

Children and Young People's Emotional Wellbeing and Mental Health:

Health Needs Assessment for Wiltshire

Acknowledgments: Wiltshire Council and its partners would like to gratefully acknowledge the contribution of the Children and Young people's emotional health and wellbeing needs assessment by Sheffield City Council (2014) in production of this report.

The development of this needs assessment authored by Karen Spence and the process was overseen and supervised by Amy McNaughton. Thanks is extended to all those involved in its development including: Sarah Heathcote, Sally Johnson, Simon Hodsdon, James Fortune, members of the Children and Young People's Emotional Wellbeing and Mental Health subgroup and all the service users and professionals who shared their views and experiences.

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Children and Young Peoples Emotional Wellbeing and Mental Health: Health Needs Assessment 2016

1. Executive Summary

The purpose of this summary is to outline the findings from a Health Needs Assessment (HNA) exploring the emotional wellbeing and mental health needs of children in Wiltshire. The HNA will be used to inform the direction of the Emotional Wellbeing and Mental Health Strategy and future design and commissioning of services.

Content is derived from national and local indicators, informed by the evidence base of protective and risk factors for emotional health and wellbeing. The report also considers service level data and self-reported measures from local surveys and consultations.

1.1 Population

The scope of the HNA is 0-19 year olds and includes a focus on Early Years and Adolescence as important periods of physical and emotional development. Pre-school years involve children undertaking a number of important developmental tasks relating to their physical development, social and emotional development and language and cognitive development which all have an impact on later childhood.

In regards to adolescence, the widening gap between physical and sexual maturity and adult social and financial independence has been offered as an explanation for growing mental health, and behavioural issues amongst young people. There is a surge of brain development in early adolescence, continuing into early 20s, and this brings with it a great potential for building lifelong wellbeing and resilience.

Tables in section 2 of the report profile the Wiltshire population of Children and Young People and also predict future patterns in these populations based on Office of National Statistics (ONS) estimates.

1.2 Protective/Risk Factors and Prevalence of Poor Emotional Health and Wellbeing

Protective and risk factors for emotional wellbeing and mental health are highlighted in sections 3 and 4 of the needs assessment. Wiltshire generally benchmarks well against regional and national averages for both protective and risk factors but these sections highlight some key at risk categories and geographical locations where inequalities exist and these are reflective of broader inequalities. Some illustrative figures for categories of children and young people at risk are shown below and further information can be found in the relevant section.

Risk Category	Estimated Number in Wiltshire	Percentage (if applicable)
Children living in poverty	11,610 (2014)	11.4%
11-17 year olds exposed to domestic abuse	7011	17.5%
Primary school exclusions	615 (14/15)	1.69%
Obese children (reception year)	362 (14/15)	7%
Obese children (year six)	682	15.1%
Families out of work	5266	2.7%
Looked after Children	405 (12 month av. May 2016)	-
Special Educational Need and Disability	1897	-
Children providing unpaid care	970 (<15 year olds) 1871 (16-24 year olds)	1.07% 3.9%
Young people not in employment, education or training	710	4.4%

Information about the prevalence of poor emotional health and wellbeing is outlined in section 5, the key messages being:

- There is limited up to date and comparable prevalence data and local data is dependent on extrapolation from national estimates
- Wiltshire has lower than average (for both England and the South West region) estimated prevalence for:
 - o % of population with any mental health disorder (age 5-16)
 - o % of population with emotional disorders (age 5-16)
 - o % of population with conduct disorders (age 5-16)
 - o % of population with hyperkinetic disorders (age 5-16)
- Wiltshire has a higher rate than the national average for hospital admissions relating to both self-harm and self-poisoning by alcohol.

1.3 What our children and young people say

There has been considerable amount of engagement with children, young people and their parents and carers during 2015 and as part of the process of developing the Children and Young People's Transformation Plan for mental health and wellbeing and the refresh of the Children and Young People's Plan. When scoping for this Needs Assessment was undertaken, a decision was made that existing consultation material would be utilised rather than undertaking a new consultative process.

Two young people attended the engagement event held specifically for this needs assessment and contributed to knowledge about data sources, available services and what works.

A summary of the feedback from previous consultation is contained in Section 6 of this assessment.

1.4 Service Mapping and Demand on Services

Child and Adolescent Mental Health Services (CAMHS) in Wiltshire are currently delivered through an operational delivery model with four distinct tiers. These services are available for 0-18 year olds who are referred by any professional working with the child or young person. Current service provision is described in brief in the introduction of this needs assessment and in further detail throughout Section 7.

Services are currently undergoing change as part of the Transformation plan for children and young people's mental health and wellbeing (2015-2020) and in line with recommendations of Future in Mind¹ and these developments are also outlined in the Service Mapping section.

The rising prevalence of mental health disorders in children and young people places pressure on current services and rising demand can lead to longer wait times. Future in Mind outlined that NHS benchmarking data and recent audits revealed increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems and a consequent rising length of stay in inpatient facilities. Since 2011, evidence appears to indicate that these difficulties are the result of financial constraints accompanied by rising demand. This needs assessment highlights in Section 7 both national and local information about demand on services.

1.5 Conclusion

The conclusion highlights the key themes identified throughout the report and makes suggestions for future work to address issues, these include:

- Projected changes in the population levels of children and young people in Wiltshire will need to be considered when developing or commissioning services to ensure that they meet the projected level of future need.
- Protective factors identified in the report could be optimised by implementing a campaign to promote the Five Ways to Wellbeing specifically for young people.
- Understanding of risk factors and populations at risk could be enhanced by sourcing additional local data in a number of key areas
- Limited prevalence data is available nationally and it may be beneficial to understand more about a few areas identified in the PHE fingertips tool where Wiltshire appears to have a higher than national estimated prevalence.
- Further work may be required to ascertain levels of demand for some of the services identified in this needs assessment.
- Limited data about transition to adult services for those approaching age 18 and further data will be gathered as part of the adult mental health needs assessment being produced during the autumn and winter of 2016/17.

¹ Future in Mind is the Department of Health and NHS England's vision document for Children and Young People's mental health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

2. Introduction

The purpose of this report is to describe the emotional wellbeing and mental health needs of children in Wiltshire. It will be used to inform the direction of future iterations of the Emotional Wellbeing and Mental Health Strategy and Transformation Plans together with future commissioning of services across all levels from prevention to inpatient care, including the 2016/17 retender process for Child and Adolescent Mental Health Services (CAMHS).

Evidence shows that one in four people on average experience a mental health problem at some point in their lives, with the majority of these beginning in childhood. Half of adult mental health problems start before the age of fifteen and seventy five per cent before the age of eighteen². Without effective interventions for emotional wellbeing and mental health, the likelihood of mental health problems continuing into adulthood is significant - interventions that get it right first time can help to prevent lifelong mental ill health and thus are critical to preventing costly and more serious problems later in life. These problems can include unemployment, physical ill health, involvement in criminal activity and substance misuse.

It is important to define the different terms used to describe mental health; the term 'emotional and mental health and wellbeing' refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships. 'Mental illness' is a term used to refer to depression and anxiety (which may also be referred to as 'common mental disorder') as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness). The term 'Mental disorder' is also often used, and can include mental illnesses as well as personality disorder and alcohol and drug dependency.

The content of this needs assessment is derived from national and local performance indicators and demand data and is informed by the evidence base of protective and risk factors for emotional health and wellbeing. The report also considers self-reported measures from local surveys and consultations. We have utilised existing data providing a baseline against which improvements in outcomes for children and young people can be benchmarked, and further identifies areas where generation of new data sources would be beneficial.

The current range of commissioned services is briefly outlined including activity levels where available. The report utilises the 3 main approaches to Health Needs Assessment in order to present as complete a picture as possible.

The 3 main approaches are:

- Epidemiological: to include a statement of the 'problem'; prevalence and incidence data; the services available
- Stakeholder evaluation (corporate): structured collection of knowledge and views of stakeholders; recognition of the importance of information and knowledge available from those involved in local services including service users and wider population.
- Comparative: contrasts with other areas where the information is available.

² Department of Health and NHS England: Future in Mind

2.1 Context

2.1.1 Local Policy Context

The findings from this Health Needs Assessment will underpin activity which relates to the following local strategies (and their respective delivery plans) in Wiltshire:

Wiltshire Joint Strategic Assessment 2013/14
Wiltshire Health and Wellbeing Board Strategy 2015-2018
Joint Mental Health and Wellbeing Strategy 2014-2021 (adults)
Wiltshire Council Business Plan 2013-17
Wiltshire Children and Young People's Plan 2016-2019
Wiltshire Children and Young People's Trust: Emotional Wellbeing and Mental Health Strategy 2014-2017
Wiltshire Carers Strategy and Action Plan 2012-2015
Wiltshire's transformation plan for children and young people's mental health and wellbeing (2015-2020)
Reducing Child Poverty Strategy 2011-2014
Hidden Harm Strategy and Implementation Plan 2011-2014
11-19 Commissioning Strategy 2012-2015
Schools and Learning Strategic Plan
Adult Joint Mental Health and Wellbeing Strategy 2014-2021
Family and Parenting Support Commissioning Strategy April 2011-2014

2.1.2 Scope

This is a rapid Health Needs Assessment utilising available data and did not generate new data. The scope included the following:

- Demographic data relating to Children and Young People (CYP), 0-25 years where available
- Protective factors for emotional wellbeing and mental health
- General population risk factors for poor emotional health and wellbeing
- High risk groups for mental disorder and low wellbeing
- Prevalence of poor emotional wellbeing and mental health
- Overview of current service provision and demand
- What children and young people say about services

To complement this Needs Assessment a separate evidence review to examine what works for children and young people's emotional wellbeing and mental health has been produced. This evidence review focusses on the role of CAMHS in providing high quality effective service both to young people and their families and also on their potential role in supporting the wider system.

Children with Complex needs where mental health and emotional wellbeing is not the primary need are outside of the scope of this needs assessment.

The services included within this report are from across all 4 Tiers (see section below) of emotional wellbeing and mental health services in Wiltshire. The services include those that are jointly or separately commissioned by NHS Wiltshire CCG and Wiltshire Council. In addition some significant voluntary sector projects have been included.

The report has been informed by the Joint Commissioning Panel for Mental health: Guidance for Commissioning Public Mental Health Services (Practical Mental Health Commissioning) (updated 2015) and the Children and Young people's emotional health and wellbeing needs assessment by Sheffield City Council (2014).

2.1.3 CYP EW&MH Service Provision

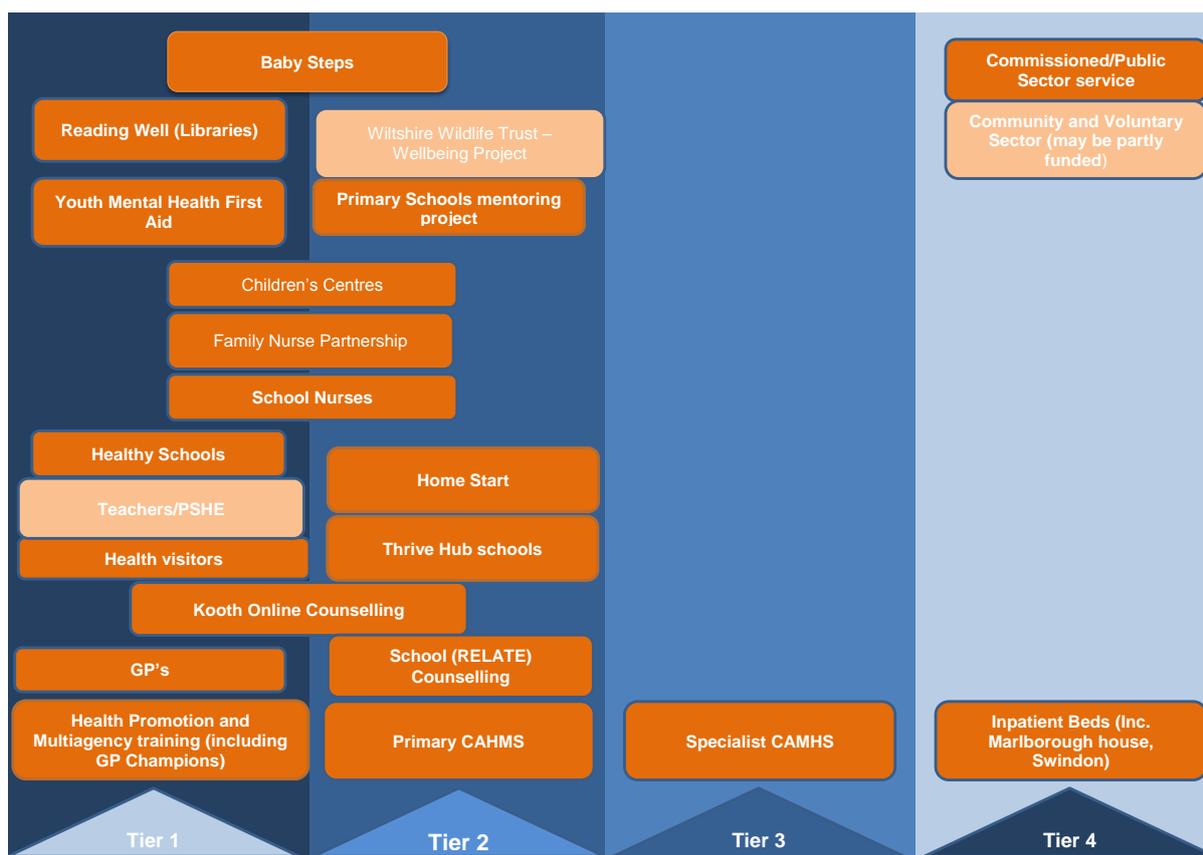
In Wiltshire, as in many areas across the country, Child and Adolescent Mental Health Services (CAMHS) are currently delivered through an operational delivery model with four distinct tiers. These services are available for 0-18 year olds who are referred by any professional working with the child or young person.

This traditional CAMHS model was useful at the time of its development in the 90's for helping to differentiate between the forms of support that might be available to children and young people; however, national research has revealed some significant downsides. These include:

- The development of divisions between services
- Unnecessary waits between the various tiers
- Children and young people having to re-tell their stories to different teams/professionals
- A lack of clarity about thresholds

The tiered model can result in children, young people and their families being '*bounced*' around the system without timely access to the support or treatment they need. Feedback from children and those who care for them also indicates that the model is too difficult to navigate and understand.

The diagram below shows top level information about current services at each tier and estimated relative need and further information about service provision is detailed later in the report.



2.1.4 CYP Population in Wiltshire

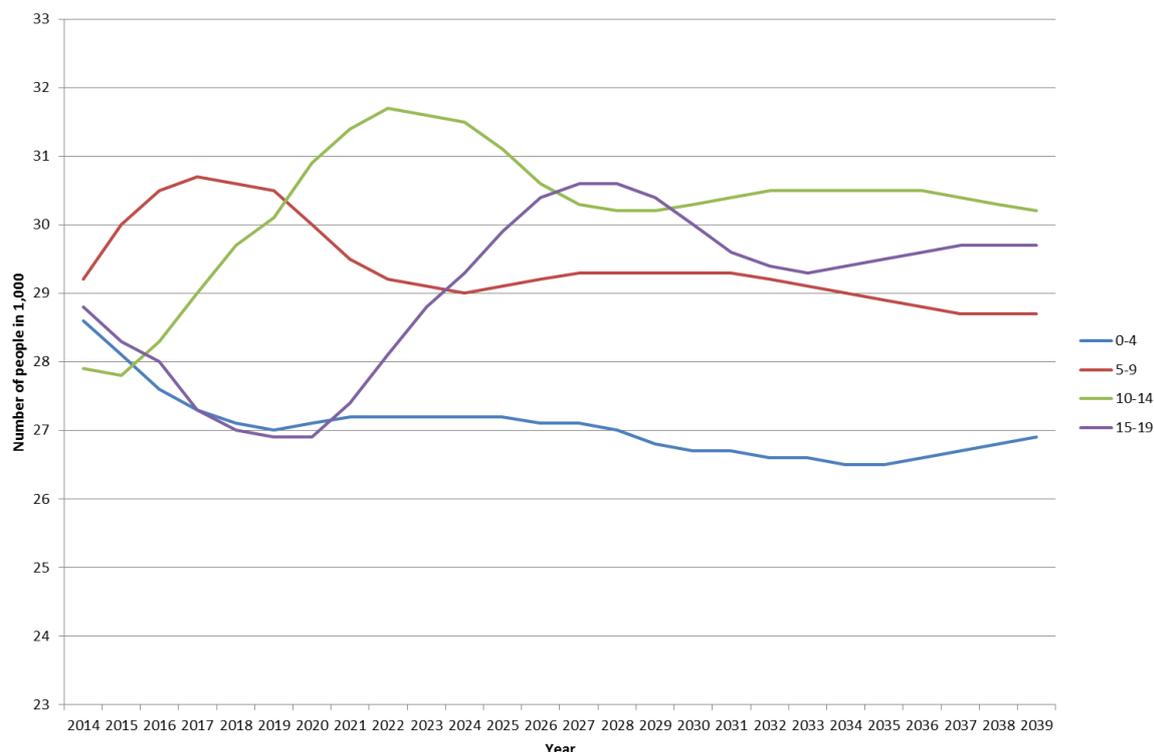
The table below shows the Wiltshire population of children and young people aged 0-25, in 5-year age bands based on 2015 mid-year estimates provided by Office of National Statistics (ONS). This report will consider data for young people up to the age 19 where it is available. Data for the older age groups will be considered in an adult Mental Health and Wellbeing needs assessment to be conducted in the second half of 2016 and will be linked to the data reported here to assist with understanding of needs during the transitional phase from child to adult orientated services.

Age Group	Male	Female	Total
0-4	14,540	13,769	28,309
5-9	15,347	14,763	30,110
10-14	14,155	13,664	27,819
15-19	14,435	14,071	28,506
20-24	12,892	10,804	23,696
0 -16 Total	50,021	48,142	98,163
0 -19 Total	58,477	56,267	114,744
16-25 Total	27,334	24,191	51,525

The graph below is based on population estimates from the ONS and shows Wiltshire population trends and projections to 2039. The number of 10-14 year olds is projected to grow by 12.5% over the next 5 years before starting to decline. There is expected to be a decrease in the number of 15-19 year olds in the shorter term followed by an increasing trend in this age group between 2020 and 2028. The numbers for 0-4 and 5-9 year olds are expected to decline and then plateau by 2019 and 2022 respectively.

When considering the future growth in the population of children and young people it is important to be cognisant of the Regular Army Basing Plan which will relocate an additional 4,000 troops to Wiltshire by 2020; in addition some 3,200 dependants will accompany them.

Figure 1 Children and Young People predicted population trends; ONS:



The additional table below re-profiles the Wiltshire population of Children and Young People to relate to usual divisions in service provision i.e. Early Years, 5-15s, 16 & 17 year olds, and 18-25 year olds.

Age Group	Male	Female	Total
0-4	14,540	13,769	28,309
5-15	32,382	31,432	63,814
16-17	5,984	5,939	11,923
18-25	21,350	18,252	39,602
0 -16 Total	50,021	48,142	98,163
0 -19 Total	58,477	56,267	114,744
16-25 Total	27,334	24,191	51,525

2.1.5 Early Years

The early years play a significant role in determining emotional wellbeing and mental health through childhood and beyond. A mentally healthy child is one with a clear sense of identity and self-worth, the ability to recognise and manage emotions, to learn, play, enjoy friendships and relationships, and deal with difficulties. A wide range of interrelated factors play a role, such as individual, family, wider society and environmental issues. Evidence shows how important the perinatal period is and that development begins before birth and that the health of a baby is crucially affected by maternal health and wellbeing. High levels of maternal stress in pregnancy pass to the baby through the placenta and can affect the child's ability to regulate their stress response in later life. Experiences and environment shape brain development with rapid development occurring during pregnancy and the first three years of a child's life. The social and emotional structure is formed during this time,

and can be adversely affected by a baby's attachment to their parents. Emotional capabilities are largely set by the time a child is 18 months old (Allen, G. 2011).

A child's wellbeing is the result of healthy development within a nurturing environment. In the early years, infants make emotional attachments and form relationships that lay the foundation for future mental health. Attachment relationships are particularly important and have far-reaching effects on developing emotional, social and cognitive skills. One in five mothers will experience mental illness during pregnancy or in the first year whether it be depression and anxiety or, in more extreme cases, post-birth psychosis. Early interactions and experiences directly affect the way the brain develops – and that also applies to exposure to problems such as domestic violence and drug and alcohol abuse.

The preschool years, including both infancy (birth through to age 1 year) and toddlerhood (1 to 3 years), involve children undertaking a number of important developmental tasks relating to their physical development (e.g. establishing healthy patterns of eating and activity), social and emotional development (e.g. establishing a capacity for self-regulation via their attachment relationship to the primary caregiver) and language and cognitive development (e.g. early acquisition of both expressive and receptive language skills, and wider learning). Fair Society, Healthy Lives (Marmot 2010) suggested that in order to reduce future social and health inequalities it is necessary to give every child the best start in life, and this reflects the view that the origins of much adult disease lie in the 'developmental and biological disruptions occurring during the early years of life' and more specifically what has recently been referred to as 'the biological embedding of adversities during sensitive developmental periods' (Davies et al 2012).

In partnership with other organisations, Local Authorities have a key part to play in the early interventions which can assist with healthy development in the early years and lead to stronger emotional wellbeing and mental health. Examples include running parenting programmes, supporting child development and the attachment bond between vulnerable infants and parents in the early years.

