**Liverpool
Public Health
Observatory**

Children and young people's emotional health and wellbeing needs assessment

Merseyside

FULL REPORT

Janet Ubido, Louise Holmes,

Sharon McAteer, Lucy Tomlinson,

Alex Scott-Samuel

PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

Acknowledgements

Authors:
Janet Ubido, Senior Researcher, Liverpool Public Health Observatory
Louise Holmes, Research Associate, Liverpool Public Health Observatory
Sharon McAteer, Public Health Development Manager, NHS Halton & St.Helens
Lucy Tomlinson, Teenage Pregnancy Strategy Coordinator, NHS Wirral
Alex Scott-Samuel, Director, Liverpool Public Health Observatory

                                        Contact: j.ubido@liv.ac.uk

Glossary

CAMHS: Child and Adolescent Mental Health Services

*ChaMPs:*Cheshire and Merseyside Public Health Network

ChiMat: The Child and Maternal Health Observatory. Child health profiles:
http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES

JSNA: Joint Strategic Needs Assessment

LSOA: Lower Super Output Area. A small geographical area within a local authority containing between 400 to 1,200 households.

Merseyside: For the purposes of this needs assessment, 'Merseyside' is defined as Halton, Knowsley, Liverpool, Sefton, St.Helens and Wirral local authorities.

NICE: National Institute for Health and Clinical Excellence.

Tellus: a series of national school surveys which gathered children and young people's views on their life, their school and their local area, with the last one carried out in 2009 (Tellus4).

TCRU: Thomas Coram Research Unit, Institute of Education, University of London.

TIIG: Trauma and Injury Intelligence Group (North West). Centre for Public Health, Liverpool John Moores University.

Youngminds: a charity aiming to improve the emotional wellbeing and mental health of children and young people.

Contents

Executive Summary

Introduction

There are many factors that can influence the emotional wellbeing of children and young people. An attempt has been made to cover the main factors in this needs assessment, painting a picture of need across Merseyside

A consideration of levels of need was based on the Child and Adolescent Mental Health Service (CAMHs) categorisation of Tiers 1 to 4 (see box 1), with the needs assessment expected to inform commissioning as follows:

- broad public health commissioning, addressing emotional health and well-being and early intervention (Tiers 1 & 2)
- commissioning services for those with common and complex mental health problems (Tiers 3 & 4)

> **Box 1**
> **Tiered response to levels of need**
>
> Tier 1: universal provision, working with all children
>
> Tier 2: early intervention/targeted provision
>
> Tier 3: specialist provision for those with complex needs
>
> Tier 4: highly specialist provision

The recent government mental health strategy *No Health without Mental Health* (DH, 2011a&b) places a firm emphasis on early intervention to stop serious mental health issues developing, particularly amongst children. In addition to CAMHS, there are a wide range of professionals and groups that can support and improve a child or young person's psychological well-being. Many will operate at a universal level such as midwives, health visitors, school teachers, school nurses and community workers and will support all children and young people in their development

The factors that contribute to positive and negative emotional health amongst children and young people are explored under six priority area headings, developed by the Children's Society (2012a). The main factors under each heading are described for Merseyside as a whole in this summary. More examples and further details for each local authority area are given in the main sections of the report. Some of the more vulnerable groups of children and young people, such as children in poverty, will have needs across more than one heading. Where numbers with mental health conditions have been estimated, the high levels of mental health risk factors on Merseyside, such as deprivation, mean that figures are likely to be underestimates. Information presented is based on the most up to date data readily available to the researcher.

Six priority areas for promoting wellbeing in children and young people

i).   The conditions to learn and develop.

Children need to be given the conditions to learn and develop, starting early, with support during pregnancy and birth and continuing on to high quality education in school. Factors explored include the following:

Peri-natal health: The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children a healthy start in life and laying the groundwork for good

health and wellbeing in later life (RCM, 2011). Across Merseyside, there are likely to be between 1,804 to 2,706 new mothers with a mental health problem.

Good level of development at age 5: Between 2009-2011, there were overall improvements in the percentages of children achieving a good level of development at the age of five in each local authority on Merseyside, as shown by the Early Years Foundation Stage profile scores (DfE, 2010). However, in Halton, less than half (48%) of all children had reached a good level of development by age 5, the lowest level in England. In Liverpool, levels were also low, at 51%.

The emotional development component of the good level of development score can be looked at separately. Amongst boys and girls aged 5 in Sefton and Knowsley, emotional development levels are slightly higher than England and North West averages. In Liverpool and Halton, scores were below national and regional averages.

GCSEs*:* Having GCSEs reduces the risk of depression at the age of 42 by five percentage points (Chevalier and Feinstein, 2006). Educational attainment, as indicated by GCSEs achieved (5 A*-C including English and Maths), has been improving in each local authority area in Merseyside since 2005. Wirral (64.1%) has levels well above the England average of 58.4%. Sefton (59.5%) is also above the national average.

School absenteeism: School absenteeism is a key risk factor for violence, injury, substance use, psychiatric disorders, and economic deprivation. In Liverpool (9.6%) and Knowsley (9.1%), persistent absenteeism rates were much higher than nationally (6.1%). Analysis at small area level shows many areas across Merseyside where absence rates are between 11.3% to 22.5%. There were a total of 13,810 pupils who were persistently absent from school during 2010/11 in Merseyside. During the same period, there were 7,760 fixed period school exclusions and 150 permanent school exclusions across Merseyside.

ii).   A positive view of themselves and an identity that is respected.

Children need to see themselves in a positive light, deserving to feel and be respected by all adults and other children. Factors explored include the following:

Children with disabilities: There was limited data available on the extent of child disability in Merseyside. Research suggests that almost 1 in 4 children (24%) who are in receipt of disability benefit have an emotional disorder (ONS, 2005). Proportions of the population aged under 16 claiming disability living allowance are highest in Sefton, at 46.6 per 1,000, which is more than twice as high as the 20.6 per 1,000 claimants in St.Helens. Across Merseyside, there are 8,820 claimants, of whom potentially 2,455 will have an emotional disorder.

Learning disabilities/ Special educational needs (SEN): In Knowsley, Liverpool, Halton and Wirral, there are more SEN children as a proportion of all schoolchildren than the national average. Amongst those with SEN, around 25% have a mental disorder, ranging from 16% at Stage 1 SEN to 43% of those with Stage 5 (SEN statement). Of the 50,760 children with SEN on Merseyside, it can be estimated that there would be around 12,502 who have a mental disorder.

Young people who smoke and drink: Of 11-15 year-olds who smoke regularly, 41% have a mental disorder, as well as 24% of those who drink alcohol at least once a week, and 49% of those who use cannabis at least once a month (MHF, 2007). In Merseyside, for under 18s admitted to hospital with alcohol specific conditions, levels are more than twice as high as the national rate of 55.8 per 100,000 in Liverpool (135.5), Halton (122.9), Wirral (117.9) and St.Helens (116.1) (2008-11). Hospital admissions rates for substance misuse in Halton (163.6), St.Helens (162.2) and Wirral (155.7) were significantly more than twice as high as the national average of 63.5 per 100,000 aged 15-24 (2008-11).

Not in education, employment, or training (NEET): Being in education, employment and training between the ages of 16-18 increases a young person's resilience (ChiMat, 2012). In 2011 across Merseyside, levels of young people who were 'NEET' were higher than the North West average of 7.1%. In Liverpool, they were as high as 11.5% of those aged 16-18. There were 5,290 young people who are NEET across Merseyside.

Pregnant teenagers: Although early parenthood can be a positive experience for some young people, low levels of emotional health and wellbeing can often be regarded as both a cause and a consequence of teenage pregnancy (Swann et al, 2003). Conception rates amongst those aged under 18 are higher than the national average in each Merseyside area except Sefton. Rates are highest in Halton and in St.Helens. Amongst those aged under 16, the picture is the same, although differences from the national average are not so extreme and in Knowsley, they are the same. Across Merseyside, there were 1,184 conceptions to those aged under 18 in 2010, and 767 to those aged under 16 over the two year period 2007-09 (more recent under 16 data not available at time of writing).

Asylum Seekers, Refugees and Immigrants: Mental health problems in some migrant groups are higher than in the general population, for example migrant groups and their children are at two to eight times greater risk of psychosis (DH, 2011a). There are no Merseyside data available on numbers of children of asylum seekers. Children from immigrant families, including asylum seekers and refugees are likely to need extra support to ensure their emotional health and wellbeing. As many as 18.1% (nearly 1 in 5) children in Liverpool and 9.3% (almost 1 in 10) in Sefton are born to mothers from outside the UK.

Gypsy, Roma and Traveller children: Gypsy, Roma and Traveller children have the worst educational outcomes of any ethnic group in the UK and high rates of school exclusion (Ridge, 2010). In 2009, there were five authorised traveller sites across Merseyside, with two in Halton and one each in Liverpool, Sefton and St.Helens, housing 174 caravans in total.

Ethnic minorities: Evidence on the impact of ethnicity on emotional well-being and mental health problems has been found to be inconclusive (TCRU, 2007). Children from ethnic minority groups are significantly over-represented amongst those with child protection plans, with twice as many as would be expected in Liverpool.

iii).   Have enough of what matters.

Children who live in poorer households are twice as likely to have low wellbeing compared to children in more economically stable households (Children's Society, 2012a). 'Having

enough' and 'fitting in' are more important than being very well off. Factors considered under this heading include the following:

Child poverty: Children in poor households are three times as likely to have mental health problems as children in well-off households (MHF, 2007). In Merseyside in 2010, each local authority (with the exception of Sefton) had levels of child poverty significantly worse than the national average of 20.6%. In Liverpool, as many as 1 in 3 (33.1%) children were living in poverty. Analysis at a small area level shows many areas across Merseyside where child poverty levels are higher than 43%.

Children Living in Single Parent Households: Lone parent families are acknowledged as one of the most disadvantaged groups in society (Whitehead et al, 2000). Children of lone parents are twice as likely to suffer from mental disorders. Children of lone parents in receipt of out-of-work benefits are especially vulnerable. Levels were highest in Knowsley, at 2.9% of the working age population and lowest in Sefton, at only 1.6%. There were 21,080 such lone parents across Merseyside in February 2012.

iv).   **Positive relationships with family and friends**.

The strongest driver of low subjective wellbeing is when children experience weak and uncaring relationships with their family or carer (Children's Society, June, 2012). Stable positive relationships with family and friends are of great importance. Factors explored here include:

Children looked after: Entering care is strongly associated with poverty and deprivation, poor educational and social outcomes and emotional and mental health problems. Around 45% of looked after children have a mental health disorder, rising to 72% for those in residential care (Meltzer et al, 2003). There has been a recent rise in children taken into care. In Merseyside, there were 2,755 children looked after in 2011 (as at 31st March 2011). The national average rate was 59 per 10,000 aged under 18. Rates across Merseyside were significantly higher than this in each local authority, with the exception of Halton, which was significantly lower. Applying national estimates, there could be around 1,240 looked after children in Merseyside with a mental health problem.

Levels of emotional wellbeing amongst looked after children are highest in Sefton (higher than national and North West averages). The other local authorities in Merseyside all had lower levels than the national and North West averages in 2011, especially in Knowsley.

The educational attainment of children looked after is low, with around half as many obtaining GCSEs compared to the general school population in some areas.

Missing children: Although many runaways are fleeing abuse, they will often be at increased risk as a result of running away (APPG, 2012). Estimates would suggest that there were up to 4,634 individual children and young people missing on Merseyside in 2009/10. The missing person incident rate, estimated for under 18s for Merseyside, was 30.49 per 1,000, which across England and Wales was second only to London and was considerably higher than rates in neighbouring areas.

Children whose parents have mental health and other problems: Children whose mothers have mental health problems can be more than twice as likely to develop emotional disorders themselves (ONS, 2008). Across Merseyside, an estimated 54,287 children are living with a parent with mental health problems. Those most at risk are the estimated 3,000 children and young people on Merseyside who live with a problem drinker who also has mental health problems and uses drugs. There are around 18,299 children and young people in Merseyside estimated to be living with a dependent drinker, and 24,399 with an illicit drug user.

v).	**A safe and suitable home environment and local area.**

Children need safe and suitable environments at home and in their local area. Feeling safe, privacy, and good local facilities are important to wellbeing, Factors such as poor quality or overcrowded housing or moving house a lot are risk factors to wellbeing

Homelessness: Behavioural problems have been found to be higher among homeless children living in temporary accommodation, and mental health problems are significantly higher among homeless mothers and children (MHF, 2007). In 2007-08, rates of family homelessness in Knowsley, St.Helens and Wirral were significantly worse than the national average of 1.9%. In Liverpool and Sefton, rates were significantly better. There were at least 997 homeless families in Merseyside in 2007-08. There were an estimated 195 homeless young people aged 17-18 in Merseyside in 2010.

Aggression and violence: People who have been abused or been victims of domestic violence have higher rates of a range of mental health problems (UNICEF, 2007). Exposure to abuse and violence is difficult to define. The following indicators were explored here:

Children with a child protection plan: If a child is identified as being at risk of harm, then they become the subject of a Child Protection Plan. There were 1,484 children with a child protection plan in Merseyside in 2011. Across Merseyside, rates per 10,000 children aged under 18 were higher than the national average of 39, with the exception of Halton, which had a rate of 29. Rates in Liverpool and St.Helens were particularly high, at 59 per 10,000.

School survey data: Although now outdated, worrying information from the Tellus2 survey (2007) revealed that as many as 1 in 12 children in St.Helens said they felt unsafe at home from being hurt by others (8.1%). Wirral, Knowsley and Halton were also above the national average of 4%.

Child hospital admissions for injury: On Merseyside, levels of child hospital admissions for injury are higher than the national average in each local authority. There were 6,426 admissions across Merseyside in 2010/11, of which it can be estimated that 707 were due to deliberate injury. In the period April 2006-Dec 2009, 366 children and young people in Liverpool had been assaulted in their own home, badly enough for them to require an emergency hospital visit.

vi). **Opportunity to take part in positive activities to thrive**.

A healthy balance of time, involving choice and autonomy, is important to wellbeing. This would include opportunity to spend time with friends and family, time to oneself and the opportunity to be active. Children and adolescents at risk in this respect include:

Teenage parents: Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth (DFES, 2006). In 2010/11 across Merseyside, all areas except Knowsley had a higher proportion of teenage mothers than the national average, significantly higher in Halton, St.Helens and Wirral.

Young carers: There is a clear relationship between poor mental health and caring. There is no data available on numbers of young carers across Merseyside. Liverpool Barnados have estimated that there are 3,000 young carers in Liverpool.

Physical activity and other positive activities: Taking part in social and voluntary activities, sport and exercise is associated with higher levels of life satisfaction (MHF, 2007). Across Merseyside in 2009/10, in Halton, Sefton, St.Helens and Wirral, physical activity levels were reported to be significantly better than the national average. In Knowsley and Liverpool, they were significantly worse.

Prevalence of mental health problems

Mental health problems: 9.6% of all children and young people aged 16 and under will have some form of mental disorder (ONS, 2005) (an estimated 18,266 in Merseyside). The most prevalent forms of childhood mental health condition are conduct disorders, which affect around 5.8% and anxiety, affecting 3.3%.

Severe mental health problems: For those children and young people with mental health conditions severe enough to be admitted to hospital, rates of admission were higher than national and North West averages in each local authority in Merseyside, significantly higher in Liverpool, Halton, Sefton and St.Helens (2010-11).

Children and young people who self-harm: Children and young people from more deprived areas are significantly more likely to be admitted to hospital for self-harm. In Merseyside, there were 675 admissions for self harm amongst young people aged under 18 in 2010-11. Rates were worse than the national average in each local authority, significantly so in St.Helens, Halton, and Wirral.

Suicide: There were 10 child deaths in the North West in 2009/10 provisionally identified as an apparent suicide.

Children in contact with mental health services

Data on referrals to child and adolescent mental health services(CAMHS) is not readily available for all areas within Merseyside. Some data was received from Liverpool and Sefton for 2011. There may be some discrepancies in the data, as there are large differences in

total numbers of referrals between Liverpool (4,962 in 12 months) and Sefton (621 in 9 months). The most commonly recorded adverse childhood experience associated with referral was parental separation and divorce, affecting as many as 1 in 4 (24.9%) of referrals in Sefton and 1 in 5 (19.2%) in Liverpool. Levels of household mental illness were also high, featuring in 16.2% of all referrals in Sefton and 11.4% in Liverpool.

Conclusion

Many of the factors associated with child wellbeing are inter-linked, with children and young people often facing more than one adverse experience. Identification of those at risk is a key feature of the Healthy Child Programme (DH HCP, 2009). This needs assessment has identified some of the protective factors and areas of risk across Merseyside and should be regarded as a working document, for local authorities and other related agencies to take away and use to identify areas for action and further exploration.

Across Merseyside, on the whole there were low levels of resilience and high levels of risk factors relating to emotional health and wellbeing. There were some exceptions and Sefton compared well to the national average on more factors than any other local authority in Merseyside, for example on levels of GCSE attainment, family homelessness and pregnant teenagers. There were different patterns of need in each local authority, for example Halton had relatively low levels of children looked after and on child protection plans, but high levels of hospital admissions for substance abuse and self-harm. Even where local authorities compare well with each other or to the national picture, there will be inequalities in need within their boundaries, as illustrated in the small area ward maps in the report. The limited amount of data readily available by small areas shows that the distribution of low levels of child wellbeing follows a very similar pattern to that of high levels of school absenteeism, to levels of child poverty, and to a lesser extent, children under 16 on disability allowance. Further exploration of small area data is required.

Promoting positive mental health in children through earlier intervention can result in large benefits (human and economic) with relatively little expenditure. With the current financial crisis, it is more important than ever to promote emotional resilience. Preventive, population based work such as that being undertaken in schools should continue to be given a high priority.

Awareness raising and training for all those involved with children and young people is essential. Child mental health workers need to be available to carry out such training and support.

There are many more factors associated with the emotional health and wellbeing of children and young people that were not included here, either because of a lack of readily available data, or because it was beyond the scope of this project. There is a shortage of data on the protective factors associated with emotional health and wellbeing, which mainly rely on the results of surveys (Hicks and Newton, 2011). Areas for further investigation have been listed in the main report.

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data, or because it was beyond the scope of this project. There is a shortage of data on the protective factors associated with emotional health and wellbeing, which mainly rely on the results of surveys (Hicks and Newton, 2011). Areas for further investigation have been listed in the main report.

Recommendations

General recommendations are presented here. More detailed recommendations can be found after each subsection of the main report.

Local authorities:

- Support whole school approaches that build on strengthening the protective factors associated with the emotional wellbeing of children and young people.

- Consider the mental health impact of wider services and initiatives, such as providing good quality family housing, opportunities for NEETs and opportunities for exercise and access to green spaces.

- *Appoint an elected member as 'mental health champion.'* This role might include raising awareness of mental health issues, including the impact of stigma and discrimination, across the full range of the authority's work and with other elected members, including lead members for children.

- Support action on child poverty, as outlined in the Liverpool City Region Child Poverty Strategy (Liverpool City Region, 2011).

- Encourage all schools across Merseyside to carry out the same standard, consistent school survey covering emotional health and wellbeing (as proposed in Scotland).

   ### Local Public Health Service:
- Develop a clear plan for public mental health, incorporating the tiered approach to improving public mental health: *Universal* interventions to build resilience and promote wellbeing for all ages*; targeted* prevention and early intervention for people at risk of mental health problems, for example early intervention with children, young people and families. Examples of effective interventions include the Healthy Child Programme 0-19 (DH HCP, 2009).

- Establish a public health lead for the emotional health and wellbeing of children and young people. This would assist in improved integration of public health with others who lead in this area, including social services, schools, CAMHS and the community and voluntary sectors.

- Together with local clinical commissioning groups (CCGs), work with maternity and child health services to identify and meet the needs of their local population.

- Commission or provide evidence-based mental health training for non-mental health professionals. Training builds awareness of mental health issues, addresses myths

and stigma, and enables professionals to support and signpost to the right services. This could include training for midwives, health visitors, police and probation staff, school and college staff, housing and hostel staff, youth workers, and health staff in acute and community settings.

- Support Clinical Commissioning Groups (CCGs) to consider and commission mental health promotion, prevention and early intervention.

- Support positive parenting through commissioning Family Nurse Partnership and Health Visiting services.

- Consider carrying out more in-depth needs assessments for some of the more vulnerable groups identified for whom there is a lack of readily available data. This would involve contacting various community and voluntary organisations and health agencies for information and consulting with the young people involved.

- Carry out further analysis to explore the particular needs of small areas within local authorities.

- Encourage related agencies to collect the data that can be used to assist in planning and commissioning, for example number and type of CAMHS referrals. Feed this work into the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategies.

   Children's Trust Board:
- Work alongside CCGs, schools and wider children's services to focus on early intervention and integrated support.

- Offer evidence-based parenting interventions to families with children at risk of conduct disorder and those experiencing conduct problems. Effective parenting support also needs to include the development of effective referral routes and awareness-raising, for example with local GPs, maternity services, health visitors and other services working with young families.

- Improve emotional support for children on the edge of care, looked after and adopted children. This can include establishing links with CAMHS to make appropriate referrals and offer integrated support, including support for adoptive parents of children with mental health problems. The children and young people's IAPT programme will ensure that more children have timely access to evidence-based psychological therapies.

Clinical Commissioning Groups (CCGs)

- *Consider the mental health needs of their whole population when commissioning, including seldom-heard groups.* This includes commissioning for effective transitions between Child and Adolescent Mental Health Services (CAMHS) and adult services.

- *Commission to intervene early.* Evidence-based and cost-effective early interventions include early treatment of childhood conduct disorder and early intervention in psychosis teams. CCGs may wish to commission some of these jointly (Tier 2).

- Provide information and intelligence from commissioning into JSNAs and Health and Wellbeing Strategies.

- Commission CAMHS and other providers to promote an awareness of local services available to schools and other professionals working with children and young people. Offer clear guidance and training on the appropriate support for different situations.

- Ensure increased access to primary care for vulnerable groups. This includes children in care, homeless people, some BME communities, lesbian, gay, bisexual and transgender people, offenders, victims of violence (including domestic violence and sexual violence) and those from gypsy and traveller communities.

- Increase awareness amongst GPs and primary care staff of the ideal opportunity that general practice presents for screening for high risk behaviours and mental health problems amongst children and young people.

- Ensure that commissioning requires providers to report numbers and types of referrals to child mental health services (including inappropriate referrals).

- Data on child hospital admissions for injury should be separated into unintentional and deliberate injury.

- Collect data on numbers of attendances at A&E for child injury, in addition to admissions to hospital, to give a better indication of local needs.

Children's health services (including CAMHS, and independent agencies)

- Encourage links with schools, primary care staff and other professionals working with children and young people, developing consultation services to:
  - ° promote awareness of what support CAMHS and others can provide for children and young people,
  - ° promote awareness of what support CAMHS and others can provide for school staff and other professionals,
  - ° provide training and clear guidance for schools and other professionals on which support is the most appropriate for different situations.

- Improve access for children, young people and their families to mental health support through universal service provision.

- Improve access to mental health services for at risk children and young people (such as children in care, those with disabilities and those with behavioural, emotional and social difficulties) (a statutory requirement).

- Ensure that parents and carers can access advice and support when they are concerned about their children's mental health.

- Improve data collection so that information on numbers of referrals, and reasons for referral and related factors, is routinely available to assist in planning and commissioning decisions.

Schools and colleges:

- Understand the link between emotional wellbeing and good educational and wider outcomes and ensure children who need professional health support are able to access services. Good schools recognise the link between emotional wellbeing and good educational and wider outcomes and have effective systems in place for monitoring and responding to children and young people's issues.

- Have a 'whole school' approach to supporting all pupils' wellbeing and resilience, with an emphasis on strengthening the associated protective factors. This includes both universal approaches, and targeted services for children and young people with, or at risk of developing, behavioural difficulties or emotional problems. Evidence-based interventions to improve wellbeing and build resilience include behavioural support, school-based counselling and parenting interventions.

- Address bullying. Bullying puts children and young people at significant risk of developing mental health problems.

- Ensure staff are aware of how mental health relates to their work. Mental health awareness can help staff recognise signs of mental ill-health and understand the link between mental health and behaviour, attendance and attainment, and will know when a child needs extra help.

- Access the e-learning packages for non-health professionals, being developed as part of the Children and Young People's IAPT programme. This will help staff recognise and support children and young people with mental health problems. The e-portal will also include specific support materials in relation to self-harm, suicide and risk in children and young people.

- Know what specialist mental health support is available. Schools and colleges can ensure they are aware of the services offered by local CAMHS and by the independent and voluntary sector, and of how children, young people and their families can access them. They can contribute to shaping specialist provision through input to JSNA and commissioning processes.

- Promote the role of school nurses in helping schools to identify those children and young people in need of specialist interventions.

- Know when to intervene early to tackle mental health problems. Schools and colleges can proactively seek to identify children and young people with the risk factors for, or the early signs of, behavioural problems and intervene early by securing access to evidence-based support. School leaders can support this through

creating a whole-school culture and ethos which supports good outcomes through a strong focus on high-quality teaching and learning, enriching extra-curricular activities and good pastoral care.

- Challenge mental health stigma by ensuring students and staff know about mental health, how and when to seek help, and how to improve their own mental health and wellbeing. Time to Change are piloting approaches to tackling mental health stigma and discrimination amongst young people. They provide useful resources that can help schools and youth groups in overcoming stigma.

Across all areas, young people's voices should be central to the process of informing the commissioning, planning, delivery and evaluation of services

Recommendations were based on the DH Mental Health Strategy (DH, 2012); the Children and Young People's Health Outcomes Forum (CYP, 2012); the ChaMPs Summary of the Mental Health Implementation Framework (Stansfield, 2012); the six objectives of the DH Mental Health Outcomes Strategy (DH, 2011b) the CAMHS review (DH, 2008); the Children and Young People's Mental Health Coalition 'Resilience and Results' guide (2012) and the findings of this needs assessment.

A matrix table in the Appendix of the main report summarises the main evidence for the interventions available at each level/ tier of need relating to the emotional health and wellbeing of children and young people.

Main Report: Introduction

Aims and objectives

The overall aim of the health needs assessment is to assist in the delivery of better mental health outcomes for children, young people, families and the communities in which they live in Merseyside. The project aims to provide a baseline of need across Merseyside in relation to children and young people's emotional health, wellbeing and mental health. It describes and quantifies the prevalence of emotional and mental wellbeing, mental health problems and mental illness in children and young people across Merseyside.

> **Health needs assessment**
> Health needs assessment is defined as *'a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities'* (NICE, 2005).

Inequalities in emotional health and wellbeing have been identified where possible, with particular reference to the demography of the local population and those groups most at risk of poor mental health by reason of their socio-economic status, sex, age, ethnicity, sexual orientation, gender identity, disability, caring responsibilities and religion/belief. The factors that contribute to positive and negative emotional health and wellbeing amongst children and young people have been explored, for example having the conditions to learn and develop and a safe and suitable home environment.

In this way, the needs assessment seeks to inform commissioning at two levels:
- commissioning services for those with common and complex mental health problems and
- broader public health commissioning, addressing emotional health and wellbeing and early intervention.

Evidence based interventions at each level are detailed.

Methods and scope

A systematic review of data available for Merseyside relating to children and young people aged 18 and under was carried out. Much of the data was obtained from nationally collected government statistics, and that provided through the Child and Maternal Health Observatory (ChiMat). Attempts were made to collect more locally available data from for example schools and voluntary bodies. However, this provided very limited and patchy data that was not comparable across the whole of Merseyside. It would have been very time consuming to collect this data for each of the six Merseyside local authorities so it was not included.

It was decided that mapping current service provision was not possible to achieve in this project, as there is currently a great deal of change in the NHS and related services, and the large geographical area would make this a significant piece of work in itself.

Towards the end of the project, the 2011 census population data started to become available by limited age groups, so this has been presented in the demography section. However,

most estimates of levels of mental health need have been based on the previous mid-2010 population datasets, as single age population data was not available at the time of analysis.

Each sub-section of the report presents local data wherever available and includes a very brief literature review and recommendations where available. As the needs assessment was relatively rapid, covering a large amount of information in a short project timescale, the literature reviews did not always track back to the original sources.

Levels of need

Child and adolescent mental health service provision (CAMHS) is organised across four tiers which reflect differing levels of need. Figure 1 summarises the range of provision across the tiers, from Tier 1, which promotes emotional wellbeing for all children and adolescents, through to Tier 4, which supports those with more complex needs. The term CAMHS is often associated only with the specialist tiers 3 and 4 services, however, CAMHS professionals can also work in schools and some GP practices (Tier 2), alongside social services, and in children's centres (Figure 1).

As described in Maughan (2010), in addition to CAMHS, there are a wide range of other professionals and groups that can support and improve a child or young person's psychological wellbeing. Many will operate at a universal level such as midwives, school teachers, school nurses and community workers and will support all children and young people in their development.

The triangular shape of Figure 1 reflects numbers, with very few children needing highly specialised tier 4 service provision. Edwards and Forbes (2009) pointed out that the costs of emotional health and wellbeing provision would see the diagram turned upside down, with specialist tier 4 care of children with complex needs taking up most of the available resources. Good support in tiers 1 and 2 can prevent the need for as much tier 3 and 4 services. *'A commissioning strategy will aim to achieve a balance between the tiers of service based on need, complexity and the evidence base for outcomes'* (Edwards and Forbes, 2009).

The CAMHS tiers correspond to the school nurse and health visiting models of service, which span four levels, from 'community' through to 'universal partnership plus' and cover provision for those aged 0-19 (DH CNO 2012)

The main focus of this needs assessment is promoting wellbeing at levels 1 and 2.

Figure 1   Tiered response to levels of need
(sources: Maughan 2010, Edwards & Forbes 2009, DH, 2004)

Tier 1 Universal provision
Working with <u>all</u> children and young people, promoting and supporting
emotional wellbeing through the environment they create and the
relationships they have with children and young people. Preventive, also
dealing with mild or minor problems. Includes teachers, youth workers, GPs,
school nurses, health visitors, early years providers, midwives

Tier 2 targeted provision
Early intervention, targeted services, single discipline.
Working with children who have specific needs, e.g. those
with learning difficulties, behavioural problems and
school atterndance problems. Includes child and
educational psychologists, community paediatricians &
nurses, and family therapists

Tier 3 specialist provision
Specific therapy for established
disorders,multidisciplinary, specialist.
Tiers 3 & 4 work with those who have
complex/ severe/ persistent needs.
Includes services across education,
social care & youth offending

**Tier 4 highly
specialised** e.g.
day units & in-
patient units

Emotional health & wellbeing

'Social and emotional wellbeing' encompasses the following:

- happiness, confidence and not feeling depressed (emotional wellbeing)
- a feeling of autonomy and control over one's life, problem-solving skills, resilience, attentiveness and a sense of involvement with others (psychological wellbeing)
- the ability to have good relationships with others and to avoid disruptive behaviour, delinquency, violence or bullying (social wellbeing).

(NICE, 2009a)

It has long been recognised that children and young people who are emotionally healthy achieve more, participate more fully with their peers and their community, engage in less risky behaviour and cope better with the adversities they may face from time to time. Emotional health in childhood has important implications for health and social outcomes in adult life (DCSF, 2010; MHF, 1999).

A recent study of 21 industrialised countries found the overall wellbeing of young people in the UK to be the poorest of all. One of the 6 dimensions of wellbeing that made up the score was 'subjective wellbeing', which was based on children's own perceptions of their lives and in which the UK again came last. Within the 'subjective wellbeing' dimension, the UK had the highest percentage of children rating their own health no more than 'fair' or 'poor' (around 23%) and average scores for perceived life satisfaction and liking school (UNICEF, 2007).

Mental health problems amongst children and young people are a growing epidemic (Weare, 2010). The current economic climate is likely to bring more challenges, as the incidence of mental health problems in young people and adults can increase in times of economic and employment uncertainty, as can the rate of suicide (DH, 2011a).

With at least one in four people experiencing a mental health problem at some point in their lives, and around half of people with life-time mental health problems experiencing their first symptoms before the age of 14 years, intervening early to promote wellbeing and protect resilience should be a key aim locally; helping to prevent mental illness from developing and mitigating its effects when it does (DH, 2011a).

National Policy

Giving every child the best start in life was the highest priority recommendation in the Marmot review of health inequalities (Marmot, 2010). Marmot noted that disadvantage starts before birth and accumulates throughout life. The review stated that action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken (Marmot, 2010).

The government White Paper *Healthy Lives, Healthy People* (DH, 2010) adopts a life-course perspective to address the wider social factors that affect people's health at different stages of their lives, and reflects the principle of proportionate universalism – by which the scale

and intensity of action is proportionate to the level of disadvantage, as advocated in the Marmot report.

Giving equal weight to both mental and physical health, the White Paper draws on the evidence of the Marmot review to emphasise early intervention and prevention as opposed to better treatment, particularly in the crucial childhood and teenage years. Consequently, *Starting well* and *Developing well* are two key life stages defined in the White Paper, where physical and mental health can be most strongly influenced. Enabling good health in mothers before, during and after pregnancy is highlighted as a critical factor in giving every child the best start in life. Identifying, treating and preventing health problems, and creating resilience and self-esteem, as children negotiate the transition into adulthood, are subsequently seen as significant for supporting the development of independence. In every aspect of development, wellbeing and mental health are essential to our quality of life. All too often 'mental health' is seen as being focused solely on people with mental health problems who are being treated in specialist services, and not as a positive resource that needs to be nurtured (DH, 2010).

One year on from Marmot, a review concluded that addressing health inequalities was as important as ever, finding that almost half of all children entering school do not exhibit a 'good level of development' (LHO, 2011). The review team produced data tables for each local authority so that health inequalities can be monitored. The indicators at local authority level include 'children reaching a good level of development at age five' and 'young people not in employment, education or training (NEET)'.

The recent government mental health strategy *No Health without Mental Health* (DH, 2011a) captures Government's ambition to mainstream mental health in England and gives emphasis to the notion that mental health is everyone's business, as demonstrated by the subtitle 'a cross-government mental health outcomes strategy for people of all ages'. A firm emphasis is placed on early intervention to stop serious mental health issues developing, particularly amongst children (DH 2011a & b).

