Future in Mind

Leeds: Health Needs Assessment

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Report v1.0

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1 Executive Summary

This report has used the Joint Commissioning Panel for Mental Health: Guidance for Commissioning Public Mental Health Services[1]; Sheffield CYP EWMH Health Needs Assessment (2014)[2]; Local Authority Interactive Tool (LAIT)[3]; Public Health England[4]; CHIMAT[5]; and Leeds Observatory[6] as key source documents and key data sources.

1.1 Introduction

National policy sets out the direction of travel to meet the mental health needs of children and young people in England. Service transformation is key. Throughout the different national policy there is an emphasis on prevention and promotion, earlier intervention and timely access to specialist services, with intervention and support being evidence-based and focused on achieving measurable outcomes. There is a need to demonstrate accountability and transparency and measurability alongside developing the appropriate workforce. Future in Mind (2015) sets out numerous recommendations, which have been re-iterated by the Five Year Forward View for Mental Health (2016). There are many wider policies affecting children and young people's mental health as their mental health is multi-faceted and involves their family, their education and their social relationships.

The local strategic direction for Leeds reflects these national policies, with an emphasis on early help, resilience-building, better support for the most vulnerable children, and service transformation, which are being addressed through the Local Transformation Plan (LTP) for Children and Young People's Mental Health. This will become part of the local Sustainability and Transformation Plan as that is developed.

Good mental health is more than the absence of mental illness; it is a positive sense of well-being. This includes the ability to play, learn, enjoy friendships and relationships, as well as deal with the difficulties experienced during childhood, adolescence and early adulthood.[7] This means that all parts of the system that work around the child and family have a part to play in promoting their mental health and supporting them when they are experiencing difficulties.

This needs assessment looked at the mental health needs of the children and young people of Leeds from the perspective of epidemiological information, stakeholders (staff and service users) and comparative data in other areas of England.

[1] Joint Commissioning Panel for Mental Health (2015) Guidance for commissioning public mental health services.] http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf]
[2] Public Health Team, CYPF, Sheffield City Council (2014) Children and Young People's Emotional Wellbeing and Mental Health: Health Needs Assessment.[http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/08/Sheffield-CYP-Emotional-Wellbeing-MH-Health-Needs-Assessment.pdf]
[3] UK Government.[https://www.gov.uk/government/publications/local-authority-interactive-tool-lait]Accessed in May, 2016
[4] Public Health England Observatories.[http://www.phoutcomes.info/] Accessed in May, 2016
[5] Child and Maternal Health Observatory [http://www.chimat.org.uk/] Accessed in May, 2016
[6] Leeds City Council. Leeds Observatory [http://observatory.leeds.gov.uk/] Accessed in June, 2016
[1] NPC (2008) Heads up: Mental Health of Children and Young People.

1.2 Population

By 2020 there are forecast to be 272,674 CYP between 0 – 25 years old living in Leeds vs 261,522 in 2014 (4.3% increase in the CYP population).

The forecast information from ONS 2012 suggests that there is expected to be little movement in the number of 0-4 year olds over the next 4 years (between 0.6% & -0.3%). The 5-9 year old population is forecast to increase by 4.6% over the next 4 years (8.7% increase against 2014 actuals). The most growth in CYP is expected to be in the 10-14 year old population, where the figure is forecast to rise by 12.8% over the next 4 years (16.5% growth against 2014 actuals). The 15-19 year old population is forecast to drop by 3.8% between 2016 & 2019, before rising sharply. The 20-24 year old population is forecast to be 3.6% smaller in 2020 than it is was forecast to be in 2016 (although this is still 1.7% higher than 2014 actuals).

The Leeds JNSA 2015 noted that 'In the last decade the BME population in the city has increased from 11% to 19%, and the number of residents born outside of the UK has almost doubled to over 86,000 people. There have been localised impacts across the city, with complex related issues such as the speed of change, 'national identity', language proficiency, transient populations and variations in birth rates that in turn influence service provision and the wider interface between communities.

1.3 Deprivation

22% of the Leeds population (167,607) live in the 10% most deprived areas in the country the story for its youngest young people is much worse. The following CYP in Leeds live in the most deprived 10% of areas in the country:

- 31% of 0-4 year olds (15,864)
- 30% of 5-9 year olds (13,488)
- 28% of 10-14 year olds (11,026)
- 22% of 15-19 year olds (11,116) - aligned with the picture for Leeds as a whole
- 17% of 20-24 year olds (12,935) - better than the Leeds average and seemingly distorted by the large student and young professional population in the city

In total 64,429 CYP aged 0-24 live in an area of Leeds categorised as within the 10% most deprived areas in the county (24.6% of the total CYP population). Conversely, just 17,192 (6.6% of Leeds CYP) live in the least deprived 10% of areas in the country.

1.4 Protective Factors

Protective factors are those factors that form the foundations that enable children and young people to thrive and develop and provide resilience against challenges and difficulties that may affect their emotional and mental health.

Protective factors that reflect favourably against national prevalence:

- At 6-8 weeks the national rate of infants totally or partially breast fed currently stands at 43.8%. Over the last 4 years Leeds LA have reported a rate equal to or greater than the

national average (currently 48.5%), and significantly higher than its statistical neighbours (currently 38.1%)[8]

- The percentage of 3 and 4 year olds benefitting from funded early education in a Good/Outstanding provider in Leeds has increased from 78% to 86% between 2014 and 2015, which is slightly better than the national average of 85% (2015).
- The percentage of 2 year olds that benefit from funded early education in a Good/Outstanding provider also rose (below right), from 87% to 93%, which is above the national rate of 85%.
- In Leeds the percentage of young people achieving 5 or more A star to C grades which include Maths and English, has tracked slightly below the national picture from 2006 to 2014, however in 2015 Leeds reported better than national average attainment results of 55.5%.
- A higher percentage of Leeds 16 & 17 year olds remained in either formal education, apprenticeships or employment with training in 2015 than the national average.

Factors that are not comparable or are derivative of national prevalence:

- In Leeds the World Health Organization's guideline of an hour of moderate-to-vigorous physical activity per day is met by 13.0% of young people, similar to the England average of 13.9%.

Protective factors that reflect unfavourably against national prevalence:

- The current rate of breastfeeding at initiation reported for all Leeds CCGs (68%) is below the national average. However, within this figure there is a local split, with Leeds North CCG reporting a breastfeeding rate at initiation of 76.7%, which is above the national average, while Leeds West (69%) and Leeds South and East (60.9%) are both below the national average.
- 61.8% of Leeds children achieved a good level of development at EYFS, which is below the England average of 66.3%, and that of its statistical neighbours 63.1%. Within this figure there is large variation in development across the city ranging from 81% in Adel and Wharfedale and Harewood through to just 46% in City and Hunslet.
- 80.2% of children reported as having achieved at least the minimum level of personal, social and emotional development in foundation stage (2015), which shows that while there have been year on year improvements nationally and locally since measurement began in 2013, Leeds has remained marginally behind both national (83.7%) and statistical neighbours (82.1%)

[8] Department for Education: Local Authority Interactive Tool – data pulled April 2016

1.5 Risk Factors

Risk factors are a range of factors in children's early lives have been consistently associated with increased risk of mental health problems in adolescence and adulthood. The greater the number of risks, and the more severe the risks, the greater the likelihood of the child developing a mental health problem. (Deprivation is a significant risk and is given its own section within the Executive Summary *above*)

Risk factors that reflect favourably against national prevalence:

- Slightly fewer families in Leeds were 'step families' than the national average (2011)
- There is a lower proportion of the Children in Need numbers for Leeds considered at need because of abuse, neglect or family dysfunction (5,401 CYP in Leeds during 2014).
- There is a lower rate of CYP providing care in Leeds than the national and regional averages
- Leeds school exclusion rates reflect favourably against both national and statistical neighbour figures.
- In 2014/15 slightly fewer CYP in Leeds reported being bullied in the past few months than the national average.

Factors that are not comparable or are derivative of national prevalence:

- Approximately 5,401 children under 18 in Leeds were in need due to abuse, neglect or family dysfunction (2014).
- Approximately 728 under 2 year olds in Leeds were in need due to abuse, neglect or family dysfunction in 2014 (based on the assumption that children in need rates were equally distributed across the Leeds under 18 population)
- Approximately 19,485 children aged 5 to 14 years in Leeds could be at risk of living with a parent dealing with mental health problems
- Approximately 260 parents died in Leeds, leaving around 450 dependent children (aged 0 to 17) in 2015
- It is estimated that 3,140 school-age population of children and young people (aged 5 to 16) in Leeds had been bereaved of a parent or sibling at some point in their childhood (2015)
- Approximately 2,492 children and young people in Leeds are affected by parental imprisonment.

Risk factors that reflect unfavourably against national prevalence:

- While there have been a reduction in rates across all CCGs, In Leeds, the highest rates of smoking at the time of delivery are found in the poorest communities and amongst women under 18 years old.
- The 2011 Census showed that there was a marginally higher than the national and regional average of lone parents in Leeds (10.9%) this equated to 55,738 CYP living in lone parent families.
- The Leeds Maternity HNA 2014 noted that the rate of Low Birth Weight (LBW) in Deprived and Non-Deprived Leeds is widening.
- 14.4% of Leeds children were living in workerless families between Jan – Dec 2014 (higher than the national average (12.6%)

- 5.56% of the Leeds child population were from households with no qualifications, which is higher than the national average of 4.8% of children (2011)
- Between 16.4% - 19.4% of Leeds CYP attending Primary and Secondary Schools were eligible for free school dinners, which is higher than the national average of between 13.9% - 15.6%, although there was much variation across the city.
- The persistent absenteeism rate for Leeds was 4.3% compared with 3.9% for its statistical neighbours and 3.7% nationally (2015).
- 6.4% of Leeds 16 -18 year olds are classed as NEET, compared with 5% for our statistical neighbours and 4.2% nationally, with significant variation across the city.
- The rate of domestic abuse stood at 21.8 incidents per 1000 of the population for Leeds, which is higher than the rate of 18.8 per 1000 for the nation as a whole.
- Leeds is ranked 114th out of 150 local authorities for youth offending rates and is higher than both its statistical neighbours and the national rate.
- The Public Health Profile figures show that 15 year olds in Leeds reported higher than national average for all tobacco, cannabis and alcohol related activities with the exception of *occasional smoking* and the percentage who have *taken drugs (excluding cannabis) in the last month.*
- 18.3% reported having three or more risky behaviours in Leeds compared to the national average of 15.9% (risky behaviours are defined as illegal or health related risky behaviour (drugs, cannabis, smoking, drinking, diet, activity).

1.6 High Risk Groups

Some groups of children and young people are more at risk of experiencing mental health problems. These include those living in poverty, Children Looked After, those in contact with the criminal justice system, those with a learning disability, children whose parents have their own mental health problems, and children living in situations of domestic violence.

Children in Need

- There was a significantly higher rate of 'children in need' within Leeds than there is nationally (748 CYP per 10,000 in Leeds compared with 674 per 10,000 nationally) (2014/15)
- Although there is a lower rate for new cases of children in need in Leeds than both the national picture and geographical neighbours, the rate of referrals was significantly higher than the national or regional picture.

Children Looked After

In Leeds 2015 there were 78 children looked after per 10,000 children aged under 18, compared with 75.7 for its statistical neighbours and 60 nationally.

- In Leeds 2015 9% of children looked after had been placed in 3 or more placements over the course of the year, which was lower than the national and regional average (10%) and statistical neighbours (9.6%)
- The Leeds SDQ score for its children looked after was 15.1 in 2015 which is higher than the national average (13.9) and that of its statistical neighbours (a Total Difficulties Score on the SDQ of 14-16 is a score of 'borderline').
- Between 2007 and 2015 Leeds Care Leavers were more likely to be in education, employment or training than their equivalent nationally.
- Offending by children aged 10-17 who have been looked after continuously for at least 12 months has declined steeply in Leeds over the last 10 years. Currently Leeds percentages are closely aligned with national and statistical neighbours volumes.

Disabilities

- Prevalence data suggests between 4,478 and 8,060 of Leeds children experience some form of disability.
- 2011 figures suggest that approximately 41,300 of 0 -25 year olds are living with a longstanding illness or disability, and approximately 184 are considered severely disabled

Learning Disability

According to Public Health Profiles, Leeds has a slightly lower than the national rates of: pupils with learning disabilities; pupils with social, emotional and mental health support needs; pupils with speech, language or communication needs and pupils with autism spectrum disorder. However, it has a higher than average number of pupils with behavioural, emotional and social support needs.

Special Educational Needs

Leeds has a lower rate of pupils identified as having a special educational need and lower rate of pupils with a SEN statement than both the national and the regional average.

Ethnicity

It is clear from the changing ethnicity profile of school aged children between 2013 & 2014 that over the next 4 years the profile of Leeds CYP ethnicity will continue to change significantly as will the ethnic profile of CYP with MH and EW needs. Whilst the impact on volumes into CAMHS will be largely unaffected by this changing ethnic profile, the challenge for all services providing emotional and mental health support to CYP in Leeds will be how to develop services that engage with often hard to reach ethnic groups and provide services that are responsive to the changing demographic.

1.7 Prevalence of MH Disorders and Illnesses

- There were 125 hospital admissions for unintentional and deliberate injuries per 10,000 0-14 year olds in Leeds, which is higher than the 109.6 rate reported nationally
- There were 117.4 hospital admissions for unintentional and deliberate injuries per 10,000 15-24 year olds in Leeds, which is lower than the 131.7 rate reported nationally
- 73% of CYP admitted for self-harm are female
- Rates of eating disorders are higher than the national average.
- Rates of autism, ADHD, learning disability and pupils with behavioural, emotional and social support needs are lower than national rates.

1.8 Forecast Prevalence

Overall disorders/ common mental health disorders in CYP (0 – 24) in Leeds are predicted to increase by approximately 1.2% from ~28,900 to ~29,200 between 2014 and 2020.

Although the overall population of CYP in Leeds is not expected to grow significantly between 2014 (210,578) and 2020 (217,719), the change in profile (a reduction in the number of 16 -24 year olds and an increase in 0 – 16 year olds) drives increases in disorders affecting children and a reduction in those typically recorded for young people/ young adults:

- There is forecast to be an increase in the number of Emotional Disorders; Anxiety Disorders; Conduct Disorders; Hyperkinetic Disorders; Less Common Disorders and Autistic Spectrum Disorders
- There is forecast to be a decrease in the number of Depression; Mixed Anxiety and Depressive Disorder; General Anxiety Disorder; Phobias; Obsessive Compulsive Disorders and Panic Disorders

Based on expected prevalence of mental disorders for children and young people from higher risk groups applied to the Leeds CYP 2020 population:

- 21,000 CYP with a parent with a mental illness are predicted to have an emotional disorder
- 11,600 11 – 16 year olds from a households with an income less than £200 are predicted to have a mental health disorder
- 5,500 children from step or single families are predicted to have a mental health issue
- 3,700 CYP with a Learning Disability are predicted to have a mental health issue
- 1,000 Children Looked After will have a mental disorder

Whilst there is significant overlap between the individual High Risk Group measures in the table above, it is clear that parental mental health and household income will continue to be significant contributing risk factors to CYP mental health in Leeds

1.9 Service Provision

The main services in Leeds where children and young people can get support with their mental health are: CAMHS, Leeds Improving Access to Psychological Therapies (IAPT) for young people, Cluster Mental Health Support, The Market Place, and Aspire. There are also a vast range of universal services and third sector organisations that support young people with their emotional health.

CAMHS

In 2015/16 CAMHS accepted 1,756 CYP (0 - 18) onto its service from the 2,826 referrals it received (62% accept rate). When compared with the total population of 0 -18 year olds in Leeds, this equates to 1.67% of the population referred to CAMHS and just 1.02% of the 0 – 18 population gaining access to CAMHS. These volumes fall significantly below forecast prevalence rates, suggesting that there is an unmet need in Leeds.

Of all rejected referrals; 52% of GP referrals were rejected (896) and 32% of Community Paediatricians referrals were rejected (52). 80% of rejections were recorded as 'does not meet the threshold' and 'signposted to other agencies'.

Ethnicity data suggests that children and young people who identified as Asian; of mixed or multiple ethnicity; or as Black/ African/ Caribbean /Other Black ethnicity are being referred into CAMHS at lower equivalent rates to children and young people who identify as White British; White and Chinese and Other.

CAMHS LD

The CAMHS LD Team received 639 referrals in 2014/15 of which it accepted 491 (77% accept rate). High Risk Group prevalence data suggests that there were approximately 2,335 CYP with a Learning Disability and a mental disorder in Leeds during that period. These accepted volumes fall significantly short of prevalence forecasts.

2 Introduction

The purpose of this Health Needs Assessment (HNA) is to describe the emotional wellbeing and mental health needs of children and young people (CYP) in Leeds. Commissioned by LSECCG as part of the Future in Mind Leeds Local Transformation Plan, this HNA will be used to inform the direction of the Future in Mind Leeds Strategy and the future commissioning of services.

There are three main approaches to a health needs assessment, which were used to develop this needs assessment:

Approach	Method within this approach
Epidemiological – prevalence and incidence data; the services available	Data from several different sources was used to identify prevalence and incidence data, and extrapolated to Leeds. Use was also made of previously collected data in the JSNA[9]; through the Leeds Observatory[10]; the Local Authority Interactive Tool (LAIT)[11]; and in in other local reports and surveys. Local services are briefly described in the report, with activity data where available.
Stakeholder evaluation – structured collection of the knowledge and views of stakeholders; recognition of the importance of information and knowledge available from those involved in local services, including service users.	Three focus groups of young people were run in Leeds: one for LGBT young people, one for Gypsy and Traveler young people, and one with a Muslim youth forum. The aims of the focus groups were to examine: • the potential emotional and mental health support needs of young people from these particular groups • whether current service provision meets these needs and if not what are the barriers and what could be done differently Using a range of visual clues and maps, young people were asked to explain what mental health meant to them, who the important people in their lives are, who they would go to help for, their coping strategies and whether they were familiar with a range of services that are on offer. The qualitative data gathered was analysed using Framework Analysis (Ritchie and Spencer, 1994[12]). This type of analysis can be adapted to research that has specific questions that need to be answered, within a particular group of participants. Direct quotes (with minor amendments to improve the flow of the quoted text) and some examples of practice highlighted by respondents have been used to illustrate the findings.

[9] Leeds City Council (2015) Leeds Joint Strategic Needs Assessment. Health and Wellbeing Board
[10] Leeds City Council. Leeds Observatory [http://observatory.leeds.gov.uk/] Accessed June, 2016
[11] UK Government.[https://www.gov.uk/government/publications/local-authority-interactive-tool-lait]Accessed in May, 2016
[12] Ritchie, J. & Spencer, L. 1994. Qualitative data analysis for applied policy research" by Jane Ritchie and Liz Spencer in A.Bryman and R. G. Burgess [eds.] "Analyzing qualitative data", 1994, pp.173- 194

Comparative: contrasts with other areas where the information is available	Benchmarking was undertaken comparing Leeds with nearest neighbours and statistical neighbours where possible.

2.1 Context

2.1.1 Local policy context

> *Leeds partners' aspiration to become a child friendly city is at the heart of our vision because if we all do what we can to ensure our children and young people are safe, healthy, successful, heard, involved and respected at home, at school, in their communities – and whenever decisions affect them – it sends the right message about how important their welfare is to us and how important they are for our future.*
>
> **Leeds Children and Young People's Plan, (CYPP) 2015-19[13]**

[13] Leeds City Council (2015) Leeds Children and Young People's Plan. [http://democracy.leeds.gov.uk/documents/s132827/94%20App%203%20cyppfinaleb2406.pdf]

The findings from this Health Needs Assessment will underpin activity which relates to the following local strategies:

Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing (2015/16)[14]
Priorities: 1. Develop a Primary Prevention Programme for Children and Young People's Emotional and Mental Health 2. Develop and Communicate a Clear Local Offer of Children and Young People's Emotional and Mental Health Support/Services 3. The Development of the MindMate website and further Digital Solutions 4. A Single Point of Access (SPA) is in place for Children and Young People Emotional and Mental Health Services 5. Local Delivery of Early Emotional Help Services 6. Redesign Specialist CAMHS to align with Local and Whole System Model 7. Develop an Evidence Based Community Eating Disorder Service for Children and Young People (CEDS-CYP) 8. Ensure Vulnerable Children and Young People receive the Support and Services needed 9. Strengthen Transition 10. Develop a Shared Quality Framework across the Partnership 11. Crisis Care for Children and Young People 12. Co-commissioning with NHS England **Outcomes:** Simpler and easier referral process, more early intervention, children are given the best start in life, vulnerable children and young people receive the support and services they need, strengthened transition.
Leeds Maternity Health Needs Assessment 2014
Specialist support for women with mild/moderate perinatal mental illnesses in both the antenatal and postnatal period is limited.
Leeds Children and Young Peoples Plan CYPP 2015/19
Outcome: All CYP are safe from harm 2. Ensure that the most vulnerable are protected **Outcome: All CYP do well at all levels of learning and have the skills for life** 5. Improve outcomes for CYP with special educational needs and disability 6. Support children to have the best start in life and be ready for learning 7. Support schools and settings to improve attendance and develop positive behaviour **Outcome: All CYP enjoy healthy lifestyles** **Outcome: All CYP have fun growing up** 12. Improve social, emotional and mental health and well being **Outcome: All CYP are active citizens who feel they have voice & influence**

[14] Leeds CCGs and Leeds City Council (2015) Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing

2.1.2 Scope of the Health Needs Assessment

The report has used the Joint Commissioning Panel for Mental Health: Guidance for Commissioning Public Mental Health Services[15]; Sheffield CYP EWMH Health Needs Assessment (2014)[16]; Local Authority Interactive Tool (LAIT)[17]; Public Health England[18]; CHIMAT[19]; and Leeds Observatory[20] as key source documents and key data sources.

In scope

- Demographic data relating to Children and Young People (CYP), 0-25 years where available
- Protective factors for emotional wellbeing and mental health
- General population risk factors for poor emotional health and wellbeing
- High risk groups for mental disorder and low well being
- Overview of current service provision and activity levels

Out of scope

- Children with complex needs where mental health and emotional wellbeing is not the primary need (including severe learning disabilities & life limiting conditions).

The services included within this report are from across all four tiers of emotional wellbeing and mental health services in Leeds. The services include those that are jointly or separately commissioned (or provided) by NHS Leeds CCGs and Leeds City Council. In addition some significant voluntary sector projects have been included.

Leeds are currently undertaking an Adult Mental Health HNA which will add further intelligence regarding young adults 16 -24.

2.1.3 Leeds

The Leeds Joint Strategic Needs Assessment[21] describes Leeds as a growing city, where many people have benefited from the success of the city's economy over the last two decades, both within the city, and beyond in neighbouring localities. Leeds is a city of great contrasts, encompassing large rural areas such as Harewood and Wetherby where the population are generally more affluent, as well as densely populated inner-city areas where people face multiple challenges. In the last decade the BME population in the city has increased from 11% to 19%, and the number of residents born outside of the UK has almost doubled to over 86,000 people. Leeds also has one of the highest student

[15] Joint Commissioning Panel for Mental Health (2015) Guidance for commissioning public mental health services.] http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf]
[16] Public Health Team, CYPF, Sheffield City Council (2014) Children and Young People's Emotional Wellbeing and Mental Health: Health Needs Assessment.[http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/08/Sheffield-CYP-Emotional-Wellbeing-MH-Health-Needs-Assessment.pdf]
[17] UK Government.[https://www.gov.uk/government/publications/local-authority-interactive-tool-lait]Accessed in May, 2016
[18] Public Health England Observatories.[http://www.phoutcomes.info/] Accessed in May, 2016
[19] Child and Maternal Health Observatory [http://www.chimat.org.uk/] Accessed in May, 2016
[20] Leeds City Council. Leeds Observatory [http://observatory.leeds.gov.uk/] Accessed in June, 2016
[21] Leeds City Council (2015) Leeds Joint Strategic Needs Assessment. Health and Wellbeing Board

populations in the UK with over 60,000 students attending the city's three universities, with the student population heavily concentrated in the city centre and Inner West areas.

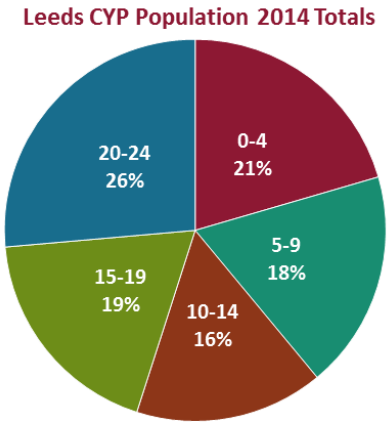
Leeds is split into 33 Wards:

1. Adel and Wharfedale
2. Alwoodley
3. Ardsley and Robin Hood
4. Armley
5. Beeston and Holbeck
6. Bramley and Stanningley
7. Burmantofts and Richmond Hill
8. Calverley and Farsley
9. Chapel Allerton
10. City and Hunslet
11. Cross Gates and Whinmoor
12. Farnley and Wortley
13. Garforth and Swillington
14. Gipton and Harehills
15. Guiseley and Rawdon
16. Harewood
17. Headingley
18. Horsforth
19. Hyde Park and Woodhouse
20. Killingbeck and Seacroft
21. Kippax and Methley
22. Kirkstall
23. Middleton Park
24. Moortown
25. Morley North
26. Morley South
27. Otley and Yeadon
28. Pudsey
29. Rothwell
30. Roundhay
31. Temple Newsam
32. Weetwood
33. Wetherby

2.1.4 Population

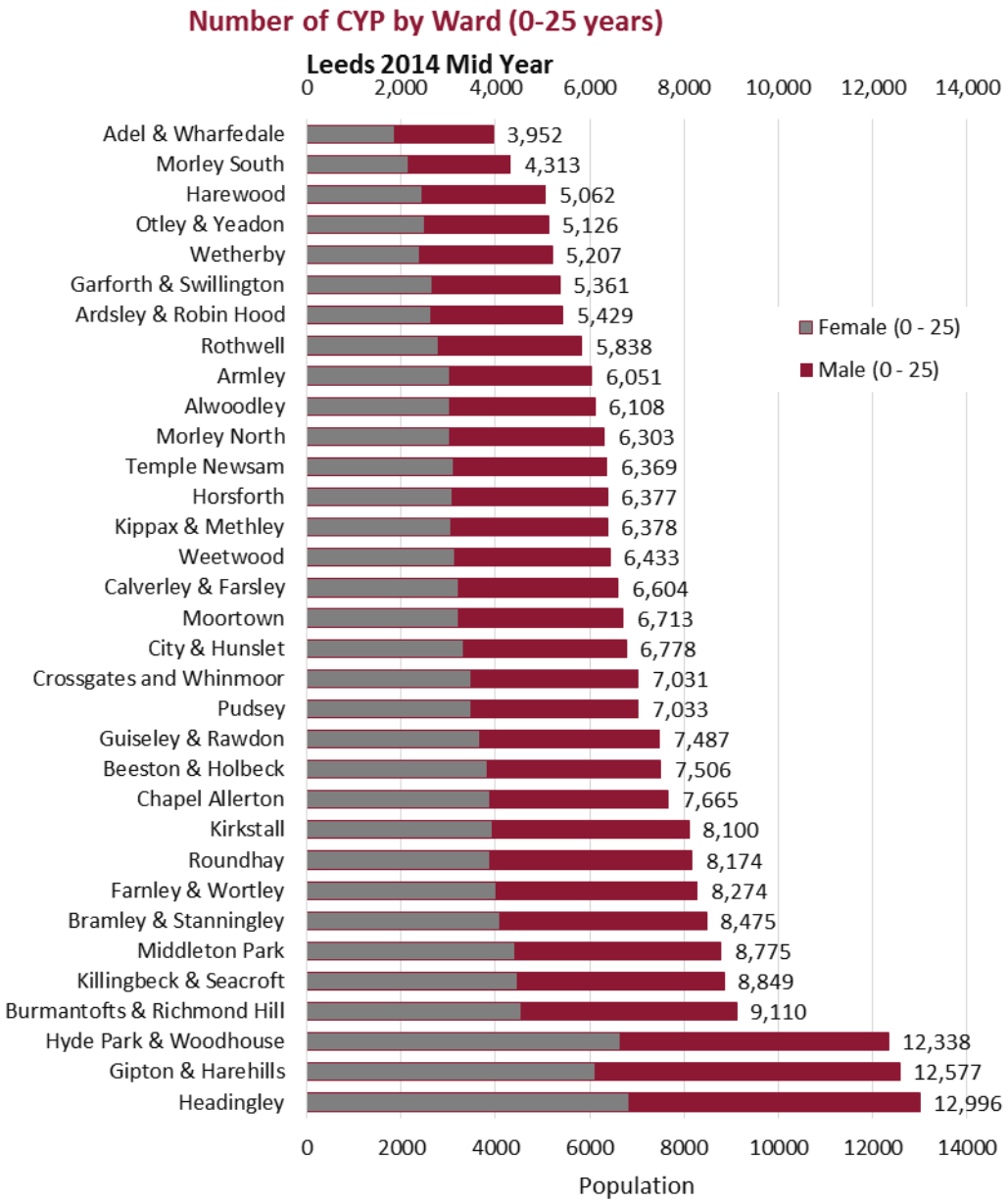
Data was obtained from the Office for National Statistics[22] on Leeds' CYP population aged 0-24 in 5-year age bands. The table and pie chart below illustrate the findings.

Age	Male	Female	Total
0-4	24,210	22,755	46,965
5-9	21,627	20,744	42,371
10-14	18,646	17,979	36,625
15-19	21,580	21,190	42,770
20-24	29,820	30,672	60,492



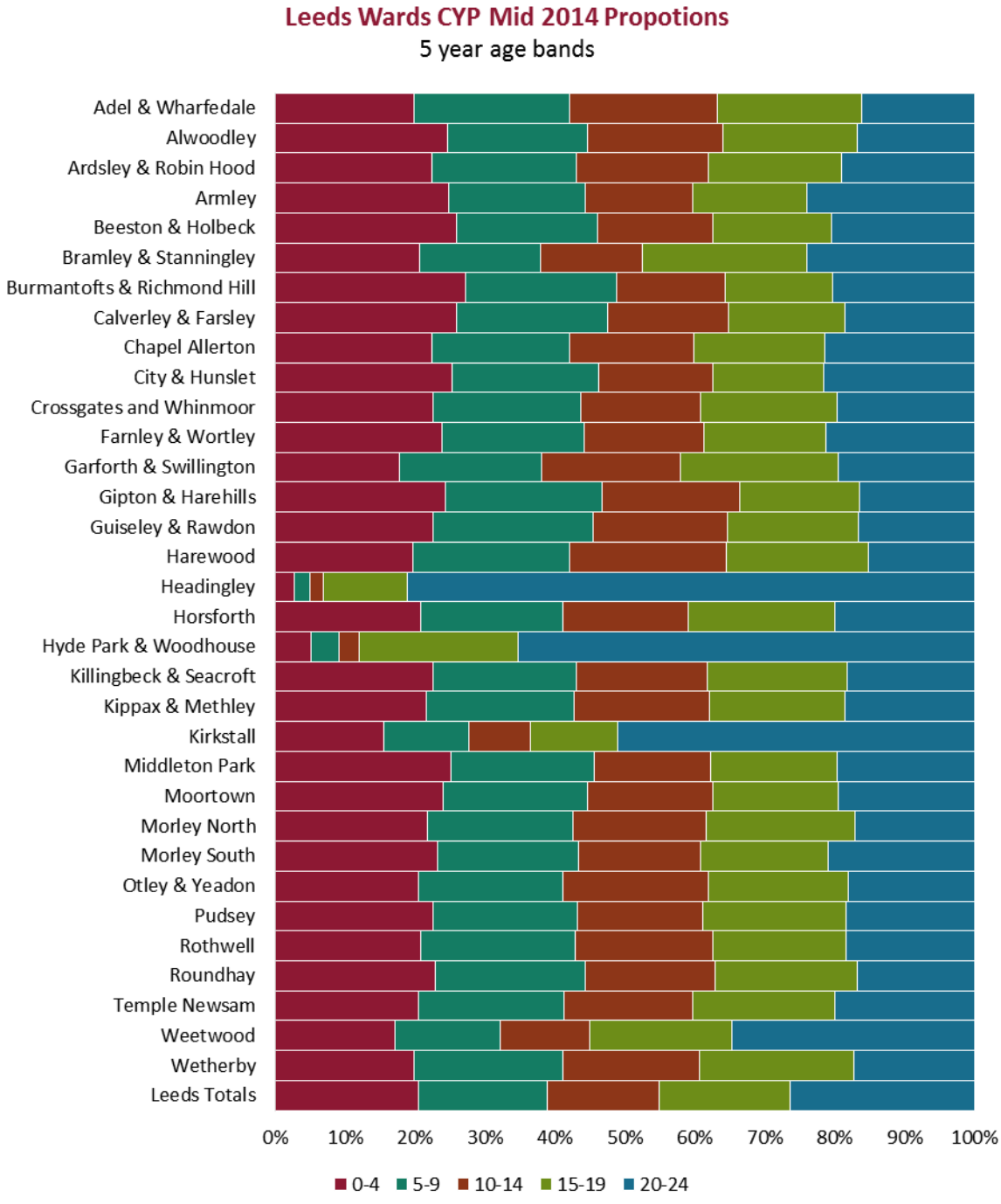
The high student population in Leeds is reflected in the age bands 15-19 and 20-24, and people in these age bands are mainly focussed around Headingley, Hyde Park and Woodhouse, and to a slightly lesser extent Kirkstall and Weetwood. When looking at the number of CYP by ward (below), the significance of this university/college population is clear and it could explain why the number of CYP in both Hyde Park and Woodhouse is so high, as shown on the next graph.

[22] ONS (2014) Mid-2014 Population Estimates for Census Output Areas in the Yorkshire and The Humber region of England by Single Year of Age and Sex

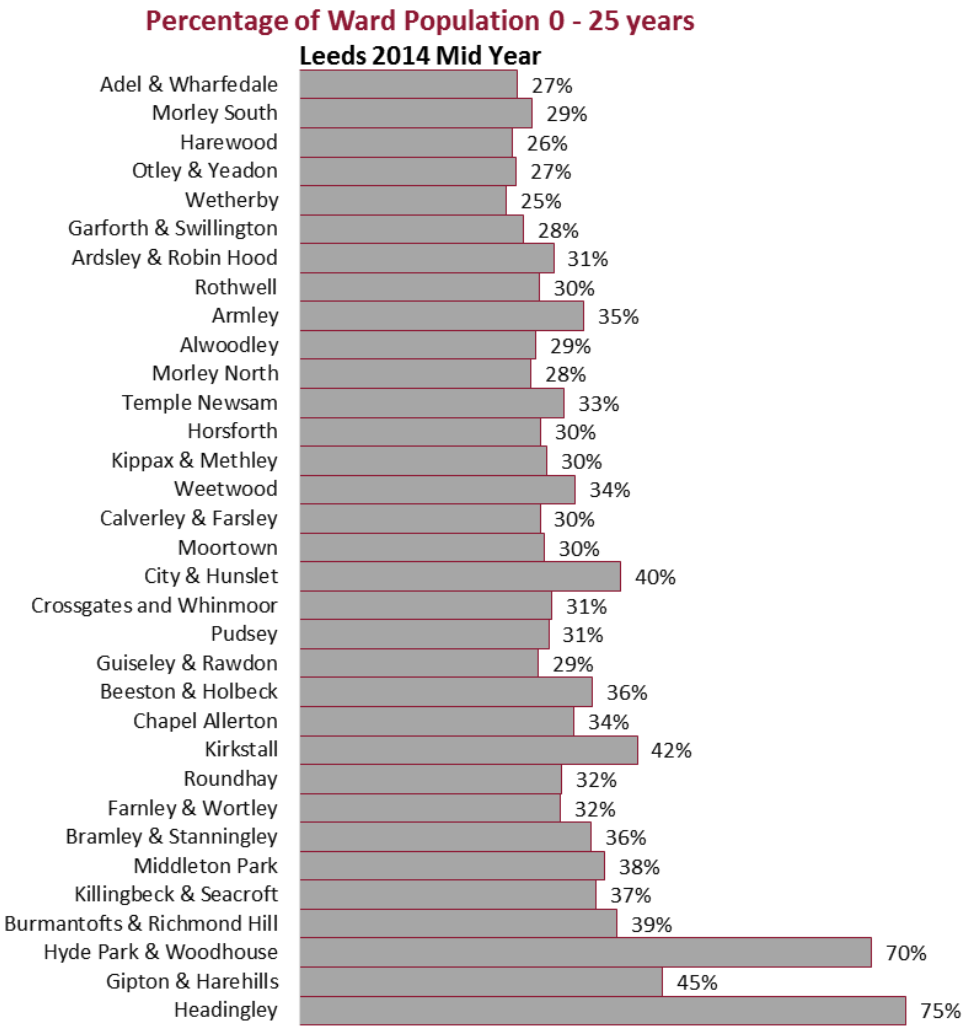


Looking at the number of CYP in each ward, the variation between more affluent and sparsely populated areas around Adel and Wharfedale, Morley South and Harewood and more densely populated and more deprived areas of Gipton and Harehills, and Burmantofts and Richmond Hill can be seen.

The impact of university, college and young professionals on the population of Headingley, Hyde Park and Woodhouse, and to a slightly lesser extent Kirkstall and Weetwood can be seen clearly on the chart below that shows the CYP in each ward split by 5 year age band, where the proportion of CYP that fall into the 20 -24 age bracket make up a significant proportion of the whole.

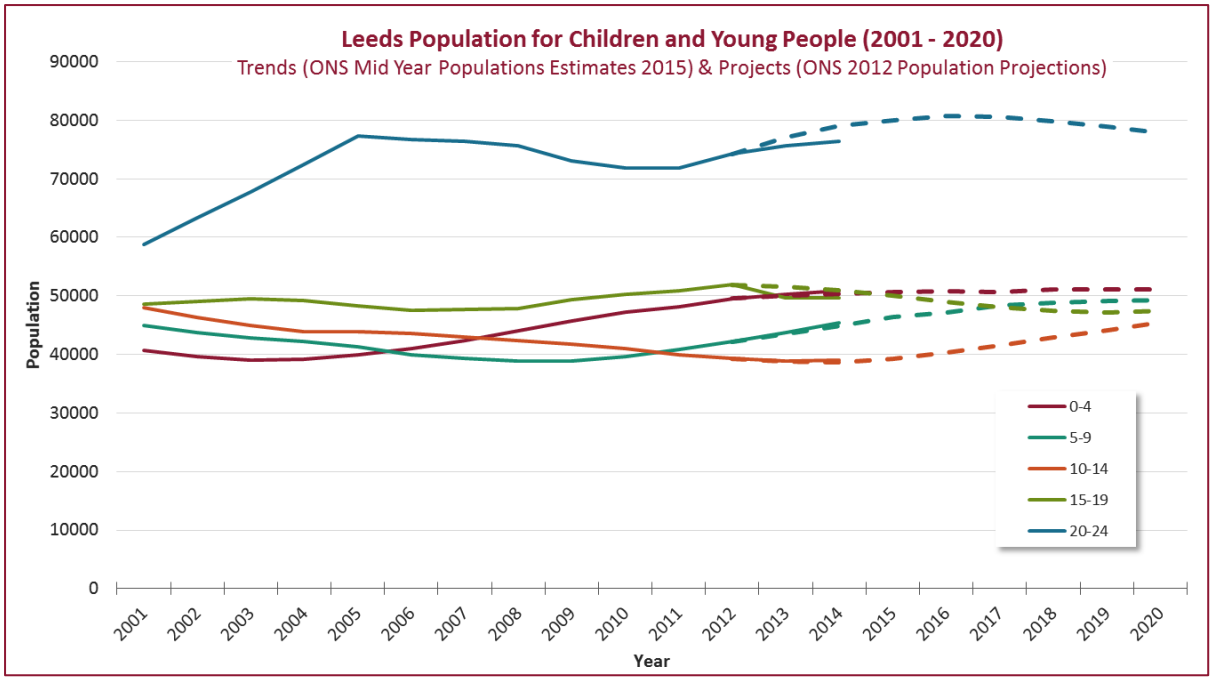


Beyond the high proportion of CYP in the university and college wards, it is in the poorer areas of Armley, Beeston and Holbeck, Bramley and Stanningley, City and Hunslet, Middleton Park, Burmantofts and Richmond Hill, Killingbeck and Seacroft, and Gipton and Harehills where the proportion of CYP are the highest (making up between 35% and 45% of the overall populations of those wards).



The graph below shows Leeds' population trends and projections to 2020, with trends being taken from ONS Mid-Year Population Estimates for 2015[23] and forecasts taken from ONS Population Projections[24]. It should be noted that while the actual numbers for the 0-4, 5-9 and 10-14 age groups were tracking well against the forecasts made in 2012 (actual volumes in 2014 are around 1% over the forecasts made in 2012), Leeds is seeing a much greater variation from the volumes forecast for 15-19 and 20-24 year olds (lower than forecast by between 2.4% and 3.3%).

[23] ONS (2015) Mid-Year population estimates for 2015 by CCG.
[24] ONS (2012) Sub-national population projections for England



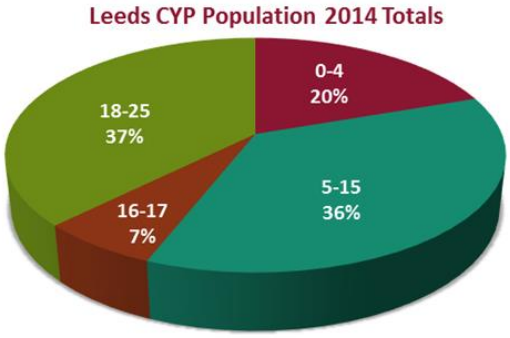
The forecast information from ONS Projections suggests that there is expected to be little movement in the number of 0-4 year olds over the next 4 years (between 0.6% & -0.3%). The 5-9 year old population is forecast to increase by 4.6% over the next 4 years (8.7% increase against 2014 actuals). The most growth in CYP is expected to be in the 10-14 year old population, where it is forecast to rise by 12.8% over the next 4 years (16.5% growth against 2014 actuals). The 15-19 year old population is forecast to drop by 3.8% between 2016 and 2019, before rising sharply. The 20-24 year old population is forecast to be 3.6% smaller in 2020 than it is was forecast to be in 2016 (although this is still 1.7% higher than 2014 actuals).