2.1.6 Adolescence

The scope of this report includes young people aged up to 19 years. This is because adolescents have experienced the least improvement in health status of any age group in UK in last 50 years (Davies et al 2012). Specifically in relation to mental health, 50% of lifetime mental illnesses arise by age 14; and 40% of young people experience at least one mental disorder by age 16 (JCPMH 2013).

One explanation commonly offered for the growth in the onset of mental health and behavioural issues amongst young people is the widening gap between physical and sexual maturity and adult social and financial independence. The gap between puberty and adult social and financial independence has widened from around 6 years in the 1950s to 15 years today (Davies et al 2012).

Early adolescence sees a surge of brain development which continues into early 20s, and this brings with it both great potential for building lifelong wellbeing and resilience, and significant risk. There is a window of vulnerability to risky behaviours around 14-17 years particularly in the presence of peers and choices made in this period heavily determine future life chances. Multiple risky behaviours are associated with a cluster of common factors such as deprivation, poor parental connection, loss, violence, low self-esteem, poor mental health. New social determinants also arise in adolescence; things like connection (sense of belonging) with peers, schools and neighbourhoods can become a key protective factor, that influence the transition from childhood into adult life.

2.1.7 Terminology

It should be noted that definitions for mental health and emotional wellbeing vary across different disciplines. Where possible this document uses the definitions used by the Joint Commissioning Panel for Mental Health (2013) as follows:

- Emotional and mental health and wellbeing – this refers to a combination of feeling good and functioning effectively as outlined in the introduction above.
- Mental illness – this refers to depression and anxiety (which may also be referred to as ‘common mental disorder’) as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness).
- Mental disorder – this includes mental illnesses as well as personality disorder and alcohol and drug dependency.

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3. Protective Factors for positive EHWP&MH

3.1 Overview

There is a well-established body of evidence relating to protective factors to facilitate positive mental health and emotional wellbeing. The JCPMH (2013) describe a range of protective factors which are associated with wellbeing:

- Genetic and early environmental factors
- Socioeconomic factors including higher income and socio-economic status
- Living environment
- Good general health
- Education
- Employment including autonomy, support, security and control in an individual's job
- Activities such as socialising, working towards goals, exercising and engaging in meaningful activities
- Social engagement and strong personal, social and community networks
- Altruism (doing things for others)
- Emotional and social literacy life skills, social competencies and attributes such as communication skills, cognitive capacity, problem-solving, relationship and coping skills, resilience and sense of control
- Spirituality is associated with improved wellbeing, self-esteem, personal development and control
- Positive self-esteem
- Values

Resilience can be defined as the ability to recover from setbacks, adapt well to change, and keep going in the face of adversity. It is strongly associated with wellbeing and can also help safeguard mental wellbeing particularly at times of adversity. It arises through the interaction between factors at the individual, family and community level. Different levels of emotional and cognitive resilience or 'capital' will include a myriad of factors as illustrated below:



Recently the Five Ways to Wellbeing has been promoted nationally and as a tool to support emotional wellbeing. These were developed by the New Economics Foundation (NEF) from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing in 2008. The *Five Ways to Wellbeing* are a set of evidence-based actions which promote people's wellbeing. They are: *Connect, Be Active, Take Notice, Keep Learning and Give* (NEF 2013).

This section looks at the prevalence of protective factors for children's wellbeing in Wiltshire; we have used the *5 Ways to Wellbeing* as a framework for this.

Data from the emotional health section of the Wiltshire Children and Young People's [Health and Wellbeing Survey 2015](#) has been utilised and illustrates the importance of children and young people's experiences of life both inside and outside school. Schools have an important part to play in promoting positive emotional wellbeing and mental health. The survey helped schools to identify areas for improvement and address particular issues raised by their own pupils and to provide evidence to influence future services provided by Wiltshire Council and their partners that improve the health and wellbeing of our young people. It was commissioned by Wiltshire Council and carried out by Foster and Brown Research Limited. All schools in Wiltshire were invited to take part in the voluntary survey, which was carried out from January to April 2015. The questionnaire was completed online by pupils in year groups 4, 5, 6, 8, 10 and 12. There were three versions of questionnaire designed separately for primary, secondary and Year 12/FE college pupils, plus a version for children and young people with special educational needs. The questions covered a wide range of aspects of young people's lives; these were healthy lifestyles, learning experience, relationships, wellbeing, safety, aspirations and support requirements. The survey was carried out in 64 schools and colleges across Wiltshire in 19 of the 20 community areas, and 6,912 pupils completed the survey. The large number of children and young people involved means that we can have confidence that the responses are representative of Wiltshire's children and young people.

3.1.1 Connect

The importance of connecting with people around you such as family, friends, colleagues and neighbours is clear and can be particularly important for children and young people. Building connections can support and enrich young people, increasing resilience and giving them cornerstones to guide them throughout their lives. These 'connections' start immediately from, and even prior to, birth. The following sections relate to 'Connect'

Attachment

There is longstanding evidence that a baby's social and emotional development is affected by their attachment to their parents. International studies show that when a baby's development falls behind the norm during the first years of life, it is more likely to fall even further behind in subsequent years, than to catch up with those that have had a better start (All Party Parliamentary Group, 2015). Insecure or anxious attachment makes the child increasingly vulnerable to life's events. Disorganised attachment can have devastating lifelong effects on the infant, including high levels of physical and mental illness (All Party Parliamentary Group, 2015).

Attachment is an important outcome of early care; through their relationships with their mothers and fathers, children develop a model for social relationships. If an infant experiences her or his parents as a source of warmth and comfort, they are more likely to hold a positive self-image and expect positive reactions from others later in life. With a secure attachment, the child has a "secure base" from which to explore, learn and develop independence (Moullin et al 2014). Evidence from a number of longitudinal studies shows that securely attached children function better across a range of domains including emotional, social and behavioural adjustment (Davies et al 2012) and have better long-term outcomes into adulthood.

Children with insecure attachment are at risk of the most prominent impediments to education and upward social mobility in the UK: behavioural problems, poor literacy, and leaving school without further education, employment or training. Behaviour problems are a particular concern for the UK where the gap in such problems between the most disadvantaged children and their peers is larger than in Australia, Canada or the US. The international research suggests that insecurely attached children are:

- at a higher risk of externalising problems, characterised by aggression, defiance, and, or hyperactivity.
- less resilient to poverty, family instability, and parental stress and depression.
- on average, have poorer language development, and weaker executive function, skills associated with working memory and cognitive flexibility.

Attachment is a complex concept to measure and in Wiltshire we do not currently have robust data on attachment among children locally. In future, there may be potential to use data collected as part of the 'two to two and a half year developmental checks undertaken by health visitors and early years education providers to explore this in more depth and target interventions accordingly..

Positive pro-active parenting (involving, for example, praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence and is protective against later disruptive behaviour and substance misuse.

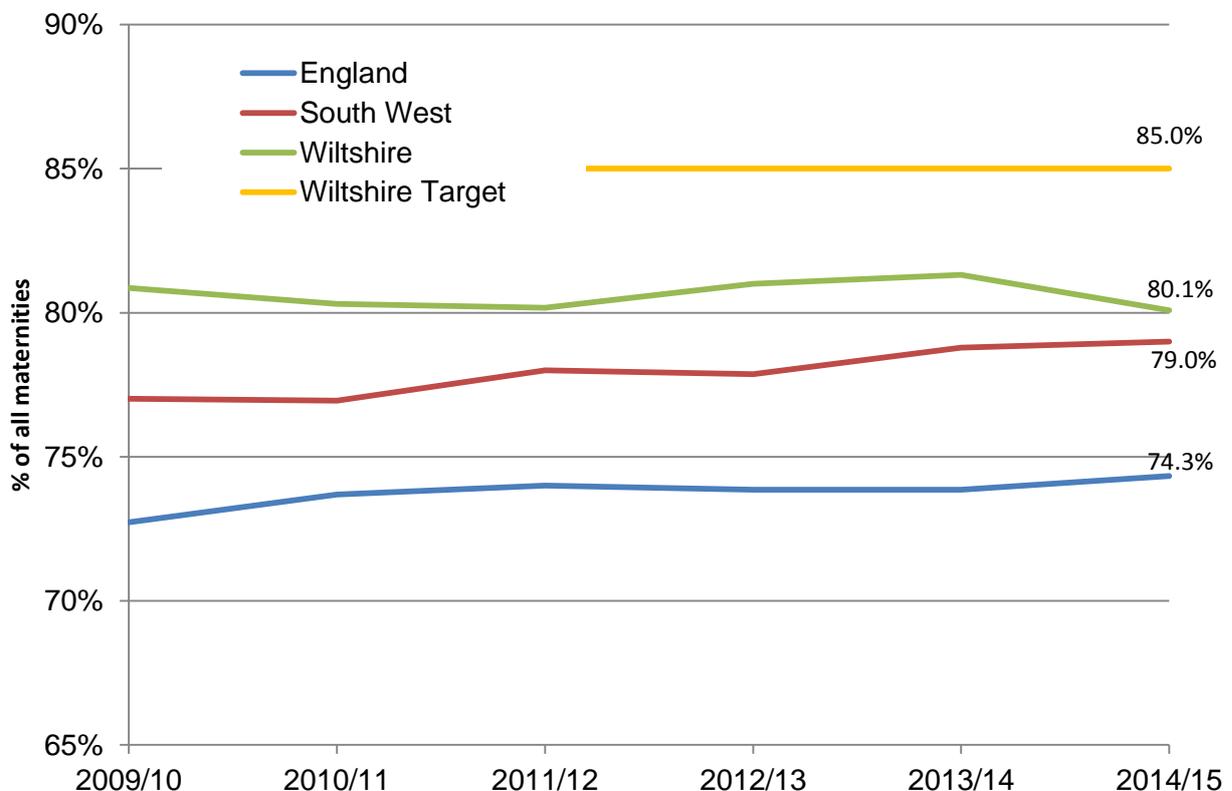
A further protective factor is having at least one healthy relationship with a supportive adult and/or a good relationship with peers. A positive adult-child relationship built on trust, understanding, and caring will foster children’s cooperation and motivation and increase their positive outcomes at school (Webster-Stratton, 1999). In a review of empirically derived risk and protective factors associated with academic and behavioural problems at the beginning of school, Huffman et al. (2000) identified that having a positive pre-school experience and a warm and open relationship with their teacher or child care provider are important protective factors for young children. These protective factors operate to produce direct and ameliorative effects for children in at-risk situations (Luthar, 1993) (taken from The Centre on the Social and Emotional Foundations for Early Learning).

Breastfeeding

Breastfeeding has been linked to positive emotional, as well as health and cognitive outcomes for children. Investing in breastfeeding and relationship building is now recognised as a positive, proactive mechanism to promote mother-infant attachment behaviours and the mental health and well-being for the mother and the child (Britton et al, 2011; Ekstrom et al, 2006; Groër, 2005; Gutman et al, 2009; Heikkilä et al, 2011; Kim et al, 2011; Oddy et al, 2009; Oddy et al, 2011; Sacker et al, 2006; Strathearn et al, 2009; Sunderland, 2007; Unite/CPHVA, 2008).³

The Wiltshire average for breastfeeding initiation in 2014/15 was 80.1%, which is higher than the national average of 74.3% and the South West region which has 79%. 49.4% of babies in the county were receiving breastmilk at 6-8 weeks, which is again higher than both the national and regional average (43.8 and 48.3 respectively).

Figure 2 breastfeeding initiation rates in Wiltshire 2009/10-2014/15:



³ UNICEF (2013) The evidence and rationale for the UNICEF UK Baby Friendly Initiative Standards http://www.unicef.org.uk/Documents/Baby_Friendly/Research/baby_friendly_evidence_rationale.pdf

Source: Department of Health Statistical Releases on Breastfeeding

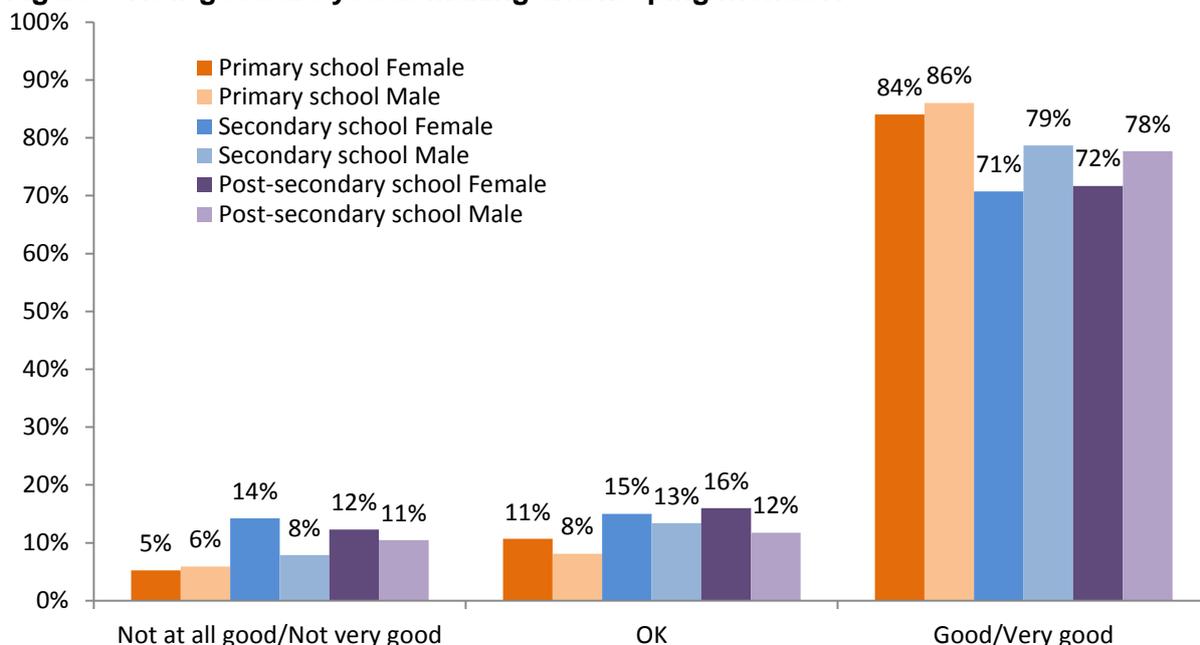
Women from disadvantaged groups are less likely to breastfeed their baby than those who are better off financially. In Wiltshire 73% of mothers in the most deprived quintile initiated breastfeeding compared with 83% in the least deprived quintile (2014/15). By 6-8 weeks the gap widens with only 40% of those in the most deprived communities breastfeeding compared with 56% in the least deprived.

Age of mother has a strongly significant impact upon breastfeeding initiation rates. The initiation rate of 59% amongst mothers aged 15-19 and 65% amongst mothers aged 20-24 are significantly lower than in any other age group and well under the all age figure of 81%. 6-8 week breastfeeding rates are again lowest amongst infants of mothers aged 15-19 at only 16%, and this is a strongly significant difference compared to older age groups and is less than half of the Wiltshire average rate. Infants of mothers aged 20-24 (24%) also have significantly lower 6-8 week breastfeeding rates compared with infants of older mothers.

Friendships

Making and maintaining strong friendships with peers is a good way of connecting and receiving social support and developing valuable social skills which are protective factors. The Wiltshire Children and Young People’s Health and Wellbeing Survey 2015 asked respondents how good they are at making and keeping friends. Figure 3 illustrates that 78% of respondents reported that they are good or very good at making or keeping friends. The proportion of the primary school sample that reported being good or very good (85%) was 10%-11% higher than the other school types. A slightly higher proportion of males reported that they were good or very good at making or keeping friends than females in all school types.

Figure 3 How good are you at making and keeping friends?:

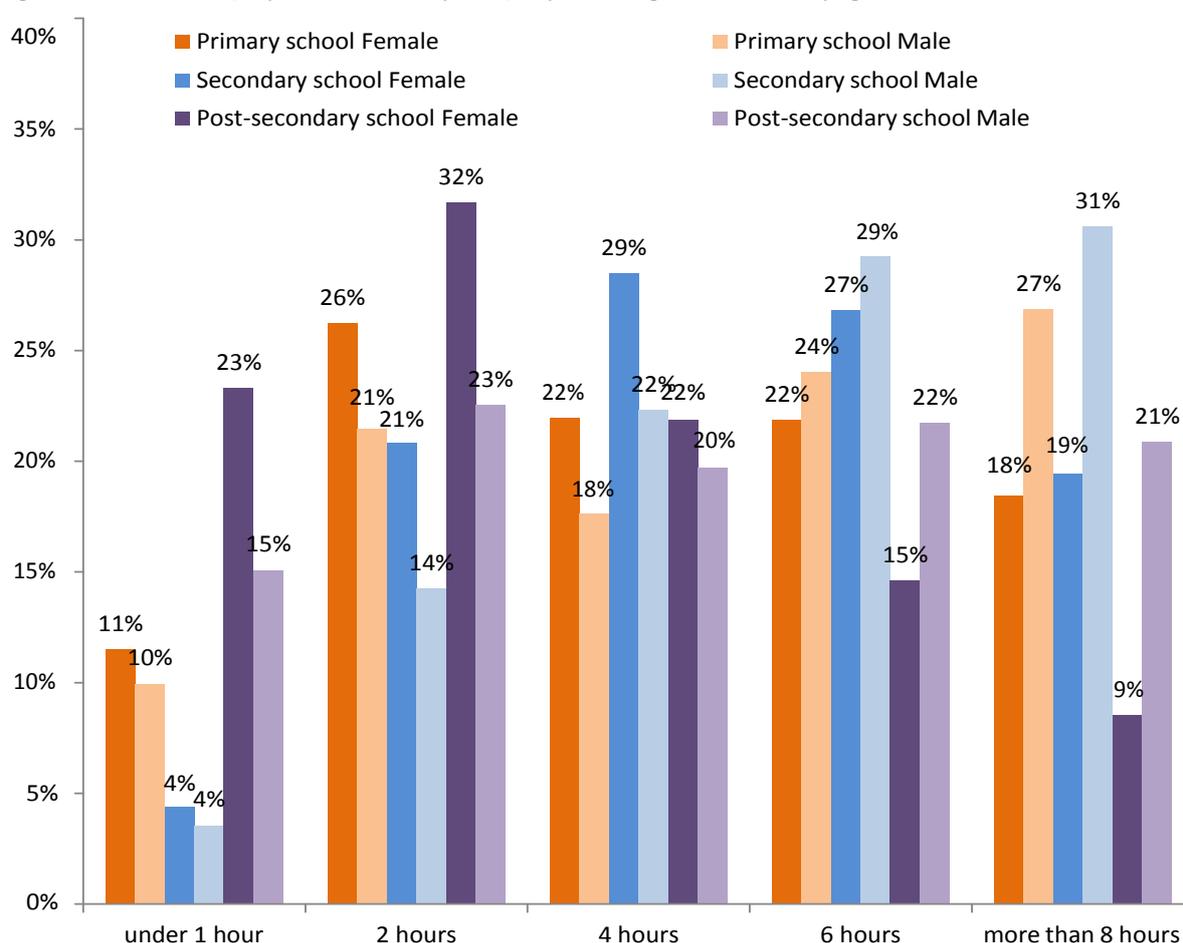


3.1.2 Be Active

There is a considerable body of evidence about the benefits of physical activity for children and young people. Regular exercise such as team or individual sports, walking, cycling, swimming can improve concentration and reduce stress and anxiety.

NHS guidelines advise at least 60 minutes of exercise a day for people between the ages of 5 and 18 years old. Results from the Healthy Lifestyles section of the Wiltshire Children and Young People’s Health and Wellbeing survey show that 46% of primary school respondents, 52% of secondary school respondents and 32% of post-secondary school respondents reported being physically active 6 or more hours a week. Males in all school phases undertake more physical activity than the females. 60% of secondary school respondents and 43% of post-secondary school respondents felt they do enough exercise quite often or always to keep themselves healthy. A higher proportion of males than females in both the secondary and post-secondary school sample felt they do enough exercise. The graph below shows the level of physical activity by school phase for pupils responding.