In order to realise the objectives set out in this strategy, action across all sectors needs to strike the right balance between commissioning services for those with common mental health problems with the broader public health commissioning addressing mental wellbeing and early intervention.

> *"By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does."*
>
> No Health Without Mental Health: A cross-government strategy
> (DH 2011a & b)

The importance of awareness raising and training is often repeated, most recently in the Children and Young People's Health Outcomes Framework report (2012). The report noted that those who work with children outside the healthcare system, such as teachers and youth workers, have an important contribution to make to improving health outcomes, but that their training in mental health is too often minimal or non-existent.

1. Demography

At the end of the data analysis stage of this report, the 2011 census population figures had just been released and have been included in this demography section. The age groups used are based on those used in the 2004 ONS morbidity survey of the mental health of children and young people (ONS, 2005): age groups 0-4 (pre-school); 5-10 (primary school); 11-16 (secondary school) and 17-18. It should be noted that for young people with learning disabilities, the upper age limit is set at 24 (see section 2 (ii), p.41 of this report).

The mid-2011 population estimates, based on the 2011 census, revealed that on Merseyside, there were 357,861 children and young people aged 0-18. Table 1 shows the numbers in each age group. Figures 2 and 3 over the page show numbers (thousands) in each age group, males and females, for each local authority in Merseyside. There are more males than females in each age group in all areas, with the exception of Halton amongst those aged 0-4 where there are slightly fewer males; in Knowsley amongst those aged 17-18, where numbers of males and females were the same; and in Liverpool amongst those aged 17-18, where there are more females than males.

There are variations when compared to the previously used mid-2010 population estimates. For example, amongst those aged 0-4, numbers vary from the mid-2010 estimates by 665 for Merseyside in total. In Knowsley, the 2011 census revealed around 300 fewer children aged 0-4 than predicted with the 2010 estimates. Some of the data used in this needs assessment is based on ChiMat statistics, which will have used the mid-2010 estimates, and therefore needs to be treated with caution.

Table 1
Population in each age group, mid-2011 estimates, based on 2011 census

numbers	Ages 0 - 4	Ages 5 - 10	Ages 11 - 16	Ages 17 - 18	Total aged 0-18
Halton	8,270	8,937	9,261	3,398	29,866
Knowsley	9,132	10,041	11,399	4,146	34,718
Liverpool	26,320	26,803	30,259	11,898	95,280
Sefton	10,323	11,185	12,633	4,547	38,688
St. Helens	14,616	16,673	19,426	6,938	57,653
Wirral	18,543	21,291	23,490	8,332	71,656
Merseyside	87,204	94,930	106,468	39,259	327,861

Source, ONS 2011 census

Figure 2

Female mid-2011 population estimates, Children & young people, Merseyside

Figure 3

Male mid-2011 population estimates, Children & young people, Merseyside
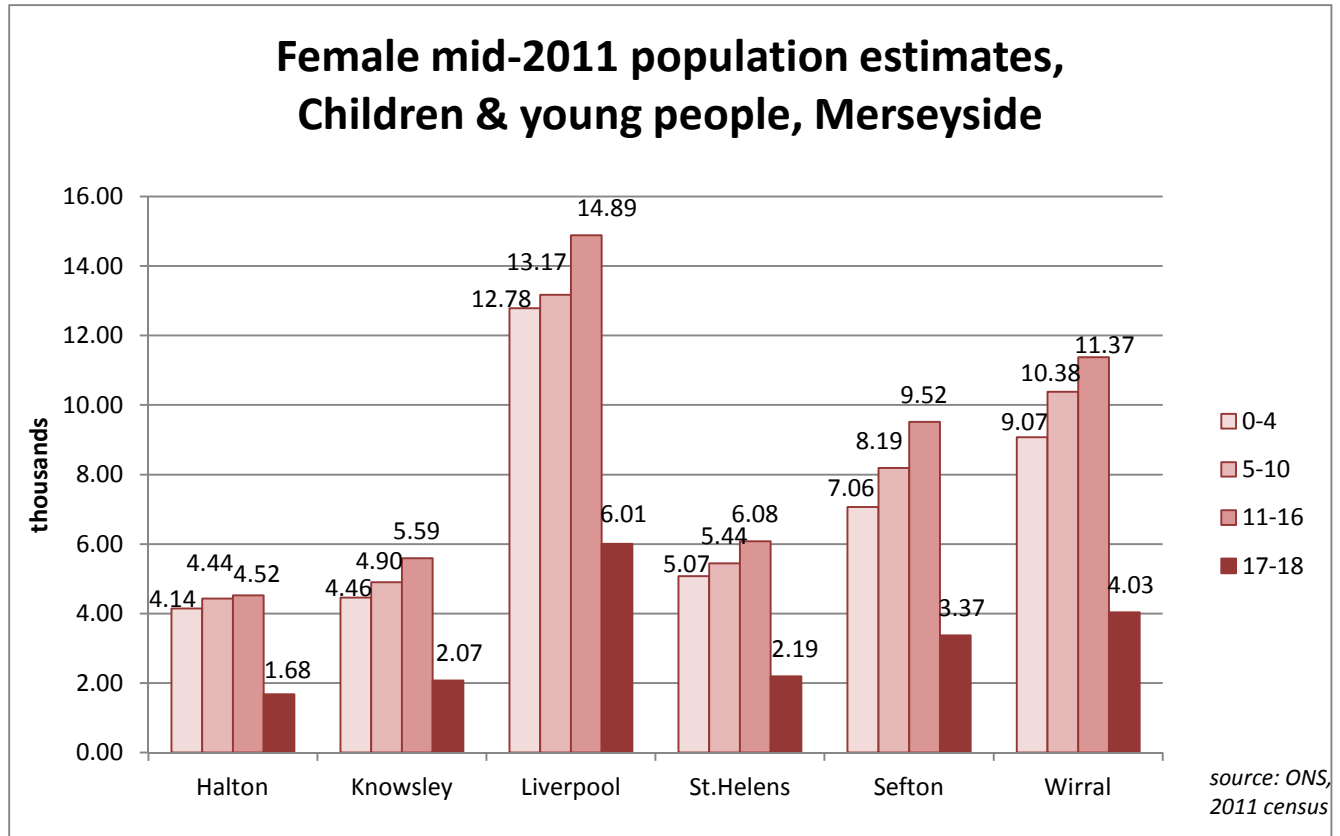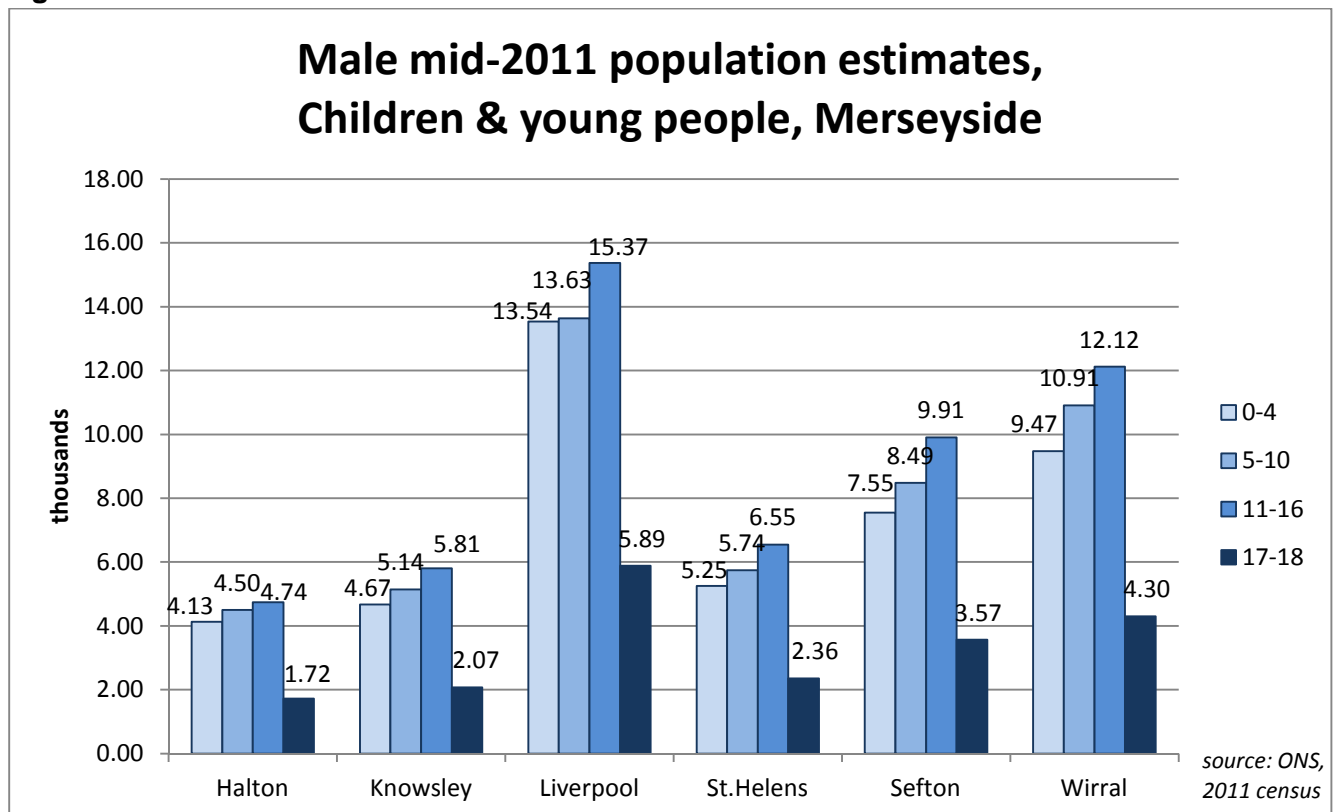
Nationally, 22.6% of the population are aged 0-18. In Merseyside, the figure is slightly lower, at 21.8% (Table 2). There is variation between local authorities. In Halton and Knowsley, proportions are higher than the national and North West averages, with those aged 0-18 accounting for 23.8% of the total population.

Table 2
Population aged 0-18 as a % of the total population, mid-2011 estimates

	%
Halton	23.8
Knowsley	23.8
Liverpool	20.5
St. Helens	22.1
Sefton	21.0
Wirral	22.4
Merseyside	**21.8**
North West	**22.6**
England	**22.6**

Source: ONS, 2011 census

Projected populations
Figure 4 shows the changes in years to come in the populations of children and young people on Merseyside, based on mid-2010 population estimates (estimates based on the 2011 census are not available yet). There will be corresponding changes in numbers requiring interventions that promote emotional health and wellbeing. Amongst those aged 0-9, there is predicted to be a rise then fall in numbers in each area from 2012 to 2035. Numbers reach their peak in 2020. In Liverpool, although numbers rise and then fall again, they will still be 2,500 higher in 2035 than in 2012. In each other area, numbers in 2035 are similar or less than in 2012.

For ages 10-19, across Merseyside there is a slight fall followed by a rise in numbers between 2012 and 2035. In each area, levels in 2035 are higher than in 2012 – much higher in Wirral (3,200 more), St.Helens (1,100 more), Liverpool (6,600 more) and Halton (1,900 more).

Figure 4

Population projections, 2012-2035

source: ONS, 2010 based projections
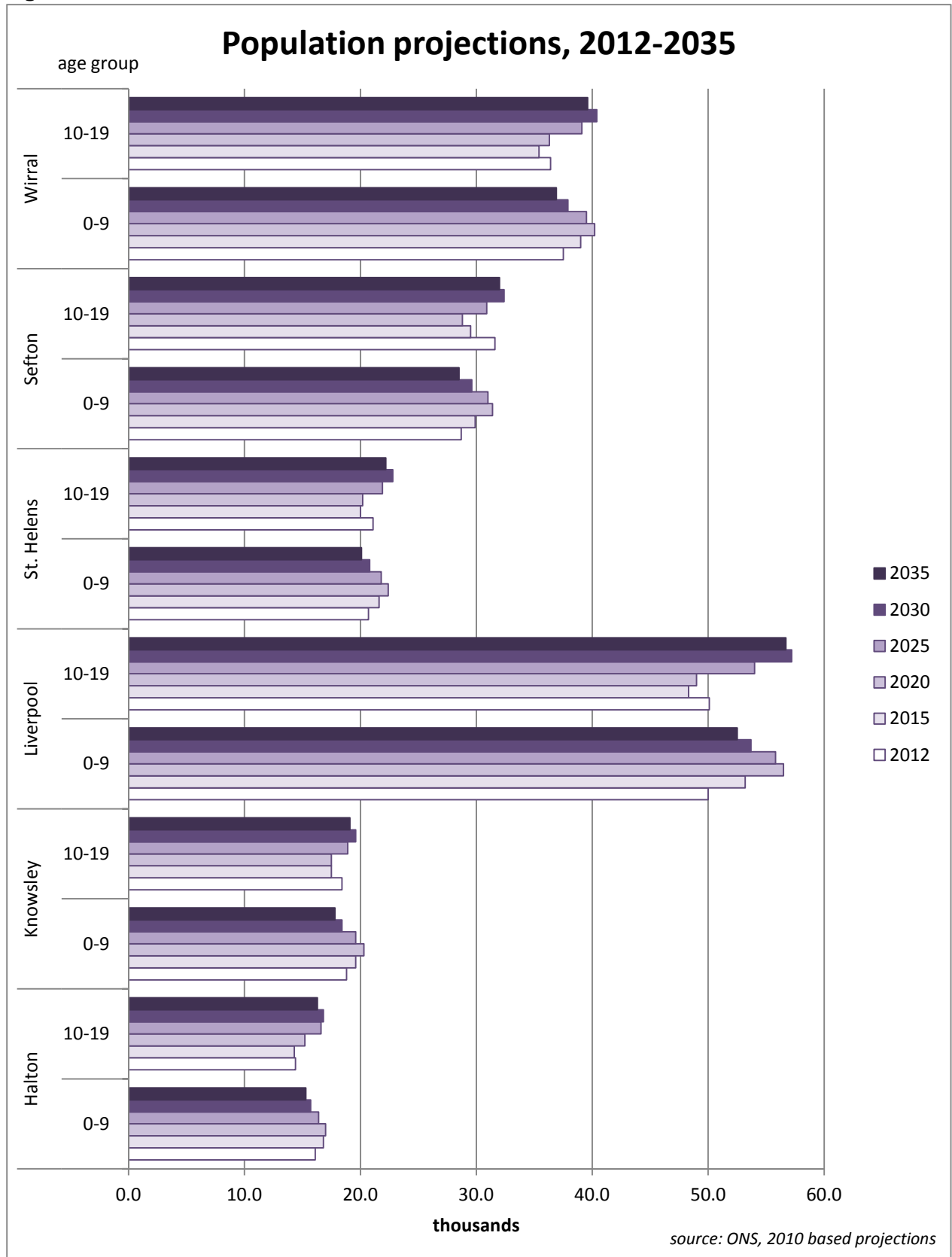
2. Profile of wellbeing

A universal, population based approach will promote positive mental health and wellbeing for all children and young people, including those without major problems. This will help to prevent problems developing. The focus is on the individual's strengths and skills, including mental health competencies based around resilience, which is the ability to bounce back from difficulties and disappointments (Weare, 2010). Social and psychological resilience or strengthening factors include a good education, strong families and friendships, and leisure activities, and are summarised in Box 1.

Resilience factors can create a sense of hopefulness about the future and influence how individuals respond to stressful life events (Weare, 2010). They help to overcome problems created by the presence of risk or reducing factors, which include poverty, experiences of poor parenting, child abuse and belonging to a vulnerable minority group such as asylum seekers, travellers and looked after children.

Box 1

strengthening factors known to protect mental health	reducing factors known to increase risk
☐ developing a sense of control	☐ stigma and discrimination
☐ improving coping skills & self-care	☐ social injustice and inequalities
☐ facilitating participation	☐ violence, abuse and neglect
☐ promoting social inclusion	☐ social exclusion

source: Department of Health 'Making it Happen' (DH, 2001b)

Six priority areas for promoting wellbeing in children

Expanding on the idea of risk and resilience factors, the Children's Society 'Good Childhood Report' identified six priority areas for promoting wellbeing in children, as follows:

i). **The conditions to learn and develop,** such as access to early years play, high quality education, good physical development e.g. diet/obesity, school activities, levels of happiness at school, health and disability.

ii). **A positive view of themselves and an identity that is respected,** such as self esteem, being listened to and not being bullied.

iii). **Have enough of what matters,** indicated by family circumstances, household income, parental employment, child poverty, access to green space, etc.

iv). **Positive relationships with family and friends**, where stable and caring relationships are important (e.g.in the case of looked after children, they are more likely to experience changes in caring relationships).

v). **A safe and suitable home environment and local area,** such as feeling safe, privacy, good local facilities, stable home life (e.g. overcrowded housing or moving

house a lot is a risk factor to wellbeing – but positive caring relationships over-ride this).

vi). **Opportunity to take part in positive activities to thrive**, involving a healthy balance of time – with friends, family, time to self, doing homework, helping at home, being active e.g. access to garden or local outdoor space.

(Children's Society, 2012a & Children's Society June 2012)

These priority areas were developed as a result of research carried out by the Children's Society into the wellbeing of children aged 8 to 15 across the UK (Children's Society, 2012a).

In the following sub-sections, the needs assessment will present national and local data on each of the above priority areas. Levels of risk and resilience factors amongst children and young people across Merseyside will be identified (for those factors where data is available).There are maps to show variations within local authorities where available. This will help to point to areas/groups in need of action and support in maintaining good levels of emotional wellbeing. Some of the more vulnerable groups of children and young people, such as children in poverty, will have needs across more than one heading.

Many of the factors identified in this needs assessment are interlinked, for example the risk factors most associated with child abuse and neglect are poverty, stress, and parental drug and alcohol abuse (UNICEF, 2007). Some of these factors can be seen as making children more susceptible to mental health problems, such as deprivation, others, such as self-harm or school exclusions could be a result of the child's pre-existing mental health problem. For many of the factors, such as with victims of bullying, the relationship can work both ways, being both a cause of and a result of mental health problems (Freer et al, 2010; Weare, 2010; Salmon et al, 2005).

Overall child wellbeing in Merseyside

Wellbeing has been defined as *'more than just happiness. As well as feeling satisfied and happy, wellbeing means developing as a person and being fulfilled'* (New Economics Foundation 2008).

On the whole, populations with high levels of wellbeing are more likely to be protected from mental ill-health than populations with low levels. An emphasis on measures to ensure the population maximises its wellbeing, rather than focusing only on treating or preventing mental illness, will have the overall effect of reducing levels of mental ill-health amongst the population (Government Office for Science, 2008).

Overall levels of wellbeing have been measured by the child wellbeing index (CWI). The CWI was commissioned by *Communities and Local Government (2009)* and is based on the approach, structure and methodology that were used in the construction of the Index of Multiple Deprivation in 2007. It gave the prevalence of a combination of the broad range of factors that are believed to influence children and young people's emotional health and wellbeing, based on material wellbeing, health, education, crime, housing, environment and children in need.

Although it is becoming outdated, the CWI scores for the Merseyside local authorities are reproduced here, as there has been nothing like it produced since then (Figure 5). Low scores indicate high levels of child wellbeing. Liverpool and Knowsley are amongst the 20 local authorities in England with the lowest wellbeing, with Liverpool's being the 3rd lowest in the country. Sefton children had the highest levels of child wellbeing on Merseyside, followed by St.Helens. National and regional scores for comparison are not available.

Figure 5

Child well-being index,
average scores,
Merseyside local authorities, 2009

source: CHIMAT
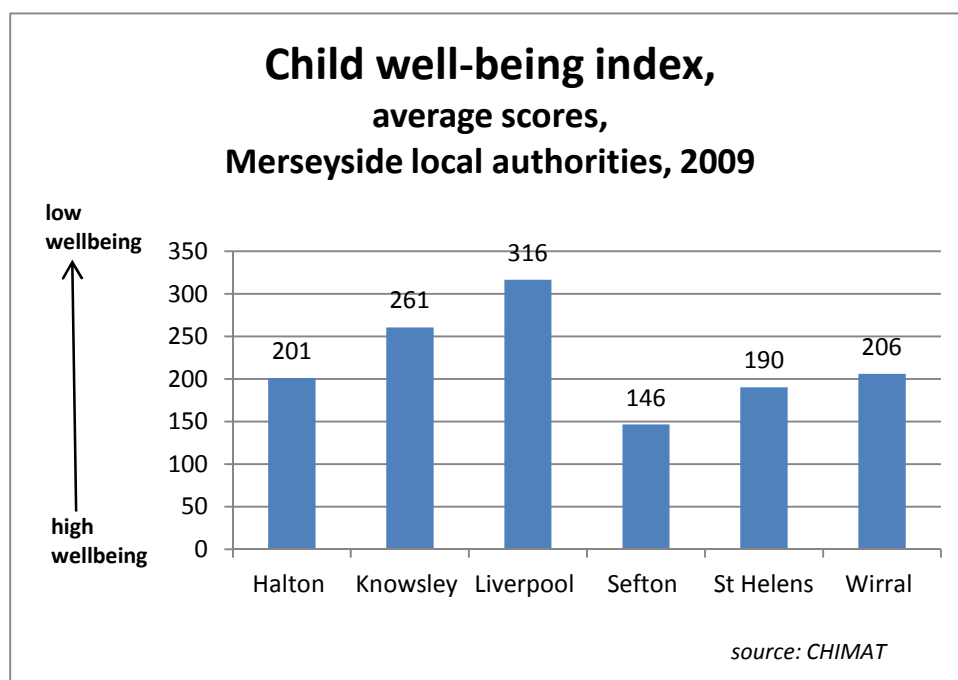
Map 1 on p.14 shows the variations in child wellbeing scores within each local authority. The scores illustrated are for lower super output areas (LSOAs). LSOAs contain between 400 to 1,200 households. Ward boundaries have been overlaid for ease of description. The numbers on the map correspond to the wards, with a key on the page after the map. Appendix 1 gives a brief description of each indicator used for mapping.

The map illustrates that in Liverpool, levels of child wellbeing were particularly low across much of the north and in Speke-Garston and parts of Belle Vale.

In Knowsley, the lowest child wellbeing was concentrated in the far north and also in a patch across the middle of the borough.

In Wirral, there were medium to high levels of child wellbeing to the west of the borough, and low wellbeing in most of Birkenhead & Tranmere and in large parts of Rock Ferry and Bidston & St.James.

Halton had high levels of child wellbeing to the north and south east of the borough. The lowest levels were found in small areas to the south of Kingsway ward and the north tip of Riverside ward in Widnes, and in very small pockets within Windmill Hill and Halton Brook wards in Runcorn.

Sefton and St.Helens had relatively higher overall levels of child wellbeing (Figure 5), but there were areas of low wellbeing within their boundaries. In St.Helens, levels were low in small parts of Parr and the town centre wards, and in a very small patch to the mid-south of Rainford ward. In Sefton, there were small areas around the south, especially parts of Linacre ward, with low levels of child wellbeing.

Within local authorities in Merseyside, the distribution of low levels of child wellbeing show a very similar pattern to that of high levels of school absenteeism (as shown in the map on p.29), to levels of child poverty (see map on p.70), and to a lesser extent, children aged under 16 on disability allowance (p.39).

School surveys on wellbeing

Tellus was a national school survey which gathered children and young people's views on their life, their school and their local area. The Tellus results have not been reported in detail in this needs assessment, as they are now out-dated, with the last one carried out in 2009 (Tellus4, 2010). Overall levels of emotional health on Merseyside reported in the survey are shown in Table 3. Compared with the rest of the country, the survey indicated that children in Liverpool, Knowsley, St.Helens and Halton are amongst those with the best levels of emotional health. Children in Wirral and Sefton have higher than average levels of emotional health.

The results are perhaps the opposite of what might be expected, when compared to the child wellbeing index in Figure 5. However, the child wellbeing index is an average score based on a set of objective indicators whereas TellUs is the subjective experience of children and young people. This means that the two sets of data are not directly comparable. The Children's Society 2012 report 'Promoting positive wellbeing for children' sums it up thus:

> *'Subjective well-being focuses on how people are feeling, whereas objective wellbeing focuses on the conditions which affect those feelings, such as health or education. Both these perspectives are valuable for understanding children's well-being'* (p.3, Children's Society, June 2012)

Table 3
Levels of emotional health as reported in the
Tellus4 survey, 2009-10 (Tellus4, 2010)

	Emotional Health
Halton	60.9%
Knowsley	62.7%
Liverpool	61.6%
Sefton	57.2%
St. Helens	61.2%
Wirral	57.2%
North West	**58.6%**
England	**56.0%**

Source: Tellus4, 2010

Map 1 (key to ward numbers on next page)

Child Wellbeing Index total score by Lower Super Output Area in Merseyside (2009)

Child Wellbeing Index total score (2009)
(Number of LSOAs in brackets) Source: Communities & Local Government

■	350 to 555 (197)
■	243 to 350 (196)
■	160 to 243 (194)
■	100 to 160 (197)
☐	0 to 100 (200)

Note: A lower score indicates a higher level of wellbeing

Contains Ordnance Survey data
(C) Crown copyright and database right 2012
Contains Royal Mail data
(C) Royal Mail copyright and database right 2012

Map Key: electoral wards in the Merseyside area

Halton
1 HOUGH GREEN
2 BIRCHFIELD
3 FARNWORTH
4 HALTON VIEW
5 APPLETON
7 KINGSWAY
8 BROADHEATH
9 DITTON
10 MERSEY
11 CASTLEFIELDS
12 DARESBURY
13 NORTON NORTH
14 WINDMILL HILL
15 NORTON SOUTH
16 HALTON LEA
17 HALTON BROOK
18 GRANGE
19 BEECHWOOD
20 HEATH
21 HALE
22 RIVERSIDE

Knowsley
1 CHERRYFIELD
2 PARK
3 SHEVINGTON
4 NORTHWOOD
5 WHITEFIELD
6 KIRKBY CENTRAL
7 PRESCOT WEST
8 STOCKBRIDGE
9 PAGE MOSS
10 SWANSIDE
11 ST BARTHOLOMEWS
12 LONGVIEW
13 ST MICHAELS
14 PRESCOT EAST
15 WHISTON NORTH
16 WHISTON SOUTH
17 ST GABRIELS
18 ROBY
19 HALEWOOD NORTH
20 HALEWOOD WEST
21 HALEWOOD SOUTH

Liverpool
1 KIRKDALE
2 COUNTY
3 WARBRECK
4 FAZAKERLEY
5 CROXTETH
6 YEW TREE
7 WEST DERBY
8 NORRIS GREEN
9 CLUBMOOR
10 ANFIELD
11 EVERTON
12 CENTRAL
13 KENSINGTON AND FAIRFIELD
14 TUEBROOK AND STONEYCROFT
15 KNOTTY ASH
16 OLD SWAN
17 CHILDWALL
18 WAVERTREE
19 PICTON
20 PRINCES PARK
21 RIVERSIDE
22 ST MICHAEL'S
23 GREENBANK
24 CHURCH
25 WOOLTON
26 BELLE VALE
27 ALLERTON AND HUNTS CROSS
28 CRESSINGTON
29 MOSSLEY HILL
30 SPEKE-GARSTON

St.Helens
1 RAINFORD
2 BILLINGE AND SENELEY GREEN
3 HAYDOCK
4 EARLESTOWN
5 NEWTON
6 BLACKBROOK
7 PARR
8 TOWN CENTRE
9 MOSS BANK
10 WINDLE
11 ECCLESTON
12 WEST PARK
13 THATTO HEATH
14 SUTTON
15 BOLD
16 RAINHILL

Sefton
1 CAMBRIDGE
2 MEOLS
3 NORWOOD
4 DUKES
5 KEW
6 BIRKDALE
7 AINSDALE
8 HARINGTON
9 RAVENMEOLS
10 MANOR
11 BLUNDELLSANDS
12 PARK
13 SUDELL
14 MOLYNEUX
15 ST OSWALD
16 NETHERTON AND ORRELL
17 FORD
18 VICTORIA
19 CHURCH
20 LINACRE
21 LITHERLAND
22 DERBY

Wirral
1 HOYLAKE AND MEOLS
2 MORETON WEST AND SAUGHALL MASSIE
3 LEASOWE AND MORETON EAST
4 WALLASEY
5 NEW BRIGHTON
6 LISCARD
7 SEACOMBE
8 BIDSTON AND ST JAMES
9 BIRKENHEAD AND TRANMERE
10 CLAUGHTON
11 UPTON
12 GREASBY FRANKBY AND IRBY
13 WEST KIRBY AND THURSTASTON
14 HESWALL
15 PENSBY AND THINGWALL
16 PRENTON
17 OXTON
18 ROCK FERRY
19 BEBINGTON
20 CLATTERBRIDGE
21 BROMBOROUGH
22 EASTHAM

Since the Tellus surveys, some local authorities on Merseyside have carried out their own similar surveys, but there is not one standard survey being used, so comparisons across local authorities are not possible. Halton have carried out surveys based on Tellus - the results from the Halton survey are due to be released soon. Knowsley use the SHEU questionnaire (Schools and Students Health Education Unit). Wirral use the HELP survey (Health, Education and Lifestyle Profile; 2012). Liverpool and Sefton use the INTEC survey (Innovation Partnership, Cambridge Institute of Technology). St.Helens plan to use the SHEU survey. Results from the latest Sefton and Wirral school surveys have been summarised in Appendix 2.

Recommendation:
Encourage all schools across Merseyside to carry out the same standard, consistent school survey covering emotional health and wellbeing (as proposed in Scotland, Parkinson, 2012).

Promoting wellbeing in children and young people, priority areas:

i): The conditions to learn and develop

Children need to be given the conditions to learn and develop, with access to play in the early years and high quality education in school (Children's Society, June 2012). This section of the report will consider indicators of levels of wellbeing including the foundations for good development that are laid at birth; measures of 'good level of development at age 5'; educational achievement; and school attendance.

Pregnancy, Birth and Beyond

Peri-natal health [1]

The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing in later life (RCM, 2011).

In 2011, the government introduced their 'Supporting Families in the Foundation Years' policy (DfE, 2011). This policy recognizes the importance of early years for future emotional and mental health and aims to make the best of the opportunities presented during pregnancy and the first five years of a child's life. The DfE noted that early intervention can forestall the physical and mental health problems that commonly perpetuate a cycle of dysfunction. After the age of three it becomes much more difficult to make changes in both a child's development and in parental behaviour. Interventions under the Healthy Child Programme can help prevent problems in these crucial first few years (DfE, 2011).

As part of the 'Supporting Families in the Foundation Years' policy, the government has produced a resource pack *'Preparation for Birth and Beyond',* which aims to help the NHS, local authorities and the voluntary sector in planning or running groups for expectant and

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[1] Peri-natal, i.e. immediately before and after birth

new parents. It addresses the emotional transition to parenthood in greater depth and recognises the need to include fathers and other partners in groups and activities (DH, 2011c).

Following on from these developments, in May 2012 the government pledged to support women with postnatal depression and make improvements to maternity care. An extra 4,200 health visitors being recruited by the government will get enhanced training so they can spot the early signs of postnatal depression (DH, 2012a).

For vulnerable young first time mothers, the Family Nurse Partnership (FNP) scheme offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. A strong evidence base has shown FNP benefits the most needy young families in the short, medium and long term across a wide range of outcomes helping improve social mobility and break the cycle of inter-generational disadvantage and poverty (DH, 2012b).

The NICE guideline 'Antenatal care: routine care for the healthy pregnant woman' (NICE 2006) outlines the care that women should be offered during pregnancy. A further guideline was produced on ante and post natal mental health (for women at risk of mental health problems) (NICE, 2007a). In recognition that pregnant women with complex social factors may have additional needs, NICE subsequently produced a separate guideline document covering their particular requirements (NICE, 2010a). The guideline applies to all pregnant women with complex social factors and contains a number of recommendations on standards of care for this population as a whole. Four groups of women were identified as exemplars:
- women who misuse substances (alcohol and/or drugs)
- women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English
- young women aged under 20
- women who experience domestic abuse.

Recognising that there are differences in the barriers to care and particular needs of these four groups, specific recommendations were made for each group.

At present, there is no data available across Merseyside on overall peri-natal health, mental health, or post-natal depression. Based on NICE guidance (NICE, 2006 and 2007a) mental health assessments should be carried out for mothers during the first eight weeks after birth. However, there are currently limited resources available to see mothers for mental health assessment in the post partum period as routine. Data around any assessments carried out is not yet readily available. In future, it may be possible to analyse this data for each area within Merseyside.

It is estimated that around 10-15% of new mothers suffer some peri-natal mental health difficulties (NICE, 2006). NICE noted that this can lead to cognitive and emotional disturbance in the baby alongside the effects on the mother. Children of depressed mothers are more likely to access Child and Adolescent Mental Health Services (CAMHS) and suffer mental health problems as adolescents and adults. Social isolation is a known risk factor for postnatal depression and reducing this may have a range of clinical and psycho-social benefits (NICE, 2006).

Using the NICE estimate of 10-15%, estimates can be calculated for local authorities across Merseyside (Table 4). Across Merseyside, there are likely to be between 1,804 to 2,706 new mothers with a mental health problem. In more deprived areas, the proportion with mental health difficulties can be as high as 25%. As the Merseyside area has high levels of deprivation, the figures presented here could be considerable under-estimates.

Table 4
Estimated numbers of new mothers with mental health problems, 2011

	Live Births 2011	Range of estimated numbers of new mothers with a mental health problem	
		from10%	to 15%
Halton	1,667	167	250
Knowsley	1,857	186	279
Liverpool	5,728	573	859
Sefton	2,862	286	429
St Helens	2,156	216	323
Wirral	3,771	377	566
Merseyside	18,041	1,804	2,706

Data taken from Birth Summary Tables, England & Wales, 2011, Released: 10th July 2012, ONS
Range of 10% to 15% based on NICE (2006)

Recommendations:

Peer social support for new mothers suffering social isolation will be beneficial (NICE, 2006). NICE have produced guidelines for routine post natal care (NICE, 2006) and ante and post natal mental health (for women at risk of mental health problems) (NICE, 2007a) which are summarised below. A related document covers pregnancy and complex social factors (NICE, 2010a).

