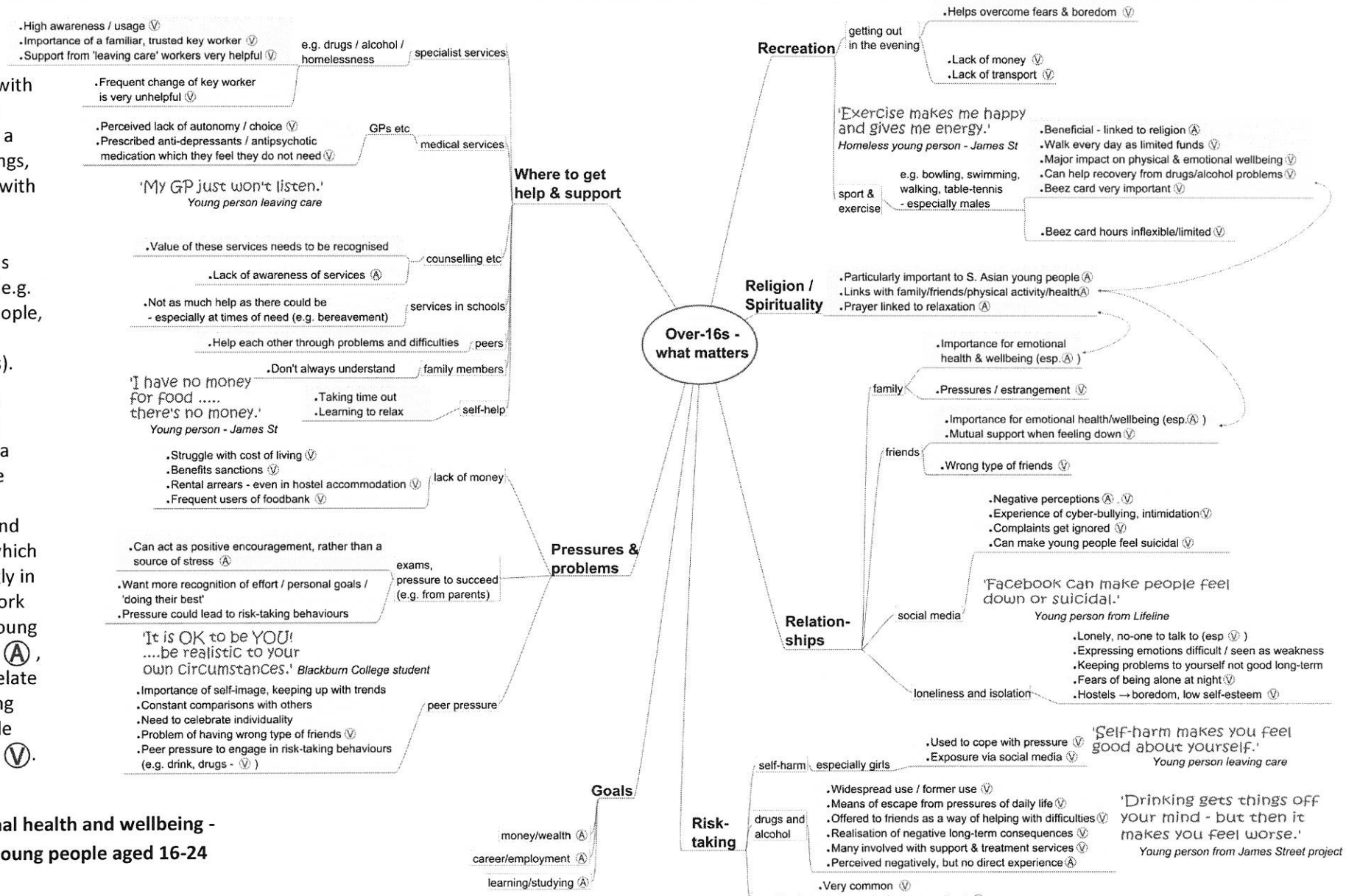


Figure 15- Emotional health and wellbeing - what matters for young people aged 16-24

Recommendations

The Integrated Strategic Needs Assessment (ISNA) of Children and Young People's Emotional Health and Wellbeing has led to several key recommendations which will inform future policy and service development. These are listed below, and explained at greater length in the main ISNA document.

1. Approaches that support positive outcomes for children and young people's emotional health and wellbeing should be built into all contracts and service specifications.

2. A programme of work should be developed that recognises emotional health and wellbeing in pregnancy as a public health issue with inportant life-course consequences.

3. Specific approaches should be developed that support teenagers at risk of self-harming.

4. All Health and Wellbeing strategies and programmes should be informed through active engagement and insight work with children and young people.

5. 'Whole school' approaches to emotional health and wellbeing that involve teachers, families and the wider community should be developed in line with national guidelines.