Figure 4 Level of physical activity or play during the week by gender:



In order to compare Wiltshire to other areas we have utilised results from the What About YOUth? Survey, a national survey collecting health behaviours of 15 year olds across England⁴. Nationally 13.9% of 15 year olds reported being physically active for at least one

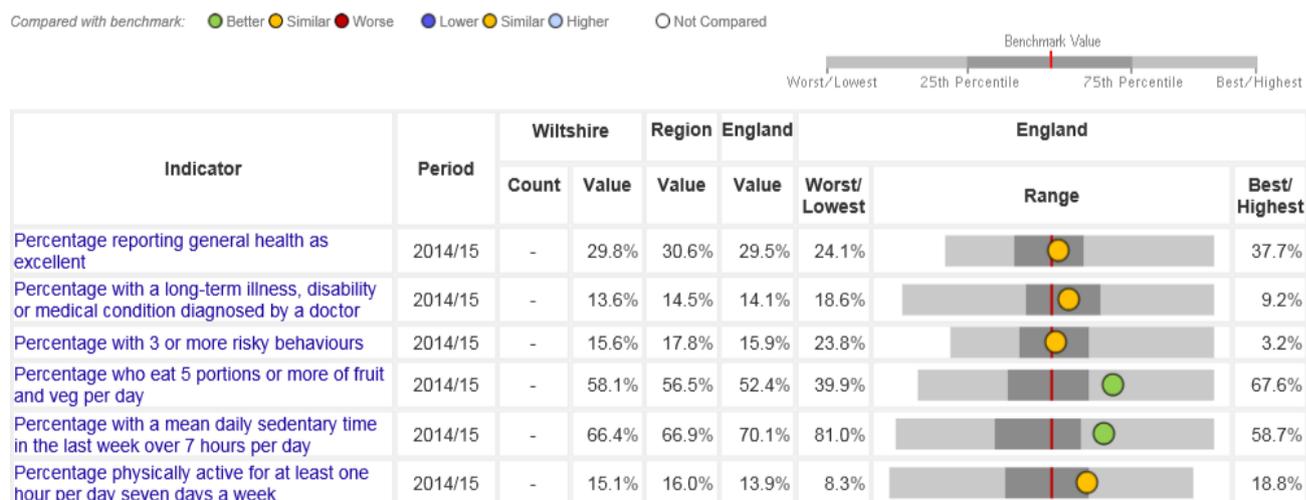
⁴ <http://fingertips.phe.org.uk/profile/what-about-youth>

hour per day seven days a week. The table below shows results from the WAY survey for Wiltshire which indicates that the County has better than average percentages for:

- young people who eat 5 or more portions of fruit and vegetables per day
- mean sedentary time of over 7 hours per day.

Additionally it shows that young people in Wiltshire have a similar to national average percentage of physical activity.

Figure 5 Health behaviours in young people – What About YOUth? Survey



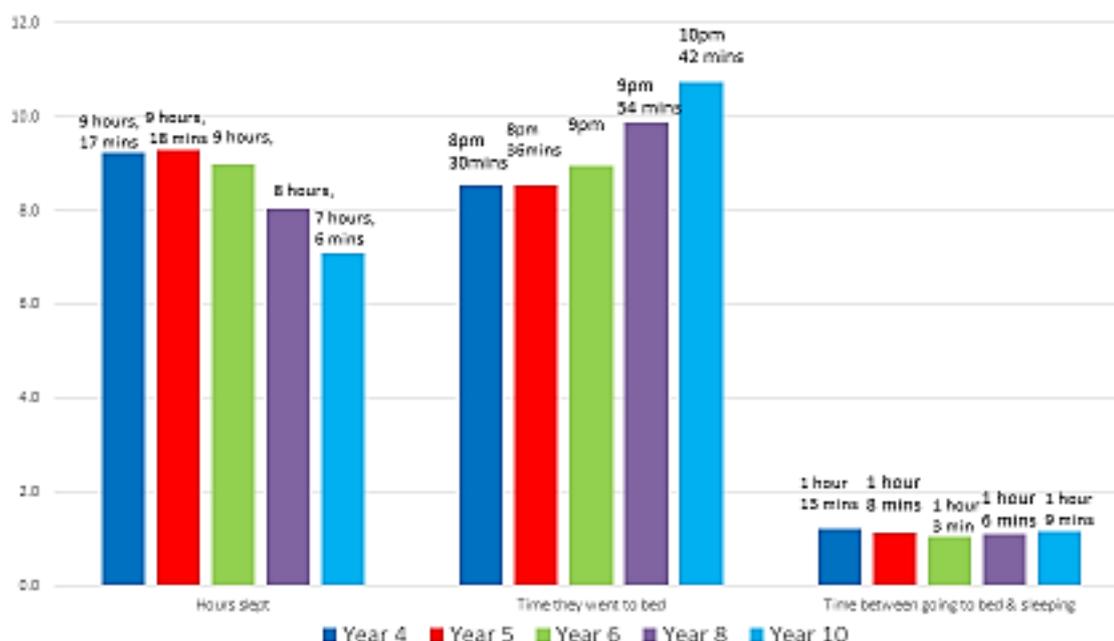
3.1.3 Take Notice

Taking notice means connecting with the world around you, being aware of yourself, others, the environment and what your feelings are about those things. This is as important for young people as for anyone, particularly given the increase in social media interaction which can have an absorbing effect on an individual.

Sleep

Sleep is an important health protecting behaviour and lack of sleep can impact negatively on mental health, without sufficient sleep it is unlikely that an individual will be able to ‘take notice’ of the world around them. Sleep experts recommend that children under 10 need at least 10 hours of sleep a night and from the ages of 10 to 18 they need at least 8 and a half. The schools survey showed that a large majority of respondents reported going to bed at 9 or 10pm (30% and 23%). When the responses were broken down into school phase the primary school respondents mainly fell into two time brackets 8pm and 9pm (37% and 38%; figure 15). The secondary school respondents had 3 main times that they went to bed, 9pm (23%), 10pm (36%) and 11pm (21%).

Figure 6 Estimation of how long someone slept for



Source: Wiltshire Emotional Health and Wellbeing School health Survey 2015

Using respondents reported hour that they went to bed and the length of time it took them to get to sleep, and making the assumption they woke up at 7am an analysis was performed for Wiltshire Council by Foster and Brown to create an estimated length respondents slept for. This is presented in Figure 6 by year group rather than school phase. The overall average time a respondent slept was 8 hours and 22 minutes. The primary school year groups had the longest lengths of time slept (9 hours or more). The older secondary year group (year 10) had the shortest length of time slept (7 hours and 6 minutes).

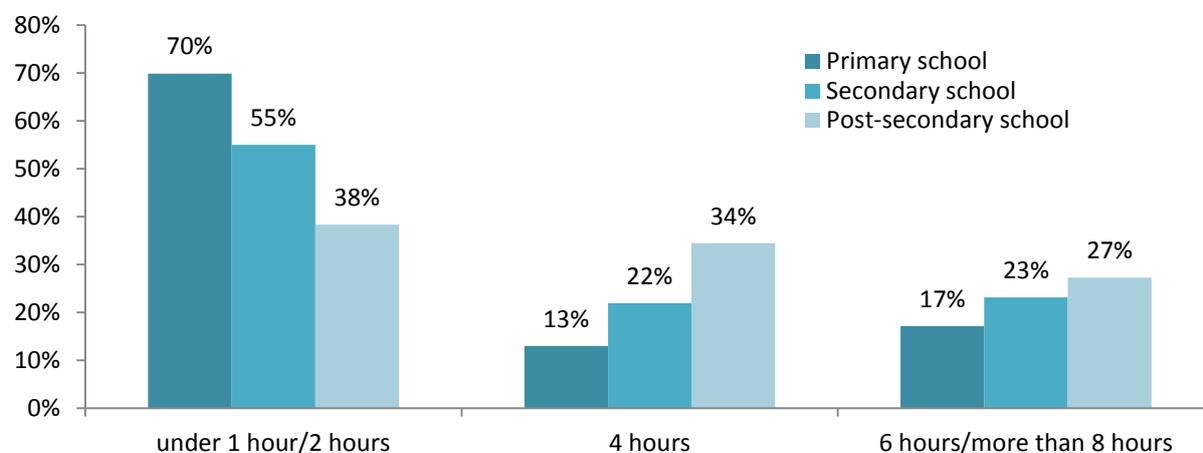
Digital and Social media engagement

There is a certain amount of conflicting evidence about the impact of digital and social media on young persons’ mental health and emotional wellbeing. There is likelihood that long period of time absorbed in digital or social media can have an impact on a persons’ ability to notice other things going on around them, although undoubtedly it can provide a rich source of information which contributes to lifelong learning. There is recent evidence to suggest that online gaming can have a positive impact on academic performance, but highlights the potentially negative effects of social media.⁵

Respondents to the schools survey were asked how long they spent online or playing computer games the previous night. Overall the majority of respondents reported only doing these activities for under 1 hour or 2 hours (29% and 29%). When broken down by the school phases a clear gradient can be seen showing an increasing use of online or electronic gaming activity.

⁵ [Guardian Report -positive link between video games and technology](#)

Figure 7; Approximately how much time did you spend last night online/playing computer games?



Source: Wiltshire Emotional Health and Wellbeing School health Survey 2015

When looking at the gender differences in each school phase a larger proportion of males spend more hours online or playing electronic computer games in all the school phases. This question did not specifically refer to mobile phones, however a previous question about use of screens did specifically include mobiles and therefore there is an assumption that people will have included mobile phones when answering this question.

3.1.4 Keep Learning

Learning takes many forms, and includes formal learning as well as learning new things for fun, watching TV documentaries, reading or taking part in organised activities. The following section focusses initially on educational attainment.

Education – provision for children under 5 years

The quality of childcare is important - In the 1990s, a team of researchers in the US launched a major longitudinal study to assess the effects of early childcare on children's attachment. The results showed that early non-parental childcare in general did not affect children's attachment. However, for children who are already at risk of poor attachment, *low-quality* early childcare elevated this risk at age 15 months and also led to heightened risk of risky behaviour and externalising problems as late as adolescence (Moullin et al 2012).

High quality pre-school can improve Key Stage 2 English results – and is equivalent to about a term and a half's progress; in Maths, it is nearly two terms. The benefits of pre-school are higher for pupils from disadvantaged backgrounds⁶. In order to qualify for Early Years Pupil Premium (EYPP) a provider must have been rated 'good' or 'outstanding' by OFSTED. Local authorities are required to remove any funding for the entitlement from a provider rated 'inadequate' as soon as is practicable.

Local authorities are funded according to the actual numbers of eligible two-year-olds taking up a place.

⁶ Sylva, K et al (2008) Final Report from the Primary Phase: Pre-school, School and Family Influences on Children's Development during Key Stage 2 (Age 7-11) EPPE.

In Wiltshire, in the summer term of 2016 there were 1307 children eligible for a funded childcare place which represented 24% of the cohort. Of these eligible children, 1046 actually accessed the funding (19% of the overall cohort and 80% of those eligible).

Figure 8 below shows numbers of 3 and 4 year olds benefitting from some free early learning provision; there is no information about the percentage of that age group who are accessing the provision, and more detail regarding the percentage uptake and comparisons on that basis would be beneficial.

Figure 8; Number of 3- and 4-year-olds benefitting from funded early education places by type of provider: Wiltshire, South West and England Comparison

	Private and voluntary providers ¹	Independent schools	Maintained nursery and state-funded primary	State-funded secondary schools ^{3,4}	Special schools ^{5,6}	All providers ⁷
England	534,352	31,368	760,665	8,690	4,356	1,339,431
South West	66,790	3,190	52,570	1,060	260	123,870
Wiltshire	6,828	436	4,124	0	12	11,400

Source: Early Years Census (EYC), Schools Census (SC) and School Level Annual School Census (SLASC)

(1) Includes some local authority day nurseries, childminders and other providers registered to receive funding.

(2) Includes primary converter academies, primary sponsor-led academies and primary free schools.

(3) Includes maintained secondary schools, secondary converter academies, secondary sponsor-led academies, secondary free schools and city technology colleges.

(4) Local authorities returned the number of 3- and 4-year-olds for which they expected to receive funding.

(5) Includes general hospital schools.

(6) Excludes pupils who are also registered elsewhere.

(7) Any child attending more than one provider will have only been counted once.

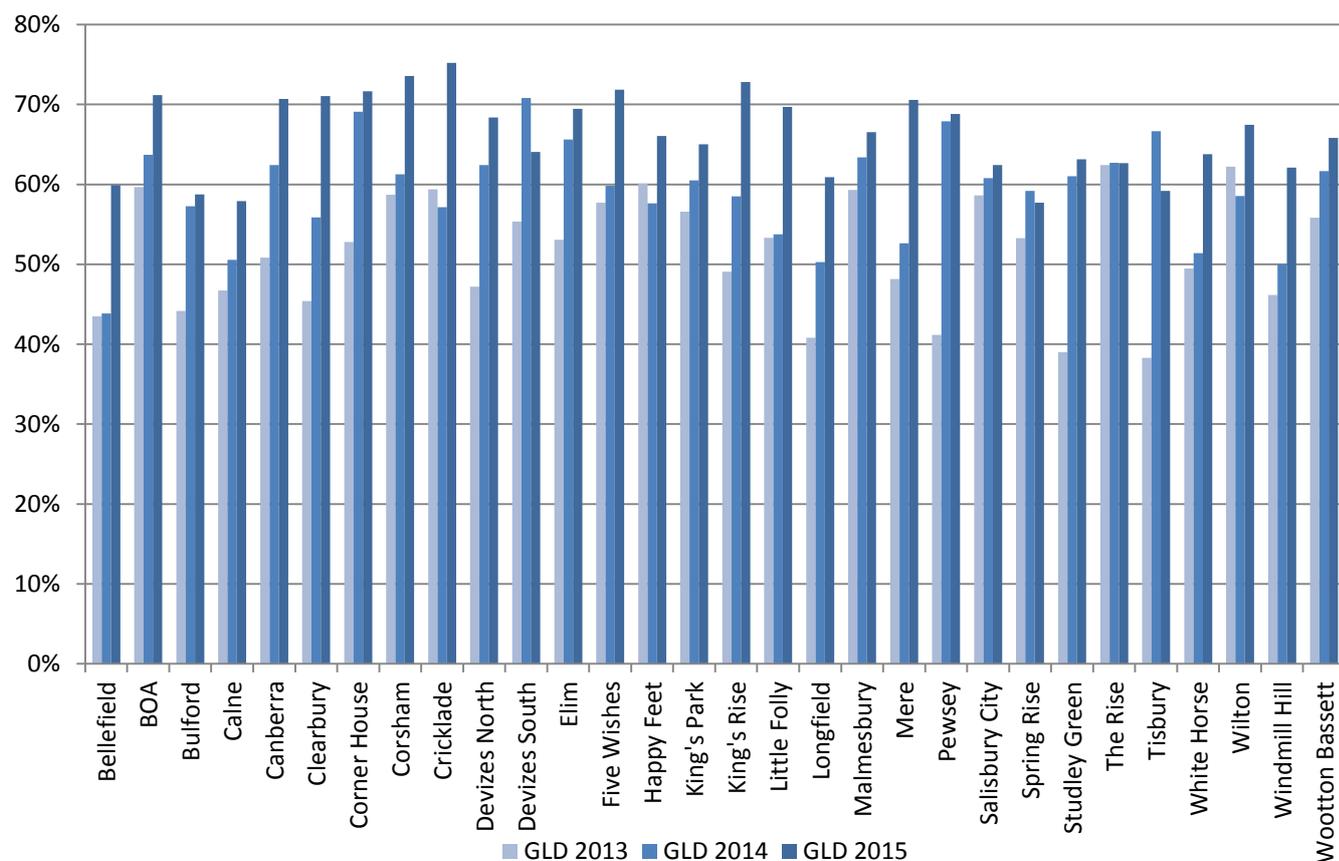
Children achieving a good level of development at Early years Foundation Stage (EYFS) Age 5

In 2012/2013 the measure of a 'good level of development' at Foundation Stage changed. To achieve a 'good' level of overall progress in 2013 a child needed to reach 'Expected' or 'Exceeding' status in 12 separate areas of learning:

- Listening and attention
- Understanding
- Speaking
- Moving and handling
- Health and self-care
- Self-confidence and self-awareness
- Managing feelings and behaviour
- Making relationships
- Reading
- Writing
- Numbers
- Shapes, space and measures

The graph below shows percentages of children with Good Level of Development (GLD) by Children's Centre Area for Wiltshire. It shows improvement for most areas between 2013 and 2015 for most areas with the exception of Devizes South and Tisbury.

Figure 9; Percentage of Children with Good Level of Development by Children's Centre Area

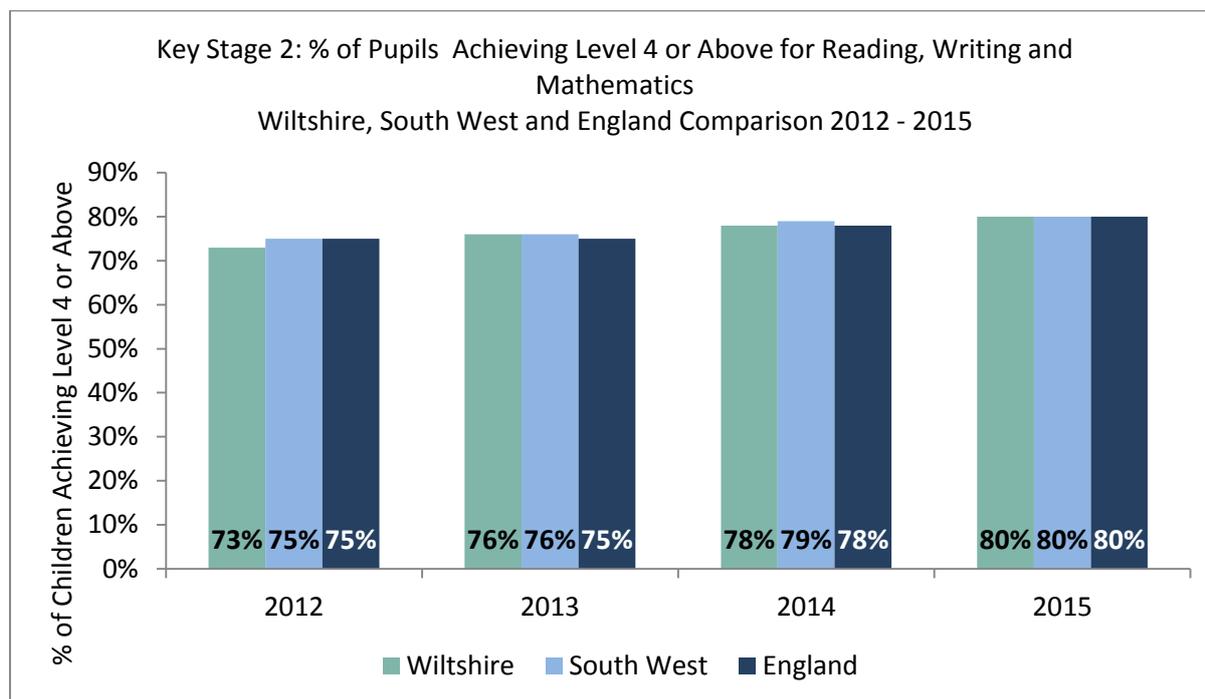


This assessment of level of development can be used as a proxy for school readiness. Readiness for school can also have a significant impact on a child's ability to integrate into a school setting and thus to continue learning and growing.

Key Stage 2 Achievement

In 2015, the percentage of pupils in Wiltshire achieving level 4 or above in reading, writing and mathematics at the end of primary school (Key Stage 2) was in line with that reported across the South West region as well as England as whole (80%) and has shown consistent improvement since 2012.

Figure 10; Level 4 Achievement

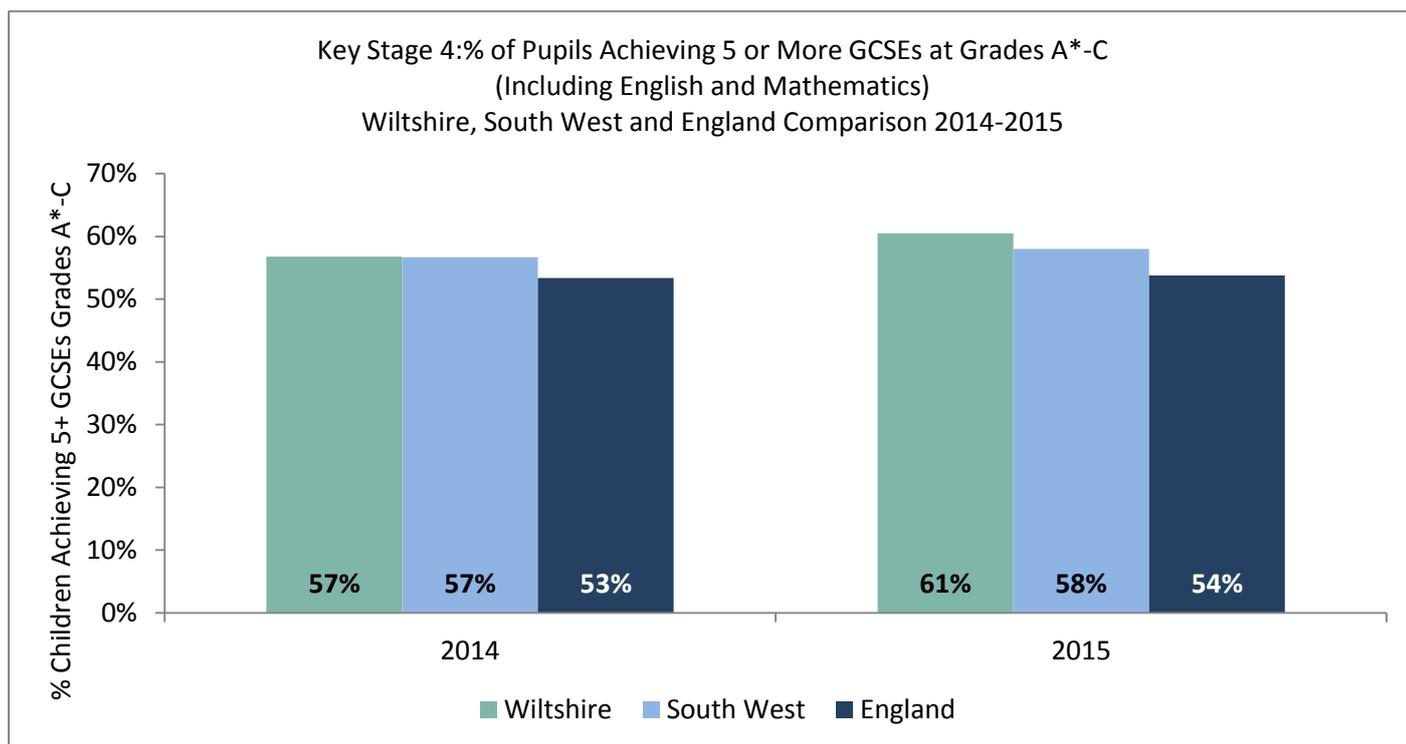


GCSE achieved 5A*-C inc English and Maths

Achieving 5 or more GCSEs at grades A*-C including English and Maths is associated with a reduced risk of depression at the age of 42 by five percentage points (Ubido et al 2012).