Peri-natal mental health: Effective interventions

Routine post natal care

NICE guidelines for health professionals for the routine postnatal care of women (NICE, 2006) include a section on *'mental health and wellbeing'* which includes the following:
- At each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.
- All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth.
- At 10–14 days after birth, women should be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms

have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further (urgent action)4.

- Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to someone about their feelings and ensuring they can access social support networks.

(NICE, 2006)

Ante and post natal mental health (for women at risk of mental health problems)

For those women assessed as having post-natal depression or any other mental health disorder, NICE guidelines for healthcare professionals include

- How to predict and detect mental health problems
- When to offer psychological treatments
- How to explain the risks of treatment versus non-treatment for mental health problems
- How to manage depression
- How to organise care, including:
  - setting up a specialist multidisciplinary peri-natal service in each locality, consisting of healthcare professionals, commissioners, managers, and service users and carers
  - identifying pathways of care for service users, with defined roles and competencies for all professional groups involved.

(NICE, 2007a).

Lifecourse approach

The independent Children and Young People's Health Outcomes Forum produced a report in July 2012. The Forum recognised that poor mental health in pregnancy is associated with low birth weight and increased rates of mental and physical ill health in children. However, they note that the current system does not recognise this. The Forum's recommendations are designed to address these issues:

- All organisations in the new health system should take a life-course approach, coherently addressing the different stages in life and the key transitions instead of tackling individual risk factors in isolation.

- Directors of Public Health and their local clinical commissioning groups (CCGs) should work together with maternity and child health services to identify and meet the needs of their local population.

- In 2013 the Department of Health should explore the development of a new outcomes measure on peri-natal mental health, and implement it as soon as possible

(CYP Health Outcomes Forum, 2012)

Parenting: Effective interventions

Family based and parenting programmes

Universal (Tier 1 provision[2])
Parenting education is a key intervention in the promotion of all round good health in children (Caestecker and Ross 2010). The parent or caregiver/child relationship is vital to a child's development and future psychological wellbeing (Caestecker and Ross 2010). Caestecker and Ross feel that the implementation of measures by the public sector aimed at supporting parents in their parenting responsibilities is a crucial priority. They cite as an example the population based parenting programme recently adopted in Glasgow (Positive Parenting Programme, or Triple P). This programme is evidence based and employs universal and targeted interventions that aim to prevent emotional and behavioural problems in children by enhancing the knowledge and skills of parents. The programme is centred in primary care, within health visiting teams.

Targeted (Tier 2 provision)
Systematic reviews of interventions to prevent conduct disorder, anxiety and depression before adulthood have shown that programmes targeting at-risk children that involve families, using parent training or child social skills training are the most effective, with a reduced rate of relapse (MHF, 2007, DH, 2011b ref 44).

Psychological therapies

The Government gave a commitment to expand the People's Improving Access to Psychological Therapies IAPT programme to children and young people in their 'Talking therapies: a four year plan of action' (DH, 2011d). This expansion was formally launched in October 2011 with Government committing £32 million to children and young people's IAPTs.

A review by the Thomas Coram Research Unit (TCRU, 2007) found good evidence that behavioural and cognitive-behavioural therapy for children and young people with emotional wellbeing and mental health problems and children with mild to moderate anxiety are demonstrably effective approaches.

Promising approaches included work with parents and carers, which was reported to offer relatively strong evidence, especially using CBT for parents/carers with children with conduct disorders. Five individual evaluation studies also suggest that supporting parents (in two studies using Brief Solution Focused Therapy) can have a positive impact on children as well as parents/carers.

Promising programmes for supporting young people with emotional disorders include social skills training and involving all members of the family using multi-systematic therapy (TCRU 2007).

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[2] See Introduction for details of Tiers of need and provision

Good level of development at age 5

The early years foundation stage (EYFS) profile records each child's achievements at the age of 5 in six areas of learning and development:
- personal, social and emotional development
- communication, language and literacy
- problem solving, reasoning and numeracy
- knowledge and understanding of the world
- physical development
- creative development

The 'good level of development' score takes these areas and sums up and describes each child's development and learning achievements at the age of five (DfE, 2010).

Between 2009-2011, there were overall improvements in the percentages of children achieving a good level of development at the age of 5 in each local authority on Merseyside (Figure 6). The most noticeable improvements have occurred in Knowsley and Sefton, with 10% more children achieving good levels in 2011 compared to 2009. However, it should be noted that despite this overall improvement, between 2010 and 2011 the percentage reduced in both Halton and Wirral.

In 2011 Knowsley (61%) and St.Helens (60%) had levels above the national average of 59% and the North West average of 58%. In Halton, less than half (48%) of all children had reached a good level of development by age 5, the lowest level in England. In Liverpool, levels were also low, at 51%.

Figure 6

% children achieving a good level of development at age 5, 2009 to 2011

	2009	2010	2011
Halton	47	50	48
Knowsley	51	57	61
Liverpool	47	46	51
Sefton	47	55	59
St. Helens	57	55	60
Wirral	52	58	57

England = 59%
NW=58%
(20011)

source: DfE EYFS
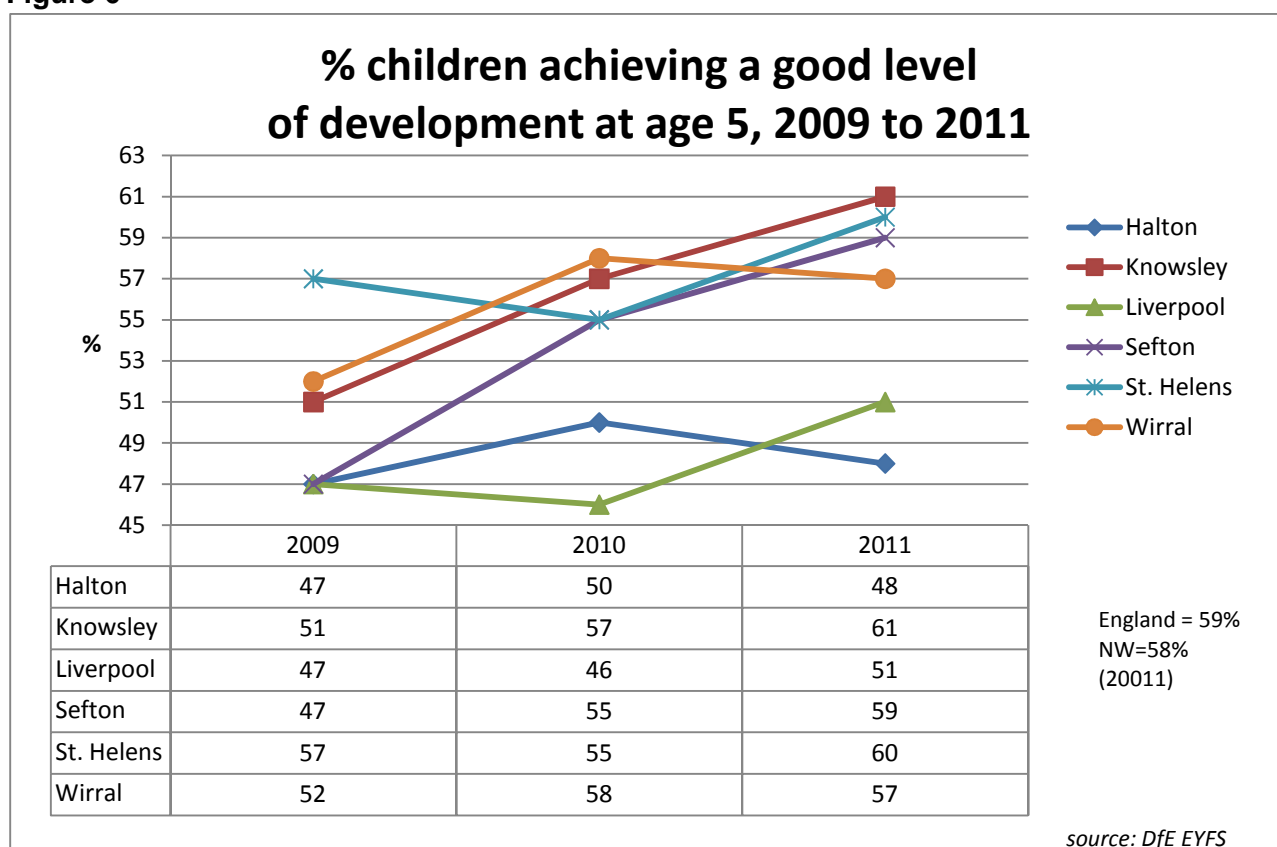
The emotional development component of the good level of development score can be taken out and looked at separately. Figure 7 shows that amongst girls aged 5 in Sefton and Knowsley, emotional development levels are slightly higher than England and North West averages. In Sefton, as many as 9 out of 10 girls had a good level of emotional development. Levels for girls were lowest in Halton, but at 83%, were still above scores for boys across Merseyside and nationally.

Boys aged 5 showed lower levels of emotional development than girls. Sefton had the highest level for boys, at 82%, which was above the national (78%) and North West (76%) averages. Halton had the lowest level for boys, at 70%.

Figure 7

source: DfE
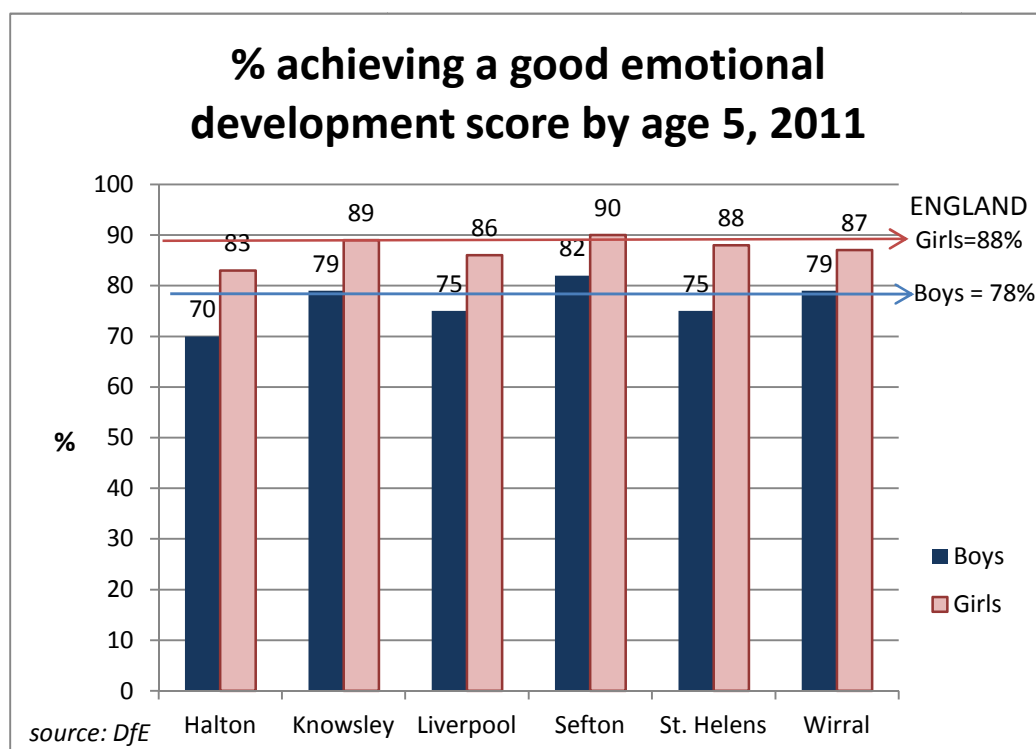
North west: girls=87%, Boys=76%

School

School is particularly important as a social and learning environment, having impacts not only on academic and vocational pathways, but also on present and future health and well being. Young people who are not engaged with learning or who have poor relationships with peers and teachers are more likely to use drugs and engage in socially disruptive behaviours, report anxiety/depressive symptoms, have poorer adult relationships, and fail to complete secondary school (Bond et al 2007).

Research carried out by Chevalier and Feinstein (2006) concluded that there are substantial returns to education in term of improved mental health. The positive impact of qualifications on mental health is biggest for individuals who gain GCSEs, for example, having GCSEs reduces the risk of depression at the age of 42 by five percentage points. Education can

directly affect health outcomes by making individuals more health conscious, by shortening time before help is sought or by following the therapy more accurately.

NICE guidance for secondary schools similarly noted that schools can provide an environment that fosters social and emotional wellbeing. They can also equip young people with the knowledge and skills they need to learn effectively and to prevent behavioural and health problems (NICE, 2009a). Chevalier and Feinstein (2006) noted that the effect of education on health may also be indirect through income, employment, working conditions or family relations.

Good level of education: GCSEs achieved

Figure 8 shows that educational attainment, as indicated by GCSEs achieved (5 A*-C including English and Maths), has been improving in each local authority area in Merseyside since 2005. Wirral (64.1%) has levels well above the England average of 58.4%. Sefton (59.5%) is also above the national average. Knowsley had the lowest levels, with only 40.8% achieving this level of educational attainment (Figure 8 and Table 5).

Figure 8
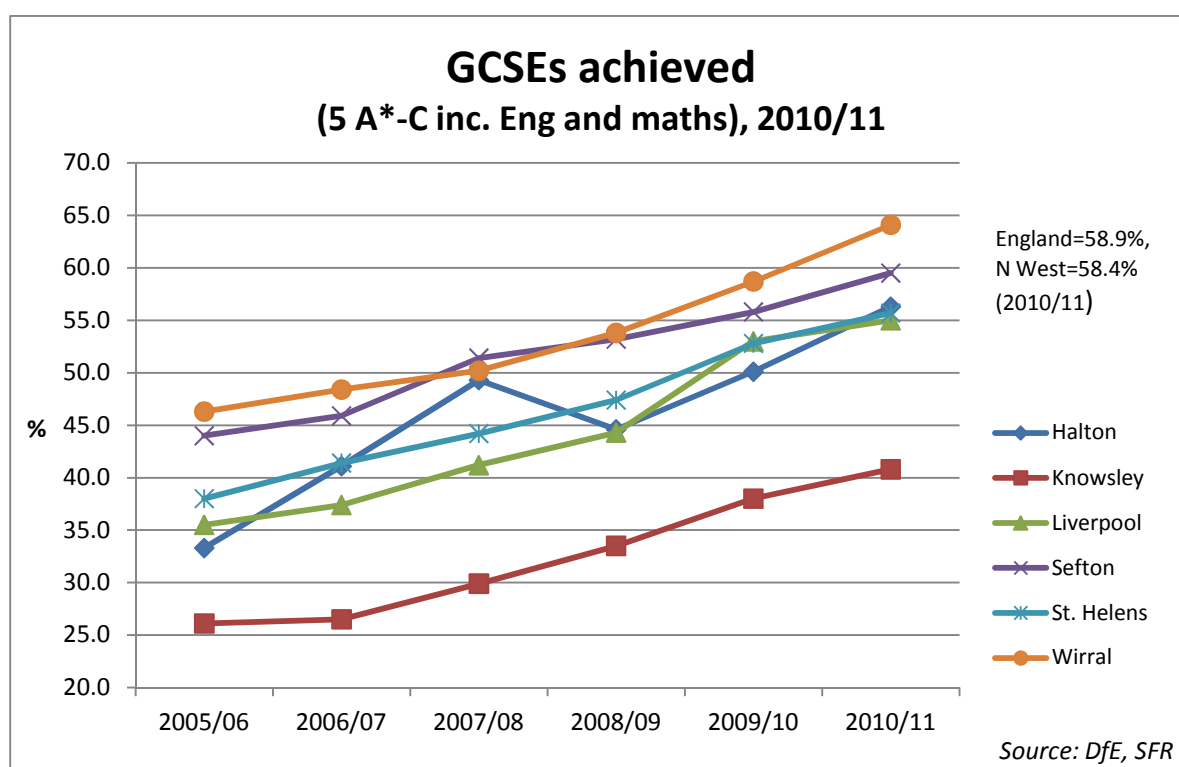
Children looked after: Table 6 shows the educational attainment of children who are looked after. In comparison to all children, their attainment levels are very low. For example in Halton, more than 4 in 5 children (86.6%) achieve five GCSEs at grades A* to C, compared to only 2 in 5 children looked after (40% - half as many). Numbers are too small to compare those achieving GCSEs that include English and Maths.

Even though levels are low, the educational attainment of children looked after in Merseyside compares well to levels elsewhere (with the exception of the Wirral) – especially in Sefton, where almost half (48%) achieve five GCSEs at grades A* to C (Table 6). Sefton, Halton and Knowsley have levels above the national and North West averages. On the Wirral, only 1 in 4 (25.5%) children looked after managed to achieve 5 GCSEs in 2011.

Table 5
All children: GCSE achievement, 2010/11

%	5+ A*-C grades inc. English & Maths GCSEs	5+ A*-C grades
Halton	56.3	86.6
Knowsley	40.8	74.7
Liverpool	55.0	84.3
Sefton	59.5	87.7
St. Helens	55.7	82.9
Wirral	64.1	84.8
NORTH WEST	**58.4**	**82.2**
England	**58.9**	**79.5**

Source: DfE, SFR

Table 6
Children Looked After: GCSE achievement, 2011
Performance of children who have been looked after continuously for at least twelve months1 at Key Stage 4

%	5+ A*-C grades inc. English & Maths GCSEs	5+ A*-C grades	*Number eligible to sit GCSEs*
Halton	x	40.0	*15*
Knowsley	x	37.5	*25*
Liverpool	16.7	36.1	*70*
Sefton	x	48.0	*25*
St. Helens	x	x	*20*
Wirral	x	25.5	*45*
NORTH WEST	**12.9**	**32.5**	
England	**12.8**	**31.2**	

Source: LAC outcomes data
x = number less than or equal to 5 or percentage where the numerator is less than or equal to 5 or the denominator is less than or equal to 10.

School absences and exclusions

It has been noted that school is a fundamental setting in which to establish and develop interpersonal relationships, attitudes to authority and elements of the personality. Failure in this setting may therefore have far-reaching consequences (Place et al, 2000).

> *'absenteeism is not just about the absentee but also has to do with the home, the school, the neighbourhood in which the home and school are situated and...... society as well' (Caroll, 1997)*

School absences

Absenteeism from school is an indicator of a wide variety of present and future problems and is a serious public health issue for mental health professionals, physicians, and educators (Kearney, 2008; Berg, 1992). School absenteeism is a key risk factor for violence, injury, substance use, psychiatric disorders, and economic deprivation. It is linked with suicide attempts, risky sexual behaviour and teenage pregnancy. Psychiatric conditions related to extensive school absences primarily include anxiety, depressive, and disruptive behaviour disorders (Kearney, 2008). Different reasons for absenteeism are related to different conditions, with school refusals associated with anxiety disturbances and truancy associated with conduct disturbances (Berg, 1992)**.** A UK study noted that children who refuse to attend school generally come from socially deprived backgrounds, have significant difficulties relating to peers, and a family life containing conflict and stress (Place et al, 2000).

Higher levels of absenteeism have been reported for schoolchildren with special educational needs, especially those with learning disabilities and emotional disturbances (Redmond and Hosp, 2008).

Merseyside
Persistent absentees are defined as pupils with an absence rate of 15% or more. There were a total of 13,810 pupils who were persistently absent from school during 2010/11 in Merseyside. Numbers for each local authority are shown in Table 7.

Table 7
Number of pupils persistently absent from school in Merseyside, 2010/11

Halton	Knowsley	Liverpool	Sefton	St Helens	Wirral	**Merseyside**
965	1,685	5,255	2,180	1,250	2,475	**13,810**

Source DfE

Nationally in 2010/11, 6.1% of pupils had persistently high absence rates. In Liverpool (9.6%) and Knowsley (9.1%), the proportions were much higher (Figure 9). Other areas within Merseyside were close to the national average.

Figures 10 to 12 show differences in rates according to the type of school (primary, secondary or special).
- In Halton, persistent absences were below the national average, except in primary schools

- Knowsley was above the national average for each type of school (especially in secondary schools)
- Liverpool was above the national average for each type of school (especially in primary schools)
- Sefton was around the national average
- St. Helens was below the national average for each type of school
- In Wirral, persistent absences were below the national average for secondary and special schools, but slightly above for primary schools

Variations within local authorities:
Map 2 on page 29 shows variations in persistent absenteeism within local authorities. The percentages illustrated are for lower super output areas (LSOAs). LSOAs contain between 400 to 1,200 households. Ward boundaries have been overlaid for ease of description. The numbers on the map correspond to the wards, with a key on the page after the map. Appendix 1 gives a brief description of each indicator used for mapping.

Within local authorities, the highest levels of absenteeism were found in the following areas:
- *Liverpool*: to the north west of the city, with small pockets to the north east, east (Belle Vale) and south (Speke-Garston).
- *Knowsley*: to the north (especially Whitefield) and across the middle of the borough, including much of Longview.
- *Sefton*: in the south and in small pockets to the north east.
- *Wirral*: along the eastern strip of the borough and parts of the mid-north.
- *Halton*: In Widnes (north of the river), highest levels are concentrated in parts of Appleton and Kingsway. Absenteeism levels are relatively lower south of the river in Runcorn.
- *St.Helens:* Parts of Parr, the Town Centre and Moss Bank have the highest levels of absenteeism*.*

Within local authorities in Merseyside, the distribution of high levels of absenteeism show a very similar pattern to that of low levels of child wellbeing (as shown in the map on p.14), to levels of child poverty (see map on p.70) and to a lesser extent, children aged under 16 on disability allowance (p.39).

Special Educational Needs: As suggested in the literature (see previous page), government statistics show that children from special schools have higher rates of absenteeism. Nationally, children from special schools had around twice as many persistent absentees compared to children in secondary schools in 2010/11 (Figures 11 and 12). In St.Helens and Halton, rates in special schools were considerably lower than the national average and in Wirral and Sefton, slightly lower.

Children with special educational needs (SEN) had persistent absenteeism rates more than twice as high as rates for all children (14.5% compared to 6.1%). Amongst SEN children, those with behavioural, emotional and social difficulties had the second highest rates (23.1%). Only those with profound and multiple learning difficulties had higher rates (29.4%).

Further characteristics of absentees are available for national data 2010/11 as follows:

- *Gender:* boys and girls had almost identical rates of persistent absenteeism (6.1% boys and 6.2% girls)
- *Age:* absenteeism rates remains fairly constant through the primary school years, but then start to increase with the age of the child, with a rate of 5% in year 7, increasing steadily to a rate of 12.8% in year 11.
- *Deprivation:* there is a strong correlation with deprivation, with a rate of 9.5% in the most deprived areas, falling steadily to only 2.6% in the least deprived.
- *Ethnic group:* 45.7% of Irish travelling children and 37% of gypsy/Roma children were persistent absentees. Mixed race children also had rates above the national average, with (7.2% compared to 6.1% national average). Comparatively low rates were found amongst Asian (5.4%), Black (3.8%) and Chinese (1.6%) children.

Figure 9

Persistent absentees, all schools 2010/11
% of pupils with absence rate of 15% or more

England average 6.1% (NW 6.3%)

source:DfE

Figure 10

Primary schools
Persistent absences, 2010/11

England average 3.9% (NW 4%)

source:DfE

Figure 11

Secondary schools
Persistent absences, 2010/11

England average 8.4% (NW 8.7%)

source:DfE

Figure 12

Special schools
Persistent absences, 2010/11

England average 16.7% (NW 16.8%)
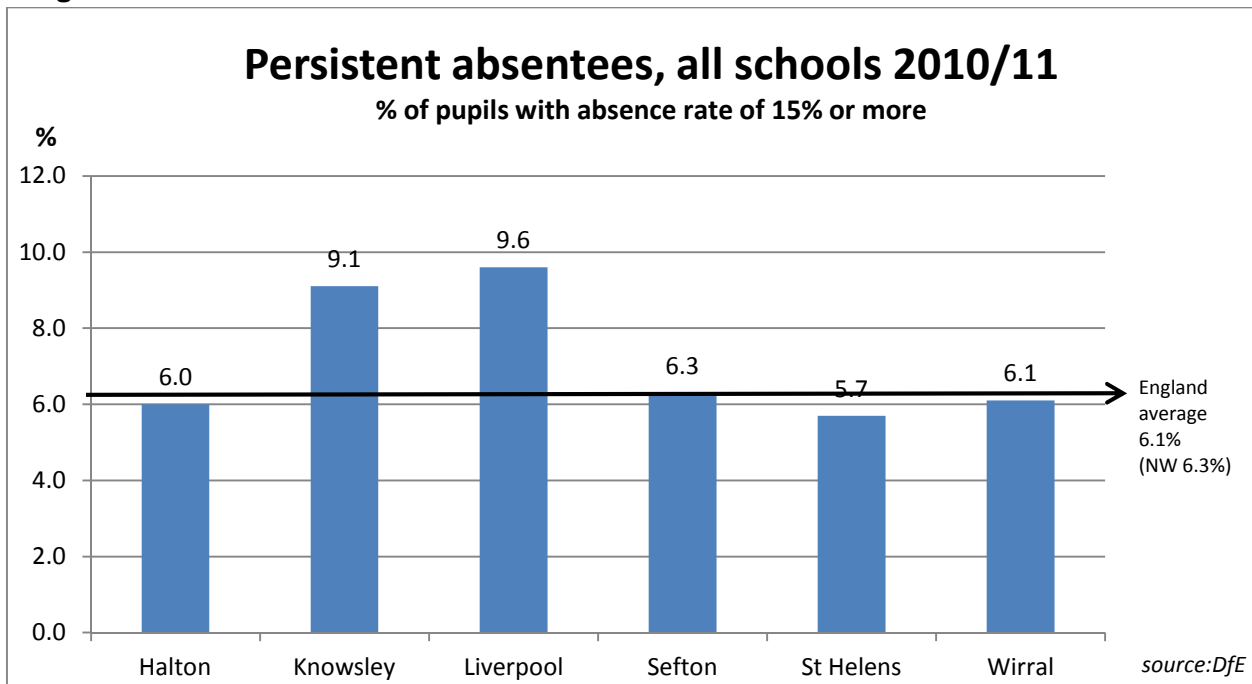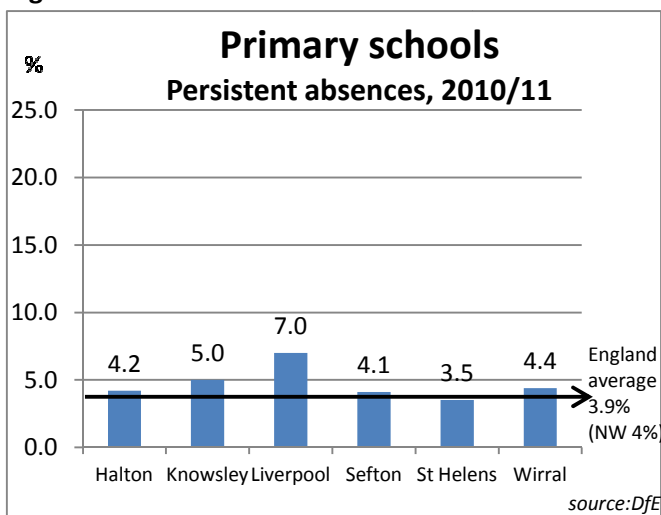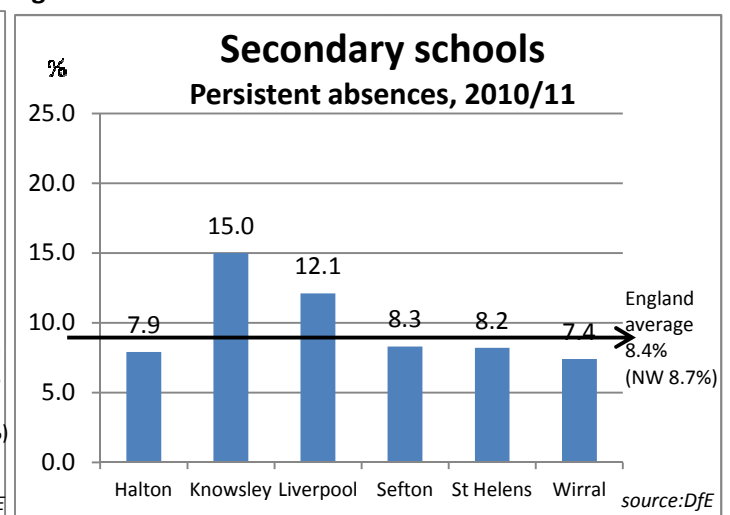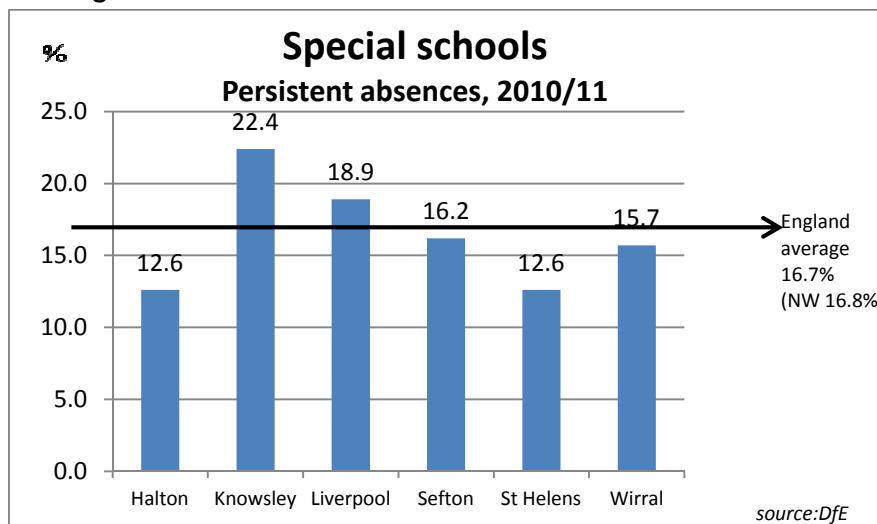
source:DfE

Map 2 (key to ward numbers on next page)

Persistent School Absenteeism
by LSOA in Merseyside 2010/11
Source: Department for Education

Persistent absentees as a proportion of enrolments
Persistent absentee: a pupil who is absent for 46 or more sessions during the year

- 11.3 to 22.5%
- 8.6 to 11.3%
- 6.3 to 8.6%
- 4.4 to 6.3%
- 1 to 4.4%
- 0 (may not be true zeroes, may be supressed due to low numbers)

Contains Ordnance Survey data.
(C) Crown copyright and database right 2012
Contains Royal Mail data.
(C) Royal Mail copyright and database right 2012

Map Key: electoral wards in the Merseyside area

	Halton		Liverpool		Sefton
1	HOUGH GREEN	1	KIRKDALE	1	CAMBRIDGE
2	BIRCHFIELD	2	COUNTY	2	MEOLS
3	FARNWORTH	3	WARBRECK	3	NORWOOD
4	HALTON VIEW	4	FAZAKERLEY	4	DUKES
5	APPLETON	5	CROXTETH	5	KEW
7	KINGSWAY	6	YEW TREE	6	BIRKDALE
8	BROADHEATH	7	WEST DERBY	7	AINSDALE
9	DITTON	8	NORRIS GREEN	8	HARINGTON
10	MERSEY	9	CLUBMOOR	9	RAVENMEOLS
11	CASTLEFIELDS	10	ANFIELD	10	MANOR
12	DARESBURY	11	EVERTON	11	BLUNDELLSANDS
13	NORTON NORTH	12	CENTRAL	12	PARK
14	WINDMILL HILL	13	KENSINGTON AND FAIRFIELD	13	SUDELL
15	NORTON SOUTH	14	TUEBROOK AND STONEYCROFT	14	MOLYNEUX
16	HALTON LEA	15	KNOTTY ASH	15	ST OSWALD
17	HALTON BROOK	16	OLD SWAN	16	NETHERTON AND ORRELL
18	GRANGE	17	CHILDWALL	17	FORD
19	BEECHWOOD	18	WAVERTREE	18	VICTORIA
20	HEATH	19	PICTON	19	CHURCH
21	HALE	20	PRINCES PARK	20	LINACRE
22	RIVERSIDE	21	RIVERSIDE	21	LITHERLAND
	Knowsley	22	ST MICHAEL'S	22	DERBY
1	CHERRYFIELD	23	GREENBANK		Wirral
2	PARK	24	CHURCH	1	HOYLAKE AND MEOLS
3	SHEVINGTON	25	WOOLTON	2	MORETON WEST AND SAUGHALL MASSIE
4	NORTHWOOD	26	BELLE VALE	3	LEASOWE AND MORETON EAST
5	WHITEFIELD	27	ALLERTON AND HUNTS CROSS	4	WALLASEY
6	KIRKBY CENTRAL	28	CRESSINGTON	5	NEW BRIGHTON
7	PRESCOT WEST	29	MOSSLEY HILL	6	LISCARD
8	STOCKBRIDGE	30	SPEKE-GARSTON	7	SEACOMBE
9	PAGE MOSS		St.Helens	8	BIDSTON AND ST JAMES
10	SWANSIDE	1	RAINFORD	9	BIRKENHEAD AND TRANMERE
11	ST BARTHOLOMEWS	2	BILLINGE AND SENELEY GREEN	10	CLAUGHTON
12	LONGVIEW	3	HAYDOCK	11	UPTON
13	ST MICHAELS	4	EARLESTOWN	12	GREASBY FRANKBY AND IRBY
14	PRESCOT EAST	5	NEWTON	13	WEST KIRBY AND THURSTASTON
15	WHISTON NORTH	6	BLACKBROOK	14	HESWALL
16	WHISTON SOUTH	7	PARR	15	PENSBY AND THINGWALL
17	ST GABRIELS	8	TOWN CENTRE	16	PRENTON
18	ROBY	9	MOSS BANK	17	OXTON
19	HALEWOOD NORTH	10	WINDLE	18	ROCK FERRY
20	HALEWOOD WEST	11	ECCLESTON	19	BEBINGTON
21	HALEWOOD SOUTH	12	WEST PARK	20	CLATTERBRIDGE
		13	THATTO HEATH	21	BROMBOROUGH
		14	SUTTON	22	EASTHAM
		15	BOLD		
		16	RAINHILL		

School exclusions

There was a rapid rise in school exclusions following the implementation of the national curriculum, league table pressures and local management of schools (Skuse, 2008). This led to the introduction of targets to reduce exclusions. In a scientific review of school exclusions. Skuse notes that the relationship between early learning difficulties, exclusion from school, and crime, has been described as a 'downward spiral', in which children who lack basic literacy and numeracy skills develop low self-esteem and become disillusioned with education, eventually leaving school early (Skuse, 2008).