6. A health and wellbeing website promoting physical and social activities should be developed, specifically aimed at children, young people and their families.

7. Resilience within families should be promoted by providing parents anc carers with the information they need to handle issues of emotional and mental wellbeing.

8. Links between adolescence, risk-taking behaviours and the prevention of accidents and unintentional injuries should be further explored.

9. More insight work should be undertaken into the use of social media and the negative impacts for children and young people's emotional and mental health.

10. Opportunities for children and young people to engage in peer-support programmes and volunteering should be explored.

11. Work should be undertaken to identify groups of children and young people that may be at risk of loneliness and social isolation.

12. All commissioners and services should challenge the culture of acceptance and inevitablility around smoking, particularly amongst vulnerable groups.

13. Insight work should be undertaken to understand factors contributing to low levels of wellbeing amongst young people in adolescence.

14. A review of specialist mental health services for children and young people should be commissioned, including vulnerable groups such as looked-after children and care-leavers.

References

[1] Children's Society (2012). *The Good Childhood Report 2012*. Available from www.childrenssociety.org.uk/sites/default/files/tcs/good_childhood_report_2012_final_0.pdf

[2] Mental Health Foundation (1999). *Bright Futures*. No longer available online (see http://www.mentalhealth.org.uk/publications/bright-futures/)

[3] Chief Medical Officer (2013). *Chief Medical Officer's Annual Report 2012, Chapter 10*. Available from https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

[4] Marmot (2010). *Fair Society, Healthy Lives*. Available from http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[5] ChiMat (2011). *Better Mental Health Outcomes for Children and Young People – a resource directory for commissioners*. Available from http://www.chimat.org.uk/resource/item.aspx?RID=104048

[6] Royal College of Psychiatrists (2010). *No health without public mental health*. Available from http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

[7] NSPCC (2013). *Prevention in mind – all babies count: spotlight on perinatal mental health*. Available from http://www.nspcc.org.uk/inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html

[8] Chief Medical Officer (2013). *Chief Medical Officer's Annual Report 2012, Annex 1 - recommendations*. Available from https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

[9] ChiMat (2012). *CAMHS Needs Assessments* (for local authorities and CCGs). Available from http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34

[10] ChiMat(2012). *CAMHS Needs Assessment – metadata document*. Available from http://www.chimat.org.uk/resource/view.aspx?RID=138618

[11] Mental Health Foundation (2005). *Lifetime Impacts*. Available from http://www.mentalhealth.org.uk/publications/lifetime-impacts/

[12] NHS IC (2009). *Adult Psychiatric Morbidity in England – 2009, Results of a household survey*. Available from http://www.hscic.gov.uk/pubs/psychiatricmorbidity07

[13] DH (2014).*Starting Well – Pregnancy to 5 years* (part of *'A Compendium of Factsheets : Wellbeing across the Lifecourse'*). Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277569/Starting_Well.pdf

[14] NHS Choices. *Self harm*. Available from http://www.nhs.uk/conditions/Self-injury/Pages/Introduction.aspx

[15] Hawton et al (2002). *Deliberate self-harm in adolescents: self report survey in schools in England*. Available from http://www.bmj.com/content/325/7374/1207

[16] Children and Young People's Health Outcomes Forum (2013). *Report of Mental Health Subgroup*. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216853/CYP-Mental-Health.pdf

[17] Childline(2013). *Can I tell you something?* Available from http://www.nspcc.org.uk/news-and-views/media-centre/press-releases/2014/childline-report/childline-report_can-i-tell-you-something_wdf100354.pdf

[18] DH (2011) *No health without mental health – the economic case for improving efficiency and quality in mental health*. Available from https://www.gov.uk/government/publications/the-economic-case-for-improving-efficiency-and-quality-in-mental-health

[19] Scott et al (2001). *Financial cost of social exclusion: follow up study of antisocial children into adulthood*. BMJ 2001;323:191. Available from http://www.bmj.com/content/323/7306/191.full.pdf

[20] Royal College of Psychiatrists (2013). *Whole-person care: from rhetoric to reality - Achieving parity between mental and physical health*. Available from http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf

[21] DH (2011). *No Health without Mental Health – Analysis of the Impact on Equality (AIE) – Annex B – Evidence Base*. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213764/dh_124514.pdf

[22] Children's Society (2013). *The Good Childhood Report 2013*. Available from http://www.childrenssociety.org.uk/good-childhood-report-2013-online/index.html

[23] NPC (2014). *Measure what you treasure*. Available from http://www.thinknpc.org/publications/measure-what-you-treasure/

[24] HSCIC (2013). Hospital statistics on teenagers: girls predominate in self-harm cases, boys in assaults. Available from http://www.hscic.gov.uk/article/3579/Hospital-statistics-on-teenagers-girls-predominate-in-self-harm-cases-boys-in-assaults

[25] Joint Commissioning Panel for Mental Health (2013). *Guidance for commissioning public mental health services*. Available from http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf

[26] SWPHO (2011). *Children's and Young People's Mental Health in the South* West. Available from http://www.swpho.nhs.uk/resource/view.aspx?RID=83804

[27] Kurtz (1996). *Treating Children Well* (Mental Health Foundation). Not found online.