The chart below shows comparative achievement levels for GCSE for Wiltshire against those for the South West and England as a whole. Amendments to the definition of this indicator were introduced in 2013 and, as a result, only annual data since the introduction of this change is presented in order to allow effective comparison between years. In 2015, the percentage of pupils in Wiltshire achieving 5 or more GCSE's including English and Mathematics at grades A*-C at the end of secondary school (Key Stage 4) was higher than that reported both regionally and nationally and has improved when compared against the previous year. Improvements shown in 2015 mean that Wiltshire now ranks in the top 25% of all Local Authorities in England.

Figure 11: Pupils Receiving 5 or more GCSE's at Grade A*-C



Source: Ofsted School Inspection Outcomes 2014-2015 www.gov.uk"

Organised/other activities

A question was asked in the survey about what children and young people do in their spare time. In primary school 42.5% participate in sports related organised activities and 36% in clubs such as drama, scouts, cadets or youth clubs. These percentages drop when considering secondary school pupils, although to a lesser extent for sports related clubs. Reading was popular in the younger age groups with 55.7% saying they enjoy doing this in their spare time; again this reduces according to age to 36.3% in secondary school age groups and 31% in post-secondary. It should be acknowledge that not all children and young people will have equal access to out of school activities and it is quite likely that those experiencing other inequalities will have the least access.

3.1.5 Give

This refers to making links to the wider community which can be incredibly rewarding and create lifelong connections to the people around an individual. It includes things like doing something nice for a friend, or a stranger, thanking someone, volunteering and joining a community group.

The Wiltshire Schools Health and Wellbeing Survey question about what young people do in their spare time asked a question about volunteering activity and the positive responses were low (7.8% primary, 8.7% secondary, 11% post-secondary). However, 21% of

respondents in primary said they spent some of their spare time caring for an adult in the family and 26% cared for brothers and sisters.

It is important to reflect that, whilst 'giving' can have a positive impact on the wellbeing of children and young people, there is considerable evidence that caring responsibilities can have a negative impact on them if they are not given the opportunity to participate in all aspects of life. Further information about young carers in Wiltshire is detailed in section 4.2.8.

4. Risk Factors for poor EHWP&MH

4.1 Overview

It is vitally important that prevention and early intervention approaches are used to address risk and reduce the likelihood that children and young people will experience poor mental and emotional health. Evidence suggests that a broad range of services are needed to improve the emotional wellbeing and mental health of all children and young people and prevent problems occurring. These should take into account risk and protective factors in a number of environments and across all age ranges. There is a growing evidence base around the benefits (both economic and individual) of interventions that will assist in reducing risk taking behaviours and identifying early signs of things like alcohol and substance misuse⁷. Tackling these risk factors has additional advantage in that this approach will help to address improvement in a wide range of other outcomes to improve the lives of children and young people.

By considering the prevalence data for risk factors, we can get an indication of the levels of local support needs for children and young people around emotional wellbeing and mental health. Furthermore, addressing those risk factors can prevent mental disorder as the number of people who have a particular disorder is *directly related to the mean* population level of the underlying *symptoms or risk factors*. A small reduction in average symptoms/risk factors within a population can reduce the overall number with mental disorder (Campion 2013). National policy therefore identifies that a twin track approach is needed for mental health: prevention and promotion as well as treatment (HMG 2011).

The opportunity for this during pregnancy, childhood and adolescence is significant given that most lifetime mental disorder has arisen before adulthood.

4.2 Inequalities and deprivation

The government, through the Department for Communities and Local Government (DCLG), has produced a set of data to aid the assessment of relative levels of deprivation across England. The Index of Multiple Deprivation (IMD), combines a number of other indices, and gives an overall score for the relative level of multiple deprivation experienced in small geographical areas. To produce the Overall IMD there are 38 separate indicators that are combined and weighted. Broadly, the indicators fall across seven Domains:

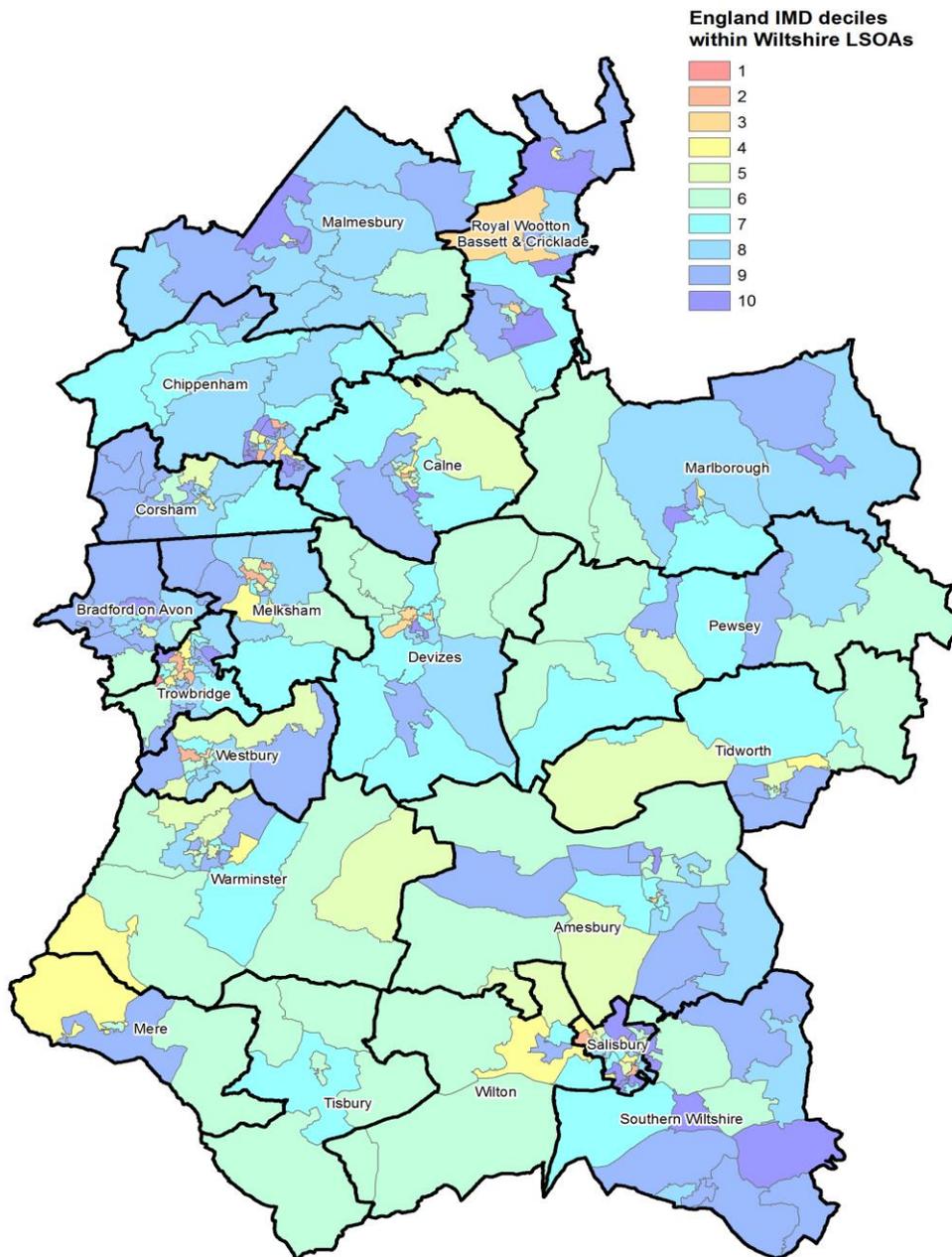
- Income
- Employment
- Health and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment.

The Indices provide scores and ranks for all 32,482 LSOAs in England for the seven deprivation domains and for a combined Index of Multiple Deprivation (IMD). This ranking allows relative levels of deprivation in Wiltshire to be compared with the rest of England. The LSOAs are ranked with 1 being the most deprived and 32,482 being the least. Wiltshire compares well against the rest of the country in terms of overall deprivation; the average IMD rank for Wiltshire's LSOAs in the Indices of Deprivation 2010 is 22,229. Wiltshire compares favourably against the national benchmark however, the county has seen an

⁷ Better Mental Health Outcomes for Children and Young People (CHIMAT and National CAHMS Support Service

increase in relative deprivation since the ID 2004. For the first time, Wiltshire now has one LSOA in the 10% most severely deprived in England; Salisbury St Martin - central. This area is now also in the 10% most deprived in England with regards to health deprivation and disability. The map shown at Figure 12 shows levels of deprivation for all of Wiltshire's LSOA's.

Figure 12; Deprivation in Wiltshire LSOAs



Relative IMD can give an indication of cumulative risk factors for poor emotional wellbeing and mental illnesses and inform areas where higher levels of service demand may be seen and, in turn locations of those services.

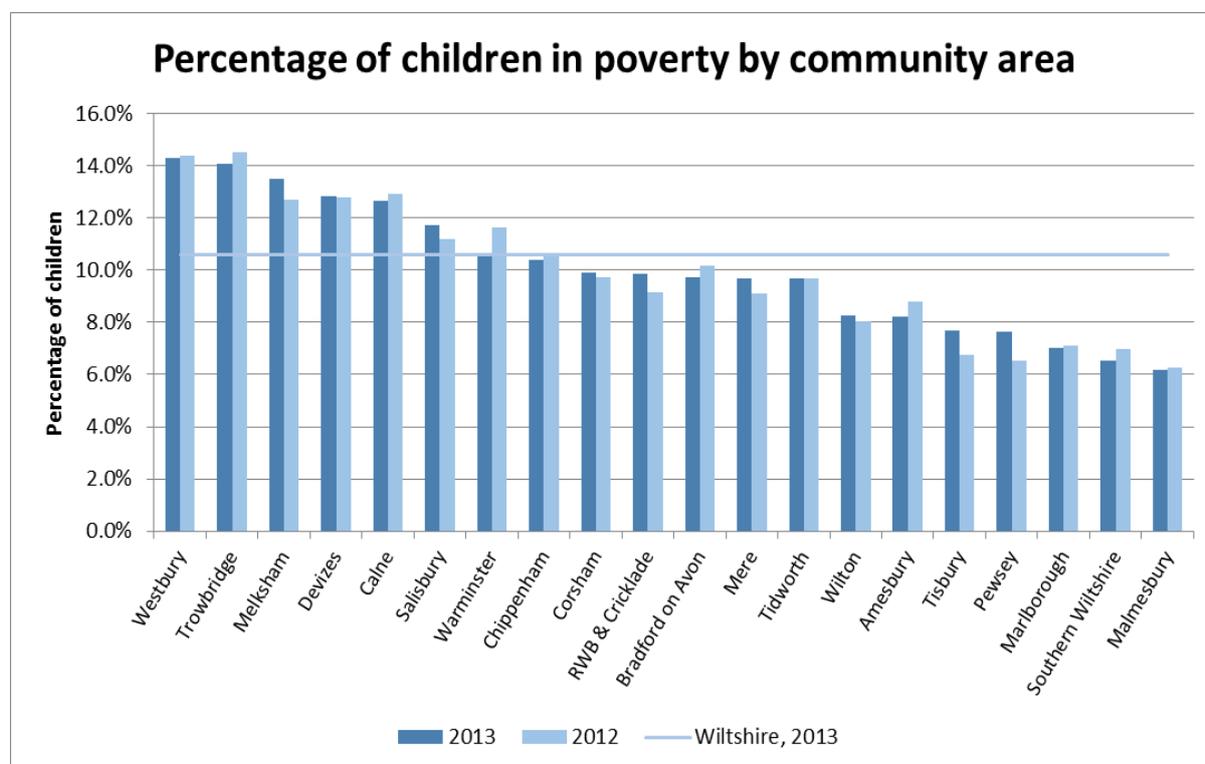
4.2.1 Child poverty

Today in the UK 20% of children, 2.3 million, live in poverty. The UK definition of child poverty is ‘the number of children (under 18 years) who live in households whose equivalised income is below 60% of the contemporary median.’ This equates to families in receipt of Child Tax Credits (CTC).

The Wiltshire Child Poverty Needs Assessment 2014 reported that an analysis by Her Majesty’s Revenue and Customs (HMRC) demonstrated that in 2011 Wiltshire had 11,610 children living in poverty, which represents 11.4% of children, according to their data, and an increase in 400 children in Wiltshire since 2008. This compares well with other local authority areas in the South West of England, but masks the fact that 28 Lower Super Output Areas (LSOA) have over 20% of the child population living in poverty. Seven LSOAs have over 30% of children living in poverty.

The percentage of children under 20 years of age living in poverty in Wiltshire has stabilised at 10.6% in 2012 and 2013 after having shown a gradual reduction since 2009. Between 2009-2013 (the most recent data available), levels of child poverty in Wiltshire have remained below that reported both regionally and nationally.

Figure 13; Child poverty in Wiltshire by community area.



There are a number of recognised health impacts of poverty on child health including low birth weight, poorer physical health outcomes and evidence shows that these, in turn, have a compounding impact on emotional and mental health throughout the life course.

4.2.2 National estimates of experiencing/witnessing domestic abuse (NSPCC)

The devastating effects of domestic violence on those experiencing it directly are well documented but far less is known about the impact on children who witness a parent or caregiver being subjected to violence. Domestic abuse can have damaging effects at any point from conception, during pregnancy and in the earliest years of life. 30% of domestic abuse begins in pregnancy (Lewis and Drife, 2001, 2001; McWilliams and McKiernan, 1993) and can be a serious source of stress that impacts not only on the wellbeing of the mother but also that of the developing foetus.

Exposure to interpersonal trauma, including witnessing domestic abuse, in the first two years of life has been shown to be especially detrimental to cognitive ability with the effects persisting at 2, 5 and 8 years of age, after controlling for socioeconomic status, mother's IQ, home stimulation and birth complications (Enrow, 2012).

A UNICEF report, *Behind Closed Doors*, found that children who are exposed to violence in the home may suffer a range of severe and lasting effects. Children who grow up in a violent home are more likely to be victims of child abuse.



These figures are based on findings from 11-17 year olds. 17.5% said they had been exposed to domestic abuse between adults in their home. In Wiltshire this could mean 7,011 children may have been exposed to domestic abuse between adults in the home.

Those who are not direct victims have some of the same behavioural and psychological problems as children who are themselves physically abused. In their 1996 comprehensive review Wolak and Finkelhor noted that 'between 11% and 20% of adults remember seeing violent partner incidents when they were young. An average of nine incidents were recalled by adults who remembered witnessing partner violence when they were growing up". It concluded that children who witness such abuse do not have a single pattern of response to their experience but that common outcomes can be behavioural (aggression, immaturity, truancy, cruelty), social (poor social skills, peer rejection, and an inability to empathize with others), cognitive (language lag, developmental delays, and poor school performance) and physical (failure to thrive, difficulty sleeping and eating, regressive behaviours, poor motor skills, and psychosomatic symptoms such as eczema and bed-wetting).

The community safety section of the Children and Young People's Health and Wellbeing survey 2015 asked questions about how safe respondents felt in their own homes and also about experience of domestic violence. When asked about safety at home, over 90% of respondents from all school types felt safe or very safe at home or the place where they live, there was little difference between the genders in regards to this. When asked about

domestic violence, the vast majority of respondents from secondary school (92%) and post-secondary school (86%) reported that they or someone in their immediate family had never or not often been the victim of domestic abuse or violence although a larger proportion of females reported incidence of domestic abuse quite often or most days compared to male respondents.

4.2.3 Persistent absence and exclusions

Evidence suggests that persistent absentees are more likely to be bullied, excluded from school and be involved in risky behaviours (experiment with drugs, alcohol etc.) than those who are not persistent absentees, and there is a clear link between absence and attainment. As detailed in other sections of this report, this will have a knock-on effect on emotional and mental health.

Fixed term exclusions data for Wiltshire for the academic year 2014-2015 shows a large disparity between primary and secondary schools in Wiltshire. There were 615 primary exclusions (1.69% of total primary school headcount) which makes Wiltshire the worst performing LA both in our statistical neighbour group (the average for the other 10 is 1.19%), and nationally (1.10%).

The secondary picture is very different. Although the general level of exclusions is much higher than in primary schools, Wiltshire (in term of the fixed period exclusion rate) was the second best performing LA (5.13%) of the eleven LAs in the statistical group (the others average 5.69%). Both figures are considerably better than the national one of 7.51%. Again the exclusions per excluded pupil and the average number of days lost per excluded pupil are broadly in line with others.

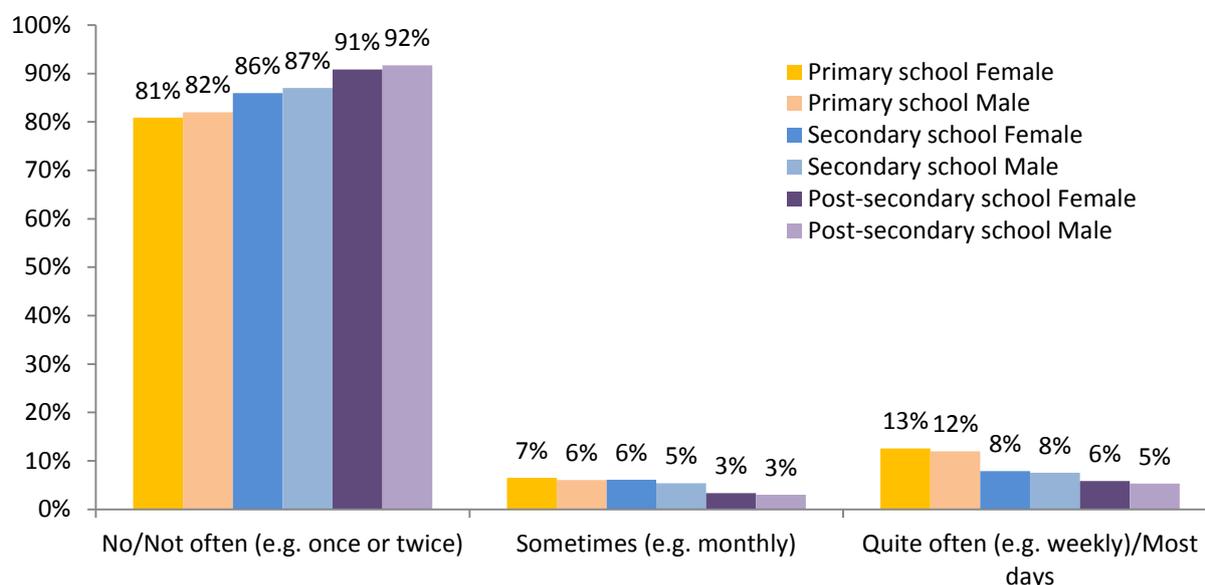
The level of exclusions from special schools varied considerably across the statistical group (average 14.57%) with Dorset at 2.64% and B&NES 41.52%. Wiltshire was ninth of the eleven with 16.61%.

4.2.4 Bullying

Children and Young People who are bullied can experience negative physical, school, and mental health issues. They are more likely to experience depression and anxiety, increased feelings of sadness and loneliness, changes in sleep and eating patterns, and loss of interest in activities they used to enjoy. These issues may persist into adulthood and can also affect those who witness bullying and those who instigate the bullying.

When respondents to the Wiltshire schools survey were asked if they had been seriously bullied in the last year the majority of respondents from all school types said no or not often (71%). In all school settings a very slightly higher proportion of females than males reported being bullied quite often or most days. These findings are similar to a national report which found that slightly more females (34%) reported that they had been bullied than boys (31%) at school in the past couple of months. When comparing the vulnerable groups to the overall school type similar patterns can be seen. All vulnerable groups in the primary school sample reported higher proportions of being bullied weekly or most days than the primary school average. In the secondary school and post-secondary school samples those offered free school meals (18% and 15%), young carers (23% and 19%) and SEN&D (20% and 13%) pupils had meaningfully higher proportions of those reporting having been bullied weekly or most days in the last year.

Figure 14: Numbers SERIOUSLY bullied in the last year by Gender



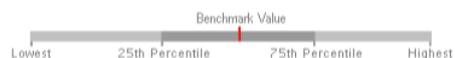
4.2.5 Population groups at risk of experiencing inequalities in EHWP&MH

There is a plethora of evidence that certain population groups are at higher risk of experiencing mental illness and disorder or low emotional wellbeing.

The Public Health England fingertips tool provides information on a range of measures considered to increase the risk of a person experiencing mental ill health and the table at Figure 15 below illustrates Wiltshire's performance across a range of these and compares to the National Averages for these proxies. It illustrates that Wiltshire compares well across these risk factors with the exception of marital break-up (percentage of adults whose marital status is currently separated or divorced).