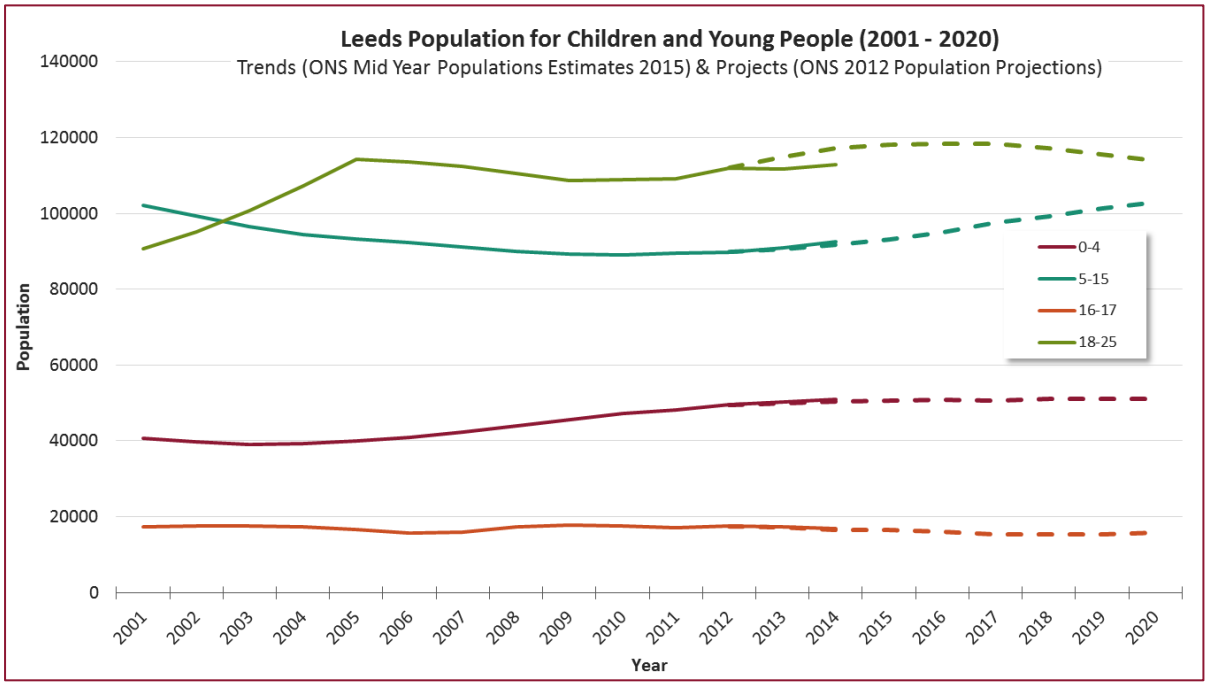
	2020 Forecast vs 2016 Forecast	2020 Forecast vs 2014 Actuals	Max Forecast Volume (2016 - 2020)	Max Forecast Increase	Min Forecast Volume (2016 - 2020)	Min Forecast Increase
0-4	0.6%	0.4%	51172	0.6%	50702	-0.3%
5-9	4.6%	8.7%	49340	4.6%	47193	0.0%
10-14	12.8%	16.5%	45487	12.8%	40315	0.0%
15-19	-3.2%	-4.6%	48955	0.0%	47106	-3.8%
20-24	-3.6%	1.7%	80659	0.0%	77771	-3.6%

The table and charts below shows the Leeds CYP population split into the usual divisions in Emotional Well-Being and Mental Health (EWMH) service provision i.e. Early Years 0-4s, 5-15s, 16 & 17 year olds, and 18-25 year olds[25].

[25] Office for National Statistics: Mid-2014 Population Estimates for Census Output Areas in the Yorkshire and The Humber region of England by Single Year of Age and Sex

Age	Male	Female	Total
0-4	24,210	22,755	46,965
5-15	44,150	42,510	86,660
16-17	8,177	7,581	15,758
18-25	44,192	45,217	89,409
0-16	72,368	68,953	141,321
0-19	86,063	82,668	168,731
16-25	52,369	52,798	105,167





The graph above looks at the population forecasts, based on the usual age-group divisions of service for 2016 - 2020, this is different to the earlier graph as it enables a focus on how the future demand on the current configuration of services could have an impact on service development. There is forecast to be 0.6% increase in the 0-4 year old population, an 8.3% increase in the 5-15 year old population, a 1.2% decrease in the number of 16-17 year olds, and a 3.9% decrease in the number of 18-25 year olds.

By 2020 there is forecast to be 272,674 CYP between 0 – 25 vs 261,522 in 2014 which accounts for an increase of 4.3% in the CYP population.

Conclusions/ Observations

The forecast information from ONS 2012 suggests that there is expected to be little movement in the number of 0-4 year olds over the next 4 years (between 0.6% & -0.3%).
The 5-9 year old population is forecast to increase by 4.6% over the next 4 years (8.7% increase against 2014 actuals).

The most growth in CYP is expected to be in the 10-14 year old population, where it is forecast to rise by 12.8% over the next 4 years (16.5% growth against 2014 actuals).
The 15-19 year old population is forecast to drop by 3.8% between 2016 & 2019, before rising sharply. The 20-24 year old population is forecast to be 3.6% smaller in 2020 than it is was forecast to be in 2016 (although this is still 1.7% higher than 2014 actuals).

By 2020 there are forecast to be 272,674 CYP between 0 – 25 vs 261,522 in 2014 which accounts for an increase of 4.3% in the CYP population.

2.1.5 Early Years

The Wave Trust[26] report that in pregnancy and in the first 2 years of a child's life that a baby's brain and neurological pathways are set for life. They describe this as the most important period for brain development and a key determinant of intellectual, social and emotional health and wellbeing. Research into risk factors that affect pregnancy and babies has established that experiencing adversity and stress in infancy (such as exposure to parental mental ill health, abuse and neglect and trauma) significantly increases the risk of a number of mental and physical health outcomes in later life.[27] Such experiences can alter the way the brain develops and functions and can lead to depression, anxiety, behavioural disorders, substance misuse, cardiovascular disease and cancers in later life.[28] [29]

The Marmot review [30] suggested that in order to reduce future social and health inequalities we need to pay particular attention to the early months of a child's life. This is echoed in the Local Government Association report which states that giving every child the best start in life is crucial in reducing health and education inequalities across the life course[31] and improving the future life chances of children. The Public Health Outcomes Framework also reflects this with outcome indicators linked to school readiness.[32]

[26] The Wave Trust (2014) The 1001 Critical Days-The importance of the conception to age 2 period. [http://www.wavetrust.org/sites/default/files/reports/1001%20Critical%20Days%20-%20The%20Importance%20of%20the%20Conception%20to%20Age%20Two%20Period%20Refreshed_0.pdf]
[27] NSPCC/Barnardos (2014) An Unfair sentence - All Babies Count: spotlight on the criminal justice system [http://www.barnardos.org.uk/an-unfair-sentence.pdf]
[28] IBID (as above)
[29] Annual Report of the Chief Medical Officer (2012). Our Children Deserve Better: Prevention Pays. DoH
[30] Marmot Review (2010) Fair Society Healthy Lives. Institute of Health Equity
[31] Local Government Association (2015) Giving our children the best start in life.
[32] Public Health Outcomes Framework 2013-16 [http://www.phoutcomes.info/]

2.1.6 Adolescence

The Annual Report of Chief Medical Officer (2012)[33] states that adolescents have experienced the least improvement in health status of any age group in UK in last 50 years. The Mental Health and Wellbeing Taskforce in their report Future in Mind[34] report that over half of all mental ill health starts before the age of 14yrs and 75% start by the age of 18. The life chances of these young people are significantly impacted – including their physical health; their educational and work prospects; their likelihood of committing crime and for some even the length of their life. The most vulnerable young people – those who are in care, those living with disability, young offenders or the children of offenders - are at greater risk of poor mental health than others of the same age. For example children of prisoners have at least double the risk of mental health problems compared to their peers[35].

Some key messages from the research in relation to this phase of development are:

- Different parts of the brain mature at different times with the last to mature being those parts which help teenagers reason and think logically and help with self-control and planning ahead [36]
- Teenagers are more prone to engage in risk taking behaviour and are not sufficiently able to interpret emotions (particularly if there is no secure attachment figure to help them)[37].
- Genes, childhood experiences, and the environment in which the young person reaches adolescence can shape behaviour significantly. Similarly to the phase of early childhood, the adolescent brain development is a period of 'use it or lose it'[38]. Brain connections that are stimulated and used repeatedly grow stronger, unused connections wither away.
- The majority of young people manage the transition to adulthood well. Resilience can be strengthened. Authoritative parenting, participation in education and training and supportive friendship groups can support resilience. Stability in both environment and relationships are hugely positive in helping young people through this phase of their lives[39].
- School years 9, 10, 11 are a period of increasing risk and decreasing protective factors. Adolescents (particularly boys) are much less likely to ask for help than younger children and building relationships of trust is particularly important for successful intervention. [40]
- Abuse or maltreatment in adolescence has a strong impact on their later outcomes. Exposure to chronic or 'toxic' stress in this period (poor living conditions, the experience of trauma, neglect or abuse including neglect and verbal abuse) has the potential to impair

[33] Annual Report of the Chief Medical Officer (2012). Our Children Deserve Better: Prevention Pays. DoH
[34] DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939
[35] NSPCC/Barnardos (2014) An Unfair sentence - All Babies Count: spotlight on the criminal justice system [http://www.barnardos.org.uk/an-unfair-sentence.pdf]
[36] HM Government (2011) Positive for youth. Stationery office.
[37] Brown, R & Ward, H (2013) Decision-making within a child's timeframe. Childhood Wellbeing Research Centre
[38] National Institute for Mental Health (2010) Teenage Brain: A work in progress (Fact Sheet) http://www.nimh.nih.gov/health/publications/teenage-brain-a-work-in-progress-fact-sheet/index.shtml#5#5
[39] Mills, KL, Goddings, AL and Blakemore.SJ (2014) Frontiers for young minds: Drama in the teenage brain. Frontiers for Young Minds
[40] Research in Practice (2016) Risk-taking adolescents and child protection. Strategic Briefing

brain development in adolescence impacting adversely on learning and memory later in life. [41]

- Their situations are often more complex than for younger children because of issues such as running away, family breakdown and violence and conflict with parents.[42]
- These young people are more likely to self-medicate using alcohol or drugs[43] [44]. Peer influence for young people is hugely significant in relation to decision making and in risk taking behaviours.
- Young people who have experienced sexual exploitation are likely to have been excluded from school, use substances, be involved in crime and go missing.[45]

2.2 Definitions of emotional wellbeing and mental health

Definitions of mental health and emotional wellbeing vary across different disciplines and agencies.

Emotional and mental health and wellbeing refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence, and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships.

Good mental health is more than the absence of mental illness; it is a positive sense of well-being. This includes the ability to play, learn, enjoy friendships and relationships, as well as deal with the difficulties experienced during childhood, adolescence and early adulthood. It is defined as:

> *Not simply the absence of disorder but a states of wellbeing in which every individual realises his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*[46]

The NPC report[47] distinguishes between mental health problems, mental health disorders and mental illness, in line with most CAMHS services:

- **Mental health problems** – a range of milder symptoms, such as feeling unusually sad, worried or angry. They affect 20-30% of children and young people and although debilitating at times, they will not be diagnosed for specialist treatment.
- **Mental health disorders** – affect about 10% of children and young people and fit diagnostic criteria. This is when behaviour or feelings are seriously outside the normal range and cause significant suffering, impairing day-to-day life.

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[41] IBID
[42] IBID
[43] Walsh D, Bennet, N (2005) Why do they act that way? Atria Books.
[44] Healy M (2004) Your Child's Growing Mind: Brain Development and Learning from Birth to Adolescence (3rd ed). Broadway Books
[45] Berelowitz et al (2012) Interim report into the Inquiry into Child Sexual Exploitation in Gangs and Groups. Office of Children's Commissioner
[46] JCPMH (2013) Guidance for commissioners of child and adolescent mental health services.[http://www.jcpmh.info/wp-content/uploads/jcpmh-camhs-guide.pdf]
[47] NPC (2008) Heads up. Mental Health of Children and Young People

- **Mental illness** - affecting 1-2% of children and young people – being more common in young people than young children. These are severe forms of psychiatric disorder, particularly of the kind also found in adulthood, for example, depressive disorder, schizophrenia and obsessive disorders.

2.3 International Comparison

In 2007, the UK ranked lowest (21st) in a comparative study of industrialised countries by UNICEF In 2009[48]. By 2009, the UK still had poor wellbeing compared to other countries and was ranked 24th out of 29 European countries for child wellbeing[49]. In 2013 UNICEF[50] reported the results of the OECD 29 rich member countries which put the UK in 16th position for children's well-being. The 2013 score was constructed by OECD from 5 indicators of wellbeing:

- Material well-being: includes monetary deprivation; and material deprivation (UK ranked 14th)
- Health and safety: incorporating infant mortality and low birth weights; immunisation rates for measles DPT3 and Pol3; and child death rate 16th)
- Education: incorporating indicators on participation in early childhood education and further education; NEET rate, and achievement (24th)
- Behaviours and risks: incorporating the components of health behaviours (being overweight; eating breakfast; eating fruit; taking exercise); risk behaviours (teenage fertility rate; smoking; alcohol; cannabis; and exposure to violence (fighting; bullying) (15th)
- Housing and environment: incorporating housing and environmental safety (10th)

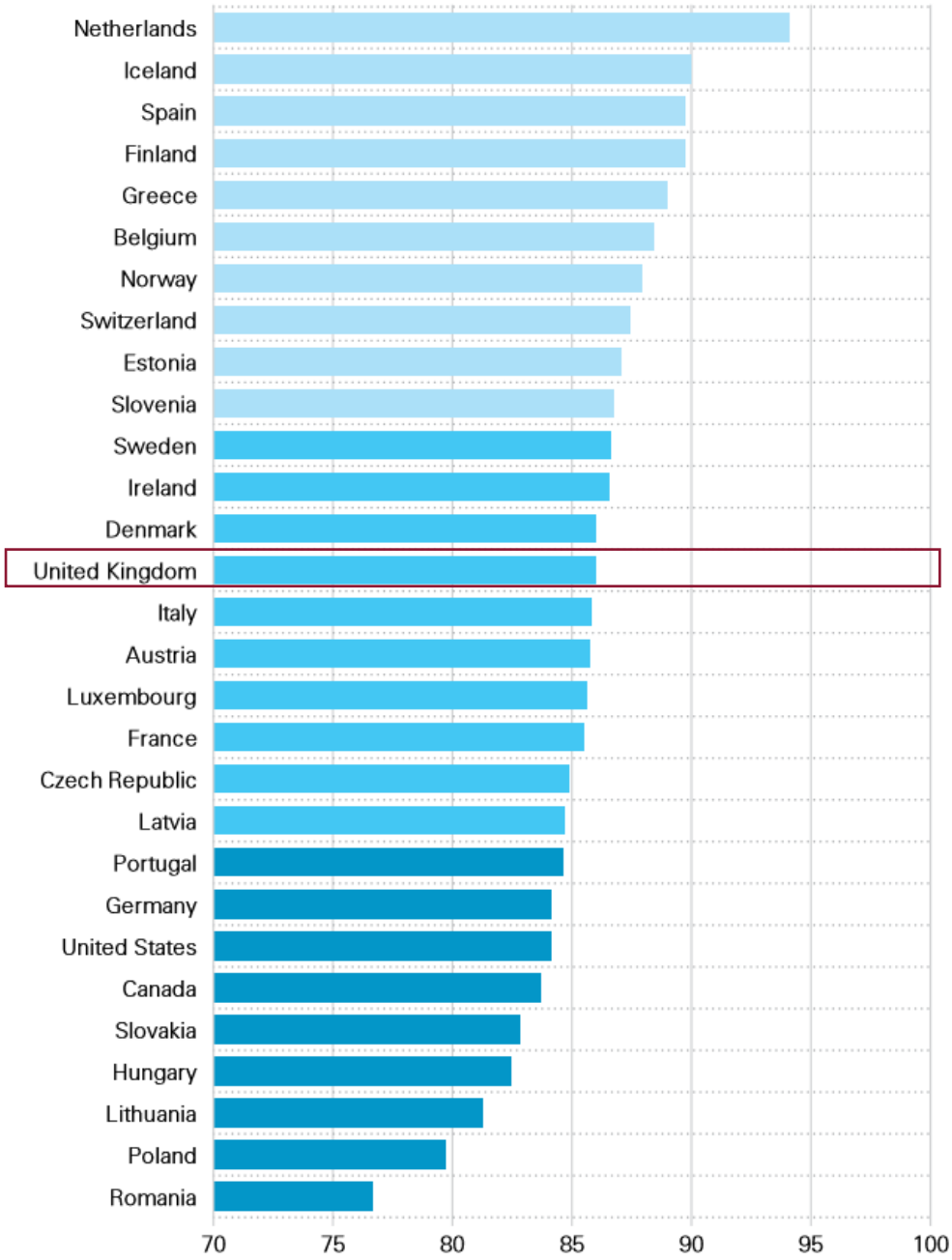
[48] UNICEF (2009) Innocenti Report Card 7. Office of Research.
[49] Bradshaw J, Richardson D (2009). An index of child wellbeing in Europe. Child Indicators Research
[50] UNICEF (2013) Child Well-Being in Rich Countries: a comparative overview [http://www.unicef.org.uk/Images/Campaigns/FINAL_RC11-ENG-LORES-fnl2.pdf]

		Overall well-being	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5
		Average rank (all 5 dimensions)	Material well-being (rank)	Health and safety (rank)	Education (rank)	Behaviours and risks (rank)	Housing and environment (rank)
1	Netherlands	2.4	1	5	1	1	4
2	Norway	4.6	3	7	6	4	3
3	Iceland	5	4	1	10	3	7
4	Finland	5.4	2	3	4	12	6
5	Sweden	6.2	5	2	11	5	8
6	Germany	9	11	12	3	6	13
7	Luxembourg	9.2	6	4	22	9	5
8	Switzerland	9.6	9	11	16	11	1
9	Belgium	11.2	13	13	2	14	14
10	Ireland	11.6	17	15	17	7	2
11	Denmark	11.8	12	23	7	2	15
12	Slovenia	12	8	6	5	21	20
13	France	12.8	10	10	15	13	16
14	Czech Republic	15.2	16	8	12	22	18
15	Portugal	15.6	21	14	18	8	17
16	United Kingdom	15.8	14	16	24	15	10
17	Canada	16.6	15	27	14	16	11
18	Austria	17	7	26	23	17	12
19	Spain	17.6	24	9	26	20	9
20	Hungary	18.4	18	20	8	24	22
21	Poland	18.8	22	18	9	19	26
22	Italy	19.2	23	17	25	10	21
23	Estonia	20.8	19	22	13	26	24
23	Slovakia	20.8	25	21	21	18	19
25	Greece	23.4	20	19	28	25	25
26	United States	24.8	26	25	27	23	23
27	Lithuania	25.2	27	24	19	29	27
28	Latvia	26.4	28	28	20	28	28
29	Romania	28.6	29	29	29	27	29

Lack of data on a number of indicators means that the following countries, although OECD and/or EU members, could not be included in the league table of child well-being: Australia, Bulgaria, Chile, Cyprus, Israel, Japan, Malta, Mexico, New Zealand, the Republic of Korea, and Turkey.

The UNICEF report[51] also provided a Children's Life Satisfaction League Table (2009/2010) with the UK ranked 14th by this measure (below), which shows the % of children aged 11, 13 and 15 who rate their life satisfaction with a score of 6 or more on the 11 step 'Cantril's Ladder of Life Scale:

[51] UNICEF (2013) Child Well-Being in Rich Countries: a comparative overview [http://www.unicef.org.uk/Images/Campaigns/FINAL_RC11-ENG-LORES-fnl2.pdf



Within the same UNICEF report, children in the UK reported that:

- 63.3% felt classmates were kind and helpful
- 83% found it easy to speak to their Mother
- 68.6% found it easy to speak to their Father

Other factors noted by the report which can have an impact on young people's emotional wellbeing and mental health:

- The percentage of children and young people who smoke cigarettes had fallen in all 21 countries for which comparable data are available. The United Kingdom halved the proportion of young people who report smoking cigarettes
- The biggest falls in alcohol abuse were recorded in Germany and in the United Kingdom. The UK saw a decline from 30% to just under 20%

- Starting from a high level, the United Kingdom also halved cannabis use among young people (from 34% to 17%)

2.4 Statistical Neighbours

The HNA includes reference to statistical neighbours within data obtained from both the Local Authority Interactive Tool (LAIT) and Public Health England Children's and Young People's Mental Health and Wellbeing Portal.

The LAIT defines Leeds's statistical neighbours as: Bolton; Bury; Calderdale; Darlington; Derby; Kirklees; Newcastle upon Tyne; North Tyneside; Sheffield and Stockton-on-Tees.

Public Health England Children's and Young People's Mental Health and Wellbeing Portal consider Leeds's statistical neighbours to be Calderdale; Kirklees and Sheffield.

3. Protective Factors

3.1 Overview

"Health is the basis for a good quality of life and mental health is of overriding importance in this" (Article 24 of the United Nations' Convention on the Rights of the Child[52]). NRC&IoM[53] define protective factors as '*characteristics at the individual, family or community level that are associates with a lower likelihood of problem outcomes'* (p82). It can also refer to factors that interact with risk factors that reduce the negative impact.

[52] UN (1989) United Nations' Convention on the Rights of the Child. UNICEF

[53] National Research Council and Institute of Medicine. (2009). preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. committee on the prevention of mental disorders and substance abuse among children, youth, and young adults: research advances and promising interventions.[http://www.ncbi.nlm.nih.gov/books/NBK32775/pdf/Bookshelf_NBK32775.pdf]

Protective factors across the life cycle are presented in the table[54] below:

	Individual	Family	School/Community
Infancy and Early Childhood	•Self-regulation •Secure attachment •Mastery of communication and language skills •Ability to make friends and get along with others	•Reliable support and discipline from caregivers •Responsiveness •Protection from harm and fear •Opportunities to resolve conflict •Adequate socioeconomic resources for the family	•Support for early learning •Access to supplemental services such as feeding, and screening for vision and hearing •Stable, secure attachment to childcare provider •Low ratio of caregivers to children •Regulatory systems that support high quality of care
Middle Childhood	•Mastery of academic skills (math, reading, writing) •Following rules for behaviour at home, school, and public places •Ability to make friends •Good peer relationships	•Consistent discipline •Language-based rather than physically based discipline •Extended family support	•Healthy peer groups •School engagement •Positive teacher expectations •Effective classroom management •Positive partnering between school and family •School policies and practices to reduce bullying •High academic standards
Adolescence	•Positive physical development •Academic achievement/intellectual development •High self-esteem •Emotional self-regulation •Good coping skills and problem-solving skills •Engagement and connections in two or more of the following contexts: school, with peers, in athletics, employment, religion, culture	•Family provides structure, limits, rules, monitoring, and predictability •Supportive relationships with family members •Clear expectations for behaviour and values	•Presence of mentors and support for development of skills and interests •Opportunities for engagement within school and community •Positive norms •Clear expectations for behaviour •Physical and psychological safety
Early Adulthood	•Identity exploration in love, work, and world view •Subjective sense of adult status •Subjective sense of self-sufficiency, making independent decisions, becoming financially independent •Future orientation •Achievement motivation	•Balance of autonomy and relatedness to family •Behavioural and emotional autonomy	•Opportunities for exploration in work and school •Connectedness to adults outside of family

[54] IBID

Resilience

The Association for Young People's Health (AYPH) (2016)[55] define resilience as:

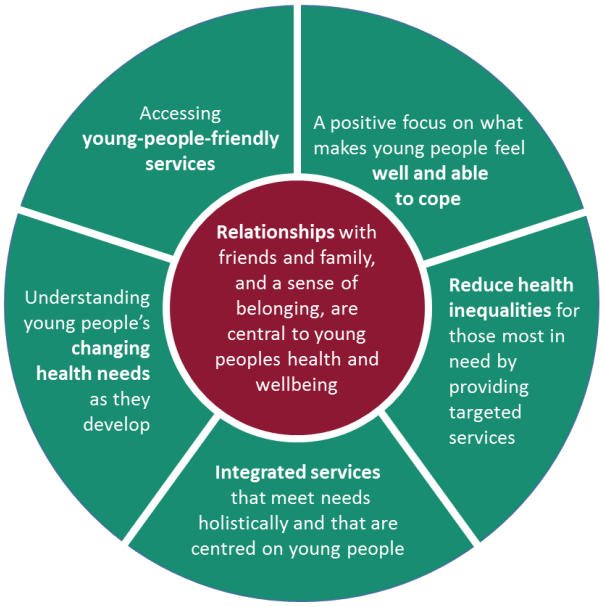
> *…. the capacity to bounce back from adversity. Protective factors increase resilience, whereas risk factors increase vulnerability. Resilient individuals, families and communities are more able to deal with difficulties and adversities than those with less resilience*.

The Future in Mind (2015)[56] taskforce acknowledged within their report that *we are by no means alone in the international community in grappling with how to give our children and young people a better start, to keep them safe and to help their mental health and resilience.*

Resilience is associated with wellbeing and can also help safeguard mental well-being particularly at times of adversity. It arises through the interaction between factors at the individual, family and community level. Different levels of emotional and cognitive resilience or 'capital' include:

- **emotional and cognitive:** includes optimism, self-control and positive personal coping strategies
- **social**: includes networks and resources that enhance trust, cohesion, influence and cooperation for mutual benefit within communities
- physical health
- **environmental:** includes features of the natural and built environment which enhance community capacity for wellbeing
- **spirituality**: incorporates a sense of meaning, purpose and engagement as well as religious belief for some.[57]

PHE and AYPH (2014)[58] identify six core principles that cut across all health topics for young people. They build on the concept of resilience, seeing relationships as pivotal. The diagram illustrates their resilience model:



AYPH (2016)[59] state that promoting resilience means supporting the development of good personal life skills, helping young people to sustain good relations and providing resources and intervention to ameliorate or prevent the

[55] AYPH (2016) A public health approach to promoting young people's resilience. A guide to resources for policy makers, commissioners and service planners and providers. http://www.youngpeopleshealth.org.uk/
[56] DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939
[57] Joint Commissioning Panel for Mental Health (2013) Guidance for commissioning public mental health services
[58] Public Health England and Association for Young People's Health (2014) Improving young people's health and wellbeing: a framework for public health.
[59] AYPH (2016) A Public Health Approach to promoting young people's resilience.

effects of 'set-backs'. Other elements[60] that are important for building resilience are preparing young people to cope with adversities, by strengthening life skills, enhancing self-efficacy, nurturing their creativity and making sure external resources are available when they need to draw on them.

PHE[61] collated the evidence and state that by building resilience, there may be better outcomes in the face of adversity, including a lower incidence of unhealthy or risky behaviours; higher attainment at school, qualifications and skills levels; better employment prospects; higher mental wellbeing and flourishing; and improved recovery from illness.

3.2 Family Protective Factors

3.2.1 Attachment & Parenting

Marmot review[62] asserts that every child should be given the best start in life in order to reduce future social and health inequalities, reflecting the view that the origins of much adult disease are in the very early years[63].

Attachment is a specific outcome of early care. Attachment theory states that a strong emotional attachment to at least one primary caregiver is critical to a child's development. It is this attachment which provides a sense of stability and security in the child. With a secure attachment in place a child has a "secure base" from which to explore, learn and develop independence[64]. Positive pro-active parenting (e.g. parenting that involves praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence and is protective against later disruptive behaviour and substance misuse.

Annual CMO report[65] cites a number of longitudinal studies that have shown that securely attached children function better across a number of domains, including emotional, social and behavioural adjustment. Whilst the majority (60%) of children are securely attached[66], 25% have avoidant attachment patterns, and 15% have disorganised or resistant attachment – this rises to 25% in disadvantaged cohorts.[67] National analysis of the 2014 Foundation Stage Profile[68] scores found a fifth of children lack personal social and emotional development at age 4years (40,000 girls; 82,000 boys).

Children with insecure attachment are at risk of doing less well in school. They are most at risk of behavioural problems, poor literacy, leaving school without further education, employment or training. They are at higher risk of externalising problems characterised by aggression, defiance and

[60] Public Health England and Association for Young People's Health (2014) Improving young people's health and wellbeing: a framework for public health.
[61] PHE (2014) Building Children and young people's resilience in schools. Gateway number 2014334
[62] Marmot Review (2010) Fair Society Healthy Lives http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[63] Annual Report of the Chief Medical Officer (2012). Our Children Deserve Better: Prevention Pays. DoH
[64] Bowlby J (1988) A Secure Base: Parent-child attachment and healthy human development. London: Routledge
[65] Annual Report of the Chief Medical Officer (2012). Our Children Deserve Better: Prevention Pays. DoH
[66] Hazan C, Shaver P. Romantic love conceptualized as an attachment process. Journal of Personality and Social Psychology. 1987; 52: 511-524
[67] Andreassen & West (2007). Figures of proportions in different attachment categories are from the US Early Childhood Longitudinal Study- Birth Cohort (ECLS-B). This is broadly consistent with figures in the National Institute of Child Health and Development (NICHD)'s Study of Early Child Care and Youth Development, and meta-analysis of studies in North America and Europe (van Izjendoorn et al, 1999
[68] Standards and Testing Agency (2014) Early Years Fondation Stage Profile Handbook

hyperactivity; poorer language development, weaker skills with their working memory and cognitive flexibility. [69]

Research relating to risk and protective factors has produced a clearer understanding of the positive effects for children in 'at risk' situations. These include:

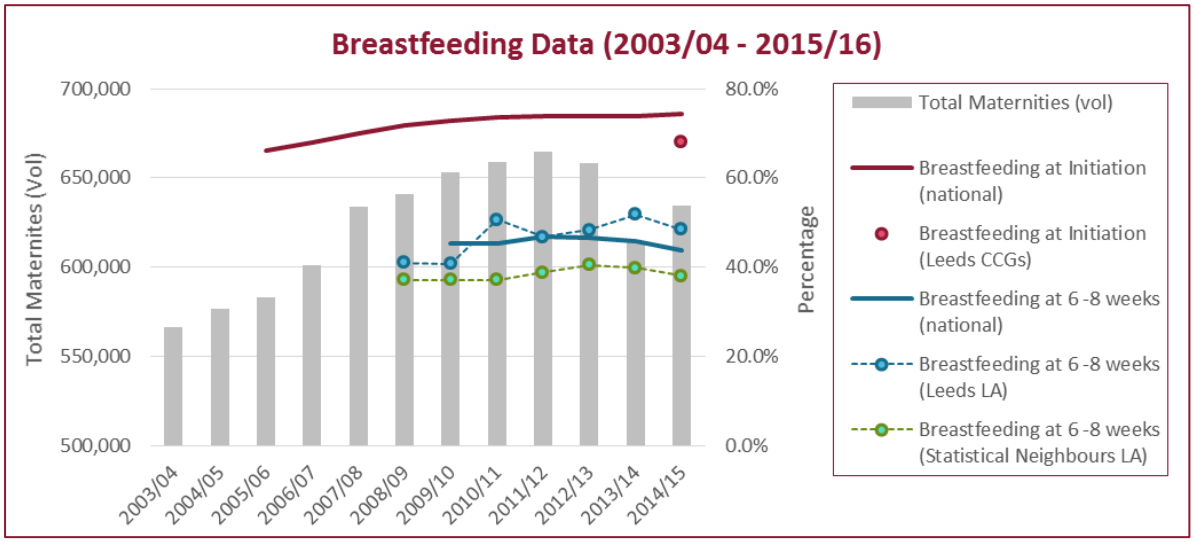
- Having at least one healthy relationship with a supportive adult and/or a good relationship with peers. [70].
- A positive adult-child relationship[71].
- A positive school experience and a warm and open relationship with a teacher or child care provider [72].

[69] Belsky, J., & Fearon, R. (2002a). Early attachment security, subsequent maternal sensitivity, and later child development. Attachment and Human Development, 4, 361-387.
[70] Luthar, S.S. (1993). Annotations: Methodological and conceptual issues in research on childhood resilience. Journal of Child Psychology and Psychiatry, 34 (4), 441-453.
[71] Webster-Stratton, C. (1999). How to promote children's social and emotional competence. London: Paul Chapman Publishing Ltd.
[72] Huffman, L., Mehlinger, S.L., & Kerivan, A.S. (2000). Risk factors for academic and behavioural problems at the beginning of school. Bethesda, MD: National Institute of Mental Health.

3.2.2 Breastfeeding

Breast-feeding has been linked to positive emotional, health and cognitive outcomes for children. The Leeds 2015 JSNA[73] acknowledges *that 'The first years of life are increasingly recognised as a priority given their profound influence on the development of a child's emotional and social capacity and cognitive growth. Analysis shows that economic investment into the early years gives the greatest return on investment[. . .] Areas of focus include breastfeeding, good antenatal nutrition, the promotion of language development and perinatal mental health services*.'

To following graph takes data from the 'Local Authority Interactive Tool'[74] and from 'NHSE Maternity and Breastfeeding statistics[75].



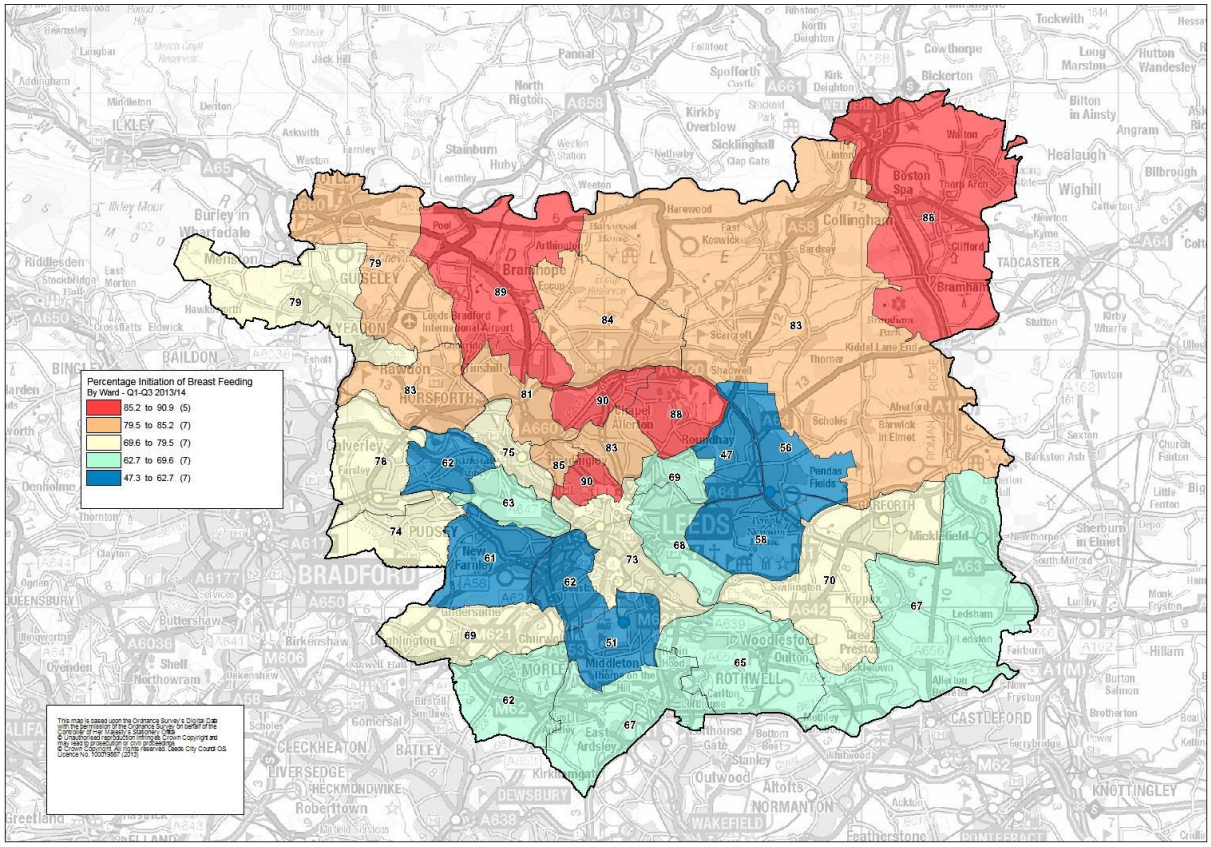
The national rate of breast-feeding at initiation has grown steadily from 66.2% in 2005/06 to 74.3% in 2014/15. The current rate reported for all Leeds CCGs is 68%, which is below the national average. However, within this figure there is a local split, with Leeds North CCG reporting a breastfeeding rate at initiation of 76.7%, which is above the national average, while Leeds West (69%) and Leeds South and East (60.9%) are both below the national average.

At 6-8 weeks the national rate of infants totally or partially breast fed currently stands at 43.8%. Over the last 4 years Leeds LA have reported a rate equal to or greater than the national average (currently 48.5%), and significantly higher than its statistical neighbours (currently 38.1%)[76]

Year to date figures taken in 2014 (Q1 – 3 2013-14) show significant variation in numbers of women initiating breastfeeding: ranging from 90% in Moortown to 47% in Killingbeck and Seacroft. This was likely to be due to a combination of the effects of ethnicity, age and income-level on breastfeeding behaviour[77]

[73] Leeds City Council (2015) Leeds Joint Strategic Needs Assessment. Health and Wellbeing Board
[74] UK Government.[https://www.gov.uk/government/publications/local-authority-interactive-tool-lait]Accessed in May, 2016
[75] NHSE (2015) NHSE Maternity and Breastfeeding statistics : Statistical Release: Breastfeeding Initiation & Breastfeeding Prevalence 6-8 weeks
[76] UK Government.[https://www.gov.uk/government/publications/local-authority-interactive-tool-lait]Accessed in April, 2016
[77] Leeds City Council (2016) Leeds Observatory: Leeds Maternity Health Needs Assessment 2014

The map below from Leeds Maternity Health Needs Assessment 2014[78] shows highest breastfeeding rates (in red) across the north of the city and lowest rates (blue) on the inner East and Inner West - these areas have a high proportion of white women living in low income communities.



Conclusions/ Observations

The current rate of breast-feeding at initiation reported for all Leeds CCGs (68%) is below the national average. However, within this figure there is a local split, with Leeds North CCG reporting a breast-feeding rate at initiation of 76.7%, which is above the national average, while Leeds West (69%) and Leeds South and East (60.9%) are both below the national average.

At 6-8 weeks the national rate of infants totally or partially breast fed currently stands at 43.8%. Over the last 4 years Leeds LA have reported a rate equal to or greater than the national average (currently 48.5%), and significantly higher than its statistical neighbours (currently 38.1%)

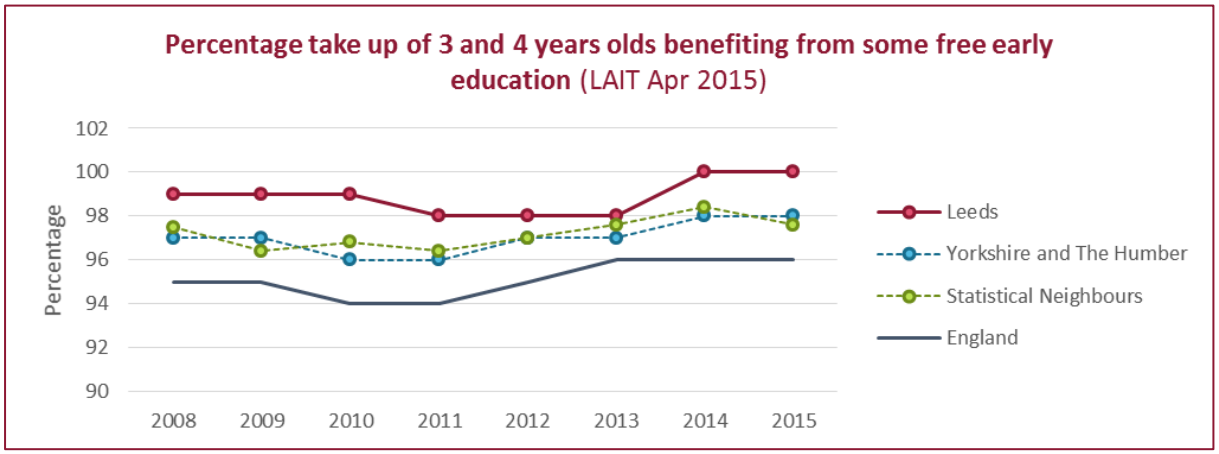
[78] IBID

3.3 School and Community Protective Factors

3.3.1 Early Year Education

In 2015, 2,550 2 year olds in Leeds benefitted from free early learning education, up from 1,400 in 2014[79].

Same source indicates that Leeds LA have consistently reported higher than national, statistical neighbour and Yorkshire and Humber figures for the percentages of 3 and 4 year olds benefitting from some free early learning provision since 2008. Since 2014 Leeds LA have reported a 100% of its 3 and 4 year olds were in some free early education. Between 2011 and 2013 Leeds LA reported a take up rate of 98% compared to its statistical neighbours who reported between 96.4% and 97.6%.



The report from the Nuffield Foundation[80] states there is evidence that attendance at high quality early education and childcare is associated with a positive impact on children's social and cognitive development. Children who have attended high quality provision are more likely to be ready for school having gained the necessary range of skills needed for good learning and development.

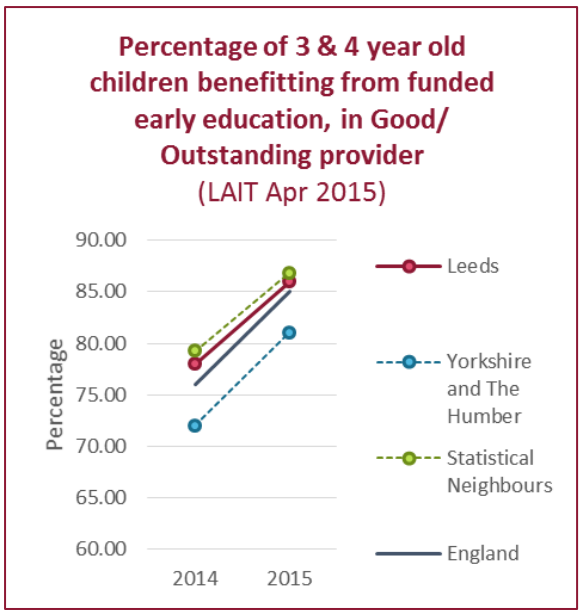
According to the Sutton Trust[81] the poorest children can be up to 19 months behind their more affluent classmates when they start school. Save the Children research shows that 80% of the GCSE attainment gap is already present by the age of seven. Good quality early learning can have a role in tackling disadvantage with the best effects found among those who attended the highest quality provision which catered for a mix of children from different social backgrounds.

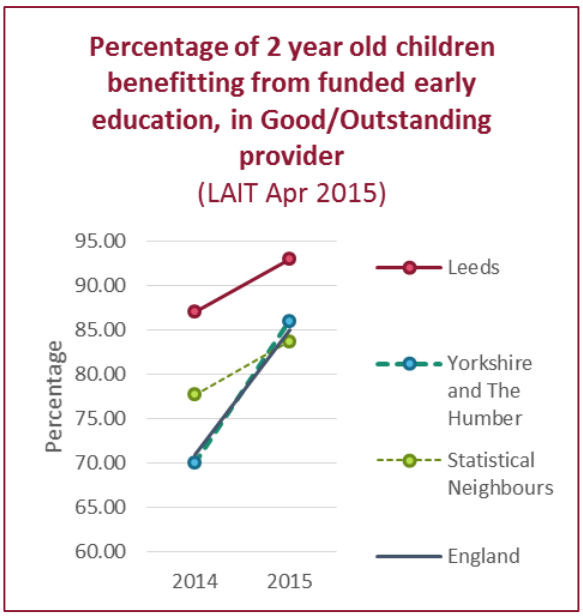
The graph below left shows that the percentage of 3 and 4 year olds benefitting from funded early education in a Good/Outstanding provider in Leeds has increased from 78% to 86% between 2014 and 2015, which is slightly better than the national average of 85% (2015). The percentage of 2 year olds that benefit from funded early education in a Good/Outstanding provider also rose (below right), from 87% to 93%, which is above the national rate of 85%.

