Children and Young People's Emotional Health and Wellbeing

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1.0 Level of need in the population

There are 108,800 children and young people aged 0-17 years in Somerset (ONS mid 2014 population). Children and young people in Somerset make up 22% of the population of Somerset. 6.8% of school children are from a minority ethnic group (Somerset Children & Learners Needs Analysis 2013)[1].

Mental health is strongly linked to positive child development and there are strong links between mental health problems in children and young people and social disadvantage, with children and young people in the poorest households three times more likely to have a mental health problem than those growing up in better-off homes. The number of children in Somerset living in relative poverty is 14.2% which is below the national average of 20.9% (Somerset Children & Learners Needs Analysis 2013.)

Children's mental and emotional health was a key feature of Chief Medical Officers (2012)[2] annual report and an issue of public health concern. The report highlights the fact that mental health problems in children and young people can be long-lasting. It is known that 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age (DH 2009)[3].

2.0 Parenting

The quality of parenting affects children's long-term physical, emotional, social and educational outcomes and therefore differences in parenting between social groups have implications for health inequalities. Positive, warm parenting, with firm boundaries and routines, supports social and emotional development and reduces behavioural problems

Some parenting practices are associated with improved outcomes for children. Parents who are more responsive to their children's needs, who bond with their children early using positive interaction and engaging them in conversations, who set firm boundaries on acceptable behaviour and bedtimes and who use encouraging words rather than criticism, are likely to be helping to support their children to reach the best possible outcomes.

Secure attachment is one of the key early goals of positive parenting and it needs to start from birth. Parents need to be caring and attentive to children's needs, to communicate and stimulate them even though they cannot talk. However, while these behaviours might seem natural, they do not always happen. Their absence can lead to cognitive impairment and can affect the degree to which people can deal with intimacy, maintain relationships, and experience compassion, empathy and resilience.

Insecure attachment is associated with poorer language and behaviour before school, and with significantly elevated levels of aggression, defiance and hyperactivity.[4]

Negative effects continue into life, with insecure children more likely to leave school without further education, employment or training ahead of them and be more likely to perpetuate domestic violence,[5] and have higher levels of alcohol and substance abuse than secure children.[6] [7]

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[1] http://www.somersetintelligence.org.uk/files/Children%20and%20Learners%20Needs%20Assessment%202013%20v5.pdf

[2] Our Children Deserve Better: Prevention Pays (2012) CMO Annual Report. DH https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

[3] Department of Health (2009) Departmental Report 2009: The Health and Personal Social Services available at www.official-documents.gov.uk/document/cm75/7593/7593.pdf

[4] Moullin S, Waldfogel J, Washbrook E. Baby bonds. Parenting, attachment and a secure base for children. London: The Sutton Trust, 2014.

[5] Dutton DG, Corvo K. Transforming a flawed policy: A call to revive psychology and science in domestic violence research and practice. Aggression and Violent Behavior. 2006;11(5):457-83.

It has been shown that that people with secure attachment show more healthy behaviours such as taking exercise, not smoking, not misusing substances and alcohol and driving at appropriate speed. A report from the United States about disadvantaged children found that securely attached children are more resilient to poverty, family instability, parental stress and depression.

Boys growing up in poverty were two-and-a-half times less likely to display behavioural problems at school if they formed secure attachments with parents in their early years[8]

Parenting Needs:

Table 1 Parenting Needs

Age	Numbers
Births improve parental health behaviours in pregnancy is one way to reduce health inequalities	5,707
Children aged 0-4 years parenting behaviours and practices are linked to positive outcomes in children	29,420
Children aged 5-10 years Focus on good pre-school to school transition	33,733
Children aged 11-18 years good time to educate the future generation of parents, to promote positive examples of relationships and to give teenagers the tools to make good lifestyle decisions and have resilience – SRE audit	57,645
Children aged 0-19 years	120,798

Creating an enabling environment for parenting:

Families who are under external stress, often find it harder to focus on positive parenting, for these reasons families living in poverty or who are homelessness are highlighted as being at risk of needing parenting support

The bedrock of positive parenting and secure attachment are ensuring that the family environment is assessed and supported where found to be lacking. Specifically housing, income, debt, skills and education

Maternal mental health issues include both mental health problems that arise at this time and those that were present before the pregnancy, they affect the woman's ability to securely attach to their infant and their ability to positively parent