It has been suggested that teachers are often uncertain of the distinction between poor behaviour and behaviour that reflects underlying psychological difficulties requiring specialist management (Skuse (2008).

Local data
In 2010/11, there were 7,760 fixed period school exclusions and 150 permanent school exclusions across Merseyside (Tables 8 and 9 below). Levels were generally lower in Mersey than nationally. They were especially low in St.Helens, which had the lowest level of fixed term exclusions in Merseyside, at 2.17% of the school population – around half as many as nationally (4.34%). St.Helens had no permanent exclusions during 2010/11 (Figures 13 and 14).

The highest levels of fixed period exclusions on Mersey were found in Knowsley, at 6.77% of the school population. Knowsley was the only Mersey local authority with levels higher than the national average of 4.34% (Figure 13). However, when it comes to permanent exclusions, Knowsley had the second lowest rate in Merseyside, at only 0.03%.

Amongst Liverpool schoolchildren, there were 0.14% of permanent exclusions. Liverpool was the only local authority on Merseyside with levels above the national average on 0.07%. Actual numbers of fixed period and permanent exclusions for each local authority are shown in Tables 8 and 9 below.

Figure 13
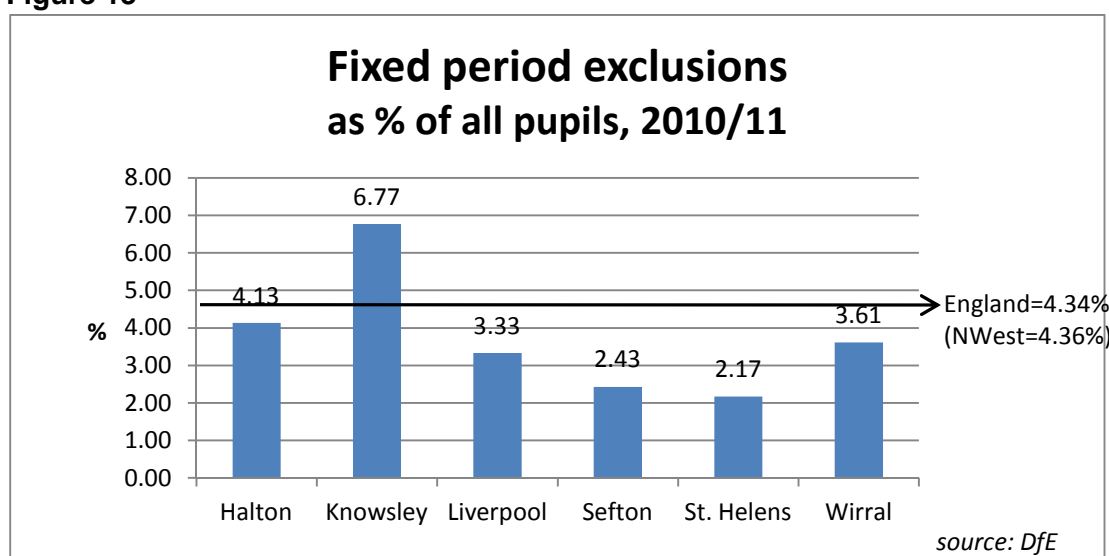
source: DfE

Table 8

Fixed period school exclusions, 2010/11

	number	% of all pupils
Halton	740	4.13
Knowsley	1,470	6.77
Liverpool	2,230	3.33
Sefton	1,000	2.43
St. Helens	550	2.17
Wirral	1,770	3.61
Mersey	**7,760**	

source: DfE

Figure 14

Permanent exclusions as % of all pupils, 2010/11
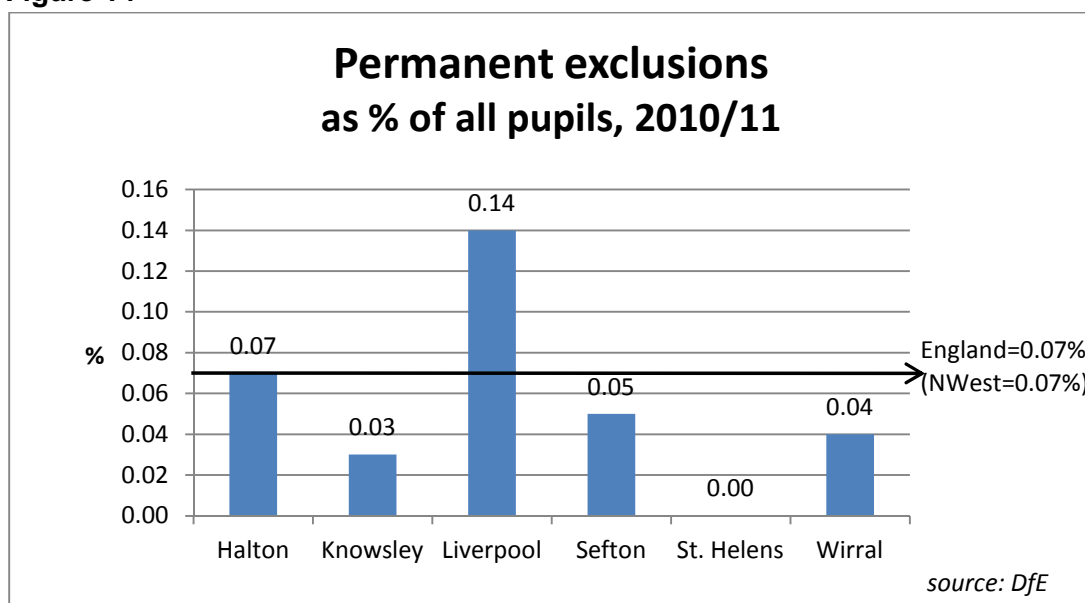
source: DfE

Table 9

Permanent school exclusions, 2010/11

	number	% of all pupils
Halton	10	0.07
Knowsley	10	0.03
Liverpool	90	0.14
Sefton	20	0.05
St. Helens	0	0.00
Wirral	20	0.04
Mersey	**150**	

source: DfE

Effective interventions in schools

Universal (Tier 1 provision)
Schools have a role in promoting factors that create resilience, helping to develop skills such as emotional management, self-awareness, optimism, a sense of coherence, social skills and empathy (Weare, 2010).

There are an increasing number of mental health based interventions in schools. This is especially the case in the US, where Weare suggests that interventions tend to have an individual skills focus. In the UK, there is more of an environmental/ whole schools approach, led by government. This began in the 1980s with the 'Healthy Schools' initiative, where emotional wellbeing and anti-bullying are key themes, led by government until recently. This was added to by the 'Social and Emotional Aspects of Learning' (SEAL) approach, introduced in the 1990s. SEAL focused on teaching social and emotional skills to pupils and staff and creating environments which promote mental health (Weare, 2010).

There have been other universal, whole school approaches used in some schools. Those listed by Weare (2010) include the PATHS programme (2012). There is less governmental support now for SEAL and similar initiatives.

Targeted (Tier 2 provision)
Targeted approaches are required for children who are showing early signs of emotional and social difficulties. NICE recommend that schools should ensure teachers and practitioners are trained to identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary schoolchildren. They should also be able to assess whether a specialist should be involved and make an appropriate request (NICE, 2008 & 2009a).

Targeted approaches in schools are mainly delivered by the voluntary sector, for example Pyramid after school clubs, which help shy, quiet, withdrawn children develop confidence (ContinYou, 2011). A recent government led initiative was Targeted Mental Health in Schools, (TaMHS) a three year project established in 2008, running in selected schools in each local authority (Weare, 2010).

Summary of evidence of good practice in schools
Effective school based programmes have the following features:
- Implemented consistently, over a long period of time, with sustained investment
- Start early – the most effective programmes are those targeting the youngest children.
- Whole school approaches are most successful, with mental health work integrated across a whole range of school activity, including the curriculum
- Include explicit work on the development of mental health skills in students, staff and sometimes parents
- Parental involvement/cooperation is essential and peer learning can be helpful
- Targeted specialist therapeutic help should be located within a universal, whole school approach, creating a supportive environment that will help to reduce stigma (as with Pyramid clubs). As with universal approaches, this should start early.

- Promising approaches for children and young people with emotional and behavioural difficulties include: cognitive behavioural therapy, the provision of rewards, supporting children to monitor their behaviour, reduce aggressive behaviours and improve their social skills, as well as changing the seating arrangements in the classroom. The FRIENDS programme (a CBT programme for children and young people with anxiety difficulties) appears to be a promising approach. As does the Triple P – Positive Parenting Programme - which offers a tiered approach to supporting parents and carers, with evidence for the reduction in conduct problems.
- Ensure teachers and staff are trained to deliver a universal, comprehensive programme to help develop children's social and emotional skills and wellbeing. They also need to be trained to identify early signs of emotional and mental health problems and to know how to respond.

(Weare, 2010; TCRU, 2007; NICE, 2008; NICE 2009a)

Early identification is critical – To ensure the best possible outcomes, children at risk of developing conduct disorders and adolescents who may have emerging personality disorder need to be identified early. The last Office for National Statistics survey results showed that only 25% of children and adolescents with conduct and emotional disorder are seen by CAMHS (DH, 2011a). Of all children aged 5-15 with mental health problems, it is estimated that around three quarters are not in contact with child and adolescent mental health services (MHF, 2007).

Recommendations for schools

NICE guidance on social and emotional wellbeing in primary education (NICE, 2008) and secondary education (NICE, 2009a) is aimed at teachers and school governors, and staff in local authority children's services, primary care and child and adolescent mental health services. Guidance focuses on universal interventions used as part of an organisation-wide approach (that is, interventions that can be used to support all young people). It does not cover targeted approaches.

Recommendations include:
- Local authorities should ensure schools provide an emotionally secure environment that prevents bullying and provides help and support for children (and their families) who may have problems.
- Schools should have a programme to help develop the emotional and social wellbeing of all children. It should be integrated into all aspects of the curriculum and staff should be trained to deliver it effectively.
- Schools should also plan activities to help children develop social and emotional skills and wellbeing, and to help parents develop their parenting skills.
- Schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed. Those at higher risk of these problems include looked after children, those in families where there is instability or conflict and those who have had a bereavement.

Approaches which are more targeted are identified in the Healthy Child Programme (DH/DCSF HCP, 2009). The following services should be available and easily accessible:

• Professional consultation following from referral to primary, targeted and specialist CAMHS support (across tiers 2, 3 and 4) for young people at risk of and/or experiencing poor mental health where there is an identified need.

• Schools to provide access to additional support for those children who need it most and their families. Interventions can include parent training/education programmes, therapeutic support for depression – cognitive behavioural therapy (CBT), psychoanalytic child psychotherapy or family therapy depending on symptoms and associated problems. They will also link with specialist CAMHS support.

The key focus in targeted support and interventions is to build resilience and prevent the development of significant problems for individuals and families exposed to significant risk. Such support is the responsibility of the School Health Team, working with education colleagues (DH/DCSF HCP, 2009).

Recommendations on absenteeism and exclusions

Absenteeism:
- A multi-disciplinary approach is required, including community and school-based mental health professionals and teaching staff in an attempt to fully understand the factors behind school absenteeism. The aim would be to develop improved and agreed policies regarding the definition, classification, assessment, and intervention of youths with problematic school absenteeism.
- Possible interventions would include individual and family psychological therapy, with a focus on strengthening the child's social skills and peer relationships. Strategies can then be developed from the particular needs identified, such as developing mechanisms for coping with bullying. (Place, 2000;Kearney, 2008).

Exclusions:

- Ensure greater integration between child mental health services and child educational services, recognising the needs of children who may not have recognised learning difficulties.
- Work with community mental health nurses in initial assessments of children. Greater collaboration between clinical and educational psychology services is likely to be helpful in meeting the needs of this group.
- Interventions for disruptive behaviour may not be effective if social communication needs are not appreciated. Specialist provision in terms of social skills training, and other specialist help should be made available to those children with social communication difficulties, with or without any previous diagnoses.
- Ensure teachers are assisted in recognising the distinction between poor behaviour and behaviour that reflects underlying psychological difficulties requiring specialist management.

(Skuse, 2008)

Promoting wellbeing in children and young people, priority areas:

ii): *A positive view of themselves and an identity that is respected*

Children need to see themselves in a positive light, deserving to feel and be respected by all adults and other children (Children's Society, June 2012 and 2012a). Possible negative influences on this aspect of wellbeing are considered in this section, including having a disability; not being in education employment or training (NEET); being pregnant; smoking and drinking; belonging to a vulnerable group, such as gypsy and traveller communities, asylum seekers or an ethnic minority; and those with sexual identity issues.

Bullying is an important aspect here, with children from more vulnerable groups being especially susceptible. The Department of Health note that providing a safe and happy learning environment is integral to achieving the wider objectives of school improvement: raising attainment; improving school attendance; promoting equality and diversity; and ensuring the welfare of all members of the school community. Schools have a legal duty to have measures in place to prevent and tackle bullying (DH/DCSF, 2009).

Children with disabilities, ill-health and special educational needs

The level, degree and prevalence of childhood disability is not comprehensively understood as data collected is not co-ordinated or consistently gathered. There is variation in definitions of, and criteria for, disability making it difficult to find definitive figures for the numbers of disabled children for each local authority (TCRU, 2008). Recognising this, the Thomas Coram Research Unit was commissioned by the DCSF to undertake a survey of all Directors of Children's Services in England to collect and analyse data on the numbers and characteristics of disabled children and the services provided to them (TCRU, 2008).

There are an estimated 0.7 million disabled children in the UK (ONS 2007). Boys are twice as likely as girls (69% to 32%) to be categorised as disabled. Children under five are less likely to be known to be disabled and there are equal numbers of young people in age range 5-11 years old and 12-18 years old (TCRU, 2008). Nationally, ONS estimated that there are 42.3 per 1,000 children who are disabled (ONS, 2007). The TCRU estimate is slightly lower, at 40.3 per 1,000. The TCRU survey presented estimates for different types of disability are shown in Table 10.

Disability Living Allowance (DLA) Claimants
Data on numbers in receipt of disability living allowance aged under 16 will give a low estimate of numbers of disabled children, as not all disabled children will have claims made. It has been suggested that almost 1 in 4 children who are in receipt of disability benefit (24%) are believed to have an emotional disorder (ONS, 2005).

Data for the Merseyside local authorities for claimants aged under 16 is presented in Figure 15. Rates are highest in Sefton, at 46.6 per 1,000 population aged under 16, which is more than twice as high as the 20.6 per 1,000 claimants in St.Helens. Estimates of numbers likely to have emotional disorders are given in Table 11.

Table 10: Type of disability, rates per 1,000 children under 18 (TCRU, 2008).

Type of disability	Rate per 1,000 (Standard Deviation)
Physical Disability (Per 1000)	**2.7** (2.4)
Sensory Impairment (Per 1000)	**1.8** (1.6)
Chronic Illness (Per 1000)	**1.0** (1.2)
Life Limiting Illness (Per 1000)	**4.7** (14.8)
Other Disability Interaction and Communication (Per 1000)	**6.1** (4.5)
Cognition and Learning (Per 1000)	**12.3** (15.0)
Emotional/Behavioural (Per 1000)	**5.3** (4.8)
Mental Health (Per 1000)	**6.5** (15.5)
Total:	**40.3 per 1000 children**

Note: Out of the 115 local authorities (LAs) asked to complete the survey, the response rate was generally low: for physical disability 68 LAs out of 115 completed the survey, for sensory impairment 64 responded out of 115, for chronic illness 25 responded out of 115, and life limiting illness data 13 LAs responded out of 115. In the 'Other Disability' section of the table, approximately 48 local authorities provided data for the survey.

Figure 15

Disability Living Allowance Claimants aged Under 16, as at February 2012, rates per 1,000.

source:DWP
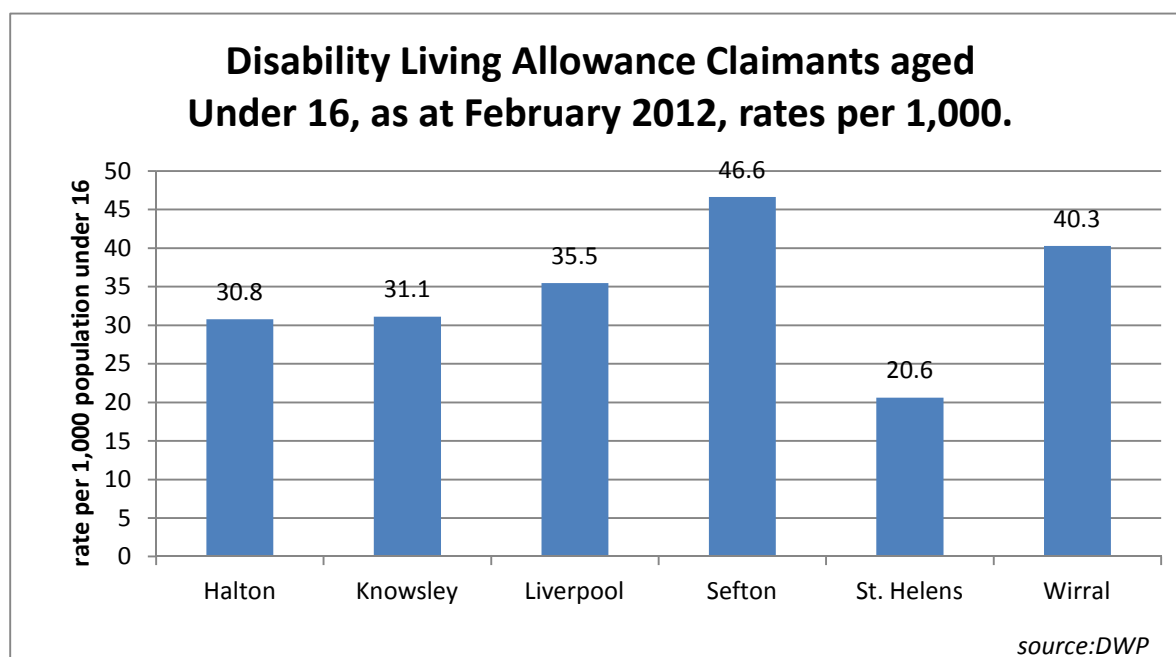
Table 11
Disability Living Allowance Claimants aged Under 16, as at February 2012.
Numbers, rates and estimated number with emotional disorders

	number of claimants aged U16	rate per 1,000 U16 (mid-2010 pop estimates)	estimated number with emotional disorders (based on ONS 2005 estimate of 24%)
Halton	790	30.8	198
Knowsley	980	31.1	245
Liverpool	2,830	35.5	708
Sefton	1,640	46.6	410
St. Helens	1,050	20.6	263
Wirral	2,530	40.3	633
Merseyside	9,820	34.4	2,455

Source: DWP data

Note - 2010 population estimates were used to calculate rates, as single age population data for 2011 census not available at time of writing

Small area analysis was undertaken of the percentage of the population aged under 16 claiming disability allowance. Results have been mapped on the following page (Map 3). They show wide variations in levels across Merseyside. There are several wards dotted about Sefton with high levels of claimants (up to 17% of the population under 16), including most of Manor ward (ward no.10 on the map). In the Wirral, there are areas with high levels of claimants around the north and east of the borough. In Liverpool, levels are highest in patches across the north of the city, and in parts of Speke-Garston and Allerton-Hunts Cross. The distribution of claimants across Knowsley is less patchy, but with slightly higher levels across the centre of the borough. Castlefields in Halton has the highest level of claimants. In St.Helens, the highest levels are found around the centre and south, and a small pocket to the north of Billinge & Seneley Green.

Map 3 (key to ward numbers on next page)

Disability Living Allowance Claims among under 16s
by LSOA in Merseyside, February 2012.
Source: DWP Information, Governance and Security Directorate

Percentage of under 16 population claiming DLA
(Number of LSOAs in category in brackets)

	5.1 to 17.1	(166)
	4 to 5.1	(172)
	3.3 to 4	(151)
	2.5 to 3.3	(149)
	1 to 2.5	(263)
	0 (may not be a true zero, data may be missing)	(83)

Contains Ordnance Survey data.
(C) Crown copyright and database right 2012
Contains Royal Mail data.
(C) Royal Mail copyright and database right 2012

Map Key: electoral wards in the Merseyside area

Halton
1	HOUGH GREEN
2	BIRCHFIELD
3	FARNWORTH
4	HALTON VIEW
5	APPLETON
7	KINGSWAY
8	BROADHEATH
9	DITTON
10	MERSEY
11	CASTLEFIELDS
12	DARESBURY
13	NORTON NORTH
14	WINDMILL HILL
15	NORTON SOUTH
16	HALTON LEA
17	HALTON BROOK
18	GRANGE
19	BEECHWOOD
20	HEATH
21	HALE
22	RIVERSIDE

Knowsley
1	CHERRYFIELD
2	PARK
3	SHEVINGTON
4	NORTHWOOD
5	WHITEFIELD
6	KIRKBY CENTRAL
7	PRESCOT WEST
8	STOCKBRIDGE
9	PAGE MOSS
10	SWANSIDE
11	ST BARTHOLOMEWS
12	LONGVIEW
13	ST MICHAELS
14	PRESCOT EAST
15	WHISTON NORTH
16	WHISTON SOUTH
17	ST GABRIELS
18	ROBY
19	HALEWOOD NORTH
20	HALEWOOD WEST
21	HALEWOOD SOUTH

Liverpool
1	KIRKDALE
2	COUNTY
3	WARBRECK
4	FAZAKERLEY
5	CROXTETH
6	YEW TREE
7	WEST DERBY
8	NORRIS GREEN
9	CLUBMOOR
10	ANFIELD
11	EVERTON
12	CENTRAL
13	KENSINGTON AND FAIRFIELD
14	TUEBROOK AND STONEYCROFT
15	KNOTTY ASH
16	OLD SWAN
17	CHILDWALL
18	WAVERTREE
19	PICTON
20	PRINCES PARK
21	RIVERSIDE
22	ST MICHAEL'S
23	GREENBANK
24	CHURCH
25	WOOLTON
26	BELLE VALE
27	ALLERTON AND HUNTS CROSS
28	CRESSINGTON
29	MOSSLEY HILL
30	SPEKE-GARSTON

St.Helens
1	RAINFORD
2	BILLINGE AND SENELEY GREEN
3	HAYDOCK
4	EARLESTOWN
5	NEWTON
6	BLACKBROOK
7	PARR
8	TOWN CENTRE
9	MOSS BANK
10	WINDLE
11	ECCLESTON
12	WEST PARK
13	THATTO HEATH
14	SUTTON
15	BOLD
16	RAINHILL

Sefton
1	CAMBRIDGE
2	MEOLS
3	NORWOOD
4	DUKES
5	KEW
6	BIRKDALE
7	AINSDALE
8	HARINGTON
9	RAVENMEOLS
10	MANOR
11	BLUNDELLSANDS
12	PARK
13	SUDELL
14	MOLYNEUX
15	ST OSWALD
16	NETHERTON AND ORRELL
17	FORD
18	VICTORIA
19	CHURCH
20	LINACRE
21	LITHERLAND
22	DERBY

Wirral
1	HOYLAKE AND MEOLS
2	MORETON WEST AND SAUGHALL MASSIE
3	LEASOWE AND MORETON EAST
4	WALLASEY
5	NEW BRIGHTON
6	LISCARD
7	SEACOMBE
8	BIDSTON AND ST JAMES
9	BIRKENHEAD AND TRANMERE
10	CLAUGHTON
11	UPTON
12	GREASBY FRANKBY AND IRBY
13	WEST KIRBY AND THURSTASTON
14	HESWALL
15	PENSBY AND THINGWALL
16	PRENTON
17	OXTON
18	ROCK FERRY
19	BEBINGTON
20	CLATTERBRIDGE
21	BROMBOROUGH
22	EASTHAM

Sefton PCT reported 682 children currently registered on the Disabled Children's Register, a voluntary register of disabled children aged 0-18. They estimated that there may be at least another 120 disabled children who are not yet registered. This voluntary register covers disabled children which excludes ADD/ADHD unless secondary to a disability (Sefton JSNA, 2010). The 682 on the Sefton child disability register would appear to be an under-estimate, as there were 1,640 children and young people aged under 16 claiming disability living allowance in Sefton in February 2012 (Table 11).

Datasets which should be available soon include limiting long-term illness ages 0-17 from the 2011 census, and numbers of disabled children in need, from the 2011-12 Children In Need (CIN) census. The CIN covers all social service activity and records disabled children in contact at the time of the census.

Children with physical disability/illness

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

We can predict the numbers of children and young people with physical disability in each local authority using the TCRU estimate of 2.7 per 1,000 aged under 18, and applying this to the most recent 2011 Census data. Table 12 gives the estimated numbers with physical disability aged 0-19 for each local authority, with a total of 951 across Merseyside.

Table 12
Estimated numbers with physical disability age 0-19, 2011

Halton	85
Knowsley	99
Liverpool	290
Sefton	164
St Helens	110
Wirral	203
Merseyside	951

based on TCRU estimate [2008] of 2.7 per 1,000 children under 18),
applied to local authority population data 0-19 (Census 2011)

Learning disability and children with special educational needs (SEN)

The definition of learning disability is the presence of significantly reduced ability to understand new or complex information, and to learn new skills (impaired intelligence); reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development (DH, 2001b)

A child has special educational needs if he or she has a learning difficulty which calls for special educational provision to be made for them (The Learning Trust, 2009). Figure 16 illustrates the difference between SEN and disability and where they overlap. As explained by The Learning Trust, a disability might give rise to a learning difficulty that calls for special educational provision to be made for a child. Many children who have SEN will also be defined as being disabled under the Disability Discrimination Act (DDA). However, not all children who are regarded as SEN will be defined as learning disabled, e.g. those with mild learning difficulties. Similarly, not all those defined as disabled under the DDA will have SEN.

Figure 16
Areas of overlap between SEN and disability
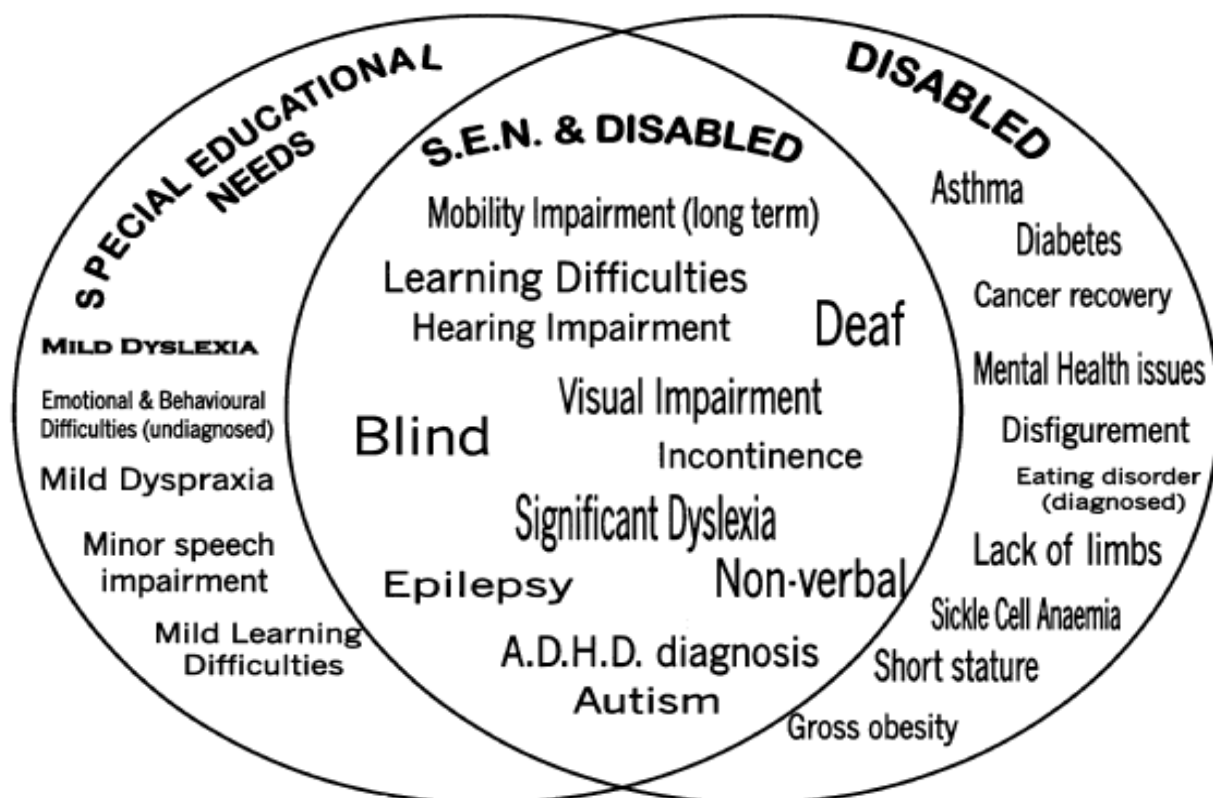
Source: The Learning Trust, 2009. Copyright C O'Mahony and R.Rieser Nov 2001.

Some children with SEN have statements. SEN statements are for those with more extreme educational needs and will describe the special help the child should receive. The local authority will usually make a statement if it decides that all of the special help the child needs cannot be provided from within the school's existing resources. The local authority may decide that the child's school can provide special help for the child's SEN without the need for a statement.

Links with mental health

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

- children with learning disabilities were three to four times more likely to have behavioural problems than peers without a disability;
- there is a 40% prevalence of diagnosable mental disorder within the learning disabled population of children, young people and adults; for children and young people with severe learning difficulties, the incidence rate is three to four times higher than in the general population;
- the learning disabled living in urban and deprived communities are at particular risk of emotional wellbeing and mental health problems
- one in ten of all children with referred mental health problems had a learning disability, and 50% of those lived in poverty.
- 25-30% of the increased risk of emotional and behavioural problems among children with learning difficulties was related to households with very low income;
- the presence of intellectual disabilities should be considered a highly significant risk factor for the development of some specific forms of psychiatric disorders (conduct disorders, anxiety disorders, attention deficit and hyperactivity disorder/hyperkinesis and pervasive developmental disorders);
- research has suggested the prevalence of intellectual disabilities among South Asian children and young people is three times higher than in other communities.

(TCRU, 2007)

As detailed above (p.26), higher levels of absenteeism have been reported for schoolchildren with special educational needs, especially those with learning disabilities and emotional disturbances (Redmond and Hosp, 2008).

Local data:

Nationally, around 1 in 5 children (19.8%) have special educational needs (DfE, 2012; ONS, 2000). In Knowsley, Liverpool, Halton and Wirral, there are more SEN children as a proportion of all schoolchildren than the national average (January 2012 data). In Knowsley, more than a quarter of schoolchildren have SEN (26.3%) (see Figure 17). Actual numbers are given in Table 13. In Sefton and St.Helens, proportions are smaller (both 19.4%), but still above the North West average of 19.2%.

For children with more severe special educational needs (i.e. SEN with a statement), in Knowsley, Wirral and Halton, proportions are higher than the national and North West average of 2.8% of all pupils (see Figure 17).

Of all schoolchildren, the proportions who have SEN but without a statement are higher than national (17%) and North West (16.4%) averages in each local authority on Merseyside (see Figure 17 (January 2012 data).

Figure 17

Pupils with special educational needs (SEN), with and without statements, as % of total pupils, Merseyside Jan. 2012

England total SEN = 19.8% (NW=19.2%)

■ % without statement

▧ % with statement

source: DfE
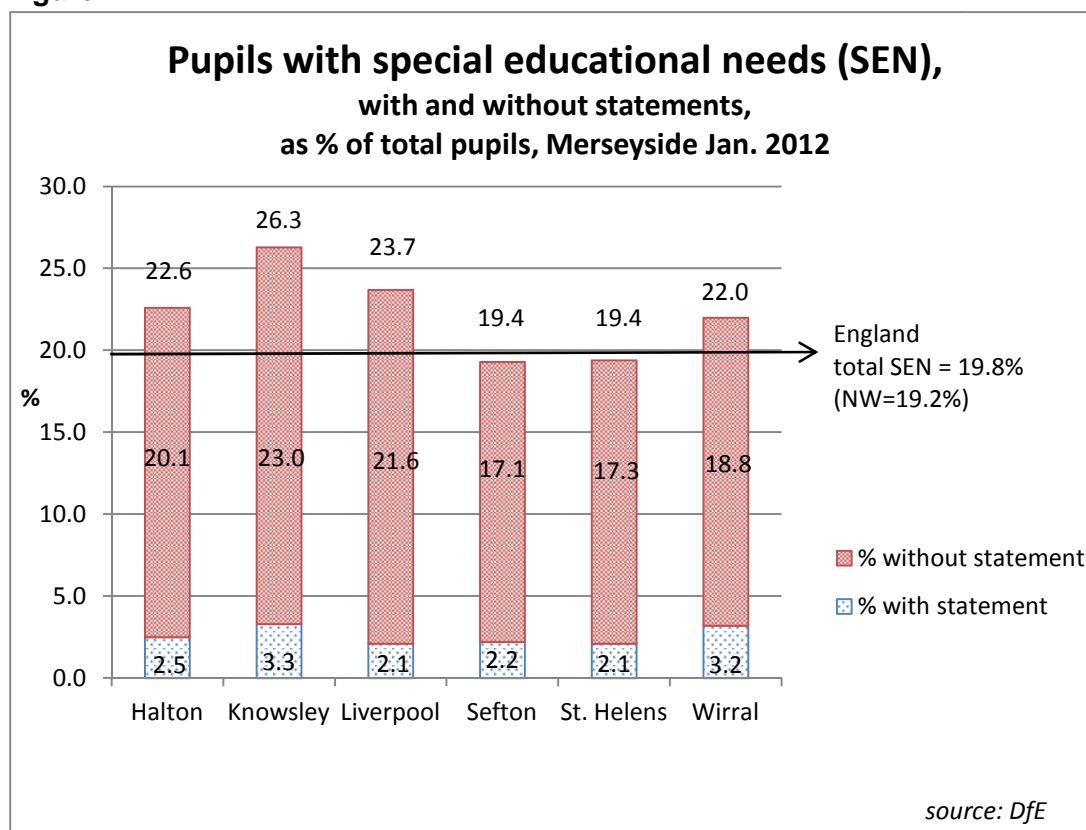
Table 13
Numbers and percentages of special educational needs (SEN) pupils, with and without statements and total SEN. January 2012

	SEN pupils with statements	% of total school population	SEN pupils without statements	% of total school population	Total SEN pupils	% of total school population
Halton	462	2.5	3,668	20.1	4,130	22.6
Knowsley	710	3.3	4,892	23.0	5,600	26.3
Liverpool	1,460	2.1	14,896	21.6	16,355	23.7
Sefton	967	2.2	7,472	17.1	8,440	19.4
St. Helens	549	2.1	4,542	17.3	5,090	19.4
Wirral	1,619	3.2	9,524	18.8	11,145	22.0
Merseyside	5,767	2.5	44,994	19.6	50,760	22.2
ENGLAND		2.8		17.0		19.8
NORTH WEST		2.8		16.4		19.2

Source: DfE

Data is not available by super output area, therefore analysis cannot be undertaken within local authorities.