[79] UK Government.[https://www.gov.uk/government/publications/local-authority-interactive-tool-lait]Accessed in April, 2016

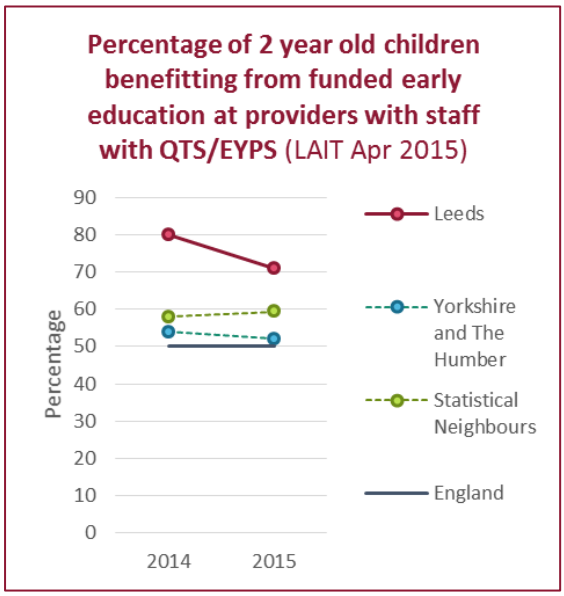
[80] Hillman J, Williams T (2015) Early years education and childcare: Lessons from evidence and future priorities. Nuffield Foundation

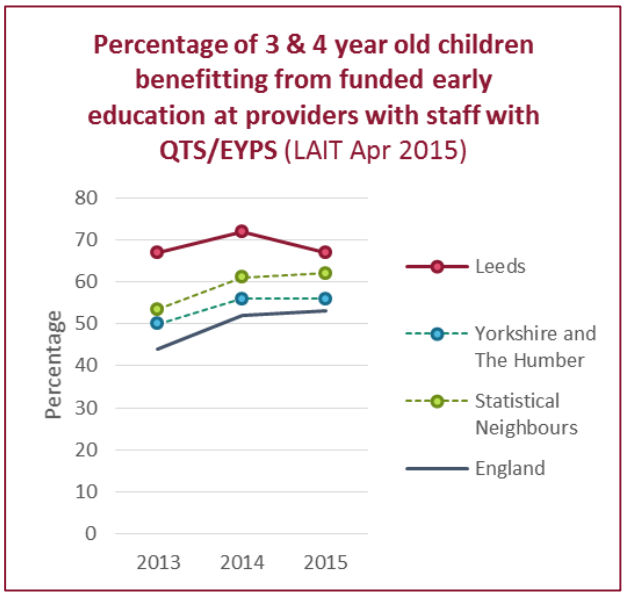
[81] Sutton Trust (2014) Sound Foundations: A Review of the Research Evidence on Quality of Early Childhood Education and Care for Children under Three





Conversely, while there have been improvements in the number of CYP between 2 – 4 years old receiving early education from providers rated good or outstanding, there has been a drop in the percentage of 2 -4 year olds receiving early education from providers with staff with either Qualified Teacher Status (QTS) or Early Years Professional Status (EYPS) (below):





Conclusions/ Observations

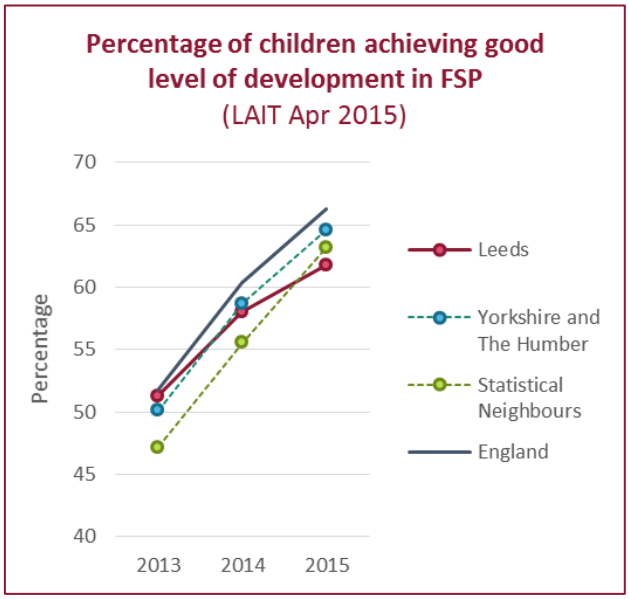
The percentage of 3 and 4 year olds benefitting from funded early education in a Good/Outstanding provider in Leeds has increased from 78% to 86% between 2014 and 2015, which is slightly better than the national average of 85% (2015).

The percentage of 2 year olds that benefit from funded early education in a Good/Outstanding provider also rose (below right), from 87% to 93%, which is above the national rate of 85%.

3.3.2 Early Years Foundation Stage Child Development

The 'Good Level of Development' (GLD) is a performance measure for pupils in the Early Years Foundation Stage. Children are defined as having reached a good level of development at the end of the EYFS if they have achieved at least the expected level in the 'prime areas' of learning:

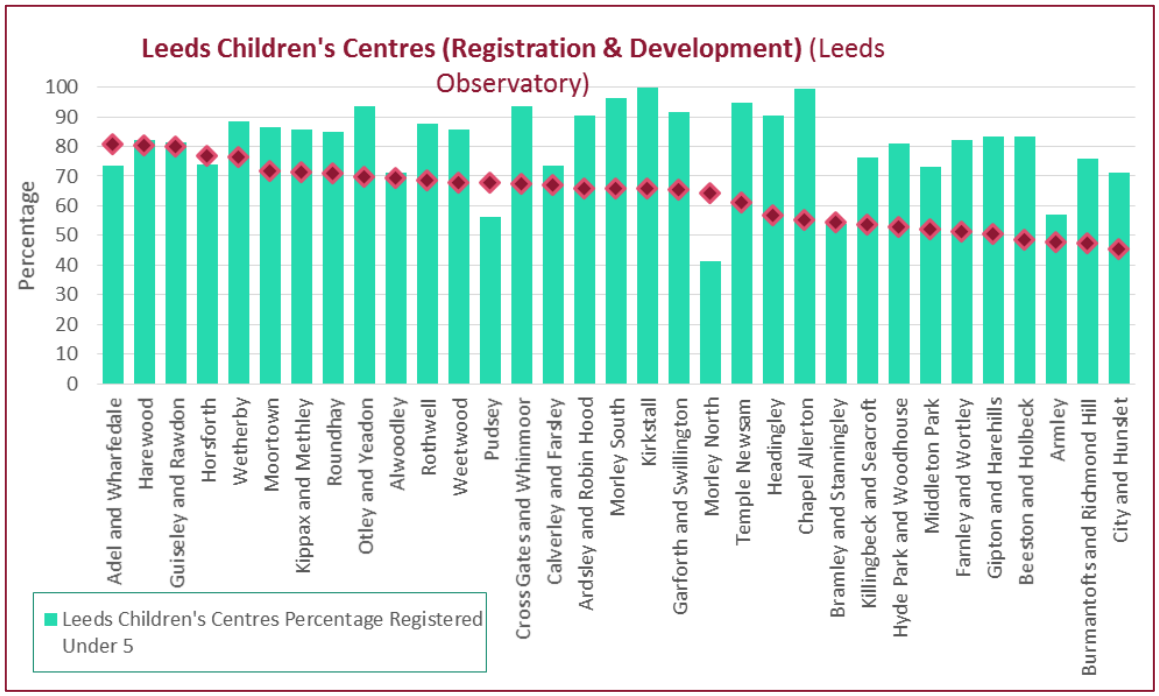
- Personal, social and emotional development;
- physical development;
- communication and language



In addition pupils must achieve the early learning goals in the specific areas of mathematics and literacy.

Within each of these are a series of learning goals. At the end of the EYFS, a child is assessed on each of the 17 learning goals and given an achievement level of: 'Emerging, Expected, or Exceeding'.

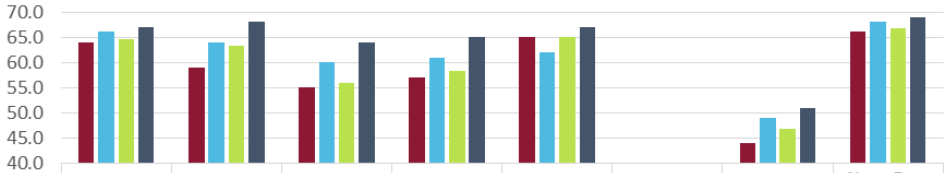
In 2015 61.8% of Leeds children achieved a good level of development at EYFS, which is below the England average of 66.3%, and that of its statistical neighbours 63.1%[82]. Within this figure there is large variation in development across the city (shown in the graph below), with the percentage of children achieving a good level of development within the Early Years Foundation Stage Profile at age 5 ranging from 81% in Adel and Wharfedale and Harewood through to just 46% in City and Hunslet:



[82] Department for Education (2015) Mental Health and behaviour in schools. London: DfE

Looking at the achievement of a good level of development in Foundation Stage Profile (FSP) split by ethnicity, it shows that while children identified as Asian typically do less well at this stage nationally, within Leeds these children are doing 9 points less well than the national picture, compared to children identified as white, who are 3 points behind the national picture, and children identified as Chinese who are just 2 points behind the national picture (below).

Percentage of children achieving good level of development in FSP (2015)

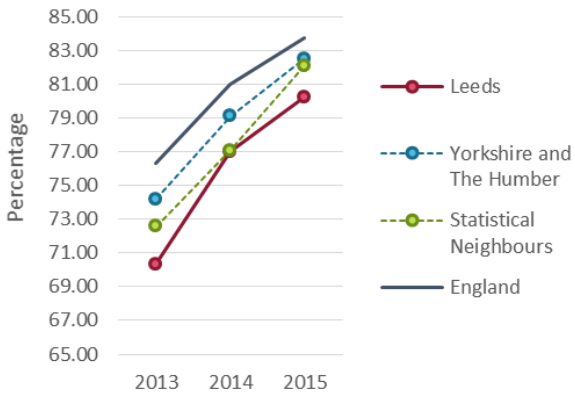


	White	Mixed	Asian	Black	Chinese		Free School Meals	Non- Free School Meals
Leeds	64.0	59.0	55.0	57.0	65.0		44.0	66.0
Yorkshire and The Humber	66.0	64.0	60.0	61.0	62.0		49.0	68.0
Statistical Neighbours	64.7	63.3	56.0	58.3	65.0		46.8	66.7
England	67.0	68.0	64.0	65.0	67.0		51.0	69.0

The previous graph also shows the significant difference in attainment between those eligible for free school meals (44%) and those not eligible (66%). Again, it is those children within the more deprived communities within Leeds that appear to be doing less well than their equivalents nationally; nationally only 51% children eligible for free school meals achieve a good level of development in the foundation stage, and in Leeds it is significantly lower at 44%.

The percentage of children reported as having achieved at least the minimum level of personal, social and emotional development in foundation stage, shows that while there have been year on year improvements nationally and locally since measurement began in 2013, Leeds has remained marginally behind both national (83.7%) and statistical neighbours (82.1%) with a 2015 rate of 80.2%)

Percentage of children achieving at least the expected level in FSP - Personal, social and emotional development (LAIT Apr 2015)



Conclusions/ Observations

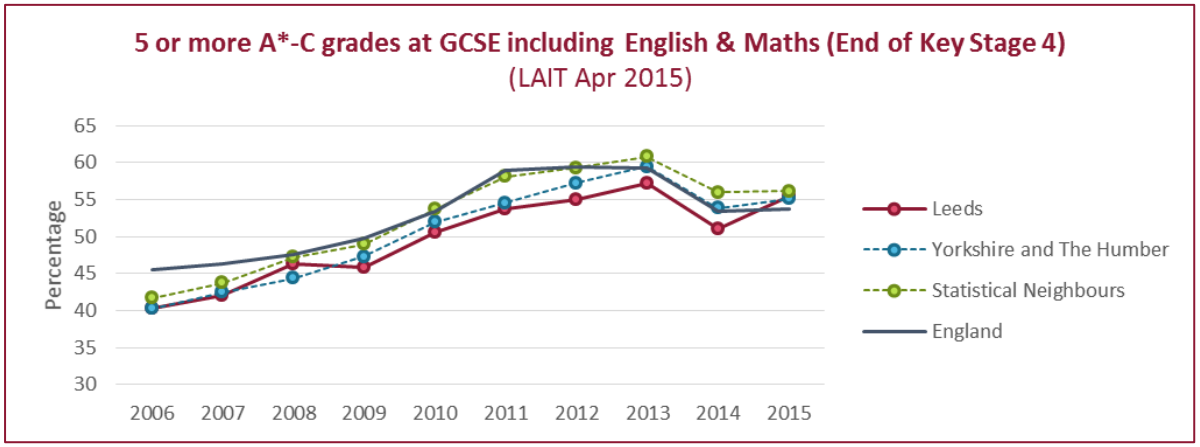
61.8% of Leeds children achieved a good level of development at EYFS, which is below the England average of 66.3%, and that of its statistical neighbours 63.1% (DfE, 2015). Within this figure there is large variation in development across the city ranging from 81% in Adel and Wharfedale and Harewood through to just 46% in City and Hunslet

80.2% of children reported as having achieved at least the minimum level of personal, social and emotional development in foundation stage (2015), which shows that while there have been year on year improvements nationally and locally since measurement began in 2013, Leeds has remained marginally behind both national (83.7%) and statistical neighbours (82.1%)

3.3.3 Academic Achievement at the end of Key Stage 4

Education improves various health outcomes but little work has been done on mental illness. Chevalier and Feinstein[83] conducted a longitudinal study into the effects of education on mental health. They found that having GCSEs is associated with a reduced risk of depression at the age of 42 by five percentage points.

Between 2006 and 2013 there were steady improvements in the percentage of young people achieving 5 or more A star to C grades which include Maths and English, and while there were reported drops in attainment between 2013 and 2014 and there was a slight improvement in 2015. Leeds attainment has been consistently lower than the national picture from 2006 to 2014, however in 2015 Leeds reported better than national average attainment results of 55.5%.



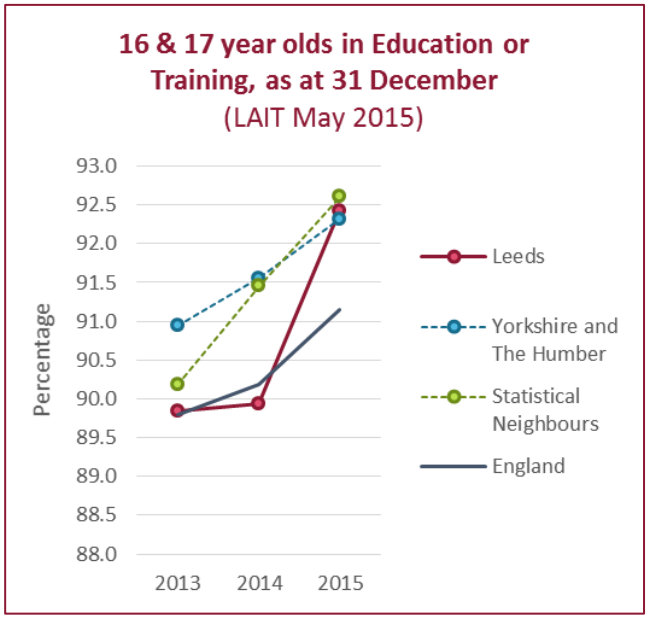
Conclusions/ Observations

In Leeds the percentage of young people achieving 5 or more A star to C grades which include Maths and English, has tracked slightly below the national picture from 2006 to 2014, however in 2015 Leeds reported better than national average attainment results of 55.5%.

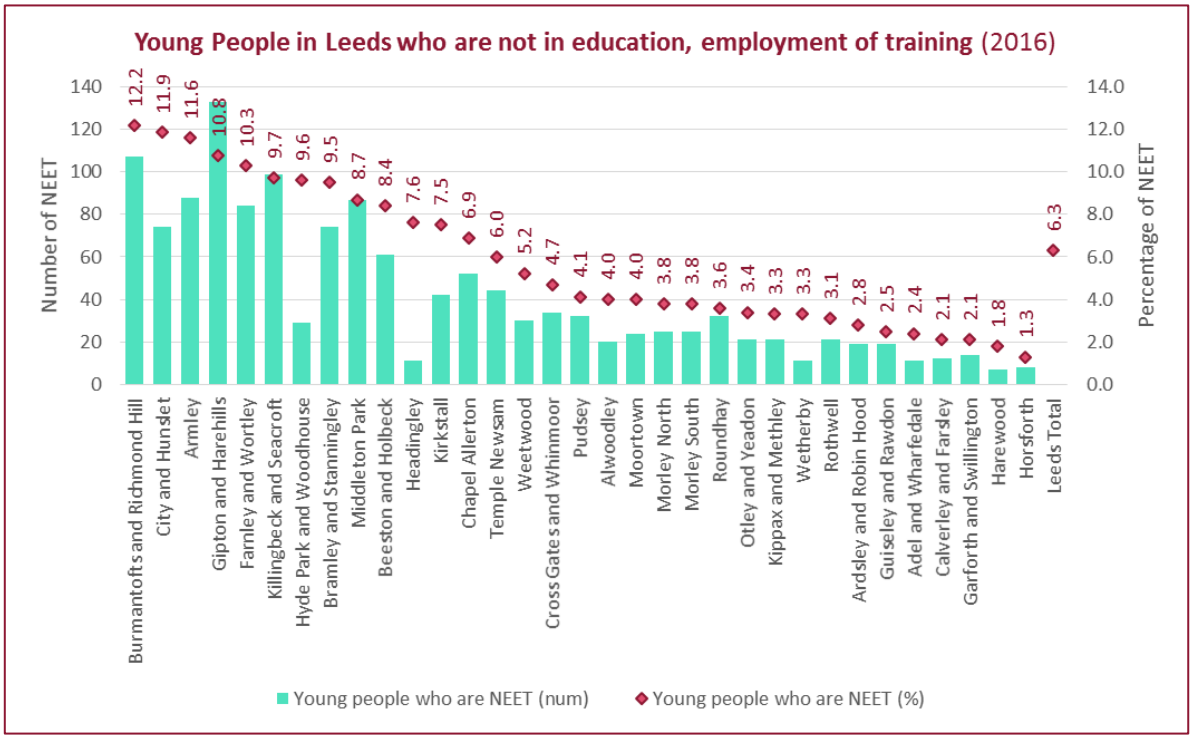
[83] Chevalier A and Feinstein L (2006) Sheepskin or Prozac: The Causal Effect of Education on Mental Health. Institute for the study of Labour (IZA) Discussion Paper No. 2231. http://ssrn.com/abstract=923530

3.3.4 Education, Training and Employment

The graph shows the percentage of 16 & 17 year olds in education or training, and reports that 92.4% of Leeds 16 & 17 year olds continued into either formal education, apprenticeships or employment with training in 2015. This is a rise from 2014 (89.9%) and is in line with regional and statistical neighbours and 1 point higher than the national average.



LAIT (May 2016) shows that 6.4% of Leeds 16 -18 year olds are not in education, employment or training (NEET), compared with 5% for statistical neighbours and 4.2% nationally. Data pulled from the Leeds Observatory website reports overall NEET figures for Leeds in Jan 2016 standing at 6.3%, however, there is a wide ranges of percentages at the ward level, with between 12.2% and 11.6% of young people in Burmantofts and Richmond Hill, City and Hunslet and Armley classed as NEET, compared with just 1.8% in Harewood and 1.3% in Horsforth.



Conclusions/ Observations

A higher percentage of Leeds 16 & 17 year olds remained in either formal education, apprenticeships or employment with training in 2015 than the national average.

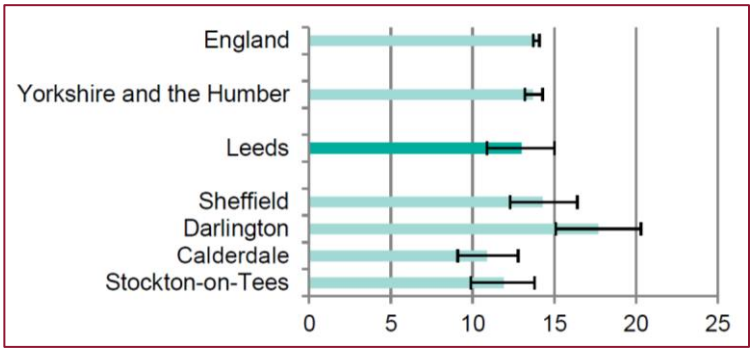
6.3% of Young People were not in education, employment or training in 2016

3.4 Individual Protective Factors

3.4.1 Participation in at least 3 hours of sport or PE at school

Good physical activity habits in childhood and adolescence are likely to be carried into adulthood, while lower levels of activity are associated with obesity.

In Leeds the World Health Organization's guideline of an hour of moderate-to-vigorous physical activity per day is met by 13.0% of young people, similar to the England average of 13.9%.



Conclusions/ Observations

In Leeds the World Health Organization's guideline of an hour of moderate-to-vigorous physical activity per day is met by 13.0% of young people, similar to the England average of 13.9%.

4 Risk Factors

4.1 Overview

WHO[84] states that a life-course perspective to risk should be taken, as risks to mental health manifest themselves at all stages of life and ensures that risks that children are exposed to are considered when they are affecting mental health later in life. Marmot[85] reinforces the need for a life course approach.

Longitudinal studies in the UK, USA and elsewhere in the Western world show that a range of factors in children's early lives have been consistently associated with increased risk of mental health problems in adolescence and adulthood[86]. The greater the number of risks, and the more severe the risks, the greater the likelihood of the child developing a mental health problem. If a child has only one risk factor in their life, their risk of developing a mental health problem has been defined as being 1-2%. However, with three risk factors the likelihood increases to 8%; and with four or more risk factors the likelihood of the child developing a mental health problem is increased to 20%[87]. Evidence suggests that children's emotional well-being can improved if the number of risk factors is reduced, and the number of protective factors is increased.[88]

It is important to note that the presence of a risk factor does not mean a child will automatically develop a mental health problem. However several risk factors together (which can often be inter-related) can have an accumulative effect which means that there is a greater likelihood that mental health problems will emerge.

Research carried out by Childhood Wellbeing Research Centre[89] identified a number of key risk factors which impede good child development. The risk factors included:

- parental depression
- parental illness or disability
- smoking in pregnancy
- parent at risk of alcoholism
- domestic violence
- financial stress
- parental worklessness
- teenage mother
- parental lack of basic skills, which limits their daily activities
- household overcrowding

[84] WHO (2012) Risks to Mental Health: an overview of vulnerabilities and risk factors. Background paper by WHO Secretariat for the development of a comprehensive mental health action plan. [http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf]
[85] Marmot Review (2010) Fair Society Healthy Lives. Institute of Health Equity
[86] The Mental Health Foundation (1999) Bright Futures: Promoting children and young people's mental health
[87] IBID
[88] Smith (2002) Research Review Promoting Children's Emotional Health. Barnardo's.
[89] Jones E. Gutman L. & Platt L. (2013) Family stressors and children's outcomes Childhood Wellbeing Research Centre

The same study found a strong correlation between many of these factors. Parental depression, smoking in pregnancy and financial stress were associated with the poorest outcomes in terms of a range of cognitive and behavioural outcomes for children aged five years[90].

Whilst risk factors increase the likelihood of experiencing mental health difficulties, the development of resilience can help people 'bounce back' or cope with difficulties. There is a significant opportunity during childhood and adolescence to actively promote the things that strengthen children's emotional and mental health. The Mental Health and Wellbeing task force in their report Future in Mind[91] reinforces the need for prevention and early intervention for young people. Over half of all mental ill health starts before the age of 14yrs and 75% start by the age of 18.

There is a strong economic case for early intervention[92] which has been built on the evidence collated by the Early Intervention Foundation and others. Proactively addressing risk factors can help prevent mental health disorders. There is now a broad consensus on the factors that help promote childhood resilience linked to:

- The physical and emotional attributes of the individual child
- The child's family network
- The child's immediate environment

This includes:

- Good attachment with at least one important adult
- The presence of a naturally occurring network of support
- Developing social and emotional skills
- Developing problem solving skills
- Opportunities to take part in a range of activities
- Schools taking steps to tackle bullying and racism.

The prevalence of risk factors in Leeds is characterised by inequalities across the city; described below where the data is available.

[90] IBID

[91] DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

[92] Graham Allen MP (2011) Early Intervention: Smart Investment, Massive Savings. The Second Independent Report to Her Majesty's Government

4.2 Family Risk Factors

4.2.1 Maternal smoking and low birth weight

Maternal smoking during pregnancy is a major public health concern with clearly established consequences to both mother and new-born including low birth.

Smoking in pregnancy has been shown to be linked to poorer behavioural outcomes and cognitive dysfunction for children[93] which includes impaired learning and memory, ADHD and conduct disorder. However, on its own, it is unlikely to be a cause of behaviour problems. Further evidence has shown that early exposure to household tobacco smoke can be associated with increased propensity toward physical aggression and antisocial behaviour when the child is older[94].

	Leeds North	Leeds South and East	Leeds West	Leeds All	England Average
Q1 2013/14	7.3%	17.2%	12.8%		12.0%
Q2 2013/14	7.0%	18.2%	11.8%		11.8%
Q2 2015/16	6.1%	16.5%	7.6%	10.4%	10.5%
Q3 2015/16	8.2%	17.8%	9.1%	12.1%	10.6%

The chart above compares quarterly (Q) returns from smoking status at time of delivery statistical collection (SATOD) for Q1 & Q2 2013/14 and Q2 & Q3 2015/16, split by local CCG. It shows that while there have been a reduction in rates across all CCGs there is still a widening gap between rates of smoking at the time of delivery between those in the most affluent areas and the poorest. In Leeds, the highest rates of smoking at the time of delivery are found in the poorest communities and amongst women Under 18 years old. The Leeds Maternity HNA 2014[95] noted that the gap in the rate of Low Birth Weight (LBW) in Deprived and Non-Deprived Leeds is widening. This indicates a need for co-ordinated efforts across a range of sectors to address the issues that result in LBW – including smoking in pregnancy and poor nutrition.[96]

Conclusions/ Observations

While there have been a reduction in rates across all CCGs, In Leeds, the highest rates of smoking at the time of delivery are found in the poorest communities and amongst women Under 18 years old.

The Leeds Maternity HNA 2014 noted that the gap in the rate of Low Birth Weight (LBW) in Deprived and Non-Deprived Leeds is widening.

[93] Knopik, V. (2009) Maternal smoking during pregnancy and child outcomes: real or spurious effect? Center for Alcohol and Addiction Studies, Brown University.
[94] IBID
[95] Leeds City Council (2016) Leeds Observatory: Leeds Maternity Health Needs Assessment 2014
[96] IBID

4.2.2 Abuse and Neglect (Brain Development)

The development of the brain begins in the first few weeks after conception. Most of the structural features of the brain appear during the embryonic period (about the first 8 weeks after fertilization); these structures then continue to grow and develop during the foetal period (the remainder of gestation). Eighty per cent of brain cells that a person will ever have are manufactured during the first two years after birth. If the process of building brain cells and connections between them goes wrong, the deficits are permanent.[97]

Research has identified specific aspects of a child's environment that are associated with later outcomes. Commonly studied risk factors include poverty/income, maternal depression, and low maternal education. They are strong predictors of later outcomes including academic performance, cognitive development, and social and emotional well-being. Early risk is associated with later behavioural and academic outcomes. For example, risk exposure during infancy appears to be more detrimental for children's school readiness than later exposure.[98] [99] [100]

The growth of brain cells is a consequence of an infant's interaction with the main caregiver [usually the mother]. The growth of the baby's brain requires positive interaction between the main care giver and infant. The development of cerebral circuits depends on it. If a baby is not treated properly in the first two years of life, the genes for various aspects of brain function, including intelligence, cannot operate, and may not even come into existence.[101]

The damage caused by neglect and other forms of abuse is proportionate to the severity of abuse: the more severe the neglect, the greater the damage.

Children who have been neglected are more likely to experience mental health problems including depression and post-traumatic stress disorder. Young people may also take risks, such as running away from home, breaking the law, abusing drugs or alcohol, or getting involved in dangerous relationships - putting them at risk from sexual exploitation.[102]

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Children in need due to abuse, neglect or family dysfunction: % of children in need	2015		67.3	70.1	45.0	5,401	5,786

Although not possible to unpick how many children between 0 -2 are in need due to neglect or abuse, Leeds Children in need data[103] suggests that there were around 5,401 children in Leeds during 2014 that were in need due to abuse, neglect or family dysfunction. 13.5% of under 18 year olds were under

[97] The Wave Trust (2014) First 1001 Critical Days: The Importance of the Conception to Age Two Period.
[98] Burchinal M.et al (2006). Social risk and protective child, parenting, and child care factors in early elementary school years. Parenting: Science and Practice. Vol 6, 79-113
[99] Sektan M, McClelland MM & Acock A, (2010) Relations between early family risk, children's behavioural regulation, and academic achievement. Early Child Research Quarterly. Vol 25, 464-479
[100] Mistry RS, et al. (2010) Family and social risk, and parental investments during the early childhood years as predictors of low-income children's school readiness outcomes. Early Childhood Research Quarterly. Vol 25, 432-449
[101] Malekpour M (2007) Effects Of Attachment On Early And Later Development. The British Journal of Developmental Disabilities Vol 53, 81-95
[102] NSPCC Website (www.nspcc.org.uk /preventing-abuse/signs-symptoms-effects/
[103] Leeds City Council. Leeds Observatory [http://observatory.leeds.gov.uk/] Accessed June, 2016

2 in Leeds in 2014. If children in need rates were equally distributed across the Leeds under 18 population this would suggest around 728 under 2 year olds in Leeds were in need due to abuse, neglect or family dysfunction.

Conclusions/ Observations

Approximately 5,401 children under 18 in Leeds were in need due to abuse, neglect or family dysfunction (2014).

Approximately 728 under 2 year olds in Leeds were in need due to abuse, neglect or family dysfunction in 2014 (based on the assumption that children in need rates were equally distributed across the Leeds under 18 population).

There is a lower proportion of the Children in Need numbers for Leeds considered at need because of abuse, neglect or family dysfunction (5,401 CYP in Leeds during 2014).

4.2.3 Family breakdown or loss of a parent

A minority of children experience long-term psychological problems following divorce. The worst outcomes are likely to occur when the break-up is hostile and acrimonious[104]

One Parent Families

In the 2004 B-CAMHS survey[105] the prevalence of children with mental disorder was higher in lone-parent (16%) compared with two-parent families (8%). The 2011 Census[106] showed that there was a marginally higher than the national and regional average of lone parents in Leeds (10.9%) this equated to 55,738 CYP living in lone parent families.

2011 Census Data	Leeds	Yorkshire and The Humber	England
All Households (Households)	320596	2224059	22063368
One Family Only; Lone Parent; Total (Households)	34888	230288	2339824
One Family Only; Lone Parent; Total (People)	90626	594094	6099353
One Family Only; Lone Parent; Total (Children)	55738	363806	3759529
Percentage of Lone Parent Households (Mar 2011)	**10.9%**	**10.4%**	**10.6%**

It should be acknowledged that the B-CAMHS survey referenced above is now 12 years old. The Health and Social Care Information Centre (HSCIC) have commissioned a new Survey of the Mental Health of Children and Young People (MHCYP) 2016, which will be similar to the 2004 survey and will collect information from children and young people and from their parents and teachers.

[104] Smith,H (2002) Research Review Promoting Children's Emotional Health. Barnardo's
[105] Office for National Statistics (2004) The mental health of children and adolescents in Great Britain. London: Office for National Statistics
[106] Census (2011) Sub-national population estimates. UK:ONS

Children in Step Families

Children living in step families are slightly more likely (14%) to experience mental disorders than those from the population as a whole.[107]

According to the 2011 Census[108], 2% of families in Leeds were 'step families' – either married or cohabiting, compared with 2.15% across England.

Conclusions/ Observations

The 2011 Census[109] showed that there was a marginally higher than the national and regional average of lone parents in Leeds (10.9%) this equated to 55,738 CYP living in lone parent families.

Slightly less families in Leeds were 'step families' than the national average (2011 Census).

4.2.4 Bereavement

For many children and young people the death of significant other such as a parent, sibling or friend can be very challenging due to the child's inability to understand and articulate their feelings. Reviews of studies from various countries on childhood bereavement following parental death[110] [111] report that bereaved children do experience a wide range of emotional and behavioural responses ranging from anxiety, depressive symptoms, fears, angry outbursts, and regression regarding developmental milestones lower self-esteem and greater external locus of control and psychosomatic manifestations.[112]

Bereavement in children and young people is fairly common. Every 22 minutes a child in Britain is bereaved of a parent.[113] In a study conducted to estimate prevalence of bereavement among children, 78% of 11-16 year olds said that they had been bereaved of a significant other.[114]

The preliminary analysis of the 1970 British Cohort Study (BCS70) indicates that by the age of 16, 4.7% or around 1 in 20 young people will have experienced the death of one or both of their parents.[115]

The Child Bereavement Network[116] estimate that each year, around 260 parents die in Leeds, leaving around 450 dependent children (aged 0 to 17). In addition they estimated that the 2015 school-age

[107] JCPMH (2013) Guidance for Commissioning Public Mental Health Services
[108] Census (2011) Sub-national population estimates. UK:ONS
[109] Census (2011) Sub-national population estimates. UK:ONS
[110] Dowdney, L. (2000). Annotation: Childhood bereavement following parental death. Journal of Child Psychology and Psychiatry, 41(7), 819-830.
[111] Haine, R.A., Ayers, T.S., Sandler, I.N. & Wolchik, S.A. (2008). Evidence-based practices for parentally bereaved children and their families. Professional Psychology: Research and Practice, 39(2), 113-121.
[112] Servaty, H., & Hayslip, B. (2001). Adjustment to Loss among Adolescents. Omega, 43(4), 311-330
[113] http://www.winstonswish.org.uk/page.asp?section=0001000100040005&pagetitle=Facts+and+figures
[114] Harrison, L & Harrington, R (2001) Adolescents' bereavement experiences. Prevalence, association with depressive symptoms, and use of services. Journal of Adolescence, 24, 159-169.
[115] Parsons S. (2011) Long-term impact of childhood bereavement: Preliminary analysis of the 1970 British Cohort Study (BCS70)
[116] http://www.childhoodbereavementnetwork.org.uk/

population of children and young people (aged 5 to 16) in Leeds who had been bereaved of a parent or sibling at some point in their childhood was around 3,140.

Conclusions/ Observations

Approximately 260 parents died in Leeds, leaving around 450 dependent children (aged 0 to 17) in 2015

It is estimated that 3140 school-age population of children and young people (aged 5 to 16) in Leeds had been bereaved of a parent or sibling at some point in their childhood (2015)

4.2.6 Children in out of work families

The ONS[117] B-CAMHS survey tells us that the prevalence of mental disorder is higher in families with neither parent working (20%) compared with those in which both parents worked (8%).

According to figures from ONS[118] 14.4% of Leeds children were living in workerless families between Jan – Dec 2014, with Leeds ranked 34 out of 201 Unitary Authorities in the UK. Based on a forecast of 143806 CYP between 0 -15 living in Leeds that would mean 20,708 CYP between 0 -15 years living in workerless families.

In 2015, there were around 1.4 million children aged 0 to 15 living in workless households, representing 11.8% of all children aged 0 to 15 in the UK. The number fell by 91,000 between 2014 and 2015, while the percentage was down 0.8 percentage points[119]. If this national drop was to be applied to households in Leeds, then the current number of children 0 -15 lining in workerless families in Leeds is approximately 142,656.

Conclusions/ Observations

14.4% of Leeds children were living in workerless families between Jan – Dec 2014 (higher than the national average (12.6%). Based on a forecast of 143806 CYP between 0 -15 living in Leeds that would mean 20,708 CYP between 0 -15 years living in workerless families.

[117] Office for National Statistics: The mental health of children and adolescents in Great Britain. London: Office for National Statistics, 2004
[118] ONS (2015) Mid-Year population estimates for 2016 for unemployment
[119] ONS (2015) Statistical bulletin: Working and Workless Households

4.3.7 Dependent Children of parents with no educational qualifications

Dependent children of parents with no educational qualification are nearly twice as likely to experience mental disorders (17%). [120]

According to the 2011 Census[121], in Leeds, 5.56% of the child population were from households with no qualifications, which is higher than the national average of 4.8% of children.

Conclusions/ Observations

5.56% of the Leeds child population were from households with no qualifications, which is higher than the national average of 4.8% of children (2011 Census)

4.2.8 Children of parents with mental disorder

It is thought that between five and seven million adults are suffering from mental illness at any one time, and 30% of these will have dependent children (0-18 years old). An estimated 9-10% of women and 6% of men will be parents with a mental health problem, most having depression/anxiety[122]. Although some parents with mental health problems can adequately care for their children, they are more likely to struggle with parenting consistently and are therefore more likely to have insecurely attached children. In these circumstances such children are at risk of developing emotional and behavioural problems and some are potentially at risk of significant harm.[123]

Moullin et al[124] point to the range of factors that can impede a parent's ability to provide sensitive and responsive parenting. Babies are particularly sensitive to their mother's stress or depression. The quality of attachment is likely to impacted in households where parents struggling with these issues. This research indicated that some groups of parents are more likely to suffer poor mental health including:

- mothers are at higher risk of mental health problems than fathers
- younger mothers are more likely to have a mental health problem than older mothers

It is important to note that where there is a good partner relationship and the father is positively involved in care this offsets the risk posed by the mother's ill health.

Where additional risk factors are also present such as poverty, disability, young age of parents or poor quality childcare, risk to the child increases.

Identifying the number of children living with a parent with a mental health problem is problematic but estimates given suggest up to 25% of children aged 5 to 15 years may have mothers who would be classed as at risk for common mental health problems. This would mean that approximately 19,485 children aged 5 to 14 years in Leeds could be at risk of living with a parent dealing with mental health problems[125].

[120] ONS (2015) Statistical bulletin: Working and Workless Households
[121] Census (2011) Sub-national population estimates. UK:ONS
[122] Chimat. Key risk factors indicating harm or poorer developmental outcomes in children http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=48&geoTypeId [accessed 21.03.16]
[123] Smith,H (2002) Research Review Promoting Children's Emotional Health. Barnardo's
[124] Moullin, S., Waldfogel, J., Washbrook, E. (2014) Baby Bonds: Parenting, attachment and a secure base for children
[125] ChiMat (2013) Better Mental Health Outcomes for Children and Young People. National CAMHS Support

We anticipate that the Leeds Health Needs Assessment for Perinatal Mental Health (PNMH HNA) will provide a more in-depth exploration of many of these issues when it is released later this year.

Conclusions/ Observations

Approximately 19,485 children aged 5 to 14 years in Leeds could be at risk of living with a parent dealing with mental health problems (CHIMAT 2013b) .

4.2.9 Domestic Violence

Exposure to discord and hostility between parents is an important determinant of emotional and behavioural problems in children; especially if the discord is persistent over time and the child becomes embroiled in hostility between the parents.[126]

Domestic violence often begins in pregnancy and evidence suggests having experienced partner violence during pregnancy results in a three-fold increase in the odds of high levels of depressive symptoms in the postnatal period. In addition to the obvious increased risk of physical injury from any attack, the child is potentially at further risk of emotional harm due to witnessing or involvement in the abuse. Moreover the quality or consistency of parenting capacity is likely to be affected by the abuse especially if it is over a sustained period.

There is no specific calculation to estimate the number of children affected by domestic abuse in Leeds, however 1.8% of children in England live in households where there is known high risk of domestic violence[127]. This equates to 4,707 CYP in Leeds.

Public Health Profiles[128] state that the rate of domestic abuse stood at 21.8 incidents per 1000 of the population for Leeds, which is higher than the rate of 18.8 per 1000 for the nation as a whole. Applied to the 0 -24 CYP population of Leeds, this would suggest that by 2020 approximately 6,000 CYP will be affected by domestic abuse.

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Domestic Abuse: incident rate per 1,000 population	2012/13		18.8	21.8	21.8	5,745	5,988

Source: PHE Public Health Profiles

Conclusions/ Observations

The rate of domestic abuse stood at 21.8 incidents per 1000 of the population for Leeds, which is higher than the rate of 18.8 per 1000 for the nation as a whole. Applied to the 0 -24 CYP population of Leeds, this would suggest that by 2020 approximately 6,000 CYP will be affected by domestic abuse.

[126] Moullin, S., Waldfogel, J., Washbrook, E. (2014) Baby Bonds: Parenting, attachment and a secure base for children

[127] http://www.phoutcomes.info/

[128] http://www.phoutcomes.info/

4.2.10 Young Carers

A Carers Health Needs Assessment was carried out by NHS Sheffield in 2012[129], which outlined that the potential risks to physical and mental health for young carers including:

- Mental strain (e.g. stress and tiredness). Young carers are often affected by poverty and isolation resulting from family illness or disability, coupled with stress and worry of having a sick or disabled parent.
- Truancy and underachievement at school and college; Young carers' attendance at school can be disrupted as a result of caring responsibilities. They may miss school or struggle to focus due to tiredness or worry. This is highly likely to impact on their level of achievement particularly in relation to qualifications gained.
- Studies have shown young carers are less likely to do well at school or to be in employment, education or training than their peers[130] and makes the transitions into adulthood more problematic.
- Increased risk of coping behaviours such as self-harm or substance misuse.

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Children providing care: % children aged <15 who provide unpaid care	2011		1.11	1.02*	1.01	1450	1574
Young people providing care: % people aged 16-24 who unpaid care	2011		4.8	4.6*	3.9	4599	4556
Children providing considerable care: % children aged <15 who provide 20+ hours of unpaid care per week	2011		0.21	0.20*	0.19	273	296
Young people providing considerable care: % people aged 16-24 who provide 20 hours + of unpaid care per week	2011		1.3	1.3*	1.0	1179	1168

[131]

Applying the percentages quoted above to the affected populations for 2014 estimates and 2020 projections it suggests that in 2014 there were approximately 6,049 CYP 0 – 14 providing unpaid care in Leeds. If the percentages of CYP remain the same then by 2020 that number will rise slightly to 6,130. The number of CYP providing considerable unpaid care per week (20 hours +) will also rise from 1,452 to 1,464.

Conclusions/ Observations

There is a lower rate of CYP providing care in Leeds than the national and regional averages. In 2014 there were approximately 6,049 CYP 0 – 14 providing unpaid care in Leeds, and approximately 1,452 CYP providing considerable unpaid care per week (20 hours +).

