# Mental Health and Wellbeing
# Pre-birth to Age 25 years
# Needs Assessment
# November 2019

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Acknowledgements: We recognise that the numbers in this document hide multiple occasions of personal tragedy and the next stage would be to capture the voices of parents, children and young people to develop a system-wide approach to improving mental health and wellbeing. We would like to thank Helen Freeman, Kathryn Goose, Ruth Kern, Vickie Braithwaite, Daniel Ng, Liz Phillips, Rebecca Percival, Tom Hughes and Paul Millard for their input.

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# Contents

## Executive Summary

The emotional health and wellbeing of a child or young person is just as important as their physical health. A good level of mental health will enable a child to handle stress better, achieve more and thus lead to better health outcomes. Using national prevalence estimates, there are approximately 34,000 children and young people aged 2-25 with a mental health disorder in Cambridgeshire and Peterborough, with a predicted 10% increase between 2019 and 2024 (based on increased population forecasts).

The mental health of the parent is important to the mental health of the child or young person and as such it has been included in this needs assessment. Up to 20% of women experience a perinatal mental health condition, with suicide remaining the biggest cause of direct deaths during the antenatal and postnatal period. As maternal depression is associated with the child having a fivefold increase of mental health illness, it is important that supporting perinatal mental health is prioritised.

Poor mental health can affect anyone, but there are certain groups which are considered to be more vulnerable, including Children in Care (CIC), children with Special Educational Needs and Disabilities (SEND), children with Autistic Spectrum Disorders, Young Carers, LGBTQQ+ young people and Young Offenders. As such, these children or young people may require additional targeted support to achieve the same outcomes as their peers.

Adverse Childhood Experiences (ACEs) can increase a child or young person's chance of developing mental health problems. The risk factors discussed in this needs assessment include:

- Young people becoming teenage parents,
- Children whose parents have a mental health problem,
- Substance misuse and domestic violence,
- The family environment,
- Children living in poverty,
- Children experiencing bereavement,
- Children subject to bullying or who bully others,
- Young people not in employment, education or training (NEET),
- Young people negatively experiencing transition into adult services and
- Young people transitioning to university.

As Cambridgeshire and Peterborough covers a large geographical area, it has a range of communities with varying health needs. Although the risk factors and vulnerable groups vary across the area, both Cambridgeshire and Peterborough have seen a sharp rise in the number of hospital admissions due to self-harm and an increased strain on most children and young people's mental health services. Findings from this needs assessment with help guide the development of the new Cambridgeshire and Peterborough Pre-birth to age 25 years Mental Health and Wellbeing strategy.

## Glossary

This section defines many terms used within this document.

- **Autism Spectrum Disorder (ASD):** A developmental disorder which affects a person's communication and behaviour [1].
- **Depression**: A long lasting low mood disorder which affects the person's ability to feel pleasure, do everyday things and take interest in activities[2].
- **Eating disorder:** An unhealthy attitude to food, which can take over a person's life and make them ill[3] .
- **Mental Health:** 'A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.' [4] (WHO, 2014)
- **Mental Health Conditions**: This is a collective term referring to a range of conditions related to mental health. Most mental health conditions are categorised under three groups:
- **Emotional disorders** include anxiety disorders, depressive disorders and mania and bipolar affective disorder.
- **Behavioural (or conduct) disorders** are characterised by repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or rules, are violated.
- **Hyperactivity disorders** are characterised by inattention, impulsivity, and hyperactivity.
- **NICE:** The National Institute for Health and Care Excellence.
- **ONS:** Office for National Statistics
- **Perinatal mental health**: Mental health problems that occur during pregnancy or in the first year after the birth of a child[5].
- **Self-harm**: Self-harm is any act of self-injury or self-poisoning carried out by a person, irrespective of their motivation[6].
- **Special Educational Needs and Disability (SEND):** A child or young person who has a learning difficulty and/or disability in which they need special education or health support[7].
- **Suicide:** Deaths from intentional self-harm for persons aged ten and over, and those aged fifteen and over for deaths caused by injury or poisoning where the intent was undetermined[8].

## Key Priorities

The key priorities will be discussed within the Children and Young People's Mental Health and Wellbeing Board and within other boards or stakeholder groups responsible for children's health and wellbeing.

Areas where Cambridgeshire and Peterborough are statistically significantly higher (worse) than England are:

- Self-harm hospital admissions, 10 to 24 year olds – Cambridgeshire and Peterborough
- Children in need due to abuse or neglect – Cambridgeshire and Peterborough
- Child protection plans due to neglect – Peterborough
- Started to be looked after due to abuse or neglect – Peterborough
- Repeat child protection cases – Cambridgeshire and Peterborough
- Teenage mothers (aged under 18 years) – Peterborough
- Children living in poverty – Fenland and Peterborough
- Family homelessness – Peterborough
- Young people aged 16-17 years not in education, employment or training (NEET) – Peterborough
- GCSE attainment – Fenland, Huntingdonshire and Peterborough
- Pupil absence – Fenland
- Identification of potential SEN pupils (rates are lower than National which suggests they may not be identified) – Cambridgeshire and Peterborough

Key priorities from the NHS Long Term Plan:

- Increasing the number of women accessing specialist perinatal mental health support
- Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required. This will contribute to helping to care for the 5-10% of **fathers who experience mental health difficulties** during the perinatal period
- Increasing the number of children and young people accessing mental health support
- Achieve and maintain 95% target for Eating disorder services; urgent cases to be seen in one week of referral, routine cases within 4 weeks of referral
- Increase 24/7 response for children and young people in mental health crisis with 100% coverage by 2023/24
- Alignment of the local transformation plan and system transformation plan, moving to children and young people mental health plans aligned with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice
- Implementation of mental health support teams in schools

- Comprehensive offer for 0-25 year olds that reaches across mental health services for children and young people and adults

## Introduction

The case for intervention is strong. **Over half of all mental health problems (excluding dementia) start by the age of fourteen, rising to seventy-five percent by eighteen**[9]. Failing to support those with mental health needs costs lives and money. Mental health illnesses can have several negative impacts on an individual's life, including physical health, work and education prospects, and life expectancy.

The Early Intervention Foundation estimates that England and Wales spend approximately £17bn a year on late interventions by addressing the damaging problems that affect children and young people, such as child neglect, maltreatment, domestic violence, abuse, mental health, school exclusion and youth crime. This includes £400m per year on child self-harm hospital admissions, £440m per year on child mental health hospital admissions and £440m on children in specialist substance misuse services. Mental health services are predicted to receive £2 billion of the extra £20 billion the NHS is due to receive over the next five years[10].

This document will explore the risk factors and vulnerable groups associated with the increased risk of developing mental health conditions, highlight the current local needs by comparing national and local data, identify the current national and local policy direction, map the current service provision to identify any gaps, and summarise the evidence for intervention to understand what preventative approaches or prevention interventions have the most success.

# Population

## Local Population

For the purpose of this needs assessment, we will be looking at children and young people aged 0-25 years. Based on national population forecasts, Cambridgeshire and Peterborough has an estimated combined population of 262,600 children and young people aged 2-25 years, as illustrated in Figure 1.

Figure 1: Estimated children and young people in Cambridgeshire and Peterborough

| Age group | Cambridgeshire | Peterborough | Total |
|---|---|---|---|
| 2 to 4 year olds | 23,400 | 9,500 | 33,000 |
| 5 to 10 year olds | 48,900 | 18,900 | 67,800 |
| 11 to 16 year olds | 44,900 | 15,800 | 60,700 |
| 17 to 19 year olds | 23,800 | 7,000 | 30,800 |
| 20 to 25 year olds | 55,400 | 14,900 | 70,300 |
| **Total** | 196,500 | 66,100 | 262,600 |

Source: 2019 population based on mid 2015 population forecasts, Research Group, Business Intelligence, Cambridgeshire County Council

## Population Changes - Births

As this needs assessment covers perinatal mental health, it is important to look at the expected birth forecasts so that parents and carers can be supported during the perinatal period and in the first two years of the child's life. Based on local population figures, there is a forecast 9% increase in the number of births across Cambridgeshire and Peterborough over the next five years, with a higher proportion in Cambridgeshire than Peterborough, as seen in Figure 2. Within Cambridgeshire; South Cambridgeshire, Huntingdonshire and Cambridge City are forecast to see the largest increase in the number of births.

Figure 2: Birth forecasts for Cambridgeshire and Peterborough

| Local Authority | Births | | | Change in births | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Number | | | Proportion (%) | | |
| | 2016/17 | 2021/22 | 2026/27 | 2016/17 to 2021/22 | 2021/22 to 2026/27 | 2016/17 to 2026/27 | 2016/17 to 2021/22 | 2021/22 to 2026/27 | 2016/17 to 2026/27 |
| Cambridge City | 1,500 | 1,600 | 1,600 | 151 | -10 | 141 | 10.2% | -0.6% | 9.5% |
| East Cambridgeshire | 1,000 | 1,100 | 1,200 | 63 | 130 | 193 | 6.3% | 12.3% | 19.4% |
| Fenland | 1,100 | 1,200 | 1,200 | 98 | -11 | 88 | 8.7% | -0.9% | 7.8% |
| Huntingdonshire | 2,000 | 2,200 | 2,300 | 179 | 96 | 275 | 8.9% | 4.3% | 13.6% |
| South Cambridgeshire | 1,800 | 1,900 | 2,100 | 194 | 120 | 315 | 11.1% | 6.2% | 18.0% |
| Cambridgeshire | 7,400 | 8,100 | 8,400 | 686 | 326 | 1,012 | 9.3% | 4.0% | 13.7% |
| Peterborough | 3,100 | 3,400 | 3,400 | 267 | 75 | 342 | 8.6% | 2.2% | 11.1% |
| Cambridgeshire and Peterborough | 10,500 | 11,400 | 11,800 | 953 | 401 | 1,354 | 9.1% | 3.5% | 12.9% |

Source: Population forecasts, mid 2015 based, Research Group, Business Information Team, Cambridgeshire County Council
Note : Actual and proportional change based on unrounded data. Totals may not agree due to rounding.

## Population Forecasts– Under 25

There are two sources of population forecasts available for examining the estimated population forecasts for children and young people (under 25) in Cambridgeshire and Peterborough. The

Office for National Statistics (ONS) projections are used for national budget setting, whilst the Cambridgeshire County Council Research Groups (CCCRG) forecasts takes into account the local planning policy, such as approved housing developments. Both sets of forecasts take into account natural change, such as births and deaths, and population migration. However, there are considerable differences between these forecasts for children and young people and so both are presented below.

Using local population forecasts from CCCRG there is an estimated 7.1% increase in the population aged under 25 years across Cambridgeshire and Peterborough over the next five years, with a higher proportion increase expected in Cambridgeshire (7.1%, 14,500 people) than Peterborough (6.8%, 4,800 people). The following five years is expected to see a lower, but still substantial increase in both areas (Cambridgeshire 4.2%, 10,900 people; Peterborough 4.4%, 3,400 people).

Using local population forecasts from the Office for National Statistics there is an estimated 1.8% increase in the population aged under 25 years across Cambridgeshire and Peterborough over the next five years, which a higher proportion in Peterborough (3.5%, 2,300 people) than Cambridgeshire (1.3%, 2,500 people). The following five years is expected to see a higher increase in Cambridgeshire (2.2%, 4,400 people) and a reduction in Peterborough (2.3%, 1,600 people).

Figure 3: Population forecasts for children and young people under 25 years

| | | | | | Change in population | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Local Authority | Population (number) | | | Number | | | Proportion (%) | | |
| | | 2019 | 2024 | 2029 | 2019 to 2024 | 2024 to 2029 | 2019 to 2029 | 2019 to 2024 | 2024 to 2029 | 2019 to 2029 |
| Cambridgeshire County Council | Cambridgeshire | 202,600 | 217,100 | 226,100 | 14,500 | 9,100 | 23,600 | 7.1% | 4.2% | 11.6% |
| | Peterborough | 69,500 | 74,300 | 77,500 | 4,800 | 3,300 | 8,000 | 6.8% | 4.4% | 11.5% |
| | Total | 272,100 | 291,300 | 303,700 | 19,200 | 12,300 | 31,600 | 7.1% | 4.2% | 11.6% |
| Office for National Statistics | Cambridgeshire | 194,300 | 196,800 | 201,200 | 2,500 | 4,400 | 6,900 | 1.3% | 2.2% | 3.6% |
| | Peterborough | 65,800 | 68,100 | 69,700 | 2,300 | 1,600 | 3,900 | 3.5% | 2.3% | 5.9% |
| | Total | 260,200 | 264,900 | 270,900 | 4,700 | 6,000 | 10,700 | 1.8% | 2.3% | 4.1% |

Source: Mid 2015 population forecasts, Research Group, Business Information Team, Cambridgeshire County Council. Mid 2016 based population projections, Office for National Statistics. Totals may not agree due to rounding.

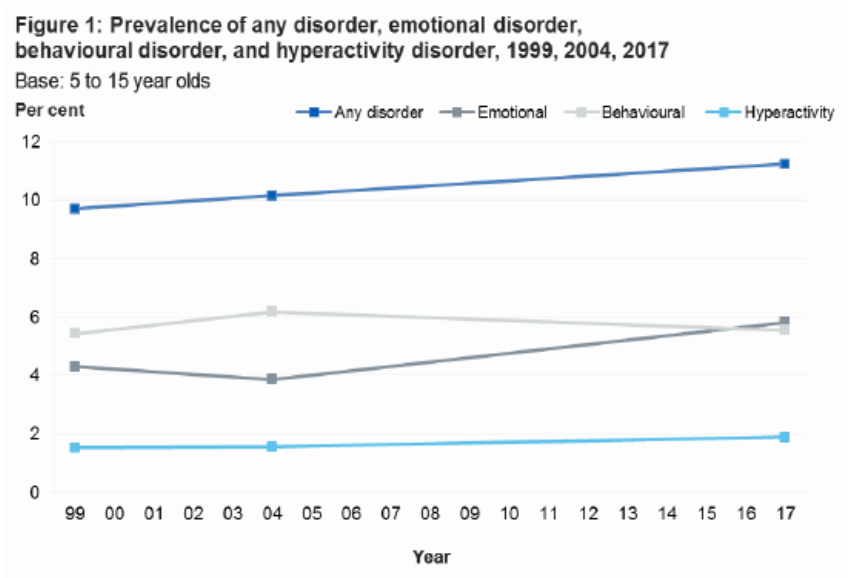
## Prevalence

### Mental Health Conditions

There is an increasing prevalence of mental health conditions within children and young people. **In 2017 one in eight (12.8%) children and young people aged 5-19 years had some form of clinically diagnosable mental health disorder**[11]. Emotional disorders were the most prevalent type of disorder experienced at 8.1%. Rates of mental health disorders increase with age, where in 2017 5.5% of 2-4-year olds experienced a mental health disorder, compared to 9.5% of 5-10-year olds, 14.4% of 11-16 year olds, 16.9% of 17-19 year olds and 16.7% in 20-25 year olds [11] [12] [13].

Although there is a growing national trend, some types of conditions are rising more than others. In particular, Emotional and Hyperactivity mental health disorders have both risen, while behavioural disorders have slightly declined, as seen in Figure 4.

Figure 4: Prevalence of mental health disorders in 5-15-year olds in England




Source: NHS Digital 2017

**Using 2017 national prevalence estimated from large scale surveys, there are approximately 34,000 people aged 2-25 years in Cambridgeshire and Peterborough with a mental health disorder,** which can be broken down into age groups as seen in Figure 5.

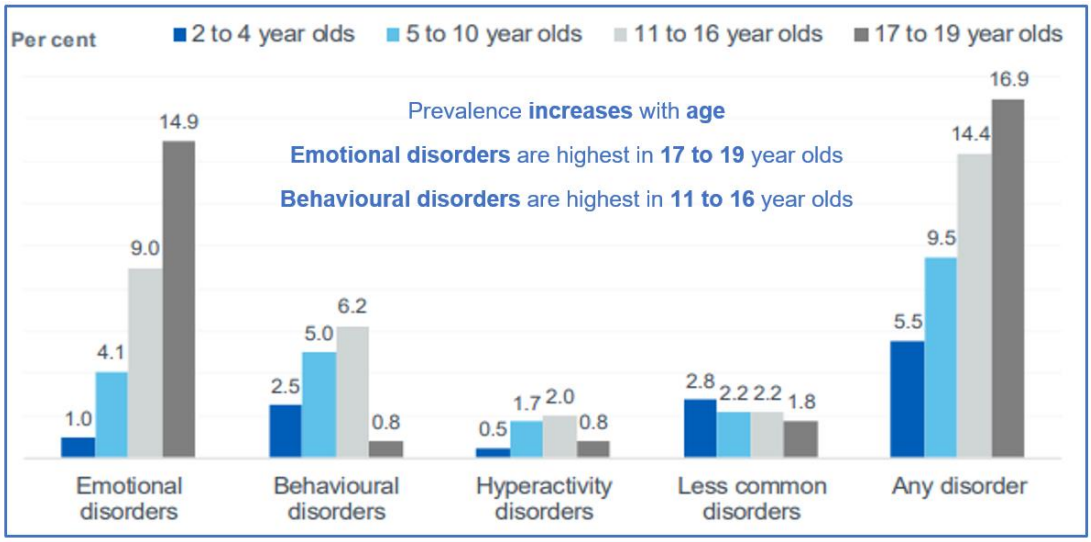
The prevalence estimates can be further broken down into the different groups of mental health conditions for the different age groups, as seen in Figure 6.