[6] Brennan KA, Shaver PR. Dimensions of Adult Attachment, Affect Regulation, and Romantic Relationship Functioning. Personality and Social Psychology Bulletin. 1995;21(3):267-83.
[7] Relationship Functioning. Personality and Social Psychology Bulletin. 1995;21(3):267-83. Walsh A. Drug-Use and Sexual-Behavior - Users, Experimenters, and Abstainers. Journal of Social Psychology. 1992;132(5):691-3.
[8] Good quality parenting programmes and the home to school transition (2014) Public Health England

Table 2: Rates of perinatal psychiatric disorder per thousand maternities[9]

Disorder	National rate	Local annual estimate of women affected based on 2012 birth rate
Percentage of women who develop a mental illness during pregnancy or within the first year of birth (including depression and anxiety)	10-20%	570-1140 during pregnancy
Percentage of women who develop a mental illness during pregnancy or within the first year of birth (including depression and anxiety)	10-20%	570-1140 first year post birth
Postpartum psychosis	2/1000	11.4
Chronic serious mental illness	2/1000	11.4
Severe depressive illness	30/1000	171
Mild-moderate depressive illness and anxiety states	100-150/1000	570-855
Post traumatic stress disorder	30/1000	171
Adjustment disorders and distress	150-300/1000	855-1710

[9] http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf

3.0 Vulnerable children and young people

Children looked after, children who have been abused, neglected or bullied and children in the criminal justice system are all likely to be less resilient and have a higher level of mental health needs. Table 2 below lists some of these at risk groups

Table 3: At risk groups

Looked-after children
As at 31 March 2014, there were 490 children looked after by Somerset council, which equates to a rate of 45 per 10,000 children aged under 18 years. This is lower than both the England average rate (60 per 10,000) and the South West average (51 per 10,000). Recent NICE guidance estimates that approximately 60% of children looked after in England have emotional and mental health problems.
Children with Special Educational Needs
It is estimated that mental health disorders affect 44% of children with special educational needs (SEN) who require statutory assessment.25 In 2015, out of 76,682 pupils in Somerset schools, 1,241 (1.6%) had a statement of special educational needs. This suggests that approximately 546 such children may have mental health disorders.
Young offenders
In 2013-14 there were 423 children and young people aged 10-17 years in Somerset known to the Youth Justice system, down from 567 in 2012-13. Prevalence estimates of mental health problems for young offenders vary hugely, from 25% to 81% or even above, with rates highest for young people in custody.
NEETs
In Somerset in 2014, 790 young people aged 16-18 were known to be NEET, or 4.4% of the age-group (SW average 4.5%). This represents a fall from 870 (or 5.0%) in 2013, but is still too high in view of the damaging consequences of becoming NEET – which include an estimated £97,000 lifetime cost to the public purse

4.0 Emotional health and well-being

In 2014 Somerset Public Health commissioned a large scale survey (n=9774) of children and young people in school years 4, 6,8,10 and 12+ so as to understand more fully the knowledge and behaviour of Somerset's school/ college age population with regard to their health and wellbeing.

When it comes to Somerset Children's emotional health and wellbeing, compared to the wider reference sample:

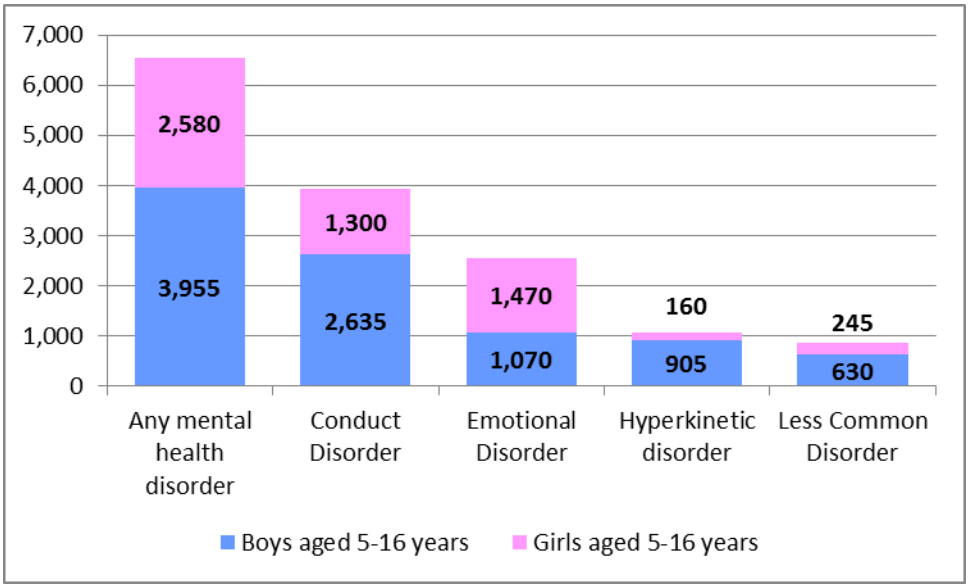
- Significantly less Somerset children reported high levels of self-esteem, compared with the reference sample and girls reported lower scores and with a lower rate of improvement as they got older, compared with boys
- Only 62% of our pupils felt that their schools took bullying seriously compared with 76% of the reference sample
- By post 16 considerably more of our students said they had worried about something so much that it had affected their studies
- 39% of our children looked after responded that they at least sometimes feel afraid of going to school / place of learning because of bullying