Figure 15; Wiltshire Performance across a range of risk related indicators

Compared with benchmark: ● Lower ● Similar ● Higher



Indicator	Period	Wiltshire		Region England		England		
		Count	Value	Value	Value	Lowest	Range	Highest
Children under 20 in poverty: % of all dependent children under 20	2013	10,780	10.6%	14.2%	18.0%	5.9%		35.5%
Children under 16 in poverty: % of dependent children under 16	2013	9,670	11.2%	14.8%	18.6%	6.1%		34.4%
Child Well-being Index: average score	2009	-	79.8	-	-	-	-	-
Underweight children (Reception year): % of children	2014/15	29	0.56%	0.57%	0.96%	0.31%		2.99%
Underweight children (Year 6): % of children	2014/15	60	1.33%	1.10%	1.42%	0.56%		3.14%
Obese children (Reception year): % of children	2014/15	362	7.0%	8.6%	9.1%	4.2%		13.6%
Obese children (Year 6): % of children	2014/15	682	15.1%	16.4%	19.1%	10.5%		27.8%
Under 18 pregnancy: rate of conceptions per 1,000 females aged 15 - 17	2014	147	16.1	18.8	22.8	8.4		42.4
Under 16 pregnancy: rate of conceptions per 1,000 females aged 13 - 15	2014	22	2.5	3.3	4.4	0.7		11.9
Children providing care: % children aged <15 who provide unpaid care	2011	970	1.07%	1.21%	1.11%	0.69%		1.72%
Young people providing care: % people aged 16-24 who unpaid care	2011	1,871	3.9%	4.2%	4.8%	3.0%		7.7%
Children providing considerable care: % children aged <15 who provide 20+ hours of unpaid care per week	2011	173	0.19%	0.21%	0.21%	0.04%		0.38%
Young people providing considerable care: % people aged 16-24 who provide 20 hours + of unpaid care per week	2011	448	0.9%	1.0%	1.3%	0.5%		2.7%
Traveller children: % school children who are Gypsy/Roma	2015/16	139	0.24%	0.17%	0.30%	0.00%		1.98%
Unaccompanied Asylum Seeking Children looked after: count	2015	6	6	40	2,030	-	Insufficient number of values for a spine chart	-
Family homelessness: rate per 1,000 households	2014/15	368	1.8	1.2	1.8	0.2		8.9
Lone parents households: % of households that have lone parents with dependent children	2011	12,022	6.2%	5.9%	7.1%	4.4%		14.4%
Families out of work: % of households with dependent children where no adult is in employment	2011	5,266	2.7%	3.0%	4.2%	1.6%		10.4%
Families with health problems: % of households with dependent children where at least one person has a long term health problem or disability	2011	8,343	4.30%	4.09%	4.62%	2.59%		7.48%
Domestic Abuse: incident rate per 1,000 population	2012/13	-	9.6	14.2	18.8	5.6		30.2
Parents in drug treatment: rate per 100,000 children 0 - 15	2011/12	46	50.5	112.7	110.4	0.0		400.0
Parents in alcohol treatment: rate per 100,000 children 0 - 15	2011/12	76	83.4	120.8	147.2	34.9		452.8
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	45,283	11.9%	12.2%	11.6%	7.7%		16.3%

Compared with benchmark: ● Lower ● Similar ● Higher



Indicator	Period	Wiltshire		Region England		England		
		Count	Value	Value	Value	Lowest	Range	Highest
School Readiness: % of children achieving a good level of development at the end of reception	2014/15	3,657	66.1%	67.2%	66.3%	50.7%		77.5%
Pupils with special educational needs (SEN): % of all school age pupils with special educational needs	2015	12,101	16.8%	16.2%	15.4%	10.3%		24.3%
Pupils with a SEN statement: % of all school age pupils with a statement	2015	1,886	2.61%	2.78%	2.80%	0.89%		4.18%
Pupils with Learning Disability: % of school pupils with Learning Disability	2015	3,234	4.48%	4.83%	4.97%	1.80%		9.18%
Pupils with behavioural, emotional and social support needs: % of school pupils with behavioural, emotional and social support needs	2014	1,151	1.61%	1.70%	1.66%	0.67%		3.23%
Pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	2015	1,404	1.95%	2.24%	2.00%	0.70%		3.92%
Pupils with speech, language or communication needs: % of school pupils with speech, language or communication needs	2015	1,559	2.16%	2.28%	2.26%	0.95%		4.73%
Pupils with autism spectrum disorder: % of school pupils with autism spectrum disorder	2015	948	1.31%	0.99%	1.08%	0.41%		2.51%
Free school meals: % uptake among all pupils	2015	5,217	7.9%	12.0%	15.2%	5.2%		40.2%
Primary school fixed period exclusions: % of pupils	2013/14	589	1.66%	1.26%	1.02%	0.04%		3.37%
Secondary school fixed period exclusions: % of school pupils	2013/14	1,308	4.5%	5.9%	6.6%	1.8%		23.5%
Fixed period exclusion due to persistent disruptive behaviour: % of school pupils	2013/14	551	0.84%	0.85%	0.89%	0.22%		3.73%
Fixed period exclusion due to drugs/alcohol use: % of school pupils	2013/14	64	0.098%	0.128%	0.100%	0.020%		0.288%
1.05 - 16-18 year olds not in education employment or training	2014	560	3.8%*	4.5%	4.7%	1.5%		9.0%
Planned spend (£000s) on special schools: spend per 100,000 pupils	2015/16	5,540	£7,847	£8,845	£10,323	£0		£23,030
Planned spend (£000s) on pupil referral units: spend per 100,000 pupils	2015/16	0	£0*	£1,517	£1,983	£0		£8,461

4.2.6 Looked After Children(LAC)

Being taken into care can be an indication of experiencing neglect and/or an abusive home and family environment. As a result these children and young people may be traumatised and at risk of poorer emotional wellbeing and mental health than their peers, particularly as they may then experience separation and may find it challenging to face the ongoing experience of going into care.

A national survey carried out by Meltzer et al in 2002 on behalf of the ONS and cited in the statutory guidance found that 45% of looked after children aged 5-15 were assessed as having a mental health disorder. This figure rose to 72% for those in residential care. This compares to around 10% of the general population aged 5-15.

37% of looked after children had conduct disorders, 12% had emotional disorders (anxiety and depression) and 7% were hyperactive. Some looked after children had more than one type of disorder. When compared to children, not looked after even those from the most deprived socio-economic groups, looked after children had significantly higher rates of mental health disorders (Ford et al, 2007 as cited in statutory guidance).

A further longitudinal study of children who remained in care for at least a year found that at the point of entry into care 72% of looked after children aged 5-15 had a mental or behavioural problem. This study also included under 5's and showed that nearly 1 in 5

showed signs of emotional or behavioural problems (Sempik et al (2008), as cited in statutory guidance).

A study by Beck in 2006 in an inner-London local authority used the Strengths and Difficulties questionnaire to compare the mental health of looked after children who move placement frequently. The study found that young people who had moved placement three or more times in the last year were three times more likely to have a 'probable' psychiatric diagnosis. They were also significantly more likely to report deliberate self-harm in the last six months compared to those who had moved placement less frequently.

The number of children looked after in the county fluctuates daily; the 12 month average figure for June 2015 to May 2016 was 405 children. If the percentages identified in the national studies identified above were conferred on the Wiltshire population we could have the following numbers experiencing the difficulties outlined:

- 182 assessed as having a mental health disorder (45%)
- 150 with conduct disorders (37%)
- 49 with anxiety disorders (12%)
- 28 with hyperactivity

LAC as a population are much more vulnerable to risk factors found in the general population. A gap has been identified in information about numbers and types of LAC's referred to CAMHS. To address this and increase understanding of the reasons for referrals and any action that may need to be taken, analysis is currently being undertaken and a report will be produced towards the end of 2016.

4.2.7 Special Educational Needs and Disability (SEND)

There are an estimated 0.7 million disabled children in the UK (ONS 2007). Boys are twice as likely as girls (69% to 32%) to be categorised as disabled. Children under five are less likely to be known to be disabled and there are equal numbers of young people in age range 5-11 years old and 12-18 years old (TCRU, 2008). Nationally, ONS estimated that there are 42.3 per 1,000 children who are disabled (ONS, 2007).

Children with a long-term physical illness are twice as likely to suffer from emotional or conduct disorder problems (DH 2011a). Although there is reason to suspect that people with physical disability will experience a higher rate of mental health conditions compared to people without disabilities, there is a lack of literature in this area, especially amongst children with disabilities (Hagiliassis et al, 2005).

A review of the evidence on the emotional wellbeing of young people by the University of London (TCRU, 2007) found the following links between learning disability and mental health:

- children with learning disabilities were three to four times more likely to have behavioural problems than peers without a disability;
- there is a 40% prevalence of diagnosable mental disorder within the learning disabled population of children, young people and adults; for children and young people with severe learning difficulties, the incidence rate is three to four times higher than in the general population;
- the learning disabled living in urban and deprived communities are at particular risk of emotional wellbeing and mental health problems

- one in ten of all children with referred mental health problems had a learning disability, and 50% of those lived in poverty.
- 25-30% of the increased risk of emotional and behavioural problems among children with learning difficulties was related to households with very low income;
- the presence of intellectual disabilities should be considered a highly significant risk factor for the development of some specific forms of psychiatric disorders (conduct disorders, anxiety disorders, attention deficit and hyperactivity disorder/hyperkinesia and pervasive developmental disorders);
- Higher levels of absenteeism have been reported for school children with special educational needs, especially those with learning disabilities and emotional disturbances (Redmond and Hosp, 2008 in Ubido et al 2012).

Wiltshire data shows that there are currently 1897 children with an SEND Statement or Education Health and Care (EHC) Plan and 276 (14.5%) of these have a primary coding of Social, emotional and mental health. There are 1,277 with SEN support where social, emotional and mental health is identified as the primary need.

4.2.8 Young Carers

Caring for someone is challenging whatever age you are, for young carers this can be compounded, and they can forget the importance of looking after themselves. It can be hard for friends and teachers to understand exactly what a young carer has to do each day and why they need to do it. Opportunities to employ 'protective factors' can be extremely limited and therefore the likelihood of young carers experiencing poor emotional wellbeing or mental illness or disorder increases over that of the general population.

The Wiltshire Young Carers Strategy reports that the 2001 Census identified at least 175,000 young carers in the UK; 13,000 of whom provided care for more than 50 hours per week. The average age was 12 and more than half lived in one-parent families and almost a third cared for someone with mental ill health. It is widely believed that the figure of 175,000 is a vast underestimate.

The 2011 census reports that 970 0-15 year olds and 1,871 16 to 24 year olds provided unpaid care, but again it is highly likely that this figure is an underestimate.

4.2.9 Children of military families

A report produced by the Wiltshire Community Foundation in 2014⁸ estimated that military personnel and dependants constitute over 20% of the total population in Tidworth, Bulford, Durrington, Upavon, Warminster East, Lyneham, Nettleton and Colerne wards, with this figure reaching 75% in Tidworth. The population in the most strongly military influenced wards is dominated by younger adults (particularly males) and these areas also show higher than average proportions of pre-school and primary school children.

White et al (2011) conducted a systematic review of studies examining the impact of parents' deployment to Iraq or Afghanistan on their children's health and well-being. Nine American studies were included which showed an increase in emotional/behavioural problems, but these were suggested to be associated with concurrent factors, notably parental mental ill-health. Since that review, two further American studies have reported that during deployment, spouses and children report more emotional and behavioural symptoms

⁸ https://wiltshirecf.org.uk/sites/default/files/0210_WCF_MainReport_FINAL%20PDF%20SP.pdf

(Aranda et al, 2011)¹², greater use of health services and reliance on medication (Larson et al, 2012).

In January 2011, 4,893 children and young people in our schools (7.6%) have a parent in the armed services. A number of military personnel have been injured whilst on active duty and their families find themselves in a caring role once they return. The Young Carers and Adult Carers services are addressing this need currently with integrated funding through the Carers Trust (formerly Princess Royal Trust for Carers).

4.2.10 Young People who are ‘not in employment, education or training’ (NEET)

Being in education, employment and training between the ages of 16-18 increases a young person’s resilience and is essential to their future employability and wellbeing (ChiMat 2012). Being NEET between the ages of 16-18 is a major predictor of later unemployment, low income, teenage parenthood, depression, and poor physical health. A study by the Princes Trust found that Young people aged 16-25 not in work are less likely to be happy (reported in Freer et al, 2010, p.243).

The numbers of 16-18 year olds in this category in Wiltshire for 2015 is shown below, the rate for the County is below the England average but the proportion who are not known is above national figures.

	16-18 year olds known to the local authority	16-18 year olds NEET [1]		% whose activity is not known
		Estimated number	%	
Wiltshire	16,110	710	4.4%	*[2] 12.9%

*Indicates that the proportion of 16-18 year olds whose current activity is not known is more than 50% above the England average of 8.4%. This could mean that the actual number and proportion of young people NEET is higher than figures quoted above. National 16-18 year old average for NEET is 6.5% (2015).

4.2.11 Census demographics for Young People from Black and Minority Ethnic backgrounds

There is evidence to suggest that different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments.⁹ In general, people from black and minority ethnic groups living in the UK are more likely to be diagnosed with mental health problems and furthermore more likely to be admitted to hospital and have a poor outcome from treatment often disengaging from mainstream mental health services. These differences may be explained by a number of factors, including poverty and racism. They may also be because mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs.

⁹ The Mental Health Foundation www.mentalhealth.org.uk

It is likely that mental health problems go unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English. The table below gives some demographic data relating to the ethnic group of people with a long-term health problem or disability.

ONS demographics - Long-term health problem or disability by general health by ethnic group by sex by age.

Ethnic Group	All categories: Ethnic group	White	Mixed/multiple ethnic group	Asian/Asian British	Black/African/Caribbean/Black British	Other ethnic group
Age						
All categories: Age	470,981	454,971	5,568	6,178	3,228	1,036
Age 0 to 15	90,968	86,087	2,527	1,337	775	242

4.2.12 Asylum seekers and refugees

Asylum seekers and refugees arriving in the UK or any other host nation may have a very limited knowledge of the health care and welfare systems of that nation (Crawley, 2010). They are likely to experience poverty, dependence and a lack of cohesive social support arriving in a new country to seek refuge. Children and young people could be living with adults that are unfamiliar to them. They may have experienced the death of a close family member or friend, or be unaware of their current circumstances leading to an increased sense of vulnerability (Connelly et al. 2006). Such factors can undermine both physical and mental health. Health is culture dependent (Burnett & Peel, 2001) and both what a young person is able to talk about in relation to their health, and the symptoms they present with may be influenced by their cultural background and current circumstances. For example, in some cultures having stomach aches or headaches or a low mood, may be their way of discussing anxiety or depression. This is experienced locally and this lack of a shared language (including with interpreters) around mental health can cause delays in accessing appropriate treatment.

On top of the basic health needs, an asylum seeker is likely to face a restrictive, complex and overloaded asylum system in an alien society and psychological distress is widespread (Burnett & Peel, 2001). Communication is also likely to be a barrier in accessing health care as many GP surgeries or other health care settings do not make interpreters available leading to complex health problems being undetected. The new government mental health strategy noted that the rates of mental health problems in particular migrant groups, and subsequent generations, can be higher than in the general population. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries (DH, 2011a).

There are differences between asylum seekers and refugees both in experience and status in terms of rights to benefits, health care, housing etc. Refugees may have experienced more trauma overseas and in terms of the nature of their 'flight' (often unplanned and sudden) but will be receiving more support on arrival in UK than asylum seekers.

4.2.13 Children from Gypsy, Roma and Traveller families

It has been noted that Gypsy, Roma and Traveller children have the worst education outcomes of any ethnic group in the UK and high rates of school exclusion (Ridge, 2010). Ridge found that many Gypsies and Travellers say that the racism they experience in the school and education system often leads to young people dropping out of school. This was found to be most marked in secondary school. This is likely then to have an important impact on social inclusion, achievement and mental health of Gypsies, Travellers and Roma right across the life course.

There is a shortage of literature on the mental health needs of travelling children. A study of the health status of adult Gypsy Travellers in Sheffield found that the proportion reporting any problems with 'nerves' or 'feeling fed up' was significantly greater than a matched comparison group of urban deprived residents (35% compared to 19%) (Van Cleemput and Parry, 2001). Van Cleemput and Parry used this terminology rather than 'anxiety and depression' which they found may have been unfamiliar to some of the gypsy and traveller community.

There is no robust local data regarding the population of gypsy and traveller children and young people in Wiltshire and this may be something that needs to be considered for a future piece of work. We were able to locate data about the number of under 18 year olds living on the five council operated sites in the county (snapshot as at August 2016) and there are 122, with by far the largest percentage of these (66%) being located on site in Thingley near Corsham.

4.2.14 Young People and Substance misuse

Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. Young people who smoke cannabis by the age of 15 are 3 times more likely to develop serious mental health illnesses including schizophrenia (Arseneault et al, 2002 in Freer et al, 2010).

The Wiltshire Schools Health Survey asked questions around the level of involvement in risky behaviours which included questions on substance misuse.

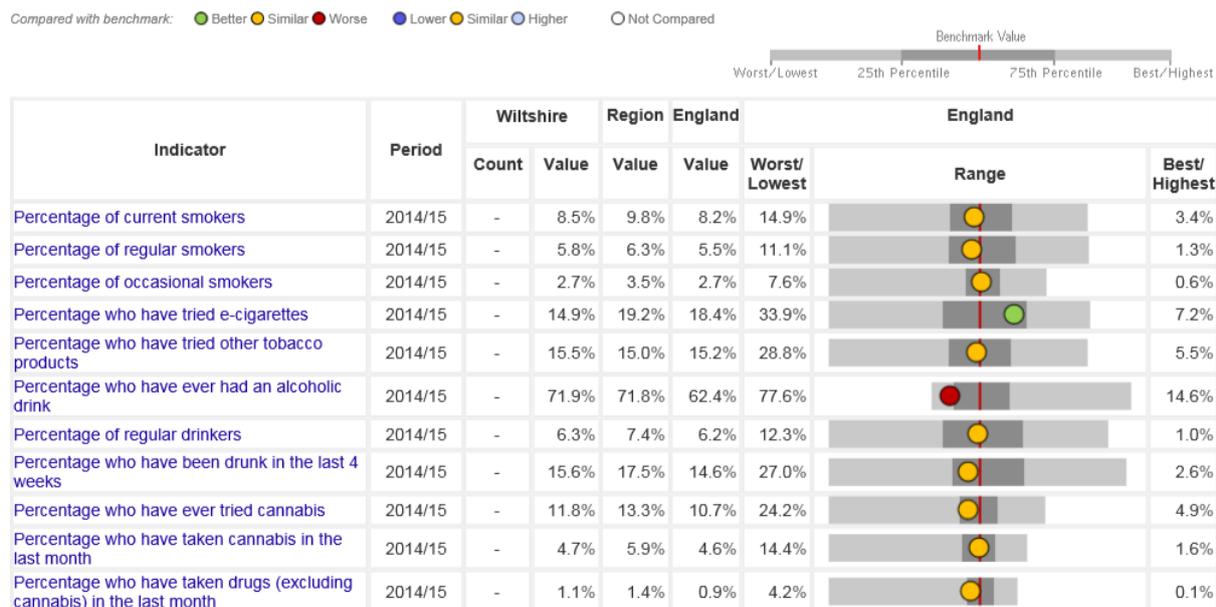
When asked about alcohol consumption in the 'Risky Behaviours' section of the Children and Young People's Health and Wellbeing survey 1% of primary school respondents, 6% of secondary school respondents and 29% of the post-secondary school sample reportedly drink alcohol weekly or most days. A majority of respondents from all the school settings normally get their alcohol from the home with their parents' permission. The second most common way for the secondary school respondents to obtain alcohol is through friends (18%). 15% of post-secondary school pupils mainly get their alcohol at a pub or club.

The What About YOUth Survey (WAY) provides further insight into drinking behaviour among teenagers and can provide a robust sub-national breakdown (local authority level) as well as further demographic breakdowns (e.g. by age, gender and deprivation level). Results revealed that 62% of respondents had drunk an alcoholic drink, with 6% being classified as regular (weekly) drinkers. Fifteen percent of respondents said that they had been drunk in the previous four weeks. Girls were more likely than boys to have had a drink (65% and 60% respectively) and to have been drunk in the past month (girls 18%; boys 12%) but were slightly less likely to be regular drinkers (girls 7%; boys 6%). Young White people were much more likely to have had an alcoholic drink than those from a Black and Minority Ethnic group background (72% compared with 27%).

Patterns of drinking also varied by deprivation group with young people in the least deprived areas being more likely to have had an alcoholic drink (66%) and to be regular drinkers (8%) than those in the most deprived areas (44% and 4% respectively). This is similar to the pattern observed for adult drinkers.