Figure 5: Estimated number (based on national prevalence) of children and young people (2-25 years) with a diagnosed mental disorder in Cambridgeshire and Peterborough– 2019

| Age group | Prevalence | Cambridgeshire | Peterborough | Total |
|---|---|---|---|---|
| 2 to 4 year olds | 5.5% | 1,300 | 500 | 1,800 |
| 5 to 10 year olds | 9.5% | 4,600 | 1,800 | 6,400 |
| 11 to 16 year olds | 14.4% | 6,500 | 2,300 | 8,700 |
| 17 to 19 year olds | 16.9% | 4,000 | 1,200 | 5,200 |
| 20 to 25 year olds | 16.7% | 9,200 | 2,500 | 11,700 |
| **Total** | | **25,700** | **8,300** | **33,900** |

*Source: Mental Health of Children and Young People in England, 2017 and Adult Psychiatric Morbidity Survey in England, 2014, NHS Digital, Applied to Mid 2015 population forecasts, Research Group, Business Intelligence, Cambridgeshire County Council*

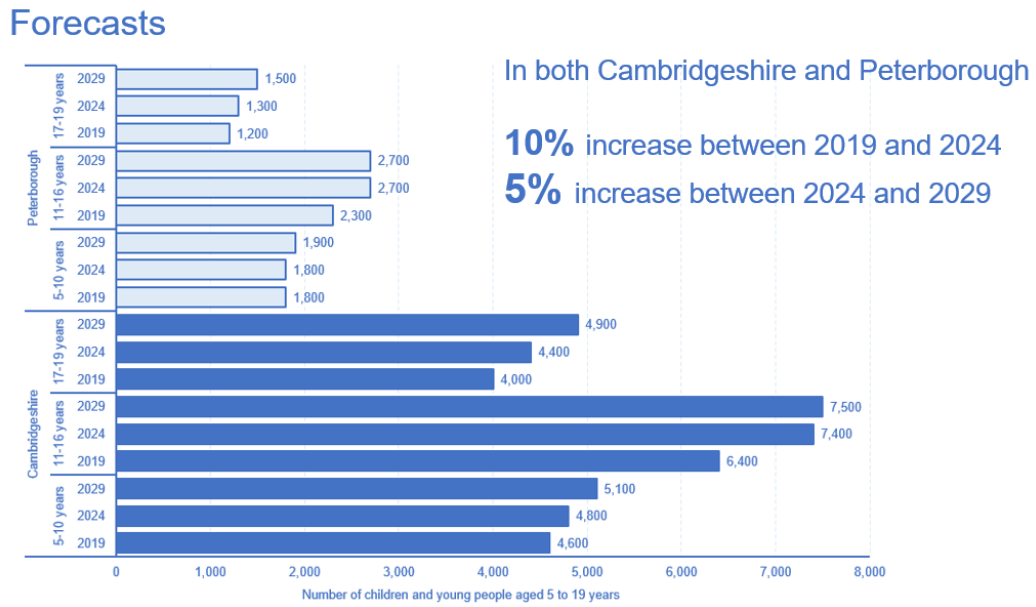
Figure 6: Estimated prevalence (based on national prevalence) of mental health disorders in Cambridgeshire and Peterborough by age group - 2019




*Source: Mental Health of Children and Young People in England, 2017 and Adult Psychiatric Morbidity Survey in England, 2014, NHS Digital, Applied to Mid 2015 population forecasts, Research Group, Business Intelligence, Cambridgeshire County Council*

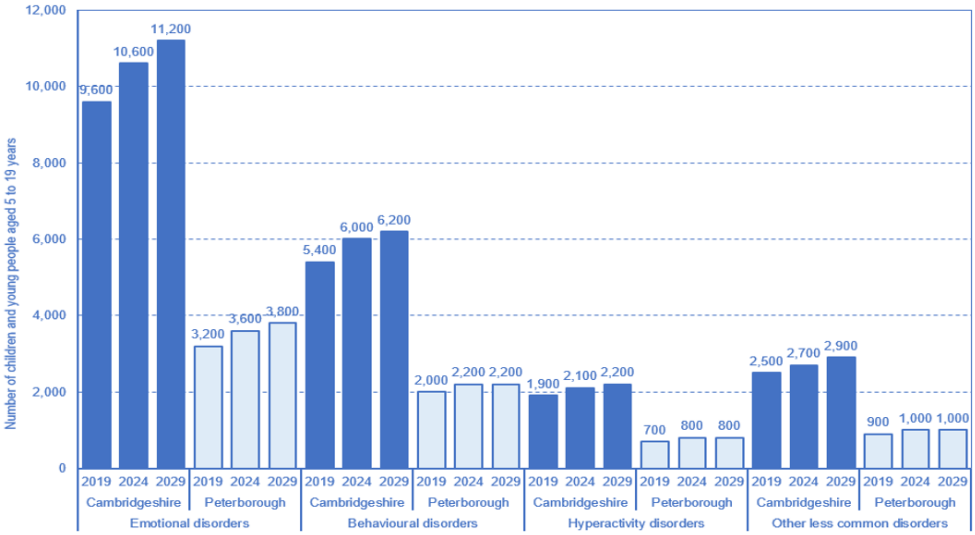
The number of diagnosed mental health conditions in children and young people in Cambridgeshire and Peterborough is forecast to grow by 10% between 2019 and 2024 and a further 5% by 2029, which can be seen in Figure 7. Figure 8 shows the forecasts broken down into the different mental health groups. It is important to note that this forecast increase is due to forecast population growth only and presumes that the prevalence of Mental Health disorders remains static which is unlikely to be the case and hence is likely to be an underestimate.

Figure 7: Forecast growth in mental health conditions in Cambridgeshire and Peterborough by age group - 2019




*Source: Mental Health of Children and Young People in England, 2017 and Adult Psychiatric Morbidity Survey in England, 2014, NHS Digital, Applied to Mid 2015 population forecasts, Research Group, Business Intelligence, Cambridgeshire County Council*

Figure 8: Forecast growth in mental health conditions in Cambridgeshire and Peterborough by type of disorders - 2019




*Source: Mental Health of Children and Young People in England, 2017 and Adult Psychiatric Morbidity Survey in England, 2014, NHS Digital, Applied to Mid 5 population forecasts, Research Group, Business Intelligence, Cambridgeshire County Council*

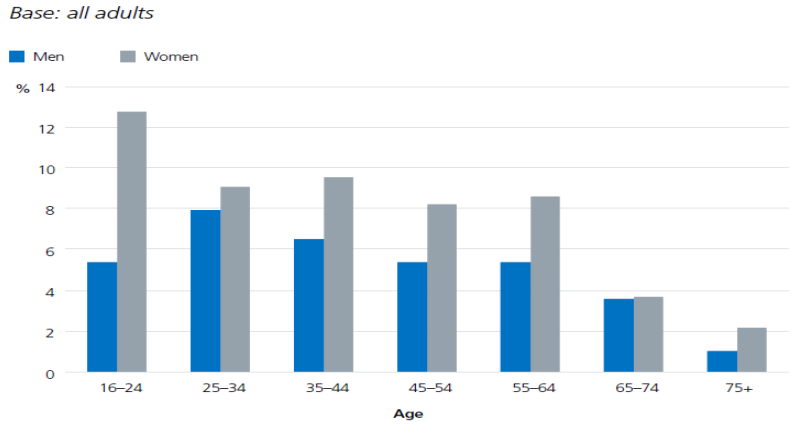
## Suicides

The best available national data on the prevalence of suicides in the UK is from the Office for National Statistics (ONS). ONS recorded that in 2018 there was 6,507 suicides registered in the UK, with over three-quarters (4,903 deaths) of the suicides in men[14]. As suicide is only recorded in children who are aged 10 and above, ONS has grouped the ages 10-24 years together.

Prevalence of self-harm is a risk factor for suicide, as those who have self-harmed are 100 times more likely to die from suicide in the year following, compared to the general population[15]. Despite under 25s having a lower prevalence of suicides overall, the rate has generally increased in recent years.

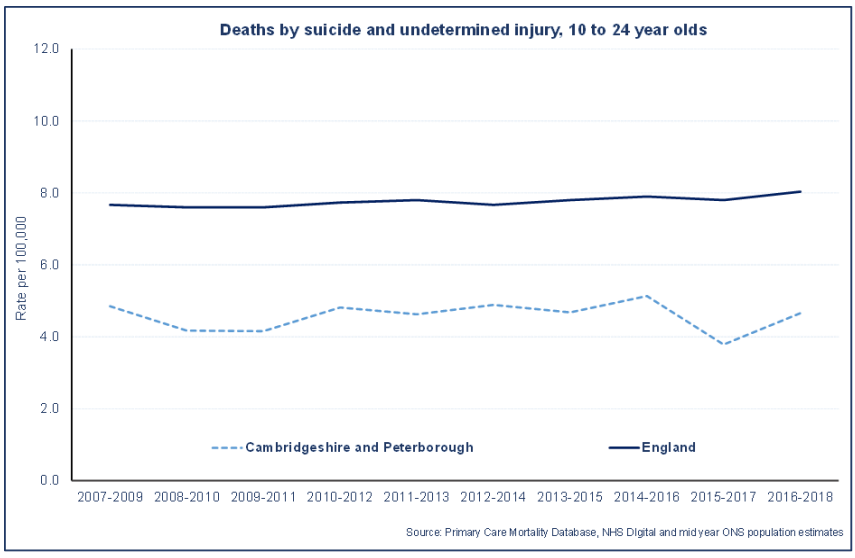
Females aged 10-24 have seen an increase in the number of suicides since 2012, to its highest level of 3.3 deaths per 100,000 in 2018. Males aged 10-24 have also seen a rise, reaching 9 deaths per 100,000 in 2018, which is an increase of 25% from 2017[16]. **The biggest increase was seen in males aged 20 to 25 years which saw a 31% increase from 12.9 deaths per 100,000 males in 2017 to 16.9 in 2018**. It is important to note that although 16-24-year olds have lower rates of suicide than other age groups, they do have the highest number of suicide attempts, as seen in Figure 9.

Figure 9: Suicides attempts in England by age and sex




*Source: Adult Psychiatric Morbidity Survey in England, 2014, NHS Digital,*

In Cambridgeshire and Peterborough the overall rate is lower than England, but this still equates to 22 deaths concluded as suicide or undetermined intent registered between 2016 and 2018 (3 years) in under 25 year olds.



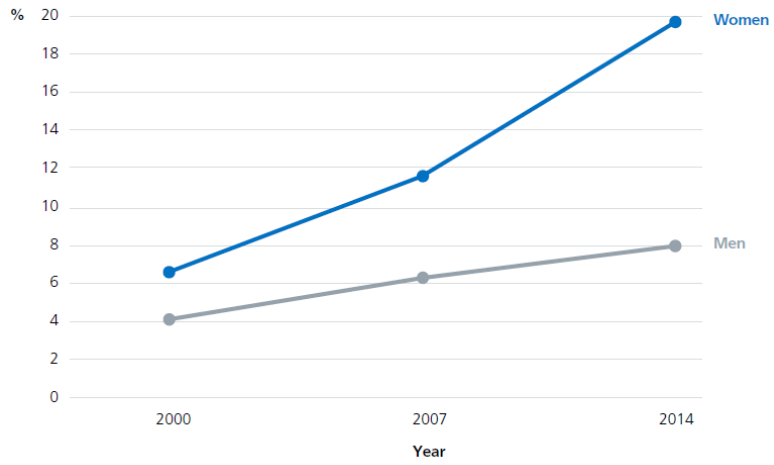
## Self-harm

The Adult Psychiatric Morbidity Survey conducted in 2014 reported that 13.2% of those aged 16-24 years had self-harmed. In contrast to suicide rates, recorded self-harm rates are higher in females in aged 16-24 year at 19.7% compared to 7.9% of males aged 16-24, which can be seen in Figure 10[17]. Hawton et al[18] (2012) states that **only one in eight episodes of self-harm that happen in the community are presented in hospital** and thus the rate of self-harm is likely to be much higher than stated in this needs assessment.

In 11-16 year olds, there is a strong correlation between those with a mental health disorder and the rates of self-harm or attempted suicide. NHS Digital's research in 2017 found that a quarter (25.5%) of 11-16-year olds who had a mental health disorder, had attempted suicide or self-harmed, compared to 3% of those who did not have a diagnosed mental health disorder. The report also found that nearly half (46.8%) of young people aged 17-19 who had a diagnosed mental health disorder, had self-harmed or made a suicide attempt[19].

Figure 10: 16-24 year olds self-harm rates in England 2000, 2007, 2014

*Base: adults aged 16–24 and living in England*




*Source: Adult Psychiatric Morbidity Survey in England, 2014, NHS Digital,*

Both Cambridgeshire and Peterborough have statistically significantly higher rates of self-harm hospital admission rates in children and young people aged 10-24 compared to England, with an increasing trend. **In 2017/18 there were 777 hospital admissions for self-harm in children and young people aged 10-24 in Cambridgeshire and 197 in Peterborough**, which are both statistically significantly higher than England's average. However, when the age groups are broken down further (seen in Figure 11), there is a decreasing trend for those aged 20-24 in Peterborough and a static trend in those aged 10-14 in both Cambridgeshire and Peterborough. Similarly with national trends, Cambridgeshire and Peterborough are also seeing more females being admitted for self-harm compared to males, as seen in Figure 12.

Different areas across Cambridgeshire and Peterborough experience different rates of self-harm. East and South Cambridgeshire have statistically significantly higher rate of self-harm admissions compared to the overall rate for Cambridgeshire and Peterborough (2017/18),

with Huntingdonshire having a statistically low rate in comparison. There has been a noticeable increase in East Cambridgeshire, which appears to be due to a small number of patients being admitted numerous times during the year. Self-poisoning is the main reason for self-harm emergency admissions in children and young people aged 10-24 in both Cambridgeshire and Peterborough. Unlike recent years, Cambridgeshire is now experiencing higher self-harm hospital admission rates than Peterborough, as seen in Figure 13.

There appears to be a correlation between self-harm emergency hospital admissions and deprivation in Cambridgeshire, with statistically significantly high rates in the fifth most deprived wards in the county compared to the fifth least deprived wards. In Peterborough there appears to be little correlation to deprivation, with the highest rate seen in the second least deprived quintile, as well as none of the quintile rates differing significantly to the Peterborough rate.

Approximately 75% of the self-harm hospital admission rates in Cambridgeshire were from children and young people who had a mental health diagnosis recorded, compared to 56% in Peterborough. Mood (affective) disorders were the main diagnoses seen in this cohort of children and young people. However, there has been a notable increase in the number and proportion of admissions with an adult personality disorders in Cambridgeshire. In Peterborough there was an increase in the proportion of mood (affective) disorders, a decrease in the proportion of mental and behavioural disorders due to psychoactive substance use and an increase in the proportion of disorders of adult personality and behaviour between 2016/17 and 2017/18. Numbers are relatively small and therefore prone to fluctuation.

There are several reasons that could help explain the high rates in Cambridgeshire and Peterborough; issues around data recording and pathways, frequent attendances by people with diagnosed personality disorders and the support available in the community.

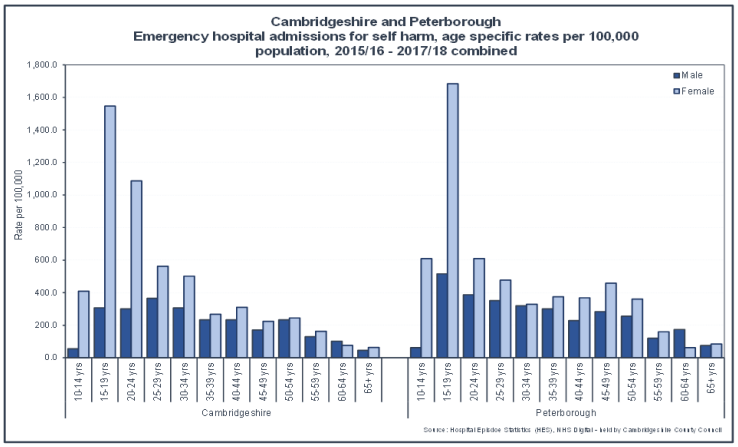
Figure 11: Self-harm hospital admission rates for children and young people in Cambridgeshire and Peterborough

Rates 2017/18

| Area | 10 to 24 year olds | | | 10 to 14 year olds | | | 15 to 19 year olds | | | 20 to 24 year olds | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Trend | Number | Rate | Trend | Number | Rate | Trend | Number | Rate | Trend |
| Cambridgeshire | 777 | 662.7 | ↑ | 102 | 282.9 | → | 387 | 1039.0 | ↑ | 288 | 666.0 | ↑ |
| Peterborough | 197 | 587.2 | ↑ | 42 | 347.7 | → | 110 | 1015.0 | ↑ | 45 | 414.5 | ↓ |
| England | - | 116.9 | | | 35.3 | | | 170.1 | | | 75.8 | |

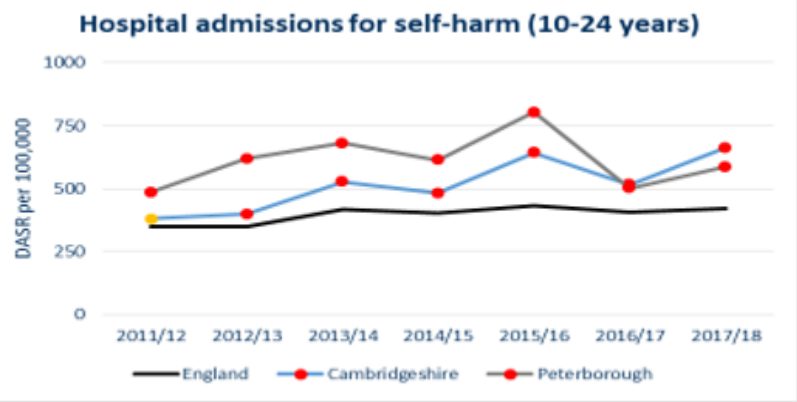
*Source: Public Health Outcomes Framework, Fingertips, Public Health England*

Figure 12: Self-harm hospital admission rates for Cambridgeshire and Peterborough by age and gender




*Source: Public Health Outcomes Framework, Fingertips, Public Health England*

Figure 13: Self-harm trend data in 10-24-year olds in Cambridgeshire and Peterborough




Source: *Public Health Outcomes Framework, Fingertips, Public Health England*

## Perinatal Mental Health

**According to NHS England, up to 20% of women experience a perinatal mental health condition.** Not only does it have a long-lasting effect on the mother, it can also have a damaging effect on the child. Maternal depression is associated with the child having a fivefold increase of mental health illness [11]. A report by the Centre for Mental Health in 2014 states that the overall long-term cost to society of perinatal psychosis, anxiety and depressions is approximately £8.1billion each year. 72% of this cost relates to the impacts on the child and £1.2billiion would fall onto the NHS and social services[20]. Furthermore the Long Term Plan recognises the need to support the 5-10% of fathers who experience mental health difficulties during the perinatal period[59].

A less researched area is parental depression following adoption. Experiences may be similar to those living with postnatal depression, but with unique characteristics owing to the complex nature of adoption. Experiences may include difficulties connecting with the adoptive child, or children, as well as feelings of guilt for the birth mother[21]. Research continues to better understand post-adoption depression and the prevalence among new adoptive parents.

**The Mothers and Babies: Reducing Risk through Audit and Confidential Enquires across the UK (MBRRACE) Report (2019) reports that one in nine maternal deaths in the perinatal periods are due to suicide** and that maternal suicides remains the leading cause of direct deaths occurring between six weeks and one year after the end of pregnancy[22].

Perinatal mental health prevalence estimates suggest that 310 women in Cambridgeshire and Peterborough have severe depressive illnesses during the perinatal period, as well as 25 having a chronic serious illness and 25 having postpartum psychosis, as seen in Figure 14. In terms of risk factors, Peterborough has statistically significantly higher rates of sole registered births, births to non-UK parents, births to under 20 year olds, children living in poverty, child protection plans, children in need, lone parent families and statutory homelessness compared to England.

Figure 14: Estimated prevalence of perinatal mental health conditions (based on national prevalence) in Cambridgeshire and Peterborough

| Estimated number of women | | Rate per 1,000 maternities | Cambridge shire | Peterborough |
|---|---|---|---|---|
| Postpartum psychosis | | 2 | 15 | 10 |
| Chronic Serious Mental Illness in perinatal period | | 2 | 15 | 10 |
| Severe depressive illness in perinatal period | | 30 | 215 | 95 |
| Mild-moderate depressive illness and anxiety in perinatal period | Lower estimate | 100 | 715 | 310 |
| | Upper estimate | 150 | 1,075 | 465 |
| PTSD in perinatal period | | 30 | 215 | 95 |
| Adjustment disorders and distress in perinatal period | Lower estimate | 150 | 1,075 | 465 |
| | Upper estimate | 300 | 2,145 | 925 |

*Source: Perinatal Mental Health Profile, Fingertips, Public Health England, 2015/16*

## Vulnerable Groups

Mental health problems can affect anyone at any time, but there are some groups of children, young people and perinatal women that are known to have an increased vulnerability. It is important to understand what groups exist and what their risk may be so that selective prevention approaches can be used to reduce their chances of developing mental ill-health. The vulnerable groups discussed in this section is not exhaustive, but instead are the vulnerable groups of concern within Cambridgeshire and Peterborough.

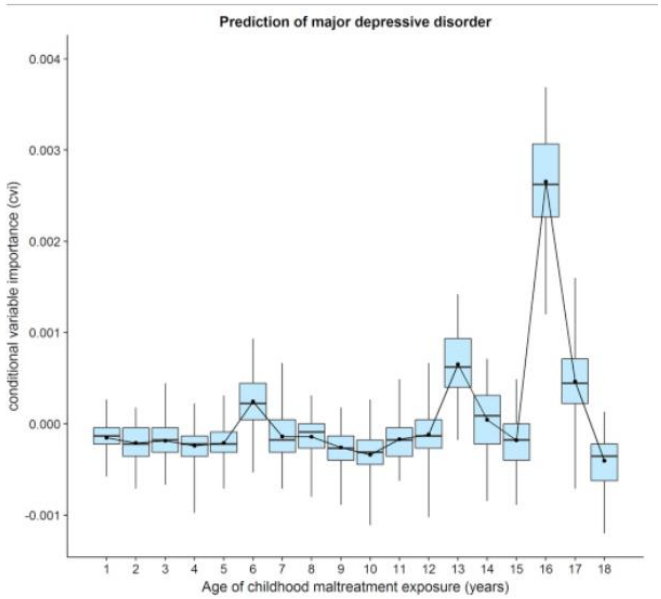
### Children in Care (CIC) and Maltreatment

Children in Care refers to children under 18 who are being looked after by the local authority, both those under the Section 31 of the Children's Act 1989 or those looked after under the voluntary agreement with their parents under Section 20 of the Act. Research has shown that 62% of looked after children are in care due to neglect or abuse. However, this trauma can have a long-lasting effect on the child's mental health and wellbeing. **In 2018, half of children in care met the criteria for a possible mental health condition, compared to one in eight of children out of care**[23].