SEN and mental health:

One in 10 of all children are likely to have a mental disorder (ONS, 2000; ONS, 2005). Amongst those with SEN, the figure rises to around 25% with a mental disorder, ranging from 16% at Stage 1 (mild SEN) to 43% of those with Stage 5 SEN (i.e. those with a statement) (Table 14) (see p.91, ONS 2000 for more details on SEN Stages).

Table 14
Prevalence of mental disorder by level of SEN

	no SEN	stage 1 SEN (mild)	stage 2 SEN	stage 3 SEN	stage 4 SEN	stage 5 SEN (statemented)	all children
% with any mental health disorder	6%	16%	18%	36%	17%	43%	10%

Source: ONS (2000)

If these proportions are applied to the Merseyside population, it can be estimated that there would be around 12,502 children with SEN who have a mental disorder on Merseyside (Table 15). Of those with SEN severe enough to have a statement, just under half (2,480) would have a mental health disorder. Estimated numbers in each local authority are given in Table 15. Given the high levels of mental health risk factors on Merseyside, such as deprivation, it is likely that these figures are underestimates.

Table 15
Estimated prevalence of mental disorder amongst pupils with SEN in Merseyside, 2012.

	SEN pupils with statements		All SEN pupils	
	number	estimated number with a mental disorder (43%)*	number	estimated number with a mental disorder (24.63%)**
Halton	462	199	4,130	1,017
Knowsley	710	305	5,600	1,379
Liverpool	1,460	628	16,355	4,028
Sefton	967	416	8,440	2,079
St. Helens	549	236	5,090	1,254
Wirral	1,619	696	11,145	2,745
Merseyside	5,767	2,480	50,760	12,502

Source: DfE(2012 and ONS (2000)
*based on ONS (2000) table 8.3
**calculated using ONS (2000) table 8.3 and totalling the prevalence for all SEN stages

Recommendations
Planning and improving services for disabled children requires accurate, comprehensive data on numbers of disabled children in the population, together with the characteristics and use of local service provision. Improving services for disabled children will be significantly hindered without this data.

'Support and Aspiration: A new approach to Special Educational Needs and Disability' sets out a programme of government reform to improve outcomes for disabled children and young people and those with special educational needs, and their families. This includes measures to ensure that children and young people get the support they need to learn and make progress, including those who need emotional support.
(DfE, 2012b).

Not in education, employment, or training (NEET)

Being in education, employment and training between the ages of 16-18 increases a young person's resilience and is essential to their future employability and wellbeing (ChiMat, 2012). Being NEET between the ages of 16-18 is a major predictor of later unemployment, low income, teenage motherhood, depression, and poor physical health. A study by the Princes Trust found that Young people aged 16-25 not in work are less likely to be happy (reported in Freer et al, 2010, p.243). In the UK rates of participation in education and training have historically been low compared to other countries in the OECD (Organisation for Economic Cooperation and Development) (ChiMat 2012).

The Marmot Review Team selected a small set of key indicators of the social determinants of health, health outcomes and social inequality (LHO, 2011). One of these is the number of young people aged 16-19 who are not in employment, education and training, or 'NEET'. Government NEET data is only collected at local authority level. Some local authorities do collect data at super output area (SOA) level, so it may be possible in future to build a picture for Merseyside by approaching individual local authorities.

In 2011 across Merseyside, levels of young people who were 'NEET' were higher than the North West average of 7.1%. In Liverpool, they were as high as 11.5% of those aged 16-18 (Figure 24). Estimated numbers are given in Table 16, with around 5, 290 young people who are NEET across Merseyside.

Recommendations:

- Maximise educational attainment, recognising that this is a protective factor for mental health
- Encourage entry to employment schemes offering a range of training and education opportunities, targeting 16-19 years olds who are not in education, training or employment. Courses can offer valuable skills and opportunities in literacy, numeracy, key skills and personal and social development.

Figure 24

% 16-18 year olds estimated NEET, 2011
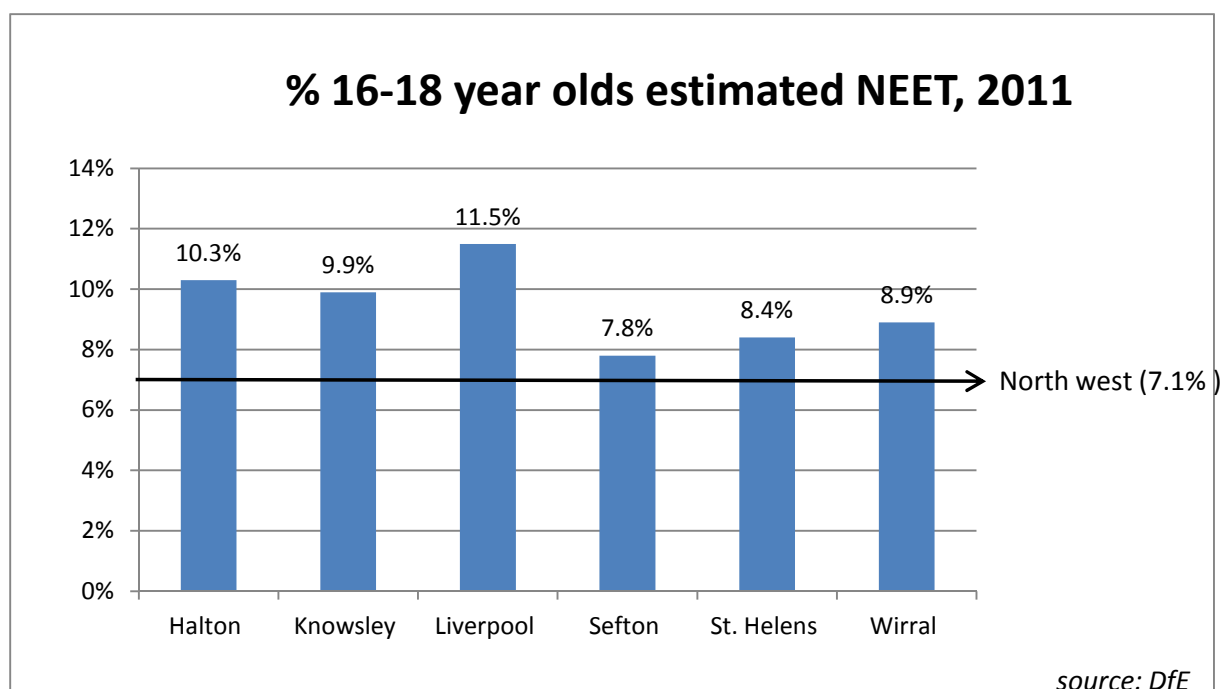
source: DfE

Table 16
Estimated numbers of those aged 16-18
not in education or training (NEET)

16-18 year olds estimated NEET, 2011

	estimated number
Halton	480
Knowsley	620
Liverpool	1,850
Sefton	760
St. Helens	490
Wirral	1,090
Merseyside	5,290

Source: DfE

Pregnant teenagers

Low levels of emotional health and wellbeing are both a cause and a consequence of teenage pregnancy. Although early parenthood can be a positive experience for some young people, it has long been recognised that becoming a parent at an early age can have a detrimental effect on the long term outcomes for teenage mothers, fathers and their children (Swann et al, 2003). With regard to teenage pregnancy, there are a number of commonly recognised vulnerable groups which include the following.

Looked After Children

Looked after children are at greater risk of early pregnancy and social disadvantage than other groups (SCIE, 2004). They are three times more likely to become teenage mothers (DfES, 2006) and have reduced access to good quality, consistent sources of sex and relationship education and advice than many other children and young people (SCIE, 2004). SCIE note that the limitations of school based programmes for looked after children are widely recognised and that additional sex and relationships education is therefore recommended. A study conducted by DfES reports that by the age of 20, a quarter of all children who have been in care are parents. Recommendations from the recent national teenage pregnancy strategy include increased focus on targeted interventions for Looked after Children.

Young people with poor mental health or low self esteem

In 1997, Kessler et al noted that young people with mental health problems have teenage pregnancy rates more than twice those of their peers. This is partly a consequence of the fact that they are more likely to become sexually active earlier and are less likely to use contraception (Kessler et al 1997). A study of young women with conduct disorders showed that a third became pregnant before the age of 17 (quoted in DFES, 2006).

Young people who are on the receiving end of poor parental aspirations are also viewed as a vulnerable group (Teenage Pregnancy Unit, 2005) and in particular, parental aspirations of young girls at the age of ten were seen to be an important precursor to becoming a teenage parent. Good quality relationships and sex education with young people exhibiting low-self esteem will help them to build confidence with regard to making decisions about their sexual health and improve knowledge around contraception choice and availability.

Young people who have criminal involvement or are part of the youth offending system

A study of young women with conduct disorders showed that a third became pregnant before the age of 17 (DfES, 2006). Teenage boys and girls who had been in trouble with the police were twice as likely to become a teenage parent, compared to those who had no contact with the police. Possible precursors to conduct disorder include temperamental problems and Attention Deficit Hyperactivity Disorder (Keenan et al, 1999). There is a long established link between youth offending and substance and alcohol misuse (Youth Justice Board, 2011).

Abortions

Of those who have an abortion, Coleman (2006) found that adolescent girls who abort unintended pregnancies are **five times more likely** to go on to seek help for psychological and emotional problems compared to their peers who carry 'unwanted' pregnancies to term.

Merseyside data

Figure 25 gives teenage conception rates on Merseyside over a 2 year combined period for the latest available data. Conception rates amongst those aged under 18 are higher than the national average in each Merseyside area except Sefton. Rates are highest in Halton and in St.Helens. Amongst those aged under 16, the picture is the same, although differences from the national average are not so extreme and in Knowsley, they are the same (Figure 25).

Figure 25

**Conception rates amongst females aged
under 16 (2007-09)
& under 18 (2008-10)**
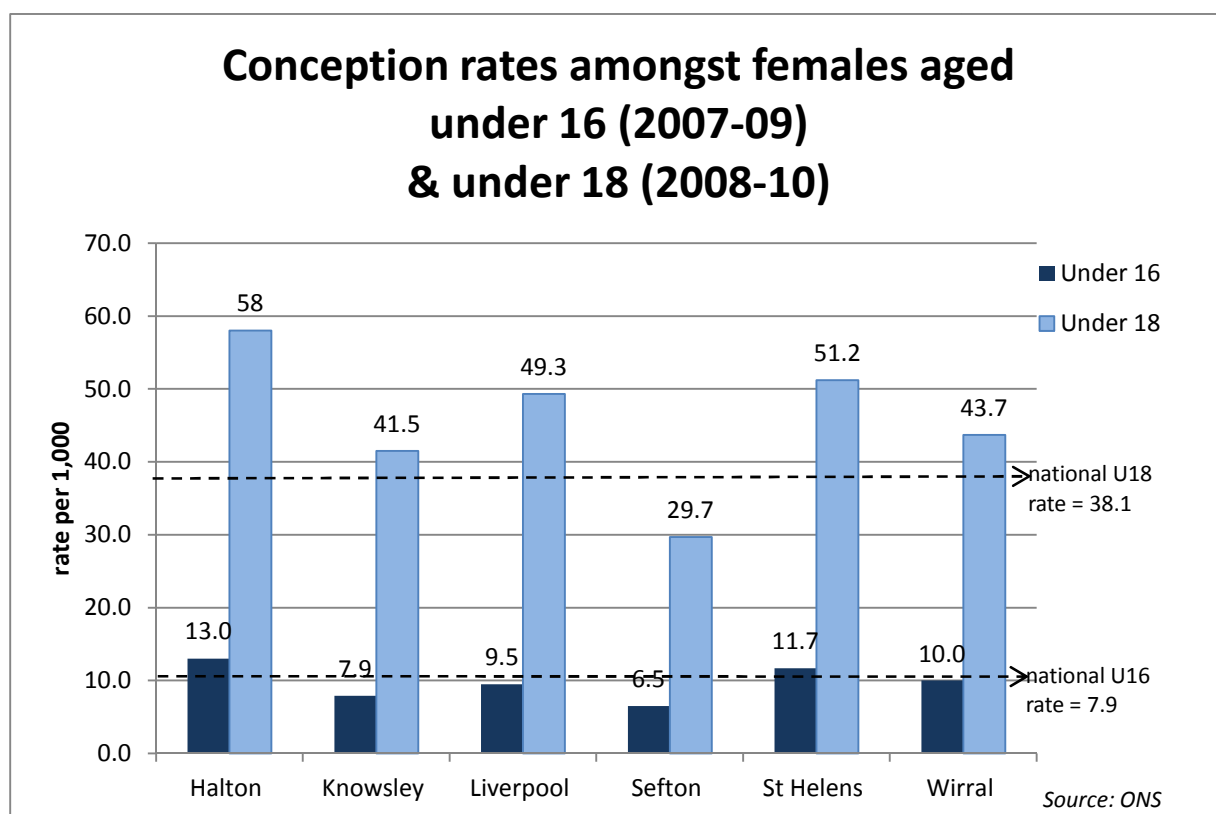
Table 17 gives actual numbers of conceptions to those aged under 18 on Merseyside during 2010. It also gives the % that led to abortion, so that for example in Halton in 2010, there were 142 women who conceived, of whom 71 (50%) went on to have an abortion. In Merseyside in 2010, 1,184 young women aged under 18 had conceptions, of which 613 led to an abortion

Amongst the under 18s, proportions having abortions were much higher than the national average of 50.3 in Knowsley (nearly 60%) and Liverpool (56%). In St.Helens, only 43.3% had an abortion.

Table 18 shows that conceptions amongst those under 16 were more likely to lead to an abortion compared to under 18s. Over a 2 year period on Merseyside, there were 767 conceptions amongst girls aged under 16, of which 484 (63.1%) led to an abortion. All areas except Halton and St.Helens were above the national average of 61.4% of conceptions leading to abortion. In Liverpool and Sefton, more than two-thirds led to abortion, compared to around half in Halton. Young women having abortions need to be targeted for specialist support, as they are much more vulnerable to developing emotional and psychological problems (see above, p.55).

Table 17
Number of conceptions in Merseyside and % leading to abortion in those aged under 18, 2010

Area of usual residence	Number of Conceptions in 2010	Percentage of conceptions leading to abortion	Number of conceptions leading to abortion in 2010
Halton	142	50.0%	71
Knowsley	122	59.8%	73
Liverpool	309	56.0%	173
Sefton	155	52.9%	82
St Helens	180	43.3%	78
Wirral	276	49.3%	136
Merseyside total	1,184	51.8%	613
England		**50.3**	

Source: ONS

Table 18
Number of conceptions in Merseyside and % leading to abortion in those aged under 16, 2007-09

	Number of conceptions between 2007-09	Percentage of conceptions leading to abortion	Number of conceptions leading to abortion between 2007-09
Halton	88	51.1%	45
Knowsley	74	64.9%	48
Liverpool	199	66.8%	133
Sefton	106	68.9%	73
St Helens	125	59.2%	74
Wirral	175	63.4%	111
Merseyside total	**767**	**63.1%**	**484**
England		**61.4%**	

Source: ONS

Under 16 data is aggregated over a 2 year period and more recent data is not yet available.

Trends
Between 2007 and 2010, the teenage conception rate declined in each area except St.Helens amongst those aged under 18 (Figure 26). The statistics paint a different picture for those aged under 16, for whom there was an increase in rates in each area except Sefton and Wirral between 2006 to 2009 (Figure 27).

(N.B. 2010 statistics for under 16s not yet available).

Figure 26

**Under 18 conception rates,
trends from 2005-2010**

rate per 1,000

Halton — Knowsley — Liverpool — Sefton — St Helens — Wirral

2005-07   2006-08   2007-09   2008-10

Figure 27

**Under 16 conception rates,
trends from 2005-2009**

rate per 1,000

Halton — Knowsley — Liverpool — Sefton — St Helens — Wirral

2005-07   2006-08   2007-09
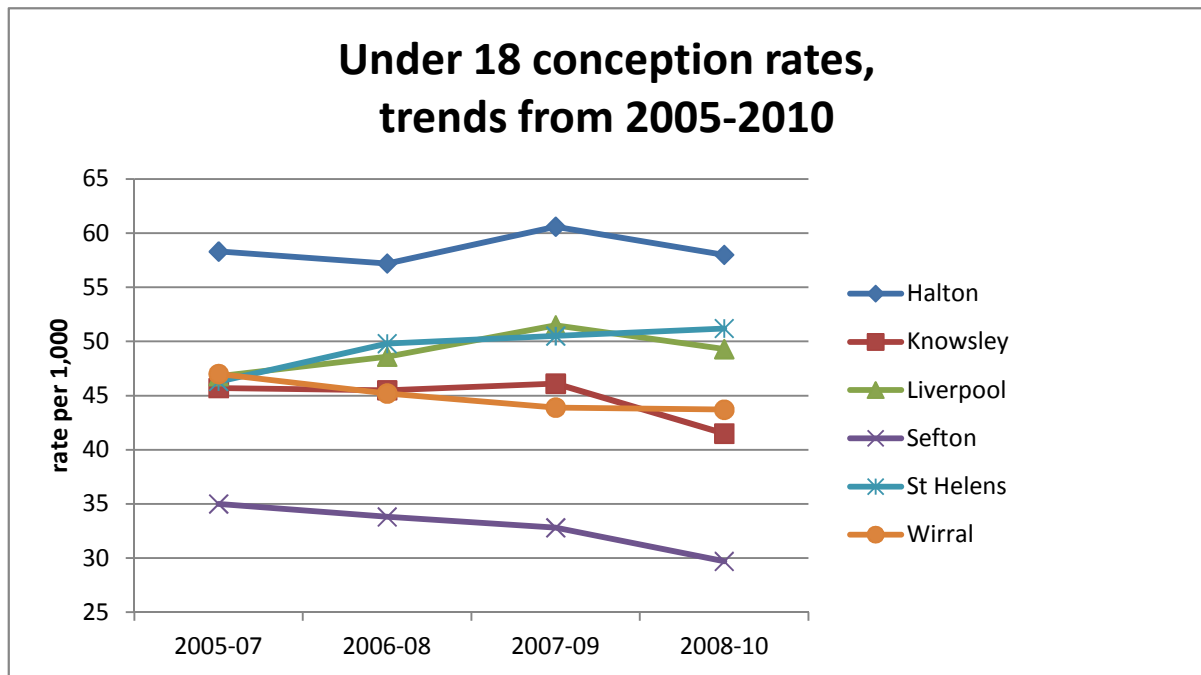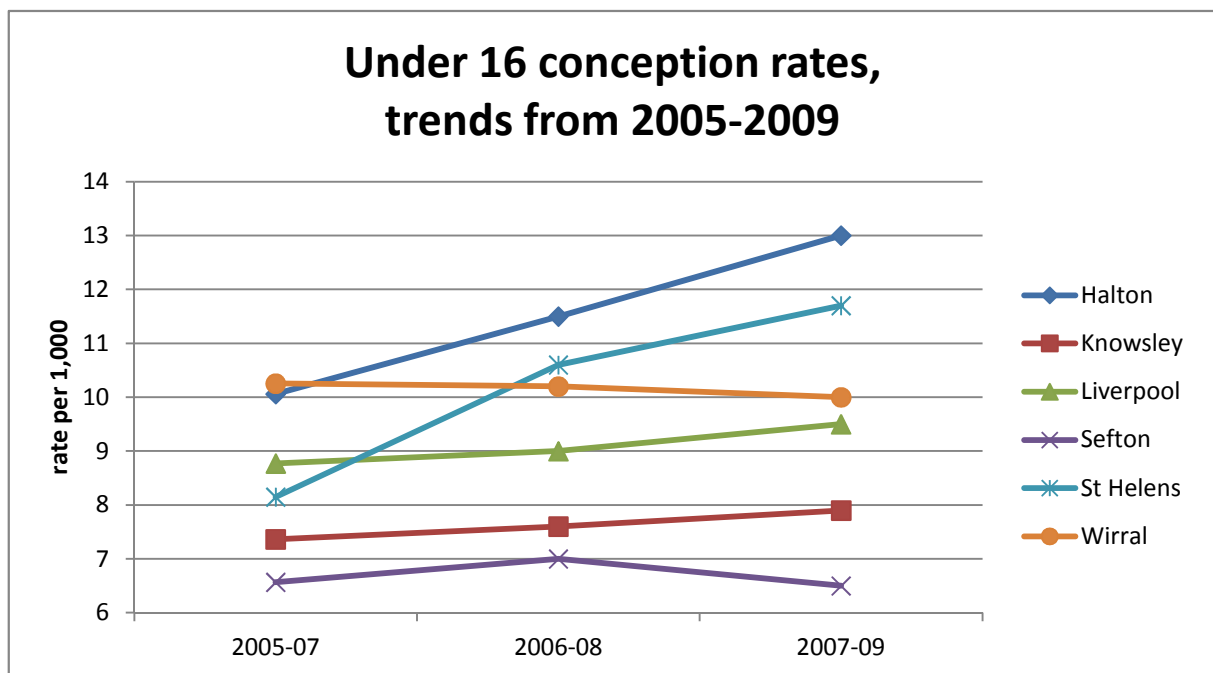
(data for 2010 under 16s not yet available).

2011 data:
The most recent full year of data currently available is 2010 for those aged under 18 and 2009 for under 16s. Data for the 1st quarter of 2011 is available now, but is subject to wide variations, so would not usually be used on its own. Early indications are of a steep decline in numbers of under 18 conceptions in Halton and St.Helens, with only 16 in Halton and 34

in St.Helens up to March 2011 (compared to 142 in Halton and 180 in St.Helens for the whole of 2010).

As mentioned above, under 16 data on conceptions and abortions is aggregated over a 2 year period and more recent data is not yet available.

Data on teenage mothers and the support they require is discussed on p.108, under section 2.vi *'Opportunities to take part in positive activities to thrive'.*

The provision of high quality, accessible contraception and sexual health services, with sufficient capacity to meet the needs of the local population, is an essential part of joint commissioning for children and young people (DH/DCSF HCP, 2009).

Recommendations relating to teenage pregnancy

- A multi-agency approach should be developed to reduce under-18 conceptions, with data sharing agreements established between key agencies
- Focus on the development of children and young people's social, emotional and behavioural skills. Some of these skills are particularly relevant to reducing the risk of teenage pregnancy and include developing self-awareness, self-esteem and confidence, along with improved social skills and a sense of responsibility for others (DFES, 2006)
- Ensure all looked after children receive adequate sex and relationships education and accessible contraceptive services. Ensure foster carers are able to access sex and relationships training. Importance of developing healthy relationships to be addressed.
- Ensure efficient data sharing for LAC and targeted interventions for this group are in place
- Include sex education and advice in interventions targeted at those with emotional and behavioural disorders – especially those aged under 16
- Development of school based holistic healthcare provision to include mental health and sexual health support
- Children and young people workforce to be aware of common precursors to teenage pregnancy through workforce development training
- Consider the support necessary to meet the emotional health and wellbeing needs of teenagers who have abortions. Referral pathways to be established with counselling services
- Consider the support necessary to meet the emotional health and wellbeing needs of pregnant teenagers and teenage parents
    – such as parenting classes for young mothers and fathers to combat stigma and , isolation;
    – support for young parents to engage in education, training or employment
  Common factors in successful support packages include a multi-agency and partnership approach; consultation with teenagers; flexibility; the availability of suitable childcare; and sympathetic staff (http://www.idea.gov.uk/idk/core/page.do?pageId=8309809)
  (see section 2(v), p.108 below on teenage parents)
A summary table of the range of SRE resources for areas to use is given in DFES (2006, p.17).

Asylum Seekers, Refugees and Immigrants

The UK is home to (less than) 2% of the total number of refugees and asylum seekers across the world. In the UK, in 2009, the number of Asylum Seeker applications was seen to be at its lowest in 16 years with 24,250 principle applicants making asylum claims (Refugee Council, 2009). Of this group, the refugee council supported around 1,000 unaccompanied children (Refugee Council 2010.)

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 (Crawley, 2010). They are likely to experience poverty, dependence and a lack of cohesive social support arriving in a new country as a refugee. Children and young people could be living with adults that are unfamiliar to them. They may have experienced the death of a close family member or friend, or be unaware of their current circumstances leading to an increased sense of vulnerability (Connelly et al. 2006). Such factors can undermine both physical and mental health. Health is culture dependent (Burnett & Peel, 2001) and both what a young person is able to talk about in relation to their health, and the symptoms they present with may be influenced by their cultural background and current circumstances. For example, in some cultures having stomach aches or headaches or a low mood, may be their way of discussing anxiety or depression.

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

Most refugee children are entitled to routine health surveillance and health promotion (DoH, 1989). In fact, the new National Institute for health and Clinical Excellence (NICE) PH28 guidance, "Promoting the quality of life of looked after children and young people" includes references to unaccompanied asylum seeking children (UASC) and they have their own specific recommendations. For example, of the 52 recommendations in the report, no 10 is to "ensure access to mental health services for UASC who are looked after". However, many young refugees find health services very difficult to access. 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 (Carey-Wood et al. 1995). This figure is likely to include children and young people. Higher rates of mental health problems in children from asylum seeker or refugee backgrounds are likely to be related to experiences they have had prior to arriving in the UK. The impact of war, torture, loss, disrupted attachments to parents and fear all impact on emotional and mental health, but so do social exclusion, isolation and racism on arrival in the UK (Levenson & Sharma, 1999).

Asylum seekers in the Merseyside area come from 66 different countries around the world. There is limited research in the UK about the health problems of asylum seekers and even less research on the health problems of children of asylum seekers.

There is no Merseyside data available on numbers of children of asylum seekers. Wirral have provided us with figures that suggest there are no more than five UASC in the Wirral in any one year and that Wirral Local Authority are pleased with the access to health services these young people have had. A number of local organisations have been approached who work with and advocate for, asylum seekers and refugees (see Box 2 below). We wanted the most up to date information on the numbers of children and young people who may be living in the county.

Box 2:
Local Organisations working with asylum seekers or refugees include:

Wirral Change www.wirralchange.org.uk/

Refugee Action Liverpool www.refugee-action.org.uk/liverpool/

PSS http://pss.org.uk/

Asylum Link Merseyside http://www.asylumlink.org.uk/

The Family Refugee Support Project www.familyrefugeesupportproject.org.uk/

Irish Community Care Merseyside http://iccm.org.uk/

We can estimate the number of children who are born to mothers who themselves were born outside the UK, and who may be living in the local area, by using the data on live births from ONS (see Table 19). It is possible that some of these will be children of asylum seekers and refugees. Children from immigrant families, including asylum seekers and refugees are likely to need extra support to ensure their emotional health and wellbeing. Table 19 shows that as many as 18.1% (nearly 1 in 5) children in Liverpool and 9.3% (almost 1 in 10) in Sefton are born to mothers from outside the UK.

Recommendations

In an expert paper, published by NICE, EP23-LAC9.4, "the health needs of unaccompanied asylum seeking children and young people" (Simmonds & Merredew 2009) a number of ways to improve the experience of asylum seeking children and young people are considered. They suggest that:

- -Assessing emotional health and wellbeing and mental health, although complex, is extremely important given that the likelihood of clinically significant disorders especially post traumatic stress disorders, depression and anxiety are very high in this population due to the stressful combination of circumstances they will have encountered in travelling to and arriving in the UK. Accessing CAMH services and other specialist mental health services will be important.
- -Primary prevention will be core to addressing these issues including high quality placements, establishing meaningful and long lasting relationships with adults, establishing friendships networks, culturally relevant networks including those that meet religious, dietary, dress beliefs and needs.
- -Advice and advocacy and links with community networks will also be significant. Contact with or information about family and friends in the country of origin may also

be very important. It is essential however, that any of this is driven through consultation and discussion with young people themselves.

Table 19
Numbers of Live Births to mothers born outside the UK, by local authority.

	Total number of Live Births 2011	Births from mothers born outside UK						
		Total % born to non-UK born mothers	No. Born to EU born mothers	No. Born to 'New EU'	No. Born to Rest of Europe born mothers	No. Born to Middle East & Asia born mothers	No. Born to Africa born mothers	No. Born to 'rest of the world' born mothers
Halton	1,667	4.8%	39	19	4	23	9	5
Knowsley	1,857	4.7%	32	15	5	40	14	7
Liverpool	5,728	18.1%	269	178	29	446	262	33
Sefton	2,862	9.3%	144	103	10	53	35	24
St Helens	2,156	4.3%	40	24	4	35	8	5
Wirral	3,771	7%	95	43	11	106	31	20

Data taken from Birth Summary Tables, England & Wales, 2011, Released: 10th July 2012, ONS

Gypsy, Roma and Traveller children

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

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

Local data

In 2009, there were five authorised traveller sites across Merseyside, with two in Halton and one each in Liverpool, Sefton and St.Helens, housing 174 caravans in total. There were no

sites in Knowsley or Wirral. The vast majority of caravans are on authorised sites. Of the 174 caravans in Merseyside, nearly half are in Halton, and nearly one-third in St.Helens (Table 20).

Table 20
Count of gypsy and traveller caravans, 16th July 2009

	Authorised sites (with planning permission)	Unauthorised sites (without planning permission)		Total all caravans	% of Merseyside total
	No. of Caravans	No. of Caravans			
		"Tolerated"	"Not tolerated"		
North West	**1164**	**58**	**193**	**1415**	
Halton (2 sites)	73	0	4	77	44.25%
Knowsley	0	0	0	0	0%
Liverpool	19	0	0	19	10.92%
Sefton	25	0	0	25	14.37%
St Helens	45	8	0	53	30.46%
Wirral	0	0	0	0	0%
Merseyside total	**162**	**8**	**4**	**174**	**100%**

Data source:
http://webarchive.nationalarchives.gov.uk/+/http://www.communities.gov.uk/housing/housingmanagementcare/gypsiesandtravellers/gypsyandtravellersitedataandstat/

Recommendations:

Apart from the Sheffield study, it has been noted that the mental health of travellers and their children has been largely ignored except for very general references to the negative impact on travellers of discriminatory behaviour by the wider society (Doyal et al, 2002). Minority groups are more vulnerable to inappropriate services if they only represent a tiny proportion of the local population. The House of Commons health committee report into the provision of mental health services reported that '*what is needed is the planning of fair access with culturally appropriate mental health services for travellers, in close liaison with local authorities, through health and social care partnership arrangements'* (House of Commons, 2000).

Sexual orientation

In their Education Guide on supporting young people who are lesbian, gay and bisexual, Stonewall (2010) noted that some schools, colleges and youth groups already provide an environment where the needs of all young people are met. However, their 2007 research, *The School Report* (Hunt and Jensen, 2007), found that 60 per cent of lesbian, gay and bisexual young people feel there is neither an adult at home or at school who they can talk to about their sexual orientation. Four in five young gay people have no access in school to resources that can help them, which Stonewall noted stops them from feeling able to be themselves.

A later piece of research (Guasp, 2009) surveyed secondary school teachers. Homophobic bullying was found to be the most frequent form of bullying, second only to bullying because of weight. It was three times more prevalent than bullying due to religion or ethnicity. Guasp found that more than a quarter of secondary school staff (28%) would not feel confident supporting a pupil who came out to them as lesbian, gay or bisexual. Two in five would not feel confident providing pupils with information, advice and guidance on lesbian, gay and bisexual issues.

As many as 65% of lesbian, gay and bisexual young people experience homophobic bullying at school. Stonewall note that this leads them to skip school and lowers their self-esteem and attainment and aspirations. Where homophobic bullying is prevented and tackled effectively, lesbian, gay and bisexual young people are more than twice as likely to feel part of their school community, they enjoy going to school and feel respected. They are nearly three times more likely to feel able to be themselves.

Stonewall suggested recommendations for adults who work with young people on supporting those who are lesbian, gay and bisexual. These include the following:
- don't make assumptions about young people's sexuality
- be positive when young people come out and know what to say
- work with parents and carers
- protect young people from bullying
- ensure lesbian, gay and bisexual young people have places to go and things to do
- provide access to resources and information
- help lesbian, gay and bisexual young people to stay safe online and when out and about
- the role of staff: openly lesbian, gay and bisexual staff can be important role models
- involve lesbian, gay and bisexual young people in any initiatives to support them, together with outside experts.

(further details in Stonewall 2007, p.26)

There is no local data available on sexual orientation. There are wide variations in prevalence estimates of homosexuality amongst adults, with between 1.5% to 6% of the adult population estimated to be lesbian, gay or bi-sexual (Joloza et al, 2010). Sexual orientation amongst adolescents is likely to be more 'fluid' – i.e. likely to change.

Ethnicity

The ethnic composition of the local authorities in Merseyside is shown in Table 21. With the exception of Liverpool, there are very small proportions of children from black and minority ethnic (BME) groups residing in local authorities in Merseyside. In Liverpool, around 1 in 6 (16.1%) of the population aged 5-16 are from BME groups, which is the same as the proportion for the North West as a whole.