5.0 Mental health disorders

The British Child and Adolescent Mental Health Surveys in 1999 and 2004 (Green et al 2004)[10] found that 1 in 10 children and young people under the age of 16 had a diagnosable mental disorder. Among the 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem while among the 11 to 16 year olds the prevalence was 13% for boys and 10% for girls (Green et al 2005).

To estimate the numbers of children and young people affected by mental health disorders in Somerset, we applied the prevalence rates found in the National CAMHS prevalence survey (Green et al 2004) to the population estimates for the relevant age-group. If we do this for children aged 5-16, we obtain the totals shown in Figure 1:

Figure 1: Somerset Children Affected by mental Health Disorder



[10] Green, H et al (2004) Mental health of children and young people in Great Britain. Office for National Statistics. HMSO London

6.0 Need for CAMHS services

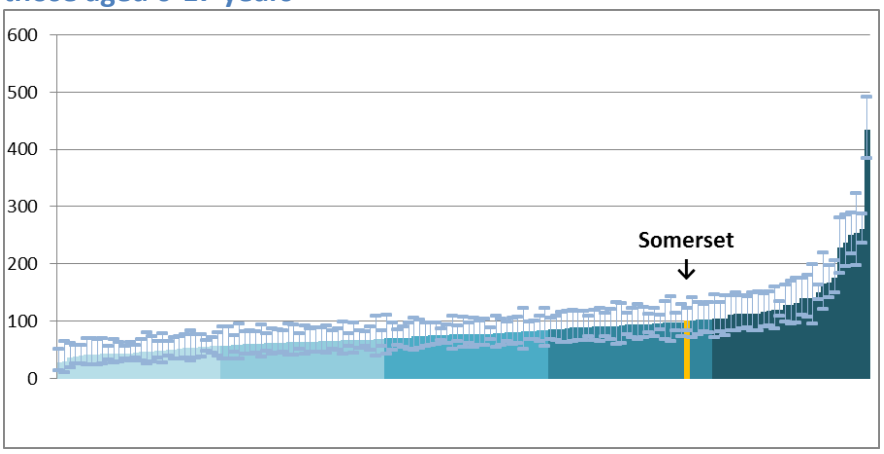
The numbers of young people locally who may be expected to require CAMHS services at different levels of need are conventionally calculated using prevalence rates published in 2004. In Table 1, these rates are applied to the mid-2014 under-18 population of Somerset, on the assumption that CAMHS services cater for young people up to age 17.

Table 4 Numbers of Children & Young People Requiring CAMHS support in Somerset, based on 2004 CAMHs prevalence survey

Tier	Description of Tier	Estimated Prevalence	Estimated numbers
Tier 4	Highly specialist / inpatient	0.075%	82
Tier 3	Require involvement of specialist support	1.85%	2,028
Tier 2	Require consultation, targeted or individual support	7%	7,674
Tier 1	Universally encountered and can be addressed in everyday service	15%	16,444

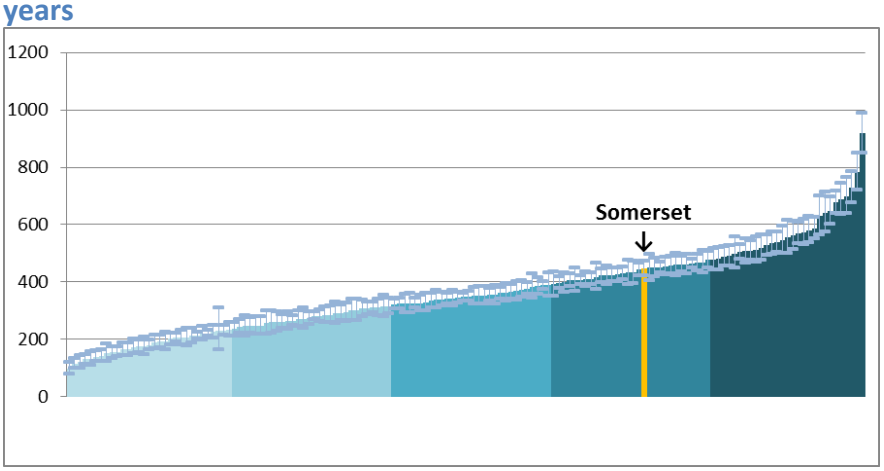
7.0 Hospital Admission Data

Figure 2 Hospital admissions for mental health disorder among those aged 0-17 years