There is evidence to support the correlations of children in care and the increased rates of mental health conditions. One report by Simkiss (2012) reported that children in care were four to five times more likely to self-harm in adulthood than non-looked after children. They also reported that between 2009-2010 Childline counselled 3,196 children and young people (aged up to 18) about problems related to being looked after, this represents 1 in 16 of all children in care in the UK at that time [24].

As stated above, maltreatment is the leading cause of children entering care and it can have long-lasting effects on the child. Child maltreatment is the neglect and abuse that occurs to children under 18 years and includes all types of emotional and/or physical ill-treatment, neglect, negligence, sexual abuse and commercial or other exploitation. The World Health organization states that children who are maltreated have an increased risk of depression as adults[25]. Research conducted from October 2013 to December 2016 into the risk of depression due to child maltreatment[26], found that maltreatment that occurs at certain age sensitive periods will predict the severity of a major depression disorder, as seen in Figure 15. As such, maltreatment prevention should cover the full range of childhood.

Figure 15: Prediction of major depressive disorder




Source: Childhood maltreatment as risk factor for lifetime depression: The role of different types of experiences and sensitive periods, Gerke et al.

It is important to note that the different types of maltreatment and the severity will affect the child's risk of mental ill-health, such as child sexual exploitation. Child sexual exploitation is a type of sexual abuse where the child is given items (e.g. gifts or money) in exchange for performing sexual activity. Young Minds report that 2 in 5 victims of Child Sexual Exploitation will experience mental health problems in their lifetime and they are 17 times more likely to experience a psychotic episode than those who have not been maltreated. It is calculated that 2,400 children are victims of sexual exploitation in England, but this number may be higher due to the amount of cases that go unreported. It is suggested that 3 in 5 of these cases are related to online grooming[27].

Children and young people who experience maltreatment, are at risk of developing Disorganised Attachment. Attachment behaviour in early childhood guides brain development, impacts social and emotional development and impacts the levels of cortisol released in response to stress. Disorganised Attachment occurs when a child's care giver who is meant to be their secure base, is simultaneously a source of terror, fear or chronic indifference. Wave Trust and PIPUK (2012) calculates that up to 80% of maltreated children could have Disorganised Attachment, stating that approximately 15% of children have Disorganised Attachment behaviour, which is linked to mental health problems.

**In 2018, there were 705 children in care in Cambridgeshire and 370 children in care in Peterborough, with rates in Peterborough statistically significantly higher than England's average**. Peterborough also has statistically significantly higher rates of child protection plans due to neglect, higher rates of looked after children due to abuse or neglect, higher rates of children in need due to abuse and a higher rate of repeat child protection cases compared to England. Cambridgeshire has significantly higher rates of children in need due to abuse or neglect and higher rates of repeat child protection cases, as seen in Figure 16.

Figure 16: Child protection plans, looked after children and children in need in Cambridgeshire and Peterborough – 2018

Child protection plans, looked after children and children in need, 2018

| | Child protection plan with initial category of : | | | | Repeat child protection cases | | Started to be looked after due to: | | | | Children in need due to: | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Abuse | | Neglect | | | | Abuse or neglect | | Family stress, dysfunction or absent parenting | | Abuse or neglect | | Family stress, dysfunction or absent parenting | | Parent disability or illness | |
| | Number | Rate per 10,000 | Number | Rate per 10,000 | Number | % | Number | Rate per 10,000 | Number | Rate per 10,000 | Number | Rate per 10,000 | Number | Rate per 10,000 | Number | Rate per 10,000 |
| Cambridgeshire | 201 | 14.9 | 275 | 20.4 | 148 | 24.3 | 232 | 17.2 | 82 | 6.1 | 2,619 | 194.7 | 266 | 19.8 | 45 | 3.3 |
| Peterborough | 84 | 16.8 | 144 | 28.8 | 96 | 27.8 | 142 | 28.4 | 22 | 4.5* | 1,282 | 256.4 | 243 | 49.6 | 15 | 3.0 |
| England | 25,160 | 21.2 | 25,820 | 21.8 | 13,900 | 20.2 | 19,420 | 16.4 | 10,950 | 9.3 | 215,270 | 181.4 | 110,530 | 93.8 | 10,490 | 8.8 |

**Cambridgeshire** has statistically significantly **high** rates compared to England of:

- children in need due to abuse or neglect
- repeat child protection cases

**Peterborough** has statistically significantly **high** rates compared to England of:

- child protection plans due to neglect
- looked after children due to abuse or neglect
- children in need due to abuse or neglect
- repeat child protection cases

Statistically significantly higher than England
Statistically similar to England
Statistically significantly lower than England

*Source: Children and Young People's Mental Health and Wellbeing profile, Fingertips, Public Health England*

## Special Educational Needs and Disability (SEND)

The department of education states that children and young people with SEND are more likely to experience mental health problems as they often experience family and school life differently to those without SEND, such as being subject to bullying[28]. Studies have shown that children with learning disabilities are six times more likely to have mental health issues at some point in their life than non-SEND children. It is estimated that 35-40% of children and adolescents with an intellectual disability are likely to develop a diagnosable mental health disorder[29].

**The prevalence of children with SEN within Cambridgeshire and Peterborough is statistically significantly lower than England's average.** Cambridgeshire has statistically similar rates of pupils with SEN in primary school and statistically significantly lower rates of pupil with SEN in secondary school. However, Peterborough has statistically significantly lower levels of SEN pupils both in primary and secondary school, as seen in Figure 17.

Figure 17: School pupils with Social, Emotional and Mental Health needs in Cambridgeshire and Peterborough – 2018

| | Primary school age | | Secondary school age | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Cambridgeshire | 1,097 | 2.12 | 569 | 1.78 |
| Peterborough | 335 | 1.61 | 254 | 1.64 |
| England | 103,326 | 2.19 | 75,431 | 2.31 |

*Source: Children and Young People's Mental Health and Wellbeing profile, Fingertips, Public Health England*

## Autistic Spectrum Disorder (ASD)

The National Autistic Society states that 70% of children with Autistic Spectrum Disorder will have a mental health concern as some point in their life[30]. The England based mental health charity Mind state that people with ASD are more likely to experience mental health

problems as they have less access to support and resources to help develop coping skills, they face more stigma and discrimination, they can experience more negative life events and their genes may also increase their likelihood [31].

### Young Carers

A young carer is a child or young person under 18 years who provides regular on-going care or support to a family member who is disabled, mentally or physically ill or misuses substances. Young Carers can become more vulnerable to mental health problems due to the added strain of caring and the isolating impacts it can have. The Local Government Association reports that there are 166,363 young carers in England, which is a fifth higher than a decade ago. They report that 1 in 20 young carers miss school due to caring responsibilities and 57% of young carers report that they provide emotional support[32].

Young Carers Trust (2013) research into young adult carers (14-25 years) found that 38% of applicants reported having a mental health problem. It is important to note that their research found that although 84% of the young adult carers intended to go to college/university, 24% reported that they would not be able to afford to go and 41% were unsure whether they could afford it. The research also found that a quarter (26%) of those surveyed reported that they had been bullied due to their caring role[33]. These additional factors can put the young carers at an increased risk, as being NEET or being bullied can further increase the young carer's chance of having mental health problems, as discussed later in this report.

**The 2011 Census showed that there were 5,727 Young Carers in Cambridgeshire and Peterborough.** There are areas where Cambridgeshire and Peterborough that are statistically similar to England average, but there are also areas where they are statistically significantly higher. In 2011, there were statistically significantly higher rates of children carers (aged 0-15) in Peterborough (Figure 18) and there were statistically significantly higher rates of children carers (aged 16-24) in Cambridgeshire (Figure 19). However, it is likely that these figures are an underestimation as many Young Carers are not known to services.

Figure 18: Children (aged 0-15) providing unpaid care in Cambridgeshire and Peterborough – 2011

| Area | Number | Rate per 100,000 | 95% Confidence Intervals |
|---|---|---|---|
| Cambridgeshire | 1,227 | 1.09 | (1.03-1.15) |
| Peterborough | 394 | 1.02 | (0.91-1.11) |
| England | 111,423 | 1.11 | (1.11-1.12) |

*Source: Child and Maternal Health profiles, Fingertips, Public Health England*

Figure 19: Young people (aged 16-24) providing unpaid care in Cambridgeshire and Peterborough – 2011

| Area | Number | Rate per 100,000 | 95% Confidence Intervals |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Cambridgeshire | 2,981 | 3.9 | (3.8-4.1) |
| Peterborough | 1,125 | 5.2 | (4.9-5.5) |
| England | 302,356 | 4.8 | (4.8-4.8) |

*Source: Child and Maternal Health profiles, Fingertips, Public Health England*

### Lesbian Gay, Bisexual Transsexual, Queer or Questioning + (LGBTQ+)

LGBTQ+ includes all the communities included in LGBTTTQQIAA which are: Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-spirit, Queer, Questioning, Intersex, Asexual, Ally, Pansexual, Agender, Gender Queer, Bigender, Gender Variant and Pangender. Many researcher states that LGBTQ+ people are more likely to experience poor mental health due to a range of factors, including inequalities and discrimination.

Rethink Mental Illness (2017) state that LGBT+ people are at an increased risk of self-harm and suicide than non-LGBT+ people and they are 1.5 times more likely to develop depression and anxiety. **Specifically, gay and bisexual men are four times more likely to attempt suicide within their lifetime that non gay or bisexual people**[34].

The Mental Health Foundation states that young LGBT+ people are at an increasing risk of mental health problems, with an estimated 34% of young people aged 14-19 who identify as lesbian, gay or bisexual have a mental health disorder, compared to 13.2% of young people who do not [35].

Young Minds state that 2 in 5 LGB youths have either considered taking their own life or directly harmed themselves because of homophobic bullying. They also report that a quarter of homeless youths identify themselves as LBGT, causing further distress for the individuals and increasing their risk of having mental health problems [36].

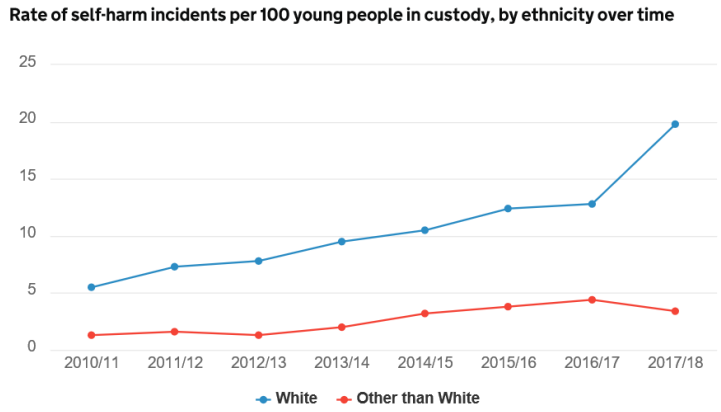
There is limited data into the number of LGBTQ+ children and young people in Cambridgeshire and Peterborough. The Health-Related Behaviour Survey (2018) completed by year 8 and 10 school pupils in Cambridgeshire and Peterborough found that 84% responded that they were straight/ heterosexual and thus a percentage of the remaining 16% could potentially be LGBTQ+ (includes ‘not sure’).

### Young Offenders

A young offender is someone who has been convicted or cautioned for a criminal offense aged between 14 and 17 years. Research conducted by the Prison Reform Trust and Young Minds (2012) reported that 43% of the 85,300 children supervised by the Youth Offending Team (in 2010/11) have emotional and mental health needs and that between a third and half of the children in custody (2010/11) have a diagnosable mental health disorders. **They state that young males in custody aged 15-17 are 18 times more likely to die by suicide and that young females under 25 in custody are 40 times more likely to die by suicide. They reported that both sexes are four times more at risk of depression and anxiety and three time more likely to be at an increased risk of a mental disorder[37].**

Alarmingly the rate for self-harm in young offenders is increasing each year. Figures released in 2019[38] found that there were 19.8 episodes of self-harm per 100 white young people in custody, compared 12.8 in 2016/17, as seen in Figure 20. The rates among non-white young people in custody is significantly lower at 3.4 per 100.

Figure 20: Rates of self-harm incidents in custody




*Source: Self-harm by young people in custody, Gov.uk*

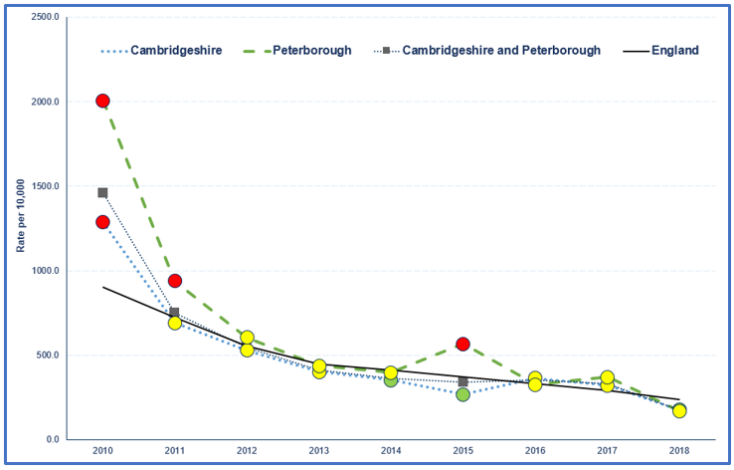
Cambridgeshire has statistically significantly lower levels of first time entrants to the youth justice system compared to England's average, whereas Peterborough has statically similar rates to England's average, as seen in Figure 21. However, similarly with England, Cambridgeshire and Peterborough are both experiencing a downward trend, as seen in Figure 22.

Figure 21: First time entrants to the youth justice system in Cambridgeshire and Peterborough -2018

| Area | Number | Rate per 100,000 | 95% Confidence Intervals | Trend |
|---|---|---|---|---|
| Cambridgeshire | 100 | 175.8 | (143.0 - 213.8) | ↓ |
| Peterborough | 32 | 169.4 | (115.9 - 239.2) | ↓ |
| England | 11,887 | 238.5 | (234.2 - 242.8) | ↓ |

*Source: Children and young people Mental Health and Wellbeing profiles, Fingertips, Public Health England*

Figure 22: First time entrants to the youth justice system in Cambridgeshire and Peterborough 2010-2018




*Source: Public Health Outcomes Framework, Fingertips, Public Health England*

### Sex

The latest data by NHS Digital[40] (2017) into children's mental health shows the different prevalence of mental health disorders in males and females. In 2-4 year olds, males are more likely to have a mental health disorder at 6.8% compared to 4.2% of females. Males aged 5-10 are also more likely to have a mental health disorder at 12.2% compared to 6.6% of females. However, this then equals out in young people aged 11-16 years at 14.4% for both males and females, but females are more likely to have an emotional disorder at 10.9% compared to 7.1% of males and males are more likely to have a behavioural disorder at 7.4% compared to 5% of females.

### Ethnic Group

The latest data by NHS Digital[40] (2017) into children's mental health shows the different prevalence of mental health disorders in children who identify at white and children who identify as black or minority ethnic. They found similar rates of mental health disorders in children aged 2-4 years who were white, black or minority ethnic. However, the difference can be seen in children aged 5-10 years, where children of white ethnic background were more likely to have a mental health disorder at 11.2%, compared to 4.2% of children identifying as black or minority ethnic. There is also a difference in children aged 11-16 years, where children of white ethnic background were more likely to have a mental health disorder at 16.9%, compared to 6.5% of children identifying as black or minority ethnic.

## Risk Factors

There are a range of protective factors that are known to keep children and young people mentally well. However, when these protective factors are outweighed by risk factors, the child or young person has an increased risk of developing mental health problems. It is important to understand what risk factors children and young people are facing nationally, but also comparing it to our local data to understand where the need for intervention may need to be.

## Teenage Pregnancy

A teenage pregnancy is where a pregnancy occurs in a female under 20 years old. Teenage mothers can face a variety of physical and psychological challenges in the months following delivery which can increase the mother's chance of developing postpartum depression. However, as adolescence-hood is a time of development, caution should be taken in defining the difference between postpartum depression due to childbirth and depression due to developmental effects. Various studies have calculated the higher rates of postpartum depression in teenage mothers, some as high as 56%, compared to depressions in 10-15% of postpartum adults and 10% in non-childbearing female teenagers. It is estimated that approximately 50% of postpartum depressive episodes are an exacerbation or reoccurrence of pre-existing mental health disorders that onset prior to pregnancy[39].

Cambridgeshire has statistically similar rates of teenage mothers to England's average, whereas Peterborough has statistically significantly higher rates of teenage mothers, as seen in Figure 23.

Figure 23: Teenage mothers (under 18 years) in Cambridgeshire and Peterborough – 2017/18

| Area | Number | Rate per 100,000 | 95% Confidence Intervals | Trend |
|---|---|---|---|---|
| Cambridgeshire | 39 | 0.6 | (0.4-0.8) | ↓ |
| Peterborough | 35 | 1.2 | (0.8-1.6) | ↓ |
| England | 4,239 | 0.7 | (0.7-0.7) | ↓ |

*Source: Child and Maternal Health profiles, Fingertips, Public Health England*

## Impact of Parental Health Factors

The mental health of the mother and family during pregnancy and infancy can have a big impact on a child's mental health. A secure and positive attachment between the mother and child can result in positive social and emotional development, causing the child to be better able to cope with stress, better able to adjust to change and adversity and have a higher perception of self-worth. Insecure attachments in early years can predict self-harm, anxiety, depression, suicidal tendencies, post-traumatic stress disorder and other mental health problems in the child.

NHS Digital[40] (2017) states that there is a higher prevalence of children and young people with mental health disorders where parents have poor mental health and the prevalence increases with the age of the child/young person. Children aged 2-4 years whose parents have poor mental health have a higher prevalence of mental health disorders at 14.9% compared to 4.1% of children whose parents have good mental health. This increases to 23.4% of children aged 5-10 years whose parents have poor mental health compared to 7.0% of children whose parents have good mental health and increases again in children aged 11-16 years, at 29.6% of 11-16 year olds whose parents have poor mental health, compared to 10.9% in children whose parents have good mental health[40].

National prevalence estimates show that there is a high percentage of children aged 0-5 years living in households where an adult is experiencing moderate mental ill-health symptoms at 31.9% (Figure 24) and a high percentage of children aged 0-5 years living in a household where an adult is experiencing severe mental ill-health symptoms at 11.5% (Figure 25).

Other parental factors which can affect a child's mental health are domestic violence and substance misuse. Research conducted by Dore, Doris and Wright (1995) suggests that children who live in households with parental substance misuse, have a higher risk of having mental health problems themselves, have a greater rate of drug and alcohol use in adolescence, have higher levels of anxiety and depression and have lower self-esteem[41].

Early Intervention Foundation (2014) states that 25% of children witness domestic violence and abuse at least once during their childhood (before the age of 18). They also found the association between exposure to domestic violence and youth offending and the link between exposure to domestic violence and child maltreatment[42].

Using national prevalence estimates from large scale surveys, there are approximately 17.4% of children in Cambridgeshire and Peterborough living in homes with moderate Domestic Violence and substance misuse or mental health issues and 4% living in homes with severe Domestic Violence and substance misuse or mental health issues.