Table 21
Black and minority ethnic group school children as % of the total school age population (ages 5-16), Merseyside local authorities, 2012.

	number	%
Halton	429	2.7
Knowsley	585	3.5
Liverpool	9,153	16.1
Sefton	1,739	4.9
St.Helens	795	3.6
Wirral	2,519	5.9
NW		16.1
England		24.6

Source: ChiMat

Mental health and ethnic group
Evidence on the impact of ethnicity on emotional wellbeing and mental health problems has been found to be inconclusive, although children and young people from minority ethnic communities may be overrepresented within CAMHS (TCRU, 2007).

The ONS survey did find some variation in mental health by ethnicity (ONS, 2005). The survey showed that children aged 5–10 who are white, Pakistani or Bangladeshi appear more likely to have a mental disorder than black children. Indian children are least likely to have such problems. Amongst black girls aged 11-16 however, the prevalence of mental health problems is much higher than average, at 17.1%, compared with 10.3% for all girls in that age group (ONS, 2005). Overall prevalence rates for ages 5-16 are shown in Table 22 (further breakdown available in ONS, 2005).

Table 22
Prevalence of mental disorder by ethnicity, ages 5-16

	White	Black	Indian	Pakistani & Bangladeshi	Other	All
Prevalence of mental disorder (%)	10.1	9.2	2.6	7.8	6.9	9.6

ONS, 2005

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

- people from black and minority ethnic communities are those most commonly cited as finding mental health services difficult to access because of either language barriers or cultural issues
- studies found that ethnic background influenced which service provider was likely to refer children and young people to CAMHS. While 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 by education services, and mixed race children by social services.
- research into differences in help seeking patterns between Pakistani and White British mothers indicated that Pakistani and White British mothers were both good at identifying problems of emotional wellbeing and mental health in their children, yet, despite this, Pakistani mothers were less likely to seek treatment or consider a referral to CAMHS for mild or moderate problems

(TCRU, 2007)

Goodman's 'Strengths and Difficulties Questionnaire' (SDQ) screening tool was used in NE London schools. Findings included very high levels of emotional problems amongst 14 year old girls from ethnic minority families in the worst 'sink' schools, compared to all other London schoolchildren (Caan, 2012, personal correspondence).

Locally and nationally, as described in Section 2(v), (p.96), children from ethnic minority groups are significantly over-represented amongst those with child protection plans and police safeguarding incidents. A recent Sefton schools survey found that pupils from ethnic minority backgrounds are more likely to report being bullied (see Appendix 2 below).

Recommendations
- Provide support to children and young people with their specific cultural situations and circumstances in mind throughout all emotional health and wellbeing provision, right through from universal to specialist CAMHS provision (TCRU, 2007).

- To assist in identifying the needs of minority groups, compile profiles for each area that will show the distribution of different ethnic groups. Link these with data on children from other minority groups such as travellers/gypsies, asylum seekers/refugees and religious groups.

Young people who smoke or drink

Smoking

It is illegal to sell any tobacco product to under 18s in the UK. However, while less than 1% of 11 and 12-year old children smoke, by the age of 15 years, 12% of children in England report being regular smokers (usually smoke at least one cigarette per week) (NHS, 2011).

According to these figures, the Department of Health has met its 2011 target of reducing smoking among 15-year-olds in England to 12% (DH, 2011e) as in a 2008 report (NHS, 2008) the smoking rates, based on measurements of cotinine in saliva, were reported to be as high as 21% in boys and 19% in girls (aged 15).

In 2010, 5% of children aged 11-15 years smoked at least one cigarette each week: 6% of girls and 4% of boys. Since 1986, girls have had consistently higher rates of smoking than boys: in 2010, 14% of 15-year old girls were regular smokers compared to 10% of boys (Figure 18 below) (NHS, 2011). On average, regular child smokers smoke 37 cigarettes per week (NHS, 2011).

Almost 40% of regular smokers began smoking before they were 16 (ONS, 2012a). However, the number of children aged 11-15 starting smoking has fallen from over 290,000 in 2000 to around 157,000 in 2010. This follows the tobacco advertising ban, and the introduction of smoke free legislation.

The adolescent years are extremely important in establishing an individual's lifetime smoking or non-smoking behaviour. Having parents, siblings and peers who smoke is a factor that encourages children to smoke. Other factors linked to an increased likelihood of smoking in childhood include school truancy and exclusion and deprivation (NHS, 2011).

Of British 11-15 year-olds who smoke regularly, 41% have a mental disorder, as well as 24% of those who drink alcohol at least once a week, and 49% of those who use cannabis at least once a month (MHF, 2007). Those aged 11-15 who smoke tobacco are 6 times more likely to develop serious psychological distress (Department of Health, 2003 in Freer et al, 2010).

Figure 18
Percentage of Children Smoking Regularly by Age, England, 2010
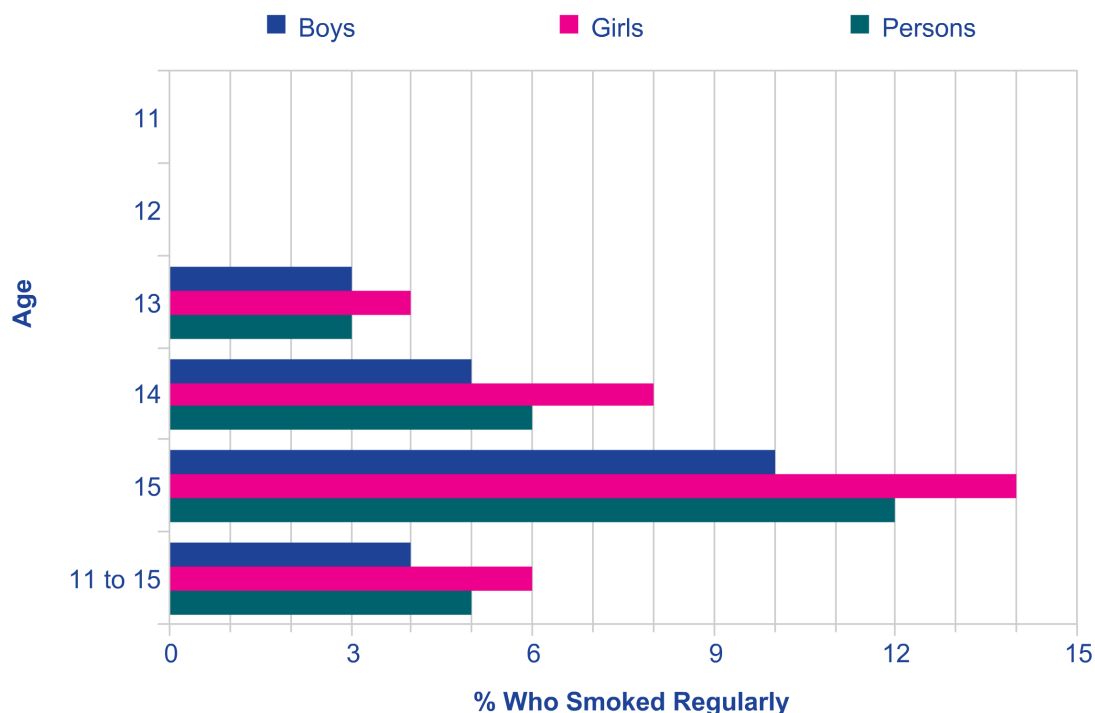
Taken from Cancer Research UK 2012

Local data

The Centre for Public Health based at Liverpool John Moores University produced a report in collaboration with Trading Standards (Atkinson et al, 2009) which found that 58.2% of 15-16 year olds in the North West (of 10,000 children surveyed) had tried smoking and 22.5% were current smokers (of which 15.6% were regular smokers).

In the Tellus4 schools survey (2009) they asked children whether they smoked (years 6, 8 and 10). Those who responded "I usually smoke between one and six cigarettes a week" or "I usually smoke more than six cigarettes a week" are shown in Figure 19 below. In Liverpool, reported smoking levels were significantly lower than the national average of 4%. Levels in Sefton and Wirral were significantly higher (data not available for St.Helens).

Figure 19
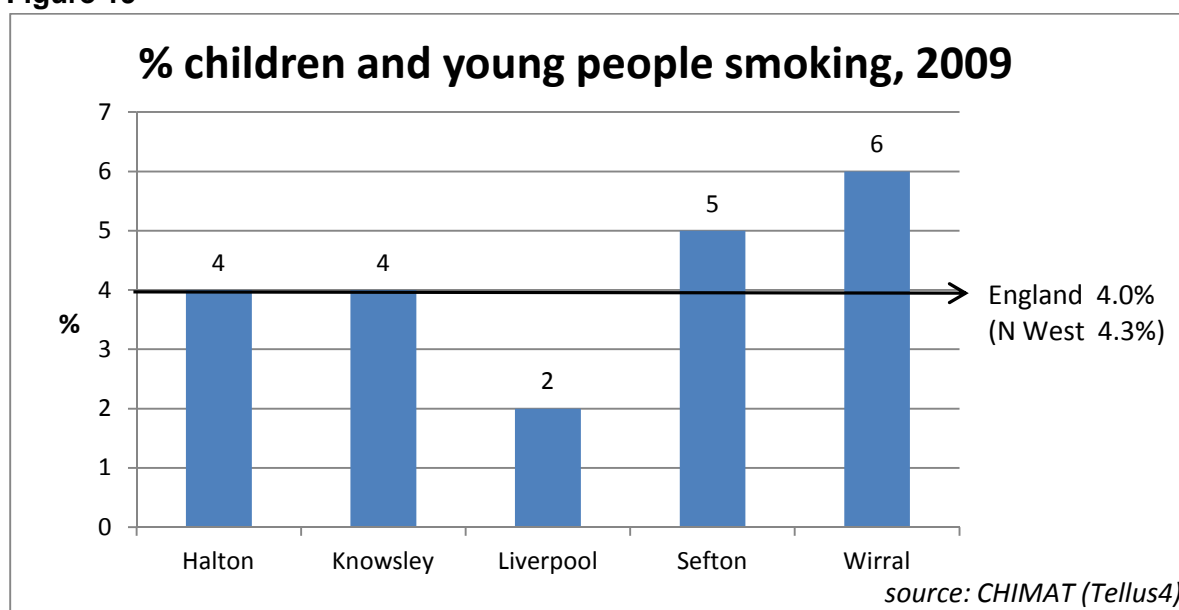
Recommendations

- Local partnerships, including education and health services, can support young people to take control of their lives within clear boundaries, and help them to make healthier, positive choices, for example about using drugs and alcohol. early identification and stepped care approaches can prevent and reduce alcohol and substance misuse among children and young people (DH 2011b).

- Children's Trusts and other professionals working with children should be involved in treatment planning, working with the health and local authorities.

- Services for young people should be able to identify and meet substance misuse needs and provide a route to specialist services.

- For smoking cessation, it is recommended that all healthcare professionals should use the 3A approach to supporting young people who smoke to quit – (i.e. 'Ask if they smoke, Advise them about stopping and the efficacy of local NHS Stop Smoking Services, and Act by offering a referral to the local service. The

local NHS Stop Smoking Services offer the most effective evidence-based opportunity to stop smoking.

(DH/DCSF, HCP, 2009)

Alcohol

In 2006, of those aged 11-15, 1 in 5 (21%) had drunk alcohol in the previous week. The number of units consumed had doubled from 5.3 in 1990 to 11.4 in 2006 (NHS, 2011). Those who drink and smoke are also much more likely to use other drugs.

Problem or harmful drinking has obvious implications for physical health. There is also a great deal of overlap between alcohol and mental illness (NEPHO, 2008). As mentioned in the previous section on smoking, 24%of those 11-15 year olds who drink alcohol at least once a week have a mental disorder (MHF, 2007). Children who regularly see their parents drink are twice as likely to binge on alcohol themselves, according to a recent survey by the Joseph Rowntree Foundation, (Bremner et al, 2011).

Local data suggest that the numbers of under 18s admitted to hospital with alcohol specific conditions is a huge problem, with levels more than twice as high as the national rate of 55.8 per 100,000 aged under 18 in Liverpool, Halton, Wirral and St.Helens (Figure 20).

Figure 20
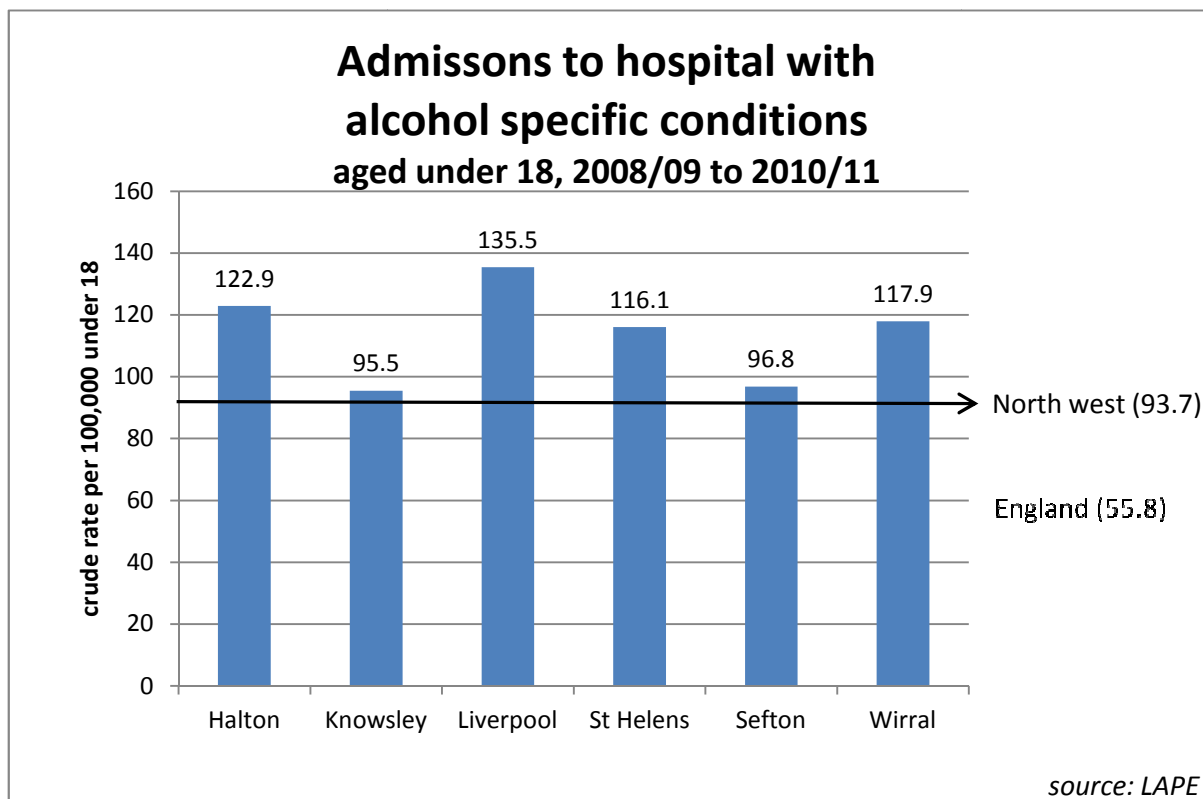
The TellUs4 survey published in ChiMat (2009) showed that levels of alcohol use in Liverpool were significantly better than the national average, and in each of the other local authorities, levels were significantly worse (no data available for St.Helens) (Figure 21).

Figure 21

% children and young people using alcohol, 2009

source: CHIMAT (Tellus4)
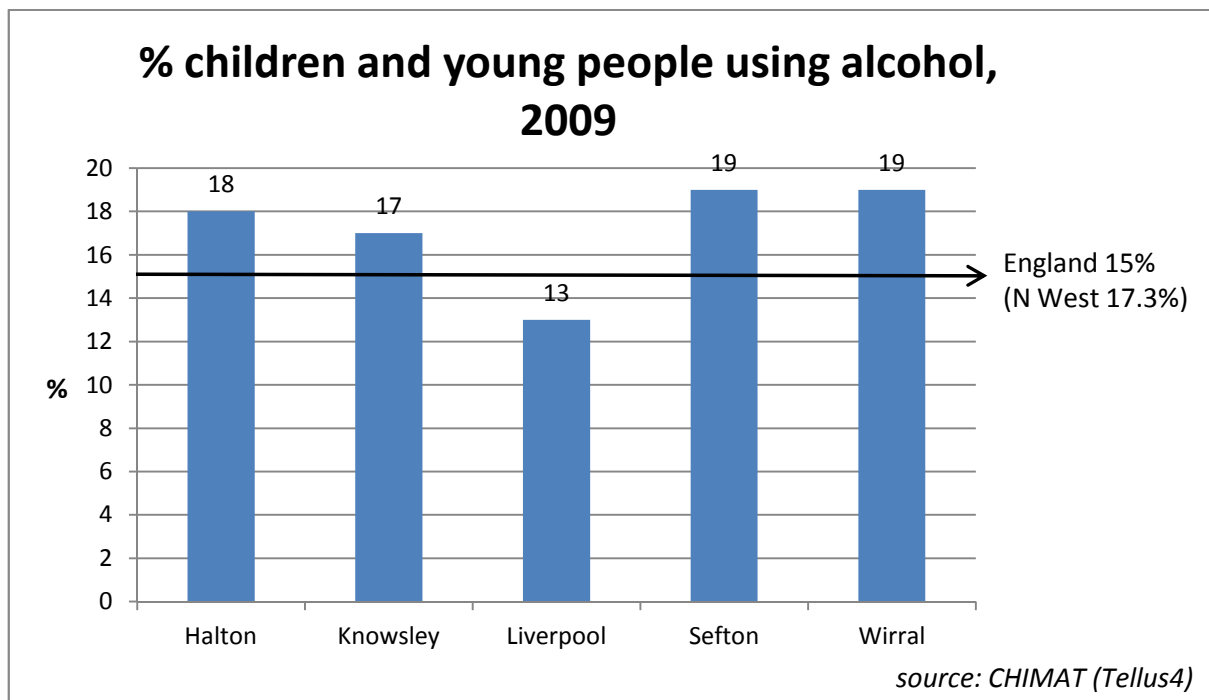
Recommendations

There is a need to take a life course approach to education around alcohol issues, in an effort to help prevent alcohol problems developing. Recommendations to reduce levels of alcohol intake in children and young people from NICE (2007b) focus on encouraging children not to drink, delaying the age at which they start drinking and reducing the harm it can cause among those who do drink. For example:

• alcohol education should be an integral part of the school curriculum and should be tailored for different age groups and different learning needs

• a 'whole school' approach should be adopted, covering everything from policy development and the school environment to staff training and parents and pupils should be involved in developing and supporting this

• where appropriate, children and young people who are thought to be drinking harmful amounts should be offered one-to-one advice or should be referred to an external service

• schools should work with a range of local partners to support alcohol education in schools, ensure school interventions are integrated with community activities and to find ways to consult with families about initiatives to reduce alcohol use.

Liverpool City Region Child Poverty Strategy recommends the following:

• a 50p minimum unit price and bylaw to reduce alcohol related harm should be introduced (Liverpool City Region, 2011)

Substance misuse

Becker and Roe (2005) define five groups of vulnerable young people: 'those who have ever been in care, those who have ever been homeless, truants, those excluded from school and serious or frequent offenders'. In 2003, 24% of vulnerable young people reported using illicit drugs frequently during the preceding 12 months, compared with 5% of their less vulnerable peers (Becker and Roe 2005). There were significantly higher levels of drug use among those who belonged to more than one vulnerable group. Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. It may also lead to an increased risk of sexually transmitted infections. In England and Wales in 2003/04, class A drug use was estimated to cost around £15.4 billion in economic and social terms (Gordon et al. 2006).

Freer points out that the cannabis used by young people today is stronger and may have more severe effects on mental health (Freer et al, 2010). Young people who smoke cannabis by the age of 15 are 3 times more likely to develop serious mental health illnesses including schizophrenia (Arseneault et al, 2002 in Freer et al, 2010). Of those aged 11-15 who use cannabis at least once a month, around half (49%) have a mental disorder (MHF, 2007).

Factors that influence substance misuse among children and young people include:
- environment (for example, availability of drugs)
- family (for example, sibling and/or parental substance misuse and lack of discipline)
- individual experience (for example, early sexual encounters and peer group pressure to misuse substances)
- mental health (for example, low self-esteem, depression)
- education (for example, parental expectations)
(adapted from Canning et al. 2004).

Those at particular risk include:
- those who are – or who have been – looked after by local authorities, fostered or homeless, or who move frequently
- those whose parents or other family members misuse substances
- those from marginalised and disadvantaged communities, including some black and minority ethnic groups
- those with behavioural conduct disorders and/or mental health problems
- those excluded from school and truants
- young offenders (including those who are incarcerated)
- those involved in commercial sex work
- those with other health, education or social problems at home, school and elsewhere
- those who are already misusing substances.

Local data

Figure 22 below presents data on self reported drug use collected as part of the Tellus4 school survey. It shows the percentages of children (Years 8 and 10) who responded "once, twice or three or more times" to question 32b : "In the last 4 weeks, how often have you taken any of the following drugs? Cannabis or skunk". Levels in Sefton and Wirral (both 6%)

were significantly higher than the national average. In Knowsley (1%), levels were significantly lower that nationally. Data for St.Helens was not available.

Data gathered by ChiMat show hospital admissions for substance misuse across Merseyside over the period 2008-11 (Figure 23). Rates in Halton, St.Helens and Wirral were significantly more than twice as high as the national average of 63.5 per 100,000, and were also higher than the regional average. In Sefton, the rate was significantly below the national average. In Liverpool, rates were very close to the national average.

Figure 22

source: CHIMAT (Tellus4)

Figure 23

source: CHIMAT
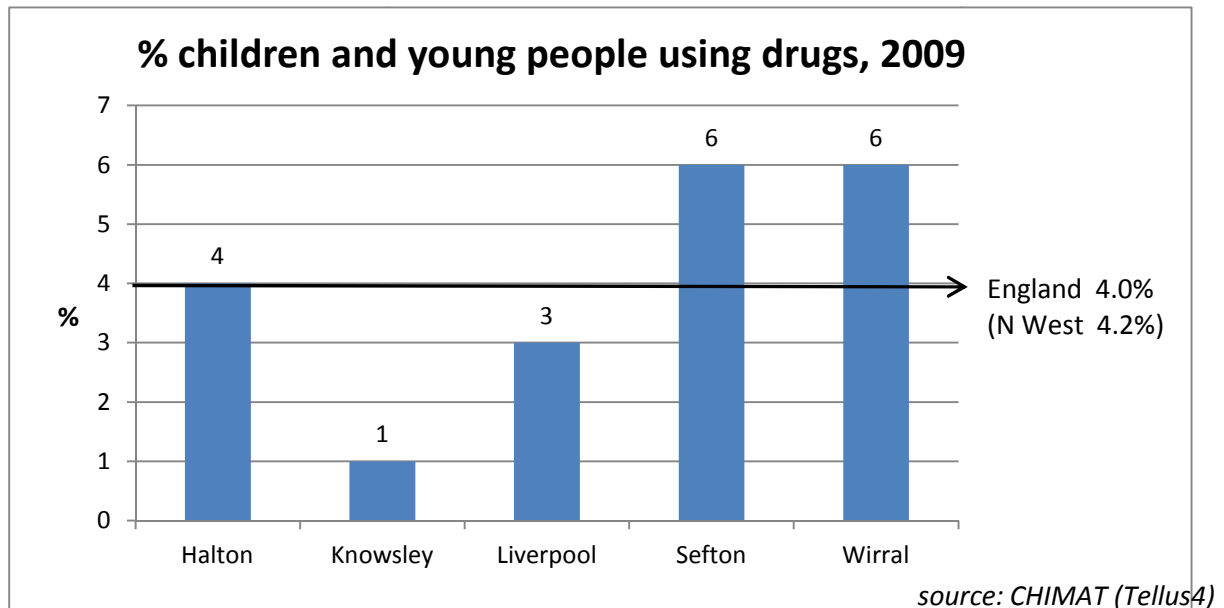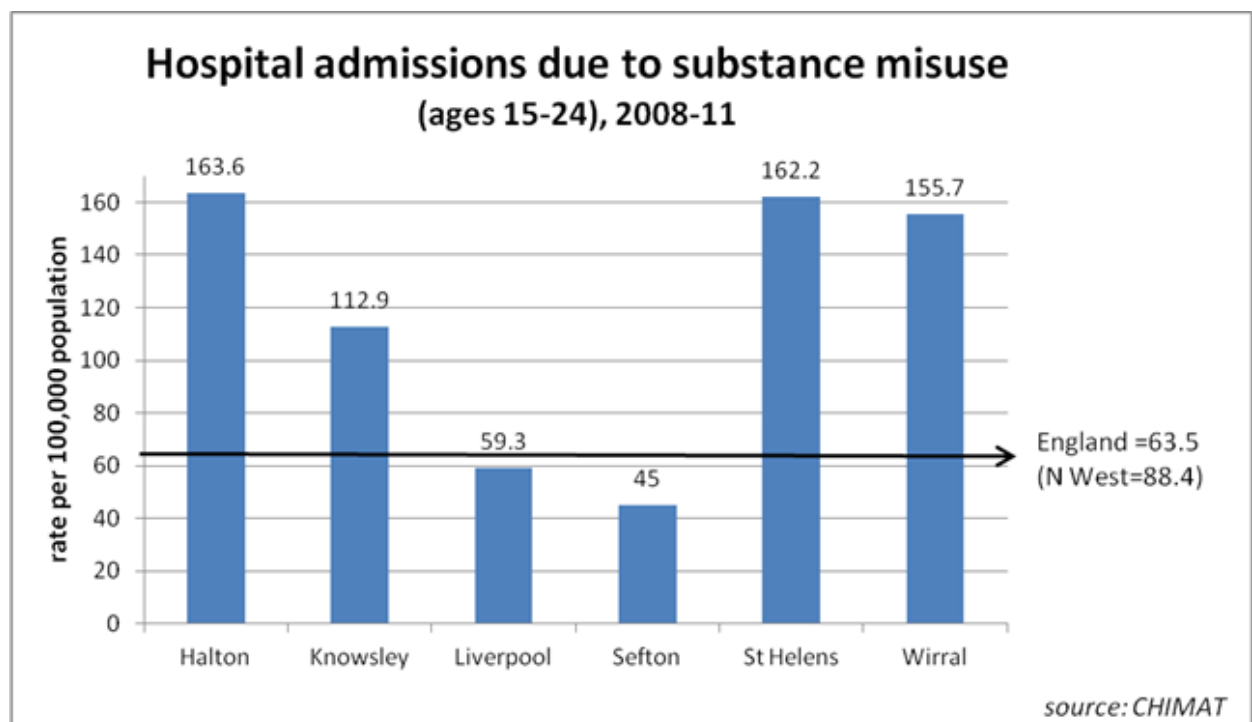
Recommendations

Recommendations from NICE (2007c) to decrease substance misuse among children and young people include:

- Develop local strategies to reduce substance misuse among vulnerable and disadvantaged young people as part of local authority agreements.

- Screen and assess vulnerable and disadvantaged children and young people who are or who are at risk of misusing substances and work with specialists to provide support. Refer as appropriate to other sources.

- Offer a family based programme of structural support over two or more years including motivational interviews, offering parent skill training, monitor school performance and provide feedback.

- Offer children group based behavioural therapy over one or two years before and during transition to secondary school.

- Offer one or more motivational interviews according to young person's needs.

A study of risk taking behaviour amongst young people in Knowsley involved a series of focus groups and questionnaires relating to alcohol, drugs, smoking and unprotected sex (Knowsley MBC, 2012). In response to being asked 'what services do you think young people need', the most common answers were:
- Sex and relationship advice
- Drugs and alcohol service
- One stop shop
- Drop-in services with no appointments (designed solely for the use of young people)
- 24 hour service/night time facilities

It was felt that service provision should include: online information, advice and guidance; general healthy life advice; workshops & group work; and a telephone helpline. The report stressed the importance of involving young people in service provision.

Promoting wellbeing in children and young people, priority areas: iii): *Having enough of what matters*

Children's wellbeing is affected by 'having enough' and 'fitting in' rather than being very well off (Children's Society, 2012a). As part of their national child wellbeing survey, a 'deprivation index' was developed by the Children's Society, consisting of 10 items. Those items with the strongest associations with wellbeing were:
- having access to a garden or outdoor space (considered in Section vi);
- clothes to 'fit in' with friends
- monthly trips out with the family

Children lacking three of the 10 items were three times as likely to experience low wellbeing.

The research also found that children who live in poorer households were twice as likely to have low wellbeing as children in more economically stable households.

Child poverty

Child poverty is defined by the government as the proportion of children living in families in receipt of out-of-work benefits or tax credits where their reported income is less than 60% median income (HM Revenue and Customs, 2011). The measure includes dependent children under the age of 20.

The government pledged to halve child poverty by 2010 compared to 1998 and to end it altogether by 2020. However, a recent Save the Children report stated that the number of UK children living in "severe poverty[3]" rose by 260,000 in the four years before the recession, 2004-08, to a figure of 1.7m (Save the Children, 2012). Currently there are an estimated 3.5 million children living in poverty in the UK, a figure expected to rise by 400,000 by 2015.

The report, based on a national survey of low income families, found that children are missing out on the things they need to have a fulfilling childhood, such as going on a family holiday, having access to the internet at home or having friends round for tea. They are also missing out on daily essentials, such as healthy food, warm clothes in winter and new shoes when they need them:
- one in seven of the poorest children surveyed say they have to go without a warm winter coat and new shoes when they need them
- nearly a fifth of children living in poverty say they miss out on school trips because their parents haven't got the money
- children worry about their family not having enough money, with more than half of those living in poverty saying the lack of cash made their parents unhappy or stressed
- almost a quarter of the poorest parents say they are arguing more or snap at their children because of their money troubles.

(Save the Children, 2012)

Children in poor households are three times as likely to have mental health problems as children in well-off households (MHF, 2007, quoting NSF, 1999). *(Note – there were no percentages included – so it was not possible to calculate estimates).*

Local data

HM Revenue and Customs recently released data on the number of children assessed as living in poverty in August 2010, which showed a reduction in the number of children and young people living in poverty in Merseyside from 91,355 to 88,880. This 3% reduction in the numbers of children and young people in poverty is mirrored nationally. However, Frank Field MP has pointed out that these figures are of limited use, reflecting falling national median income rather than rising incomes. He suggests current measures are of limited use

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[3] Save the Children defines severe poverty as those living in households with incomes of less than 50% of the UK median income (disregarding housing costs) (Save the Children, 2012)

in trying to understand poverty and its root causes, and has recommended using a set of Life Chances Indicators, which would measure the drivers of poverty (Liverpool City Employment Strategy, 2012).

In Merseyside in 2010, each local authority (with the exception of Sefton) had levels of child poverty significantly worse than the national average of 20.6%. In Liverpool, as many as 1 in 3 (33.1%) children were living in poverty (Figure 28). Actual numbers are shown in Table 23.

Variations in levels of child poverty within each local authority are shown in map 4 on page 70. There are considerable inequalities, with fewer than 8.3% of children living in poverty in large parts of some boroughs and many areas with levels higher than 43%. Patterns of inequality in child poverty within boroughs are similar to those of low child wellbeing and school absences (see maps on p. 14 and 29 above) and to a lesser extent child disability allowance claimants (p.39), as follows:

- In much of north Liverpool, Speke-Garston to the south and Belle Vale in the east of Liverpool, more than 43% of children live in poverty.
- In Knowsley, high levels of child poverty are found in the north, especially in parts of Shevington, Northwood, Whitefield and Kirkby Central and across the centre of the borough.
- In Halton, the highest levels of child poverty are found in Riverside and Castlefields and parts of the surrounding wards.
- The worst child poverty in St.Helens is concentrated in the centre of the borough, especially in the Town Centre, and parts of Parr and Thatto Heath. Also, to the north east of Rainhill and to the south east of Rainford, there are pockets of child poverty in otherwise relatively affluent wards.
- In the Wirral, child poverty levels are higher than 43% in wards along the north east side, especially in Birkenhead & Tranmere, Bidston & St.James and large parts of Seacombe and Rock Ferry.
- Although in Sefton, overall child poverty levels were lower than the national average, there are areas to the south where levels are higher than 43%, especially in Linacre ward.

In light of the current economic climate and growing cost of living, there is a risk of child poverty deteriorating greatly in the years ahead. A contraction in the employment market is also a key risk factor (End Child Poverty, 2011).