The WAY survey shows that, for Wiltshire the percentage of young people who have never had an alcoholic drink is lower than both the national and regional average figures, meaning that more young people have had an alcoholic drink locally than the national and regional average. This is illustrated in the table below

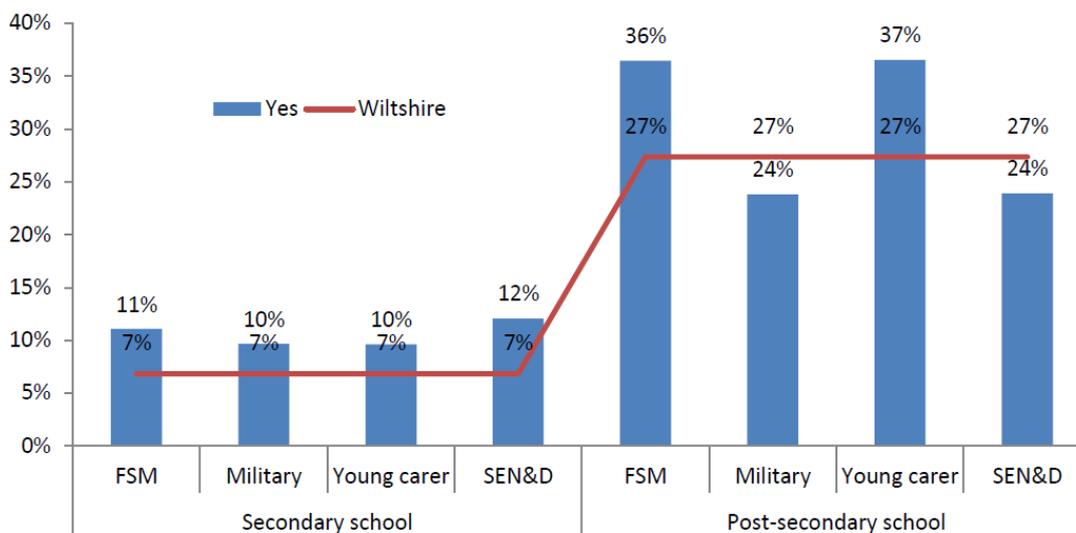
Figure 16; WAY Survey Results for Wiltshire



When asked about substance misuse in the Wiltshire survey, less than 1 in 10 secondary school respondents reported trying illegal drugs. In the post-secondary school sample 27% of respondents reported having tried illegal drugs. A National survey of 15 year olds also found that 24% had taken drugs (Health and Social Care Information Centre, 2015). In the Wiltshire school health survey 14% of 15 year olds reported trying illegal drugs.

As shown in Figure 17 below there are a slightly larger percentage of respondents from the vulnerable groups in the secondary school sample who have tried illegal drugs than the Wiltshire average. In the post-secondary school sample a very large proportion of young carers and those receiving free school meals appear to be more susceptible to trying illegal drugs (37% and 36%) than any other vulnerable group and the Wiltshire average.

Figure 17: Have you ever tried illegal drugs? Vulnerable Groups



Substance misuse treatment services in Wiltshire are provided by Motiv8 which is the commissioned young persons' substance service through DHI (Developing health and independence) which is a charity based in Bath. The service works with young people from the ages of 11 – 18 both within the community and family homes. Referrals are received from Education, YOT, Social services, CAMHS, G.P's, Care homes, School nurses, Relatives and self-referrals. The service works in partnership with other young people services so the young people have the best opportunities to make a difference to their lives.

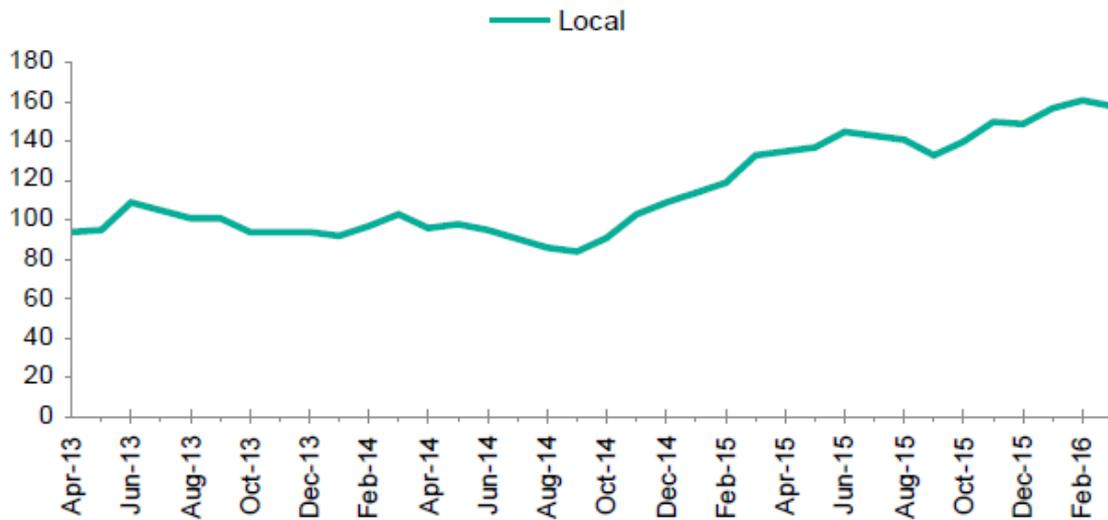
The service engages young people in structured and non-structured treatment and also work with the police regarding community resolutions for young people. In the past year the service has engaged with over 400 young people in education through harm reduction workshops. Recently taken 12 young people were taken away on an activity residential to promote wellbeing and to promote a substance free weekend.

Figures relating to those in treatment are illustrated below.

NOTES: The graphs below show the rolling 12 month trends for young people (YP) since 1 April 2013.

- Number of young people in specialist substance misuse services within the community on a rolling 12 month basis.
- Substances cited are from any episode in the past 12 months prior to the month shown (any citation in drug 1, 2 or 3). Percentages are of all YP in treatment.
- Completion rates (planned exits) are out of all exits for the rolling 12 month period shown.
- Re-presentation rates are out of all planned exits for the re-presentation period.

Numbers in treatment



Numbers of young people in treatment in Wiltshire have been on an upward trend (19% increase over the last 12 months) against a declining picture nationally (7% decrease over the same period). Wiltshire has a full outreach service investing in prevention and engagement and thus are picking up more of the hidden population which may provide an explanation for this increasing trend.

Planned exits are when a young person leaves the service in a planned way meeting the goals through their care plan. They would be drug free or an occasional user though the main drug they came in to treatment using should be reduced. In Wiltshire our percentage of planned exits are higher than the national average at 84% (national 79%), however representation for those with planned exits is also higher at 8% (national 6%).

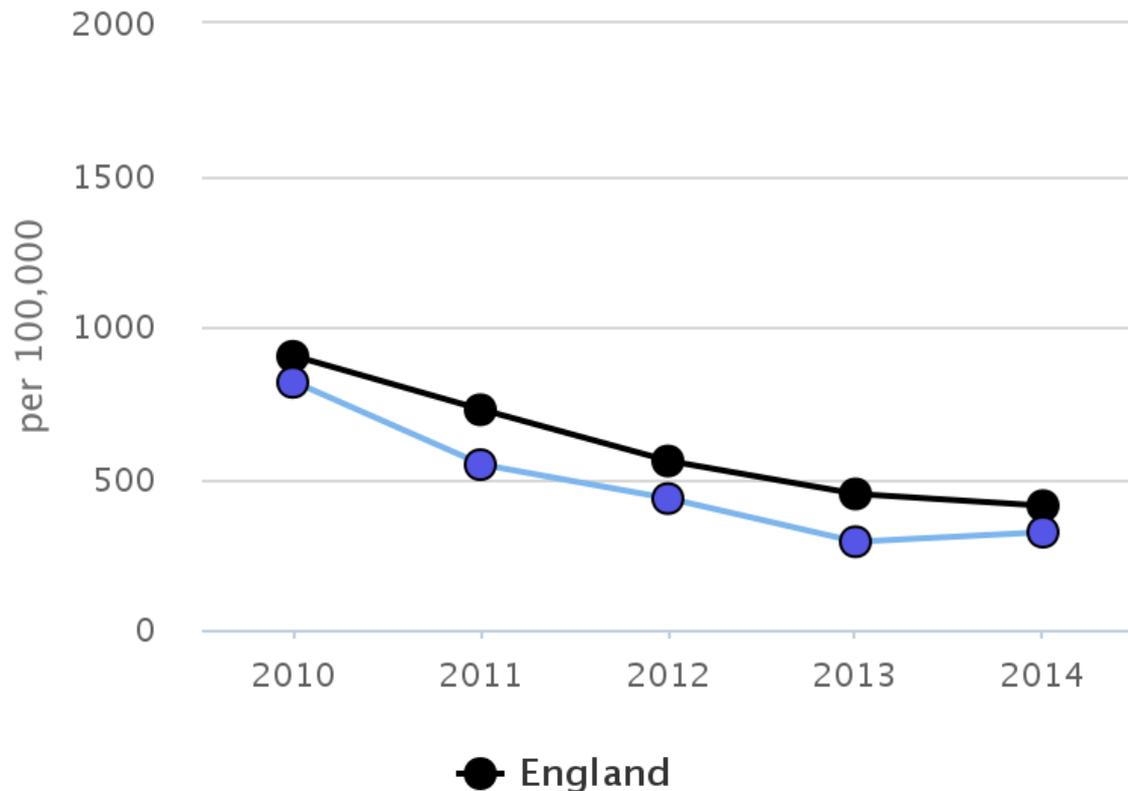
The age profile for those in treatment is shown below and is fairly consistent with the national picture with the exception of the 15 year old age bracket where Wiltshire has a higher proportion (32% local 26% national) and the 17 year old bracket where the proportion is lower than national (21% local 26% national). For the period April 2015 to March 2016 there were 42 females (39.3%) and 65 males (60.7%) commencing treatment.

When considering wider vulnerabilities, 26% were categorised as having a mental health problem and 28% were self-harming, both of these figures are higher than the national level.

4.2.15 Youth Offending:

Young offending as measured by First Time Entrants to the Youth Justice System (age 10-17) rates per 100,000 population has decreased locally to 322 per 100,000 from a rate of 813 in 2010. There is a decreasing national trend as shown in the figure below and Wiltshire compares well with the picture in England overall.

1.04 – First time entrants to the youth justice system – Wiltshire



The correlation between young people involved in the criminal justice system and mental health and emotional wellbeing needs has been documented in a number of studies over the years and most recently highlighted in the research published by Young Minds: 'Same Old... the experiences of young offenders with mental health needs.' (Young Minds 2013). A study from the National Office of Statistics found that 95% of young people in young offenders' institutions aged between 16 and 20 years had a mental disorder and many of them had more than one disorder (Lader, et al, 1997). More specific to Sheffield, the Youth Justice Service undertook an audit in February 2014 which found that over, a two year period, 87% of cases sampled had an identified emotional or mental health need. Within the audit the most common behaviour related to these needs was the presentation of anger and aggression. This is undoubtedly one of the reasons for violence being a top cause of young people entering the criminal justice system. The second and third most common presentations of mental health and emotional wellbeing needs were suicide attempt/ideation and self-harm, showing that these young people pose a risk to themselves as often as others.

In 2015/16 the Youth Offending service managed 276 intervention programmes and 199 Young People. The intervention programmes included voluntary support programmes, parenting programmes, referral orders, youth rehabilitation orders and a small number of detention and training/custody orders. The Youth Offending service has dedicated mental health workers seconded to the team, and where a mental health need is identified, the intervention will include mental health input.

4.2.16 Early Years Risk Factors

There are lots of factors which can put babies and young children and greater risk of experiencing poor emotional or mental health. They relate strongly to the factors highlighted earlier in this section in that having a parent who experiences any of the identified risk factors (either now or in the past) can mean that the baby or infant is more likely to be adversely affected too.

One major factor is having a parent having who themselves has been maltreated in childhood as outlined in a Parliamentary Working Group report in 2015¹⁰

“Since a significant proportion of the population has been maltreated – 20% or more according to both national and international surveys – and many of these parents have large families, this represents a high proportion of infants potentially at risk for this reason. Maltreated mothers are at elevated risk for ante- and postnatal depression, relationship problems, being with violent partners and teenage pregnancy. Maltreated fathers are at elevated risk of committing domestic violence. Fortunately, while a minority of people who were maltreated in childhood do go on to commit abuse or neglect, the majority do not. Protective factors such as a relationship with a loving sibling, parent, grandparent or partner come into play.”

Babies are disproportionately vulnerable to abuse and neglect. In England they are seven times more likely to be killed than older children. Around 26% of babies (198,000) in the UK are estimated to be living within complex family situations, of heightened risk where there are problems such as substance misuse, mental illness or domestic violence. 36% of serious case reviews involve a baby under one.¹¹

Other factors include family breakdown / loss of a parent, children in out of work families, housing need, and maternal / paternal mental health.

¹⁰ Building Great Britons: Conception to Age 2 (All Party Parliamentary Working Group, Feb 2015) – pge 7 –

¹¹ (1001 Critical Days Cross Party Manifesto, Nov 15)

5. Prevalence of Poor Emotional Health and Wellbeing and Mental Health

There is limited up to date and comparable prevalence data for mental disorders and local data is dependent on extrapolation from national estimates. Many of the measures illustrated below have only recently been brought into use and it is not, therefore, possible to consider trends. This means that it is important to consider this prevalence information alongside the data about risk factors and service provision detailed in other sections of this report.

The Public Health England fingertips tool provides information on a range of prevalence measures for mental health. The table at figure 17 below illustrates Wiltshire's performance across a range of these and compares to the National Averages. The table at Figure 18 below shows mental health admissions

Figure 18; Prevalence of mental ill health

Indicator	Period	Compared with benchmark: Lower Similar Higher Not compared																	
		England	South West region	Bath and North East Somerset	Bournemouth	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Estimated prevalence of any mental health disorder: % population aged 5-16	2014	9.3*	8.9*	8.4*	9.0*	9.6*	9.1*	8.8*	8.7*	8.7*	7.9*	8.6*	9.7*	8.9*	9.0*	8.5*	9.2*	9.6*	8.5*
Estimated prevalence of emotional disorders: % population aged 5-16	2014	3.6*	3.5*	3.3*	3.4*	3.7*	3.5*	3.4*	3.4*	3.4*	2.9*	3.3*	3.7*	3.4*	3.5*	3.3*	3.6*	3.7*	3.3*
Estimated prevalence of conduct disorders: % population aged 5-16	2014	5.6*	5.3*	4.9*	5.4*	5.8*	5.5*	5.3*	5.2*	5.2*	4.8*	5.1*	5.9*	5.3*	5.4*	5.1*	5.6*	5.8*	5.0*
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2014	1.5*	1.5*	1.4*	1.5*	1.6*	1.5*	1.4*	1.4*	1.4*	1.3*	1.4*	1.6*	1.5*	1.5*	1.4*	1.5*	1.6*	1.4*
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	2013	*	-	3879*	3499*	8931*	7169*	10412*	4798*	8335*	23*	2418*	5146*	1868*	6945*	3946*	2885*	1628*	6079*
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	2013	*	-	4080*	3672*	9303*	7600*	11141*	5250*	8825*	23*	2546*	5534*	1979*	7394*	4251*	3038*	1737*	6589*
Children who require Tier 3 CAMHS: estimated number of children <17	2012	-	-	630	610	1655	1920	2610	1430	2265	10	775	945	545	2010	1060	880	460	1920
Children who require Tier 4 CAMHS: estimated number of children <17	2012	-	-	30	25	70	80	110	60	95	5	35	40	25	85	45	40	20	80

Figure 19; Mental Health Admissions

Child admissions for mental health: rate per 100,000 aged 0 -17 years 2014/15 Crude rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	10,132	87.4	85.7	89.1
South Central NHS region	475	60.0*	-	-
NHS Aylesbury Vale CCG	26	57.7	37.7	84.6
NHS Bath And North East S...	34	88.8	61.5	124.1
NHS Bracknell And Ascot C...	17	54.4	31.7	87.0
NHS Chiltern CCG	33	45.5	31.3	63.9
NHS Gloucestershire CCG	87	69.1	55.3	85.2
NHS Newbury And District...	13	51.1	27.2	87.3
NHS North & West Reading...	8	33.9	14.7	66.9
NHS Oxfordshire CCG	88	60.7	48.7	74.8
NHS Slough CCG	28	71.1	47.3	102.8
NHS South Reading CCG	8	27.8	12.0	54.7
NHS Swindon CCG	46	90.1	65.9	120.1
NHS Wiltshire CCG	60	61.4	46.8	79.0
NHS Windsor, Ascot And Ma...	10	30.8	14.8	56.7
NHS Wokingham CCG	17	49.2	28.6	78.7

Source: Hospital Episode Statistics (HES) Copyright © 2014, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Figure 19 above shows the inpatient admission rate per 100,000 population for young people aged 0 to 17 years and is based on Hospital Episode Statistics for people admitted with a primary diagnosis code of mental health or behavioural disorders. Local data for 2014/15 indicates that the actual number of admissions to psychiatric beds within Oxford Health for Wiltshire CCG area is 20.

Figure 20; Hospital admissions Self Harm and self-poisoning

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

Indicator	Period	England	South West region	Bath and North East Somerset	Bournemouth	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
MH&WB: Hospital stays for self-harm	2014/15	191.4	249.2	233.4	358.3	292.3	228.6*	247.9	250.1	255.5	*	245.5	246.8	253.9	236.9	186.9	352.3	314.3	197.6
Child admissions for mental health: rate per 100,000 aged 0 -17 years	2014/15	87.4	86.0	90.1	58.5	81.6	82.7*	106.2	82.9	70.3	0.0*	61.2	100.6	94.2	84.5	117.4	92.6	163.5	57.7
Hospital admissions as a result of self-harm (10-24 years)	2014/15	398.8	537.9	422.0	593.2	514.1	383.7*	565.1	515.5	526.0	*	600.7	473.6	686.5	605.8	432.4	911.5	923.9	478.3
Young people hospital admissions for self-harm: rate per 100,000 aged 10 - 24	2010/11 -12/13	352.3	418.4	459.3	433.2	425.7	408.9	397.0	343.7	406.7	*	302.1	450.6	418.0	445.9	329.9	572.3	555.2	476.7
10.05 - Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) (Persons)	2014/15	51.7	67.2	74.7	32.7	74.9	74.7	72.3	43.0	76.1	*	58.7	69.0	58.8	70.4	53.8	87.8	71.9	67.5
10.05 - Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) (Female)	2014/15	58.6	80.2	82.5	47.6	90.1	89.2	84.1	47.7	97.6	0.0	75.6	76.9	81.0	74.1	67.0	96.2	69.3	86.1
10.05 - Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) (Male)	2014/15	45.0	54.4	68.3	19.0	60.4	59.9	60.4	38.0	55.2	*	41.6	61.2	37.1	66.7	41.0	79.5	74.2	49.3
Adults in treatment at specialist drug misuse services: rate per 1000 population	2013/14	5.0	4.6	6.0	8.6	10.5	3.6*	2.7	4.0	3.7	*	4.9	8.1	2.9	3.1	3.8	4.2	7.2	2.2
Adults in treatment at specialist alcohol misuse services: rate per 1000 population	2013/14	2.3	1.7	2.6	1.8	1.6	2.1*	2.2	2.1	1.3	*	1.4	2.1	1.4	0.7	0.8	2.5	4.5	1.2
Adults in treatment at specialist drug misuse services: rate per 1000 population	2014/15	4.8	4.3	5.2	7.7	9.6	3.6*	2.6	3.3	3.7	-	4.8	8.3	3.0	3.2	3.5	4.6	6.2	2.6
Adults in treatment at specialist alcohol misuse services: rate per 1000 population	2014/15	2.1	1.6	2.1	1.7	2.0	1.4*	1.3	1.9	1.3	-	1.5	2.0	1.6	1.0	0.8	2.5	4.2	1.7

Wiltshire has a higher rate of hospital admissions for both self-harm and self-poisoning by alcohol than national rates.

6. What our children and young people say

There has been considerable amount of engagement with children, young people and their parents and carers during 2015 during the development of the Children and Young People's Transformation Plan for mental health and wellbeing and the refresh of the Children and Young People's Plan. When scoping for this Needs Assessment was undertaken, a decision was made that existing consultation material would be utilised rather than undertaking a new consultative process in order to avoid duplication and make best use of time and resources.

Two young people attended our HNA engagement event and contributed to knowledge about data sources, available services and what works. A summary of the previous consultation is contained in the following paragraphs.

6.1 Children and young people told said that the following things were important

The Council has a Voice and Influence team who conduct regular consultation with children and young people. The key issues raised regarding emotional wellbeing and mental health for children and young people from consultation carried since March 2012 are:

- Better mental health education in school is needed.
- Staff teachers do not know what to do if a student is suffering with a mental health difficulty.
- Cyber bullying is on the increase. There is a need for better e-safety education.
- Isolation and depression – young people need to be able to get to people and places easily.
- It needs to be made easier for young people to be able to talk to someone in confidence, ask for help and get advice about their emotional wellbeing.
- Physical activity and clubs (positive activities) – more things to do to keep young people emotionally healthy.
- Help to build young people's self-esteem and confidence.
- Stigma – the stigma associated with mental health means that young people do not feel able to speak out if they are having difficulties with their mental health. More needs to be done to raise awareness and tackle stigma
- Staff / teachers are the most likely people who young people will go to (after friends) so those staff need to know what help is available and what to do.
- Publicity – knowing what is available and knowing where to get help as soon as you think you need it (early help).
- School counselling – knowing it is there and being able to access it.
- Staff need to have the skills to challenge bullying – there is a question about whether staff utilise training and actually do challenge instances of bullying.

It was noted in the Wiltshire Children and Young People's Trust Emotional Wellbeing and Mental Health Strategy (2014-2017) that children and young people have not mentioned GPs or parents / carers / families in their key priorities.

Additional concerns were raised by young people during consultation for the Emotional Wellbeing and Mental Health Transformation Plan including:

- Help and support should be easier to access, as close to home as possible
- Better information about local support and services and how these can be accessed

Feedback has additionally been received from CAHMS service users and their families and revealed similar messages to those outlined above; the majority felt that there was not enough information about mental health generally or about what was available locally. There was divided opinion about how easy it was to access services and it was felt that priorities for the future should include things like days out/activities for young people, support groups, more staff and shorter wait times, and ways of asking questions anonymously.