Figure 24: Estimated children (0-5) living in households where there is domestic violence, mental ill-health and substance misuse across Cambridgeshire and Peterborough 2018- Moderate severity

| Adult has .. | Prevalence in children aged 0 to 5 years | Estimated number of children aged 0 to 5 years Cambridgeshire | Estimated number of children aged 0 to 5 years Peterborough |
|---|---|---|---|
| Ever experienced domestic violence and abuse | 26.7% | 12,300 | 5,200 |
| Reported substance misuse | 11.2% | 5,200 | 2,200 |
| Moderate or higher mental ill-health symptoms | 31.9% | 14,700 | 6,200 |
| At least 1 issue | 45.9% | 21,100 | 8,900 |
| 2+ issues | 20.0% | 9,200 | 3,900 |
| DV&A + substance misuse issues | 5.2% | 2,400 | 1,000 |
| DV&A + mental health issues | 16.6% | 7,600 | 3,200 |
| DV&A + substance misuse issues or mental health issues | 17.4% | 8,000 | 3,400 |

Domestic violence and abuse (DV&A) = ever experienced
Parental substance misuse (alcohol or drugs) = engages in
Parental mental health issues = moderate or higher symptoms of mental or psychiatric disorders

*Source: Estimated the prevalence of the 'toxic trio', Evidence from the Adult Psychiatric Morbidity Survey, Vulnerability Technical Report 2, July 2018, Children's Commissioner's Office. Mid 2017 population estimates, ONS*

Figure 25: Estimated children (0-5) living in households where there is domestic violence, mental ill-health and substance misuse across Cambridgeshire and Peterborough 2018- High severity

| Adult has .. | Prevalence in children aged 0 to 5 years | Estimated number of children aged 0 to 5 years Cambridgeshire | Estimated number of children aged 0 to 5 years Peterborough |
|---|---|---|---|
| Adult experienced DV&A in the last year | 7.1% | 3,300 | 1,400 |
| Adult has alcohol or drug dependency | 4.4% | 2,000 | 900 |
| Adult has severe mental ill-health symptoms | 11.5% | 5,300 | 2,200 |
| Adult has as least 1 issue | 16.7% | 7,700 | 3,200 |
| Adult has 2+ issues | 5.1% | 2,300 | 1,000 |
| Adult has DV&A + substance misuse issues | 1.3% | 600 | 300 |
| Adult has DV&A + mental health issues | 4.0% | 1,800 | 800 |
| Adult has DV&A + substance misuse issues or mental health issues | 4.0% | 1,800 | 800 |

Domestic violence and abuse (DV&A) = within the last year
Parental substance misuse = dependent on alcohol or drugs
Parental mental health issues = severe symptoms of mental or psychiatric disorders

*Source: Estimated the prevalence of the 'toxic trio', Evidence from the Adult Psychiatric Morbidity Survey, Vulnerability Technical Report 2, July 2018, Children's Commissioner's Office. Mid 2017 population estimates, ONS*

## Adverse Childhood Experiences (ACE)

Adverse Childhood Experiences are stressful events which occur during childhood that directly effects a child or the environment they live in. Various researchers suggest that there is a link between a high proportion of ACEs and poor outcomes in life. According to a study by Public Health England and Liverpool Moores University[43], people with four of more ACEs are:

- Four times more likely to have had or caused an unintended pregnancy
- Four times more likely to have had sex under the age of 16
- Eight times more likely to have been a victim of violence (in the last 12 months) or incarcerated (lifetime)
- Ten times more likely to have been a perpetrator of violence (in the last 12 months)

Psychological trauma is the emotional response which a child or young person may have after experiencing a distressing ACE. However, trauma does not always occur from a single traumatic event and is often the cumulative impact of adverse relationships, events or environments which can impact the child's emotional, psychological and neurological development. **Young Minds suggests that 1 in 3 mental health conditions relate directly to ACEs** [48]**.** Therefor it is vital to understand the different types of trauma and complexities that children and young people can face.

## Family Environment

An adequate safe house and the feeling of safety is important for a child's attachment and their health and wellbeing. NHS Digital's children and young people's mental health report[11] (2017) outlines the factors that are associated with mental disorders in children, which can be seen in Figure 26.

There are many factors associated with the increased chance of mental health disorders in children aged 5-10 years, including sex, ethnicity and parental mental health, and the following:

- Parental marital status effects a child's likelihood of mental ill health as a child whose parents are married are less likely to have a mental health disorder at 6.2%, compared to 12.2% whose parents are cohabitating, 17% whose parent is a lone parent and 18.2% whose parents were previously married.
- Living with stepsiblings increases a child's likelihood of having a mental health disorder at 15%, compared to 8.7% of children who do not live with stepsibling.
- House tenure effects a child's mental health as 17.9% of children living in social rented accommodation are likely to have a mental health condition, compared to 9.5% of children living in privately rented accommodation and 5.9% in owner occupied accommodation.
- Household income effects a child's mental health chances as rates of mental disorders were higher in children living in households earning in the middle-income quintal or below, compared to children living in the highest income households.
- The qualification of the parents also plays a factor in the child's mental health, as 16.8% children whose parents have no qualifications are likely to have a mental health disorder, compared to 8.4% of children whose parents have at least one qualification [11].

In children aged 11-16, ethnicity and parental mental health can affect the child's likelihood of developing a mental health disorders, as well as parental marital status. 27.4% of children whose parents reported being a lone parent are likely to have a mental health disorder, compared to 18.5% of children whose parents were previously married and 11.6% of children whose parents reported being married. Income also affects the child's likelihood as children living in households in the highest levels of income had lower rates of mental health disorders compared to children in the lower levels of household income [11].

Based on national prevalence applied to local data, Peterborough have a statistically significantly higher prevalence of children in low income families (under 20), parents with no qualification, lone parent's families, step children in families and children living in social rented accommodation, but Peterborough does have statistically significantly lower rates of white pupils. As Cambridgeshire has a mixture of rural and urban areas, the data has been applied to the different districts, as seen in Figure 27. There are some areas in Cambridgeshire that have statistically significantly lower levels of the factors associated with mental health, such as South Cambridgeshire, but some have statistically significantly higher rates such as the Fenlands.

Figure 26: Factors that are associated with mental health disorders in children*

| Preschool children | Primary schools | Secondary schools |
|---|---|---|
| Boys | Boys | White ethnic group |
| White ethnic group | White ethnic group | Unhealthy family functioning ** |
| Parental poor mental health *** | Unhealthy family functioning ** | Poor parental mental health *** |
| In receipt of benefits (low-income and disability) | Poor parental mental health *** | Lone parent - single |
| | No parental qualifications | In receipt of benefits (low-income and disability) |
| | Lone parent – previously married | |
| | In receipt of benefits (low income and disability) | |
| | Either/both stepchildren and stepsiblings in household | |
| | Living in social rented accommodation | |

*Source: Source: Mental Health of Children and Young People in England, 2017 ** based on McCaster Family Assessment Device (FAD) *** based on GHQ-12 scores Source * based on odd ratios to determine the likelihood of a mental disorder occurring relative to the reference category, whilst controlling for other factors e.g. the odds of a boy having a mental disorder compared to girls is statistically higher*

Figure 27: Percentage of children in Cambridgeshire and Peterborough with factors that are associated with mental health disorders

| | Cambridge | East Cambridgeshire | Fenland | Huntingdonshire | South Cambridgeshire | Cambridgeshire | Peterborough | England |
|---|---|---|---|---|---|---|---|---|
| White pupils [1] | 68.8% | 91.4% | 93.9% | 88.6% | 85.3% | 85.8% | 68.7% | 73.3% |
| Children in low income families (under 20) [2] | 14.1% | 9.1% | 18.0% | 10.4% | 7.9% | 11.4% | 18.7% | 17.0% |
| No qualifications [3] | 5.2% | 5.3% | 9.6% | 4.8% | 3.2% | 5.2% | 10.3% | 7.3% |
| Lone parent families [3] | 21.9% | 16.9% | 27.4% | 20.7% | 16.0% | 20.1% | 29.8% | 28.7% |
| Step children in family [3] | 6.0% | 8.4% | 11.0% | 9.5% | 6.8% | 8.3% | 8.8% | 8.0% |
| Social rented accommodation [3] | 31.3% | 16.8% | 15.5% | 15.9% | 14.6% | 18.0% | 21.2% | 21.3% |

Almost all districts in Cambridgeshire have statistically significantly high proportions of White populations.
Fenland and Peterborough have the highest number of statistically significantly high risk factors.

Statistically significantly lower than England
Statistically similar to England
Statistically significantly higher than England

*Source: Mental Health of Children and Young People in England, 2017 ** based on McCaster Family Assessment Device (FAD) *** based on GHQ-12 scores*
** based on odd ratios to determine the likelihood of a mental disorder occurring relative to the reference category, whilst controlling for other factors e.g. the odds of a boy having a mental disorder compared to girls is statistically higher [1] Pupil characteristics, School Census 2019, DfE [2] 2016 Public Health Outcomes Framework, Fingertips, PHE [3] Census 2011, based on dependent children in families, ONS (definitions used from https://cambridgeshireinsight.org.uk/wp-content/uploads/2017/08/Children-and-Young-People-Report-2011-Census.pdf)*

## Poverty

There is a two-way relationship between mental health and deprivation: Mental health problems can lead to reduced income and employment, which entrenches poverty, but poverty is risk factor for poor mental health. A systematic review in 2008 reported that the prevalence of anxiety or depressed mood was 2.5 times higher among 10-15-year olds who had a lower socioeconomic status, compared to those of the same age from a high socioeconomic status[44].

The Institute of Health Equity 2014's report into health inequalities states that there is an association between low income and the increased risk of poor mental health, including maternal depression. They report that children living in poverty are more likely to be born premature and weigh less at birth, suffer chronic diseases such as asthma and have a greater risk of early mortality[45].

Individuals from more deprived neighbourhoods are twice as likely to be admitted to hospital for self-harm compared to more affluent areas (although there are some exceptions). This is postulated to be related to poorer health perceptions in the school environment and the local neighbourhood and due to poorer communication within families. However, the percentage

of self-harm patients attending GPs who are then referred to mental health services is lowest in those who are most deprived.
Child poverty is measured by the percentage of children under 16 living in households which are in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of Income support or Job Seeker's Allowance. Overall Cambridgeshire has statistically significantly lower levels of children (under 16) living in poverty, but Fenland and Peterborough has statistically significantly higher rates of poverty, as seen in Figure 28. All areas are experiencing a downward trend, as seen in Figure 28. Although there are pockets of poverty among all areas of Cambridgeshire and Peterborough, as seen in Figure 30.

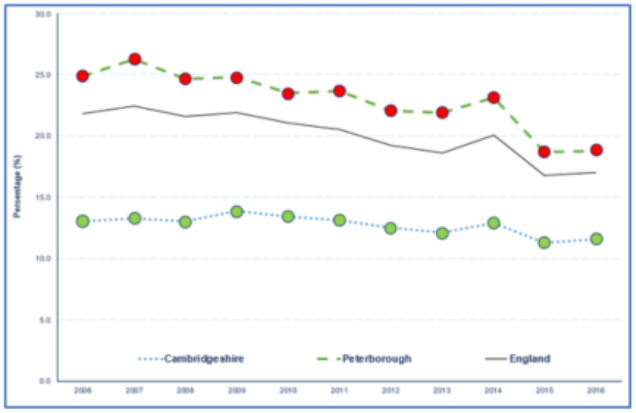
Homelessness is an association with extreme poverty and evidence suggest that it can adversely affects a child's mental health. Homelessness can put stress onto the parents and child, increasing their risk of mental health conditions. 80% of homeless people in England reported mental health issues, with 45% who had a diagnosed mental health condition[46]. Cambridgeshire has statistically similar rates of homelessness than England average, but Peterborough has statistically significantly higher rates of homelessness with an increasing trend, as seen in Figure 31.

Figure 28: Percentage of children (under 16) living in poverty – 2015

| District | % of children | Trend |
|---|---|---|
| Cambridge City | 13.7% | ↓ |
| East Cambridgeshire | 8.6% | ↓ |
| Fenland | 18.4% | ↓ |
| Huntingdonshire | 10.5% | ↓ |
| South Cambridgeshire | 7.6% | ↓ |
| Cambridgeshire | 11.3% | ↓ |
| Peterborough | 18.7% | ↓ |
| Cambridgeshire and Peterborough | 13.5% | ↓ |
| England | 16.8% | |

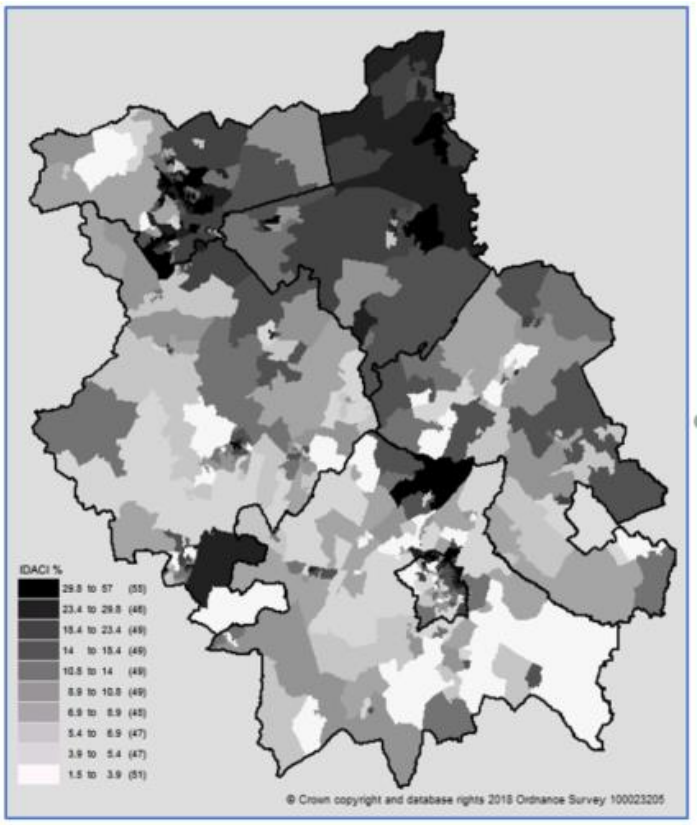
Source: Children (under 16 years) living in poverty Public Health Outcomes Framework, Fingertips, PHE

Figure 29: Percentage of children (under 16) living in poverty – 2015




Source: Children (under 16 years) living in poverty, Public Health Outcomes Framework, Fingertips, PHE

Figure 30: Income deprivation affecting children aged 0-15 years (%)




Source: Income Deprivation Affecting Children Index (IDACI), Department for Communities and Local Government

Figure 31: Family homelessness in Cambridgeshire and Peterborough, 2017/18

| Area | Number | Rate per 1,000 households | 95% Confidence Intervals | Trend |
|---|---|---|---|---|
| Cambridgeshire | 479 | 1.8 | (1.6 - 1.9) | ↔ |
| Peterborough | 461 | 5.8 | (5.2 - 6.3) | ↑ |
| Cambridgeshire and Peterborough | 940 | 2.7 | - | ↑ |
| England | 40,990 | 1.7 | (1.7 - 1.8) | ↑ |

*Source: Public Health Outcomes Framework, Fingertips, Public Health England*

## Bereavement

The death of a loved one can be difficult for anyone, but especially children as they try to understand what has happened and how to communicate and process their feelings. Childhood bereavement network estimates that in 2014 there were 41,000 dependent children aged 0-17 bereaved[47]. Research conducted in 2011 [48] found that children who had been bereaved by a parent were 1.5 times more likely to develop mental health disorders than children that were not. **Young Minds suggest that children who experience a bereavement have three times the risk of depression of those who have not**[49].

## Bullied/Cyberbullied

Bullying is when someone seeks to harm, coerce or intimidate someone else who is assumed to be more vulnerable. Cyberbullying is the use of an electronic communication to bully another person. The **Annual Bullying survey (2018) revealed that 28% of those surveyed (9,150 people aged 12-20) reported that they had self-harmed as a result of being bullied, 34% had suicidal thoughts, 50% felt depressed, 45% felt anxious, 15% developed an eating disorder and 11% had attempted suicide.** [50] However, this appears to be a repeated cycle. The Mental Health Foundation (2018) states that children who have a mental health disorder are twice as likely to have been bullied or cyberbullied in the last year, but they are also more likely to bully others[51].

In Cambridgeshire and Peterborough's Health Related Behaviour survey completed by year 8 and 10 pupils reported that young people with a mental health disorder were more likely to have been bullied and/or cyberbullied. In Cambridgeshire 6% of pupils responded that they 'often' or 'very often' feel afraid of going to school because of bullying and 12% of boys and 22% of girls reported being worried about being bullied 'quite a lot' or 'a 'lot'. In Peterborough 9% of pupils responded that they 'often' or 'very often' feel afraid of going to school because of bullying and 16% of boys and 27% of girls reported being worried about being bullied 'quite a lot' or 'a lot'.

As mentioned, people who have been bullied are more likely to bully others. In the Health Related Behaviour survey 3% of pupil responded that they think others may fear going to school because of them, compared to 4% in Peterborough. Although this does not necessarily mean they bully, this may cause anxiety in others and also prevent them from attending school and receiving good grades which are protective factors for mental health.

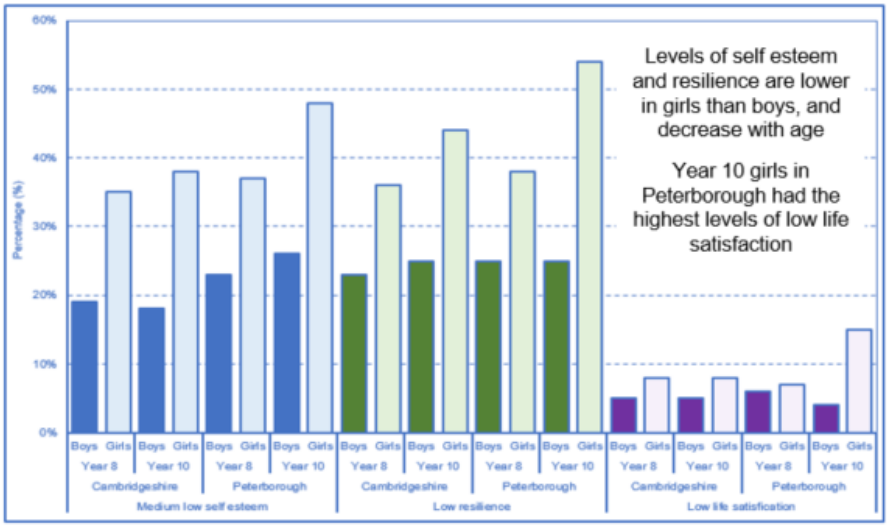
## Health Related Behaviour Survey

The Health Related Behaviour survey is a self-reported questionnaire conducted in most secondary schools across Cambridgeshire and Peterborough, completed by year 8 and 10 pupils. The report helps with strategic planning, jointly with the school and local council to prevent children developing mental and physical health problems.

In Cambridgeshire and Peterborough there were a high proportion of girls who reported low to medium levels of self-esteem, with similar levels in year 8's and 10's, but notably higher in year 8 girls in Peterborough. The results also show that there is a higher proportion of girls who reported low levels of resilience, with a notably increase between year 8 and year 10 girls. Overall Peterborough's Year 10 girls reported having lower levels of self-esteem and resilience compared to Cambridgeshire's, as seen in Figure 32. Top worries were also rated which can be seen in Figure 33. The top worries that pupils reported were about their careers, schools work, relationships with friends and parents/carers, as well as their parents/carer relationships, their health and the way they look, although clear differences can be seen between girls and boys.