Recommendations

The Liverpool City Region Poverty Strategy has produced a comprehensive, wide ranging plan for poverty reduction, setting out some of the key roles for a number of groups and individuals (Liverpool City Region, 2011). These cover many of the topics considered in this needs assessment, including action to be taken by local councils, schools and parents. Full details can be found in the following weblink:
http://www.liverpoolcitystrategyces.org.uk/projects/overview-of-what-is-being-done-to-tackle-child-poverty/

Figure 28

% of Children in Poverty, 2010

source: Liverpool City Employment Strategy
http://www.liverpoolcitystrategyces.org.uk/news/fall-in-child-poverty-numbers/
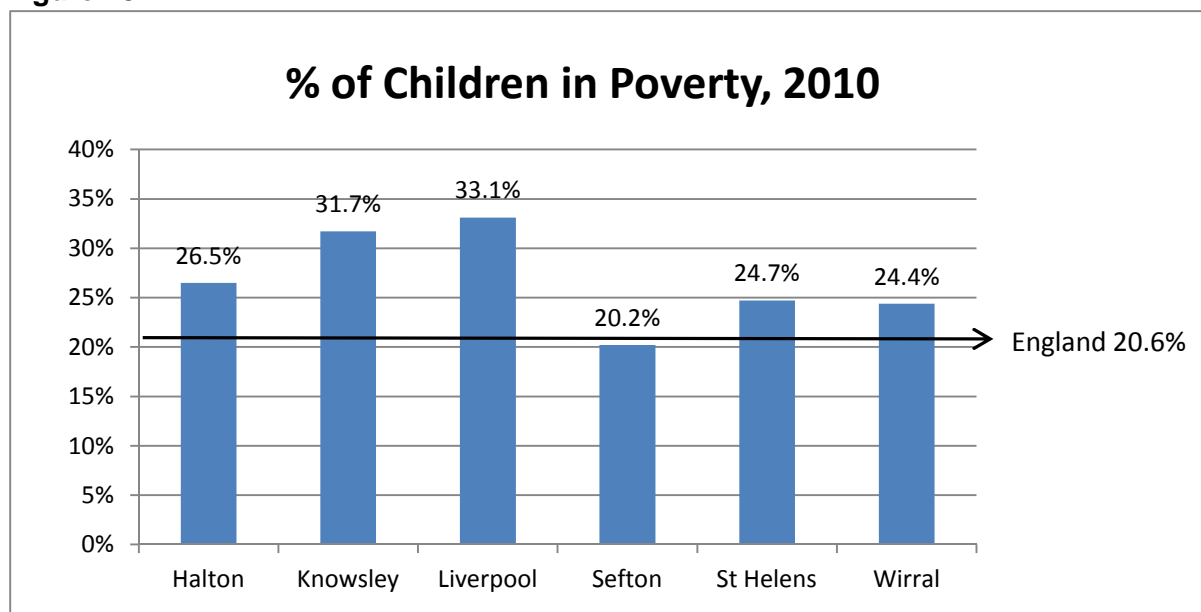
Table 23
Children living in poverty

	August 2009		August 2010	
	Number	Percentage	Number	Percentage
Halton	7,990	27.2%	7,800	26.5%
Knowsley	11,850	32.3%	11,840	31.7%
Liverpool	32,460	34.4%	31,070	33.1%
Sefton	11,665	20.3%	11,480	20.2%
St Helens	9,775	25.2%	9,535	24.7%
Wirral	17,615	20.9%	17,155	24.4%
Merseyside	91,355	26.8%	88,880	27.2%
England	2,429,305	21.3%	2,367,335	20.6%

source: Liverpool City Employment Strategy (2012)
http://www.liverpoolcitystrategyces.org.uk/news/fall-in-child-poverty-numbers/

Map 4 (key to wards on next page)

Percentage of children living in poverty
by LSOA in Merseyside, 2010.
Source: HMRC

Percentage of Children in Poverty
(Number of LSOAs in brackets)

	43.7 to 67.9	(197)
	29.8 to 43.7	(198)
	16.6 to 29.8	(193)
	8.3 to 16.6	(199)
	1 to 8.3	(192)
	0 (may not be a true zero, data may be missing)	(5)

Contains Ordnance Survey data.
(C) Crown copyright and database right 2012
Contains Royal Mail data.
(C) Royal Mail copyright and database right 2012

Map Key: electoral wards in the Merseyside area

	Halton		**Liverpool**		**Sefton**
1	HOUGH GREEN	1	KIRKDALE	1	CAMBRIDGE
2	BIRCHFIELD	2	COUNTY	2	MEOLS
3	FARNWORTH	3	WARBRECK	3	NORWOOD
4	HALTON VIEW	4	FAZAKERLEY	4	DUKES
5	APPLETON	5	CROXTETH	5	KEW
7	KINGSWAY	6	YEW TREE	6	BIRKDALE
8	BROADHEATH	7	WEST DERBY	7	AINSDALE
9	DITTON	8	NORRIS GREEN	8	HARINGTON
10	MERSEY	9	CLUBMOOR	9	RAVENMEOLS
11	CASTLEFIELDS	10	ANFIELD	10	MANOR
12	DARESBURY	11	EVERTON	11	BLUNDELLSANDS
13	NORTON NORTH	12	CENTRAL	12	PARK
14	WINDMILL HILL	13	KENSINGTON AND FAIRFIELD	13	SUDELL
15	NORTON SOUTH	14	TUEBROOK AND STONEYCROFT	14	MOLYNEUX
16	HALTON LEA	15	KNOTTY ASH	15	ST OSWALD
17	HALTON BROOK	16	OLD SWAN	16	NETHERTON AND ORRELL
18	GRANGE	17	CHILDWALL	17	FORD
19	BEECHWOOD	18	WAVERTREE	18	VICTORIA
20	HEATH	19	PICTON	19	CHURCH
21	HALE	20	PRINCES PARK	20	LINACRE
22	RIVERSIDE	21	RIVERSIDE	21	LITHERLAND
	Knowsley	22	ST MICHAEL'S	22	DERBY
1	CHERRYFIELD	23	GREENBANK		**Wirral**
2	PARK	24	CHURCH	1	HOYLAKE AND MEOLS
3	SHEVINGTON	25	WOOLTON	2	MORETON WEST AND SAUGHALL MASSIE
4	NORTHWOOD	26	BELLE VALE	3	LEASOWE AND MORETON EAST
5	WHITEFIELD	27	ALLERTON AND HUNTS CROSS	4	WALLASEY
6	KIRKBY CENTRAL	28	CRESSINGTON	5	NEW BRIGHTON
7	PRESCOT WEST	29	MOSSLEY HILL	6	LISCARD
8	STOCKBRIDGE	30	SPEKE-GARSTON	7	SEACOMBE
9	PAGE MOSS		**St.Helens**	8	BIDSTON AND ST JAMES
10	SWANSIDE	1	RAINFORD	9	BIRKENHEAD AND TRANMERE
11	ST BARTHOLOMEWS	2	BILLINGE AND SENELEY GREEN	10	CLAUGHTON
12	LONGVIEW	3	HAYDOCK	11	UPTON
13	ST MICHAELS	4	EARLESTOWN	12	GREASBY FRANKBY AND IRBY
14	PRESCOT EAST	5	NEWTON	13	WEST KIRBY AND THURSTASTON
15	WHISTON NORTH	6	BLACKBROOK	14	HESWALL
16	WHISTON SOUTH	7	PARR	15	PENSBY AND THINGWALL
17	ST GABRIELS	8	TOWN CENTRE	16	PRENTON
18	ROBY	9	MOSS BANK	17	OXTON
19	HALEWOOD NORTH	10	WINDLE	18	ROCK FERRY
20	HALEWOOD WEST	11	ECCLESTON	19	BEBINGTON
21	HALEWOOD SOUTH	12	WEST PARK	20	CLATTERBRIDGE
		13	THATTO HEATH	21	BROMBOROUGH
		14	SUTTON	22	EASTHAM
		15	BOLD		
		16	RAINHILL		

Deprivation

The index of multiple deprivation (IMD) was devised specifically to indicate deprivation at a small geographical level. It comprises seven separate domains of deprivation, based on 38 indicators. Most of the indicators can be updated regularly, for example 'unemployment claimant counts', so forming a dynamic index. The seven domains are: Income, Employment, Health and Disability, Education Skills and Training, Barriers to Housing and Other Services, Crime and Living Environment (Communities and Local Government, 2011).

All the local authorities in Merseyside have deprivation levels significantly above the national average (Figure 29). In Halton, they are more than twice as high, and in Liverpool and Knowsley, around three times as high.

Figure 29

Deprivation levels, 2010
% of people living in 20% most deprived areas of England

source: APHO health profiles 2012
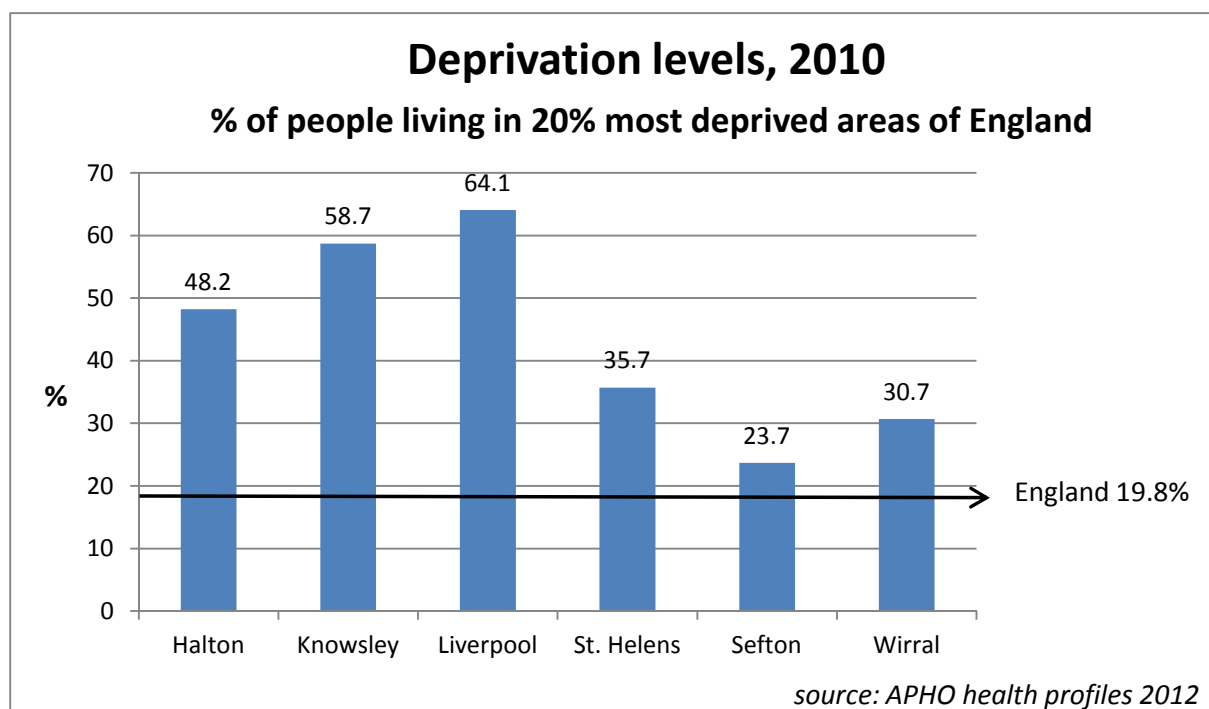
The map in Appendix 3 shows deprivation levels by lower layer super output area in Merseyside, with ward boundaries overlaid. The 2010 index of multiple deprivation scores have been sorted into quintiles. In Liverpool, there are several wards across the north, plus Speke-Garston in the south, with deprivation levels in the top fifth on Merseyside. Levels are also high in the north of Knowsley, south west Sefton, central Halton and mid-east Wirral. In St.Helens, two wards in the centre of the borough have particularly high levels of deprivation. There are large areas in Wirral, Sefton and St.Helens with low levels of deprivation. As would be expected, patterns of deprivation are very similar to those of child poverty, as illustrated by the map on p.70.

Appendix 4 illustrates the possibilities of small area analysis of deprivation by parish.

Parents on benefits/ parental unemployment

In households where neither parent is working 1 in 5 children have an emotional disorder (ONS, 2005). Table 24 shows the numbers of children living in such households across Merseyside.

Table 24
Number of Children aged 0-18 living in all Out-of-work Benefit Claimant Households by Local Authority and Age at May 2011

	age 0-18	number of households
Halton	8,010	4,270
Knowsley	11,440	6,390
Liverpool	30,340	16,910
Sefton	11,700	6,550
St. Helens	9,870	5,470
Wirral	16,930	9,220
Merseyside	88,290	48,810

Source: DWP

Small area analysis was undertaken to show the percentages of children living in out-of-work benefit claiming households. Results are illustrated in the map in Appendix 5, which shows considerable inequalities within boroughs across Merseyside. On the whole, areas with the highest levels are the same as areas with high levels of child poverty, as shown in the child poverty map on p.70 and described on p. 68.

Similar patterns are also found in analysis of income deprivation affecting children, which has also been mapped for Merseyside (see Appendix 6).

Children Living in Single Parent Households

From both a social policy and a health perspective, lone parent families are acknowledged as one of the most disadvantaged groups in society in many countries (Whitehead et al. 2000). The numbers of single parent households has remained stable in the last 10 years. Approximately 25% of all dependent children live in single parent households compared to 12% in 1971 and today 2 million children live in one parent households (ONS, 2012b). There are a number of factors which can increase the likelihood of children being disadvantaged by living in single parent households. However, there are also common misconceptions about single parent families; for example nearly half of single parent households had their children within marriage, and 49% of single parents are divorced, or widowed. The average duration of being a single parent lasts 5 years (Skew et al. 2008) before they find another partner, and 8% of single parent families are run by men (12% of single parent fathers are widowed) (ONS, 2012b).

Employment rates for single parent households depend on the age of the young child. If the child is 12 or over then employment rates are similar for mothers in couple led households (about 71%) (DWP, 2010). However, poverty is still linked with single parent households

more than the couple led households and paid work is not a guaranteed route out of poverty. Poverty rates for single parents who are working are 23% part time and 18% full time (DWP, 2011). 41% of children in single parent households are poor compared to 2 in every 10 children in couple led families (DWP, 2011). 43% of social housing tenants are single parents, compared to 12% of couples with children (DWP, 2010) and the Family Resource Survey, UK 2008-2009 reported that 63% of single parents have no savings compared to 34% of couples (DWP, 2010).

Parental separation by itself is not considered predictive of poor outcomes in children (Mooney et al 2009). Parental conflict has been identified as a key variable in producing negative outcomes for children and compared to conflict in single parent families to couple parenting families, children fared worse in couple households (Mooney et al. 2009).

There has been a long established link, with children from single-parent family units suffering from more mental health problems than those in two-parent families and it is reported that they are twice as likely to suffer (ONS, 2005). Moilanen & Rantakollio (1998) reported from a longitudinal study of Swedish children that there was a higher frequency of mental disorder in single parent families, especially those lacking in a father during the whole of the child's life than compared to children living with two parents. When neither parent worked, one fifth of children had a mental health problem, compared to 8% when both worked. The family's type of accommodation also had a bearing, with 17% of those in the social sector and 14% in the private rented sector compared with 7% owning their own homes affected (ONS, 2005).

Section 4 of this report presents the most commonly recorded adverse childhood experience associated with referral to CAMHS (specialist child and adolescent mental health services). In Sefton and Liverpool, the most commonly recorded experience was parental separation and divorce, affecting as many as 1 in 4 (24.9%) of referrals in Sefton and 1 in 5 (19.2%) in Liverpool.

Local data
There is no current local data available on lone parents. As mentioned on the previous page, nationally there has not been much increase in the proportions of families who are lone parents, so data from the 2001 census is presented below. Table 25 shows the local authority figures for lone parents with dependent children in Liverpool, Wirral, Halton and Sefton. Data for St Helens was not available. It also shows the proportions of lone parents who were in work, either part-time or full-time, for male and female lone parents.

Data on lone parents in receipt of out-of-work benefits is available. This only covers a proportion of lone parents as many will work, as illustrated in Table 25 above. However, it will give some figures and the children of these parents may be those most at risk. Table 26 shows the percentages of the working age population who are lone parents receiving out-of-work benefits. Levels were highest in Knowsley, at 2.9% and lowest in Sefton, at only 1.6%. There were 21,080 such lone parents across Merseyside in February 2012.

Table 25
Lone Parent Households with Dependent Children, 2001 census data

	All LP households (1)	Male LP households total (2)	Male LP F/T %(3)	Male LP P/T % (4)	Female LP households total (5)	Female LP F/T % (6)	Female LP P/T % (7)
Halton	4,667	348	45%	6.61%	4,319	16.83%	25.13%
Knowsley	7,163	371	42%	7.00%	6,792	13.00%	21.00%
Liverpool	21,553	1,463	42.52%	6.56%	20,090	13.37%	19.8%
Sefton	8,940	638	48.59%	5.64%	8,302	20.97%	25.55%
St Helens	-N/A	- N/A	-	- N/A	- N/A	- N/A	- N/A
Wirral	11,815	838	50.48%	5.25%	10,977	17.77%	25.13%
North West	215,610	18,810	52.18%	6.59%	196,800	20.33%	26.3%

1.All lone parent households with dependent children. 2. Male lone parent households (total count). 3. Male lone parent households where the man works full time (%) 4. Male lone parent households where the man works part time (%) 5. Female lone parent households (total count). 6. Female lone parent households where the woman works full time (%) 7.Female lone parent households where the woman works part time (%).

Source: Office for National Statistics, Neighbourhood Statistics, table KS22,

Table 26
Lone parents in receipt of out-of-work benefits,
as a % of the total working age population, Feb 2012.

	number	%
Halton	1,830	2.4
Knowsley	2,760	2.9
Liverpool	7,480	2.4
Sefton	2,630	1.6
St.Helens	2,230	2.0
Wirral	4,150	2.2
Merseyside	21,080	

Source: ONS (nomis)

Promoting wellbeing in children and young people, priority areas:
iv): *Positive relationships with family and friends*

The Children's Society research (June 2012) found the strongest driver of low subjective wellbeing to be when children experience weak and uncaring relationships with their family or carer. Stable positive relationships with family and friends are of great importance. Children at risk here include those who are looked after, and those whose parents have mental health or related problems.

Also at risk are children of prisoners, children of service personnel and those who have a parent in hospital. Lack of data and time constraints meant that these particular groups were not considered in this needs assessment.
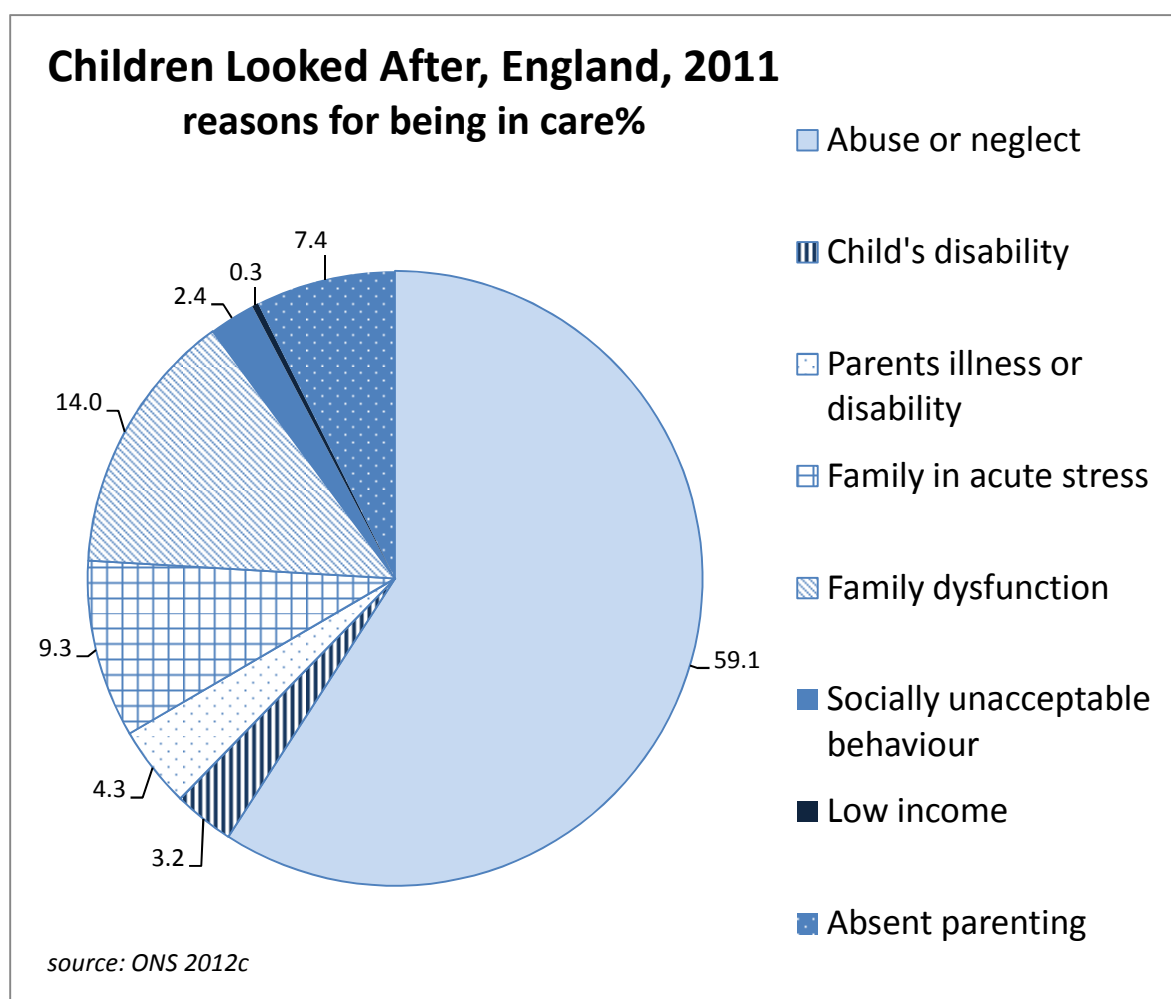
Children looked after

The Department of Health's *'No health without mental health'* (DH, 2011b) notes that in England, 0.5% of all under-18-year-olds are looked after, with 72% living in foster placements. Although the number of children being looked after has increased year-on-year since 2008, ONS point out that this may be due to increased intervention by social services rather than an increase in any of the categories stated. The most common reason for a child being looked after was 'Abuse or neglect' which, accounted for nearly 60% of all cases nationally in 2011. The next most common reason was 'Family, dysfunction' (14%) although family reasons, excluding parental illness or disability, between them accounted for nearly 31% of cases. Disability, either the child's or the parent's disability, or illness, accounted for 7.5% of all children being taken into care (Figure 30) (ONS, 2012c).

Entering care is strongly associated with poverty and deprivation (for example, low income, parental unemployment, relationship breakdown) and the outcomes associated with deprivation often persist into adulthood (DH, 2009). Many children and young people who are looked after experience significant health inequalities throughout childhood, and on leaving care continue to experience poor health, educational and social outcomes (Liverpool PCT, 2009, DH, 2011b). They are five times less likely to achieve five good GCSE grades, nine times more likely to be excluded from school and six times less likely to enter higher education than their peers (DfES, 2007). Local statistics on educational outcomes of children looked after are presented on page 24 above.

Children leaving care
On leaving care, by far the most common outcome for children is to be returned home to their family. However, around half of the abused or neglected children who enter care each year are abused or neglected again when they return home (NSPCC 2012). Less than one in 20 care leavers are adopted, so the NSPCC suggest that focusing support on the far higher number who return home would have a substantial impact on reducing repeated harm. They have introduced a new support service, run in partnership with local authorities, to help support children returning home (NSPCC).

Figure 30

Children Looked After, England, 2011
reasons for being in care%

Legend:
- Abuse or neglect
- Child's disability
- Parents illness or disability
- Family in acute stress
- Family dysfunction
- Socially unacceptable behaviour
- Low income
- Absent parenting

Values shown on pie chart: 7.4, 0.3, 2.4, 14.0, 9.3, 4.3, 3.2, 59.1

source: ONS 2012c

Missing and runaway children

A recent government enquiry found that children who are looked after are three times more likely to run away than children living in their own homes (APPG, 2012). Of the 65,000 children in care, 5,000 are in children's homes. Half of all children in children's homes (46 percent) live outside their own local authority. Placed far from home, family and friends, these are the children most likely to run away, putting them at increased risk of sexual abuse and other dangers. One female runaway stated *'I just wanted to be with someone I know'* (BBC Radio Merseyside news, 18/6/12).

The majority of missing children are 'hidden' from the system, and therefore unable to access the help they require. This is demonstrated by the huge discrepancy between police data, which shows an estimated 10,000 young people go missing each year from local authority care, compared to government statistics, which put the figure at only 930 (APPG, 2012).

(See p.82 for more details on missing children).

Mental health of Children Looked After

Early experiences may have long-term consequences for the health and social development of children and young people (NICE, 2010b). NICE note that many will have positive

experiences in the care system and achieve good emotional and physical health, do well in their education and have good jobs and careers. However, entering care is strongly associated with poverty and deprivation, and with emotional and mental health problems. Children and young people who are looked after have a five-fold increased risk of mental disorders (42% versus 8% amongst ages 5-10), a six- to seven-fold increased risk of conduct disorder and a four- to five-fold increased risk of attempting suicide in adulthood (DH 2011b, NICE 2008, Meltzer et al, 2003).

Recent NICE guidance (2010b) suggests some 60% of Looked After Young People have emotional and mental health problems. A more recent DH publication suggests that around 45% of looked after children have a mental health disorder, rising to 72% for those in residential care (DH, 2011b, based on ONS survey by Meltzer et al, 2003). The Department of Health state that timely and effective health assessments, involving the use of screening tools, are crucial to the speedy identification of problems and referral to support services. (p.16 in DH 2011b includes an example of a package of care that has led to improved outcomes).

Local data
There has been a recent rise in children taken into care. In Merseyside, there were 2,755 children looked after in 2011 (as at 31st March 2011). The national average rate was 59 per 10,000 aged under 18. Table 27 shows that rates across Merseyside were significantly higher than this in each local authority in 2011, with the exception of Halton, which was significantly lower (47 per 10,000). All except Halton and Sefton were higher than the North West average of 77, with the highest rates found in Liverpool (111) and Wirral (102).

Table 27
Children looked after at 31 March 2011

	Number	Rate per 10,000 aged under 18	Estimated number with a mental health problem (45%)
Halton	125	**47	56
Knowsley	285	*85	128
Liverpool	940	*111	423
Sefton	380	*70	171
St Helens	345	*91	155
Wirral	680	*102	306
Merseyside	2755		1240

= significantly higher than the England average of 59
***= significantly lower*
North West average=77

Data source: Department for Education (DfE, 2012)
Note: *These estimates of levels of mental health problems do not take account of variations in the age and sex structure of local populations, or variations in related factors such as deprivation, which may be higher in local populations like Merseyside. Also, figures do not take into account the higher prevalence of mental health problems amongst those in children's homes (72%) compared to those in foster care. Therefore levels of mental health problems presented here are **likely to be underestimates***

Applying the DH estimate above, there could be around 1,240 looked after children in Merseyside with a mental health problem (45% of 2,755), with the highest numbers in Liverpool (425) and in Wirral (306) (Table 27). As these young people reach adulthood, they will be requiring support from the adult mental health services across Merseyside. The figures are an underestimate, (see note with Table 27).

The Department for Education collect outcomes data for looked after children, which includes emotional and behavioural health, based on the Strengths and Difficulties Questionnaire (SDQ). The SDQ is a brief behavioural screening questionnaire about 3-16 year olds. The questions cover emotional symptoms, conduct problems, hyperactivity/ inattention, peer relationship problems and prosocial behaviour.

Figure 31 below shows the average scores across Merseyside. Levels of emotional wellbeing amongst looked after children are highest in Sefton, with an SDQ score of 14.1, which is higher than the national average of 13.9 and the North West average of 13.0. The other local authorities in Merseyside all had lower levels than the national and North West averages in 2011, especially in Knowsley, with a score of 11.

Local research in Knowsley indicates that there are a number of children in private foster care placements who may not be as visible to support services as they should be. They will be at increased risk of not receiving the support they require if they have mental health problems (Knowsley, 2011).

There is no routinely available nationally held data at a level below local authority. Such data may be made available by special request.

Recommendations for Children Looked After

The White Paper '*Care Matters: Time for Change'* (DfES, 2007) outlined the government's strategy for children and young people in care, with four central principles:
- There should be high ambitions for children in care.
- Good parenting should be available from everyone in the system.
- There should be stability in every aspect of the child's experience.
- The voice of the child should be central.

Free access to positive activities: Children in care may not have had the same play opportunities as their peers. The provision of free access to positive activities is emphasised as a priority, along with sex and relationship education and support with the financial implications of after-school clubs and music tuition. Also included would be access for looked after children who are teenage parents, with arrangement for necessary childcare (DfES, 2007). In Section 2.vi above, it was noted that looked after children are more likely to be teenage mothers.

Figure 31

Emotional and behavioural health of looked after children, 2009 to 2011

	2009	2010	2011
Halton	15.8	16.7	12.4
Knowsley	12.3	14.5	11.0
Liverpool	13.5	13.4	12.5
Sefton	13.4	13.8	14.1
St. Helens	12.8	11.7	12.1
Wirral	15.3	12.2	12.5

England = 13.9
N West= 13.0
(2011)

souce: DfE, based on Strengths & Difficulties Questionnaire (SDQ)
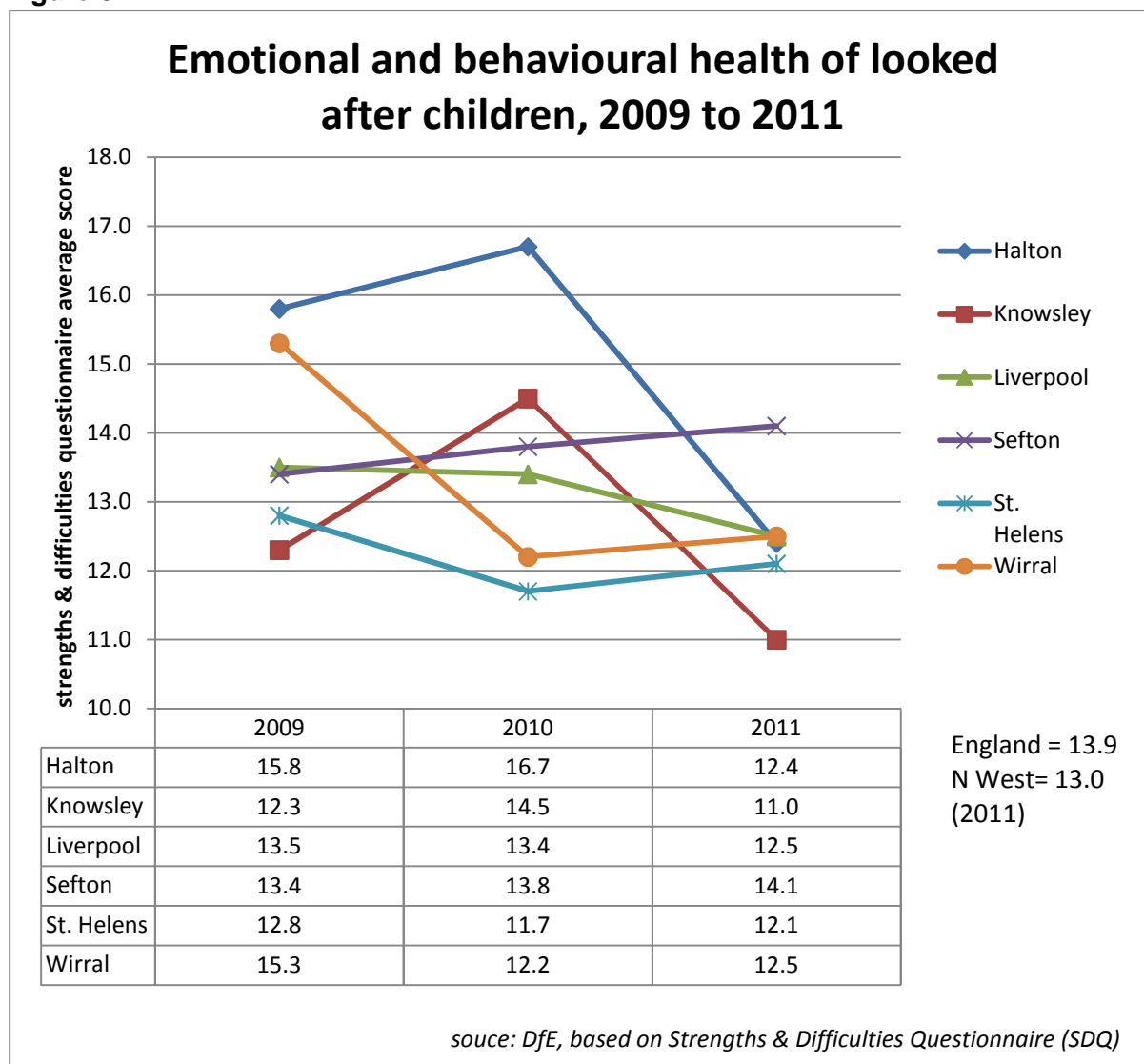
This SDQ score represents the average local authority score (X/Y) for former National Indicator (NI) 58, entitled 'Emotional and behavioural health of looked after children where:

X = The sum of all individual SDQ 'total difficulties scores' for looked after children aged 4 to 16 (inclusive), who have been in care continuously for 12 months at 31 March, and

Y = The number of valid primary carer SDQs that have been completed for looked after children aged 4 to 16 (inclusive), who have been in care continuously for 12 months at 31 March excluding any children who were looked after on that date under an agreed series of short term-placements (DfE).

In order to plan what support will be necessary, it is important to develop a local profile of children, to include:

- those in care (by type of care, including private foster placements),
- children leaving care (where they go to)
- children missing from care

(DH, 2009)

Young voices:

Local authorities are required to ensure the voices of looked after children are heard as part of the process of informing the commissioning, planning, delivery and evaluation of services (DH, 2009). McAuley & Davis (2009) suggest that it is crucial to know more about what children and young people want from the services. If children and young people's voices are

taken into account the service is more likely to be effective. YoungMinds (2006) reported, when reviewing five mental health services for looked after children, that young people wanted a personalised service, one that is about their specific needs, easily accessible and flexible, understands young people and provides support for young people.

The Department of Health has published statutory guidance on promoting the health and wellbeing of looked after children (DH, 2009). As noted in the Healthy Child Programme (DH/DCSF HCP. 2009) and 'No Health Without Mental Health (DH, 2011b), there is a need for the following:

- *Improved identification and assessment*: Timely and effective health assessments of looked after children are crucial to the speedy identification of problems and referral to support services. The use of screening tools such as the Strengths and Difficulties Questionnaire can help to prioritise referrals to child and adolescent mental health services (CAMHS). The responsibility for health assessment is shared between the Local Authority and the Clinical Commissioning Group and should be reviewed at least once a year. Every looked after child should also have a health plan. The looked after children lead in the Children's Trust has the responsibility to ensure that these interventions are being delivered according to local protocols and practice.
- *More effective commissioning* ensures that the needs of looked after children, including those living outside their local authority area and care leavers, are reflected in joint strategic planning. Children and young people with the highest levels of need may require a complete package of care that addresses their mental health needs – for example through the Multidimensional Treatment Foster Care programme, which is evidence-based treatment for children with chronic antisocial behaviour, emotional and/or conduct disorders and unstable foster placements. The programme has demonstrated improved outcomes for children and young people.

(DH, 2011b)

NICE guidance on promoting the quality of life of looked after children and young people (NICE, 2010b) included recommendations covering local strategy and commissioning, multi-agency working, care planning and placements, and timely access to appropriate health and mental health services. In particular, the aim is to:

- promote stable placements and nurturing relationships
- support the full range of placements, including with family and friends
- encourage educational achievement
- support the transition to independent living
- meet the particular needs of looked-after children and young people, including those from black and minority ethnic backgrounds, unaccompanied asylum seekers, and those who have disabilities
- places looked-after children and young people at the heart of decision making.