6.2 People who work with or care for children (including parents and carers)

The views of around forty professionals from across the whole system (including education, health, social care and the voluntary and community sector) were gathered at a local workshop in 2014. Areas for development were highlighted as follows:

- Lack of knowledge about who does what and what is available
- Pathways and access to services not clear
- Promotion of services available locally and nationally
- Schools need to put emotional wellbeing and mental health on their agenda e.g. signing mental health charter
- More positive mental health strategies / tools for young people to use (including self-help tools). More investment should be made in promotion, prevention and early intervention
- Thresholds and access criteria need to be clearer including training and guidance for referrers
- Services are patchy and there are geographical gaps
- More access to support from Primary CAMHS and school counselling services
- Promotion of Youth Mental Health First Aid Training
- Better multi-agency communication and support where parents have mental health issues that impact on the child and result in vulnerability
- More support for schools to support those young people who don't meet threshold for specialist service
- Help GPs and schools to have a better understanding of CAMHS
- Improving transitions to adult mental health services
- More direct involvement of tier 2 and universal colleagues in discharge planning
- Lack of capacity among the school nursing service in Wiltshire is having a direct impact on the increasing number of referrals into PCAMHS
- There is a gap in support for under 5's and those with autism
- Improved capacity and support is needed in schools
- Agencies need to work better together, particularly re: parents with mental health problems
- Vulnerable children and young people require better care and support during key transitions
- There should be a focus on building resilience in children and families
- More needs to be done to tackle bullying.

A survey of parents/carers (March 2015) undertaken by Wiltshire Parent Carer Council revealed concerns in relation to CAMHS, including ineffective joint working, underrated customer experience, poor access and long waiting times.

These views have been used to inform the development of new/pilot services within the Transformation Plan and will continue to inform the commissioning of services.

7. Service Mapping

7.1 Overview

As described in the introduction on page 7 Child and Adolescent Mental Health Services (CAMHS) in Wiltshire are currently delivered through an operational delivery model with four distinct tiers. These services are available for 0-18 year olds who are referred by any professional working with the child.

This tiered system was first introduced across the country in the 1990's and defined the system in terms of the services that provide the care. This approach has been widely questioned and the Future in Mind report levelled the criticism that this often means that children and young people have to fit the services, rather than the services fitting the changing needs of the child or young person. The tiers model can unintentionally create barriers between services, embedding service divisions lead to fragmentation of care. This can mean that children and young people fall into gaps between tiers and experience problems with transitions between different services.

Future in Mind advocated a move away from a tiered approach towards models which create a seamless pathway of care and support, and which address the need for the diversity of circumstances and issues with which families and young people approach mental health services. One suggestion is to utilise the Thrive Model as an approach to structuring services.¹² The Thrive Model is a conceptualisation that addresses the key issues outlined above and is aligned to emerging thinking on payment systems, quality improvement and performance management. The model outlines groups of children and young people and the sort of support they may need and tries to draw a clearer distinction between treatment on the one hand and support on the other, as opposed to an escalator model of increasing severity or complexity. The model is illustrated below:



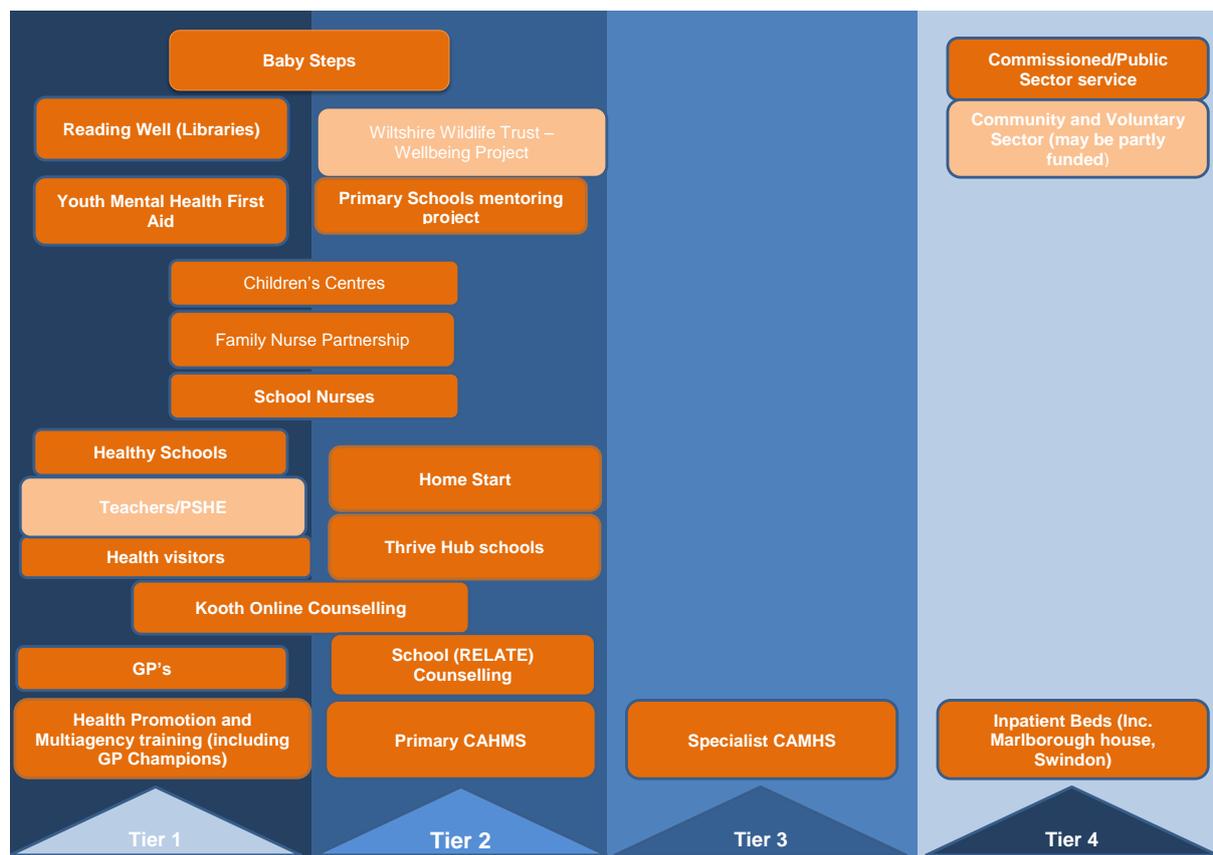
The information about services in this section has been grouped by Tiers as that is how the majority of our services are currently structured and categorised. However, the Transformation Plan for Children and Young People's emotional wellbeing and mental health

¹² THRIVE
The AFC–Tavistock Model for CAMHS

has implemented new services and processes which will assist a move towards a more holistic approach to commissioning and structuring services which meet the needs of children and young people in the County. The new services are highlighted in the section below and include Online Counselling, Thrive Hubs and GP Champions. Further new initiatives will be introduced during the life of the Transformation Plan.

In the diagram below we have illustrated the main services available in the county and have attempted to show how some of them work across more than one tier. The text in the following sections provides further detail about the provision of these services. It is acknowledged that there is a vast array of other service providers who are delivering interventions and guidance for children and young people across the county, and we have captured those we are aware of in Appendix 1. For the majority of these we do not currently have information about demand levels and this may be an area for future work. It is likely that if these organisations ceased to deliver the services they currently provide, a gap in provision may emerge.

Figure 20: Service Wall – key services for children and young people’s emotional wellbeing and mental health



7.2 Description of each service by Tier

7.2.1 Current Tier 1 Services:

As outlined in the overview above, the information about services in this section has been grouped by Tiers as that is how the majority of our services are currently structured and categorised. The aspiration going forward is to move away from this approach and towards the thrive model; it is intended that any future iterations of this needs assessment will reflect this approach to service structure.

General practice (GP) is the cornerstone of primary care and a key point of contact throughout the life-course for people experiencing mental ill health. They will assess, liaise as required with the primary care liaison service and CAMHS, prescribe medication, signpost or refer on to other services and monitor progress, particularly if there are safeguarding concerns. Communication between maternity services, health visiting and general practice during the perinatal stage is crucial.

GP Champions will be established in each locality across Wiltshire. With close links to CAMHS they will have a key role in providing information and advice to other GPs on child and youth mental health issues in their local area.

Youth Mental Health First Aid, Mindfulness etc: Skilling up of the children's services workforce through health promotion and multi-agency training (Mindfulness, Youth Mental Health First Aid, PSHE courses and CAMHS school training)

Early Years:

Health Visitors and midwives play a central role in promoting positive perinatal mental health, recognising perinatal and infant mental health problems, ensuring women are referred appropriately, promoting secure attachment and breastfeeding and supporting women and their partners to achieve the best outcomes for themselves and their babies.

7.2.2 Current Tier 1 spanning over to Tier 2

Early Years:

Baby Steps is a targeted perinatal education programme for disadvantaged families including those suffering from mild mental health problems in pregnancy (both parents) – delivered from 6 sites around Wiltshire.

Family Nurse Partnerships (FNP) is a preventative programme for vulnerable, first-time mothers aged nineteen and under at the time of conception and offers intensive and structured home visits delivered by specially trained Family Nurses working from early pregnancy until the child reaches two years of age. The programme uses in-depth methods to work with young parents on attachment, relationships and psychological preparation for parenthood.

Children's Centres are open access and their core purpose is to improve outcomes for young children and their families as well as reducing inequalities.

Parental and infant mental health can be supported through a variety of things like baby massage, 1:1 parenting support, Stay and play sessions and Evidence Based Parenting Programmes.

School Nurses: The school nursing service runs drop in clinics for senior school students in the 29 state schools in Wiltshire. These drop-in clinics are generally run at lunchtime and are for students to attend with any health or other issues that they may need advice or support with. The drop in style service is something that is seen nationally as a positive model for school nursing services to address young people's health and wellbeing issues.

Kooth Online Counselling is a free online service that offers emotional and mental health support for children and young people. Young people can choose to stay anonymous and can utilise a drop in online chat session with a counsellor or therapist or book a one to one session

THRIVE Hubs: this is a school based model which brings together professionals that have a role in supporting the emotional wellbeing and mental health needs of pupils both in and out of school (e.g. school pastoral staff, parent support advisors, school counsellor and nurse etc.). Building on the success of our healthy schools programme Thrive Hubs will create a setting where mental health is as important as physical health. Utilising the expertise of CAMHS, the Hubs will provide a one stop shop within a community for information, advice and support (including the provision of evidence-based parenting programmes) for children with emotional and mental health difficulties. Each Hub will be supported by a specialist CAMHS liaison worker who will be based regularly on the secondary school site providing consultation and advice as well as up skilling other professionals. The Hubs are will be located in pilot schools which were selected based on areas where child poverty is greatest (Abbeyfield Chippenham, John of Gaunt Trowbridge, Matravers Westbury, John Bentley Calne, Stonehenge School Amesbury, Sarum Academy Salisbury).

7.2.3 Current Tier 2 Services:

Early Years:

Maternal mental health is supported by adult services including Primary Care Liaison Service (PCLS), hospital mental health liaison, and IAPT. Perinatal mental health champions have been identified within each of the 3 PCLS locality teams.

Primary CAMHS offers assessment and short-term interventions for children and young people with mild to moderate mental health problems. The primary service also includes the provision of counselling through a partnership with Relate.

Counselling: The local charity Relate is the main provider of community and school based counselling services in Wiltshire. Time to Talk provides counselling in a number of primary schools for children aged 6-11 years. Talkzone supports young people aged 7-18 years who are experiencing emotional distress, with counselling provided at home, in school or other community setting. Many schools also purchase counselling services directly from Relate or other organisations or employ their own counsellors.

Wiltshire IAPT: Provide a range of therapies available for anyone over the age of 16 who is registered with a GP practice in Wiltshire. These include courses to help people manage stress, anxiety and depression, Mindfulness courses, coping with low mood and depression, beating low self-esteem, anger awareness, assertiveness and building confidence.

7.2.3 Current Tier 3 Services:

|

Specialist CAMHS provide:

- Multi-professional community services for children and young people with more severe, complex and persistent mental health difficulties.
- Learning Disability CAMHS for those young people with complex needs
- Family Assessment and Safeguarding Service (FASS) – a specialist multi-disciplinary service providing child and parenting assessment and treatments for families where there is a high risk of severe parenting problems.
- Therapeutic support for family placements - a Clinical Psychologist and Child Psychotherapist are seconded wholly to placement services within Wiltshire Council Children's Services to work with foster carers and adopters to promote placement stability.
- Outreach Service for Children and Adolescents (OSCA) - targets priority groups of young people aged 11-18 years (up to 25 for care leavers) whose needs are more complex and are less likely to engage with traditional CAMHS. There is a particular focus on Looked After Children. Evidence based approaches (e.g. Dialectical Behaviour Therapy) are used along with appointments in community settings, by phone and using FaceTime. The service offer routine appointments 7 days a week over extended hours.
- Community Eating Disorder Service - highly specialised multi-disciplinary eating disorder teams provide evidence-based treatment to children and young people with eating disorders. This includes an outreach service for home treatment which operates 7 days a week assisting with meal support.
- Emergency on call service 365 days a year, 24 hours a day. The service is staffed by qualified senior mental health professionals, Consultant Child and Adolescent Psychiatrists and managers. It responds to emergency mental health presentations.
- Oxford Health offers local children and young people access to a range of evidence-based/NICE approved treatments and interventions including:
 - Cognitive Behavioural Therapy (inc. Dialectical Behavioural Therapy and CBT-E)
 - Multi-Family Therapy
 - Systemic Family Practice
 - Interpersonal Therapy

Maternal mental health is supported by adult mental health services provided by AWP

7.2.4 Current Tier 4 Services:

The Inpatient Service in Swindon is called Marlborough House and is a self-contained unit (containing 12 inpatient beds) offering both inpatient and day patient facilities including an on-site school.

Maternal mental health services at Tier 4 is provided by AWP

7.2.5 Additional services for specific groups of CYP

Specific services for **young carers** in Wiltshire are provided by Spurgeons, the national children's charity and include:

- 1 to 1 mentoring and peer support
- Getting involved in activities in your community
- Trips and activities to give you a break.
- Someone to talk to, especially if someone close to you dies, and support and advice around things like self-esteem, confidence, bullying, anxiety and stress.

- Extra support when you move from primary to secondary school, and when it's time to move on from school to something else like further education, training or finding a job.
- Someone to speak up for you and make sure that your views are heard and respected by the adults that are making decisions about you
- If you're a carer aged between 15-25 years you can also access adult carer support services

The Learning Disability Service offers assessment for children and young people with Special Educational Needs and/or Disabilities.

8. Demand on Emotional Health and Wellbeing and Mental Health services

8.1 Overview

Nationally, the prevalence of mental health problems in children and adolescents was last surveyed in 2004¹³. This study estimated that:

- 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
- 7.7% or nearly 340,000 children aged 5-10 years have a mental disorder
- 11.5% or about 510,000 young people aged between 11-16 years have a mental disorder

This means in an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder¹⁴. The most common diagnostic categories were conduct disorders, anxiety, depression and hyperkinetic disorders.

The rising prevalence of mental health disorders in children and young people places pressure on current services and rising demand can lead to longer wait times. Future in Mind outlined that NHS benchmarking data and recent audits revealed increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems and a consequent rising length of stay in inpatient facilities. Since 2011, evidence appears to indicate that these difficulties are the result of financial constraints accompanied by rising demand.

8.2 Referrals to CAHMS services in England

The Children's Commissioners lightning review of access to CAHMS in May 2016 was commissioned in order to cast light on potential issues existing within mental health service provision for vulnerable young people. The data collected for the review highlighted that in England in 2015:

- About 1 in 2501 children were referred to CAMHS services by professionals, their family/carers or self-referrals (about 40% of referrals came from GPs).

¹³ Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

¹⁴ YoungMinds Mental Health Statistics. Available at: www.youngminds.org.uk/training_services/policy/mental_health_statistics

- On average, 28% children and young people referred to CAMHS were not allocated a service. However, this varied widely across England.
- 79% of CAMHS stated that they imposed restrictions and thresholds on children and young people accessing their services – meaning that unless their cases were sufficiently severe they were not able to access services.
- In some areas, waiting times were extremely long (the example being one CAMHS in the West Midlands where the average waiting time was 200 days).

A survey carried out in 2004 by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm¹⁵.

8.3 Demand on Services in Wiltshire

8.3.1 CAMHS Referrals

In recent years demand for CAMHS services in the county has been rising although a slight reduction was seen in the total number of referrals for 2015/16. The Transformation Plan highlighted that the majority of the referrals were from GP's and this remains the case. The tables below show data about the number and source of referrals, the outcome of the referral with regard to whether the referral was accepted or not, caseloads and age/gender split.

Referrals Made

	2012-13	2013-14	2014-15	2015-16
Routine referrals into Single Point of Access	1892	2062	2138	1974
All referrals	2828	2740	2742	2734

Outcome of referral

Referral outcome	No of referrals (2014-15)	%	No of referrals (2015-16)	%
Accepted into Tier 2	797	29%	820	30%
Not accepted	610	22%	501	18%
Signposted to Tier 3	1268	46%	1391	51%
Waiting decision	67	2%	22	1%

The table above shows that 18% of CAMHS referrals made in 2015/16 (22% for 14-15) were not accepted as they did not meet the criteria for CAMHS services. A CCG audit project in August 2015 found that high numbers of rejected referrals came from GP and universal settings, an indication that there was potential confusion about referral pathways and services available. It should be noted that recently an Access Coordinator has been recruited and 'not accepted' referrals are now contacted to discuss their problem and either directed to a service that can help them. This should mean that, moving forwards, everyone

¹⁵ Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). Mental health of children and young people in Great Britain, 2004.

referred to Wilts CAMHS should get help, either by Oxford Health, or another suitable service.

Waiting Times

In line with national trends outlined in the overview above, Wiltshire has seen a significant increase in wait times since 2012/13. Over the same period, levels of referrals have remained relatively steady and therefore reasons for this increase in wait times need to be examined. The reasons could relate to increase in complexity of cases being referred but that appears to be only anecdotal. The length of time from referral to assessment is one of the performance indicators monitored regularly as part of the CAMHS contract.

Referrals assessed within:	2012-13		2013-14		2014-15		2015-16	
	Tier 2	Tier 3						
4 wks	91%	96%	61%	88%	27%	63%	15%	64%
8 wks	N/A	97%	N/A	94%	65%	84%	41%	82%
12 wks	N/A	N/A	N/A	N/A	89%	95%	65%	90%

Source of referrals

Referrals into Wiltshire CAMHS come from a wide range of sources, the most common being from GP's. Children and young people can self-refer but currently only in certain areas of the county.

Source of referral (all referrals)	2014-15	2015-16
Accident & Emergency	19	69
Carer	3	1
Community-based paediatrics	163	182
Drug treatment service	2	3
Education	294	260
GPs	1248	1212
Hospital-based paediatrics	284	61
Children's Social Care	118	0
Other	528	292
Police	5	8
Self-referral	60	43
Specialist Nurse	8	0
Youth Offending Team	10	3
LA		65
Trust		535
TOTAL	2742	2734

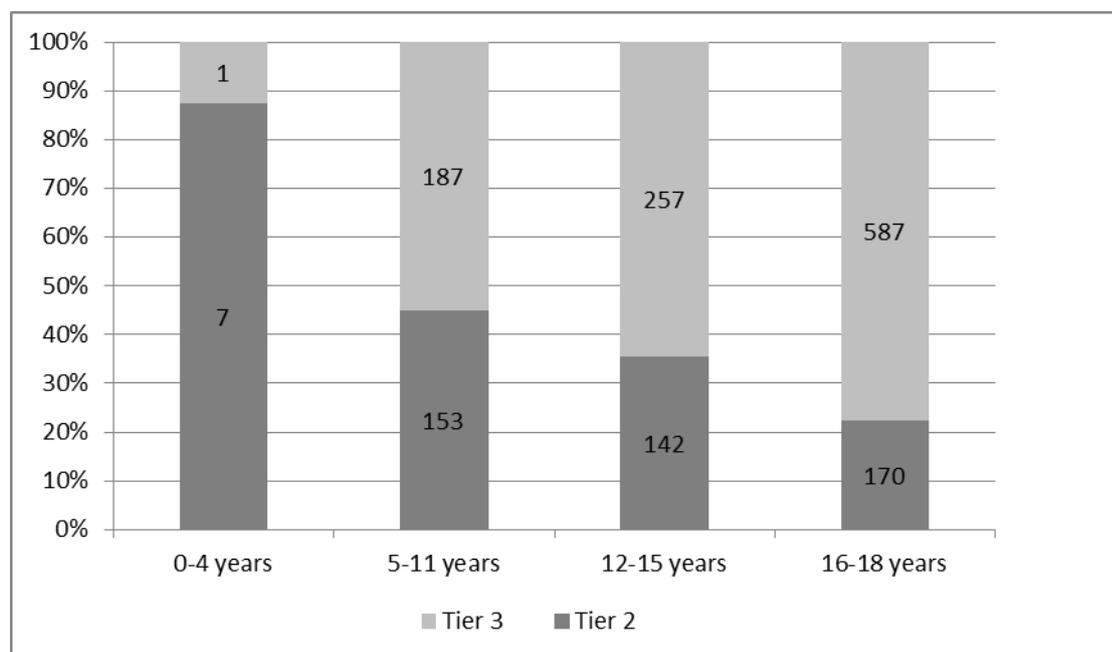
Service caseloads

The average service caseload in the County has risen since 2013/14. The data below only gives an overall service caseload, York and Lamb (2005) estimated capacity calculations based on providing an epidemiologically needs based service for 0 to 16 year olds. These suggest that current specialist CAMH services are overburdened and that team capacity should be set at 40 new referrals per whole time equivalent (WTE) per year to enable specialist CAMHS to respond quickly, flexibly and offer evidenced based treatments for long enough for them to be effective. This may be something that needs to be analysed further.