The Health Related Behaviour survey also asked pupils to report on their lifestyle, such as whether they smoke, drink alcohol, take drugs and about their diet and fitness levels, which are all considered risk factors for mental ill-health. They also increase the young person's likelihood of dying by suicide or self-harming. Figure 34 shows the 2018 results surround the lifestyle questions which shows healthy lifestyles decreasing from year 8's to year 10's and Peterborough's children having poorer positive lifestyle behaviours than Cambridgeshire, with the exception of alcohol use.

Figure 32: Health Related Behaviour survey, 2018 Emotional Health and Wellbeing results




*Source: Health Related Behaviour Survey, 2018, School Health Education Unit*

Figure 33: Health Related Behaviour survey, 2018 Worries results

| Top worries 'quite a lot' or 'a lot' | | | |
|---|---|---|---|
| **Boys** | | **Girls** | |
| **Cambridgeshire** | | | |
| Their career | 43% | School-work/exams/tests | 67% |
| School-work/exams/tests | 38% | The way they look | 61% |
| Relationships with friends | 37% | Relationships with friends | 55% |
| Relationships between parents/carers in their family | 35% | Their career | 49% |
| Their health | 29% | Relationships between parents/carers in their family | 43% |
| **Peterborough** | | | |
| Their career | 52% | School-work/exams/tests | 65% |
| Relationships between parents/carers in their family | 50% | The way they look | 59% |
| Relationships with friends | 43% | Their career | 57% |
| Relationships between children and parents/carers in the family | 40% | Relationships with friends | 53% |
| Their health | 39% | Relationships between parents/carers in the family | 49% |

*Source: Health Related Behaviour Survey, 2018, School Health Education Unit*

Figure 34: Health Related Behaviour survey, 2018 lifestyle results

| | Cambridgeshire | | | Peterborough | | |
|---|---|---|---|---|---|---|
| | Year 8 | Year 10 | Total | Year 8 | Year 10 | Total |
| Number of pupils | 3,860 | 3,473 | 7,333 | 710 | 514 | 1,224 |
| No fruit or vegetables on the day before the survey | 7.3% | 10.0% | 8.6% | 10.9% | 15.9% | 13.0% |
| Nothing to eat or drink before lessons on day of survey | 10.3% | 12.9% | 11.5% | 13.9% | 20.5% | 16.7% |
| Unfit or very unfit | 15.8% | 21.6% | 18.6% | 19.4% | 26.1% | 22.2% |
| Ever smoked | 5.9% | 22.1% | 13.5% | 7.2% | 21.8% | 13.3% |
| Drank alcohol in the 7 days before the survey | 15.0% | 35.5% | 24.7% | 13.9% | 34.2% | 22.3% |
| Ever offered drugs | 11.2% | 36.8% | 23.2% | 17.8% | 37.3% | 25.7% |
| Ever taken drugs | 3.5% | 16.0% | 9.4% | 4.5% | 18.3% | 10.1% |
| Don't know if local contraception advice service | 79.7% | 71.3% | 75.8% | 82.8% | 58.8% | 73.5% |
| In sexual relationship or had sex in the past | 2.0% | 14.8% | 8.0% | 3.5% | 16.2% | 8.3% |
| Experienced at least one negative behaviour * in relationship with a current or previous boyfriend/girlfriend | 22.4% | 28.1% | 25.1% | n/a | n/a | n/a |

*Source: Health Related Behaviour Survey, 2018, Schools Health Education Unit*

The Health Related Behaviour Survey also asks young people about their sexual and personal relationships. Negative relationship behaviours increase with age and are generally higher in Peterborough than Cambridgeshire, but the numbers are relatively small and therefore prone to fluctuation. Issues with friendships whilst in a relationship appear to be the highest harmful behaviour noted in both schools years and in both Cambridgeshire and Peterborough.

Around 1 in 6 Year 10 pupils have been in a sexual relationship. The proportion who have taken risks with sex after drinking alcohol or drug use is higher in Peterborough than Cambridgeshire but the numbers involved are very small.

Figure 35: Health Related Behaviour survey, 2018 sexual and personal relationship results

| | Cambridgeshire | | | Peterborough | | |
|---|---|---|---|---|---|---|
| | Year 8 | Year 10 | Total | Year 8 | Year 10 | Total |
| Number of pupils | 3,860 | 3,473 | 7,333 | 710 | 514 | 1,224 |
| Relationships (with a previous or current boyfriend/girlfriend) | | | | | | |
| Used hurtful or threatening language to me | 7.9% | 12.5% | 10.1% | 10.3% | 18.3% | 13.4% |
| Was angry or jealous when I wanted to spend time with my friends | 15.5% | 21.2% | 18.2% | 19.3% | 25.8% | 21.8% |
| They kept checking my phone | 7.1% | 11.8% | 9.3% | 9.2% | 16.3% | 11.9% |
| Put pressure on me to have sex or do other sexual things | 4.1% | 8.7% | 6.3% | 4.8% | 10.6% | 7.0% |
| Threatened to tell people things about me | 6.1% | 8.6% | 7.3% | 7.1% | 10.9% | 8.5% |
| Threatened to hit me | 3.3% | 4.6% | 3.9% | 5.6% | 7.0% | 6.1% |
| Hit me | 3.9% | 5.7% | 4.8% | 7.5% | 7.2% | 7.4% |
| Sexual relationships | | | | | | |
| Currently in a relationship and thinking about having sex | 2.0% | 5.2% | 3.5% | 2.1% | 4.7% | 3.1% |
| In a sexual relationship or have had sex in the past | 2.0% | 14.8% | 8.0% | 3.5% | 16.2% | 8.3% |
| Taken risks with sex after drinking alcohol or drug use | 0.5% | 5.0% | 2.7% | 4.5% | 10.4% | 9.0% |
| Gone further than would like after drinking alcohol or drug use | 2.2% | 7.6% | 4.8% | 2.0% | 6.1% | 3.6% |

*Source: Health Related Behaviour Survey, 2018, Schools Health Education Unit*

## Excess weight

It is well known that there is a correlation between obesity and mental ill health, even starting at a very young age[52]. Research has shown correlation between obesity and poor mental wellbeing, with the evidence particularly strong for the link to depression[53]. Proposed mechanisms include weight-based stigmatization/teasing and perceived weight and shape[54].

Cambridgeshire has statistically significantly low proportions of overweight and obese pupils in both Reception and Year 6 compared to England. Proportions are statistically similar to the national averages in Peterborough, with the exception of severe obesity in Reception and overall excess weight in Year 6 pupils, which are statistically significantly high.

Figure 36: Excess weight in Reception and Year 6 pupils, 2018/19

| | Reception (4-5 year olds) | | | | | | | | Year 6 (10-11 year olds) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Overweight | | Obese (includes severely obese) | | Severely obese | | Total excess weight | | Overweight | | Obese (includes severely obese) | | Severely obese | | Total excess weight | |
| | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| Cambridge | 100 | 9.4% | 56 | 5.2% | 11 | 1.0% | 156 | 14.6% | 123 | 12.6% | 129 | 13.3% | 24 | 2.5% | 252 | 25.9% |
| East Cambridgeshire | 76 | 8.9% | 54 | 6.3% | 11 | 1.3% | 130 | 15.2% | 106 | 11.7% | 136 | 15.0% | 21 | 2.3% | 242 | 26.7% |
| Fenland | 135 | 12.9% | 108 | 10.4% | 23 | 2.2% | 243 | 23.3% | 135 | 14.1% | 197 | 20.6% | 42 | 4.4% | 332 | 34.7% |
| Huntingdonshire | 234 | 12.7% | 125 | 6.8% | 28 | 1.5% | 359 | 19.4% | 224 | 12.8% | 258 | 14.7% | 45 | 2.6% | 482 | 27.5% |
| South Cambridgeshire | 182 | 10.4% | 92 | 5.3% | 17 | 1.0% | 274 | 15.7% | 204 | 11.7% | 196 | 11.2% | 29 | 1.7% | 400 | 22.9% |
| Cambridgeshire | 727 | 11.1% | 435 | 6.6% | 90 | 1.4% | 1,162 | 17.7% | 792 | 12.5% | 916 | 14.5% | 161 | 2.5% | 1,708 | 27.0% |
| Peterborough | 331 | 11.8% | 278 | 9.9% | 86 | 3.1% | 609 | 21.7% | 392 | 14.2% | 629 | 22.7% | 140 | 5.1% | 1,021 | 36.9% |
| England | 77,151 | 12.9% | 57,869 | 9.7% | 14,495 | 2.4% | 135,020 | 22.6% | 84,514 | 14.1 | 121,409 | 20.2% | 26,158 | 4.4% | 205,923 | 34.3% |

*Source: National Child Measurement Programme, NHS Digital*

## Not in Employment, Education or Training (NEET)

NEET refers to young people aged 16-24 years who are not in employment, education or training. Evidence suggests that young people who are NEET are likely to have a two way relationship to mental health; as poor mental health can result in NEET and people who are NEET are more likely to have mental health problems[55]. A study released in the Journal of Child Psychology and Psychiatry found that almost 60% of NEET participants had already experienced more than one mental health problem, compared to 25% of young people that were in education, employment or training. The survey revealed that 13.5% of NEET participants had generalised anxiety disorder compared to 6.4% of those who are non-NEET and 35.4% of NEET suffered depression, compared to 18.1% non-NEET.

**In 2017, 3.2% of 16-17 year olds in Cambridgeshire and 7% of 16-17 year olds in Peterborough were NEET,** which can be seen in Figure 37. This means that Cambridgeshire is statistically significantly lower than England's average, but Peterborough were statistically significantly higher.

Figure 37: 16-17 year olds not in education, employment or training (NEET) in Cambridgeshire and Peterborough - 2017

| Area | Number | Percentage (%) | 95% Confidence Intervals |
|---|---|---|---|
| Cambridgeshire | 390 | 3.2 | (2.9 - 3.5) |
| Peterborough | 320 | 7.0 | (6.3 - 7.8) |
| Cambridgeshire and Peterborough | 710 | 4.2 | (3.9 - 4.5) |
| England | 68,070 | 6.0 | (6.0 - 6.0) |

*Source: Public Health Outcomes Framework, Fingertips, PHE*

As NEET is a risk factor for poor mental health, it is important that all young people in Cambridgeshire and Peterborough achieve a good level of development and receive adequate GCSE results. Although in 2017/18 Cambridgeshire performed statistically significantly higher than England's average, there were areas within Cambridgeshire than were not performing as well, as seen in Figure 38. Peterborough also has statistically significantly lower levels than England's average.

Figure 38: GCSE – Attainment 8 for Cambridgeshire and Peterborough - 2017/18

| Area | Mean Score | 95% Confidence Intervals |
|---|---|---|
| Cambridge | 52.3 | (50.6 - 54.0) |
| East Cambridgeshire | 48.2 | (46.8 - 49.6) |
| Fenland | 40.9 | (39.7 - 42.1) |
| Huntingdonshire | 45.6 | (44.6 - 46.6) |
| South Cambridgeshire | 53.3 | (52.3 - 54.3) |
| Cambridgeshire | 48.1 | (47.6 - 48.6) |
| Peterborough | 42.3 | (41.5 - 43.1) |
| England | 46.7 | (46.6 - 46.8) |

*Source: Child and Maternal Health Profile, Fingertips, PHE*

Educational attainment can be linked to the prevention of NEET and thus is an important protective factor for young people. On average Cambridgeshire has statistically significantly lower rates of pupil absence than England's average, whereas Peterborough has statistically similar rates. Similarly, with GCSE attainment, Cambridgeshire is experiencing altering prevalence rates in certain areas of the county, notably in the Fenlands as seen in Figure 39.

Figure 39: Pupil absence in Cambridgeshire and Peterborough - 2017/18

| Area | Number | Percentage (%) | 95% Confidence Intervals | Trend |
|---|---|---|---|---|
| Cambridge | 210,466 | 4.93 | (4.56 - 5.33) | ↑ |
| East Cambridgeshire | 180,996 | 4.44 | (4.07 - 4.83) | ↓ |
| Fenland | 211,561 | 5.27 | (4.88 - 5.68) | ↓ |
| Huntingdonshire | 313,445 | 4.37 | (4.10 - 4.66) | ↓ |
| South Cambridgeshire | 510,460 | 4.22 | (3.95 - 4.50) | ↓ |
| Cambridgeshire | 1,229,927 | 4.56 | (4.41 - 4.71) | ↓ |
| Peterborough | 548,926 | 4.84 | (4.62 - 5.08) | ↑ |
| Cambridgeshire and Peterborough | 1,778,853 | 4.64 | (4.52 - 4.77) | ↓ |
| England | 118,236,069 | 4.81 | (4.80 - 4.83) | ↑ |

*Source: Public Health Outcomes Framework, Fingertips, PHE*

## Transition to Adult Services

As three quarters of mental health conditions are developed before the age of 18-24, young people aged 16-25 are particularly vulnerable to mental ill-health due to a period of psychological change and by making the transition into adulthood. This can be a challenging time for many young people already receiving mental health support, as they may feel the turbulence of transitioning from CAMHS to adult mental health services. A report by the Joint commissioning panel [56] for Mental Health state that almost a third of young people receiving mental health care are lost during transition and a further third experience a disruption in their care, putting them at an increased risk.

## Transition to University

Students transitioning to university are vulnerable for several reasons. In many cases full time students move away from their social support network and face new challenges, such as living with strangers, occurring debt, academic pressure and rising living costs. Due to the increasing competitive job market, many students are also under stress to achieve a high graded degree. With three quarters of mental health conditions developed by aged 18-24, the onset of most disorders is between 18 and 25, with over 80% of undergraduates falling into this range[57]. Research done by National Union of Students in 2013 of 1,200 students found that 20% considered themselves to have a mental health problem and 13% have suicidal thoughts. The research also found that an alarming 92% of those surveyed revealed that they had had feelings of mental distress, with a third suffering mental distress every week[58].

Cambridgeshire has two universities located in Cambridge City centre. Although the exact number of students is difficult to calculate, there is also no data on amount of the students living in Cambridge. However, it can be expected that there are is large number of students living in Cambridge City centre.

## Policy Context

There are strong national drivers with increased focus on developing mental health support for people of all ages. However, with seventy-five percent of mental health conditions developed by the age of 18-24, many strategies and policies highlight the importance of focusing on perinatal, children's and young people's mental health. Below we have highlighted the key national and local policy documentation and evidence which will guide a pre-birth to twenty-five mental health strategy.

### National Policy Context

The NHS Long Term plan [59] includes their focus on ensuring a 'strong start in life' for children and young people, including improving children and young people's mental health services. They state that three quarters of all mental health disorders are established by 24 and so their 'A strong start in life for children and young people' section includes children and young people up to the age of 24. The plan sets out the priorities as:

- Expanding mental health services for children and young people, including crisis centres to reduce the burden on A&E departments, boosting children's and young people's eating disorder services and embedding mental health support into schools and colleges.
- Taking actions to improve circumstances for children and young people with learning disabilities and Autism, including reducing waiting times for specialist services, tackling the causes of morbidityy and preventable deaths and increasing investment in crisis, intensive and forensic community support.
- Developing mental health services so that 70,000 more children and young people will access treatment by 2020/21.
- Expanding community-based mental health services so an additional 345,000 more children and young people will have access to support by 2023/24.
- Embedding mental health support for children and young people in schools and colleges, ensuring that one fifth of schools have access to a Mental Health Support Team by 2023.
- A new approach to support young people aged 18-25 as they transition into adulthood, by expanding and developing new care models and working with the Mental Health in Higher Education Programme to build universities capability and capacity for student welfare services.

The Long Term Plan aims to improve access to, and the quality of, perinatal mental healthcare for mothers, their partners and children.

Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth (care is currently provided from preconception to 12 months after birth), in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of a child's life;

• Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions;
• Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required. This will contribute to helping to care for the **5-10% of fathers** who experience mental health difficulties during the perinatal period;
• Increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting. **Maternity outreach clinics** will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

The Government's Prevention vision [60] states their plan to give every child the best start in life, including:

- Protecting and improving children's mental health, ensuring government funded organisations work together to do everything they can.
- Schools have an important part to play, in terms of the opportunities they offer to be active, the food they serve and how they support children's mental health.
- Taking a whole family approach by coordinating support across a range of areas, including employment, debt, housing and physical and mental health.

Transforming children and young people's mental health provision: a green paper (2017) [61] noted that there were significant differences in referral treatment times, ranging from 4 to 100 weeks. As such, the paper proposed to introduce a new waiting time standard and sets out how mental health support in school will be improved and has three main elements:

- Funded new Mental Health Support Teams to provide extra capacity for ongoing help and early intervention.
- Incentives for every school and college to identify a designated senior Lead for mental health to oversee the approach to mental health and wellbeing.
- Trials of four week waiting times for access to specialist NHS children and young people mental health services.

The Healthy Child Programme From 5-19 years old [62] stresses the importance of prevention and early intervention in children and young people: 'Lifestyles and habits established during childhood, adolescence and young adulthood influence a person's health throughout their life.' Lack of intervention in childhood and adolescent-hood will cause further health implication in the future and add an additional financial pressure on the Healthcare system. The programme focuses on a universal preventative service, with the aims to improve many areas of children's and young people's health and wellbeing.

Five Year Forward View for Mental Health (2016) [63] sets out a list of priorities for mental health, emphasising the need for a shift towards prevention and better integration of care. They make several recommendations on the transformation of mental health care including:

- Helping 70,000 more children and young people to access high quality mental health care when they require it.
- Supporting 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.
- Investment to ensure no acute hospital goes without an all-age mental health liaison service within their A&E department and inpatient wards.
- Ending the practice of sending children and young people out of their local areas for acute inpatient care.

No Health without Mental Health (2011) [64] is a cross-government outcomes strategy which sets out six shared priorities to improve mental health care and support for people of all ages. It highlights its ambition for mental health to be given equal priority to physical health and something that everyone must be concerned with.

Suicide Prevention Strategy for England (2012) [65] is a cross-government outcomes strategy which sets out six key action areas to help deliver the following two objectives:

- Better support for people beavered or affected by suicide.
- A reduction in the suicide rate in England.

Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing (2012) [66] sets out clear national ambitions via proposals to transform the design and delivery of mental health services for children and young people, including:

- Ensuring that children and young people in every part of the country have timely access to clinically effective mental health support when needed.
- Increased use of evidence-based treatment with services that are focused on outcomes.
- Improved care for children and young people in crisis in order for them to be treated close to home and at the right time.

Better births (2016) [67]: 'Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.' (National Maternity Review, 2016)
Within this vision, the review sets out seven recommendations for actions including better postnatal and perinatal mental health care to address the historical underfunded provision that includes:

- Smoother transition between midwifery, obstetric and neonatal care and the ongoing care in the community
- Investment in perinatal mental health service in specialist care and the community
- Resourcing postnatal care appropriately

## Local Policy Context

This strategy falls within the scope of the Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy 2019-24 under priority 2: Helping children achieve the best start in life. However, this strategy cannot be achieved in isolation and thus is supported by other local strategies.

Health and Wellbeing Strategy 2019-2024 sets out four key priorities to improving the health and wellbeing of the people living with Cambridgeshire and Peterborough. These priorities are:

- Priority one: Places that support health and wellbeing
- Priority two: Helping children achieve the best start in life
- Priority three: Staying healthy throughout life
- Priority four: Quality health and social care

Think Communities is Cambridgeshire and Peterborough's approach to creating a shared approach, vision and priorities for building community resilience and reducing the communities demand for statutory services. Think communities will adopt a place-based approach, with the emphasis of long term system change.

Special Education Needs and Disabilities (SEND) strategy 2019-24 [68] sets out the shared belief that SEND should be 'everyone's business' and is the responsibility of all service providers who come into contact with children and young people with SEND. It has three priority areas:

1) SEND is everybody's business - embedding the vision of the SEND Strategy into the practice of everyone who works with children and families in ways that strengthen families.
2) Identify and respond to needs early - a holistic and joined up early identification of and graduated response to needs.
3) Deliver in the right place at the right time - improving outcomes for children and young people through making best use of resources, ensuring a graduated response and high quality local support and provision.