[129] Gilwihite, E. (2012) Carers in Sheffield needs assessment. Public Health, NHS Sheffield
[130] DoH and University of Leeds (2010) Profile of young carers in the Yorkshire and Humber region [http://www.sociology.leeds.ac.uk/assets/files/Circle/yh-carers-final.pdf]
[131] PHE Health Profiles

4.2.11 Children with parents in prison

No official record exists of children of prisoners as neither the courts, governments, nor local services ask routinely about them. They are unlikely to reveal themselves for fear of social stigma and bullying and so remain hidden from local services.

According to Barnardo's[132] there are estimated to be 200,000 children affected by parental imprisonment across England and Wales, and children with a parent in prison are:

- Twice as likely to experience conduct and mental health problems, and less likely to do well at school.
- Three times more likely to be involved in offending. Sixty five per cent of boys with a convicted father will go on to offend themselves.

We also know that children with a parent in prison feel isolated and ashamed - unable to talk about their situation because they are scared of being bullied and judged.

Currently there are estimated to be 13,543,880 children and young people in England and Wales, so based on the assertion that approximately 200,000 CYP are affected by parental imprisonment that equates to 1.477% of the child population. As the prison population has stayed relatively stable since the Barnardo's report was published: 83,500 (2009) to 85,300 (June 2016) we are going to assume that the proportion of children affected has also remained relatively stable. Therefore, based on an estimated 0 -19 year old population of 168,731 for Leeds, we can estimate that approximately 2,492 children and young people in Leeds that are affected by parental imprisonment.

Conclusions/ Observations

Approximately 2492 children and young people in Leeds are affected by parental imprisonment.

[132] Barnardo's (2009) Children affected by parental imprisonment [http://www.barnardos.org.uk/what_we_do/our_work/children_of_prisoners.htm]

4.3 School and Community Risk Factors

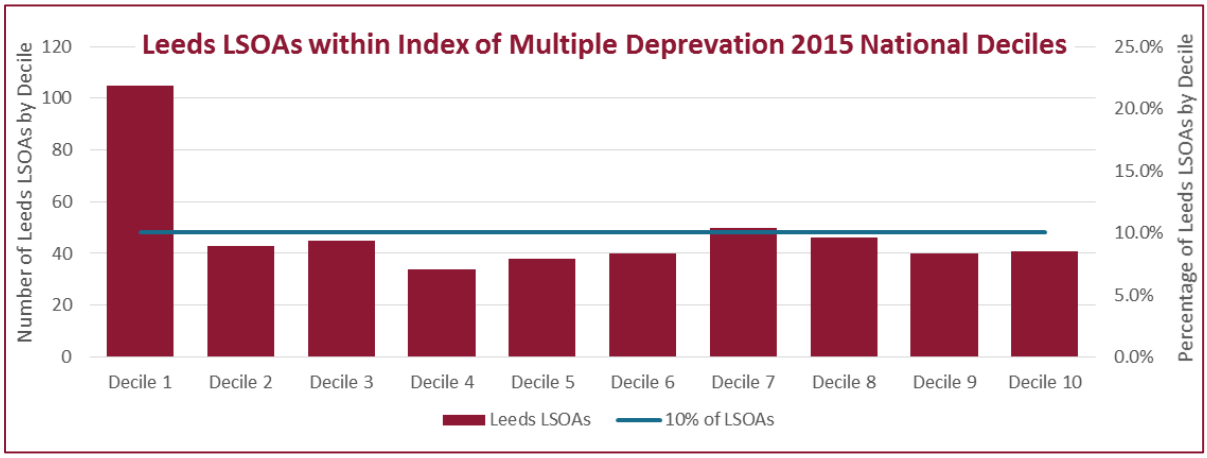
4.3.1 Inequalities and deprivation

The assessment of poverty in Leeds highlights the correlation between economic disadvantage and poor outcomes for children, young people and adults in the city. The clear impact of worklessness, financial exclusion and poor housing on health, educational attainment and broader life chances is concentrated in particular communities.[133]

The Index of Multiple Deprivation (IMD[134]), combines a number of the other indices, and gives an overall score for the relative level of multiple deprivation experienced in small geographical areas (Lower Super Output Areas - LSOAs). To produce the Overall IMD there are 38 separate indicators that are combined and weighted. Broadly, the indicators fall across seven Domains:

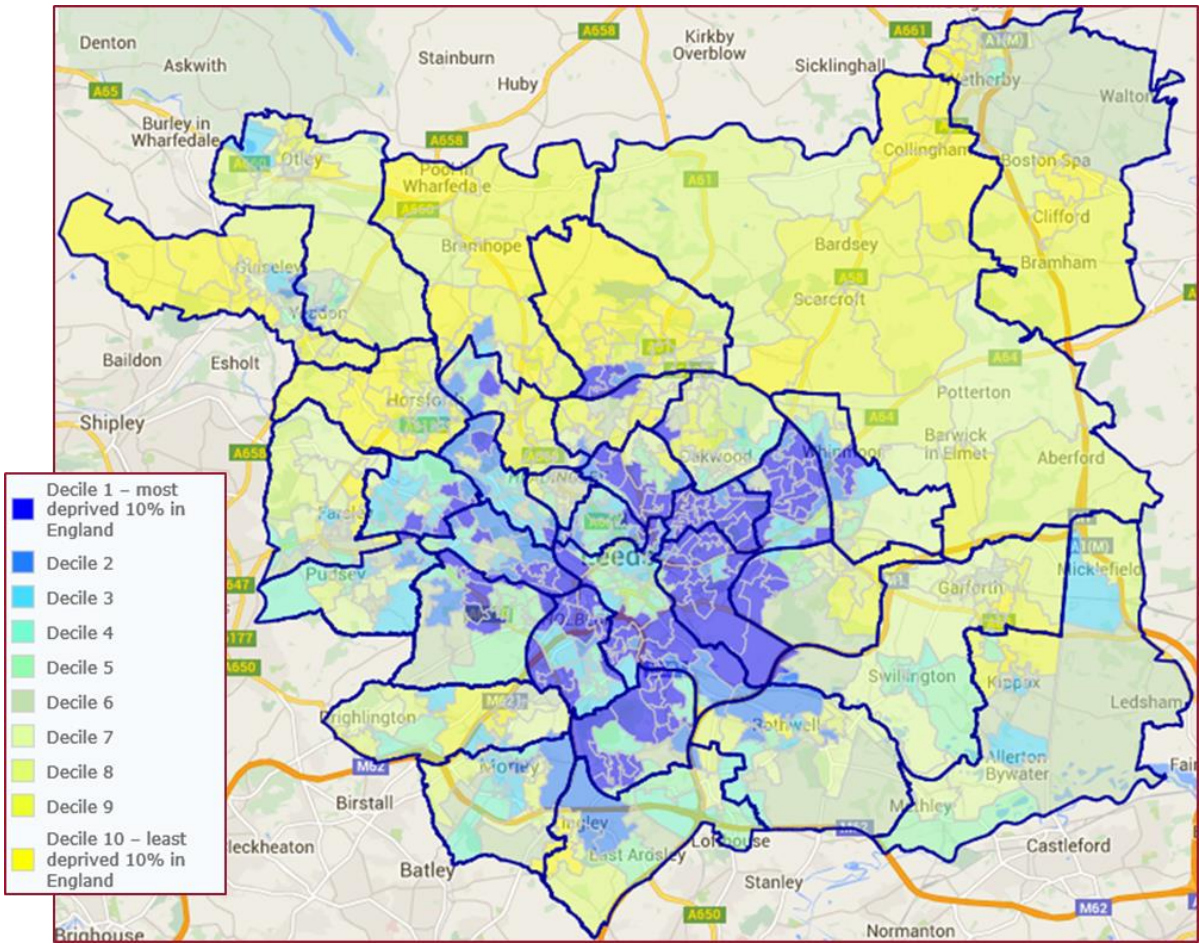
- Income
- Employment
- Health and Disability
- Education, Skills and Training
- Barriers to Housing and Services
- Crime
- Living Environment

As such, relative IMD can give an indication of cumulative risk factors for poor emotional wellbeing and mental illnesses. These IMD for the country as a whole are then split into 10 equal sized pieces (deciles) from 1 being the most deprived 10% LSOAs in England and 10 being the least deprived 10%. If Leeds were to exactly match the profile of the country as a whole there would be 10% of its LSOAs in each of the IMD deciles. However as the graph below shows, 22% of Leeds LSOAs fall within the most deprived 10% of LSOAs in the country.



[133] Leeds City Council (2015) Leeds Joint Strategic Needs Assessment. Health and Wellbeing Board
[134] Department for Communities and Local Government (2015) The English Index of Multiple Deprivation

As with many major cities, within Leeds there is great inequality in deprivation, as seen the map below:

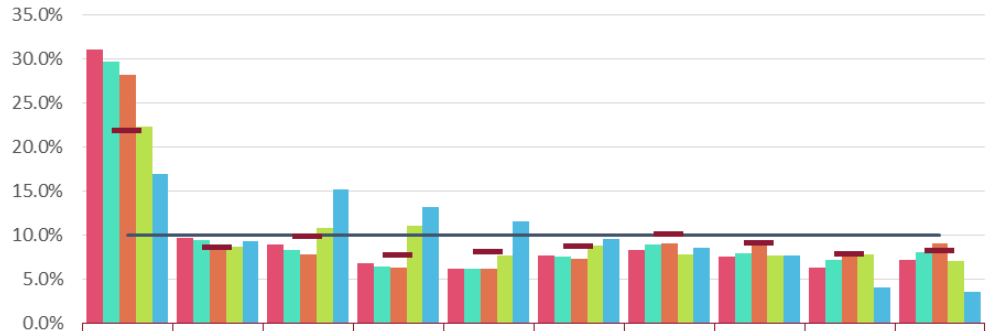


Leeds has within it great deprivation inequality, with a high level of deprivation around its centre and to the south, while its outskirts, particularly to the north and east, are amongst the least deprived.

What is important to note for Leeds is that although 22% of its LSOAs fall within the 10% most deprived areas in the country, when these IMDs by LSOA are compared with the ONS 2014 population data (grouped into 5 year age brackets) a more concerning picture for its children emerges:

Percentage of Leeds CYP within Index of Multiple Deprivation

(ONS population data 2014 and Indices of Multiple Deprivation 2015 by 5 year age bands)



	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Age 0-4	31.1%	9.7%	9.0%	6.8%	6.2%	7.7%	8.4%	7.5%	6.4%	7.2%
Age 5-9	29.7%	9.4%	8.3%	6.4%	6.2%	7.6%	9.0%	7.9%	7.2%	8.1%
Age 10-14	28.2%	8.9%	7.8%	6.3%	6.2%	7.4%	9.1%	8.8%	8.1%	9.1%
Age 15-19	22.4%	8.7%	10.8%	11.0%	7.7%	8.8%	7.9%	7.8%	7.9%	7.1%
Age 20 -24	16.9%	9.3%	15.2%	13.3%	11.6%	9.6%	8.6%	7.7%	4.1%	3.6%
National Average	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
Leeds All Ages	21.9%	8.6%	9.8%	7.7%	8.1%	8.7%	10.1%	9.0%	7.9%	8.3%

The graph above shows that while 22% of the Leeds population (167,607) live in the 10% most deprived areas in the country the story for its younger children is considerably worse. The following CYP in Leeds live in the most deprived 10% of areas in the country:

- 31% of 0-4 year olds (15,864)
- 30% of 5-9 year olds (13,488)
- 28% of 10-14 year olds (11,026)
- 22% of 15-19 year olds (11,116) - aligned with the picture for Leeds as a whole
- 17% of 20-24 year olds (12,935) - better than the Leeds average and seemingly distorted by the large student and young professional population in the city

In total 64,429 CYP aged 0-24 live in an area of Leeds categorised as within the 10% most deprived areas in the county (24.6% of the total CYP population). Conversely, just 17,192 (6.6% of Leeds CYP) live in the least deprived 10% of areas in the country.

Conclusions/ Observations

22% of the Leeds population (167,607) live in the 10% most deprived areas in the country the story for its youngest young people is much worse.

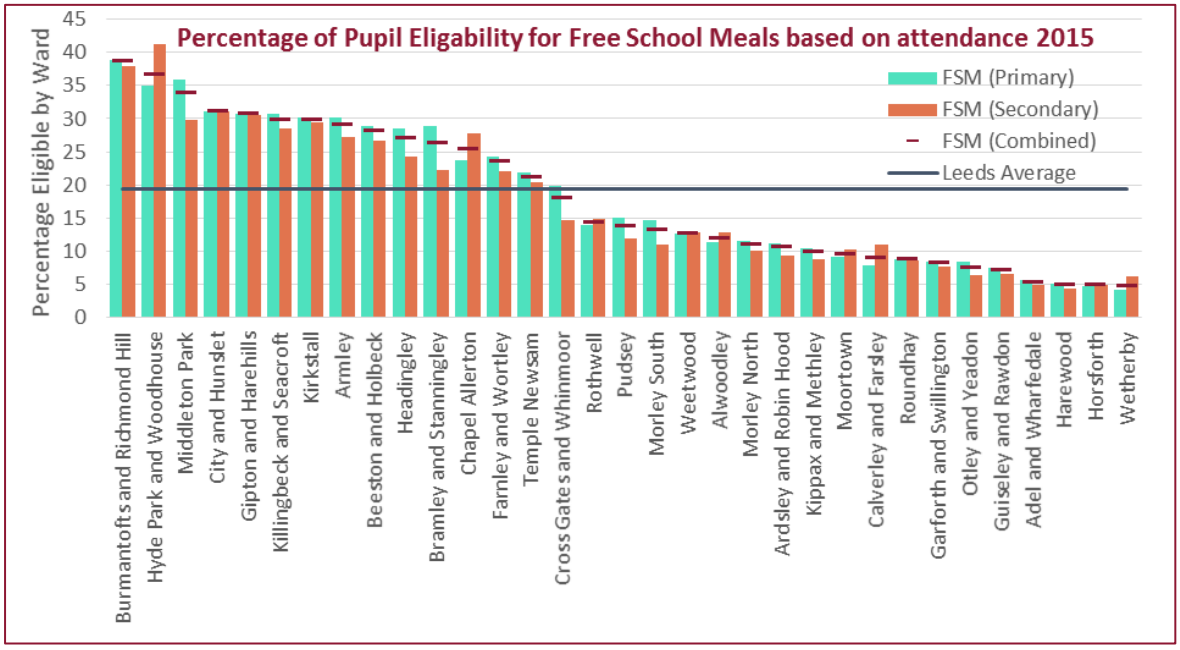
In total 64,429 CYP aged 0-24 live in an area of Leeds categorized as within the 10% most deprived areas in the county (24.6% of the total CYP population). Conversely, just 17,192 (6.6% of Leeds CYP) live in the least deprived 10% of areas in the country.

4.3.2 Free School meals

Number of children in receipt of free school meals (FSM) can also be used as a deprivation measure and can help to demonstrate challenges faced at school level.

There is a discrepancy within the data taken from two different sources: The Leeds Observatory and the Department for Education Local Authority Interactive Tool. Both sources are referenced as The Leeds Observatory are able to provide a ward level profile, while the LAIT provides a comparison with Leeds' statistical neighbours and England as a whole.

According to the Leeds Observatory, 19.4% of Leeds CYP attending Primary and Secondary Schools were eligible for free school dinners, although again there was much variation across the city, with 38.6% of CYP from Burmantofts and Richmond Hill eligible for FSM vs Wetherby where only 4.7% of its CYP were eligible. [135] (See below)



However, according to LAIT 18.2% of Leeds primary school attendees were eligible for FSM compared with 15.6% nationally, and 16.4% of secondary school attendees were eligible for FSM compared with 13.9% nationally.

	Leeds	Yorkshire and The Humber	Statistical Neighbours	England
% Primary pupils eligible for and claiming free school meals 2015 (LAIT 2016)	18.2	16.6	17.91	15.6
% Secondary pupils eligible for and claiming free school meals 2015 (LAIT 2016)	16.4	15	16.25	13.9

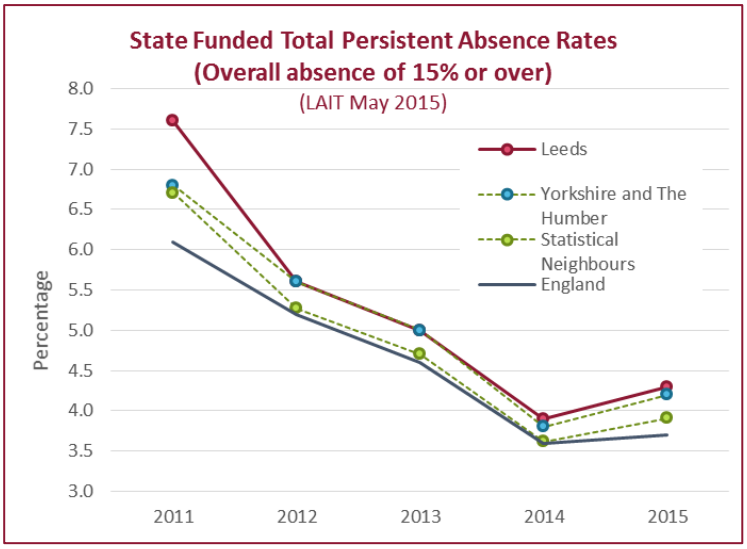
Conclusions/ Observations

Between 16.4% - 19.4% of Leeds CYP attending Primary and Secondary Schools were eligible for free school dinners, which is higher than the national average of between 13.9% - 15.6%, although there was much variation across the city.

[135] Leeds Observatory (2015) January School Census - Free School Meal (FSM)

4.3.3 Persistent absence

Persistent absence is defined as absence for 15% of the time a child should be in school. For Leeds, the rate has dropped year on year from 2011 but still does not compare well with statistical neighbours nor nationally. In 2015 the national rate was 3.7% far lower than the rate for Leeds (4.3%).



Conclusions/ Observations

The persistent absence rate for Leeds was 4.3% compared with 3.9% for its statistical neighbours and 3.7% nationally (2015).

4.3.4 Exclusions

In 2014 there were 9 permanent exclusions from Leeds schools (all from Secondary Schools), but 147 fixed term exclusions from Primary Schools and 1415 fixed term exclusions from Secondary Schools. These numbers reflect favourably against both national and statistical neighbour figures.

	Leeds	Yorkshire and The Humber	Statistical Neighbours	England
Number of all school fixed period exclusions expressed as a percentage of the school population 2014 (LAIT 2016)	3.89	4.42	3.431	3.5
Total Permanent Exclusions from school as a % of the school population 2013/14 (LAIT 2016)	0.01	0.04	0.053	0.06

Public Health report different numbers for 2013/14 and suggest that although fixed term exclusions for primary aged children are lower than the national average, for secondary pupils and based on exclusions for persistent disruptive behaviour or drug and alcohol use the rate in Leeds is higher than the national rate[136].

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Primary school fixed period exclusions: % of pupils	2013/14		1.02	1.11	0.60	**321**	**360**
Secondary school fixed period exclusions: % of school pupils	2013/14		6.6	9.1	8.4	**3,980**	**4,468**
Fixed period exclusion due to persistent disruptive behaviour: % of school pupils	2013/14		0.89	1.51	1.37	**1,382**	**1,551**
Fixed period exclusion due to drugs/alcohol use: % of school pupils	2013/14		0.1	0.110	0.129	**130**	**146**

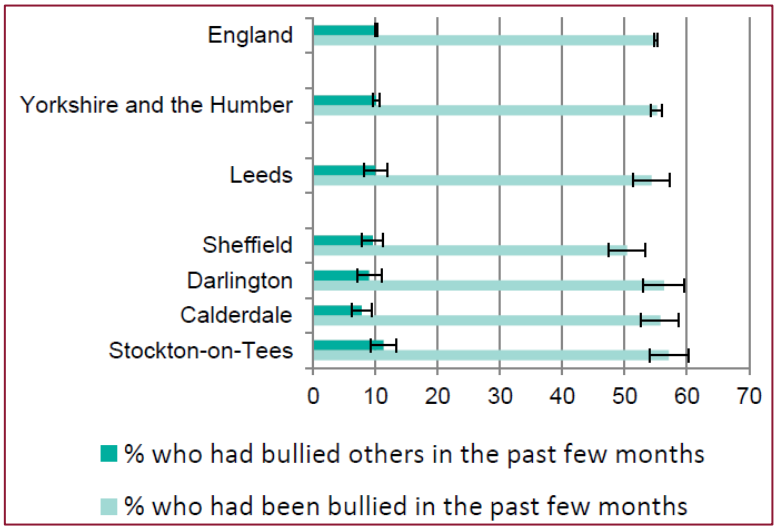
Conclusions/ Observations

Leeds school exclusion rates reflect favourably against both national and statistical neighbour figures.

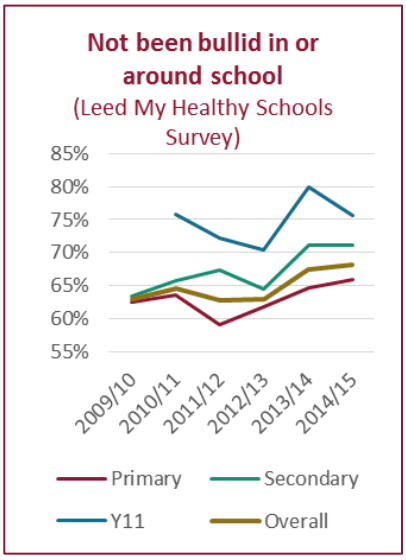
[136] PHE Public Health Profiles[http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh]

4.3.5 Behaviour in schools – bullying

Bullying in schools can negatively impact health, educational attainment and can pose a suicide risk. The 'What About YOUth?' Survey provides local authority level estimates for several topic areas, based on what 15 year olds themselves said about their attitudes to healthy lifestyles and risky behaviours.[137] The 2014 survey reported that in Leeds 54.3% of children reported they had been bullied in the past couple of months, and 10.0% had bullied others. This survey's definition of bullying included physical and verbal bullying, as well as text messages and online activity.



The Leeds 'My Health, My School Survey' [138] describes itself as quick and easy to complete and aims to give pupils/students the opportunity to share their views, knowledge and experiences around a number of different health topics including healthy eating, physical activity, smoking, bullying and personal safety. In 2014/15 the overall sample size (including primary, secondary and year 11 pupils was 5,843). It reported that the rate of children who reported that they had not been bullied in or around school in the last 12 months has increased in years 5, 6, 7, 9 & 11 to 68%. However it also appears that bullying is more prevalent in Primary Schools than it is in Secondary Schools (66% of primary aged children reported they had not been bullied in or around the school, compared to 77% in secondary school).



Conclusions/ Observations

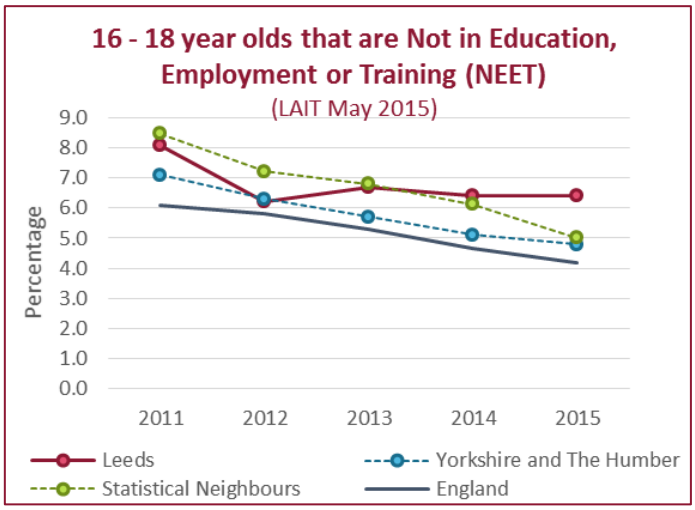
In 2014/15 slightly less CYP in Leeds reported being bullied in the past few months than the national average.

[137] http://fingertips.phe.org.uk/profile/what-about-youth
[138] Leeds City Council/Heathy Schools (2014/15) My Health, My School Survey. [http://www.myhealthmyschoolsurvey.org.uk/]

4.3.6 Young People who are NEET and at risk of NEET

Evidence suggests that being in education, employment or training increased resilience[139]. A number of studies including the Marmot review[140] and reports from Public Health England[141] show that not being in education employment or training (NEET), particularly for prolonged periods, is associated with a range of negative effects on later outcomes including:

- Higher risk of depression (particularly young men)
- Unemployment as an adult/being in low paid work
- Increased likelihood of using drugs/alcohol
- Increased risk of involvement in crime
- Teenage motherhood
- Lower life expectancy and worse health outcomes (than those who are more qualified or stayed in education longer)



A study by the Princes Trust found that Young people aged 16-25 not in work are less likely to be happy[142].

In Leeds in January 2016 there were 1,402 young people not in education, employment or training. As a proportion of total age 16-18 year olds: this equates to 6.3%.

Indicator	Period	Leeds	Yorkshire and the Humber	Statistical Neighbours	England	Rank
16 - 18 year olds that are Not in Education, Employment or Training.	2015	6.4	4.8	5.0	4.2	142.0

Conclusions/ Observations

6.4% of Leeds' 16 -18 year olds are classed as NEET (LAIT May 2016), compared with 5% for our statistical neighbours and 4.2% nationally, with significant variation across the city.

[139] ChiMat 2012).[http://www.chimat.org.uk/]
[140] Marmot Review (2010) Fair Society Healthy Lives http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[141] PHE Public Health Profiles[http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh
[142] Princes Trust (2014) Youth Index 2014. [https://www.princes-trust.org.uk/Youth-Index-2014.pdf]

4.4 Individual Risk Factors

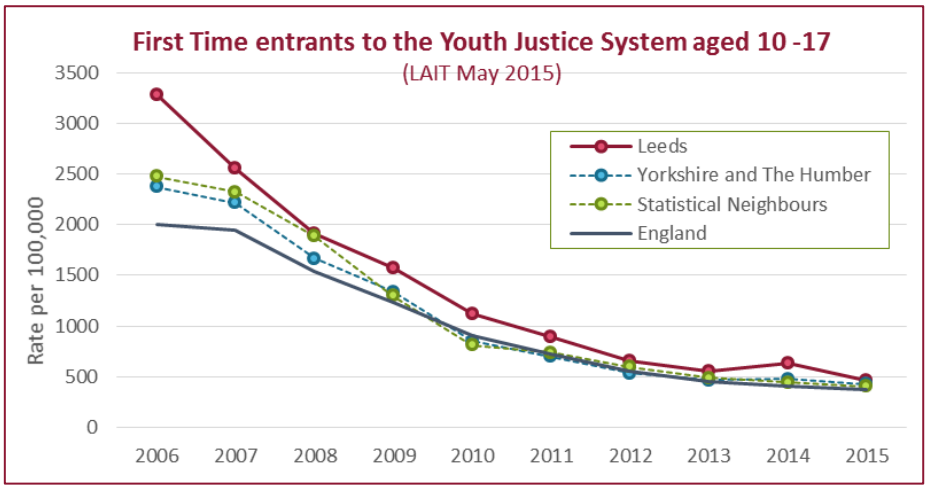
4.4.1 Young Offenders

Young prisoners are one of the most excluded and most needy groups in society[143]:

- 90 per cent have a diagnosable mental illness, substance abuse problem, or both (Lyon, Dennison & Wilson, 2000).
- They are 13 times more likely than other children to be looked after by their local authority
- They are 20 times more likely to have been excluded from school.

Rather than resolving the difficulties of these young people, prison often compounds their problems[144]. Within two years of their release, three-quarters will have re-convicted and 47% will be back in jail. [145]

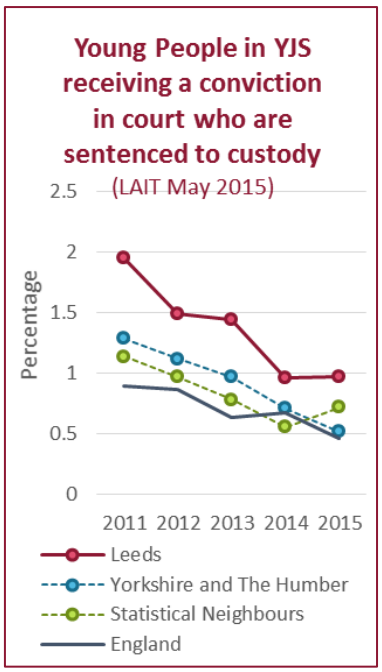
The correlation between young people involved in the criminal justice system and poor mental health has been well documented. A study from the National Office of Statistics found that 95% of young people in young offenders' institutions aged between 16 and 20 years had a mental disorder and many of them had more than one disorder[146] .



Rate of first-time entrants (FTEs) aged 10-17 to the criminal justice system in England is based on data recorded on the Police National Computer (PNC). These statistics are for a rolling twelve month reference period. This time period has been chosen over shorter timeframes to minimise the volatility caused by seasonality - for example reduced court volumes every December when many of the courts are closed over the Christmas period.

Youth offending as measured by First Time Entrants to the Youth Justice System (age 10-17) rates per 100,000 population has decreased locally to 460 per 100,000 from 3,282 in 2006. In 2006 the rates of first time entrants to the youth justice system was significantly greater in Leeds than either its statistical neighbours or England as a whole, and although the downward trend is reflected nationally,

[143] Lyon, J, Dennison, C, Wilson, A (2000) 'Tell them so they listen' Message from young people in custody. Home Office Research study 201
[144] IBID
[145] Social Exclusion Unit (2002) Reducing re-offending by ex-prisoners. Office of the Deputy Prime Minister.
[146] ONS (1997) Psychiatric Morbidity among Young Offenders in England and Wales. London: DH



the decrease has been steeper for Leeds and has brought Leeds rates much more in line. That said, Leeds is ranked 114th out of 150 local authorities and is still higher than both its statistical neighbours and the national rate.

The youth justice statistics 2014/15 for England and Wales reports that in the year ending March 2015, the number of self-harm incidents per 100 young people has continued to increase compared with both the year ending March 2010 and the year ending March 2014. The rate was 5.3 in the year ending March 2010 and increased to 6.6 in the year ending March 2014 and 7.7 in the year ending March 2015.

In the year ending March 2015, the number of assaults per 100 young people increased compared with both the year ending March 2010 and the year ending March 2014. In the year ending March 2010 it was 9.0 and increased to 14.3 in the year ending March 2014 and 16.2 in the year ending March 2015.[147]

The Youth Justice Board Safeguarding Report (April 2013 – March 2016) stated that during 2013/14, over half of safeguarding reports related to notifications of attempted suicide (65% (115) and 58% (87) in 2013/14 and 2014/15 respectively).

During 2013/14, 37% (66) of safeguarding incidents notified involved Children Looked After. This was also reflected in 2014/15, during which 48% (64) of notifications involved looked-after children.

In addition, 7% (12) and 9% (14) of safeguarding incidents reported in 2013/14 and 2014/15 respectively involved children who had previously been looked after but were not at the time of the incident. This shows that a disproportionate number of incidents involved a young person who was, or had been, a looked-after child.

Throughout both of the reporting years, whilst overall the majority of safeguarding notifications involved males, safeguarding incidents that fell within the mandatory reporting criteria of 'victim of rape' predominantly involved females (96% (22) of incidents in 2013/14, and 90% (26) of incidents in 2014/15).[148]

[147] Youth Justice Statistics 2014/15 England and Wales, Youth Justice Board / Ministry of Justice
[148] The Youth Justice Board Safeguarding Report (April 2013 – March 2016)

Indicator	Period	Leeds	Yorkshire and the Humber	Statistical Neighbours	England	Leeds Rank
First Time entrants to the Youth Justice System aged 10 -17	2015	460.0	425.8	407.8	368.7	114
Young People in YJS receiving a conviction in court who are sentenced to custody	2015	0.97	0.52	0.72	0.46	131
Proportion of young offenders who re-offend	2013	40.0		40.8	38.0	93

[149]

Conclusions/ Observations

Youth offending as measured by First Time Entrants to the Youth Justice System (age 10-17) rates per 100,000 population has decreased locally to 460 per 100,000.

Leeds is ranked 114th out of 150 local authorities for youth offending rates and is higher than both its statistical neighbours and the national rate.

4.4.2 Substance misuse

The detrimental impact of substance misuse on health in young people is well documented. It is widely associated with significant physical and emotional health risks including anxiety, memory/ cognitive loss, accidental injury, hepatitis, HIV infection, coma and premature death. There is research that indicates that youngsters smoking cannabis by the age of 15 are 3 times more likely to develop serious mental health illnesses including schizophrenia. Drug use at an early age is a predictor of addiction later in life.[150]

According to the What about YOUth? 2014 survey of 15 year olds looking at their health and wellbeing nationally:

- 24% of young people had ever smoked. 8% of young people were current smokers, which comprised 5% who were regular smokers and 3% who smoked occasionally.
- 26% of young people said they had ever been offered cannabis. 11% of young people said they had ever tried cannabis, including trying cannabis once. Looking at young people overall, 5% had taken cannabis in the last month, 9% had taken it in the last year, and 2% had taken it more than a year ago. 'In the last year' includes 'in the last month'.
- The majority (87%) had never been offered any other drugs, with over one in ten saying they had been (13%). 98% of young people had not tried other drugs.
- 6% of young people did not engage in any risky behaviour, 16% of young people engaged in three or more risky behaviours while 5% engaged in four or more risky behaviours.[151]

[149] LAIT May 2016

[150] Arseneault, L, Cannon, M, Witton, J, Murray. RM (2004) Causal association between cannabis and psychosis: examination of the evidence. British Journal of Psychiatry, 184, 110-117.

[151] http://fingertips.phe.org.uk/profile/what-about-youth

Indicator	Period	England	Yorkshire and the Humber	Leeds	Statistical Neighbours: Calderdale	Statistical Neighbours: Kirklees	Statistical Neighbours: Sheffield
Percentage with 3 or more risky behaviours	2014/15	15.9	17.9	18.3	20.9	15.7	17.0
Percentage of current smokers	2014/15	8.2	8.7	10.0	9.9	7.8	8.2
Percentage of regular smokers	2014/15	5.5	6.2	8.3	7.4	5.5	5.5
Percentage of occasional smokers	2014/15	2.7	2.5	1.7	2.5	2.3	2.7
Percentage who have tried e-cigarettes	2014/15	18.4	23.2	20.9	29.5	22.3	26.3
Percentage who have tried other tobacco products	2014/15	15.2	12.6	15.8	16.1	18.4	13.3
Percentage who have ever had an alcoholic drink	2014/15	62.4	66.2	66.8	67.9	56.7	62.1
Percentage of regular drinkers	2014/15	6.2	7.7	6.4	8.5	5.5	7.7
Percentage who have been drunk in the last 4 weeks	2014/15	14.6	16.2	16.0	17.8	14.6	17.5
Percentage who have ever tried cannabis	2014/15	10.7	9.8	12.7	13.2	9.3	10.3
Percentage who have taken cannabis in the last month	2014/15	4.6	4.1	6.0	4.2	4.1	4.9
Percentage who have taken drugs (excluding cannabis) in the last month	2014/15	0.9	0.7	0.5	0.6	0.9	1.1

[152]

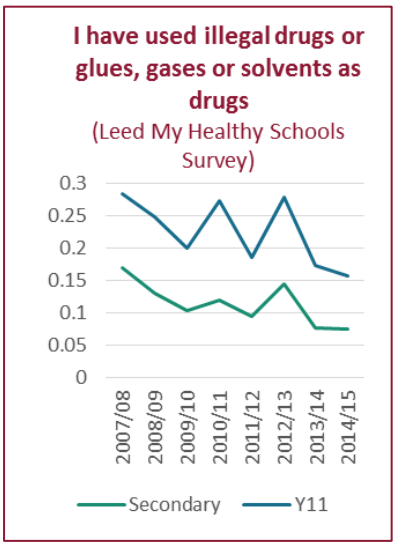
The figures for Leeds locally show that 15 year olds in Leeds reported higher than the national average for all tobacco, cannabis and alcohol related activities with the exception of *occasional smoking* and the *percentage who have taken drugs (excluding cannabis) in the last month*.

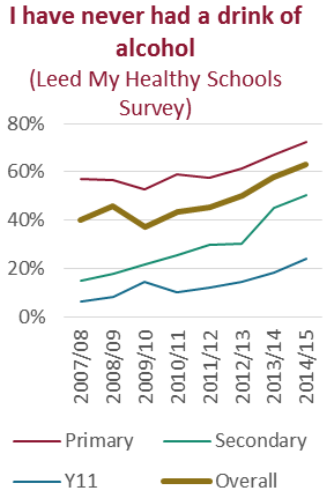
18.3% reported having 3 or more risky behaviours in Leeds compared to the national average of 15.9% (Risky behaviours are defined as illegal or health related risky behaviour (drugs, cannabis, smoking, drinking, diet, activity)).

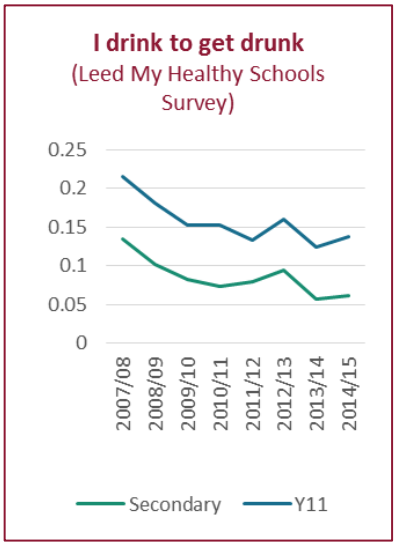
The 'My Health My Schools Survey'[153] for Leeds reported that the number of Secondary and Year 11 pupils answering positively to the question: 'Have you ever used illegal drugs or glues, gases or solvents as drugs?' has also been falling between 2007/08 and 2014/15.

[152] PHE Public Health Profiles
[153] Leeds City Council/Heathy Schools (2014/15) My Health, My School Survey. [http://www.myhealthmyschoolsurvey.org.uk/]

The survey also showed that there had been a reduction in the number of school age children reporting that they had drunk alcohol, and the number of Secondary and Year 11 pupils that drank to get drunk:







However, the public health data for hospital admissions shows that based on the last available information, Leeds was statistically similar to the national average for alcohol and substance misuse hospital admissions for children and young people[154]:

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Statistical Neighbours: Calderdale	Statistical Neighbours: Kirklees	Statistical Neighbours: Sheffield
Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18	2010/11 - 12/13		42.7	42.8	44.5	55.7	46.1	17.1
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	2012/13 - 14/15		88.8	94.8	81.4	128.0	90.3	41.4

Conclusions/ Observations

The Public Health Profile figures show that 15 year olds in Leeds reported higher than the national average for all tobacco, cannabis and alcohol related activities with the exception of *occasional smoking* and the *percentage who have taken drugs (excluding cannabis) in the last month*.

18.3% reported having 3 or more risky behaviours in Leeds compared to the national average of 15.9% (risky behaviours are defined as illegal or health related risky behaviour (drugs, cannabis, smoking, drinking, diet, activity).

[154] PHE Public Health Profiles

5. High Risk Groups

5.1 Overview

Some groups of children and young people are more at risk of experiencing mental health problems. These include children living in poverty, those with a learning disability, children whose parents have mental health problems, and children living in situations of domestic violence. Children and young people who have experienced severe adversity such as abuse and neglect are at a particularly high risk of developing a mental health problem, as are Children Looked After and young people in contact with the criminal justice system.

5.2 Children Looked After

5.2.1 CLA and prevalence of mental disorders

National prevalence rates suggest that 45% of children who are Looked After meet criteria for a mental health disorder[155] and 75% have emotional and behavioural difficulties. [156]

- 37% of Children Looked After had conduct disorders
- 12% had emotional disorders (anxiety and depression)
- 7% were hyperactive.
- Some Children Looked After had more than one type of disorder.

Predictably, children in care are very likely to have experienced the risk factors that predispose to the development of mental disorders.

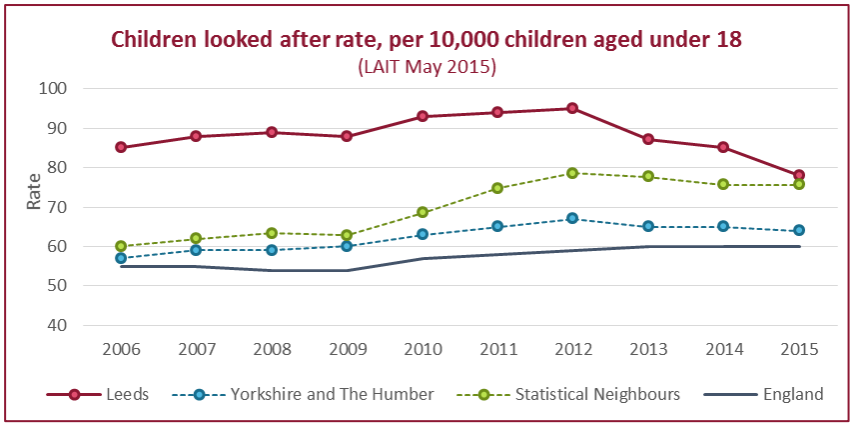
In Leeds, 9% of Children Looked After had been placed in 3 or more placements over the course of the year. This is lower than the national and regional average (10%) and statistical neighbours (9.6%)[157]

For the financial year 2014/15 there were 1213 Children Looked After in their home in Leeds, and 915 in a placement.[158] The table below applies the above prevalence data to these numbers of Children Looked After in Leeds:

Emotional Wellbeing and Mental Health Prevalance in Looked After Children (LAC) applied to the Leeds LAC Population (FY 2014/15)	Percentage Prevalence	LAC Home	LAC Placement	TOTAL
Total Leeds LAC	**100%**	**1213**	**915**	**2128**
LAC (aged 5-15) assessed as having a mental health disorder	45%	545.9	411.8	**957.6**
LAC in Care (aged 5-15) with a mental or behavioural problem at the point of entry into care	72%	873.4	658.8	**1532.2**
LAC with emotional and behavioural difficulties	75%	909.8	686.3	**1596.0**
Under 5's showing signs of emotional or behavioural problems at the point of entry into care	20%			
LAC with a conduct disorders	37%	448.8	338.6	**787.4**
LAC with emotional disorders (anxiety and depression)	12%	145.6	109.8	**255.4**
LAC that are hyperactive	7%	84.9	64.1	**149.0**
LAC 3+ time more likely to have a'probable' psychiatric diagnosis (based on number of	9%	109.2	82.4	**191.5**

[155] ONS (2002) The mental health of young people looked after by local authorities in England. London: DH
[156] Sempik, J (2008). Mental Health of Children Looked After in the UK: Summary. Centre for Child and Family Research
[157] Lee Leeds City Council. Leeds Observatory [http://observatory.leeds.gov.uk/] Accessed June, 2016
[158] IBID

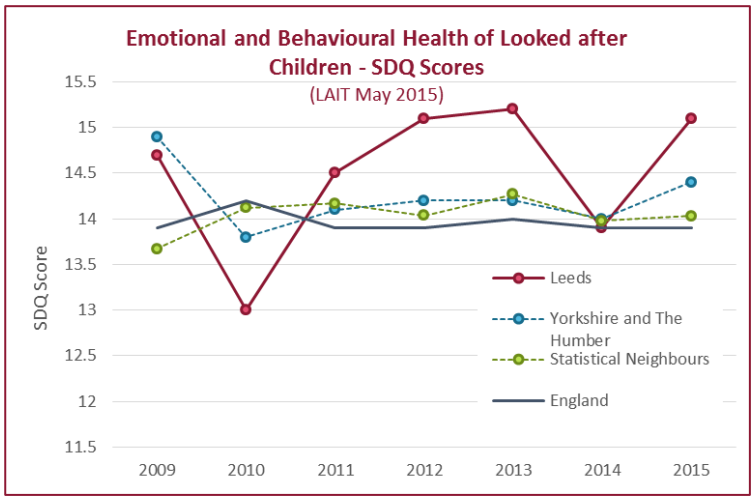
Overall numbers of Children Looked After in Leeds have been consistently and substantially higher that the national average and the average of its statistical neighbours. However, between 2012 and 2015 there was a 17 point drop in rate of Children Looked After per 10,000 children in Leeds, whilst there was significant growth in these rates for statistical neighbours between 2009 and 2012, meaning that by 2015 there were 78 Children Looked After per 10,000 children aged under 18 in Leeds, compared with 75.7 for its statistical neighbours and 60 nationally. [159]



Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Looked after children: Rate per 10,000 <18 population	2014/15		60	63.6*	77.6	1,245	1,334
Looked after children in foster placements: % of looked after children	2015		74.8	74.0	79.6	991	1,062
Looked after children in secure units, children's homes and hostels: % of looked after children	2015		9.4	9.6	5.6	70	75

5.2.2 Strengths and Difficulties Questionnaire (SDQ)

The emotional and behavioural health of children looked after is locally and nationally assessed through the completion of the Strengths and Difficulties Questionnaire (SDQ) for each looked after child from parents or carers collected by social workers. It is used with children aged between 4 and 16 who have been in care for at least 12 months. The SDQ is a short behavioural screening questionnaire. It has five sections that cover details of emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also positive behaviour. Good performance is a low SDQ score.