[28] DfE (2013). *Children looked after in England, including adoption*. Available from https://www.gov.uk/government/publications/children-looked-after-in-england-including-adoption

[29] NICE (2010). *PH28 – Looked-after children and young people*. Available from http://publications.nice.org.uk/looked-after-children-and-young-people-ph28/context

[30] DfE (2014). *Outcomes for children looked after by local authorities*. Available from https://www.gov.uk/government/publications/outcomes-for-children-looked-after-by-las-in-england

[31] DfE (2014). *Special educational needs in England*. Available from https://www.gov.uk/government/publications/special-educational-needs-in-england-january-2013

[32] Ministry of Justice (2014). *Youth justice annual statistics 2012-2013 (Regional Tables)*. Available from https://www.gov.uk/government/publications/youth-justice-statistics

[33] Mental Health Foundation (2002). *Mental Health Needs of Young Offenders – Update*. Available from http://www.mentalhealth.org.uk/publications/mental-health-needs-young-offenders/

[34] PHE (2013). *Community Mental Health Profiles 2013*. Available from http://www.nepho.org.uk/cmhp/

[35] ComRes (2013). *NEETs survey for University and College Union*. Available from http://www.knowledgeeconomy.org.uk/files/2013/07/NEETs-final.docx

[36] Children and Young People's Mental Health Coalition (2010). *Improving children and young people's mental health: the business case*. Available from http://www.cypmhc.org.uk/resources/improving_children_and_young_peoples_mental_health/

[37] DfE (2014). *NEET data by local authority*. Available from https://www.gov.uk/government/publications/neet-data-by-local-authority-2012-16-to-18-year-olds-not-in-education-employment-or-training

[38] PHE (2013). *North West Mental Wellbeing Survey 2012/13*. Available from http://www.nwph.net/nwpho/Publications/NW%20MWB_PHE_Final_28.11.13.pdf

[39] PHE (2014). *Mental Wellbeing in Blackburn with Darwen – Findings from the North West Mental Wellbeing Survey 2012/13.*

[40] ONS (2014). *Suicides in the United Kingdom, 2012 registrations*. Available from http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2012/stb-uk-suicides-2012.html

[41] NSPCC (2014). *Child deaths: suicides*. Available from https://www.nspcc.org.uk/Inform/research/findings/howsafe/indicator03_wdf95541.pdf

[42] NICE (2013). *Social and emotional wellbeing for children and young people*. Available from http://publications.nice.org.uk/social-and-emotional-wellbeing-for-children-and-young-people-lgb12

[43] FPH (2013). *School mental health promotion*. Available from http://www.fph.org.uk/school_mental_health_promotion

[44] Glasgow Centre for Population Health (2013). *Social capital and the health and wellbeing of children and adolescents*. Available from http://www.gcph.co.uk/assets/0000/3818/BP38_Final.pdf

[45] Nef. *Five ways to Well-being*. Available from http://www.neweconomics.org/projects/entry/five-ways-to-well-being

[46] Children's Society (2014). *Ways to well-being*. Available from http://www.childrenssociety.org.uk/what-we-do/research/well-being/ways-well-being

[47] Commons Health Committee. *Children's and adolescent mental health and CAMHS*. Available from http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/

[48] CMO (2013). *CMO's Annual Report 2012 – CMO's Summary as a web-page*. Available from https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays/cmos-annual-report-2012-our-children-deserve-better-cmos-summary-as-a-web-page

[49] ONS (2014). *Measuring National Wellbeing – Children's Wellbeing, 2014*. Available from http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/children-s-well-being--2014/rpt---children-s-well-being-2014.html

[50] ONS (2014). *Measuring National Wellbeing – Young People's Wellbeing, 2014*. Available from http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/young-people-s-well-being--2014/rpt-young-peoples.html

[51] Bradley Commission (2014). *Young adults (18-24) in transition: mental health and criminal justice*. Available from http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf

[52] Singh S et al (2010). *Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study*. British Journal of Psychiatry, 197, 305-312 http://www.ncbi.nlm.nih.gov/pubmed/20884954

[53] Knapp et al (2011). *Mental health promotion and mental illness prevention – the economic case.* Available from http://www.centreformentalhealth.org.uk/pdfs/Economic_case_for_promotion_and_prevention.pdf

[54] Pupils of Blackburn Central High School with Crosshills (2014). *Emotions matter*. Video available from https://www.youtube.com/watch?v=L6fNuGrCa1s&feature=youtu.be