Best Start in Life Strategy 2019-2024 (prebirth to age 5) [69] aims to improve the lives of children across Cambridgeshire and Peterborough by improving outcomes for children, narrowing the gap in attainment and by addressing inequalities. The three headline outcomes for children pre-birth to age 5 are:

- Children live healthier lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning.

## Service Mapping

This section provides an overview of the mental health services across Cambridgeshire and Peterborough for children, young people and women during the perinatal period. The purpose of the service mapping is to better understand the current provision and to identify any gaps. Services are categorised into three group; children and young people's mental health services, children and family services and perinatal mental health services. It is important to note that one of the limitations of this service mapping is that it does not take into account the capacity of each service and thus the strain on each service cannot be seen.

### Children's and Young People's Mental Health Services

Core services:

- Child and Adolescent Mental Health Service (CAMHS) provides assessment and treatment for children and young people (up to aged 17) who are experiencing emotional problems, anxiety difficulties, major eating problems, psychosis or other mental health problems.
- First Response Service (FRS) provides a 24-hour access to mental health care, advice, support and treatment to people of all ages across Cambridgeshire and Peterborough (as long as they are registered with a Cambridgeshire or Peterborough GP). FRS has trained CAMHS mental health staff (5-11 pm) who can help service users over the phone, to prevent them going to the local acute hospital.
- The Emotional Health and Wellbeing Service offers telephone support and guidance to professionals from the educational setting. The team has recently expanded to include Children's Wellbeing Practitioners who deliver evidence-based interventions for children and young people who are:

- Aged 5-8 year olds who have behavioural difficulties
- Aged 5-18 year olds with anxiety
- Aged 11-18 year olds with low moods

  Two new additional posts have been secured to work specifically in Fenland and East Cambridgeshire to deliver an enhanced level of support for professionals to ensure young people access the correct level of support that meets their needs. The next phase for the team will be to work with Chums to deliver group session to young people.

- Chums is a mental health and emotional wellbeing service for children and young people. They are commissioned to deliver mental health and emotional wellbeing provision to children and young people aged 0-17 in Peterborough and up to 25 in Cambridgeshire. When the contract started in January 2018, they had a target of reaching 2,000 children and young people a year. However, they have exceeded the target, with 4,275 referrals being received from April 2018-March 2019 and 2,446 children and young people receiving a service.
- Transition pathway with CAMH provision helps young people transition into adult mental health services. Analysis of access data reveals that the number of 17-year olds treated in community CAMH services has increased from 352 in FY 2016/17 to 582

in FY 2018/19. This is an increase of an additional 230 17-year olds, which is significantly above the original set target of increasing access by 100 17-year olds.

- Community Eating Disorder Service (CEDS) provides evidence-based treatment to people with an eating disorder, commissioned to see approximately 100 cases per year.
- CAMEO is a service for young people and adults (14-65 years) who are experiencing symptoms of psychosis for the first time.
- Trained Mental Health A&E staff work within the three main A&E departments, working 4pm to midnight every night to help children and young people who are having a mental health crisis.
- School nurses work across education and health settings, providing the link between school, home and community. They provide confidential advice and support to children, young people and their parents or carers. In Cambridgeshire and Peterborough, they also operate the ChatHealth text messaging service for 13-19 years which offers support on a range of topics such as mental health, self-harm and bullying.
- School Mental Health Support Teams - As part of the Transforming Children and Young People's Mental Health Provision: A Green Paper, the Department of Health and the Department for Education will fund the new school mental health support teams. Cambridgeshire and Peterborough have been given funding for two roles, with further funding expected so the whole of Cambridgeshire and Peterborough will have access to this service.
- School mental health training: All schools are encouraged to have a mental health lead and for all staff to have some form of mental health training. The Kite Trust, the Emotional Health and Wellbeing service, Chums, YMCA Trinity Group and CPFT CAMHS all offer mental health training to schools across Cambridgeshire and Peterborough. However, uptake of the training is variable, even when the training is free of charge.
- PSHE: A range of PSHE resources are available for schools through the Keep Your Head website, including short films to guide teachers through delivery of PSHE sessions on Healthy Relationships, Body Image, Anti-bullying, Conflict Resolution and My Emotions. The local PSHE service also provide anti-bullying and resilience training to schools.
- Healthy Schools Service: Provide training and resources to support a whole school approach to promote resilience and mental health.
- Kooth is an online counselling and emotional well-being platform for children and young people. Young people can access the on-line counselling until 10pm.
- Centre 33 offers drop-ins and a helpline to young people (up to 25 years) in Cambridgeshire and Peterborough to assist with a range of concerns such as sexual health, emotional health, finances, housing and young carers.
- Here:Now offers a range of advice, guidance and support for young people aged 13-25 on a range of lifestyle subjects, including emotional and mental health. They offer

advice and information, 1:1 support, 1:1 counselling, mindfulness sessions and therapy activities. They are currently located in Huntingdon and Peterborough.

- Cambridgeshire and Peterborough Neurodevelopment service is a service for school aged children and young people (5-17 years) who are diagnosed with or suspected to have ADHD, autism or a diagnosed learning difficulty.
- Cambridgeshire Child and Adolescent Substance Use Service (CASUS) provides information, support and specialist treatment in Cambridgeshire for young people (up to 18 years) and their families on alcohol and drug use.
- The Darwin Centre for Young People is an inpatient adolescent mental health unit in Cambridgeshire providing intensive, inpatient treatment of children and young people with severe and high risk mental health disorders. It is one of 6 inpatient wards for adolescents in the East of England.
- CAMH Intensive support team is a community focused team with close links to the Darwin Centre, offering an alternative to hospital admission for young people aged 12-18 years who are experiencing a crisis in their mental health and offers support for their families or carers.
- The Croft Child and Family Unit is an inpatient mental health unit that admits children under 12 with severe mental health disorders for assessment and treatment, and works intensively with families to improve children's mental health.
- The Phoenix Centre is an inpatient mental health unit for adolescents with eating disorders based in Cambridgeshire, and is the only specialist inpatient ward for young people with eating disorders in the East of England.
- The Youth Offending Psychology team aims to support young offenders with appropriate interventions that allows them to progress to adulthood and achieve the best possible personal outcome. The team's structure is about to change due to the increased demands on the service. The changes will allow the new psychology team to provide a resource to both Cambridgeshire's and Peterborough's Youth Offending Teams and the wider TYSS Youth and Family, Community and Intervention teams in Peterborough.
- East of England Community Forensic Child and Adolescent Mental Health Service (FCAMHS) is a service that provides advice, consultation and specialist support to services and teams working with young people in the community who exhibits risky behaviours or who are already in the youth justice system.
- Complex case management service offers support, guidance and intervention in complex cases where there is a risk that the child or young person (under 18 years) might fall through the gaps between services.
- Improving Access to Psychological Therapies (IAPT) as part of CPFT's Psychological Wellbeing Service provides psychological therapy for people aged 17 and above with mild to moderate depression and anxiety disorders.
- SEND service Cambridgeshire County Council's SEND Service (0-25) is a local authority service. Specialist teachers and Educational and Child Psychologists work in schools and settings directly with children and young people (0-25 years), as well as indirectly with parents, carers and professionals that work in schools. They provide

targeted support and training in all aspects of special educational needs (of which social, emotional and mental health is one). The main aim of the service is to help meet the needs of children and young people within their local community. The service aims to help children and young people with social, emotional and mental health needs to develop their independence and learning, as well as their social and emotional skills.

Voluntary services:

- Fullscope is a consortium of seven charities with a shared mission to improve the mental health and wellbeing of children and young people in Cambridgeshire and Peterborough. The seven charities include: Arts and Minds, Blue Smile, Cambridge Curiosity & Imagination (CCI), Centre 33, CPSL Mind, the Kite Trust and YMCA Trinity Group. The overarching aim of Fullscope is to work collaboratively to enable Cambridgeshire and Peterborough communities to raise happier, healthier children and young people who are without mental ill health.
- YMCA Trinity Group is a local charity which offers emotional wellbeing services for children and young people.
- The Kite Trust offers supports and promotes the health, wellbeing and inclusion of LGBT+ young people across Cambridgeshire.
- The Proud Trust offers support to LGBTQ young people aged 16-25 in Peterborough.
- STARS offers pre and post bereavement counselling support to children and young people (up to 25 years) in Cambridgeshire.
- Time4U offers support for those in Cambridgeshire and Peterborough affected by sexual violence.
- Red Balloon supports young people who self-exclude from school or who are missing education due to bullying or trauma.
- Blue Smile provides art-based, long term therapy in Cambridgeshire schools for children aged 3-12 who are struggling with mental or emotional issues.
- CPSL Mind is the local Mind charity for Cambridgeshire, Peterborough and South Lincolnshire, helping everyone to have positive mental health and feel connected to their community. The charity offers a range of projects and services across the county to support those recovering from mental health challenges.
- K9 project offers educational and personal development opportunities, community projects and canine assisted coaching programmes in Cambridgeshire.
- Link to Change offers support to people aged 12-26 who are at risk or have been victims of Child Sexual Exploitation and Child Criminal Exploitation in Cambridgeshire, Peterborough, Luton and Bedfordshire.
- The red hen project is a local charity working with five primary schools in North Cambridge to support children and their families to overcome barriers to leaning, blending the link between home and school.
- Arts on Prescription is a series of friendly, weekly art workshops for people experiencing depression, stress or anxiety.

- Make Do and Mend provides workshops for people who experience mental distress, aiming to promote recovery by developing self-esteem through developing skills.
- The Road Victims Trust is a charity that offers emotional and practical support services to victims of serious road collisions across Cambridgeshire, Hertfordshire and Bedfordshire.
- The Cogwheel Trust provides counselling and psychotherapy support for people in Cambridgeshire experiencing mental health problems.

Gaps in children and young people's mental health services:

- Lack of integration and many services working in silos
- School training: Although it is assumed that many schools across Cambridgeshire and Peterborough are accessing mental health training, there is little evidence on what training they are undertaking, whether the training is being used and whether learning is being passed on to colleagues. Schools can access training from providers of their choice, including locally and nationally, but there is little communication with each school across Cambridgeshire and Peterborough to understand which schools are accessing training and which may require assistance to do so.
- Duel trained staff: There is a known barrier between nurses trained in physical health and those trained in mental health, with little overlap. However, most physical problems will affect a child's mental health and vice versa. There are many occasions where children and young people will try to access help and be met by a professional who is only trained in physical health and thus, they must wait to be seen by a mental health professional. Examples of this includes many A&E staff and paramedics.

### Children and Family Services

Core services:

- Parenting programmes are offered across Cambridgeshire and Peterborough and cover a host of topics such as stepping stones which is a parenting course for parents with children who have SEND, courses for parents raising teens, courses for parents raising children with ADHD and many others.
- Mental Health Clinicians are embedded in social care teams in Cambridgeshire (SWFF the Hackney model) to work with children and families in the social care system with mental health disorders. This is to be slimmed down and in part replaced with fewer mental health nurses working only with adults (the Herefordshire model).

Voluntary services:

- Family Voice and Pinpoint are two charities based in Cambridgeshire and Peterborough working together to provide support for parents or carers whose child or young person has mental health difficulties.
- Romsey Mill is a Christian charity creating opportunities for children, young people and families in Cambridgeshire, including young parenting programmes and youth development.

- Annabelle Davis Centres are community-based early intervention and prevention hubs created to tackle a range of issues effecting young people and their families. They embrace partnership working and information sharing across multiple agencies in order to make it easier for those in needs to find help sooner. There is currently one centre located in Yaxley (Peterborough), with a second centre due to be built in Wisbech.
- Ormiston families provides early support for people experiencing mental and emotional health problems and works with families affected by imprisonment or offending behaviour of a relative.
- Aiming High Group offers support groups to parents or carers of children with disabilities or special needs.
- Barnardo's offers a range of support and guidance to children, young people and families, which provides support to:

- Young people leaving care
- Young people who requires help with employment, training and skills
- LGBTQ young people
- Children and young people with mental ill-health
- Young carers
- Children and families affected by domestic abuse
- Young people and their families experiencing problems with alcohol and drugs
- Children with a parent in prison
- Children seeking asylum

### Perinatal Mental Health Services

Core services:

- Specialist community perinatal mental health team is a multi-disciplinary mental health service for perinatal women with severe or complex mental health needs. They work with the women and their families on a range of areas including preconception, postnatal and when there are complex issues in the home e.g. substance misuse or domestic violence. The team also offers training to a range of other professionals such as Health Visitors, Midwives, General Practitioners, Social Workers, Family Centre staff and voluntary sector staff.
- Specialist Mental Health Midwives bring people together to improve the quality and coordination of care, helping to ensure important information about women and their families is shared effectively and women with mental ill-health receive high quality support. There are two specialist mental health midwives at the Rosie (Cambridge) who are providing training to other midwifes within the Rosie, but there is little information on NWAFT's stance.
- The Rainbow team are based in Peterborough City Hospital, dedicated to support women with additional pregnancy needs, such as teenage pregnancy, women with mental health problems, women with drug and alcohol problems, women with diabetes and women with HIV.

- Specialist Bereavement Midwives work in all three hospitals across Cambridgeshire and Peterborough, offering support to women and their families following a bereavement.
- Healthy Child Programme Health visitors will conduct a maternal mental health assessment at the 6-8 week home visit, as well as looking out for signs of mental ill-health in all their visits. Cambridge Community Services NHS Foundation Trust (CCS) has one full time family mental health specialist for 0-19 and two champions for family mental health 0-5. There are no specialists within CPFT, but there is one champion health visitors and five practitioners with the Institute of Health Visitors Mental Health champion training. Many Health visitors also have Newborn Observation, listening and motivational interviewing techniques training. Student Health visitors have two day training in perinatal and infant mental health.
- Child and families centres offer some services which are aimed at infant mental health and attachment, including: Newborn Observation, 5 to Thrive, antenatal education, the FAB project, the Acorn project, CALMS, Next steps and baby massage. However, these services are all generally small, catering for less than 10 families at a time and have long waiting lists.
- The Family Nurse Partnership & Enhanced Young Parent Pathway is an intensive home visiting programme for first time mothers aged under 19.
- Improving Access to Psychological Therapies (IAPT) services provides DBT, CBT and talking therapies to perinatal women experiencing mild to moderate mental health problems. There current target is to assess 500 women, but this target will slowly increase due to requirements from the NHS Long Term plan.
- Antenatal education classes are offered by the community midwives, and there is specialist mental health training within the antenatal classes in Fenland.
- Kingfisher Mother and Baby Unit offers hospital admissions for women and their babies when the mother is experiencing severe perinatal mental health problems when treatment cannot be provided at home.

Voluntary services:

- CPSL Mind is a charity designed to help those who face a mental health problem. They offer formal peer support groups for women with perinatal mental health problems as part of their Connecting Mums and Mums Matter group. Their support groups are meant to be for women with mild to moderate mental health, but they are receiving a lot of parents with severe mental health problems.
- The Northamptonshire Parent Infant Partnership (NorPip) is a charity which helps parents who are struggling to form a secure attachment with their babies. They are currently providing a small amount of attachment therapy work with mothers and infants in Huntingdonshire, but there is no clear pathway.
- Ormiston families offers a ‘Small steps together’ service based in Cambridgeshire which offers support via support groups and home visits to perinatal women who have low to moderate mental health and wellbeing needs. Currently this service is only offered in Fenland.

Gaps in perinatal mental health services:

- Paternal mental health: There are currently no services specifically for the mental health of fathers.
- Bereavement support: There are no specialised bereavement support for families who have experienced a stillbirth or bereavement (post-hospital).
- Mild to moderate mental health: There are currently no specific core services for perinatal women experiencing mild to moderate mental health however Continuity of Carer through the maternity transformation programme will support this in future.
- Social support: There is a lack of social linkage for perinatal women, especially from certain vulnerable groups such as teenager mothers, travellers and the South East Asian community in Peterborough.
- Separation support: There are no formalised post-care procedures to support both the child's and mother's mental health upon the separation.
- Intensive care support: There is no specialised mental health support to parents whose child enters intensive care in Hinchingbrooke Hospital or Peterborough City Hospital. This is only offered in the Rosie.
- Foetal medicine support: There is no specialised foetal medicine mental health support. For example, support with making the decision whether to terminate a pregnancy when the child will be born with a health problem.

## Evidence Review

Having considered the services which currently exist across Cambridgeshire and Peterborough, it is important to understand what prevention approaches and prevention interventions have evidence to work in reducing mental ill-health. It is also important to take the relevant NICE guidance into consideration as they are based on the best available clinical evidence and thus will ensure a consistent effective approach. Due to the vast amount of evidence of what works to prevent mental ill-health, the evidence outlined in this section is not an exhaustive list but does provide a summary on which prevention approaches and prevention interventions have proven success.

This section has been written by the authors of the needs assessment and with the assistance of Vickie Braithwaite and Daniel Ng.

Before discussing the evidence, it is important to understand the different levels and types of prevention, which are outlined below.

Levels of prevention:

- Primary prevention aims to prevent injury or disease before it occurs. It focuses on preventing people from being exposed to areas which can be hazardous, by increasing resistance or by altering unsafe or unhealthy behaviours.
- Secondary prevention aims to reduce the impact of injury or disease. It focuses on identifying people who already have existing health problems and aims to slow down the deterioration or improve their situation.
- Tertiary prevention aims to minimise the impact of an ongoing injury or disease which has lasting effects. It focuses on helping people with complex or long-term health problems, in order to improve their life quality or life expectancy.

Prevention approaches:

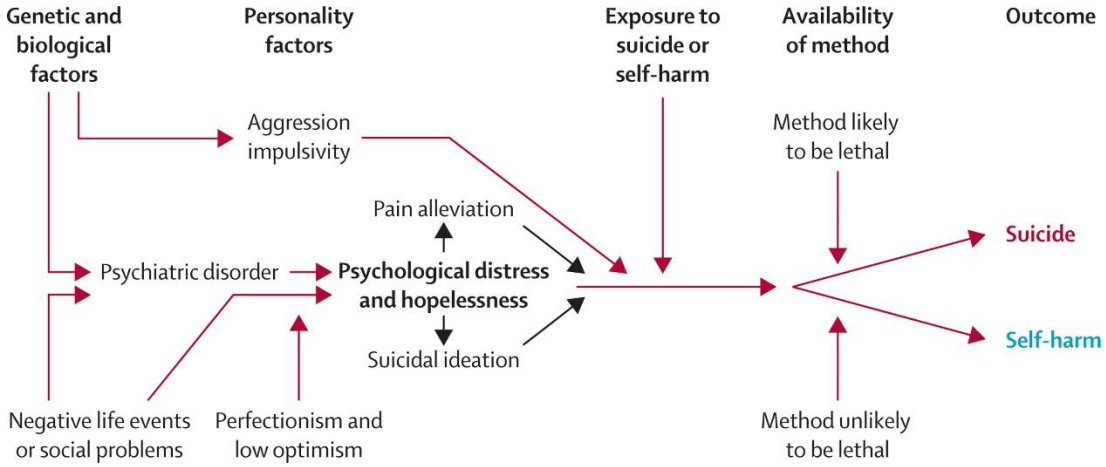
- Universal prevention is aimed at the entire population without regards to specific vulnerable groups or risk factors.
- Selective prevention is aimed towards people who have an increased risk.
- Indicated prevention is aimed at individuals who have specific symptoms.

### Research

#### Self-harm and Suicide

Self-harm and suicides preventions can be targeted at any stage of a person's journey. Figure 40 shows the key stages leading to adolescents self-harming or taking their life.