Over the last 6 years the Leeds SDQ scores have fluctuated around the national average which currently

[159] PHE Public Health Profiles

stands at 13.9[160]. The Leeds SDQ score for its Children Looked After was 15.1 in 2015 which is higher than the national average and that of its statistical neighbours (a Total Difficulties Score on the SDQ of 14-16 is a score of 'borderline').

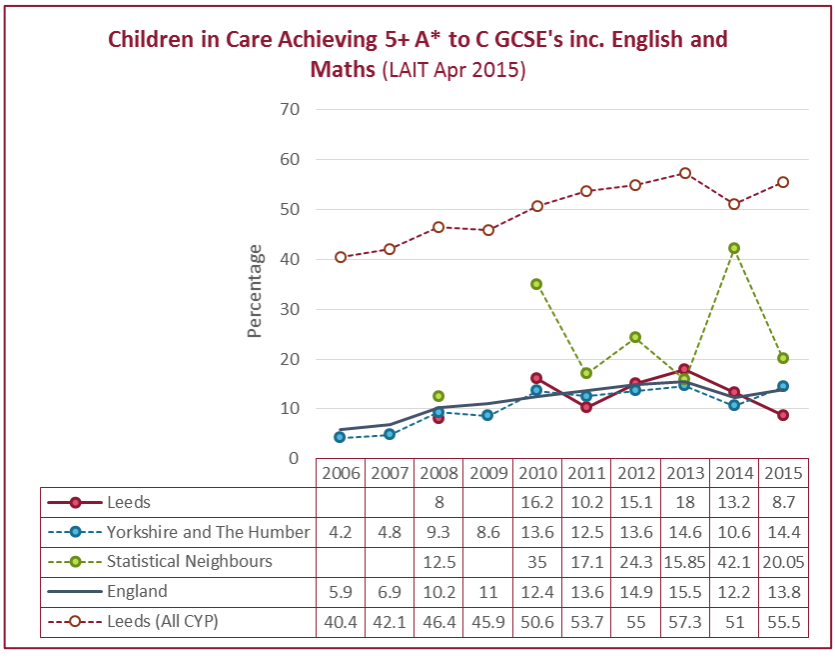
Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds
Emotional well-being of looked after children: average score	2014/15		13.9	14.4	15.1
Emotional and behavioural health assessment of looked after children: % eligible children assessed	2014		68	68.0	49.0

Only 49% of eligible children were assessed via the SDQ in Leeds compared to a national average of 68%.

5.2.3 CLA and Population risk factors

CLA as a population are much more vulnerable to risk factors found in the general population.

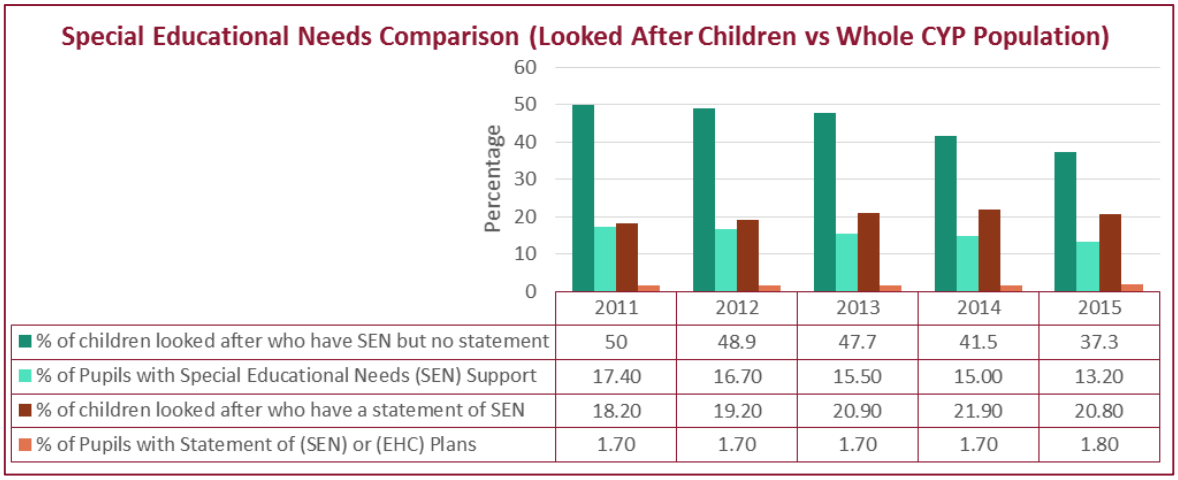
In 2015 just 8.7% of Children Looked After achieved 5+ A* to C grade GCSE's including English and Maths in Leeds, compared to 55.5% of its population that achieved the same at the end of key stage 4. The English average for Children Looked After achieving 5+ A* to C grade GCSE's including English and Maths was 13.8%, and while in 2015 the Leeds average was 5 percentage points lower, in reality the Leeds average has fluctuated either side of the national average since 2010 (between 18% & 8.7%).



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Leeds			8		16.2	10.2	15.1	18	13.2	8.7
Yorkshire and The Humber	4.2	4.8	9.3	8.6	13.6	12.5	13.6	14.6	10.6	14.4
Statistical Neighbours			12.5		35	17.1	24.3	15.85	42.1	20.05
England	5.9	6.9	10.2	11	12.4	13.6	14.9	15.5	12.2	13.8
Leeds (All CYP)	40.4	42.1	46.4	45.9	50.6	53.7	55	57.3	51	55.5

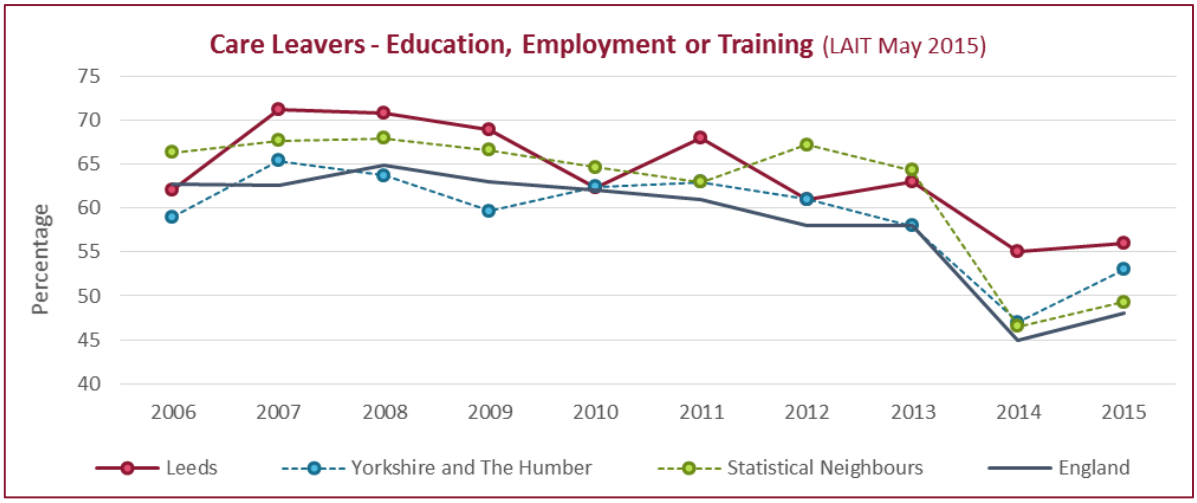
Looking at the comparative data for Special Educational Needs for Children Looked After and the Leeds population as a whole, it is clear that a significantly larger proportion of Children Looked After registered SEN that the population as a whole.[161]

[160] PHE Public Health Profiles
[161] LAIT May 2016

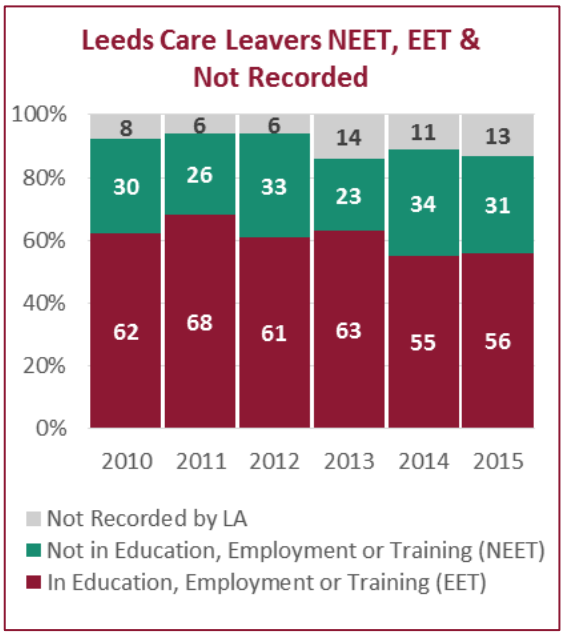


	2011	2012	2013	2014	2015
% of children looked after who have SEN but no statement	50	48.9	47.7	41.5	37.3
% of Pupils with Special Educational Needs (SEN) Support	17.40	16.70	15.50	15.00	13.20
% of children looked after who have a statement of SEN	18.20	19.20	20.90	21.90	20.80
% of Pupils with Statement of (SEN) or (EHC) Plans	1.70	1.70	1.70	1.70	1.80

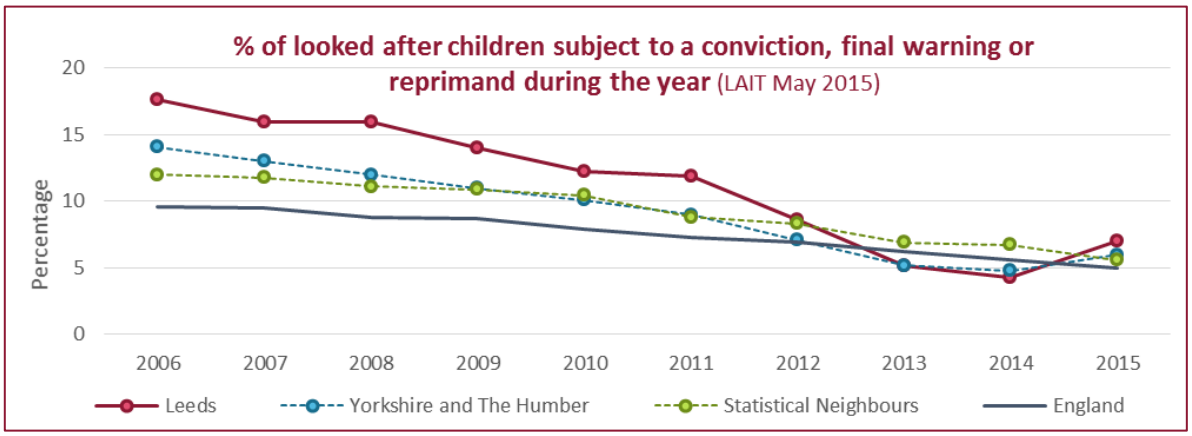
Care leavers are less likely to be in education, employment or training than the general population. Between 2006 and 2013 the percentage of care leavers recorded as being in education, employment and training in Leeds fluctuated between a high of 71% (2007) and low of 61% (2012), however there has been a sharp fall in the percentage of care leavers recorded as EET during 2014 & 2015 where the percentage of care leavers recorded as EET has dropped to between 55% and 56%.



This drop reflects national trends, although the drop has not been as steep in Leeds as it has been nationally and for its statistical neighbours. It is worth noting that although there has been a 12 percentage point drop in care leavers recorded as EET between 2011 and 2015, the increase in those recorded as NEET has only increased by 5 percentage points during the same period due to the increase in those care leavers whose education, employment or training status was not recorded by the local authority.



Offending by children aged 10-17 who have been looked after continuously for at least 12 months has declined steeply in Leeds over the last 10 years, from 18% in 2006 to 4% in 2014. There was a slight increase between 2014 & 2015 to 7%. Based on the current Leeds LAC population, this equates to 149 Children Looked After, up from 91 in 2014. Currently Leeds volumes are closely aligned with national and statistical neighbours volumes.



The latest information on percentage of LAC identified as having a substance misuse problem during the year for Leeds was 1.3% recorded in 2013 (approximately 23 CYP based on current LAC population), which was trending below the national average of 3.5%[162]

[162] LAIT May 2016

Conclusions/ Observations

Overall numbers of Children Looked After in Leeds have been consistently and substantially higher that the national average and the average of its statistical neighbours. However, between 2012 and 2015 there was a 17 point drop in rate of Children Looked After per 10,000 children in Leeds, whilst there was significant growth in these rates for statistical neighbours between 2009 and 2012, meaning that by 2015 there were 78 Children Looked After per 10,000 children aged under 18 in Leeds, compared with 75.7 for its statistical neighbours and 60 nationally.

In 2015, 9% of Children Looked After in Leeds had been placed in 3 or more placements over the course of the year, which was lower than the national and regional average (10%) and Statistical neighbours (9.6%)

The Leeds SDQ score for its Children Looked After was 15.1 in 2015 which is higher than the national average (13.9) and that of its statistical neighbours (a Total Difficulties Score on the SDQ of 14-16 is a score of 'borderline').

Between 2007 and 2015 Leeds Care Leavers have been more likely to be in education, employment or training than their equivalent nationally.

Offending by children aged 10-17 who have been looked after continuously for at least 12 months has declined steeply in Leeds over the last 10 years. Currently Leeds percentages are closely aligned with national and statistical neighbours volumes.

5.3 Children in Need

Section 17 of the Children Act 1989 defines a child as being in need if:

- He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA;
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA;
- He or she has a disability.

Development can mean physical, intellectual, emotional, social or behavioural development. Health can be physical or mental health.

Having a disability is defined as a person who is blind, deaf, dumb, suffering from a mental disorder, substantially and permanently handicapped by illness, or congenital deformity or from suffering from some other disability as may be prescribed. The definition will include any child or young person under the age of 18.[163]

The Public Health Profiles has good quality data for Children In Need in Leeds which suggests that in 2014/15 there was a significantly higher rate of children in need within Leeds than there is nationally (748 CYP per 10,000 in Leeds compared with 674 per 10,000 nationally), however within those

[163] Coram CLC Children's Legal Centre www.protectingchildren.org.uk

numbers, there is a lower proportion of CYP considered at need because of abuse, neglect or family dysfunction (5,401 CYP in Leeds during 2014). [164]

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Children in need: Rate of children in need during the year, per 10,000 aged <18	2014/15		674	725	748	**12,003**	**12,858**
New cases of children in need: Rate of new cases identified during the year, per 10,000 aged <18	2014/15		348	370	316	**5,071**	**5,432**
Children in need due to abuse, neglect or family dysfunction: % of children in need	2015		67.3	70.1	45.0	**5,401**	**5,786**
Children in need for more than 2 years: % of children in need	2015		31.3	31.3	29.6	**3,553**	**3,806**
Children in need referrals: Rate of children in need referrals during the year, per 10,000 aged <18	2014/15		548	677	741	**11,891**	**12,737**
Assessment of children in need referrals: % of referrals with a completed initial assessment	2013/14		46.9	43.0*	40.1	**4,768**	**5,108**

Conclusions/ Observations

There was a significantly higher rate of Children in Need within Leeds than there is nationally (748 CYP per 10,000 in Leeds compared with 674 per 10,000 nationally) (2014/15).

Although there is a lower rate for new cases of children in need in Leeds than both the national picture and geographical neighbours, the rate of referrals was significantly higher than the national or regional picture.

There is a lower proportion of the Children in Need numbers for Leeds considered at need because of abuse, neglect or family dysfunction (5,401 CYP in Leeds during 2014).

[164] PHE Public Health Profiles

5.4 Children with a Disability

The mean percentage of disabled children in English local authorities has been estimated to be between 3.0% and 5.4%, through a survey of all Directors of Children's Services in England undertaken by the TCRU. If applied to the population of Leeds this would equate to between 4,478 and 8,060 children experiencing some form of disability.

The Department for Education (DfE) has stated that:

- Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education.
- The educational attainment of disabled children is unacceptably lower than that of non-disabled children and fewer than 50% of schools have accessibility plans.
- Disabled young people aged 16-24 are less satisfied with their lives than their peers and there is a tendency for support to fall away at key transition points as young people move from child to adult services.
- Families with disabled children report particularly high levels of unmet needs, isolation and stress.
- The prevalence of severe disability is increasing.

Children with a long-term physical illness are twice as likely to suffer from emotional or conduct disorder problems[165]. Although there is reason to suspect that people with physical disability will experience a higher rate of mental health conditions compared to people without disabilities, there is a lack of literature in this area, especially amongst children with disabilities.[166]

Estmated number of CYP living with longstanding illness or disability, and CYP who are severley disabled (ONS 2011)	The Health of Children and Young People (ONS 2011)		Leeds Volumes (Estimates)	
	Male	Female	Male	Female
Leeds Population (0-19)			**86063**	**82668**
Age 0-19 living with longstanding illness or disability estimate (ONS)	19%	17%	16352	14054
Age 0-19 who are severely disabled estimate (ONS)	11 per 10,000	5 per 10,000	95	41
Leeds Population (0-25)			**115883**	**113340**
Age 0-25 living with longstanding illness or disability estimate (based on 0-19 estimates)			22018	19268
Age 0-25 who are severely disabled estimate (based on 0-19 estimates)			127	57

Conclusions/ Observations

TCRU prevalence data suggests between 4,478 and 8,060 of Leeds children experience some form of disability.

ONS 2011 figures suggest that approximately 41,300 0 -25 year olds are living with a longstanding illness or disability, and approximately 184 are considered severely disabled.

[165] Hagiliassis N et al 2005, 'The Bridging Project: Physical disability and mental health', InPsych, [online], August 2005, http://www.psychology.org.au/publications/inpsych/bridging

[166] IBID

5.5 Children with Learning Disabilities

Learning disability is strongly associated with mental health problems in children and young people. Those children and young people with learning disabilities are 3 to 4 times more likely to have behavioural problems and 40% will have a diagnosable mental health disorder. For those with severe learning difficulties, the rate is 3 to 4 that of the general population. Those with learning disabilities living in deprived, urban areas are at particular risk of mental health problems. One in ten of all children with referred mental health problems had a learning disability, and 50% of those lived in poverty.[167]

Children and young people with learning disabilities are at greater risk of developing mental health problems as compared with their peers. Emerson and Hatton (2007)[168] report that 36% of children and young people with learning disabilities will have a mental health problem, compared with 8% of non-disabled children.

The increased risk of having a mental health problem cuts across all types of psychiatric disorders with problems worst for those who are unable to communicate feelings or their distress.
Children with learning disabilities are:

- 33 x more likely to have an autistic spectrum disorder than the general population
- 8 x more likely to have ADHD
- 6 x more likely to have a conduct disorder
- 4 x more likely to have an emotional disorder
- 3 x more likely to experience schizophrenia
- 1.7 x more likely to have a depressive disorder

Research has suggested the prevalence of intellectual disabilities among South Asian children and young people is three times higher than in other communities[169].

[167] Redmond, S., Hodp, JL (2008) Absenteeism Rates in Students Receiving Services for CDs, LDs, and EDs: A Macroscopic View of the Consequences of Disability

[168] Emerson and Hatton (2007) The Mental Health of Children and Adolescents with Learning Disabilities in Britain. Institute for Health Research, Lancaster University.

[169] Chevalier A and Feinstein L (2006) Sheepskin or Prozac: The Causal Effect of Education on Mental Health. Institute for the study of Labour (IZA) Discussion Paper No. 2231. http://ssrn.com/abstract=923530

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Pupils with Learning Disability: % of school pupils with Learning Disability	2015		4.97*	4.99*	3.78	**3,813**	**4,278**
Pupils with behavioural, emotional and social support needs: % of school pupils with behavioural, emotional and social support needs	2014		1.66	1.6	1.7	**1,725**	**1,935**
Pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	2015		2.00*	1.83*	1.86	**1,876**	**2,105**
Pupils with speech, language or communication needs: % of school pupils with speech, language or communication needs	2015		2.26*	2.20*	3.29	**3,319**	**3,724**
Pupils with autism spectrum disorder: % of school pupils with autism spectrum disorder	2015		1.08*	0.93*	0.52	**525**	**589**

[170]

The Leeds JSNA on Learning Disabilities 2015 states that the 'Level of acuity of need in Leeds is unprecedented. Particularly of note is the number of people with learning disability and complex autism. The Autism Act and development of a local diagnostic service is expected to increase demand for services. The number of adult service users with learning disabilities receiving a service in Leeds has increased by 16% over the last five years.'[171]

There is currently a Transformation Care Programme underway involving 48 Transforming Care Partnerships who have been working on plans aimed at improving services for children, young people and adults with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. Led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH).

Leeds Transforming Care Partnership's (TCP) plan focuses on developing the way it plans and pays for services so that they can deliver improved partnership working with health and social care providers to support people closer to home, give people the best choice and control and provide the range of community services which the local population needs.

The TCP's plans also focus on how it will develop and improve the specialist learning disability health care services which it provides by maximising the resources it has to improve people's heath and reduce hospital admissions.[172]

[170] PHE Public Health Profiles: Learning Disabilities
[171] Leeds JSNA(2015) Learning Disabilities
[172] www.england.nhs.uk/learningdisabilities/care

Conclusions/ Observations

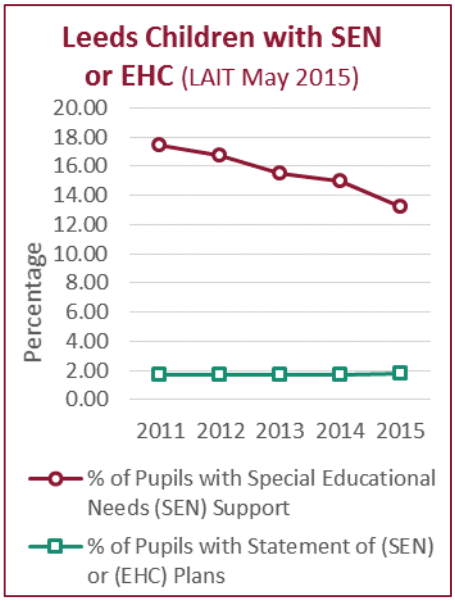
According to Public Health Profiles, Leeds has a slightly lower than the national rates of: pupils with learning disabilities; pupils with social, emotional and mental health support needs; pupils with speech, language or communication needs and pupils with autism spectrum disorder. However, it has a higher than average number of pupils with behavioural, emotional and social support needs.

5.6 Children with Special Educational Needs (SEN)

Leeds pupils are overall less likely that the national average to have been identified as having a special educational need (SEN), and less likely still to have a statement of SEN[173]:

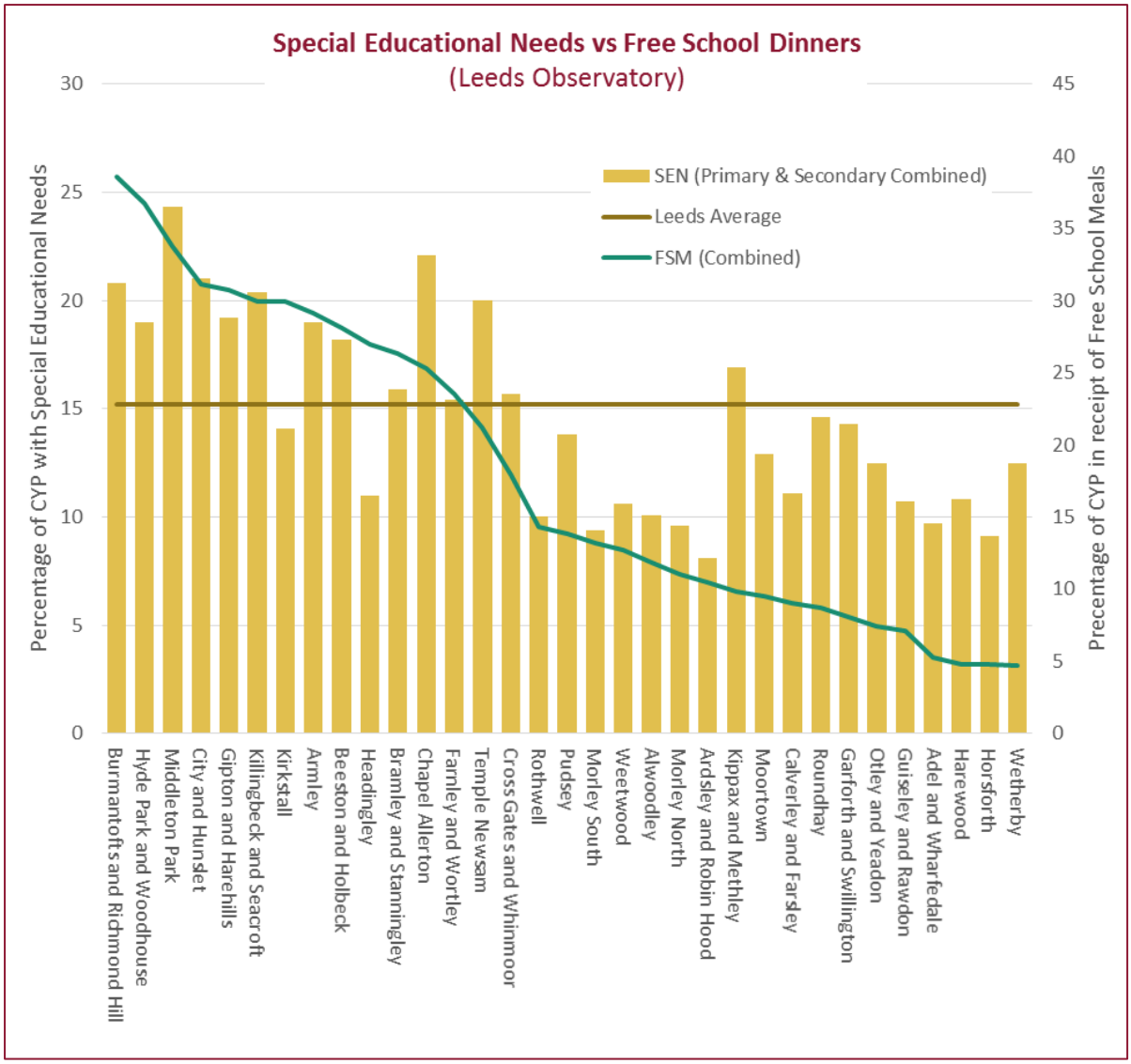
Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Pupils with special educational needs (SEN): % of all school age pupils with special educational needs	2015		15.4*	15.1*	15.0	15,133	16,977
Pupils with a SEN statement: % of all school age pupils with a statement	2015		2.80*	2.40*	1.76	1,776	1,992

Leeds data illustrates that between 2011 and 2015 there has been a year on year decrease in the percentage of children identified with SEN overall, from 17% to 13%, although the percentage pupils with statements of special educational need (SEN) or Education, Health and Care Plan (EHCP) has remained steady at 2% over the same period.



The graph below ranks all Leeds wards by the percentage of pupils in receipt of free school meals as an indicator of its depravation, and then applies each areas percentage number of pupils with special educational needs. As expected, poorer areas of the city show a greater number of children and young people with SEN, however although this trend follows to some extent from Burmantofts and Richmond Hill through to Ardsley and Robin Hood, there appears to be a step back up in the number of SEN from Kippax and Methley through to Wetherby.

[173] Public Health Profiles



Conclusions/ Observations

Leeds has a lower rate of pupils identified as having a special educational need and lower rate of pupils with a SEN statement than both the national and the regional average.

5.12 Black and Minority Ethnic groups

Research suggests that just over 10% of White children have a mental disorder. Children of Black ethnic origin also have a fairly high rate of mental disorders (9%), followed by Pakistani/Bangladeshi group (8%)[174].

A review of the evidence on the emotional wellbeing of young people by the University of London [175] has been found to be inconclusive although children and young people from minority ethnic communities may be overrepresented within CAMHS.
The same research found the following significant links between ethnicity and mental health:

- People from black and minority ethnic communities may face additional barriers to access due to language cultural issues
- Pakistani mothers are less likely to seek treatment or consider a referral to CAMHS for mild or moderate problems they identified
- Family ethnic background influenced referrals to CAMHS:
    - White British children were more likely to be referred by GPs
    - Black and South Asian children were more likely to be referred by specialist doctors
    - Black children more likely to be referred by education services
    - Mixed race children more likely to be referred by social services

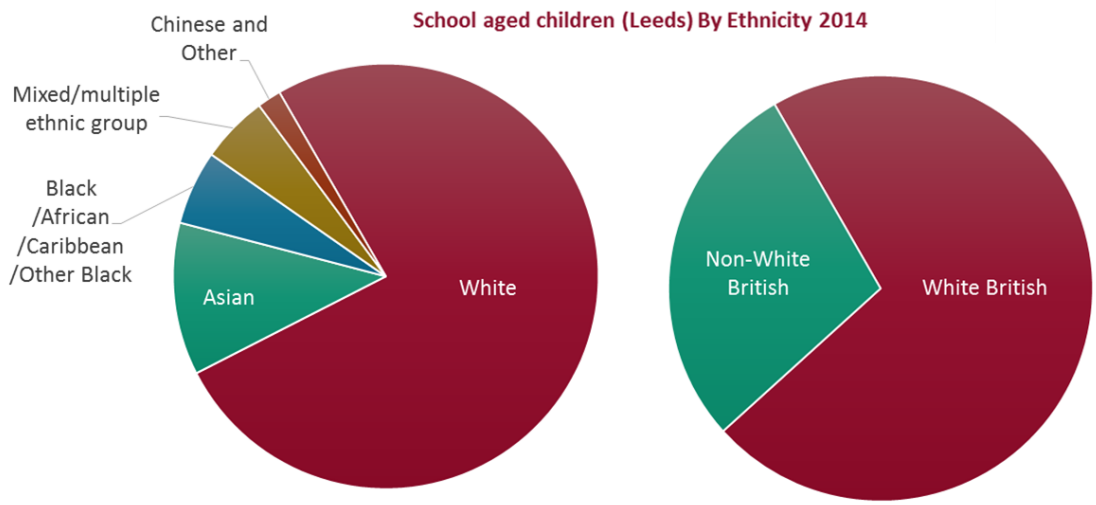
The Leeds JNSA[176] noted that 'In the last decade the BME population in the city has increased from 11% to 19%, and the number of residents born outside of the UK has almost doubled to over 86,000 people. There have been very localised impacts across the city, with complex related issues such as the speed of change, 'national identity', language proficiency, transient populations and variations in birth rates that in turn influence service provision and the wider interface between communities.

- Data from the city's schools, shows there are increasing numbers of children and young people of black and minority ethnic heritage, particularly Black African and White Eastern European
- The number of children and young people with English as an additional language (EAL) has also increased in recent years, from 13% in 2010 to 16% in 2014. The main languages spoken are Urdu, Punjabi and increasingly Polish.[177]

School aged children (Leeds) By Ethnicity	2013	2014	2014 Number
Percentage White British ethnic group	73.2	71 ↓	67647
Percentage Non-White British ethnic group	26.8	28.1 ↑	26814
Percentage White ethnic group	76.8	75.2 ↓	71640
Percentage Asian ethnic group	11.2	11.5 ↑	10965
Percentage Black/African/Caribbean/Other Black ethnic group	5.4	5.6 ↑	5320
Percentage Mixed/multiple ethnic group ethnic group	4.9	5.1 ↑	4855
Percentage Chinese and Other ethnic group	1.8	1.8 →	1685

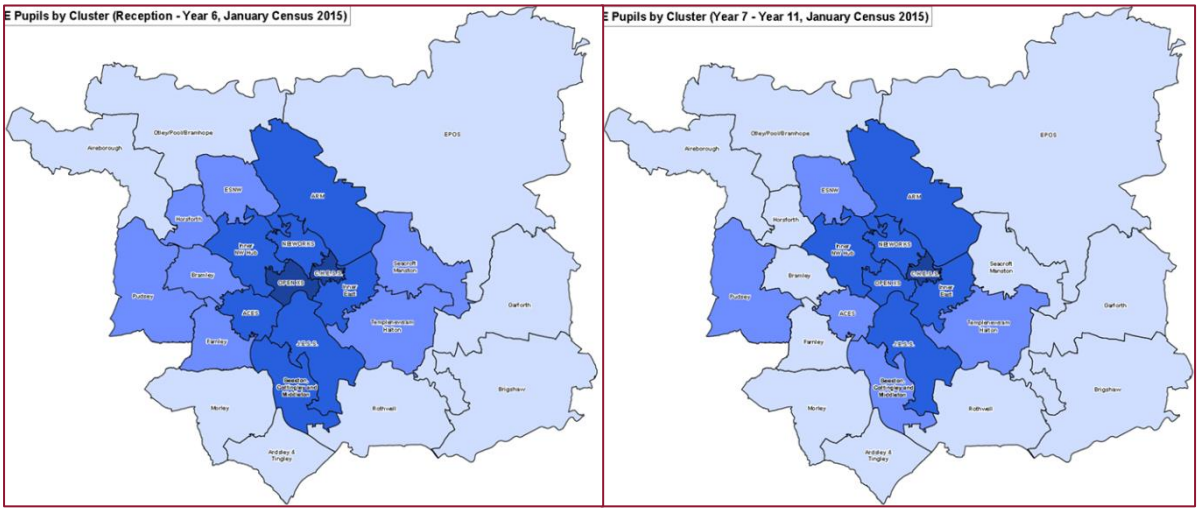
[174] Office for National Statistics (2004) The mental health of children and adolescents in Great Britain. London: Office for National Statistics
[175] TCRU (2007) *Young London Matters: The emotional well-being and mental health of young Londoners: A focused review of evidence*. Thomas Coram Research Unit, University of London. http://tinyurl.com/947vxek
[176] Leeds City Council (2015) Leeds Joint Strategic Needs Assessment. Health and Wellbeing Board
[177] IBID

The school age children by ethnicity data appears to be split into both 'white British and non-white British' which combined make approximately 100%, and 'White, Asian, Black, Mixed, Chinese and other ethnic groups' which combined also make approximately 100%.

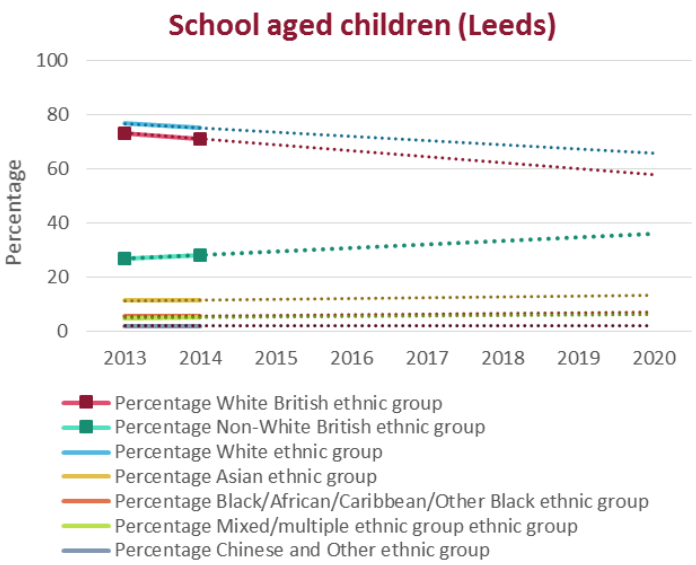


It is also worth noting that the BME population is clustered around the centre of Leeds and predominantly within the more deprived areas of the city, as see in the maps below showing the percentage of BME Pupils by cluster taken from the January Census 2015 (dark blue high proportion of CYP from the BME community).

Reception – Year 6 Year 7 – Year 11



While it is not possible to take any real quantifiable conclusions from trends seen in just 2 years of data, it is clear from the changing ethnicity profile of school aged children between 2013 & 2014 that over the next 4 years the profile of Leeds CYP ethnicity will continue to change significantly as will the ethnic profile of CYP with MH and EW needs.



Conclusions/ Observations

It is clear from the changing ethnicity profile of school aged children between 2013 & 2014 that over the next 4 years the profile of Leeds CYP ethnicity will continue to change significantly as will the ethnic profile of CYP with MH and EW needs.

Whilst the impact on volumes into CAMHS will be largely unaffected by this changing ethnic profile, the challenge for all services providing emotional and mental health support to CYP in Leeds will be how to develop services that engage with often hard to reach ethnic groups and provide services that are responsive to the changing demographic.

5.12.1 Asylum Seekers, refugees and immigrants

Research into the mental health needs of asylum seekers and refugees has shown that they are likely to experience poorer mental health than native populations[178] and are amongst the most vulnerable and socially excluded people in our society.[179] In terms of known factors that might predispose an individual to develop mental health issues, including serious and enduring problems, refugees are a group with high indicators of mental health need. Refugees are likely to have experienced war, persecution or inter-communal conflict, resulting in multiple losses including: family, friends, home, status and income.[180] Reports have also highlighted the continued difficulties this group may experience in exile.[181]

Asylum seekers arriving in the UK or any other host nation may have a very limited knowledge of the health care and welfare systems of that nation. [182] They are likely to experience poverty, dependence and a lack of cohesive social support arriving in a new country as a refugee.

Rates of mental health problems in particular migrant groups, and subsequent generations, can be higher than in the general population[183]:

- Migrant groups and their children are at two to eight times greater risk of psychosis
- Studies of refugees of all ages have found that one in six has significant physical health problems and over two thirds have suffered from anxiety or depression
- Public health experts advise that the mental health needs of children seeking asylum are underestimated and neglected (Faculty of Public Health, 2008).
- Common mental health problems for refugee and migrant children include post-traumatic stress disorder, low level and severe depression, anxiety, sleep disorders, self-harming behaviour, and loneliness

In Leeds in 2015 there were 13 unaccompanied asylum seeking children looked after.

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds
Unaccompanied Asylum Seeking Children looked after: count	2015		2030	50	13 [184]

Conclusions/ Observations

In Leeds in 2015 there were 13 unaccompanied asylum seeking children looked after.

[178] Tribe, R. (2002) Mental health of refugees and asylum-seekers. Advances in Psychiatric Treatment, 8, 240-247

[179] Burnett, A. and Peel, M. (2001) Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees

[180] Warfa, N. and Bhui, K.(2003) Refugees and mental health care.

[181] Burnett, A. and Peel, M. (2001) Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees.

[182] IBID

[183] The Children's Society (2012) The Good Childhood Report.

[184] PHE Public Health Profiles

5.12.2 Gypsy, Roma and Traveller children

There is a shortage of literature on the mental health needs of traveller children but the following points are of note:

- Gypsy, Roma and Traveller children have the worst education outcomes of any ethnic group in the UK combined with high rates of school exclusion[185]
- Roma in England are concentrated in the North West and London, with significant populations in Yorkshire and the Humber and the East and West Midlands. They live in predominantly urban, multi-ethnic areas. The numbers in Wales, Scotland and Northern Ireland are relatively small.
- Roma tend to live as part of a national diaspora in private housing and high densities.
- The experience of discrimination and racism in the school and education system impacts on social inclusion, achievement and mental health.[186]
- This population have a life expectancy 10 years lower than other European citizen.
- Child mortality rates are between 2 and 6 times higher than the general population of Europe.
- Less than half of Roma children complete primary school and a very low number attend secondary school.
- Employment rates are lower for Roma than the general population.
- Housing is often poor, with inadequate access to services[187].

Locally as an example of work to identify needs, a study in Sheffield[188] has found the most commonly identified primary needs of Roma pupils are learning difficulties, behavioural emotional and social difficulties, speech and language problems and a disproportionate prevalence of hearing impairments.

They found the proportion of people reporting any problems with 'nerves' or 'feeling fed up' was significantly greater than a matched comparison group of urban deprived residents (35% compared to 19%) This terminology was used as it was more familiar to the community.

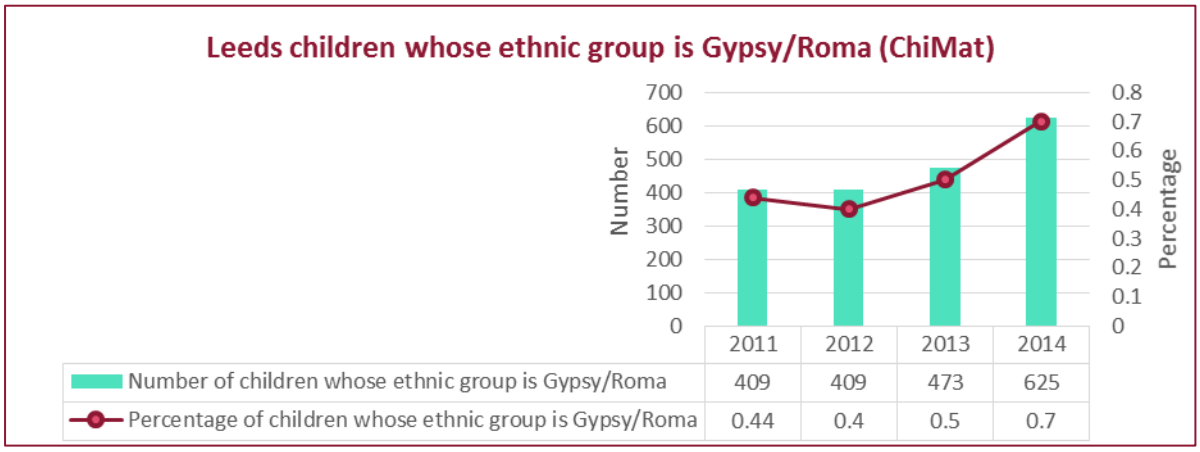
Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Traveller children: % school children who are Gypsy/Roma	2015/16		0.3	0.7	0.7	658	746

[189]

Based on school children being all children in Leeds aged between 5 – 16 and percentages reported by Public Health, there were estimated to be 658 school children in Leeds who are of Gypsy/Roma ethnicity, although the actual figure reported by ChiMat for 2014 was 625 (Public Health report that 0.71% of school children and of Gypsy/Roma ethnicity, while ChiMat reports 0.67%).