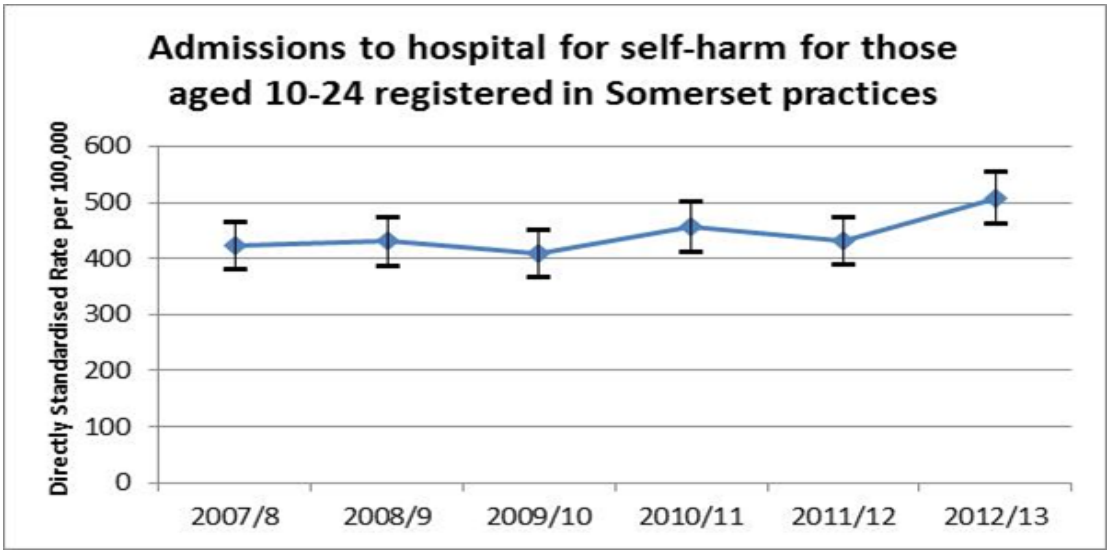
Mental health disorders
In Somerset in 2012/13, there were 110 hospital admissions of children and young people aged 0-17 for mental health disorders, which equates to 101.3 per 100,000. This was the 34th highest rate of any upper-tier local authority (Figure 7), but not significantly different to the England average of 87.6 per 100,000.

Figure 3 Hospital admissions for Self harm among those aged 10-24 years



Self-harm
For the three-year period 2010/11-2012/13, the rate of self-harm hospital admissions for Somerset residents aged 10-24 was 445.9 per 100,000. This rate had been fairly stable in recent years but was slightly higher in this three-year period. It is currently the 42nd highest in England (national average 352.3 per 100,000).

Figure 4: Admissions to Hospital for Self Harm for those aged 10-24 years Registered in a Somerset GP practice



The rate of admissions to hospital as a result of self harm are increasing in Somerset and this rate is significantly higher than the national rate. However, it is important to note that in line with NICE guidance Somerset admits all young people who present to A&E with self-harm to enable a full assessment and appropriate treatment, which may not be the case in other areas and this may explain why we have higher admission rates than other areas.

8.0 Child suicides

The youngest age-group for which suicide statistics are routinely published at the local authority level is 15-34, which goes well beyond our definition of 'young people'. The rules on disclosure have recently been relaxed, and annual counts at the local authority level can now be found in the public version of the HSCIC Indicator Portal (https://indicators.ic.nhs.uk/webview/). By either definition, there were 10 (5 male and 5 female) suicides in the 15-34 age-group in Somerset in 2013. If those registered with a death following an injury of unknown intent are added there were 66 in this age-group in Somerset in 2013.

Young people aged 15+

For 2010-2012 as a whole, the rate of suicide or injury undetermined in Somerset was 7.3 per 100,000 persons aged 15-34, which compares with an England average of 7.8 per 100,000. This difference is not statistically significant.