Figure 40: Stages for adolescent self-harm and suicide[18]




A systematic review conducted by Zalsman et al[70] (2018) compared 1797 studies into suicide prevention strategies. Their research shows that **school-based awareness programmes had proven to be successful at reducing suicide attempts** (odds ratio 0:45) and suicide ideation (0:5). The evidence shows that restrictions to access had strengthened from 2005 to 2015, especially with regards to control of analgesics (decrease of 43%) and hot-spots for suicide jumping (reduction of 86% since 2005, 79% to 91%). They reported that there is insufficient evidence into the possible benefits of suicide prevention in primary care settings.

A systematic review and meta-analysis by Robinson et al[71] (2018) into youth suicide prevention generally showed that clinical, school and environment prevention approaches were successful in reducing self-harm and suicide ideation. From 34,463 articles, 99 studies aimed at reducing suicide-related behaviours among young people were chosen for analysis. Their analysis showed little evidence that clinical-based interventions reduced repetition of self-harm post-intervention but did state there was little valuable research on clinical prevention. There was also little evidence for interventions which were educational, or workplace based. However, two large scale studies by Wasserman et al[72] (2015) and Schilling et al [73](2016) on school-based interventions showed a reduction in self-harm post intervention. Overall these studies showed that school-based psycho-educational interventions coupled with screening had evidence to be effective.

From their research, they conclude that interventions targeting suicide ideation were more effective than those targeting self-harm and state that interventions were stronger when theoretical underpinned. Although the research included all valuable evidence, they did report on many gaps and issues with the research, including:

- Lack of research from primary care settings although General practitioners tends to be the first point of call for children and young people with mental health problems
- Few studies which have conducted in workplaces or universities compared to schools, although suicide rates are highest in post-school age
- Only six studies tested online interventions, but all were in educational settings and CBT based

- Some groups are underrepresented in research, such as LGBT young people and some groups were overrepresented such as females

A Cochrane review by Hawton et al[74] (2015) into the interventions for children and adolescents who self-harm reported that there were very few studies which investigated the treatment of self-harm in children and adolescents. The review states that there was no clear evidence on the effectiveness for home-based family interventions, individual cognitive behavioural therapy based psychotherapy, compliance enhancement, provision of an emergency card or group adolescent therapy. Only one study proved to have reliable results which was the use of a mentalisation therapeutic approach which saw a reduction in the frequency of repetition of self-harm.

### Mental Health conditions

Prevention of mental health conditions in children and young people can be broken down into three areas: School-based interventions, community-based interventions and digital interventions. These will be discussed in turn below.

School-based interventions: A systematic review of targeted group-based interventions in UK schools to promote emotional well-being[75] states that schools need to be specific in their intervention approach. They calculate that only 25-34% of children receive treatment for their mental health, but many terminate prematurely or fail to respond as interventions are offered too late and the adverse effects of the disorders have become entranced. The article explains that Group based delivery is often effective as children are particularly responsive to socialisation, it is less threatening towards one child and it allows the school to cover a range of behavioural and emotional difficulties.

The study found that the most effective interventions were nurture provisions in primary schools. Nurture provisions in schools are short-term, focused intervention for children or young people with particular social, emotional and/or behavioural difficulties. However, nurture interventions in secondary schools were not as effective than primary. In primary schools, the sub-streams ‘participates constructively’, ‘engagement’, ‘attachment’ and ‘accommodates to others’ saw the best results. The study stated that SEAL approaches had little effect. Social and emotional aspects of learning (SEAL) is a whole-school approach to promoting emotional and social skills which underpin effect learning, emotional health and wellbeing and positive behaviour. In the three SEAL small group interventions discussed in the systematic review, only one saw results, but these were immediate and faded in the four month follow-up.

A systematic review by Hawton et al[76] (2015) of school-based interventions to promote mental and emotional well-being (worldwide) found that universal prevention interventions had little effect, with targeted programmes being the most effective. They found that Primary-school based CBT programmes saw better results in children from high risk groups. Some of the programmes include FRIENDS and ‘Think Feel Do’. CBT programmes in secondary schools shows to have little effect, with some reporting small positive outcomes and some reporting small negative outcomes. The review includes two studies that used

mindfulness-based interventions, both in secondary schools and both reported statistically significant positive effects on both depression and well-being and were maintained months after the intervention. It is important to note that this systematic review consisted mainly of studies of Australian, USA and Canadian schools, as there were no reviews focused solely on studies in UK schools.

Community-based interventions: Community-based interventions can be broad and include different prevention approaches. The reviews outlined below are those which have shown to have positive results in reducing mental ill health.

A systematic review on the effects of participating in creative activities by Bungay and Vella-Burrows[77] (2013) found that adolescents participating in creative activities showed positive effect in terms of self-esteem, self-confidence, behavioural changes, physical activity and level of knowledge.

A systematic review on preventing mental disorders in children by Waddell et al[78] (2007) into community-based parent and social skills training designed for at-risk children in early years who had anxiety and depression showed a significant reduction in mental health symptoms.

A meta-analytic review by Farahmand et al[79] (2012) into community-based behavioural and mental health programs for low income youths suggests that environment-only and person and environmental interventions had positive results, whereas person-only interventions did not. However, evidence from another meta-analytic review by Durlak and Wells[80] (1997) on primary prevention mental health programs found that individually focused mental health promotion which attempts to assist with stressful transitions, showed significant results in reducing problems and increasing competencies.

Digital interventions: A systematic review by Clarke et al[81] (2015) into online youth health promotion interventions analysed 20 studies, consisting of 15 prevention interventions. Their research showed that online cognitive behavioural therapy for adolescents and young adults with depression or anxiety symptoms was effective, but the rates of non-completion were moderate to high across a number of the studies included.

Calear and Christnsen's[82] (2010) reviewed internet-based prevention and treatment programs in children and adolescents which included eight studies of four internet-based programmes for depression and anxiety. Six of the eight studies showed reductions in the symptoms of depression and/or anxiety post intervention. The programs were delivered in a variety of settings and with differing level of professional support and so highlights the versatility of the internet-based programs. However, caution should be taken as there are very few studies into internet based interventions and many take different approaches.

## Perinatal mental health interventions

Research conducted by Personal Social Services Research Unit[83] (2016) into the benefits of different forms of early interventions to reduce or prevent perinatal mental health and their long-term effects found the following interventions to have positive effects:

Universal interventions

- Parenting education: A US study by Feinberg (2008) found that universal prevention programmes with a particular focus on involving fathers had positive success.
- Infant sleep intervention: A study conducted by Hiscock et al (2014) evaluated a universal prevention programmes offered by nurses to parents during the first home visit (after birth) which addressed postnatal depression and infant crying and sleeping problems. They concluded that the intervention was successful in reducing postnatal depression and did improve infant sleeping and crying problems.
- Yoga: Newham et al (2014) evaluated the use of an eight week yoga course offered to low-risk women during pregnancy. They concluded that the course led to significant reduction in pregnancy-specific anxiety and prevented increases in depression.

Selective prevention:

- CBT addressing multiple risks: A large US study conducted by Wilson et al (2013) evaluated the use of CBT to address depression in women with high risk factors such as smoking, domestic violence and depression. The research found that the intervention did significantly reduce pre-term birth outcomes.

Interventions for mild to moderate mental health symptoms

- Parenting and mother-infant support: Various studies have examined the benefits of home visits which focused on reducing the impact of risk factors, proving problem-solving skills and strengthening relationships. Visits which had a blanket parent-infant interaction approach showed little results, whereas a study that provided three home visits by a clinical psychologist starting during pregnancy and completed postnatal targeting maternal caregiving, found to reduce fussing or crying and increase infant sleep was successful in reducing the severity of postpartum depression.
  One study conducted by Milgrom et al (2011) evaluated a self-help intervention focused on reducing the impact of risk factors, proving problem solving skills and strengthening relationships. The women were given self-help workbooks and encouraged to discuss the content with a psychologist in weekly telephone support sessions. This intervention had an 11% recovery rate at 12 months after the intervention, allowing for the average 50% relapse rate.
- Group CBT: A US study conducted by Tandon et al (2014) evaluated the use of CBT-based group interventions designed to prevent major depression in low-income women. The intervention consisted of six two-hour intervention sessions delivered weekly between pregnancy and booster sessions after birth. As the intervention focused on preventing major depression, the relapse rate was not added and instead the different between affected women was used which was 17%.

Interventions for moderate to severe mental health symptoms

- Facilitated-self help: Two UK studies conducted by the same lead researcher O'Mahen (2013& 2014) evaluated the same type of facilitated self-help in the form of

computer-delivered, behavioural activation intervention offered during the postnatal period. This intervention had a 10% recovery rate at 12 months after the intervention, allowing for the average 50% relapse rate.

- Multi-disciplinary, specialist care in 'parent and baby day unit': One study compared the outcomes of parent and baby day units for women with moderate to major depression, offering a range of activity groups including: yoga and relaxation, hobbies and activities, stress management, couple and family counselling, creative therapy, group therapy, parents and older children, pharmacotherapy and assertiveness training. The results found little short-term results but found a reduction in postpartum depression in the six months follow up where 21 of the 30 women (70%) were no longer depressed. This intervention had a 23% recovery rate at 12 months after the intervention, allowing for the average 50% relapse rate.
- CBT (including mindfulness-based) during pregnancy: There is growing evidence to support mindfulness-based CBT in reducing anxiety in pregnancy. One study in 2013 where individualised home-based CBT was provided to females with moderate or severe depression during pregnancy had a 69% recovery rate. This intervention had a 15% recovery rate at 12 months after the intervention, after allowing for the average 50% relapse rate.
- CBT during postnatal period: There is a mixture of results for CBT therapy offered during the postnatal period. One study in 2009 which used health visitors trained in assessment for postnatal depression combined with psychological interventions using PCA and CBT approaches found a recovery rate of 4.7% at 12 months after the intervention. Another study conducted in 2010 where women with depression symptoms were referred for psycho-education group, consisting of eight 2-hour weekly meetings ran by health visitors, had a 14.5% recovery rate at 12 months after the intervention after allowing for the average 50% relapse rate. A third study in 2005 where women took part in group-based CBT within clinics, consisting of 90 minutes sessions, conducted by senior therapists and consisted of a range of topics including, time management, relaxation and partner sessions, had a 13.5% recovery rate at 12 months after the intervention after allowing for the average 50% relapse rate.
- Interpersonal therapy (IPT): A systematic review conducted in 2013 found interpersonal therapies to be cost-effective and effective in reducing postpartum depression. The most effective study conducted in 2009, offered advanced IPT to socioeconomically disadvantaged women from a particular ethnic group. The intervention consisted of acute IPT sessions before birth and maintenance IPT up to six months after birth. The intervention had an 18.5% recovery rate after allowing for the average 50% relapse rate.
- Complementary therapy: There is sufficient evidence to show that complementary therapists alongside specific psychological therapist or usual care are effective in reducing depression or anxiety in pregnancy. Various researchers including Mitchell et al (2012) and Field et al (2103) reported that 12 week yoga intervention offered during pregnancy reduced depression and anxiety. However, there is little data to support this finding.

Interventions addressing major symptoms

- Facilitated exercise: A study conducted by Daley et al (2015) where women were offered facilitated exercise, 2 face-to-face consultations and two telephone support calls alongside usual care found the intervention had an 11.4% recovery rate after allowing for the average 50% relapse rate.
- Massage therapy: A study conducted by Field et al (2009) compared group massage therapy for females with major depression during pregnancy, along with IPT. The results showed that women who received both therapies showed a decrease in anxiety and depression. However, there is little data to support this finding.
- CBT: One study evaluated the use of 15 weekly CBT sessions provided to females from vulnerable groups with major depression three month after birth as part of the home visits. The intervention had a 10.5% recovery rate, after allowing for the average 50% relapse rate.

### NICE Guidance

This section provides a summary of NICE guidance applicable for perinatal, children's and young adult's mental health, split into three sections: self-harm, perinatal mental health and mental health and wellbeing.

Self-harm: There are two current NICE guidelines regarding self-harm; the short-term (48 hrs) management and prevention of self-harm in children over 8 written in 2004[84] and the self-harm in over 8s long term management written in 2011[85].
The major recommendations from the short-term management guidance applicable to prevention planning are the following:

- Training: Clinical and non-clinical staff who come into contact with people who self-harm should be provided with self-harm specific training.
- Co-production: People who self-harm should also be involved in the commissioning, planning and evaluation of services.
- Primary Care: Referral and next steps should be decided jointly with healthcare professional and service user.

The major recommendations from the longer-term management guidance applicable to prevention planning are the following:

- Person-centred: Service users should have the opportunity to make informed decisions about their care (and longer term care) and treatment in partnership with health and social care professionals.
- Psychosocial assessment: Patients should be offered an integrated and comprehensive psychosocial assessment of need; including, coping strategies, mental health, physical health, social, family and life circumstances and the needs for intervention and of any dependent children.

A further NICE guideline 'Drug misuse prevention: targeted interventions NICE guideline [NG64]'[86] provides recommendations specifically on interventions for drug misuse in people who are 18 or over.

### Perinatal mental health

There is one current NICE guideline on Antenatal and postnatal mental health[87]. The major recommendations from the guideline applicable to prevention planning are the following:

- Childbearing: Females of child bearing age with mental health conditions should be informed on the use of contraception, how pregnancy and childbirth can affect a mental health problem and the likelihood of a relapse, how mental health problems and its treatment will affect the mother, the foetus and baby and the effects of mental ill health on parenting.
- Information and advice: Mental health professionals should provide detailed advice about the possible risks of mental health problems and the harm that treatment could cause.
- Recognising mental health problems: During a women first primary care contact, the women should be asked about their mental health.

The NICE guideline 'Postnatal care up to 8 weeks after birth clinical guideline [CG37]'[88] provides guidance on mental health and wellbeing, including:

- Women should be asked about their emotional wellbeing, family and social support and coping strategies for day-to-day matter at each postnatal contact.
- All healthcare professional should be aware of maternal mental health problems.
- Women should be assessed for postnatal depression if baby blues symptoms persist into the 10-14 day visit by the health visitor.

A further NICE guideline 'Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors clinical guideline [CG110]'[89] provides guidance on supporting women with vulnerabilities.

Mental health and wellbeing: There are various NICE guidelines that covers the mental health and wellbeing of children and young people, which are outlined below.

The NICE guideline 'Depression in adults: recognition and management Clinical guideline [CG90]' provides guidance on depression in people aged 18 years or above, including:

- Providing information and support: Information should be offered to the person who is depressed and their families or carers, ensuring it is appropriate to their level and in a language they can understand. People should be informed about self-help groups, support groups and other local and national resources.
- Supporting families and carers: Families or carer should be supported when they are supporting a person with chronic or severe depression, ensuring they are informed about depression, its management and possible support.
- Identification: Healthcare professionals should be alert to possible depression in all.

The NICE guideline 'Social and emotional wellbeing: early years Public health guideline [PH40]'[90] provides guidance on early years social and emotional health, including:

- Life course perspective: Disadvantages should be identified before birth and in the child's early years.
- Vulnerable children: There should be a focus on the social and emotional wellbeing of vulnerable children, ensuring they are identified, and their needs are addressed.
- Multi-agency working: All healthcare professionals should work collaboratively for the safety and wellbeing of the children.
- Family centred: Healthcare professional should support the development of mother-child and father-child relationships and tailor their support to their needs and circumstances.

The NICE guideline 'Social and emotional wellbeing in primary education Public Health guidelines [PH12]'[91] provides guidance on children's social and emotional wellbeing in primary schools, including:

- Schools must take a whole school approach, ensuring everyone is engaged in the school's efforts.
- Schools are encouraged to provide curriculums that promotes positive behaviours and successful relationships and helps reduce bullying and disruptive behaviour.
- Teachers should have training on how to help children develop their social, emotional and psychological wellbeing.
- Schools should develop targeted interventions for children at risk.

The NICE guideline 'Social and emotional wellbeing in secondary education Public Health guidelines [PH12]'[92] provides guidance on children's social and emotional wellbeing in secondary schools, including:

- Secondary schools should work in partnership with young people to develop, implement and evaluate organisation-wide approaches.
- Secondary schools should work in partnership with parents, carer and other family members to promote young people's social and emotional wellbeing.
- Teachers should have training on how to help children develop their social, emotional and psychological wellbeing.
- Schools are encouraged to provide curriculums that promote positive behaviours and successful relationships and helps reduce bullying and disruptive behaviour.

The NICE guideline 'Mental wellbeing at work Public health guidelines [PH22]'[93] sets out recommendations for workplaces in order to support their employee's mental wellbeing.

Mental Health Conditions: As there is a big range of mental health conditions, this needs assessment will not discuss each one in turn. However, some common mental health conditions have been included in the appendix:

- Appendix A provides Public Health England's summaries on anxiety disorders, Attention Deficit Hyperactivity Disorder (ADHD), conductive disorders, depression, eating disorders, schizophrenia and self-harm and suicide, including the national prevalence, risk factors and recommended actions to reduce the prevalence.
- Appendix B provides a summary of NICE guidance relating to common mental health conditions, including Attention Deficit Hyperactivity Disorder (ADHD), Psychosis and schizophrenia and eating disorders.
- Appendix C provides a list of guidelines relating to mental health conditions.
- Appendix D provides a list of guidelines relating to vulnerable groups and risk factors.

## Conclusion

Although not all children and young people will experience a mental health condition, many will experience a turbulence in their emotional and mental health due to the response of a stressful or difficult situation. It is important that these children and young people are supported to prevent them from developing a mental health condition and it is important to support those with mental health conditions, so they can lead fulfilling lives.

Good mental health does not start with the child or young person, instead it starts with the family and thus it is important that families are supported, especially as mental health issues are more likely to be missed in children. It is just as important that perinatal women are supported during this stage of their lives, ensuring that the mental health of mother is good; so that they are able to provide adequate emotional care for their child.

All health and care, education, community and voluntary organisations must work together in order to face the mental health challenges identified in this needs assessment. They must also take on the national and local direction to ensure all children, young people and perinatal women are receiving effective care under national guidance.

Although there are various services across Cambridgeshire and Peterborough to support those suffering with mental ill-health, they work in silos, there are long waiting lists for some services and some service users who do not meet the thresholds for some of the services. An integrated approach is essential to ensure that no child, young person or perinatal women is left unsupported due to a lack of seamless care.

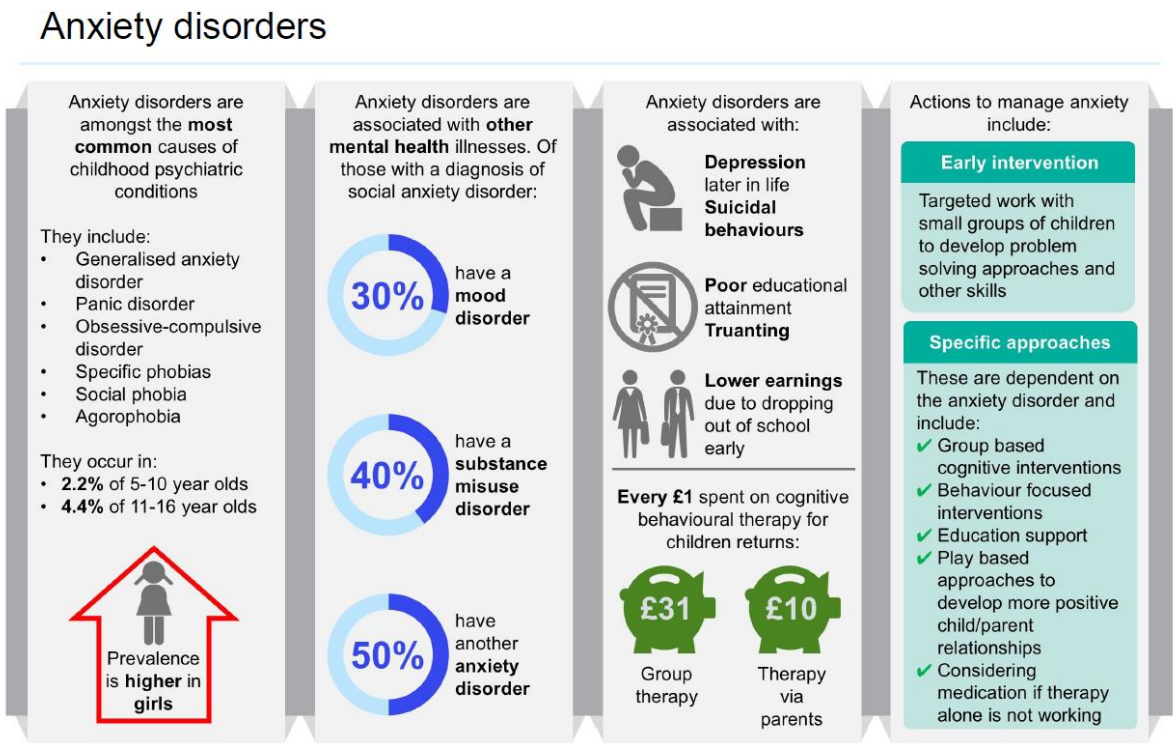
There are a range of prevention approaches and prevention interventions available, but some have proven more successful than others and thus it is important that we look at the published research when developing the strategy.