[185] Davis, R (2010) Working with Travellers and Gypsies. Community Care. [http://www.communitycare.co.uk/2010/06/07/working-with-travellers-and-gypsies/]
[186] Brown, P, Scuillion,L, Martin, P (2013) Migrant Roma in the UK. University of Salford
[187] Ibid
[188] Van Cleemput P, Parry G. (2001) Health status of Gypsy Travellers Journal of Public Health Medicine, 23, p129 - 134
[189] PHE Public Health Profiles

If the proportion of school children remains the same (0.7%) then 746 school children in Leeds will be of Gypsy/Roma ethnicity by 2020 (based on Public Health data). However, Chimat reports a steep increase in the proportion of school children of Gypsy/Roma ethnicity between 2012 and 2014 (below), which if it were to continue would mean that Gypsy/Roma school population would be significantly higher by 2020.



Conclusions/ Observations

Public Health report that 0.71% of school children and of Gypsy/Roma ethnicity, while ChiMat reports 0.67%. If the proportion of school children remains the same (0.7%) then 746 school children in Leeds will be of Gypsy/Roma ethnicity by 2020. However, Chimat reports a steep increase in the proportion of school children of Gypsy/Roma ethnicity between 2012 and 2014 (below), which if it were to continue would mean that Gypsy/Roma school population would be significantly higher by 2020.

6. Prevalence of Mental Disorders

6.1 Overview

Mental health problems in children and adolescents are common and account for a significant proportion of ill health issues in this age group.[190] Mental ill health in children causes distress and can have wide-ranging effects, including negative impact on

- educational attainment,
- social relationships,
- social skills
- likelihood of self-harm and suicide rate
- likelihood of engaging in health risk behaviour, including substance misuse and smoking and
- physical health.

According to JCPMH Guidance for Commissioning Public Mental Health Services[191] mental health problems may develop early in the life course and, as such impact on the course of a young person's life significantly. Research indicates that:

- 50% of lifetime mental illness (except dementia) arises by age 14 [192]
- 40% of young people experience at least one mental disorder by age 16 [193]
- 75% of lifetime illness (excluding dementia) starts by mid-twenties [194]

For children and adolescents, only 30-40% of children and adolescents who experience clinically significant mental disorder have been offered evidence-based interventions at the earliest opportunity for maximal lifetime benefits. [195]

6.1.1 Estimates of prevalence of mental disorders in children aged 5-16

Public Health England data[196]suggests that in the age group between 5-16 years, the prevalence of mental health disorders is close to 1 in 10. This figure has been relatively stable over the past 15 years (see Office for National Statistics, 2004). There has been less research on the profile and rates of problems in the under-5s. One study showed that the prevalence of problems for 3-year-old children was similar to the 5-16 year-olds, and was in the region of 10%.[197]

[190] Murphy M. &Fonagy, P. (2012) Mental health problems in children and young people. In Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays.
[191] JCPMH (2015) Guidance for commissioning public mental health services.
[192] Kim-Cohen, J. Caspi A, Moffitt TE et al (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. Archives of General Psychiatry
Kessler RC, Berglund P, Demler O et al (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archives of General Psychiatry
[193] Kessler RC, Amminger GP, Aguilar-Gaxiola S et al (2007). Age of onset of mental disorders: a review of recent literature. Current Opinion in Psychiatry
[194] Jaffee SR, Harrington H, Cohen P, Moffitt TE (2005). Cumulative prevalence of psychiatric disorder in youths. Journal of the American Academy of Child and Adolescent Psychiatry
[195] Green H, McGinnity A, Meltzer H, et al (2005). Mental health of children and young people in Great Britain, 2004.
[196] Public Health England Observatories. Retrieved from http://www.phoutcomes.info/
[197] Stallard P (1993) The behaviour of 3-year-old children: Prevalence and parental perception of problem behaviour: a research note. J Child Psychol Psychiatry 34: 413- 421

6.1.2 Estimates of prevalence of mental disorders in young people aged 16-24

ONS survey on adult psychiatric morbidity records the following prevalence rates for 16–24-year-old age group: 16.4% had anxiety disorder; 2.2% had a depressive episode; 4.7% screened positive for posttraumatic stress disorder; 0.2% experienced a psychotic illness and 1.9% had a diagnosable personality disorder.[198]

6.1.3 Self-harm

One of the greatest concerns relating children with mental disorders is the rate of self-harm. ONS (2004) survey[199] recorded a fairly low rate of self-harm in 5–10 year olds with no disorder (0.8%), rising to 6.2% in those with an anxiety disorder and 7.5% among the group of children with hyperkinetic disorder, conduct disorder or one of the less common disorders. The prevalence in adolescence is higher. Adolescents with no disorder have a prevalence rate of 1.2, and those with anxiety disorder have notably higher rate of 9.4%. Adolescents with depression have the highest self-harm rate of almost 19%.

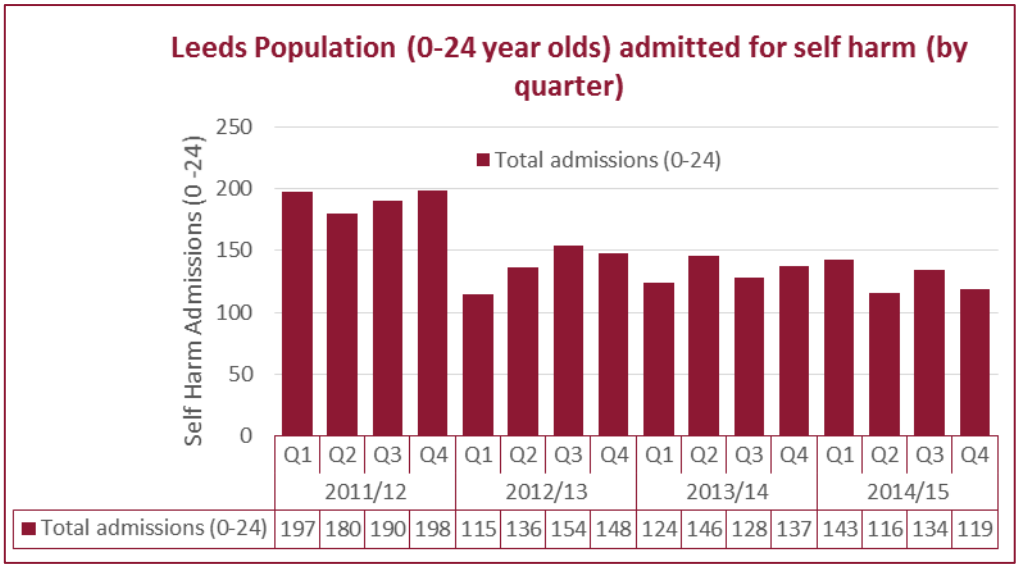
Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Child hospital admissions for unintentional and deliberate injuries: rate per 10,000 children 0-14	2014/15		109.6	116.0	125.0	1,692	1,844
Young people hospital admissions for unintentional and deliberate injuries: rate per 10,000 young people 15-24	2014/15		131.7	138.1	117.4	1,481	1,470

[200]

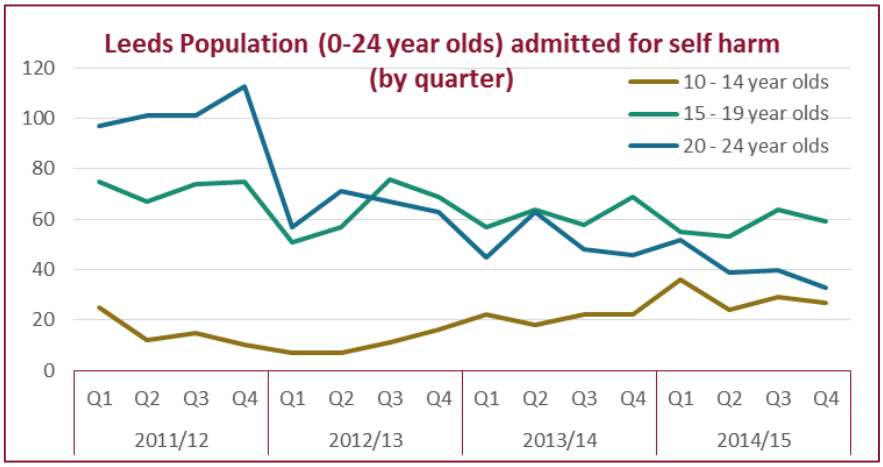
Leeds CAMHS provided self-harm/ crisis intervention to 491 CYP during 2014/15. Looking at records of admissions for self-harm by quarter for Leeds from the financial year 2011/12 to 2014/15, we can see that on average there were 591 admissions each year within the 0 – 24 age group. However, there was a 28% drop in self-harm admissions between 2011/12 and 2012/13 from 765 in 2011/12 to 553 the following year, which suggests a change in either classification or recording methodology.

From 2012/13 to 2014/15 there has been a year on year drop in self-harm admissions within the 0 - 24 year old bracket from 553 in 2012/13 to 512 to in 2014/15 (below).

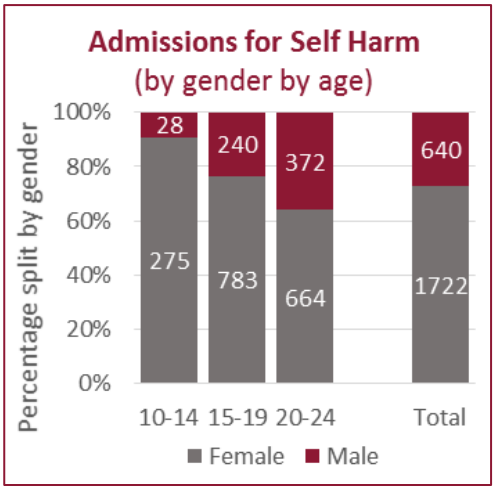
[198] McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. Adult psychiatric morbidity in England, 2007. Results of a household survey.
[199] Office for National Statistics (2004) The mental health of children and adolescents in Great Britain. London: Office for National Statistics
[200] PHE Public Health Profiles



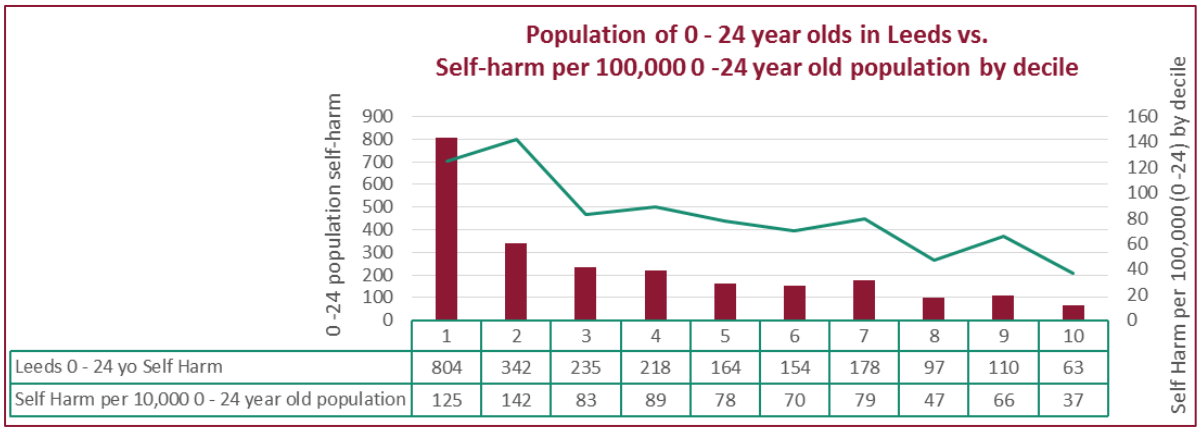
Breaking Leeds self-harm admissions down in to 5 year brackets, it appears that while the number of 15 – 19 year olds has remained largely stable through the 4 financial year , the number of 20 – 24 year olds admitted for self-harm is declining, and the number of 10 -14 year olds in increasing (albeit from a lower starting point).



The split of male and females admitted for self-harm shows that overall 73% of CYP admitted for self-harm are female, the proportion of males admitted increases from just 9% of 10 -14 year olds, to 36% of 20 to 24 year olds (left).



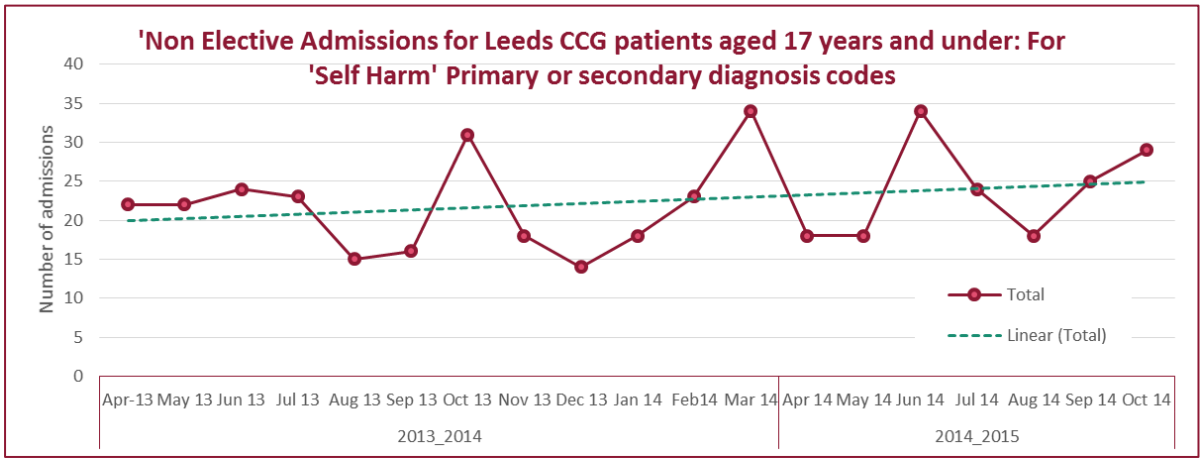
It is also possible to look at the volumes of CYP being admitted for self-harm by IMD decile over the 4 year period. This analysis shows that although the volume of CYP being admitted for self-harm from the bottom decile is significantly higher than those from all other deciles, the number of children and young people living in that decile in Leeds is also highest meaning that overall 125 children in every 10,000 from the lowest decile were admitted for self-harm, which is the second most prevalent rate after the 2nd lowest decile where 142 CYP in every 10,000 were admitted for self-harm.



	1	2	3	4	5	6	7	8	9	10
Leeds 0 - 24 yo Self Harm	804	342	235	218	164	154	178	97	110	63
Self Harm per 10,000 0 - 24 year old population	125	142	83	89	78	70	79	47	66	37

Overall, 90 CYP in every 10,000 were admitted for self-harm during the 4 year measurement period.

A second data set from Leeds shows that there were 426 Non-elective admissions for Leeds CCG patients aged 17 years and under for 'Self Harm' recorded as either a primary or secondary diagnosis code between April 2013 and October 2014.



This equates to an average of 22.4 admissions per month, although the monthly fluctuation is volumes is high, with the expected drop in incidents during holiday seasons. The liner trend suggests that there is an increasing number of young people presenting over time, although this is contradicted by the longer previous dataset.

Of the CYP aged 17 and under presenting with self-harm:

- 83% were female
- 85.4% of non-elective admissions for self-harm were through poisoning
- 12.9% through use of a sharp object
- 1.6% were via a number of different self-harming methods

Conclusions/ Observations

There were 125 child hospital admissions for unintentional and deliberate injuries per 10,000 0-14 year olds in Leeds, which is higher than the 109.6 rate reported nationally.

There were 117.4 child hospital admissions for unintentional and deliberate injuries per 10,000 15-24 year olds in Leeds, which is lower than the 131.7 rate reported nationally.

The gender split of self-harm admissions shows that overall 73% of CYP admitted for self-harm are female.

6.1.4 Suicide

The ONS survey on adult psychiatric morbidity[201] indicates that 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed at some point in their life. Certain groups of young people are at more risk of self-harm or suicide, including lesbian, gay, bisexual, transgender and questioning young people[202], indicating that mental health specialists should work alongside those delivering services to this vulnerable group as well as the provision of training and consultation to those staff.

Self-harm is a predictor of suicide: 0.5% - 1% of those admitted to hospital for self-harm took their own life in the subsequent year. It is also strongly associated with depression, anxiety, psychosis and alcohol misuse. The Centre for Mental Health (2015)[203] on reviewing the evidence for interventions in self-harm found that the paucity of evidence meant that they could not recommend any specific treatment. However:

- Clinical consensus suggests that all children who self-harm should be assessed by a professional with specialist child mental health training.
- There is evidence that approaches focusing on prevention of further suicide attempts may not be effective in the presence of co-morbid depression.
- Brief intervention (problem solving) with families of adolescents following a suicide attempt can improve adolescents' feelings of depression and suicidality, enhance positive maternal attitudes towards treatment and reduce subsequent use of residential and foster care

[201] McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. Adult psychiatric morbidity in England, 2007. Results of a household survey.
[202] PHE/AYPH (2014) Improving young people's health and wellbeing
[203] Centre for Mental Health (2015) Investing in children's mental health.

6.2 Self-Reported Emotional Wellbeing and Mental Health

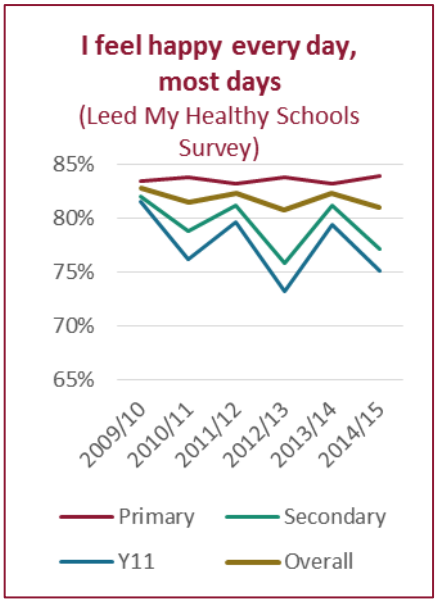
Local Leeds survey[204] found that 15 year olds were less likely to engage in or experience bullying than national average and were also less likely to report low life satisfaction. Overall, the 15 year olds from Leeds had a marginally higher 'Warwick-Edinburgh Mental Well-being Scale' (WEMWBS) mean score than England and its statistical neighbours within Yorkshire and Humber.

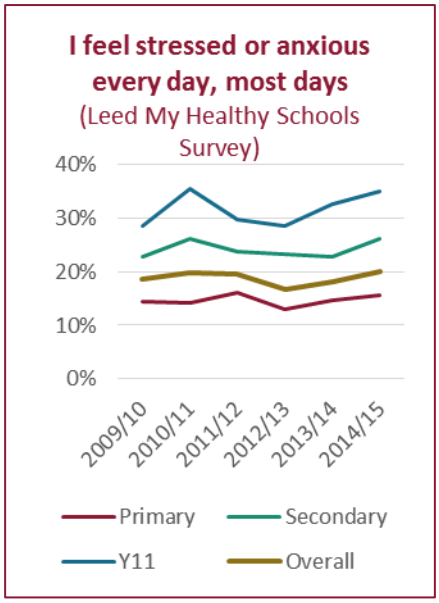
Public Health: Health behaviours in young people – What About YOUth? survey

Indicator	Period	England	Yorkshire and the Humber	Leeds	Statistical Neighbours: Calderdale	Kirklees	Sheffield
Percentage reporting general health as excellent	2014/15	29.5	28.8	25.9	29.2	28.0	28.7
Percentage who think they're the right size	2014/15	52.4	52.5	52.2	49.1	54.5	53.7
Mean score of the 14 WEMWBS statements	2014/15	47.6	47.7	47.9	47.6	47.7	47.4
Percentage reporting low life satisfaction	2014/15	13.7	13.1	12.9	14.2	12.9	14.7
Percentage who were bullied in the past couple of months	2014/15	55.0	55.2	54.3	55.7	55.3	50.4
Percentage who had bullied others in the past couple of months	2014/15	10.1	10.1	10.0	7.8	12.6	9.6

In addition, the Leeds 'My Health, My School Survey' has tracked pupils sense of emotional wellbeing from for years 5, 6, 7, 9 & 11 since 2009/10 and have shown that over the last 5 years there has been a fractional drop (2 percentage points) in the number of pupils overall who report 'feeling happy every day, most days' to 81%, and a 5 percentage point rise in the percentage of pupils who reported feeing stressed or anxious every day, most days to 20%. It is worth noting that number of pupils who reported 'feeling stressed or anxious every day, most days' increases significantly through the school brackets: 16% of Primary; 26% of Secondary & 35% of Year 11 pupils. The opposite is true for pupils who reported 'feeling happy every day, most days'.

[204] http://fingertips.phe.org.uk/profile/what-about-youth





Conclusions/ Observations

Overall the 15 year olds from Leeds had a marginally higher 'Warwick-Edinburgh Mental Well-being Scale' (WEMWBS) mean score than England and its statistical neighbours within Yorkshire and Humber.

6.3 National and Local Levels of Mental Disorders

Local levels of emotional, conduct and hyperkinetic disorders are associated with deprivation:

- emotional disorder: 2% for least deprived areas and 6% for most deprived areas
- conduct disorder: 3% for least deprived areas and 9% for most deprived areas
- hyperkinetic disorder (ADHD): 1% for least deprived areas and 3% for most deprived areas.

Since less common disorders (autism, tics, eating disorders and selective mutism) do not show such associations with deprivation, local numbers can be estimated by applying the national prevalence levels (1%) to local population size.

Local levels of self-harm can be estimated by applying national rates and taking into account numbers with emotional, conduct and ADH disorders.[205]

[205] JCPMH (2015) Guidance for commissioning public mental health services

6.3.1 Public Health England Children's and Young People's Mental Health and Wellbeing Portal

Public Health England have developed the 'Children's and Young People's Mental Health and Wellbeing Portal' to support an intelligence driven approach to understanding and meeting need. It collates and analyses a range of publically available data on risk, prevalence and detail (including cost data) on those services that support children with, or vulnerable to, mental illness.

The table below takes information extracted from that portal and applies it to the appropriate subset of the Leeds population (2014 mid-year estimates and 2020 projection) to estimate how many CYP from that particular age bracket fall into the given indicator.

Prevalence Data Calculations/ Source

The following estimated prevalence data included in the tables below is based on the prevalence from the ONS survey (2004)[206] adjusted for age, sex and socio-economic classification:

- Estimated prevalence of any mental health disorder: % population aged 5-16
- Estimated prevalence of emotional disorders: % population aged 5-16
- Estimated prevalence of conduct disorders: % population aged 5-16
- Estimated prevalence of hyperkinetic disorders: % population aged 5-16

The *'Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds'* is the estimated number of people aged 16-24 who score two or more (the clinical threshold for diagnosis of an eating disorder) on the SCOFF scale, based on applying the percentages for this age group given in the Adult Psychiatric Morbidity Survey (APMS) to the resident population aged 16-24. The percentages used were 6.1% for males and 20.3% for females. Scoring 2 or more on the SCOFF scale should prompt a more detailed investigation to be undertaken to diagnose if an eating disorder is present. (***NB**: **There are significant concerns regarding the quality of this data***).

The *'Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds'* is the estimated number of people aged 16-24 with attention deficit hyperactivity disorder (ADHD) based on applying the estimated prevalence percentage (13.8%) to the resident population aged 16-24. (There are significant concerns regarding the quality of this data).

The following estimated prevalence data is based on the numbers of children aged 17 years and under who may experience mental health problems appropriate to a response from CAMHS Tier 3 or CAMHS Tier 4 in the local authority[207] (There are significant concerns regarding the quality of this data).

- Estimate of the numbers of children who may require Tier 3 CAMHS
- Estimate of the numbers of children who may require Tier 4 CAMHS

NB: The 'Leeds Population Estimates' (below) assume no change in prevalence rates.

[206] Office for National Statistics (2004) The mental health of children and adolescents in Great Britain. London: Office for National Statistics

[207] Kurtz, Z. (1996) Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.

The data quality in the table below for England, Yorkshire and the Humber, and Leeds is described as 'Some Concern' (amber) or 'Significant Concern' (red)

Indicator	Period	Data Quality	England	Yorkshire and the Humber	Leeds	Leeds Population Estimates 2014	Leeds Population Estimates 2020
Estimated prevalence of any mental health disorder: % population aged 5-16	2014		9.3*	9.7*	9.5*	9,584	10,752
Estimated prevalence of emotional disorders: % population aged 5-16	2014		3.6*	3.7*	3.7*	3,733	4,188
Estimated prevalence of conduct disorders: % population aged 5-16	2014		5.6*	5.9*	5.8*	5,851	6,564
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2014		1.5*	1.6*	1.6*	1,614	1,811
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	2013		*	-	15604*	184,007	182,292
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	2013		*	-	16163*	16,274	16,122
Children who require Tier 3 CAMHS: estimated number of children <17	2012		-	-	2905	2,976	3,214
Children who require Tier 4 CAMHS: estimated number of children <17	2012		-	-	120	123	133
Child admissions for mental health: rate per 100,000 aged 0 -17 years	2014/15		87.4	69.3	49.2	790	846
Young people hospital admissions for self-harm: rate per 100,000 aged 10 - 24	2010/11 - 12/13		352.3	368.2	450.8	7,446	7,744

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Compared to the national picture, Leeds has 0.2 percentage point above the estimated prevalence of mental health disorders in 5-16 year olds (2014) but 0.1 percentage point below prevalence data from ONS 2004. In addition Leeds has a slightly higher prevalence for emotional disorders, conduct disorders and hyperkinetic disorders.

It also sees a much lower rate of CYP admitted for mental health issues compared to the national figure, but a much higher rate of hospital admissions for self-harm.

[208] PHE Public Health Profiles

6.3.2 Local levels of child and adolescent mental disorder

To determine the current and future mental health prevalence for Leeds, we take the detailed breakdown of the National Percentage Prevalence of Mental Disorders[209] for children and young people aged 5 – 16 years old (broken down by gender and age bracket (5-10 & 11-16) and the ONS Adult Psychiatric Morbidity in England[210] (broken down by gender and age bracket: 16 -24 years old)

Prevalence (ONS 2004 & 2007)	5 - 10 year olds		11 - 16 year olds		16 - 24 year olds	
	Male	Female	Male	Female	Male	Female
Emotional Disorders	**2.2**	**2.5**	**4**	**6.1**		
Anxiety Disorders	2.1	2.4	3.6	5.2		
Depression/ Depressive Episode	0.2	0.3	1	1.9	1.5	2.9
Mixed Anxiety and Depressive Disorder					8.2	12.3
Generalised Anxiety Disorder					1.9	5.3
All Phobias					0.3	2.7
Obsessive Compulsive Disorder					1.6	3
Panic Disorder					1.4	0.8
Conduct Disorders	**6.9**	**2.8**	**8.1**	**5.1**		
Hyperkinetic disorders	**2.7**	**0.4**	**2.4**	**0.4**		
Less Common Disorders	**2.2**	**0.4**	**1.6**	**1.1**		
Autistic Spectrum Disorders	1.9	0.1	1	0.5	1	0.5
Any Disorder/ Any Common Mental Disorder (CMD)	**10.2**	**5.1**	**12.6**	**10.3**	**13**	**22.2**

We apply these prevalence numbers against the mid-year population figures for Leeds 2014 and projections for Leeds 2020 (splitting the 16 year old population in half and applying one half to the 11 – 16 year old prevalence data and one half to the 16 -24 year old data to account for an overlap in population groups):

2014 Leeds Prevalence	5 - 10 year olds		11 - 16 year olds		16 - 24 year olds		All
	Male	Female	Male	Female	Male	Female	
2014 Leeds Population (by age)	**27,304**	**26,197**	**22,056**	**21,213**	**55,888**	**57,920**	**210,578**
Emotional Disorders	**601**	**655**	**882**	**1,294**			3,432
Anxiety Disorders	573	629	794	1,103			3,099
Depression/ Depressive Episode	55	79	221	403	838	1,680	3,275
Mixed Anxiety and Depressive Disorder					4,583	7,124	11,707
Generalised Anxiety Disorder					1,062	3,070	4,132
All Phobias					168	1,564	1,732
Obsessive Compulsive Disorder					894	1,738	2,632
Panic Disorder					782	463	1,246
Conduct Disorders	**1,884**	**734**	**1,787**	**1,082**			5,486
Hyperkinetic disorders	**737**	**105**	**529**	**85**			1,456
Less Common Disorders	**601**	**105**	**353**	**233**			1,292
Autistic Spectrum Disorders	519	26	221	106	559	290	1,720
Any Disorder/ Any Common Mental Disorder (CMD)	**2,785**	**1,336**	**2,779**	**2,185**	**7,265**	**12,858**	**29,209**

[209] IBID

[210] McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. Adult psychiatric morbidity in England, 2007. Results of a household survey.

2020 Leeds Prevalence	5 - 10 year olds		11 - 16 year olds		16 - 24 year olds		All
	Male	Female	Male	Female	Male	Female	
2014 Leeds Population (by age)	31,009	28,972	25,027	22,028	55,311	55,374	217,719
Emotional Disorders	**682**	**724**	**1,001**	**1,344**			3,751
Anxiety Disorders	651	695	901	1,145			3,393
Depression/ Depressive Episode	62	87	250	419	830	1,606	3,253
Mixed Anxiety and Depressive Disorder					4,535	6,811	11,346
Generalised Anxiety Disorder					1,051	2,935	3,986
All Phobias					166	1,495	1,661
Obsessive Compulsive Disorder					885	1,661	2,546
Panic Disorder					774	443	1,217
Conduct Disorders	**2,140**	**811**	**2,027**	**1,123**			6,101
Hyperkinetic disorders	**837**	**116**	**601**	**88**			1,642
Less Common Disorders	**682**	**116**	**400**	**242**			1,441
Autistic Spectrum Disorders	589	29	250	110	553	277	1,809
Any Disorder/ Any Common Mental Disorder (CMD)	**3,163**	**1,478**	**3,153**	**2,269**	**7,190**	**12,293**	**29,546**

We then compare the most recent prevalence estimates for Leeds with the original national prevalence estimates and adjust accordingly where possible:

- Estimated prevalence of any mental health disorder: % population aged 5-16
    - Leeds 2014: 9.5%
    - ONS 2004: 9.6%

      Equivalent to a 1.04% decrease on 2004 prevalence data

- Estimated prevalence of emotional disorders: % population aged 5-16
    - Leeds 2014: 3.7%
    - ONS 2004: 3.7%
    - Equivalent to 2004 prevalence data

- Estimated prevalence of conduct disorders: % population aged 5-16
    - Leeds 2014: 5.8%
    - ONS 2004: 5.8%
    - Equivalent to 2004 prevalence data

- Estimated prevalence of hyperkinetic disorders: % population aged 5-16
    - Leeds 2014: 1.6%
    - ONS 2004: 1.5%

      Equivalent to a 6.67% increase on 2004 prevalence data

As there is an overlap between the 2004 prevalence study into 5-16 year olds, and the 2007 prevalence study that includes 16-24 year olds, for local calculations the 16 year old population is split in half and one half assigned to each (5-16 & 16-24).

Prevalence (ONS 2004 & 2007) vs. Local Prevalence	Var.		Leeds 2014		Leeds 2020	2014 - 2020
			210,578		217,719	⇧ 7,141
Emotional Disorders			3,432		3,751	⇧ 319
Anxiety Disorders			3,099		3,393	⇧ 294
Depression/ Depressive Episode			3,275		3,253	⇩ -22
Mixed Anxiety and Depressive Disorder			11,707		11,346	⇩ -361
Generalised Anxiety Disorder			4,132		3,986	⇩ -146
All Phobias			1,732		1,661	⇩ -70
Obsessive Compulsive Disorder			2,632		2,546	⇩ -86
Panic Disorder			1,246		1,217	⇩ -28
Conduct Disorders			5,486		6,101	⇧ 615
Hyperkinetic disorders	6.67%	⇧ 97	1,553	⇧ 109	1,751	⇧ 198
Less Common Disorders			1,292		1,441	⇧ 149
Autistic Spectrum Disorders			1,720		1,809	⇧ 88
Any Disorder/ Any Common Mental Disorder (CMD)	-1.04%	⇩ -304	28,904	⇩ -308	29,238	⇧ 334

What is interesting, is that although the overall population of CYP in Leeds is not expected to grow significantly between 2014 (210,578) and 2020 (217,719), the change in profile (a reduction in the number of 16 -24 year olds and an increase in 0 – 16 year olds) drives increases in disorders affecting children and a reduction in those recorded for young people/ young adults.

Based on the simplistic view of changing population, the overall number of MH disorders affecting CYP in Leeds is predicted to increase by 334 from 2014 (28,904) to 2020 (29,238).

Conclusions/ Observations

Based on the detailed breakdown of the National Percentage Prevalence of Mental Disorders for children and young people aged 5 – 16 years old; the ONS Adult Psychiatric Morbidity in England; local variation reported in the Public Health profiles and the changing forecast population for Leeds:

- Overall disorders/ common mental health disorders in CYP in Leeds are going to increase by approximately 1.2% from ~28,900 to ~29,200 between 2014 and 2020

Although the overall population of CYP in Leeds is not expected to grow significantly between 2014 (210,578) and 2020 (217,719), the change in profile (a reduction in the number of 16 -24 year olds and an increase in 0 – 16 year olds) drives increases in disorders affecting children and a reduction in those typically recorded for young people/ young adults:

- There is forecast to be an increase in the number of Emotional Disorders; Anxiety Disorders; Conduct Disorders; Hyperkinetic Disorders; Less Common Disorders and Autistic Spectrum Disorders
- There is forecast to be a decrease in the number of Depression; Mixed Anxiety and Depressive Disorder; General Anxiety Disorder; Phobias; Obsessive Compulsive Disorders and Panic Disorders

6.3.3 Local levels of mental disorder (including higher risk groups)

Levels of mental disorder also need to be estimated in higher risk groups by applying the local numbers from such groups (see earlier) to the level of increased risk they experience.

The JCPMH Guidance[211] contains a table of expected prevalence of mental disorders for children and young people from higher risk groups. The following applies these percentages against the relevant higher-risk subset of the Leeds CYP population to determine the projected number of CYP experiencing a mental health disorder.

PROPORTION OF LEEDS CHILDREN AND ADOLESCENTS FROM HIGHER RISK GROUPS AFFECTED BY MENTAL DISORDER

Higher Risk Group	%age of Leeds pop	Leeds Pop 0-24 yo		Expected prevalence of mental disorders	Leeds MH Disorders	
		2014	2020		2014	2020
		261,522	272,674			
Looked after children	0.81%	2,128	2,219	45%	958	998
Children with special educational need requiring statutory assessment	1.80%	4,707	4,908	44%	2,071	2,160
Children with learning disability	3.78%	9,886	10,307	36%	3,559	3,711
Children absent from school more than 15 days in previous term	4.30%	11,245	11,725	17% (emotional disorder)	1,912	1,993
	4.30%	11,245	11,725	14% (conduct disorder)	1,574	1,641
	4.30%	11,245	11,725	11% (hyperkinetic disorder)	1,237	1,290
Children with a parent with mental illness (conduct disorder)	1.15%	3,008	3,136	51% (emotional disorder)	1,534	1,599
	1.15%	3,008	3,136	18% (severe emotional disorder)	541	564
Children with a parent with mental illness (emotional disorder)	16.20%	42,367	44,173	48% (emotional disorder)	20,336	21,203
Children from households with no working parent	4.40%	11,507	11,998	20%	2,301	2,400
Children from families receiving disability benefits	4.21%	11,010	11,480	24%	2,642	2,755
Children from household reference person in routine occupational group				15%		
Children of parents with no educational qualifications	5.56%	14,550	15,170	17%	2,473	2,579
Children living in 'hard pressed' areas	24.60%	64,334	67,078	15%	9,650	10,062
Children from weekly household income <£100	20.40%	53,350	55,625	16%	8,536	8,900
11-16 year olds from weekly household income <£200	21.30%	55,704	58,080	20%	11,141	11,616
Children in stepfamilies	2.00%	5,230	5,453	14%	732	763
Children from lone parent families	10.90%	28,506	29,721	16%	4,561	4,755

Total Numbers (projected) of CYP from Higher Risk Groups affected by Mental Disorders in Leeds	2014	2020
Emotional Disorder	**23,782**	**24,796**
Conduct disorder	**1,574**	**1,641**
Hyperkinetic disorder	**1,237**	**1,290**
Severe Emotional Disorder	**541**	**564**
All MH Disorders	**75,759**	**78,990**

Please note, these are individual calculations and do not take into account the fact that many CYP will sit within multiple higher-risk groups listed (e.g. households with no working parents; CYP living in

[211] JCPMH (2015) Guidance for commissioners of child and adolescent mental health services

hard pressed areas; children from households with weekly income <£100; children from households with weekly income <£200; & children from lone parent families):

- The number of children with a parent with a conduct disorder is calculated by looking at the percentage of adults between 18 – 54 that have either Anti-social Personality Disorder (ASPD) or Borderline Personality Disorder (BPD) as reported in the ONS Adult psychiatric morbidity in England (2007): 1.15%
- The number of children with a parent with an emotional disorder is calculated by looking at the percentage of adults between that have a Common Mental Disorder (CMD) as reported in the ONS Adult psychiatric morbidity in England (2007): 16.2%
- We were unable to gain any Leeds specific data or otherwise on the proportion of CYP from household reference person in 'routine occupational group'.
- Children from weekly household income <£100 is calculated from 'Children under 20 in poverty: % of all dependent children under 20'
- 11-16 year olds from weekly household income <£200 is calculated from 'Percentage of children in low income groups'

The actual volume of projected cases of mental disorders for these higher-risk groups is significantly in excess of the overall levelled numbers calculated on a normalised local prevalence and should be used primarily to indicate where hard to reach CYP may be experiencing MH issues and where additional support may be required.

Conclusions/ Observations

Based on expected prevalence of mental disorders for children and young people from higher risk groups applied to the Leeds CYP 2020 population:

- 21,000 CYP with a parent with a mental illness are predicted to have an emotional disorder
- 11,600 11 – 16 year olds from a households with an income less than £200 are predicted to have a mental health disorder
- 5,500 children from step or single families are predicted to have a mental health issue
- 3,700 CYP with a Learning Disability are predicted to have a mental health disorder
- 1,000 Children Looked After will have a mental health disorder

Whilst there is significant overlap between the individual High Risk Group measures in the table above, it is clear that parental mental health and household income will continue to be significant contributing risk factors to CYP mental health in Leeds

7. Local Strategies

7.1 Whole system review 2015

In September 2014, Leeds Integrated Commissioning Executive endorsed the need for a 6 month rapid whole system review of children and young people (CYP) emotional wellbeing and mental health (EMH) services in Leeds[212]. That review reported back in March 2015 with the following key recommendations:

1. The development of a Primary Prevention public health programme supported by each Children's Centre and school having an EMH champion/contact who has undertaken additional training
2. A clear local offer developed for CYP as primary audience but will have value as a reference for parents and local professionals
3. Development of the MindMate website and of the digital solutions to promote the local offer, promote self-care/resilience and delivery as part of intervention
4. A Single Point of Access (SPA) for referrals into the whole system with proactive communication and support whilst waiting to CYP/Parents
5. Specialist CAMHS – redesigned to have a named professional aligned to each school cluster and embedded within targeted services (for vulnerable groups) – to provide expertise, consultation, supervision and co-working where appropriate
6. To focus on ensuring vulnerable children and young people receive the support and services they need
7. To focus attention on strengthening transition arrangements
8. CYP IAPT principles to inform the quality framework for all commissioning
9. Whole system commissioning framework with clear roles and responsibilities for all partners: Increased development of co-commissioning arrangements between clusters and partners and between NHSE and CCGs
10. Develop and agree a single identifier for children and young people across all the city's services to enable the integration of data
11. HNA refreshed once new national prevalence survey published (2016/17)

As part of that review the team acknowledged that 'The need in the city is more than is commissioned and provided for (recognised national and local position). Challenging financial pressures in Local Authority poses risk to services that contribute to emotional wellbeing and mental health (e.g. targeted youth work).' (p.1)

[212] Mischenko,J, Bollom, P (2015) Whole system review of CYP emotional wellbeing and mental health services in Leeds. Leeds:ICE

7.2 The Leeds Local Transformation Plan priorities

The findings and recommendations made in the whole system review were assessed and incorporated within the 'Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing 2015/19'.

The Local Transformation Plan is a five-year strategic plan to deliver whole system change to children and young people's emotional and mental health support and service provision in the city. The plan incorporates priorities from primary prevention through to specialist provision and focuses on improving both children and young people's experience and outcomes.