	2012-13		2013-14		2014-15		2015-16	
	Tier 2	Tier 3	Tier 2	Tier 3	Tier 2	Tier 3	Tier 2	Tier 3
Caseload average	264	755	324	794	342	781	340	967
No of direct contacts	1569	9752	3060	11396	3666	12048	2515	12007

Age breakdown of caseload (snapshot as at March 2016)

The largest number cases in current caseloads are in the 16 to 18 year age bracket followed by the 12 to 15 year age group. When planning for future service capacity it will be important to take into account the predicted growth in these age group populations as outlined on page 6. There may be an increase in the number of infant cases following the introduction of routine screening for parent-infant attachment by the health visiting service in April 2016 as part of the infant emotional and mental health pathway.



Transition to Adult Services

In Wiltshire, children and young people who are receiving CAMHS services and are approaching their 18th birthday with ongoing mental health needs will usually be transferred across to the adult service provider AWP. This is recognised to be a difficult transition and some young people will not meet the threshold for the adult equivalent services.

In 2015/16 the Oxford Health was subject to a CQUIN which stipulated an audit be conducted of patients who transitioned to adult services in AWP which included numbers referred to AWP and accepted. The Audit showed that out of 35 referrals from Wiltshire only 17 (49%) were accepted onto adult services.

For patients who were over 18 and didn't meet the criteria for adult services, they were usually helped as much as possible and directed towards services like IAPT, or ADHD/Autism services in Bristol.

Further data about transition to adult services will be gathered as part of the adult Mental Health Needs Assessment which will be produced during the autumn and winter of 2016.

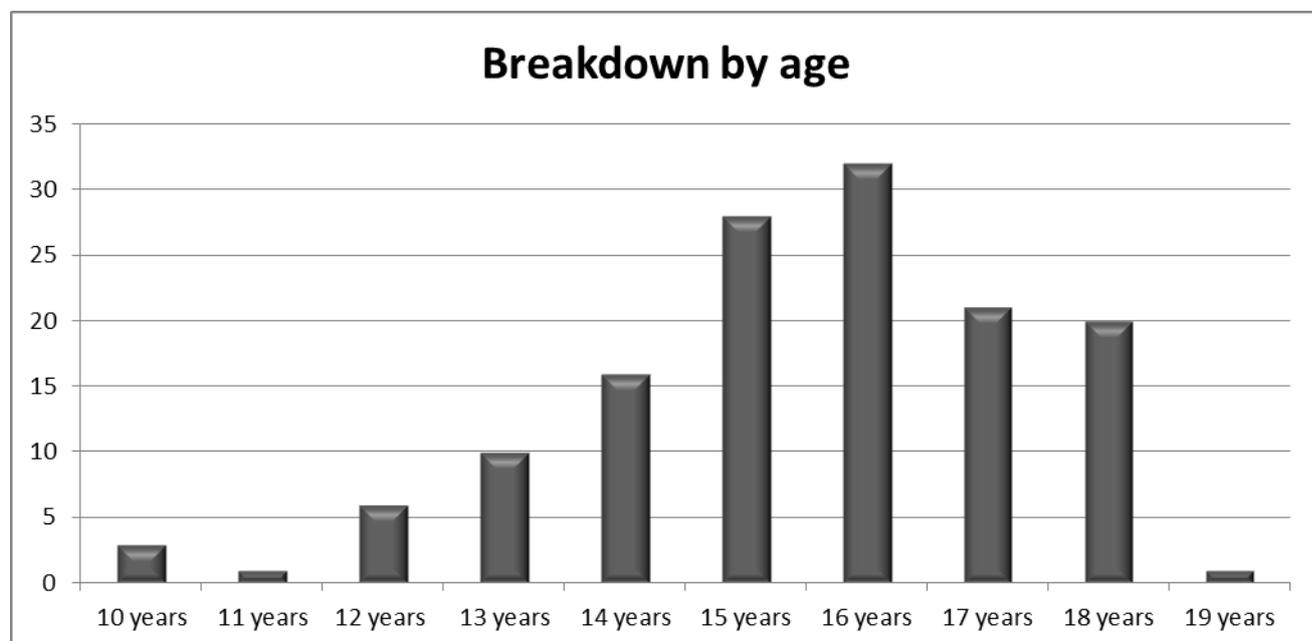
Specialist Eating Disorder Services

The specialist eating disorder service has seen an increase in the number of referrals year on year since 2013 and an increase in wait times since 2013/14. The breakdown by age is illustrated in the chart at Figure 21. The referrals are predominantly female (88%) and classify their ethnicity as White British (83%)

	2012-13	2013-14	2014-15	2015-16
Number of referrals	48	84	93	138

	2012-13	2013-14	2014-15	2015-16
Mean wait time	36 days*	12 days	15 days	17 days

Figure 21; Eating Disorder Service – Breakdown of referrals by age



School Nurse drop-ins

Weekly School Nurse drop in sessions are provided in all state secondary schools in the county although there have been some breaks in service in certain schools since the

instigation of the new core service in 2011. A re-audit of school nurse drop in sessions was conducted in September 2014 and has provided some data about levels of demand as shown in the following paragraphs. Attendance at the drop-in varies according to location, and it was felt that those which had been established the longest had the highest level of attendance.

The audit was conducted for 4 weeks and in this period there were 143 attendees; 103 girls (72%) and 40 boys (28%). 90 of the attendees were asked to attend again. 92 had attended before and 55 were attending for the same issue as the previous visit. Of all these, 18 were going to be referred to another service – 5 to CAMHS, 4 to Pastoral Support and the rest to a mixture of GP, Social care, No worries etc.

The year group that attended most was year 8 (34%) followed by year 10 (28%), year 7 (24%), year 9 (10%), year 11 (6%). This potentially means drop ins across Wilts have approximately 1400 attendees in a school year.

The analysis of the data shows various reasons for attendance and with many children there was more than one issue. The highest category for attendance was EMH&W (Emotional Health and Wellbeing). Of the 122 reasons for attendance listed, 35% were classed as Emotional Health and Wellbeing. The next highest was self harm 12%, followed by 10% general health advice.

Kooth Online Counselling

The new online counselling service is provided by Kooth and has been running since April 2016 and data from the first quarterly report has been provided for this section. It is, of course, too early to accurately assess potential demand on this service, particularly as it is only currently being actively promoted in the THRIVE hub schools and a few others. The data does however give a useful snapshot of how young people are utilising the service.

The service had 195 new registrations between April and June 2016 (with no returning users as it was the first quarter in Wiltshire). The largest proportion of these young people came from Amesbury area and 64% of these were female.

The service provides chat counselling, support sessions and support messages and in total during April-June 2016 young people received in total 133 chat counselling and support sessions and 448 support messages.

Young people are asked whether they would like to set a goal and the most common achieved goals were around emotional exploration and getting further help. Anxiety/Stress was the most common presenting issue and 98% of young people who responded said that they would recommend the service to a friend. The most frequent age of the participants was 14-15 (39%) followed by 13-14 (30%) and 16-17 (22%).

9 Conclusion

9.1 Key Themes Identified

This needs assessment has highlighted key themes in relation to the emotional wellbeing and mental health of children and young people in Wiltshire, populations at risk, prevalence of mental ill health, services and the level of demand upon them.

Some of the key things highlighted are:

9.1.1 Population

The population of children and young people in some age brackets is projected to change in some age brackets. As outlined in section 2.1 above, the number of 10-14 year olds is projected to grow by 12.5% over the next 5 years before starting to decline. There is expected to be a decrease in the number of 15-19 year olds in the shorter term followed by an increasing trend in this age group between 2020 and 2028. The numbers for 0-4 and 5-9 year olds are expected to decline and then plateau by 2019 and 2022 respectively.

Recommendation: These changes in the population will need to be considered when developing or commissioning services to ensure that they meet this projected level of need. This should include particular emphasis on the forthcoming growth in the population of military families due to the imminent Army Rebasing Programmes

9.1.2 Protective Factors

Protective factors in line with the Five Ways to Wellbeing have been identified in this report; implementation of strategies in line with these protective factors can have a positive impact on the emotional wellbeing of children and young people. In some areas, responses to the Children and Young People's Health and Wellbeing Survey indicate that young people may not be benefitting from some of the things that can act as protective factors. This is particularly true when considering use of social and digital technology and the extent to which this may impede a young person's ability to 'Connect'. We have not actively run a campaign or promoted the Five Ways to Wellbeing locally to children and young people locally although there have been some relatively low profile national campaigns

There is no local data about attachment and potential attachment difficulties which represents a gap in understanding.

Recommendations:

- Consider implementing a campaign to promote the Five Ways to Wellbeing and perhaps run activities to compliment the approach.
- Consider further research on attachment for example exploring the feasibility of utilising data gathered as part of the two to two and a half year review.

9.1.3 Risk Factors and Populations at Risk

Section 4 of this needs assessment identifies risk factors and populations at risk of poor emotional and mental health. There are some areas where the data is of limited use because it provides insufficient detail and in order to fully understand the wider picture it would be worth considering sourcing additional data locally for the following:

- The Public Health fingertips tool indicates that we have a higher than average rate of couples experiencing relationship breakdown and this is something that it may be worth undertaking further research into.
- We also have a higher than average rate of children and young people with SEND and it is important to ensure we are correctly targeting information about and interventions for emotional and mental health at this, (and other at risk) population groups. The Wiltshire SEND Strategy 2016-2019 identifies as a priority:

“To have in place a series of data collection, monitoring and evaluation processes reporting to a defined hierarchy of meetings and committees. To ensure that practice and delivery is evaluated and informed by children, young people and their families. To ensure children are safe from harm. “

The data collection and monitoring elements of this priority will help to improve understanding about the emotional and mental health needs of this group of children and young people.

- Ensure that the current data gathering for CAMHS referrals of Looked After Children informs service planning for this group
- There appears to be a gap in our knowledge about the children of military families and methods of improving our understanding of the needs of this group should be considered.
- Wiltshire has a higher than average number of NEET children and young people in the ‘unknown’ category. This is something that there may be benefit in investigating further to enable us to improve our understanding of this group of people who are likely to be disenfranchised and thus at greater risk of experiencing many of the other factors associated with poor emotional and mental health.
- The data we were able to locate about ethnicity for children and young people health for Wiltshire was not sufficient to give any comprehensive picture.
- A better understanding of the mental health needs of the asylum seeker, refugee and gypsy and traveller population would be helpful.

9.1.4 Prevalence of Poor Emotional Health and Wellbeing and Mental Health

There is limited prevalence data available nationally and this position is mirrored in Wiltshire. There are national moves to improve the availability of data as outlined in Future in Mind and progress on this should be monitored.

A few areas are identified in the PHE Fingertips tool where Wiltshire appears to have higher than national average estimated prevalence amongst children and young people aged 16-24 and it would be useful to understand more about these:

- Eating Disorders
- ADHD
- Children who require Tier 3 services
- Children who require Tier 4 services

Current information about hospital admissions for children and young people is limited although current data does indicate that Wiltshire has a higher than average rate of admissions to hospital for self-harm and self-poisoning by alcohol. A research proposal to look at avoidable numbers of children and young people in Wiltshire attending A&E departments and being admitted to hospital is currently being developed by Public Health and may help to address this gap in information.

9.1.5 Service Mapping and Service Demand

The service mapping exercise for this needs assessment has been as comprehensive as time allowed and has drawn on the knowledge of people attending the engagement event held for this purpose. In the time available we have not been able to ascertain levels of demand/use for all of those services identified and this may be something to be considered for the future.

Concern has been widely expressed about transition to adult services for those approaching age 18, limited data has been gathered during this needs assessment, and further data will be gathered as part of the adult Mental Health Needs Assessment which will be produced during the autumn and winter of 2016. This will contribute to our understanding about the broader interface between children and young people's and adult mental health as well as issues like the impact of the mental health of an adult on the children who are close to them.

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Appendix 1 – Service Mapping detailed list

Name of service	Scope What does it provide and to whom?	Contact	Geography (County wide or specific area(s)?)
Wiltshire Healthy Schools	Key messages, audit tool and accreditation for schools. Linked to local school support and training. Includes emotional wellbeing and mental health as one of the core themes www.wiltshirehealthyschools.org	Nick Bolton	Wiltshire
Emotional Literacy Support Assistant (ELSA)	ELSA is a programme of training and ongoing support for teaching assistants in primary and secondary schools who work with children with social, emotional and mental health difficulties. The rationale is that training and supporting school staff can develop a school community's internal capacity to provide support based on continuing relationships with consistency over time. ELSA was established in Wiltshire in September 2010.	Kate Hindley	Wiltshire (maybe some other counties?)
Reading Well	Reading Well for Young People (RWYP) is a new public library scheme to help 13-18 year olds manage their mental health, wellbeing and resilience using recommended reading (evidence based). www.wiltshirehealthyschools.org/core-themes/emotional-health-and-wellbeing/reading-well/	Sarah Hillier Development Librarian - Children and Young People 01373 865602 sarah.hillier@wiltshire.gov.uk	National scheme. Wiltshire provision launched July 2016 (now ongoing)
Online counselling from Kooth	Online counselling and related online services for secondary school pupils from 2016. www.wiltshirehealthyschools.org/partnership-projects/kooth/	Michaela Bisogno Integration & Participation Worker, B&NES & Wiltshire 07958 290552/ 0845 3307090 mbisogno@xenzone.com	Wiltshire (National service commissioned by various LAs)
Wiltshire School Mental Health Network	Online and face to face cpd for school staff and others who work with young people (August 2016 - summer 2017). Funded following a successful bid to Health Education England. Input and training from a range of local and national organisations.	Organised by Dr Pooky Knightsmith from the Charlie Waller Memorial Trust. (Local contact:	Wiltshire & Swindon (also Brighton & Medway)

	www.wiltshirehealthyschools.org/partners/hip-projects/cwmt-school-mental-health-network/	Nick Bolton)	
RSPH Youth Health Champions	<p>Training for secondary school pupils and (school staff lead) to enable them to lead on school health campaigns. In Wiltshire this includes Mental Health campaigns – funded by Public Health.</p> <p>www.wiltshirehealthyschools.org/partners/hip-projects/rsph-youth-health-champions/</p>	(Local contact: Nick Bolton)	Just working with 2 Wiltshire secondary schools at the moment
Thrive Hubs	<p>6 secondary schools who are receiving additional support around mental health over 5 years.</p> <p>This support and good practice will be shared with other schools in subsequent years.</p> <p>www.wiltshirehealthyschools.org/core-themes/emotional-health-and-wellbeing/healthy-mind-healthy-life/thrive-hubs/</p>	Nick Bolton	Wiltshire
www.onyourmind.org.uk	<p>Not yet live – hopefully by Sept 2016</p> <p>New website for Wiltshire young people with information about mental health and links to further support. (Sections also planned for parents and professionals)</p> <p>The posters and some materials can be seen at the link below for now:</p> <p>www.wiltshirehealthyschools.org/core-themes/emotional-health-and-wellbeing/healthy-mind-healthy-life/</p>	Judy Edwards	Wiltshire
Personal, Social, Health and Economic (PSHE) Education	<p>Programme of universal and targeted education delivered by teachers to children and young people in all schools.</p> <p>Includes a focus on emotional and mental health e.g. in primary schools use of the SEAL programme materials.</p>	<p>Individual schools</p> <p>Supported by many local and national partners.</p> <p>(County adviser:</p>	Wiltshire and beyond.

	Many local and national materials available to schools, including Wiltshire and other south west schemes of work, focusing on EW&MH.	Nick Bolton)	
Home-Start Kennet	In home weekly support, from professionally trained volunteers – for up to 6 months. Referred families (mostly HV referral) with at least one child under 5. Universal/ CAF/CIN stepping down families supported. Needs assessed, reg. reviewed, family journey tracked.	Be Crompton 01672 569457 homestartkennet.m@btconnect.com	Marl, Pewsey, Devizes, Tidworth, Chippenham/ Calne Community areas. High numbers Military/veteran families supported.
Mandala therapeutic services, delivered by Barnardo's SPECIALIST	Range of creative and family therapies, including psychotherapy, play, art and drama therapy for children who have experienced trauma, including therapeutic parenting support for foster carers and adoptive parents.	Michael Hammond Mandala Service Manager Michael.hammond@barnardos.org.uk 01823270938	County-wide – spot-purchase and commission options
ARCH (Achieving Resilience, Change and Hope) Project An evidence-based Emotional Resilience Brief Intervention delivered by Barnardo's TARGETED	Barnardo's delivers individual and groupwork with children and young people aged 2 to 14 years who have emerging emotional and behavioural difficulties, and also with their parents/carers. ARCH is based on children's resilience framework which focuses on six areas, which are key protective factors for child mental health.	Gwenda Perry Business Development AD Gwenda.perry@barnardos.org.uk 01179375506 Jenny Lewis Wiltshire Children's Services AD Jenny.lewis@barnardos.org.uk 01179247118	Barnardo's model which could be a standalone service or integrated into CAMHS
Protective Behaviours An evidence-based programme based on personal safety delivered by	The approach is based in CBT and can be used with children and young people with additional needs; children and young people with little understanding of risk or danger; and children and young people who have been in difficult and dangerous circumstances (experienced trauma).	Jenny Lewis Gwenda Perry	Barnardo's model which could be a standalone service or integrated into CAMHS

Barnardo's TARGETED			
Upside Online Barnardo's online and web-based counselling service UNIVERSAL/TARGETED	Upside Online is a free, safe and confidential website for young people aged 11-18, with extensive knowledge articles, info and online counselling	Jenny Lewis Gwenda Perry	Online service, currently in place in Staffordshire and Stoke on Trent
CAMHS Care Navigators Barnardo's deliver in Buckinghamshire SPECIALIST	YP are assigned a Barnardo's 'Buddy' to provide consistent support through their care pathway and help them, and parents/carers, navigate CAMHS	Jenny Lewis Gwenda Perry	Barnardo's model which could be part of CAMHS delivery
Barnardo's Against Sexual Exploitation (BASE) SPECIALIST	Barnardo's evidence-based practice, a trauma-informed neuroscience approach, to work with children and young people experiencing/at risk of CSE	Jenny Lewis Gwenda Perry	Barnardo's model which could be a standalone service or integrated into CAMHS
PATHS® (Promoting Alternative Thinking Strategies) An evidence-based social and emotional learning (SEL) developmental programme delivered by Barnardo's UNIVERSAL	A universal whole-school programme aimed at 4/5 – 11 year olds (primary age), that teaches pro-social skills, emotional understanding, social problem-solving and self-control.	Jenny Lewis Gwenda Perry	Barnardo's model which originated in Northern Ireland. Locally Barnardo's are delivering PATHS in Swindon.
Go Girls	For years 8 - 10 across secondary schools in Wiltshire. Provides opportunities to engage with sessions on issues that affect girls, promote self-esteem, assertiveness,	Sue Nash	Wiltshire wide and about to implement a

	<p>healthy relationships, keeping safe, stress and anger, substance abuse and on the final session the girls get the opportunity to learn how to make jewellery.</p>		<p>Go Girls programme for CAMHS</p>
<p>Wiltshire Mentoring Scheme</p>	<p>Wiltshire Mentoring Scheme matches children and young people aged 8-17 years who have been referred to the scheme due to their vulnerability and/or offending behaviour. The emphasis is on building a relationship, relaxing and having fun with the aim of boosting the young person's confidence and self-esteem, supporting them in expressing their feelings and exploring some of the issues that they face.</p> <p>Meetings take place on a one to one basis, away from home e.g. in a local café, sports centre, library etc.</p> <p>Activities may include going for a meal, playing a sport, sharing an interest, using the internet, looking for a job, visiting somewhere new or just chatting.</p> <p>Volunteer Mentors meet with young people for around a hour a week, up to a period of one year</p>		
<p>Other Things</p>	<ul style="list-style-type: none"> • Dove – self esteem input to Wiltshire students and staff • Winston’s Wish – support to families around bereavement, with a specialism on military families • Brighter Little Minds – input to primary schools from a local psychotherapist (BOA area) on using therapeutic stories. • Rounded & Grounded – work with Wiltshire primary schools and training for staff on using the outside environment to improve wellbeing. • Splitz Teenztalk programme – free and traded input to targeted groups of secondary pupils around relationships and domestic violence. • NSPCC School Service – talks to primary school children about worries, abuse etc. and asking for help. • Wiltshire Wildlife Trust – Mental Health projects/ Wellbeing Programme/ North Wilts Project – Care Farm • MindEd – E learning and Apps etc. • Wiltshire MIND • YoungMinds • My CAMHS Choices • Rethink • Alabare • Youth Health Talk – provides advice and support on mental health issues from young people for young people (National organisation) • Action on Addiction • Army Welfare Services • Domestic violence support services – Splitz (11-16yrs) 		