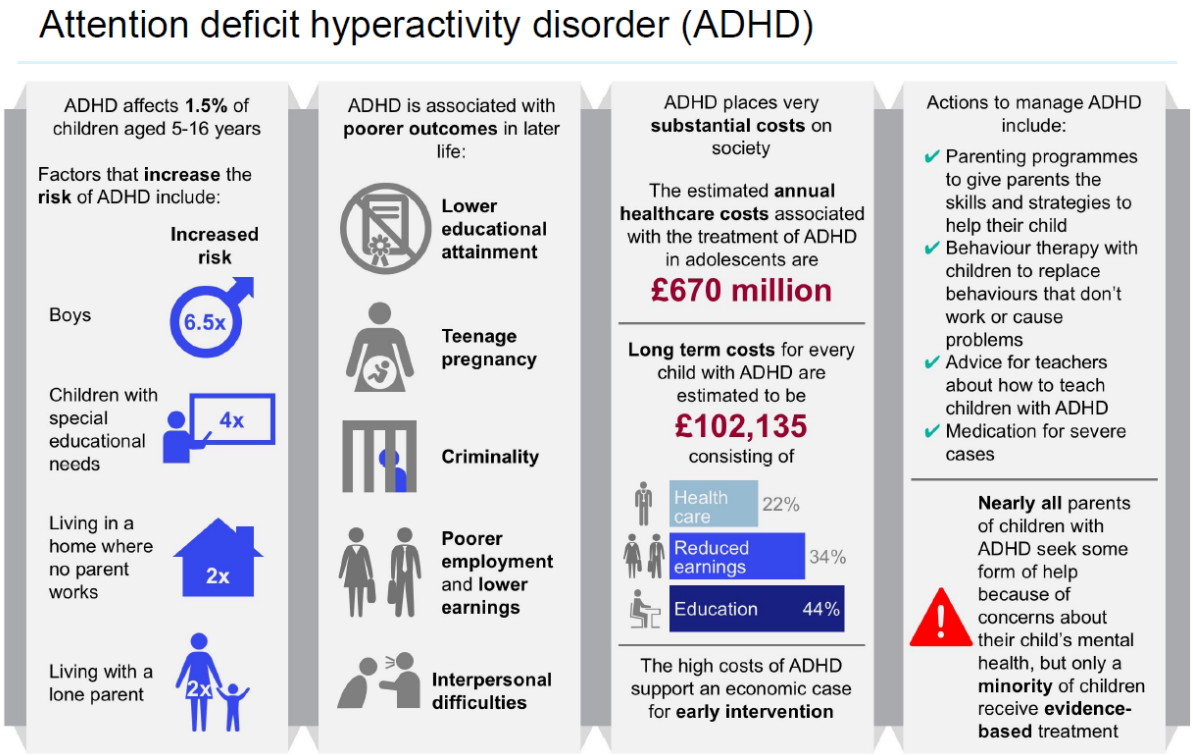
Lastly, it is important that all healthcare professionals have some form of mental health training, understanding that there is no physical health without mental health and thus it is everyone's responsibility. This includes a better understand of the vulnerable groups and risk

factors so that individuals are not left suffering in silence and a better collaborative approach to ensure that no individuals fall between the gaps in services when they are most vulnerable.

# Appendix

## Appendix A: Public Health England infographics



# Conduct disorders

Conduct disorders such as defiance, aggression and anti-social behaviour, affect **5.8%** of children aged 5-16 years. Factors that **increase** the **risk** of conduct disorder include:

Boys

Low income families

Children with conduct disorders are **more likely** to have **poorer** outcomes:

**2x more likely** to leave school with no qualifications

**4x more likely** to be drug dependent

**6x more likely** to die before the age of 30 years

**20x more likely** to end up in prison

The case for **prevention** of conduct disorders is clear

**£5.2 billion**
Estimated lifetime costs of a one-year cohort of children with conduct disorder

**£60 billion**
Estimated costs in England and Wales of crime attributed to adults who had conduct disorders in childhood

Potential savings from each case prevented through early intervention:

Severe: **£150,000**

Moderate: **£75,000**

The **cost** of managing conduct disorders is **very low** relative to the potential benefits

Every **£1** invested in the **early years saves**

- Family nurse partnership £2
- Parenting programmes £2
- School based interventions £27
- Whole school anti-bullying interventions £14

Every **£1** invested in **adolescence saves**

- Aggression replacement therapy £22
- Functional family therapy £14
- Multi-systemic therapy £2

Actions to manage conduct disorder include:

- **Classroom-based** emotional learning and problem-solving programmes
- Group **parent training** programmes
- **Multisystemic therapy** to young people aged 11-17 years
- Do **not** offer pharmacological interventions for the **routine** management
- Develop local **care pathways** between education and healthcare that **promote access** to services

# Depression

About **67,600** CYP in England are seriously depressed

**7x**
Depression is 7x **more** common in **older** children:

| **5-10 years** | **11-16 years** |
|---|---|
| 0.2% | 1.4% |

**Prevalence (%)**

1.1 (girls) 0.6 (boys)

Depression is **more common** in girls aged 5-16 years

**Prognosis**

**10%** recover by 3 months

**40%** recover by 1 year

**20%** recover by 2 years

**30%** do not recover by 2 years

Depression is caused by a **combination** of **risk factors** including:

**Biological**
Family history of depression

**Family**
Lone parent
More than 1 child
Unemployment

**Factors intrinsic to the child**
Chronic ill health
Disability

**Interpersonal**
Poor friendships
Being bullied
History of abuse

**Psychological**
Emotional distress e.g. bereavement
Emotional temperament
High levels of critical self thought

Behavioural therapy to manage depression is **cost effective**, with benefits including:

- **Higher earnings**
- **Lower** costs in the **NHS**
- **Lower** costs in the **education system**

**Every £1** spent on cognitive behavioural therapy for children returns:

£32 Group therapy

£2 Individual

**Most** parents of children with depression seek advice, but **only** about **25%** have contact with a children's mental health service

Actions to manage depression include:

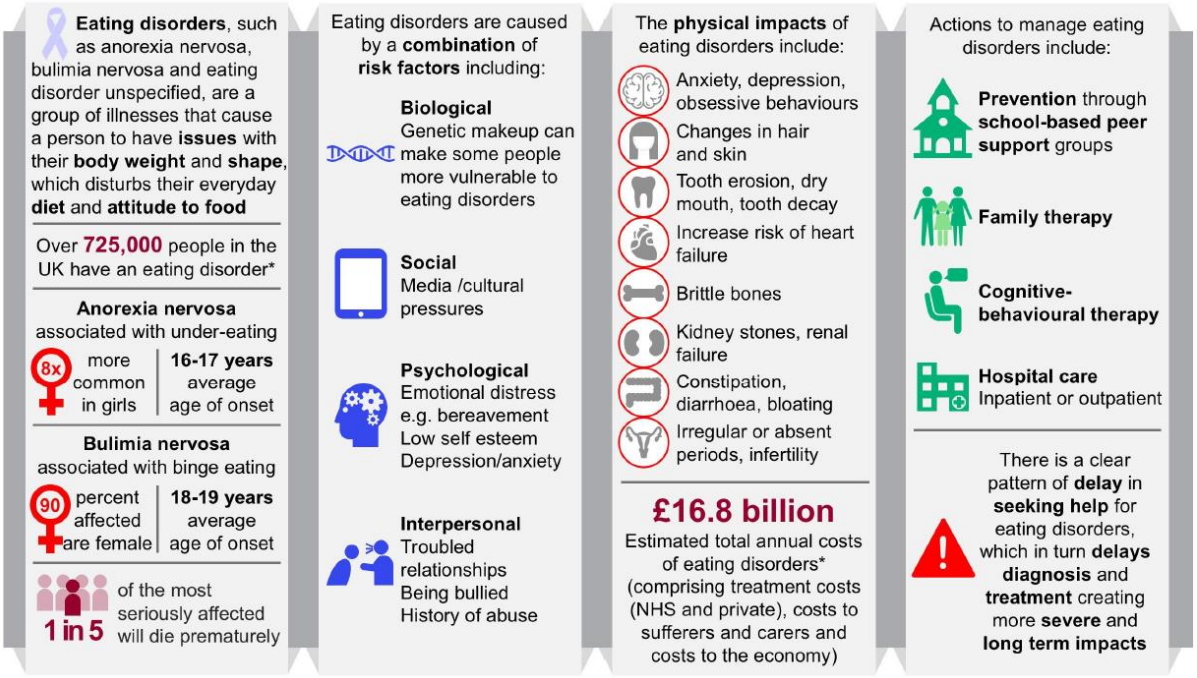
**Mild depression**

- ✔ Watchful waiting
- ✔ Psychological therapy, if there are no co-morbid conditions or suicidal ideation
- ✔ Referral to tier 2 or 3 CAMHS team if no response after 2-3 months

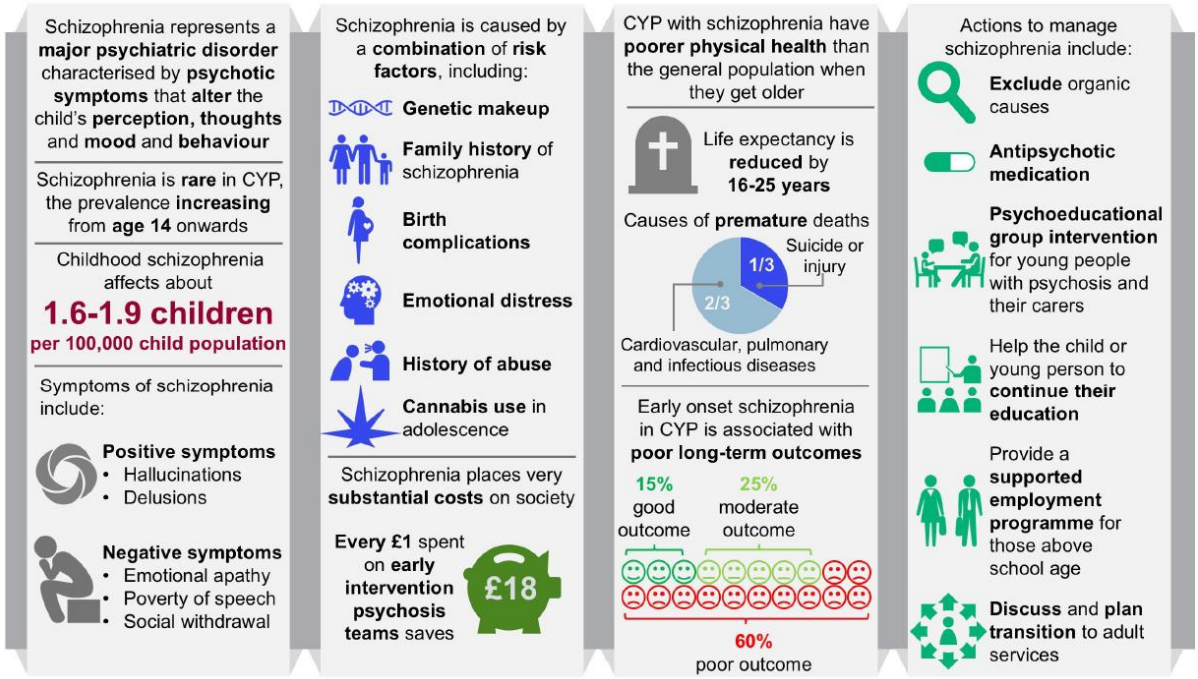
**Moderate or severe depression**

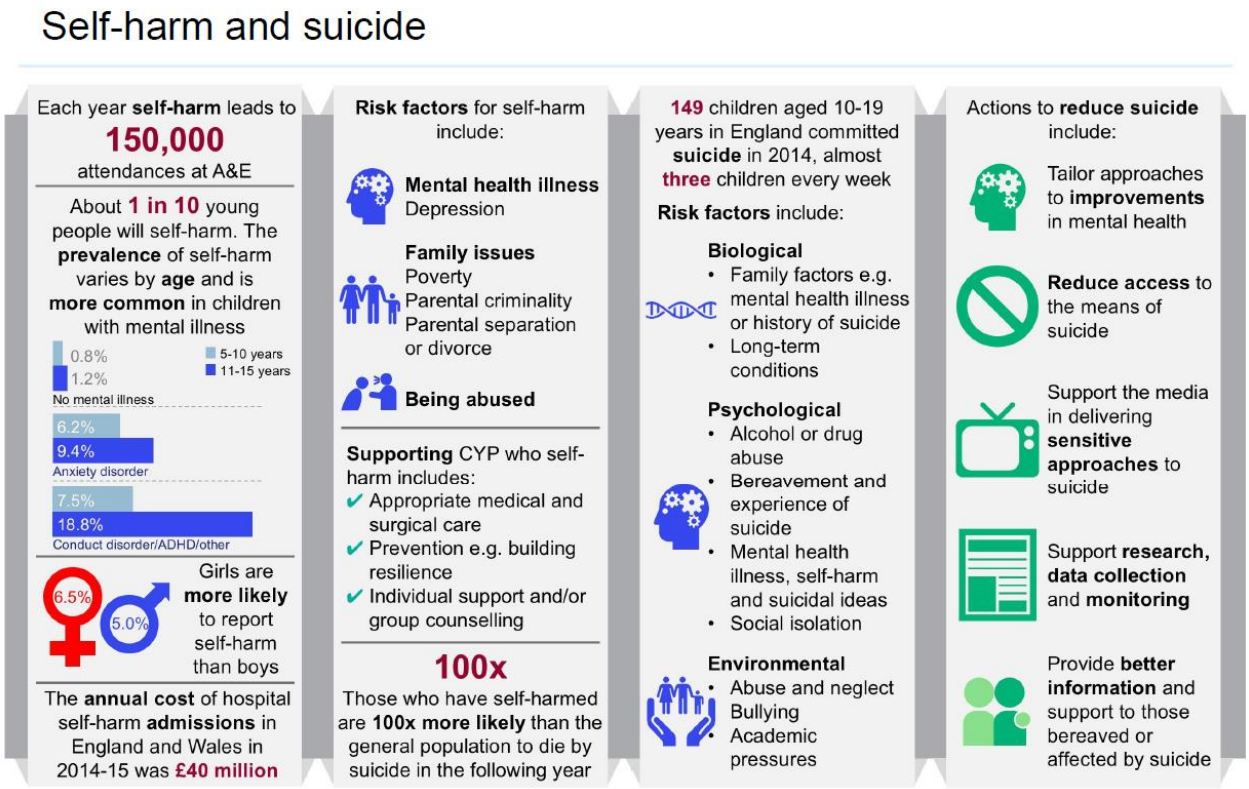
- ✔ Review by tier 2 or 3 CAMHS team
- ✔ Individual psychological therapy
- ✔ Consider medication
- ✔ Multidisciplinary review if unresponsive to psychological therapy
- ✔ Consider inpatient treatment if high risk of suicide or self-harm

## Eating disorders




## Schizophrenia






Source: Pubic Health England, 2016

## Appendix B: Summary of NICE guidance on Mental Health Conditions by Daniel NG

Attention Deficit Hyperactivity Disorder (ADHD): NICE provides guidance on the identification and management of antisocial behaviour and conduct disorders in children and young people[94]. Services are recommended to be designed with a multi-agency approach, with multidisciplinary teams specialised in ADHD created as appropriate according to local circumstances.

Transition to adult services should use the **Care Programme Approach**. Principles of care can overlap significantly with NICE guidance on antisocial behaviour and conduct disorder, although not all children and young people with ADHD will have co-existing antisocial behaviour or conduct disorder. Families should be provided with ADHD-focused support. Further recommended interventions vary by age, with ADHD-focused group parenting-training programmes strongly favoured over medication for those aged under 5. At 5 years and older, medication is recommended if appropriate parental-training programme has been insufficient and should only be initiated by healthcare professionals with ADHD expertise. CBT may also be considered in addition to this, if appropriate. Dietary interventions are not a generally applicable treatment, and if done should be supported by a dietician and mental health specialist or paediatrician.

Psychosis and Schizophrenia: NICE provides guidance on assessment and management of psychosis and schizophrenia in children and young people aged under 18[95]. There is no specific recommendation for overall service design, but general principles of care are referred to from general guidance on adult mental health services[96] and schizophrenia in adults[97].

Recommended interventions consist of antipsychotic medication and psychological intervention (individual CBT with family intervention). Arts therapies may also be used.

Eating Disorders: NICE provides guidance on assessment and management of eating disorders in both children and young people and adults in a single combined guideline[98]. There is no specific recommendation for overall service design, but separate guidance on transition to adult services is referenced[99]. Interventions detailed below do not target or significantly affect body weight, except for in anorexia nervosa. Physical therapy should not be provided for eating disorders.

- Anorexia nervosa: Support and care should be multidisciplinary and coordinated between services. Intervention is mainly psychological (anorexia-nervosa-focused family therapy for children and young people, individual eating-disorder-focused CBT, adolescent-focused psychotherapy for anorexia nervosa). Medication as a sole treatment is recommended against
- Binge eating disorder: Intervention is mainly psychological (guided self-help, group/individual eating-disorder-focused CBT). Medication as a sole treatment is recommended against
- Bulimia nervosa: Interventions are mainly psychological (bulimia-focused-focused family therapy, individual eating-disorder-focused CBT). Medication as a sole treatment is recommended against

## Appendix C: List of guidelines regarding mental health conditions:

- Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) NICE guideline CG158
- Bipolar disorder: assessment and management (2014) NICE guideline CG185
- Borderline personality disorder: recognition and management (2009) NICE guideline CG78
- Common mental health problems: identification and pathways to care (2011) NICE guideline CG123
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (2011) NICE guideline CG120
- Depression in adults with a chronic physical health problem: recognition and management (2009) NICE guideline CG91
- Psychosis and schizophrenia in adults: prevention and management (2014) NICE guideline CG178

## Appendix D: List of guidance on vulnerable groups and risk factors

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence year (2011) NICE guideline CG115
- Alcohol-use disorders: prevention (2010) Public health guideline PH24
- Alcohol interventions in secondary and further education (2019) NICE guideline NG135

- Autism spectrum disorder in under 19s: recognition, referral and diagnosis (2017) NICE guideline CG128
- Bipolar disorder: assessment and management (2018) NICE guideline CG185
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015) NICE guideline NG11.
- Child abuse and neglect (2017) NICE guideline NG76
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care (2015) NICE guideline NG26
- Domestic violence and abuse: multi-agency working (2014) Public Health guideline PH50
- Harmful sexual behaviour among children and young people (2016) NICE guideline NG55
- Learning disabilities and behaviour that challenges: service design and delivery (2018) NICE guideline NG93
- Looked-after children and young people (2010) Public Health guideline PH28
- Teenage mothers and young fathers: support framework – Public Health framework
- Teenage pregnancy prevention framework – Public Health framework

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