1. Develop a Primary Prevention Programme for Children and Young People's Emotional and Mental Health
2. Develop and Communicate a Clear Local Offer of Children and Young People's Emotional and Mental Health Support/Services
3. The Development of the MindMate website and further Digital Solutions
4. A Single Point of Access (SPA) is in place for Children and Young People Emotional and Mental Health Services
5. Local Delivery of Early Emotional Help Services
6. Redesign Specialist CAMHS to align with Local and Whole System Model
7. Develop an Evidence Based Community Eating Disorder Service for Children and Young People (CEDS-CYP)
8. Ensure Vulnerable Children and Young People receive the Support and Services needed
9. Strengthen Transition
10. Develop a Shared Quality Framework across the Partnership
11. Crisis Care for Children and Young People
12. Co-commissioning with NHS England

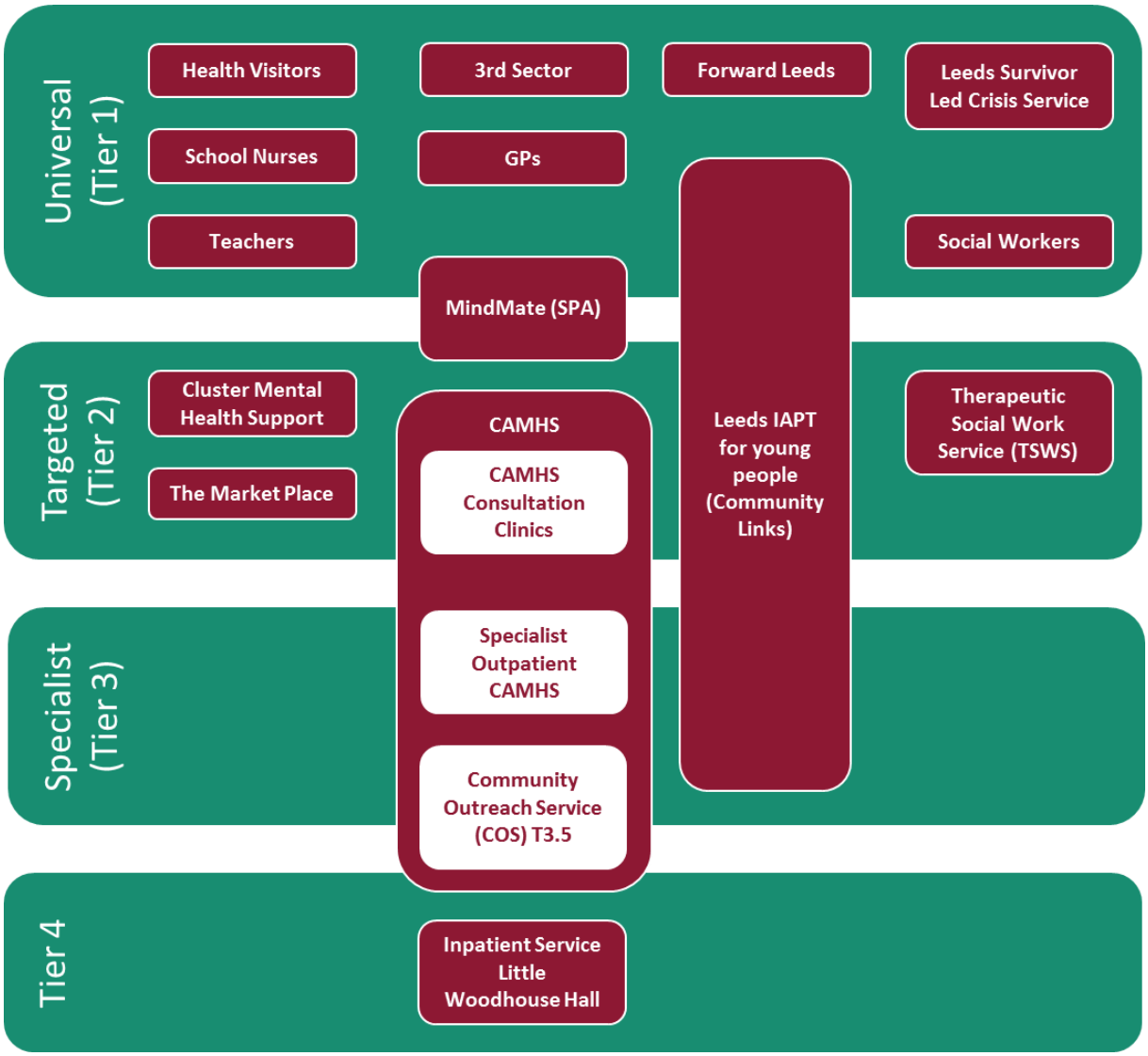
8. Service Provision

8.1 Overview

The definitions of the tiers are taken from JCPMH Guidance.[213]

The Leeds Picture (from *CYP Report Healthwatch Young Minds)*

The main services in Leeds where children and young people can get support with their mental health are: CAMHS, Leeds Improving Access to Psychological Therapies (IAPT) for young people, Cluster Mental Health Support, The Market Place, and Aspire. There are also a range of universal services and third sector organisations that support young people with their emotional health.



[213] JCPMH (2015) Guidance for commissioners of child and adolescent mental health services

Leeds CAMHS service describes itself as a specialist Tier 3 and 4 service provided by Leeds Community Healthcare NHS Trust. CAMHS provides assessment and therapeutic treatments to children and young people with mental health problems (e.g. anxiety, depression, self-harm and eating disorders) and neurodevelopmental conditions. They offer a citywide service from a number of locality based multi-disciplinary teams. Clinics are held in over 30 different locations across the city. There is also an inpatient unit (Little Woodhouse Hall) which is a regional unit.

The Therapeutic Social Work Team is funded and delivered by Leeds City Council. It provides therapeutic support to children and young people who are looked after.

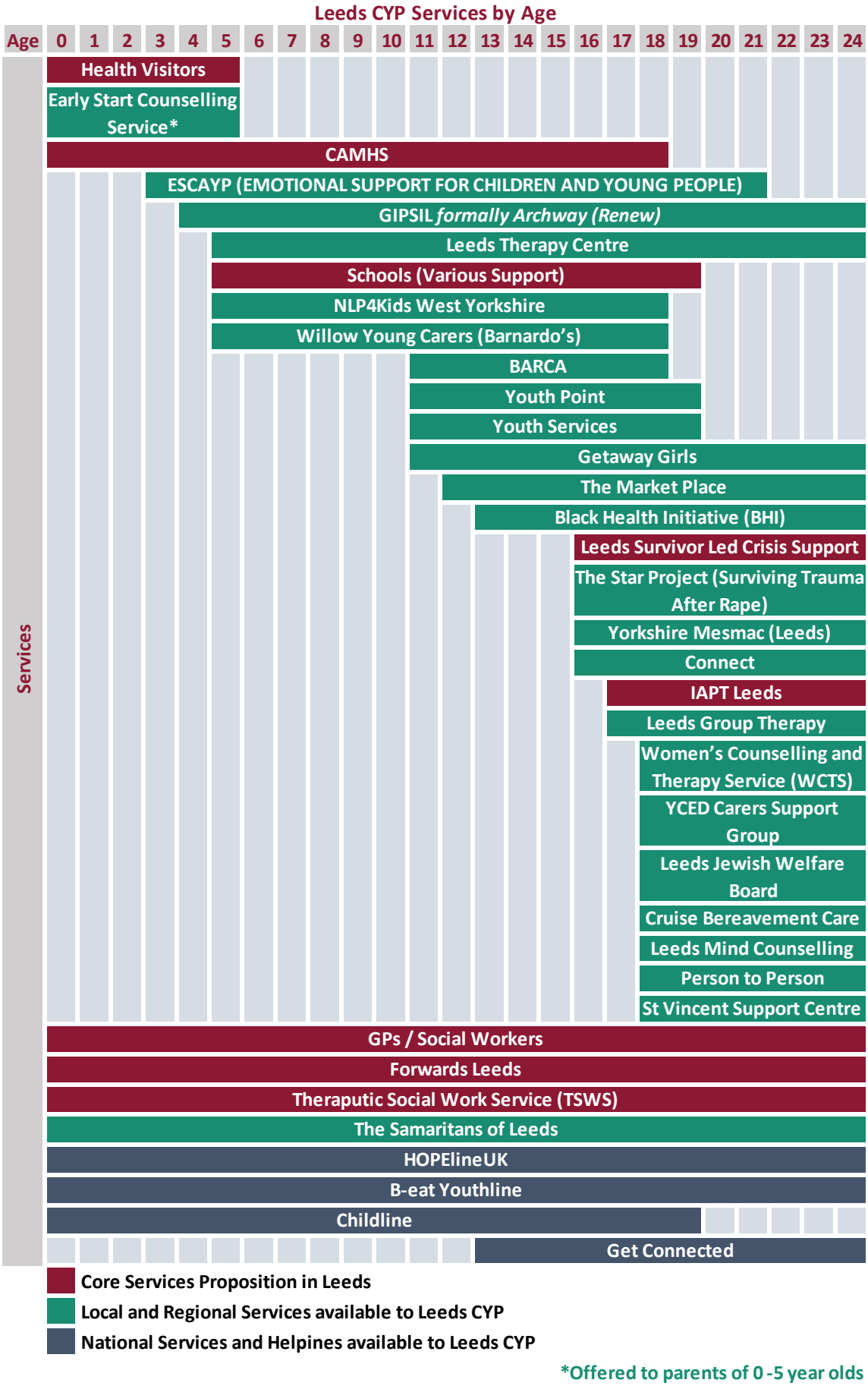
Cluster Mental Health Support (previously known as TaMHS) is a citywide service that provides early intervention and short term specialist mental health support. It is funded in the main by school clusters with a contribution from the CCGs and is available in all 26 local clusters in the city.

The Market Place is a city centre based third sector organisation commissioned by the CCGs to provide 1:1 support, counselling, open access through a drop-in facility and self-harm support groups.

Aspire is a citywide Early Intervention in Psychosis Service provided by Community Links. It provides intensive support for people experiencing early signs of psychosis. Psychiatric support for young people under 18 in this service is provided by CAMHS. It is commissioned by the CCGs.

Improving Access to Psychological Therapies (IAPT) for young people is a service provided by Community Links for 17-21 year olds with the aim of making talking therapies more widely available to anyone who needs them. It is commissioned by Leeds North CCG on behalf of the three CCGs in Leeds.

Leeds City Council and the CCGs are currently reviewing the whole system of emotional and mental health in the city and are proposing to redesign in order to produce a coordinated system of children's emotional and mental health services in Leeds. This includes all the services commissioned and provided by the CCGs and Leeds City Council and working with educational clusters.


Leeds CYP Services by Age
Age
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
Services
Health Visitors
Early Start Counselling Service*
CAMHS
ESCAYP (EMOTIONAL SUPPORT FOR CHILDREN AND YOUNG PEOPLE)
GIPSIL formally Archway (Renew)
Leeds Therapy Centre
Schools (Various Support)
NLP4Kids West Yorkshire
Willow Young Carers (Barnardo's)
BARCA
Youth Point
Youth Services
Getaway Girls
The Market Place
Black Health Initiative (BHI)
Leeds Survivor Led Crisis Support
The Star Project (Surviving Trauma After Rape)
Yorkshire Mesmac (Leeds)
Connect
IAPT Leeds
Leeds Group Therapy
Women's Counselling and Therapy Service (WCTS)
YCED Carers Support Group
Leeds Jewish Welfare Board
Cruise Bereavement Care
Leeds Mind Counselling
Person to Person
St Vincent Support Centre
GPs / Social Workers
Forwards Leeds
Theraputic Social Work Service (TSWS)
The Samaritans of Leeds
HOPElineUK
B-eat Youthline
Childline
Get Connected
Core Services Proposition in Leeds
Local and Regional Services available to Leeds CYP
National Services and Helpines available to Leeds CYP
*Offered to parents of 0 -5 year olds

In addition to the above; Relate Leeds, West Indian Family Counselling and Solace offer services in Leeds that appear to include services for children and young people, although what ages specifically are supported has not been ascertained.

8.2 Universal Services (Tier 1)

Tier 1 or universal services primarily focus on prevention, promotion and resilience building. These are services whose primary remit is not that of providing a mental health service, but as part of their duties they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services include GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies.

It is worth noting that there are often overlaps between tier 1 and tier 2 services, and different views of which tier services should be in. For the purpose of this report, services are mapped as 'tier 1' if they are non-mental-health services.

8.2.1 Health Visitors

Health Visitors deliver the **Healthy Child Programme** 0-5 years, in partnership with other health and social care colleagues. [214]They offer support, guidance and programmes of health promotion to all families from pregnancy and birth to primary school and beyond.

Health Visitors offer support and interventions on a range of issues impacting on early parenting including breast-feeding, post-natal depression in mothers. They work in partnership with parents on assessing parenting skills, the family and home situation and the development needs of young children. Standardised points of intervention are nationally prescribed. [215]

Leeds Health Visitors and local Children Centre services are a combined Early Start Service, working together to deliver integrated, evidence-based services focussing on prevention, promotion and early intervention

The Health Visiting Team aims to provide:

- Antenatal Visits
- Infant Mental Health Services
- Birth Visits
- 6 – 8 Week Screening
- Physical and Developmental Checks
- Individual Level of Care

[214] NHS England (2013) Securing Excellent in Commissioning for Health Child Programme 0-5 years 2013-2015.
[215] NHSE (2016) Health Visiting Programme. Accessed in August, 2016 [https://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/]

Health Visitors in Leeds work closely with other health colleagues such as Midwives, GPs, hospitals and specialist support centres. Access to drop in clinics and groups that are running across the city is open to all families and most of them within children's or health centres where other services can also be obtained.

8.2.2 Children's centres

There are 75 Children's Centres in Leeds: 20 (North); 21 (East); 16 (South); 18 (west).

8.2.3 GPs

The NHS website lists 780 GP practices and medical centres in Leeds.

In Future in Mind (FiM)[216], young people emphasised the difficulties many of them had faced in discussing their problems with their GP. Many GPs across the country have improved accessibility to young people by using the 'You're Welcome' standards and self-audit, even though they are not primary care specific. FiM suggested that the use of You're Welcome should be encouraged amongst GP practices in order for young people to access a less stigmatising environment than a mental health clinic to discuss their mental health concerns.

FiM also suggests that GPs should be enabled, through commissioning approaches, to offer social prescribing, where activities such as sport are used as a way to improve wellbeing. FiM proposes that there should be a dedicated, named contact in targeted or specialist mental health services for each GP practice, who would provide timely advice on the management or referral of cases, including consultation, co-working or liaison.

8.2.4 Schools

The important and valuable role that teachers, teaching assistants, Parent Support Advisors (PSAs), learning mentors and school nurses etc. have in promotion and prevention of mental health cannot be overstated. There are 224 Primary Schools and 41 secondary schools listed on the Leeds City Council Website.

Services available in Leeds:

- National Healthy School
- PSHE
- Cluster Mental Health Support
- Voluntary groups

School Nurses: School nurses are specialist public health nurses who deliver public health interventions to school-aged children and young people, and provide the **Healthy Child Programme** (5-19 years). This programme offers school aged children a schedule of health and development

[216] DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

reviews, screening tests, immunisations and health promotion, as well as tailored support for children and families, and expects that every child is offered a health review which includes attention to their mental and emotional wellbeing.

Personal, Social and Health Education (PSHE)

Leeds operates a Healthy Schools programme, with an Ofsted-ready version of National Healthy Schools Status (previously Whole School Review/Annual Review). Schools review their provision for health and wellbeing across 4 areas: PSHE, Healthy Eating, Physical Activity and EWMH. Includes a section on staff wellbeing. Schools can self-validate and receive a certificate on a 3 year cycle, although an external assessment visit and feedback report (on a three year cycle) is also available.[217]

Healthy Schools can help children lead a healthy lifestyle directly – emotional health and well-being is one of the elements of the healthy schools programme. There is guidance for schools on developing emotional health and well-being, although this was published in 2007 [218].

By July 2016 74% of Leeds schools were signed up to this programme (197 schools), up from 186 schools in July 2015.

8.2.5 The Youth Service

The Youth Service is a key part in Leeds City Council's 'youth promise' to ensure that all young people have: something to do; someone to talk to; somewhere to go to; something to say. The Youth Service provision currently operate across 3 locality areas (wedges) covering East North East, South South East and West North West. The number of local centres to provide youth services from has reduced greatly over recent years, although the Youth Service were unable to provide an up-to-date number of centres. The Youth Service primarily offers services to young people aged 11 – 19.

8.2.6 Forward Leeds

Forward Leeds is a confidential service open 5 days a week (9am until 5pm) which helps adults, young people and families whose lives are affected by alcohol or drug problems. Forward Leeds supports young people who are struggling with drugs or alcohol in Leeds, delivering tailored interventions for young people that are relevant and developed according to age and maturity.

The service is managed by: DISC; Barca Leeds; St Anne's Community Service; St Martin's Healthcare Service; and Leeds & York Foundation Trust[219]

8.2.7 Leeds Survivor Led Crisis Support

Leeds Survivor Led Crisis Service provides emotional support to people in crisis aged 16+.

The service provide a number of different strands of support:

[217] www.healthyschools.org.uk
[218] The Department for Children, Schools and Families (2007) Guidance for Schools on Developing Emotional Health and Well-Being
[219] www.forwardleeds.co.uk

Leeds Suicide Bereavement Service (LSBS) was set up as a result of a partnership between Leeds Mind and Leeds Survivor Led Crisis Service, (LSLCS) with support from Leeds Bereavement Forum (LBF). Leeds City Council has provided funding for the project, which is initially to run as a pilot for three years. The previous Coalition Government's Suicide Prevention Strategy recognised that people bereaved by suicide are a target group for support, as being bereaved by suicide makes a person much more at risk of suffering negative health outcomes and ending their own life. This service offer support groups and individual support.

Dial House is an out-of-hours service for people in crisis. They state they have an open attitude to 'crisis', seeing it as something that could be related to a person's mental health problems being particularly bad, or a 'life crisis' such as relationship breakdown, losing a job etc. Some people visit Dial House once or only a few times, until their crisis has passed. Others use the service in a more long-term way, for out-of-hours support with serious mental health problems or because their lives are very difficult.

The service is open 6pm to 2am, Friday to Monday (including Christmas and Bank Holidays), and offer one-to-one support sessions, or simply a space to socialise with staff and other visitors, have something to eat, a shower etc.

Dial House has space to support up to eight visitors per night.

Dial House @ Touchstone is a partnership between Leeds Survivor Led Crisis Service (LSLCS) and Touchstone. It brings together LSLCS's expertise in providing crisis services and Touchstone's in supporting people from BME groups.

The service provides out-of-hours crisis services to people from BME groups in acute mental health crisis. The service is staffed by a Manager, Senior Crisis Support Worker and three Crisis Support Workers who are all from BME groups.

The service is a place of sanctuary, emotional support and information. Staff at Dial House @ Touchstone also work at Dial House in Halton. The aim is to provide a culturally specific service at Dial House @ Touchstone, but also to provide a bridge to Dial House and make the latter more accessible to members of BME groups.

Dial House @ Touchstone has received £500k in Lottery funding for five years. The project opened to new visitors on 1st October 2013 at the Touchstone Support Centre in Harehills and is open every Tuesday and Thursday evenings from 6pm to 11pm.

The Connect Helpline (16+ yo) is a telephone helpline open 6pm-2am every night of the year for people living in Leeds. The service provides emotional support and information for people in distress. People can ring who are in crisis, anxious, depressed or lonely. Provided by Leeds Survivor Led Crisis Service. Connect supports people in crisis, as well as providing a preventative service, by supporting people before they reach crisis point. Connect also receives funding to provide emotional support to people who are carers.

- They receive around 5000 calls a year.

Group Work: In addition to the above, the Leeds Survivor Led Crisis Service provides the following group work:

- Horse Sanctuary Group (free equine-assisted therapy sessions which help people with building confidence and self-esteem)
- LGBT Group
- Trans Group
- My Time Thursday Group (learn or improve skills needed for socialising and building positive relationships with people)
- Coping with Crisis Group
- Hearing Voices Group (This group is facilitated by people with lived experience of hearing voices and seeing things that others do not see)
- Creativity Group (This group is a space for people who want to explore creativity as a coping skill)

8.2.8 The Voluntary Sector

There are many organisations providing emotional support and therapeutic interventions to children and young people across Leeds. Those listed below have been identified via The MindMate Website, The Youth Wellbeing Directory, and the Leeds specific Volsec (Voluntary Sector) Counselling Leaflet 2013:

WCTS: Women's Counselling and Therapy Service (WCTS) (18 – 100 yo) A low-cost accessible counselling and psychotherapy service for Leeds women on low incomes.

Yorkshire MESMAC (Leeds) (16-99yo): Yorkshire MESMAC provides community based social wellbeing, sexual and mental health services across West Yorkshire. Yorkshire MESMAC is part of a group of services, which includes: Free, fast and confidential HIV testing, condoms, signposting and sexual health information services open to all genders and sexualities above 16 years of age, although they specialise in gay, bisexual and men who have sex with men. Services include: Counselling/Therapy; Drop-in; Information; Signposting; Support (e.g. informal help); and Training. Key services available include:

Free and flexible counselling service which is open to anyone who identifies as part of the LGBTQ community or is questioning their sexuality between the ages of 16-25.

The BLAST project that works with young men and boys involved in or at risk of becoming involved in sexual exploitation in Leeds and Bradford.

The Samaritans of Leeds: (any age) Samaritans provide confidential, non-judgemental support 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide. The Samaritans offer a 24 hour telephone line and 9am – 9pm drop in centre in Leeds (LS2).

Early Start Counselling Service (Northpoint Wellbeing Ltd) (0 – 5 yo): Counselling available to anyone in the Leeds area who has caring responsibility for a child under 5, or who is pregnant or whose partner is pregnant. Sessions are held within various children's centres, and the service describes itself as independent, confidential, and professional. The service is free and for parents or carers of children aged 5 or under in Leeds

- 78% of clients using the service experienced either improvement or recovery in their emotional health following their counselling
- 93% reported that using the service helped improve their family relationships.

Leeds Group Therapy (Northpoint Wellbeing Ltd) (17 yo+): Leeds Group Therapy is a service run by Northpoint Wellbeing, a registered charity. They support people with emotional disturbance or unhappiness or seeking help with a variety of issues, including relationship difficulties, difficult feelings or bereavement.

Leeds Therapy Centre (Northpoint Wellbeing Ltd) (Various): Northpoint Wellbeing acts as a gateway for clients who want to access private therapy services. They host a number of therapists who see clients in private practice at their Leeds Therapy Centre at Leeds Bridge House. These therapists work independently of Northpoint Wellbeing and offer a range of therapeutic modalities.

YCED Carers Support Group (Northpoint Wellbeing Ltd): (18 yo+) Based at the Yorkshire Centre for Eating Disorders (YCED) in Seacroft Hospital, Leeds. The YCED Carers Support Group aims to support people who care for anyone over 18 who is living with an eating disorder. They provide monthly support meetings for carers where people can meet up and share experiences and provide mutual support to help other carers support their loved one through recovery. The group is supported by Northpoint Wellbeing, a local charity, and the YCED, part of Leeds Partnerships NHS Foundation Trust.

Willow Young Carers (Barnardo's) (5 – 18 yo) Willow is a support service for children and young people who care for a family member affected by a physical or mental health illness, disability or substance misuse problem living in Leeds. They provide one-to-one and group support for young people, as well as working in the community, schools and youth projects providing information, signposting and support.

Youth Point (11 – 19 yo): Offer support to young people through one to ones or group sessions.

GIPSIL *formally Archway (Renew)* (4-26 yo) are a Youth information, advice and counselling service based in the Harehills area of Leeds. They offer a housing support service, advice drop-in, counselling and personal development activities, including sports, arts, cooking and other courses and programmes. They also deliver 1-1 and group health and wellbeing work, mediation and counselling in primary and secondary schools in Leeds*

*Currently going through transitional stage as service was incorporated within GILSIP portfolio in April 2016 and no formal listing of service proposition is currently available

Getaway Girls (11 – 25 yo): Enables vulnerable young women from Leeds to build confidence, develop new skills and take positive risks in an environment which offers co-operation and support.

BARCA Leeds (11 – 19 yo): BARCA-Leeds is a multi-purpose charity supporting children and young people across Leeds through a range of projects aimed at improving their health and well-being, reducing the likelihood of them entering the looked after system, improving their school attendance and attainment and reducing the numbers of NEET young people in Leeds. As well as this, they run a number of youth clubs and sporting clubs across West Leeds, and also have a counselling service.

Leeds Jewish Welfare Board (18+ yo): Leeds Jewish Welfare Board provides a comprehensive range of high quality, professionally delivered, culturally sensitive, social, residential and community care

services, primarily to the Jewish Community. Offering signposting, support (e.g. informal help), training, one to one support, and groups for young people and families.

Aspire, Community Links: We are the Leeds Early Intervention in Psychosis (EIP) Service. They work with young people who are experiencing early signs of psychosis, specifically a first episode of psychosis. They link with employment specialists and have run a pilot project with nutritional assessments for their users, and have access to health and wellbeing workers to focus on their physical health.

NLP4Kids West Yorkshire (5 – 18 yo): 1 to 1 support and small group work for children, teens, parent/carers, teachers. They provide work on self-esteem, anxiety, behaviour issues, bullying, concentration, stress, communication skills, confidence building, motivation, fears and phobias, stress management, relationship building, exam stress, learning strategies, coaching.

ESCAYP (EMOTIONAL SUPPORT FOR CHILDREN AND YOUNG PEOPLE) (3 -21 yo) Counselling & Therapeutic Play for children and young people, offering a supportive empathic environment in which to explore their issues. ESCAYP state they will work with all issues including: sexual/physical abuse, bereavement, bullying, disruptive/difficult behaviours, low self-esteem/ confidence, cyber trauma and self-harm etc.

The Star Project (Surviving Trauma After Rape) (16+ yo): Confidential helpline (Monday to Friday from 9am to 5pm) offering support and signposting to anyone who has been raped or sexually assaulted in West Yorkshire. The Star Project can also offer face to face emotional and practical support to victims of sexual violence.

Black Health Initiative (BHI) (13+ yo)

For African, African Caribbean and Dual Heritage communities. Free to young people and sliding scale for adult and family counselling. Number of sessions: reviewed after 8 sessions. Areas of special expertise: individual, group and family therapy.

Cruse Bereavement Care (18+ yo)

National Helpline: People who have been bereaved can speak immediately to a Bereavement Volunteer, and the Leeds office can arrange a series of 1:1 support, face-to-face, on the telephone or in a group

Leeds Mind Counselling (18+ yo)

For people seeking support with a variety of issues and mental health difficulties. Short, medium or longer term counselling

Person to Person (18+ yo)

A drop in listening service for anyone who is worried, anxious or distressed and wishes to speak to someone in confidence

St Vincent's Support Centre (18+ yo)

Low cost, negotiable rates. Number of sessions: short and long term. Therapeutic approach: person centred, integrative.

Relate Leeds

For individuals, couples, families, same sex couples, young people

West Indian Family Counselling

For individuals and families who live in Chapeltown and Harehills.

Solace

Solace offers psychotherapy for asylum seekers and refugees, from two full-time therapists, three part-time therapists and 18 volunteer therapists. They have interpretation services in the therapeutic sessions. Solace helped over 200 people in 2015, providing over 3000 hours of therapy[220]. They also offer training to other services, alongside mentoring, supervision and consultancy to other mental health professionals that offer support to survivors of torture. Other services include advocacy and practical help.

8.2.9 MindMate

MindMate is a Leeds-based website, for young people, their families and the professionals who support them. It is aimed at helping the user to explore emotional wellbeing and mental health issues and offer information about where support is available.

The website was created in consultation with young people, parents, carers and professionals including the three NHS Clinical Commissioning Groups in Leeds and other key partners such as Leeds City Council, Leeds Community Healthcare NHS Trust, GPs, Common Room, YoungMinds, The Market Place and other third sector organisations.

Content includes sections for young people, parents and carers and professionals.

The section entitled 'I'm a young person' contains information on coping with common issues; top tips on feeling good; and useful tips and information on where to go for help, support and advice in Leeds whether you are 16 and under or a young adult (16 -25).

The website also includes mental health related games, including 'Find your MindMate' that help children and young people identify their own support network.

Website also contains advice on how to help, where to get help, links and resources for both parents and carers and professionals.

Local Support Signposted by MindMate: The Market Place; Child and Adolescent Mental Health Service (CAMHS); Forward Leeds; Leeds Survivor Led Crisis Service; Care leavers support; Leeds's Therapeutic Social Work team and Youth Wellbeing Directory

National Helplines Signposted by MindMate:

MindMate offers signposting (with telephone numbers and websites) to the following helplines and other services:

- **ChildLine (19 yo or younger)** is a free, private and confidential service for children and young people up to the age of 19. You can contact a ChildLine counsellor about anything - no problem is too big or too small
- **Samaritans** (see Samaritans Leeds)

[220] http://www.solace-uk.org.uk/about-us/what-we-do [accessed 24/1//16]

- **HOPELineUK (under 35 yo)** is a confidential support and advice service for Young people under the age of 35 who may be having thoughts of suicide or for anyone concerned a young person may be having thoughts of suicide
- **Get Connected (13 – 25 yo)** has a free, confidential helpline where young people can talk about their problems and get help.
- **B-eat Youthline (under 25 yo)** offer help if you're affected by eating disorders or other difficulties with food, weight and body image.
- **The Learning Disability Helpline (Mencap):** can give you information and advice about learning disabilities.

8.3 Single Point of Access (SPA)

The Single Point of Access grew out of the review of Emotional Wellbeing and Mental Health services for Children and Young People which identified that although there are a range of effective services in Leeds, referrers and families often find it difficult to get timely support from the right service.

The Leeds SPA is designed to provide one place to access the full range of services as well as seeking out essential information in order to get the right support more rapidly for families.

The Leeds Single Point of Access (SPA) is for professionals to refer into, when they are working with children and young people and identify that they have a need for an emotional wellbeing and mental health service. It is for all children and young people up to the age of 18 who have a Leeds GP.

The SPA aims to provide one place to access the full range of services available in Leeds, including self-help advice, school cluster support, the Therapeutic Social Work Service, The Market Place, and CAMHS.

A professional can refer by telephone or by completing and emailing a referral form, after they have made a professional judgement that all appropriate interventions at the universal services level have been attempted. The only exception is schools, which are continuing to refer to their cluster support and guidance panel.

Referrals requiring an Urgent CAMHS assessment are also made through the SPA.

In the initial phase, the SPA is for professionals only. However, they advise that if a child / young person contacts the SPA directly the team will endeavour to find appropriate support for them.

8.4 Tier 2 Services

Tier 2 services are services delivered to particular groups of children at risk of experiencing mental health problems, for example Children Looked After (LAC) or children with learning disabilities. There is also some limited evidence to suggest that working with the child and parent on specific risk factors for depression, such as bereavement, may make a difference to some outcomes, including depression and internalising symptoms. These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies. Arrangements vary across the country and according to the nature of the service.

They are often delivered by mental health professionals working singularly rather than as part of a multi-disciplinary team; and, school counsellors and voluntary sector youth counselling services.

Tier 2 services are most likely to be in involved in the provision of early intervention. Early intervention[221] seeks to avoid young people falling into crisis and reduces the need for expensive and longer term interventions. One of APYH's ten reasons to invest in young people's mental health[222] is that mental health issues are often diagnosed at this age, and half of all psychiatric disorders start by age 14, three quarters by age 24. It is estimated that 60-70% of children and young people who experience clinically significant difficulties have not received appropriate interventions at a sufficiently early age.

The tier 2 services in Leeds are:

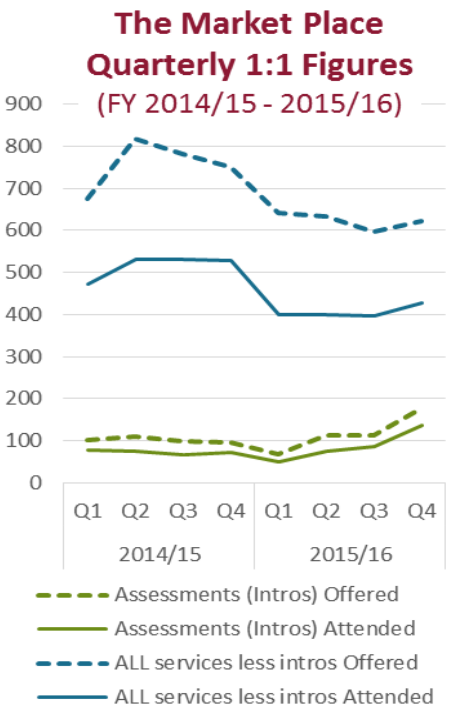
[221] DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

[222] AYPH (2015) Ten Reasons to invest in young people's mental health [http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/08/Ten-reasons-to-invest-in-young-peoples-health.pdf

8.4.1 The Market Place

Long Term Counselling and Psychotherapy

The Market Place project for young people has been established in Leeds since 1989, and states it is one of very few organisations able to offer young people long-term counselling and psychotherapy. The team is made up of 4.1 FTE of paid practitioners/clinical staff in addition to a team of volunteers.



Short-term and Crisis Counselling

There is a new service known as Short-term and Crisis Counselling which offers fast access into the service for crisis work and for clients wanting only short term support. Some young people receive just four weeks of counselling, while others have had their 4 week support extended to 8 weeks. Others have finished 4 weeks short term support and move onto the general counselling waiting list for longer-term counselling.

Bereavement Service

The Market Place offers a range of creative ways in which a young person can explore their thoughts and feelings around their bereavement or loss.

In addition to the services above, there is also a service for children who are looked after or are care leavers. The table below shows 2 years of annual activity for each of the key services provided by the Market Place.

Over the last two financial years, the number of assessments, bereavement sessions, and care leaver sessions conducted have increased, whilst the number of counselling sessions has gone down. (The Fast Assess service 2015/16 only contains 9 months of data due to the introduction of the new Short-term and Crisis Counselling service).

DNAs

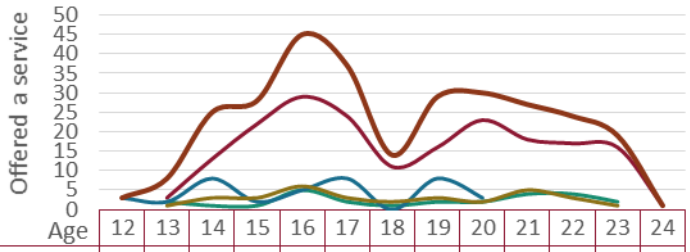
DNA rates across the service are high at 32% (2014/15) and 35% (2015/16) across all services with the exception of Assessments (Intros), but much higher for care leavers (42%).

The Market Place Activity (2014/15 - 2015/16)		1:1 Figures			Individuals		
		2014/15	2015/16		2014/15	2015/16	
Assessments (Intros)	Offered	408	473		381	443	
	Attended	**292**	**350**	⇧	**290**	**350**	⇧
	DNA Rate	*28%*	*26%*		*24%*	*21%*	
Counselling	Offered	2756	2213		402	351	
	Attended	**1885**	**1449**	⇩	**347**	**277**	⇩
	DNA Rate	*32%*	*35%*		*14%*	*21%*	
Fast Access	Offered	183	65		40	29	
	Attended	**116**	**42**	⇩	**30**	**21**	⇩
	DNA Rate	*37%*	*35%*		*25%*	*28%*	
Bereavement	Offered	124	162		43	51	
	Attended	**75**	**103**	⇧	**31**	**41**	⇧
	DNA Rate	*40%*	*36%*		*28%*	*20%*	
Care Leavers	Offered	205	221		34	47	
	Attended	**118**	**128**	⇧	**26**	**40**	⇧
	DNA Rate	*42%*	*42%*		*24%*	*15%*	
ALL services less intros	Offered	3027	2497		473	427	
	Attended	**2063**	**1622**	⇩	**398**	**338**	⇩
	DNA Rate	*32%*	*35%*		*16%*	*21%*	

Service User Profile

Due to the relatively small number of service users a stable service user profile by age is hard to determine, although it is clear that there is a peak at around 16 years of age. 71% of service users identified as female, 28% identified as male and 1% described themselves as uncertain or non-binary.

The Marketplace Service User Profile (2015/16)

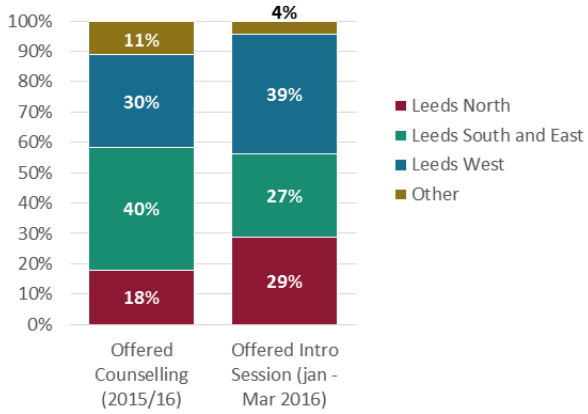


Age	12	13	14	15	16	17	18	19	20	21	22	23	24
Counselling Service		3	13	22	29	24	11	16	23	18	17	16	1
Fast Access (9 months)		2	1	1	5	2	1	2	2	4	4	2	
Bereavement Services	3	2	8	2	5	8	0	8	3				
LAC/Care leaver's Service		1	3	3	6	3	2	3	2	5	3	1	
Total	3	8	25	28	45	37	14	29	30	27	24	19	1

Wedges

On examination of the workloads for CAMHS wedges, there was a very clear split of work, with Leeds North taking 20% of the work, and both the West and the South and East wedge picking up approximately 40% each. The split for the Market Place is less clear, although this will be impacted to some extent by the much lower volumes.

The Market Place
Work split by Location (2015/16)



Presentation Type

The Market Place provided 12 months of presenting issues recorded for counselling sessions for 193 children and young people. Due to a lack of standardised naming conventions there were 6086 presenting issues recorded against a total of 286 different issue types, making any type of useful analysis extremely difficult. The top 20 most recorded are shown in the list below.

Issue	Clients
Relationship with parents/guardian	111
Anxiety	98
Self-esteem	94
Worry	90
Confidence	89
Anger	88
Concerns about the future	88
Relationship with friends	88
Relationship with other family members	87
Not being listened to/heard	83
Self Reflection	82
Trust	79
Feeling let down/disappointment/betrayed	78
Relationship issues	76
Decision making/exporing options	74
Expectations	74
Depression	72
Feeling/being stuck	69
Feelings of loss	69
Relationship with siblings	69

Funding

During financial year 2014/15 the local authority, CCG other agencies combined provided The Market Place with £356,500 of funding across Leeds.

8.4.2 Therapeutic Social Work Service (TSWS)

The Therapeutic Social Work Team (TSWT) is described as Leeds Children's Services' innovative response to promote the emotional well-being of children and young people who are looked after, living in kinship care, subject to child protection plans or subject to a supervision order. The TSWT is a city-wide service based in East Leeds that offers direct therapeutic work, a fostering surgery for all carers of Leeds children; life story clinics; consultation to local authority Children's Homes; group parenting programmes; and Training and consultation to professionals.

The team works with children and young people up to the age of 18, or to 25 if the young person is a care leaver. The TSWT does not work with children subject to Child in Need plans (unless children are placed with kinship carers and would otherwise be in care).

The TSWT is staffed by experienced social workers many of whom hold additional therapeutic qualifications. The team also benefits from clinical psychology input.

The Therapeutic Social Work Service incorporates the LAC CAMHS service and is based within the Local Authority. In 2015 it has 13.5 WTE practitioner/clinical staff on the establishment, although only 10 WTE were in post as of June 2015. In addition it has 1.5 WTE of non-practitioner/clinical staff.

For the financial year 2014/15 it received 519 referrals but accepted only 121 giving an accept rate of just 23%. There is an 8 week average waiting time to assessment/ first contact, and another 8 – 12 weeks between assessment and intervention (where appropriate). Its caseload on 31st March 2015 was 225.

During financial year 2014/15 the local authority provided the TSWS with £657,000 of funding across Leeds.

8.4.3 Multi Systemic Therapy Service

The Multi Systemic Therapy Service (MST Service) is provided by the Children's Social Work Service on behalf of Leeds Local Authority, and provided a service to 100 children and young people during 2014/15. This was made up of 100 accepted onto the MST Service, and 12 accepted onto the MST-CAN (MST Child Abuse and Neglect) service.

The average waiting time to access the standard MST Service was between 5 & 6 weeks (depending on wedge) and 2 weeks 1 day for the MST-CAN Service (2014/15).

During 2014/15 the MST Service offered 2885 face to face appointments (approximately 29 per accepted referral) and the MST-CAN service offered 1981 face to face appointments (approximately 165 appointments per accepted referral).

The MST Service is provided by 20 FTE practitioner/clinical staff (18 FTE in post at point of data collection) and 7 FTE non-practitioner/clinical staff.

The service is sole funded by the Local Authority and in 2014/15 cost £1,194,000.

8.4.4 Cluster Mental Health Support (previously known as TaMHS)

Cluster Mental Health Support is a citywide service that provides early intervention and short term specialist mental health support. It is funded in the main by school clusters with a contribution from the CCGs and is available in all 26 local clusters in the city. This includes the new Specialist Inclusive Learning Centre (SILC) cluster. This work in the clusters is part of their Guidance and Support multi-professional team.[223]

The Emotional Wellbeing and Mental Health support offered in schools is provided by Northpoint Wellbeing, Barca, CAMHS in Schools, Relate, Impact North, The Beck and support from EWMH workers, which are described below:

Place2Be work out of 6 schools in the Leeds area providing counselling service for children and young people in primary and secondary schools. They provide an integrated therapeutic approach and counselling through play. Work within early intervention and long term complex needs, and also offer parent partnership work to support the children who are accessing the counselling service. Place2be are part of the Cluster Mental Health Support offering.

School Counselling Leeds (Northpoint Wellbeing Ltd): Northpoint Wellbeing (formerly Leeds Counselling) offers brief counselling interventions to pupils and/or their parents in many Leeds schools as part of the Cluster Mental Health Support offering. The counselling usually takes place on school premises for pupils referred with a variety of issues, including bereavement, family breakdown, past abuse, anger management problems, and difficulties at school. Referrals to this service are through the school.

BARCA: BARCA-Leeds is a multi-purpose charity in Bramley that provides specialist services to help people overcome a broad range of issues. BARCA-Leeds purports to supports all members of the local community, from children and young people to adults and families.

Relate: Relates services include Relationship Counselling for individuals and couples, Family Counselling, Mediation, Children and Young People's Counselling and Sex Therapy. They also provide friendly and informal workshops for people at important stages in their relationships.

They have a network of Relate Centres across the UK (including in Leeds) and a group of licensed local counsellors that provide face-to-face counselling and support.

The Beck: The beck offers free Counselling service for people aged between 16 and 25.

Impact North and **CAMHS in Schools** also provide Emotional Wellbeing and Mental Health support within Leeds Schools.

The Leeds Baseline Data collected for the CAMHS Transformation Plan states that there were 23.66 FTE practitioner/clinical roles within the School based/ education cluster based services as at June 2015 of which 23.3 were in post.

There is currently very little centralised information about mental health offerings in school settings across Leeds, although there are efforts underway to improve that. In June 2016, the LTP programme board were presented with key messages gleaned from the 1st MindMate Wellbeing Support Data relating to Cluster Mental Health Support across Leeds. This document had significant data health warnings attached, but included the following key information:

[223] www.schoolwellbeing.co.uk/pages/tamhs-leeds

- 1659 CYP referred in the 6 months directly from schools
- 307 CYP referred in the 3 months from the SPA (Since its launch)
- Of those referred 695 received specialist service (mental health qualified practitioner)
- There is very varied demand (referrals both from the SPA and directly from schools) across the clusters (expected)
- Also varied presenting needs, though certain ones present frequently, such as anger/behaviour issues and anxiety, stress and low mood featuring highly and self-harm also significant
- Average length of treatment is 10 weeks but with heavy caveats as to reliability at the moment

During financial year 2014/15 the local authority, CCG other agencies combined funded £2,023,853 of Cluster Mental Health Support across Leeds.

8.5 Specialist CAMHS (Tier 3 - Tier 3.5)

8.5.1 CAMHS

Leeds CAMHS is a specialist mental health service for children and young people (Tier 3 plus Tier 3.5 Crisis Support) offering a range of different assessment techniques and evidence based therapies. Staff work closely in teams so that we can offer services tailored to the needs of the children, young people and families.

Most accepted children and young people will be initially seen in a consultation clinic, although urgent referrals will be given an assessment and advice about keeping safe, before proceeding in a similar way to the consultation clinic.

The Leeds CAMHS website states that for many children, young people and families, two or three sessions are all that is needed. However further specialist assessments (Attention Deficit Hyperactivity Disorder, eating disorders and Autistic Spectrum Conditions (ASC) etc.) or therapy work (Cognitive Behavioural Therapy, family therapy and creative therapies etc.) are provided if required.

In addition Leeds CAMHS has both intensive outreach and inpatient services, and CAMHS nurses are also based in the Leeds YOTs (Youth Offending Teams).

Referrals into CAMHS

Referrals into CAMHS are via the MindMate SPA, and self-referrals are not accepted. CAMHS only work with young people and children who have had help from other professionals first (for example their school learning mentor, a school counsellor or a school nurse).[224]

In 2015/16 CAMHS recorded receiving 2,871 referrals for 0 -18 year olds, which accounts for 1.67% of the equivalent projected population (171,570). This is a 0.01 percentage point increase on the number

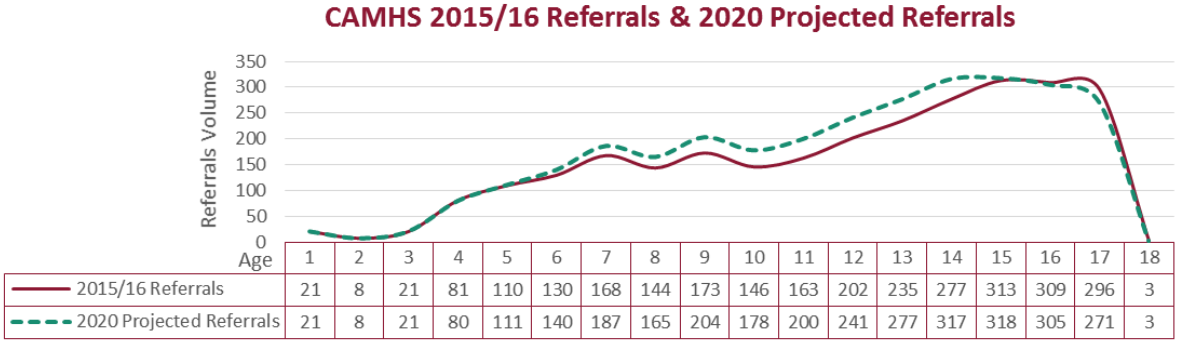
[224] www.leedscommunityhealthcare.nhs.uk

of 2014/15 referrals (2826) as a percentage of the equivalent 2014 mid-year population (170,510). It is clear that these volumes fall significantly short of prevalence forecasts.

Referrals Profile

The 2015/16 referrals volumes broken down by age show an increasing number of referrals into the service by age, from very few referrals for 0 -5 year olds increasing to the mid-hundreds per single year age for 6 –10 year olds, before ramping up significantly from 11 to 16/17 year old.

Applying the 2015/16 referrals profile against population projections it can be seen that overall referrals are expected to increase to 3,107 per annum by 2020 (below), and this will be seen largely in the 7 – 14 age group due to the forecast change in overall profile.



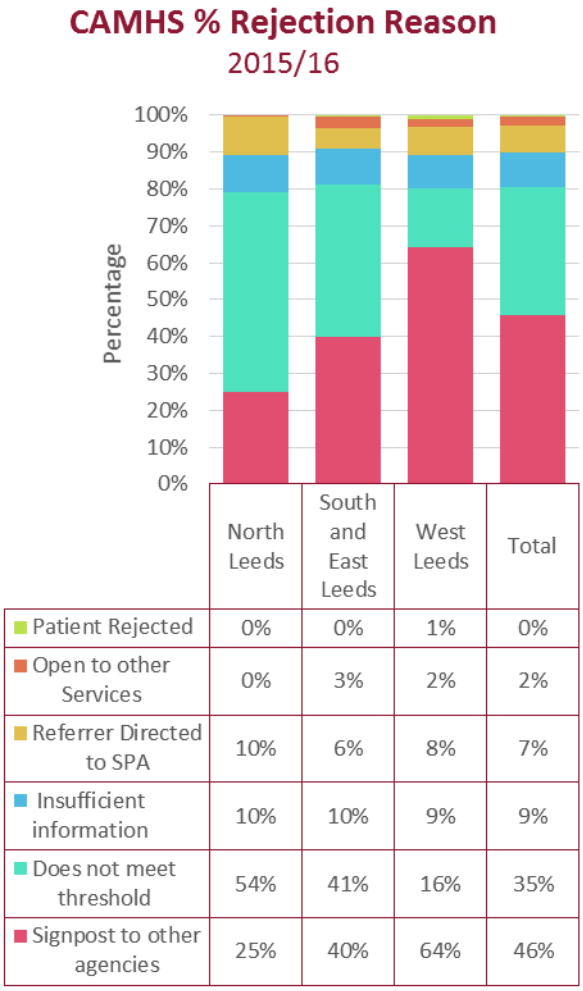
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
2015/16 Referrals	21	8	21	81	110	130	168	144	173	146	163	202	235	277	313	309	296	3
2020 Projected Referrals	21	8	21	80	111	140	187	165	204	178	200	241	277	317	318	305	271	3

Referrals and Accepted Referrals by Source 2015/16

The largest referrer into CAMHS in 2015/16 was GPs, accounting for 1,725 of the 2,826 referrals received. The next largest referrer was the Acute Trust (not A&E) who referred just 192, and then A&E who referred 165.

Of those 2,826 referrals into CAMHS, 1,756 were accepted into the service (62% of all referred). Of those, the 896 GP referrals rejected (52%) and the 52 Community Paediatricians referrals rejected (32%) accounted for the largest volumes of rejected referrals.

Looking at the reason for rejected referrals, there is some difference in wedges between the percentages recorded as 'does not meet the threshold' and 'signposted to other agencies', together they consistently accounted for approximately 80% of reason given for rejection. There were some significant differences in the proportion of rejected referrals that were signposted onto other agencies from each wedge, and it will be important to monitor this now that all referrals go through the SPA. In 2014/15, 46% of rejected referrals overall were signposted to other agencies.



External Referrals, Rejected and Accepted Referrals by Referrer (2015/16)	Number of Referrals	Rejected Referrals	*Percentage Rejected*	Accepted Referrals
General Medical Practitioner	1725	896	*52%*	829
Acute Trust (Not A&E)	192	18	*9%*	174
A&E	165			165
Community Paediatrician	163	52	*32%*	111
Education	74	19	*26%*	55
Community Health	73	14	*19%*	59
Health Visitor	73	7	*10%*	66
Trust outside Leeds	66	9	*14%*	57
Social Services	48	13	*27%*	35
Other	40	9	*23%*	31
Child Health	38	11	*29%*	27
Self Referral	32			32
CAMHS in Schools	25	3	*12%*	22
TAMHS	21	3	*14%*	18
Youth Offending Team	20	1	*5%*	19
Acute Trust - Paediatrician	19	10	*53%*	9
Aspire	15			15
Clinical Psychology	13	1	*8%*	12
Self Harm Rota	8			8
Police	5	1	*20%*	4
Primary Care Mental Health	4	3	*75%*	1
Agency	3			3
CAF	1			1
Local Authority	1			1
Substance Misuse Team	1			1
Voluntary Sector	1			1
Adult Psychiatrist				
Total for month	2826	1070	*38%*	1756

Monthly Referrals and Activity Data 2015/16

Looking at the monthly data for 2015/16, there is a significant drop off in external referrals through January, February and March 2016 which appears to tie in with a drop in the percentage of referrals rejected and coincides with the opening of MindMate SPA. It was noted at the time that some referrals were taking longer to process at SPA, therefore fewer were received in CAMHS. Also, many fewer referrals were being rejected as they are being triaged and assessed for appropriateness at SPA. There also appears to be a slight increase in the number of internal referrals and assessments conducted over the same 3 month period.

Monthly Referrals & Activity 2015/16	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Total
External Referrals	250	243	289	272	163	267	297	290	287	179	150	139	2826
Rejected Referrals	89	87	116	117	66	101	127	128	129	67	25	18	1070
Referrals Reject Rate (%)	*36%*	*36%*	*40%*	*43%*	*40%*	*38%*	*43%*	*44%*	*45%*	*37%*	*17%*	*13%*	*38%*
Accepted Referrals	161	156	173	155	97	166	170	162	158	112	125	121	1756
Internal Referrals	50	68	64	96	57	73	68	67	54	116	84	100	897
Assessments Conducted	79	68	122	108	63	141	117	151	162	226	155	208	1600
Total Activity	1386	1334	1626	1566	1016	1411	1350	1552	1445	1718	1686	1722	17812
DNAs	116	115	168	158	123	120	104	103	143	156	143	144	1593
DNA Rate (%)	*8%*	*9%*	*10%*	*10%*	*12%*	*9%*	*8%*	*7%*	*10%*	*9%*	*8%*	*8%*	*9%*

DNA rates have stayed largely consistent at between 7% - 12% (9% average for the year).

Assessment Profile

Although there is no 'reason for referral' data, an indication of the type of referrals and severity of issues can be identified by the nature of assessments conducted and internal referrals made over the 12 month period (left).

Of the 1,600 first appointments recorded, 54% were consultation clinic appointments and 22% were self-harm assessments. The remaining 24% were split amongst 29 different types of first appointments, with Infant Mental Health assessment (4.3%) and Emergency Assessment (3.4%) being the most prevalent of these.

Eating disorder assessments accounted for 0.8% of all first assessments conducted.

Leeds CAMHS 1st Appointments Attended by Assessment Type (2015/16)	Total	Percentage
Consultation Clinic	856	53.5%
Self Harm Assessment	353	22.1%
Infant Mental Health	68	4.3%
Emergency Assessment	55	3.4%
General Assessment	52	3.3%
Assessment - Single Clinician	41	2.6%
Medication	29	1.8%
General Intervention	17	1.1%
LD Nursing	17	1.1%
Transition	16	1.0%
ASD Clinic	13	0.8%
Eating Disorder Assessment	12	0.8%
Adoption	7	0.4%
CBT	7	0.4%
LD Assessments	6	0.4%
Aspire Medics	5	0.3%
Interpersonal Therapy	5	0.3%
LD Nursing - Positive Behaviour	5	0.3%
ADHD Assessment	4	0.3%
Drama therapy	4	0.3%
LD Multidisciplinary Intervention	4	0.3%
Child Psychotherapy	3	0.2%
CO&TS Outreach	3	0.2%
Complex Assessment	3	0.2%
Medication (exceptional)	3	0.2%
Mental State Examination	3	0.2%
CBI	2	0.1%
Eating Disorder Care	2	0.1%
Family Therapy	2	0.1%
YOS Nursing	2	0.1%
Play Therapy	1	0.2%
Total for month	1600	

Internal Referrals

The internal referrals (below) within CAMHS shows that:

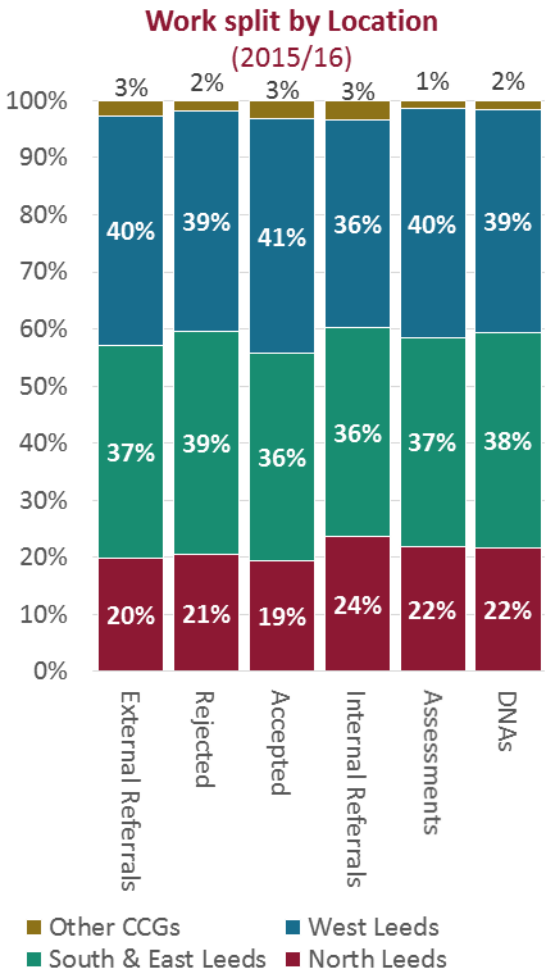
- 14% of internal referrals were for Medication
- 12% for ASD Assessments
- 11% for General Assessments
- 10% for Transition
- 9% were for CBT (Levels 1 – 3)
- 2% for Complex Assessments
- 2% for Eating Disorder

Internal Referrals *(Care Gateway Referred to)* 2015/16	Volume	Percentage
Medication	129	14.4%
ASD Assessment	110	12.3%
General Intervention	101	11.3%
Transition	85	9.5%
CBT	67	7.5%
Group Therapy	52	5.8%
Family Therapy	45	5.0%
ADHD Assessment	39	4.3%
CO&TS Outreach	38	4.2%
Drama Therapy	25	2.8%
Interpersonal Therapy	25	2.8%
General Assessment	24	2.7%
Child Psychotherapy	22	2.5%
Complex Assessment	16	1.8%
Eating Disorder	15	1.7%
EMDR	14	1.6%
CBT(Level 3)	13	1.4%
LD Nursing	11	1.2%
Assessment - Single Clinician	10	1.1%
LD Multi disciplinary Intervention	7	0.8%
Play Therapy	7	0.8%
Psychometric Assessment	6	0.7%
LD Nursing - Assessment	5	0.6%
Mental State Examination	5	0.6%
Adoption	4	0.4%
Consultation Clinic	4	0.4%
Emergency Assessment	3	0.3%
LD Nursing - Positive Behaviour	3	0.3%
ASPIRE Medics	2	0.2%
Infant Mental Health Care	2	0.2%
LD Nursing - Intervention	2	0.2%
Medication (Exceptional)	2	0.2%
State of Mind Assessment	2	0.2%
LD Multi disciplinary Assessment	1	0.1%
Risk Assessment & Management	1	0.1%
Total Referrals	897	

CAMHS CCGs

The Leeds CAMHS service is provided via 3 CCGs: North Leeds; South & East Leeds; and West Leeds.

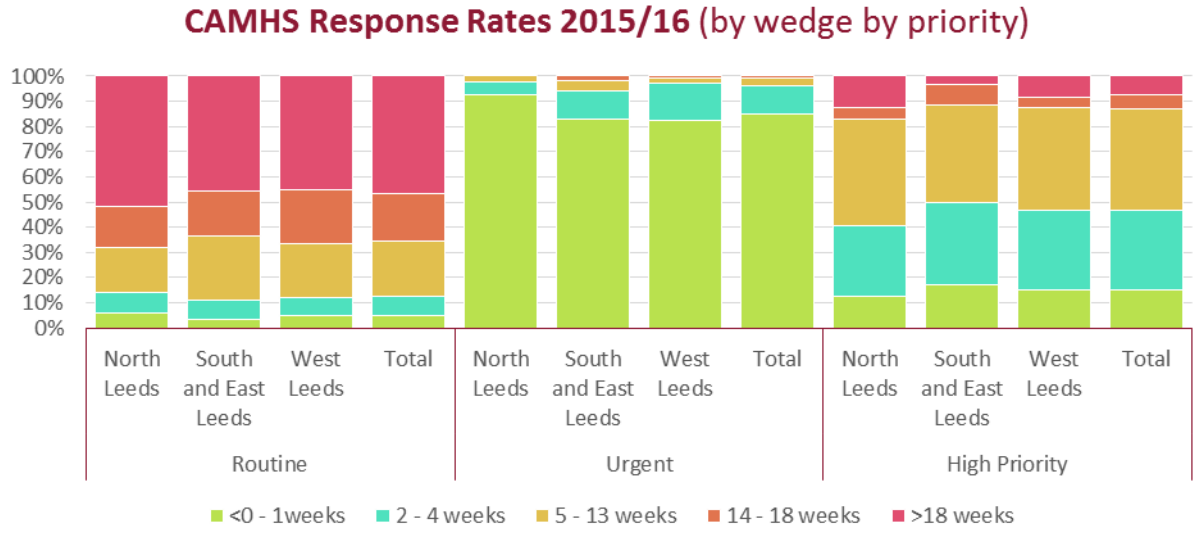
Looking at the distribution of work coming in and being conducted across the CCGs, there is a very consistent split of work throughout the process, with North Leeds picking up about 1/5 of the work, and South and East Leeds and West Leeds both picking up about 2/5 each.



Waiting Times

The 2015/16 CAMHS CQUIN has 2 key elements relating to waiting times and waiting for a service; one is on reducing the waiting times for the initial consultation (target 12 weeks), the second is to work in co-production with children, young people and parents to ensure meaningful information and support is in place whilst on the waiting list. This CQUIN forms part of the Leeds Local Transformation Plan for Children and Young People's Mental Health and Wellbeing.

The graph below shows that overall the wait profile by wedge was fairly consistent across 2014/15:



There appears to have been an improvement in waiting times for CAMHS Consultation Clinic over the last 6 months. Information pulled from the CAMHS website in February stated that:

In January 2016, 90% of the children and young people attending a first consultation clinic appointment were seen within 29.4 weeks.*

However the CAMHS website in July stated that:

In May 2016 90% of the children and young people attending a first consultation clinic appointment were seen within 9.4 weeks.*

This represents a significant improvement in waiting times over the 4 month period.

This is not true for Emergency Appointments which appear to have increased from 90% of the children and young people who needed to be assessed as an emergency were seen within 3 hours 47 minutes in January 2016, however the website states that *'in May 2016 90% of the children and young people who needed to be assessed as an emergency were seen within 5 hours and 4 minutes.'**

Subsequently information from CAMHS states that the 90th percentile time for Emergency Appointments has reduced to less than 4 hours in June and July 2016.

Urgent appointment waits have also increased dramatically, with 90% of CYP who needed an assessment urgently increasing from 3.7 days (Nov 15); 2 days (Dec 15): 1.5 days (Jan 16) to 7 days in May 16.*

*The 90th percentile is utilised to reduce the likelihood of statistical outliers skewing figures

Referrals by Ethnicity & Hard to Reach Groups

Comparing the 2014 schools ethnicity data with CAMHS referrals by ethnicity data, it appears that there is a disconnect between the children and young people population of Leeds as a whole and the ethnicity of children and young people being referred into the service.

NB: Unfortunately 30% of referred children and young people into CAMHS did not have an ethnicity recorded against them and these null and not recorded values must be discounted for the sake of this analysis. However, this 30% will hide either a greater disconnect or closer alignment of CAMHS referrals and population profiles, but to what extent is not possible to say. CAMHS have subsequently advised that the recording of ethnicity has improved, with national ethnicity codes now employed and Mind Mate SPA capturing ethnicity for around 50% of all external referrals. CAMHS have reported that 'latest figures show 89% of patients have their ethnicity recorded for open spells of care with an appointment in 2016'.

Leeds School Aged Ethnicity Descriptors	% of school age population (2014)	CAMHS Referrals Ethnicity Descriptors	Number of CAMHS Referrals (2015)	Number of CAMHS Referrals (2015) by School Ethnicity Descriptor	Percentage of population with CAMHS Referral (excluding Null & Not Stated)	Percentage of population with CAMHS Referral (including Null & Not Stated)
White British	71.0%	British*	1692	**1692**	**83%**	**58%**
White Ethnic Group	75.2%	British*	1692	**1744**	**85%**	**60%**
		Any other White background	47			
		Irish*	5			
Asian Ethnic Group	11.5%	Pakistani	45	**110**	**5%**	**4%**
		Any other Asian background	27			
		Indian	15			
		White and Asian	13			
		Bangladeshi	10			
Black/ African/ Caribbean /Other Black Ethnic Group	5.6%	White and Black Caribbean	34	**108**	**5%**	**4%**
		African	23			
		White and Black African	18			
		Any other Black background	17			
		Caribbean	16			
Mixed/ Multiple Ethnic Group	5.1%	Any other mixed background	35	**35**	**2%**	**1%**
Chinese and Other Ethnic Group	1.8%	Any other ethnic group	42	**49**	**2%**	**2%**
		Chinese	7			
TOTAL with Ethnicity Recorded				**2046**		
		NULL	793	**860**		**30%**
		Not stated	67			
Grand TOTAL (Including NULL & Not Stated)				**2906**		

*CAMHS Ethnicity Records have 'British' and 'Irish' as ethnicities - For the purpose of this analysis, the assumption is made that these descriptors refer to 'white British' and 'white Irish'

The comparison data above, shows that although 11.5% of the schools' children and young people identified as of Asian ethnicity (red), only 5% of referrals with recorded ethnicity identified as Asian (green). Children and young people from a mixed or multiple ethnicity ethnic background also appear to not be being referred into CAMHS in proportionate numbers, with 5.1% of the school population identifying as of mixed or multiple ethnicities, but only 2% of referrals being recorded as from that background.

Referrals for children and young people from Black, African, Caribbean, or other Black ethnic backgrounds appear to be proportionate to the school population, while children and young people of White or White British ethnicity appear to be most likely to be referred into CAMHS, with 85% of all CAMHS referrals with an ethnicity recorded were for white children and young people.

Applying the ONS 2005 prevalence by ethnicity to the Leeds children and young people's ethnicity profile it can be seen that the potential profile for CAMHS referrals for Leeds children and young people changes:

There a slight increase in the proportion of referrals expected from children and young people of white ethnicity (76%), a drop in those children and young people from an Asian ethnic background (9% down from 11.5%) and an increase in proportion of children and young people of Black/ African/ Caribbean/ or Other Black Ethnicity (7% up from 6%) and Mixed / multiple ethnicity (6% up from 5%).

Leeds School Aged Ethnicity Descriptors	% of school age population (2014)	Prevalence by ethnicity**	CAMHS Referral profile *(Leeds CYP ethnicity vs. ethnic specific prevalence rates)*	Number of CAMHS Referrals (2015) by School Ethnicity Descriptor*	Percentage of population with CAMHS Referral (excluding Null & Not Stated)	Percentage of population with CAMHS Referral (including Null & Not Stated)
White British	71.0%	*10.0%*	71.7%	**1692**	**83%**	**58%**
White Ethnic Group	75.2%	*10.0%*	75.9%	**1744**	**85%**	**60%**
Asian Ethnic Group	11.5%	*8.0%*	9.3%	**110**	**5%**	**4%**
Black/ African/ Caribbean /Other Black Ethnic Group	5.6%	*12.0%*	6.8%	**108**	**5%**	**4%**
Mixed/ Multiple Ethnic Group	5.1%	*12.0%*	6.2%	**35**	**2%**	**1%**
Chinese and Other Ethnic Group	1.8%	*10.0%*	1.8%	**49**	**2%**	**2%**
TOTAL with Ethnicity Recorded				**2046**		
				860		**30%**
Grand TOTAL (Including NULL & Not Stated)				**2906**		

*CAMHS Ethnicity Records have 'British' and 'Irish' as ethnicities - For the purpose of this analysis, the assumption is made that these descriptors refer to 'white British' and 'white Irish'

** Prevalence by ethnicity percentages does not take into account the proportion of Leeds school children of Indian background incorporated into the 'Asian Ethnic Group'; Indian children have a 4% MH prevalance rate, compared to 8% for Pakistani and Bangladeshi children. There are no stated prevalance rates for Mixed/ Multiple Ethnicity nor Chinese and Other Ethnicity, so for the this analysis proxy rates of 12% and 10% are applied.

These changes slightly reduce the gap between actual and anticipated referrals from children and young people of Asian ethnicity (as a proportion of the whole), but suggest there may be a gap between the proportion of referrals from Black/ African/ Caribbean /Other Black Ethnic Group CAMHS should expect and are receiving.

NB: Overall, regardless of proportion of referrals received by ethnicity, the overall number of referrals received by CAMHS falls significantly short of those expected based on prevalence data.

Staffing

NHS provider CAMHS services are recorded via the Baseline Data Collection for the CAMHS Transition plan as having 85.71 FTE of practitioner/clinical staff on the establishment, although only 70.36 FTE were in post at the time of data collection. The total FTE of non-practitioner/clinical staff supporting clinical staff was 25.46, meaning that 77% of staff are practitioner/clinical staff.

8.5.2 CAMHS Learning Disability (LD)

The CAMHS LD Team received 639 referrals in 2014/15 of which it accepted 491 (77% accept rate).

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides specialist adult mental health and learning disability services to people in Leeds.

8.5.3 Intensive home intervention service (T3.5)

Leeds CAMHS also operates a Tier 3.5 intensive home intervention service which accepted 38 of 46 referrals in 2014/15. There is minimal wait to access the service.

Data on this service is embedded within the CAMHS dataset.

8.5.4 Self-harm

See 6.1.3 Self Harm

8.6 Specialised CAMHS (Tier 4)

These include day and inpatient services and some highly specialist outpatient services including services for children/young people with gender dysphoria ; CAMHS for children and young people who are deaf; highly specialised autism spectrum disorder (ASD) services; and highly specialised obsessive compulsive disorder services. These services have, since April 2013, been commissioned directly by NHS England.[225]

[225] CAMHS Tier 4 Steering Group (2014) Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report

During 2014/15, there were 35 adolescents from Leeds admitted into Specialised CAMHS services (24 female and 11 male) and 32 discharged (20 female and 12 male). Of those 35 adolescents admitted, 3 were from West Leeds, 6 from South & East Leeds, and 26 from North Leeds.

Admissions	Female	Male	Total
CAMHS Acute	9	3	**12**
CAMHS LD	7	3	**10**
CAMHS PICU	7	3	**10**
CAMHS Medium Secure	0	1	**1**
Eating Disorder	1	0	**1**
Unknown - Not Provided	0	1	**1**
Total	**24**	**11**	**35**

Discharges	Female	Male	Total
CAMHS Acute	18	6	**24**
CAMHS Psychiatric Intense Care Unit	2	3	**5**
ASD/Aspergers	0	1	**1**
CAMHS Learning Disability	0	1	**1**
Unknown - Not Provided	0	1	**1**
Total	**20**	**12**	**32**

Little Woodhouse Hall

Little Woodhouse Hall is part of the Child and Adolescent Mental Health Services, tier 4 service. The unit provides up to eight beds for young people from the age of 13 up to the age of 18. Leeds Child and Adolescent Mental Health Service (CAMHS) offer assessment and help to children and young people with significant emotional and behavioural difficulties (e.g. anxiety, depression, eating disorders) and their families. The Care Quality Commission (CQC) inspection on the 29 July 2013 found Little Woodhouse Hall compliant with the essential standards of quality and safety.

In 25 November 2014 the CQC conducted a further inspection of Little Wood Hall, which rated it as Good overall (from a rating scale of: outstanding; good; requires improvement; or inadequate). The inspection rated the Tier 4 ward as 'good' in relation to its effectiveness, how caring it was, its responsiveness and how well led it was, however it the ward was rated as 'requires improvement' for its safety.

Key concerns around the Safety at Little Woodhouse Hall were listed as:

Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging.

The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.

Staff were specially trained to use the least form of restraint possible. Staff recorded the incidents of restraint in the patients' notes. However, no-one collated the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks patients.

The hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to restrain a young person or child.[226]

[226] CQC Leeds Community Healthcare NHS Trust CAMH wards Quality Report April 2015

The children's Place of Safety suite (The Becklin Centre)

The children's Place of Safety suite at The Becklin Centre, in Burmantofts, is a new unit in Leeds for under 18s who have been detained by the police under Section 136 of the Mental Health Act. The new two-room specialized space in a bid to prevent young people in crisis spending time in police cells.

Previously children detained under Section 136 would have been assessed alongside adults in one unit but LYPFT invested £230,000 in a new space for adults in October last year. The new Child and Adolescent Mental Health Service (CAMHS) space is situated in the old joint unit, which has been refurbished and dedicated to young people.

This latest development is part of LYPFT's Crisis Assessment Service which saw a new Crisis Assessment Unit open in July 2015.

The unit offers services for adults experiencing an acute and complex mental health crisis that require a period of assessment of up to 72 hours.

Conclusions/ Observations

The main services in Leeds where children and young people can get support with their mental health are: CAMHS, Leeds Improving Access to Psychological Therapies (IAPT) for young people, Cluster Mental Health Support, The Market Place, and Aspire. There are also a vast range of universal services and third sector organisations that support young people with their emotional health.

CAMHS
In 2015/16 CAMHS accepted 1,756 CYP (0 - 18) onto its service from the 2,826 referrals it received (62% accept rate). This equates to 1.67% of the 0 -18 year old population referred to CAMHS and 1.02% of the 0 – 18 population gaining access to CAMHS.

52% of GP referrals were rejected (896) and 32% of Community Paediatricians referrals were rejected (52), and 80% of rejections were recorded as 'does not meet the threshold' and 'signposted to other agencies'

The CAMHS LD Team received 639 referrals in 2014/15 of which it accepted 491 (77% accept rate). High Risk Group prevalence data suggests that there were approximately 2,335 CYP with a Learning Disability and a mental disorder in Leeds.

Volumes of referrals into core CAMHS and CAMHS LD services fall significantly below forecast prevalence rates, suggesting that there is an unmet need in Leeds.

Ethnicity
Ethnicity data suggests that children and young people who identified as Asian; of mixed or multiple ethnicity; or as Black/ African/ Caribbean /Other Black ethnicity are being referred into CAMHS at lower equivalent rates to children and young people who identify as White British; White and Chinese and Other.

9. Participation – Service Users Perspective

9.1 Participants

Overall, 11 participants took part in the three focus groups: five in the LGBT group, two in the Gypsy/Traveller group and four in the Youth Muslim forum group. In order to preserve anonymity, the demographic data will be presented cumulatively for all 11 participants.

Out of 11 participants, six were female, two were male and two were members of the trans* community. Six identified as heterosexual, three as pansexual and two as gay. The age of the participants varied between 13 and 22, with a median age being 17.

Nine out of 11 persons are currently in Education, Training or Employment. Ethnicities varied widely, with four people identifying as White British, one Black African, four as Asian and two as Traveller/Gypsy/Roma. Only one person had experience of being in care or being a looked after child. None of the participants identified as a disabled person and none had parenting/guardianship or caring responsibilities. Also none identified as a refugee/asylum seeker.

9.2 Findings

9.2.1 The definition of emotional and mental health/wellbeing

Many young people defined mental health as being 'emotionally stable' and being able to 'deal with bad events'. Notably, young people recognised that emotional wellbeing does not equate perpetual state of happiness, but equally that good mental health is more than the absence of mental illness. LGBT representatives particularly emphasised the link between worrying excessively how they are perceived by others and poor mental health. To these young people, being mentally healthy meant having confidence to rely on their own judgment and initiative rather than on how they may appear to others.

Emotional health was defined as an 'inward' process and how content a person is with their own life, rather than how they may appear to others:

> *It's so much to do with your inward self, for me I think it's really important to be content within your own mind and body. I think that if you're not content within your own mind and body then it's really difficult to go out there and do day to day things and carry out tasks when inside you're not really wired up and thinking straight.*

Some young people also commented on the importance of significant others in one's life and that the systems of support a person has in place, can play a vital role in their emotional wellbeing:

> *It's like having a good sort of support system around you, whether it be like friends or family and having things in your life that give you happiness whether it's a social life or career all that can contribute to emotional wellbeing*

The importance of a good support system was particularly emphasised when talking about recognising signs of poor mental health. Most young people agreed that sometimes it is hard for a person, especially one on a downward spiral, to recognise the symptoms by themselves and to reach out for help:

You can feel helpless, like no one likes you, like you're alone in the dark and you can't find any light. You can't talk to people because you think people are going to judge you because of the way you are mentally feeling and being more and more antisocial. They could have thoughts of suicide or whatever, that could happen if noone helps them in time-that's why you need people around you.

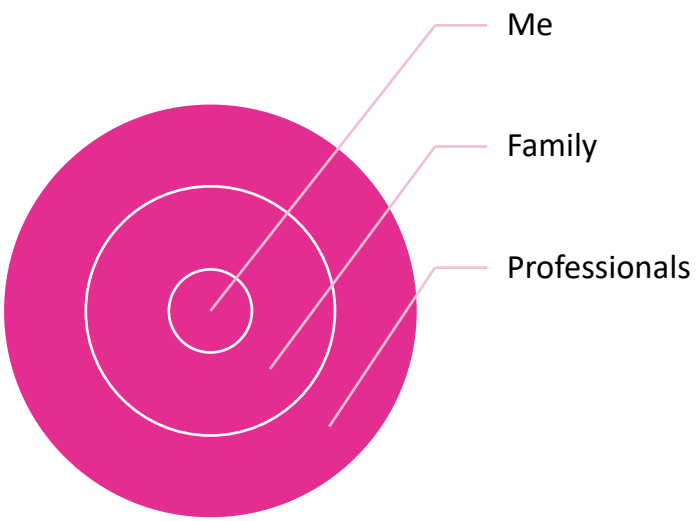
Virtually all young people agreed that mental health is still not something that is widely talked about and that young people tend to shy away from those conversations for fear of being ostracised by their peers and/or families. Muslim Youth Forum participants added that this is sometimes a cultural thing-whereby a person is expected to 'deal with it' in private and move on. Young people did however agree that talking about mental health is essential on the road to recognition of symptoms and recovery, and that 'getting things off one's chest' was often the way in which they kept themselves emotionally healthy, especially the representatives from the Gypsy/Traveller group:

I think talking about it really helps to get out in the open, it's like you feel better once it's off your chest, it's like if you sit and you feel down and try to keep it all to yourself you just feel -Urgh-, like it's all still there. Whereas if you get to off load to somebody then you feel better for it.

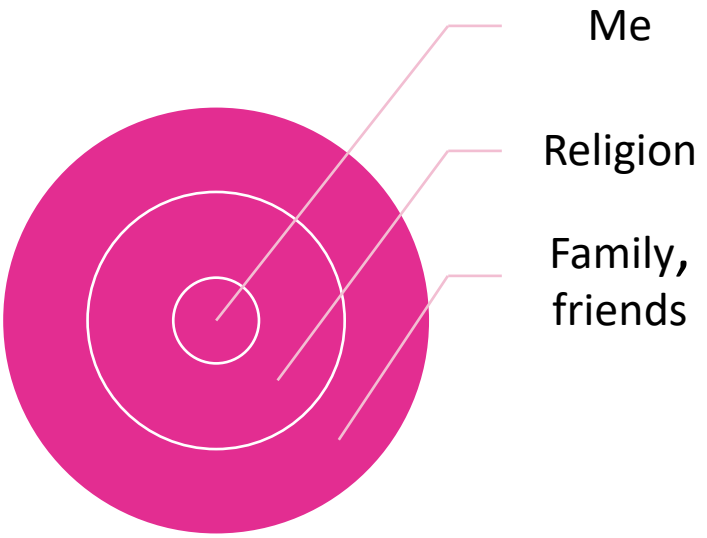
9.2.2 Who would you go to for help?

As part of this exercise, young people were asked to draw circles of support around themselves representing who they would go to help for and who they would go to in a crisis. Their answers varied markedly, depending on the group.

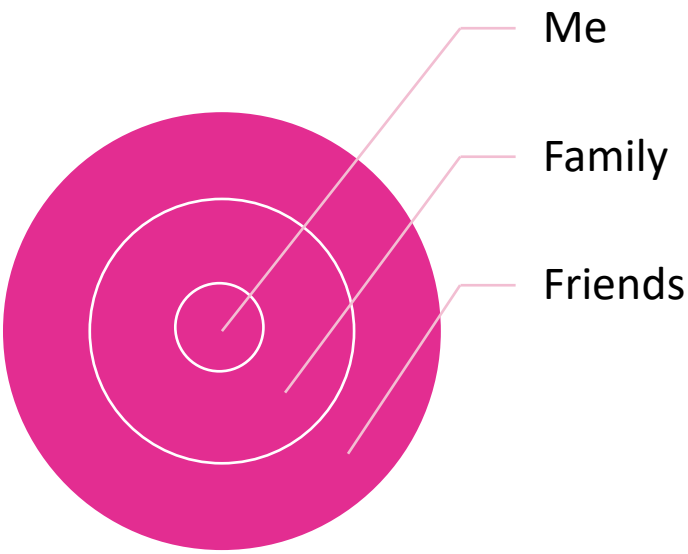
Young people from LGBT group said that they would typically go to their school counsellor, teachers or youth workers, as illustrated below. In a crisis, they would probably talk to a GP or a counsellor at school first.



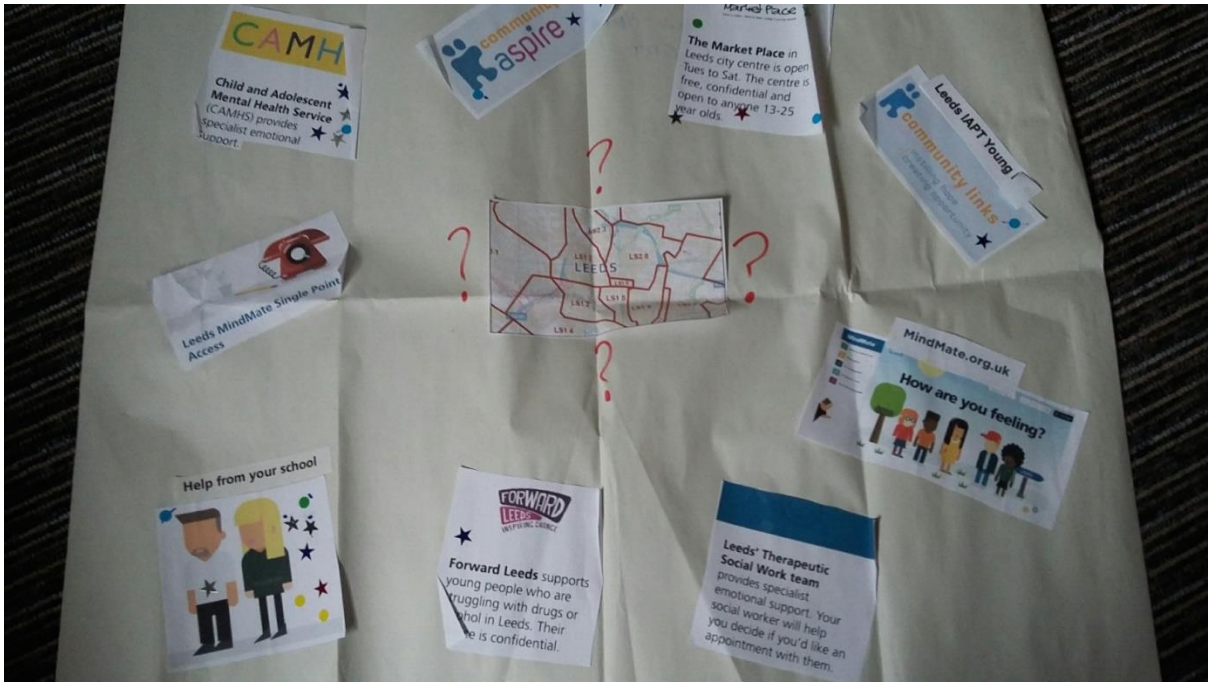
Young people from Muslim Forum, however, said that they would often turn to their religion before speaking to others. The next port of call would be family members, and then friends. In a crisis, they would be more likely to contact a mental health professional, typically via school.



Young people from Gypsy/Traveller group, on the other hand, agreed that they would only turn to their family and friends for help, even in a crisis.



9.2.3 Knowledge of local services



With exception of support in school/college of which most young people were aware, they did not have much awareness of other services in their area. The LGBT group seemed to have a somewhat more thorough knowledge of the services than the rest, and the participants from the Gypsy/Roma focus group, appeared least informed about the local offer.

Leeds Services Map: Who has heard of the following services?

Service	No of LGBT young people	No of Muslim forum young people	No of Gypsy/Traveller young people	Total
CAMHS	3	2	0	5
Aspire (EIP)	1	2	0	3
The Market Place	5	0	0	5
IAPT	1	1	0	2
MindMate website	0	0	0	0
Leeds TSWT (Therapeutic Social Work Team)	0	0	0	0
Forward Leeds	1	0	0	1
Support in school / college	3	4	2	9
MindMate SPA	0	0	0	0

It is worth noting here that young people from Muslim forum and Gypsy/Traveller group, both of whom placed greater emphasis on turning to family and friends when experiencing a mental health problem, had less knowledge of the local services than the LGBT young people. It would be worth investigating which way the causal relationship faces in this instance: whether some young people have less knowledge of local services because they turn to their significant others first, or do they turn to the significant others because they have limited knowledge of the local services.

LGBT young people talked about the importance of the word of mouth when deciding whether to use a particular service. One person said that if they had had an unfavourable report from another young person, they would be much less likely to turn to them:

Probably the reputation for young people. If they have a bad reputation from young people who talk to me, then I wouldn't go there. What might attract me to them is how they treat young people and how they handle the problem, whether they keep it confidential or do they tell everyone or how they handle a teenager at the hotspot.

When discussing the advantages of face-to-face counselling versus Internet and social media, young people universally gave considerable preference to face-to-face counselling. They were generally aware of a range of Internet websites which offered help, as well as Smart Phone Apps (notably, none were aware of MindMate website), but felt that this information/services were not necessarily subject to the same standard as the face-to-face services. However, young people believed that help should be available to young people 24/7 and that Internet and social media helped significantly with that. Some young people, especially those from the Muslim Forum group, said that while they used social media on occasions to connect to support groups, these were not their chief source of support:

I think what you said about social media its interesting because it is used for communication and it is used to keep in touch with friends yet I would never use any form of social media as a support mechanism […] I feel like you can write something but the other person can interpret it in another way. I think if it was me and the contact was made initially through Whatsapp, if I had a problem then it would be over the phone probably.

9.2.4 What should the services look like?

Young people were asked whether they would be happy using these services, and what should the services look like. Some of the most common responses included:

- Short waiting times to see a professional (no more than a week)
- Inviting, pleasant settings (not overly formal or clinical)
- Assurance of confidentiality
- Judgement-free attitude of the professional
- Out-of-hours availability
- Good communication skills and empathy in a professional
- Greater possibility for self-referral

Young people also said that mental health problems require a different approach and setting to physical health. As a result, some young people said that they would feel uncomfortable going to a doctor unless they absolutely had to:

I feel like with mental health it's not something you can walk in and they just say 'OK, here you go this will sort it'. With mental health it's so much more deeper than that. I think the hardest step is to actually step into one of

these places, the first step is the hardest. If I was in that situation, I would genuinely find it hard to contact someone from one of these [services].

When asked how they would best like to access an organisation, young people said that they preferred self-referral routes to traditional routes via GP. Some young people would go to well-known national charities such as Mind, while others said that access should be available via their education institution. Most young people agreed, however, that services need to be advertised more in the community and make themselves better known to young people:

They should advertise these things a lot better, because you don't see any of these things on TV. That could be quite a popular thing you know, if somebody sees that on TV they might think 'It is best for me to talk to somebody about how I am feeling to make sure I am fully well' and get that reassurance that there is something there. If you're not feeling too great they need to do something more to show that there is more options for people.

9.3 Summary of findings

- On the whole young people had a fairly good understanding of mental health, but agreed that mental health is still a taboo in many circles. Addressing mental health stigma is therefore one of top priorities.
- Knowledge of local services is still fairly low, except for young people who have previously used them. In cultures where reliance on family and friends for help is greater, the knowledge of local services is lesser. Reaching out to hard-to-reach groups is therefore important for Leeds services, and this could be done via social media, through school counselling service and greater visibility in the community.
- Face-to-face consultations are preferred to online interventions and social media support groups. Young people do, however, acknowledge the importance of the Internet and social media in providing accessible, round –the-clock support and help for young people. Local services should therefore make themselves more visible in the social media and have more presence on the Internet.
- When asked what their ideal service would look like young people said that it should be a 24/7 self-referral service operating in an inviting, informal setting, with non-judgemental and empathic professionals. First and foremost, however, the service would need to be visible in the community.