(NICE, 2010b)

There is a need for a greater focus on the needs of children *leaving* care, involving partnership working with the voluntary sector, such as the NSPCC, in providing support services (NSPCC, 2012).

Missing and runaway children

Every year, an estimated 200,000 people go missing in the UK, with children and young people under 18 accounting for approximately two-thirds (64%) of cases. Those aged 15-17 make up around one-third of all missing reports. As many as two-thirds of young people who run away are not reported to the police as missing and even fewer as having run away. Most cases are repeats, with the same child going missing (Home Office, 2011; NPIA, 2011; APPG, 2012).

As noted on p.77, children who are looked after are three times more likely to runaway or go missing than children in their own homes (APPG, 2012). Other factors linked to a child running away or going missing include:
- having a parent with alcohol or drug problems (see section 2(iv), p.85-86);
- violence or abuse in the home, with repeat runaways more likely than children in general to say they had been 'hit a lot' by their parents;
- sexual exploitation (sometimes whilst a child is in care);
- problems at school (such as bullying);
- alcohol or drug use problems – children and young people with such problems were at least four times as likely to run away as those without;
- mental health problems – these were reported by 25% of missing children and young people, with 5% citing mental health problems as the reason for running away
- abduction - parental abductions are increasing, e.g. as a result of a custody battle by a parent taking a child from care, and can detrimentally affect the long term wellbeing of the child, with a sudden change of locality and lack of contact with other family and support services

(Home Office, 2011, PACT, 2005)

Although many runaways are fleeing abuse, they will often be at increased risk as a result of running away. Children who go missing are at very serious risk of physical abuse, sexual exploitation and sometimes so desperate they will rob or steal to survive (APPG, 2012). A study in 2005 found that 25% suffered some form of abuse whilst missing, 13% were physically hurt and 8% were physically assaulted (PACT, 2005). It is estimated that one in six missing children end up on the streets sleeping rough and one in eight resort to begging or stealing to survive (Children's Society, 2012b). They may suffer mental health problems such as depression, as a result of going missing. Repeatedly going missing from home is recognised as an indicator that a child may be the victim of sexual exploitation (Home Office, 2011).

Missing children on Merseyside
In 2009/10, there were a total of 13,382 missing person incidents on Merseyside (NPIA, 2011). If children and young people aged under 18 account for 64% of all reported missing persons (NPIA, 2011, Home Office, 2011), then it can be estimated that there were 8,565 missing persons incidents amongst those aged under 18 on Merseyside in 2009/10.

Using ONS population estimates, rates per 1,000 under 18s were calculated. The rate for Merseyside was 30.49, which across England and Wales was second only to Greater London (34.78 per thousand) and considerably higher than rates in neighbouring areas (Figure 32).

Figure 32

**Missing persons
aged under 18, 2009/10**

**estimated incident rate per 1,000,
Merseyside & neighbouring areas**
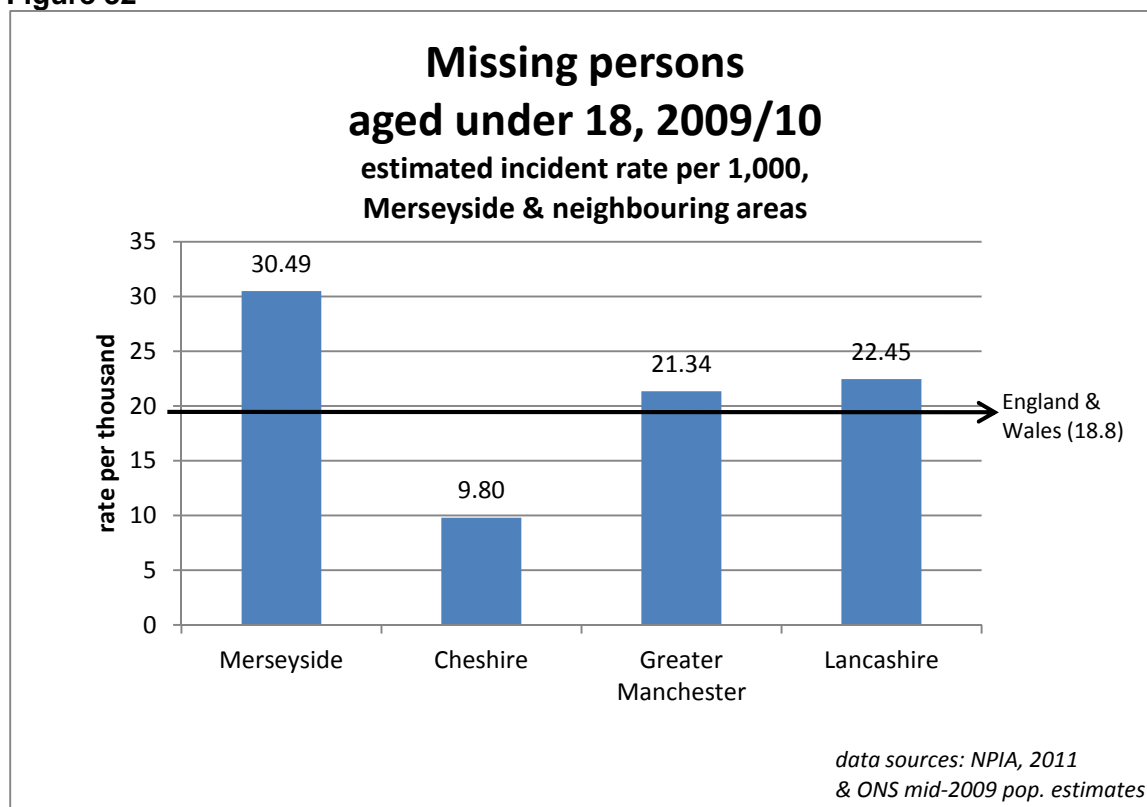
Allowing for repeat incidents: This data includes repeat incidents. For all-age data, it was estimated that the number of individuals reported missing made up 54% of the total number of missing person incidents (with a range of 47% to 66%. Data was not available for all areas) (NPIA, 2011). If this estimate was applied to the Merseyside under 18 data, then this would suggest that there were up to **4,634 individual children and young people missing on Merseyside in 2009/10.** However, it is possible that the proportion would be lower for those aged under 18, with the number of repeat incidents likely to be higher.

Factors behind the high rates of missing young person incidents in Merseyside need to be explored. This would include mapping the size and numbers of children's homes and other Looked After Children in this and surrounding areas. As shown in Table 27 above, rates of Looked After Children were significantly higher than the England average in 5 out of 6 local authorities in Merseyside, and were higher than the North West average in 4 out of 5.

Recommendations
The Missing Children and Adults Strategy 2011 (Home Office, 2011) acknowledges the need for local areas and agencies at national level, to deliver on 3 objectives:

1   prevention (reducing the number of people who go missing) –
2   protection (reducing the risk of harm to those who go missing) and
3   provision (providing missing people and their families with support and guidance).

The strategy aims to help support local agencies to deliver these objectives. The links between mental health and people going missing are acknowledged by Government, statutory agencies and the voluntary sector. This means that providers of mental health

services are crucial local partners in delivering effective strategies to prevent and reduce the numbers of people going missing (DH 2012c).

Recommendations relating to young runaways and missing children include the following:

- investigate factors behind high rates of missing young person incidents in Merseyside
- improve training to increase awareness of these issues amongst all agencies involved. Too often, children with the most complex needs are seen as troublesome or promiscuous, when they should be viewed as vulnerable and in need of protection
- ensure less dependence on the use of agency staff in children's homes, so that children are able to build up relationships with regular workers
- remove barriers to sharing information between agencies, for example so that police are aware of the location of children's homes, enabling them to monitor their safety and keep an eye on potential predators in the area
- improve systems for reporting runaways
- ensure full use is made of 'return interviews', with relevant agencies coming together in an attempt to understand the issues around the young person
- work with voluntary sector projects in the area which have an important role as they are often a trusted point of contact for young people and their families, providing confidential and impartial advice.

(APPG, 2012; Home Office, 2011)

Children of parents with mental health and related problems

Parental mental health

Up to 17.8% of children in the UK live with a parent who has a mental disorder (Manning et al, 2009). In most cases, parents with mental health problems are able to bring up their children effectively, but there are increased risks (Liverpool PCT, 209): Between a third and two thirds of children whose parents have mental health problems will develop problems either in childhood or adult life (MHF, 2007). The ONS Survey of the development and emotional wellbeing of children and young people (ONS, 2008) followed up the children who in 2004 had no mental health disorders (original survey in ONS, 2005). Of these children, those whose mothers had mental health

> **Box 3**
> **Mother's mental health for children and young people who had no mental disorder in 2004**
>
> *Emotional disorder in children and young people*: onset of disorder by 2007 significantly more likely amongst those whose mothers scored high (7%) versus low (3%) on a psychological distress measure.
>
> *Conduct disorder in children and young people*: onset by 2007 significantly more likely among those whose mothers scored high (4%) versus low (3%) on a psychological distress measure.
>
> (ONS, 2008)

problems were more than twice as likely to develop emotional disorders. The association with conduct disorders was not as strong, but still significant (Box 3). It has been noted that children of depressed parents have a 50% risk of developing depression themselves before the age of 20 (WHO, 2004, ONS, 2008, DH 2011b).

Merseyside

Across Merseyside, an estimated 54,287 children are living with a parent with mental health problems. Between one to two thirds of these children are likely to develop mental health problems themselves. Estimates for local authorities within Merseyside are given in Table 28. It is clear that this is a group of children who would benefit from targeted interventions.

Section 4 of this report presents the most commonly recorded adverse childhood experience associated with referral to CAMHS (specialist child and adolescent mental health services). Levels of household mental illness were high, featuring in 16.2% of all referrals in Sefton and 11.4% in Liverpool.

Table 28
Children and young people aged under 18 living with parents who have mental health problems, or who are substance misusers. Estimated numbers across Merseyside, 2010

Percentage of children & young people exposed	Estimated numbers						
	Halton	**Knowsley**	**Liverpool**	**St.Helens**	**Sefton**	**Wirral**	**Merseyside total**
Living with a parent with mental illness (17.8%)	4,860	5,982	15,119	6,705	9,731	11,890	**54,287**
Living with at least 1 binge drinking parent (30%)	8,191	10,081	25,482	11,300	16,401	20,040	**91,495**
Living with a hazardous drinker (22.1%)	6,034	7,426	18,772	8,324	12,082	14,763	**67,401**
Living with a dependent drinker (6%)	1,638	2,016	5,096	2,260	3,280	4,008	**18,299**
Living with an illicit drug user (8%)	2,184	2,688	6,795	3,013	4,374	5,344	**24,399**
Living with a problem drinker who has concurrent mental health problems (4.2%)	1,147	1,411	3,567	1,582	2,296	2,806	**12,809**
Living with a problem drinker who also uses drugs (3.6%)	983	1,210	3,058	1,356	1,968	2,405	**10,979**
Living with a drug user who has concurrent mental health problems (2.6%)	710	874	2,208	979	1,421	1,737	**7,930**
Living with a problem drinker who has concurrent mental health problems and uses drugs (1%)	273	336	849	377	547	668	**3,050**

source: estimates for under 17s from Manning et al, 2009 (extended to include children under 18). Applied to ONS mid-2010 population estimates.
Acknowledgement: format taken from draft Halton & St Helens Joint Strategic Needs Assessment: Looked After Children (McAteer, 2012).

Parents with alcohol and other substance misuse problems

Living with parents who have drink or substance misuse problems can have negative impacts on the emotional wellbeing of children and young people. It can result in behavioural problems in the child and the development of problem drinking and associated risky behaviours in adolescence. The child may experience social isolation due to the shame of bringing friends home, or from caring responsibilities (Velleman & Templeton, 2007).

Around 30% of children under the age of 16 live with at least one adult binge drinker and 22% with at least one hazardous drinker (Manning et al, 2009) (see Box 4 for definitions of drinking levels).

Merseyside
Table 28 above gives estimates for Merseyside of children and young people living with adults who have varying degrees of alcohol and other substance misuse problems (based on the survey reported by Manning et al, 2009). Those most at risk are the estimated 3,000 children and young people on Merseyside who live with a problem drinker who also has mental health problems and uses drugs. There are around 18,299 children and young people on Merseyside estimated to be living with a dependent drinker, and 24,399 with an illicit drug user. Estimates for areas within Merseyside are given in Table 28.

Box 4
Definitions of drinking levels

Binge drinking involves consumption of 6 or more units in a single drinking occasion for women and 8 or more units for men

Problematic drinking includes hazardous, harmful and dependent drinking:
- *Hazardous drinking* is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others
  (exceeding 14 and 21 units weekly for females/males respectively. >8 on AUDIT*)

- *Harmful or moderately dependent drinking* is consumption that results in consequences to physical and mental health.
  (>16 on AUDIT*)

- *Dangerous or severely dependent drinking* refers to those exceeding 35 and 50 units weekly for females/males respectively.

(Manning et al, 2009, Singleton et al, 2001)
*Alcohol Use Disorders Identification Test, in Saunders et al (1993)

Recommendations (parental mental health)
The WHO (2004) reported that a range of interventions aimed to prevent transgenerational transfer of mental health problems have been developed, by addressing risk and protective factors in the children and their families. Studies are summarised by the WHO (2004) as follows:
- home visiting programmes during the first year after birth focusing on improving early parent–infant interaction
- school-based screening and early intervention programmes among indicated children with increased anxiety symptoms and anxious parents and
- a cognitive-oriented group programme for adolescent children of depressed parents with an elevated level of depressive symptoms but no disorder
  (reported in WHO, 2004)

The WHO note that controlled outcome studies on such programmes are still scarce, although some show promising outcomes. For example, a randomised trial on a cognitive-oriented group programme found a prevalence of new and recurrent depression of 25% in the control group compared with only 8% in the intervention group in the first year of the intervention, and respectively a rate of 31% compared with 21% at the second year follow-up (Clarke et al., 2001). This finding replicated the findings from an earlier controlled study (WHO, 2004).

The Healthy Child Programme recommends:
- Referral of one or both parents to specialist adult mental health (AMH) service.
- The HCP Team to contribute to a care package led by specialist service.
- The HCP Team to ensure that any safeguarding concerns are identified and that links are in place to appropriate children's services.

(DH/DCSF HCP, 2009)

Promoting wellbeing in children and young people, priority areas: _v): A safe and suitable home environment and local area_

Children need safe and suitable environments at home and in their local area. Feeling safe, privacy, and good local facilities are important to wellbeing, Factors such as poor quality or overcrowded housing or moving house a lot are risk factors to wellbeing. However, the existence of positive caring relationships can over-ride these negative influences (Children's Society, June 2012).

Housing type

Good-quality, affordable, safe housing is seen as essential to our wellbeing. Poor housing or homelessness can contribute to mental ill health or can make an episode of mental distress more difficult to manage (MIND 2007a).

Shelter have reported that there is a shortage of good quality housing and that social housing is often associated with poor quality buildings, high levels of unemployment and crime, and poor access to local services (Shelter report from 2007 quoted in MIND 2007a).

Social housing is also associated with overcrowding. A survey carried out by Shelter found that children growing up in social housing have, on average, seven square metres less space in which to play and develop, than the national average (Shelter, 2005).

Children living in social sector housing are at greater risk of developing mental health problems (Mental Health Foundation, 2007).

Poor housing:
- More than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm housing.
- Cold housing negatively affects children's educational attainment, emotional wellbeing and resilience.

- Parents and children both complain of the social stigma of living in bad housing.

(McAteer 2011)

Possible interventions include:
- Educating families about health risks
- Referrals to local health providers
- Making houses dryer and warmer by installing insulation
- Modifying houses to address health and disability needs
- Transferring families to other houses to address overcrowding or in some cases, increasing the number of bedrooms in a house

(McAteer 2011)

Local data is available on fuel poverty, but analysis was beyond the scope of this project. In future, analysis of this data by small area would be useful to assist in assessing the needs of local populations.

Homelessness

You are legally homeless if the place you live is unsafe, unsuitable or you have no legal right to be there (GOV.UK, 2012). Homelessness is increasing with 14% higher numbers of people being classed as homeless in 2011 than in 2010. In part, this is a result of poor economic growth since the 2008 recession and the high unemployment it has caused (Department for Communities & Local Government, 2012). The annual rate of young people aged 16-24 accepted as homeless is highest in Scotland (15.1 young people per 1,000 young people in population) followed by Wales (8.2), England (4.9) and Northern Ireland (4.8) (JRF, 2008).

The Mental Health Foundation in collaboration with Barnardos (MHF, 2002) produced a literature review from available evidence and spoke with homeless young people about their mental health needs. They found a compelling body of evidence indicating that many suffer from severe mental health problems and that such problems are eight times as high for people living in hostels and bed and breakfast accommodation and eleven times higher for those who sleep rough, compared to the general population (MHF, 2002).

As with mental health, the homeless population tend to suffer from a similar range of physical problems as the general population, but more often and more severely due to restricted access to basic commodities (Grenier, 1996). In two studies of homelessness, high rates of self-reported problems covering a diverse range of complaints were found, for example, stomach problems, headaches, aching joints, chronic bronchitis, skin troubles and epilepsy (Wrate and Blair, 1999). Perceived physical health status was seen as below age-matched 'norms' (Wrate and Blair, 1999).

Self neglect may result from a combination of practical barriers and the manifestation of mental health problems. Self-harming is thought to be relatively common among young homeless people and suicide is the biggest single cause of death among the street homeless. There is a relatively high prevalence of sexual risk behaviour among the young homeless population. Rohde et al. (2001) found that 'depression is frequent in homeless older adolescents and has a complex association with STD-related behaviours'. The risks

associated with such behaviour include sexually transmitted infections, unplanned pregnancy and potential for abuse or exploitation. For example, in one study 40% (16/40) of homeless young women in London who were re-interviewed a year later had at least one confirmed pregnancy, all of which were unplanned (Craig et al., 1996).

Young people understand the dangers of street living and harbour associated fears. Young homeless people are more likely to be the victims of crime rather than the perpetrators. While 'street children' are the most visible section of the young homeless population, they comprise the smallest group, with many more young people with insecure domicile having high levels of need. Homelessness can instigate or compound existing mental health problems and/or drug misuses problems amongst young people, and there is a strong association between homelessness and withdrawing from education (JRF 2008). It also impedes the acquisition of social capital, undermines the young person's sense of identity and exposes young people to a wide range of dangers and stressors (MHF, 2002).

The Joseph Rowntree Foundation in partnership with the Centre for Housing Policy at the University of York and Centrepoint, reported in May 2008 that the scale of homelessness (which is limited to young people who are in contact with services) indicates that at least 75,000 young people were accepted as homeless following the extension of priority need groups in the early 2000's but numbers have since fallen in England and Wales in the last three years (JRF, 2008). Their review confirmed that income poverty and worklessness are associated with homelessness, with evidence that homelessness leads to increased proportions of young people not in education, employment or training. Young people found it difficult to study or work and afford present rent levels together with Housing Benefit restrictions and problematic administration (JRF, 2008).

Key facts about the homeless population in the UK
(taken from Homeless Link)

9 out of 10 rough sleepers are male.

9% aged under 25.

46% are white British.

13% were black or black British.

33% of homeless people have drug problems.

48% have alcohol problems.

30% of homeless people have a mental health problem.

21% have neither a drug or alcohol or mental health problem.

10% have been in care at some point in the past

Homeless Link is the only national charity supporting people and organisations working directly with homeless people in England and they represent homelessness organisations among local, regional and national government. As the national collaborative hub for information and debate on homelessness, they seek to improve services for homeless people and to advocate policy change aiming to end homelessness in England and have provided key facts about homelessness in the UK. In Autumn 2010 rough sleeping estimates

in England were 1,768 a 42% increase on 2009 figures, breaking a long trend of declining numbers. There are 198 day centres in England serving 10,000 people per day and 43,000 bed spaces in England for the homeless population. There are approximately 267 direct access hostels in England, with 1,174 second stage accommodation projects (Homeless Link).

Local data

In Merseyside, there are no recorded figures on the number of young people who may be homeless. The Supported Lodgings project (formerly Merseyside Accommodation Project, or MAP) provides supported lodging for young people who are aged 16-18 and have 133 householders across Merseyside. Young people can be referred through a number of pathways, including self referral and Connexions and must agree to participate in some form of training, education or employment. In 2006/7 MAP's Liverpool scheme received a total of 63 referrals for placements, giving some indication of the numbers of 16-18 year olds, who may be homeless in any one year. We can estimate the numbers of 17-18 year olds who may be homeless in each local authority, using population data (Table 29). This is likely to be an underestimate as the known factors that increase the likelihood of homelessness (poverty, worklessness etc) are higher in Merseyside than in other counties in England. Taking into account that some studies include young people aged 16-24, these figures below would be considerably higher.

Table 29: Estimates for numbers of homeless young people (aged 17-18)

| Local authority	Number of 17-18 year olds in Local authority (mid-2010 population estimates)	Estimates of numbers of homeless young people (using JRF rate of 4.9 per 1,000 young people aged 17-18 in England)
Halton	3262	16
Knowsley	4306	21
Liverpool	11265	55
Sefton	7677	38
St Helens	5081	25
Wirral	8191	40
Merseyside total estimate	**39,782**	**195**

Family homelessness

Behavioural problems have been found to be higher among homeless children living in temporary accommodation, and mental health problems are significantly higher among homeless mothers and children (MHF, 2007).

The Child and Maternal Health Observatory (ChiMat) collect data on family homelessness. They define family homelessness as the number of applicant households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance, as a percentage of total households. Their latest child health profiles give figures for 2007-08. Rates of family homelessness in Knowsley, St.Helens and Wirral were significantly worse than the national average of 1.9%. In Liverpool and Sefton, rates were significantly better (Figure 33). There were at least 997 homeless families in Merseyside in 2007-08 (Table 30).

This was the most recent readily available data and was based on the HSSA return (Housing Strategy Statistical Appendix) which has now been abolished. The only source of homelessness figures now from the Department for Communities and Local Governments is the P1E return. Future investigation would involve exploring what is available here.

Figure 33
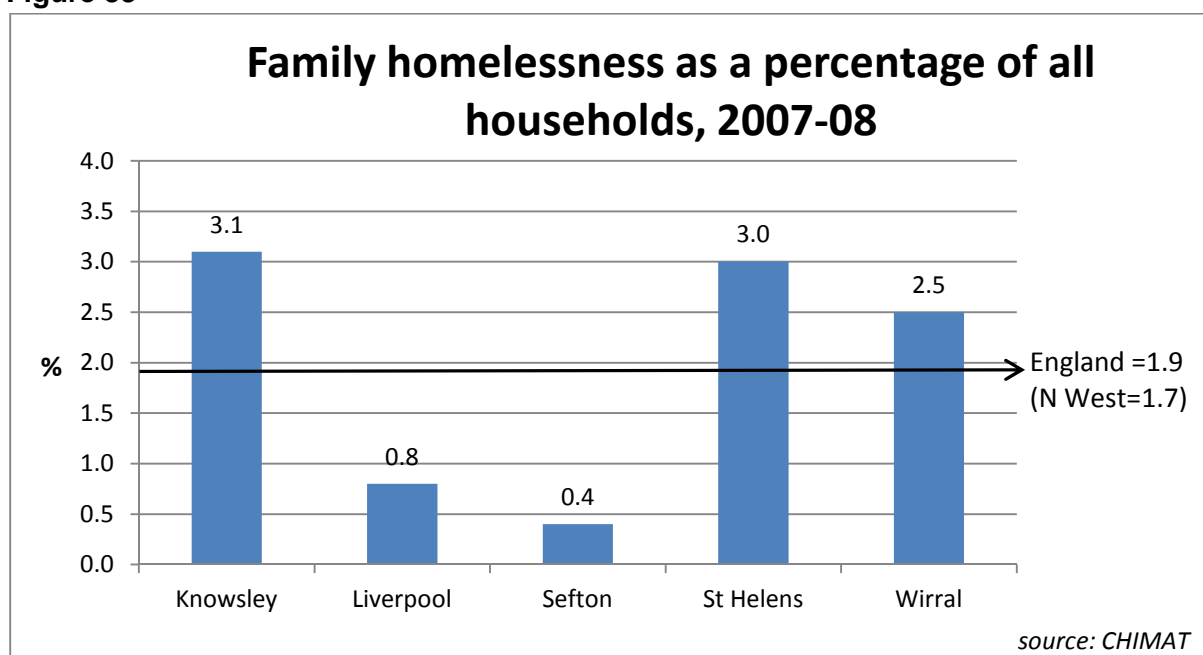
(data for Halton not available from ChiMat)

Table 30
Number of homeless families, 2007-08

Halton	n/a
Knowsley	208
Liverpool	150
Sefton	53
St Helens	233
Wirral	353
Merseyside	997

Source: ChiMat

Recommendations
Recommendations have been made in previous literature studies and reports to improve the emotional wellbeing and physical health of young homeless people. These have been summarised by the Mental Health Foundation (MHF, 2002):

- *Practical support:* While specific clinical help is essential, many emotional problems may be alleviated by the simple and reliable provision of practical help.

- *National Service Framework (NSF):* The Social Exclusion Unit (SEU) proposes a NSF for runaways – ensuring greater resource allocation and better joint working.

- *Listen to young people:* It is critical that young people's voices are heard, not just to map their routes into homelessness and its impact on their mental health, but also to help workers assess the availability and appropriateness of supportive provision.

- *Active intervention:* Early and pro-active, rather than reactive services are essential as are multiple and intense support services. More assertive outreach work is needed to reach young people with the most pressing problems.

- *Improve access:* Access to services has to be negotiated, paying attention to such factors as physical proximity and timing to ensure continued access to benefits, day centres and other essential services.

- *Improved inter-agency working:* There is a need to increase services' capacity to deal with young peoples' varied and multiple needs.

- *Preventive housing measures:* These include improved housing quality and availability to those at the lower end of the housing market, increases in housing benefit, more secure tenancies and better regulated private and social landlords. For example, the potential reform of the 16 hour rule for Housing Benefit claimants when studying and living in hostels would represent a first step in addressing these problems (JRF, 2008).

- *Accommodation provision:* A range of secure and flexible accommodation will have both preventive and healing effects on psychiatric morbidity. Supported accommodation and half-way houses can be crucial resources for young people.

- *Definition:* The acceptance of a common definition of homelessness would make referrals easier and service provision more consistent.

- *Preventive familial measures:* These include family mediation and respite services.

- *Preventive health measures:* More education and active health promotion around mental health issues is required, in different settings and styles. Preventive and primary care services need to be more accessible to young homeless people and provide continuity.

- *Support care-leavers:* Care-leavers independence needs to be promoted at a time when the young person is receptive and looking to move on.

Aggression and violence

As noted by UNICEF (2007), exposure to violence in the home – both directly through child abuse and indirectly through witnessing aggression and violence between adults – can be a cause of long lasting distress to children of all ages. People who have been abused or been victims of domestic violence have higher rates of a range of mental health problems. Women's Aid (2012) noted that it is now well accepted that abuse (both in childhood and in adult life) is often the main factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse. Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life (Women's Aid, 2012).

Statistics include:
- Women who have been abused in childhood are four times more likely to develop major depression in adulthood.
- People who experienced childhood sexual abuse are almost three and a half times as likely to be treated for psychiatric disorders in adulthood as the general population. They are five times as likely to have a diagnosis of personality disorder.

(MHF, 2007)

Exposure to abuse and violence is difficult to define and the available indicators are inadequate (UNICEF, 2007). Indicators to be explored here are:
1. Children who are the subject of local authority Child Protection Plans. Also commissioned Merseyside police data on incidents involving safeguarding children.
2. School survey data on feeling safe.
3. Children admitted to hospital due to injury.

Local data

Child protection
If a child is identified as being at risk of harm, then they become the subject of a Child Protection Plan. Categories of abuse for children on Child Protection Plans are: neglect, physical abuse, emotional abuse and sexual abuse. After 2009/10 child protection plan and children in need data ceased to be available by areas below the local authority level. Data is presented here for the local authorities on Merseyside.

There were 1,484 children with a child protection plan in Merseyside in 2011 (as at 31st March). Across Merseyside, rates per 10,000 children aged under 18 were higher than the national average of 39, with the exception of Halton, which had a rate of 29. Rates in Liverpool and St.Helens were particularly high, at 59 per 10,000 (Table 31).

Table 31
Children subject to a Child Protection Plan, 31st March 2011

	Number of children	Rate per 10,000 aged under 18
Halton	78	29
Knowsley	165	49
Liverpool	503	59
Sefton	224	41
St Helens	224	59
Wirral	290	43
Merseyside	1,484	49
North West	6,300	43
England		39

Source: Department for Education

Figure 34 shows the category of abuse for children on child protection plans in Merseyside, as at 31st March, 2011. Physical, emotional and sexual abuse together account for just under half of all cases.

Figure 34

Children subject to a Child Protection Plan, by type of abuse, 31st March 2011, Merseyside

Multiple 288 (20%)
Neglect 481 (34%)
Emotional abuse 267 (19%)
Sexual abuse 75 (5%)
Physical abuse 324 (23%)

source: Department for Education
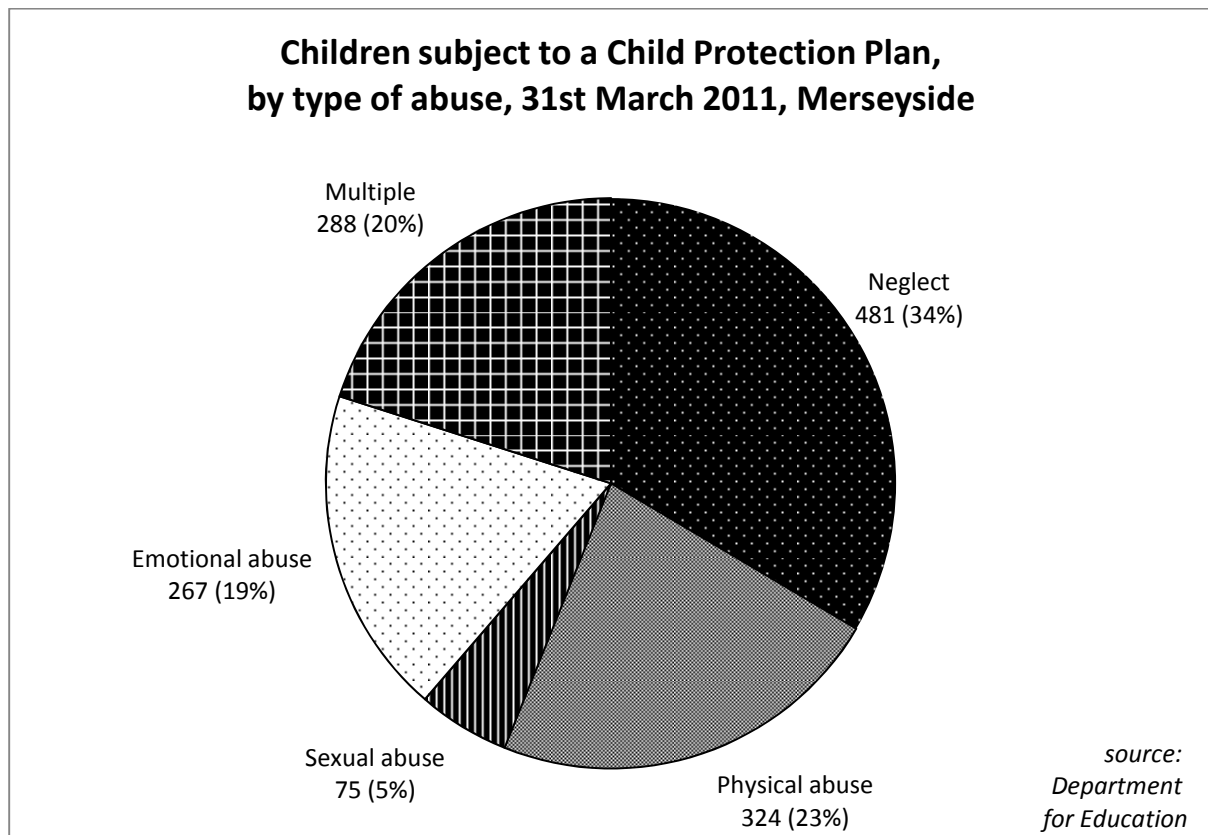
Within local authorities, there were variations which may reflect different needs, or may be a result of different recording procedures. For example in Sefton, around half of all cases involved physical abuse, compared to 23% in Merseyside as a whole. In Liverpool, more

than half of all cases involved multiple abuse (i.e. when more than one category of abuse is relevant to the child's current protection plan), compared to only 20% in Merseyside (Table 32).

Table 32
Children subject to a Child Protection Plan, by type of abuse, 31st March 2009

	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple	total
Halton	29	x	x	30	0	59
Knowsley	51	x	16	77	x	144
Liverpool	108	36	x	62	288	494
Sefton	64	121	10	29	0	224
St Helens	82	52	27	63	0	224
Wirral	147	115	22	6	0	290
Merseyside	**481**	**324**	**75**	**267**	**288**	**1,435**

X=less than 5
Source: Department for Education

Ethnic group
Children from ethnic minority groups are significantly over-represented amongst those with child protection plans. The black and minority ethnic group (BME) population aged under 19 in Liverpool is around 9.1% of the total population (2007-9 figure). However, in Liverpool, children from BME groups account for as many as 18% of the total with child protection plans, as illustrated in Table 33 below. This would be twice as many as expected. Similarly in Sefton, children from BME groups account for 11% of those on child protection plans and yet only 3.2% of the under 19 population are from minority ethnic groups (ChiMat 2007-09 data).

Numbers by ethnic group in Halton, Knowsley, St.Helens and Wirral were too small to be considered.

Table 33
Child protection involving children from black and minority ethnic groups, Liverpool.

	Children on Child Protection Plans (March 31st 2011)	Police incidents involving safeguarding children, 2007-09	Safeguarding referrals to Alder Hey's Rainbow Centre (2007-09)	Population aged under 19 (ChiMat 2007-09)
Black and minority ethnic groups as % of all cases	18%	11.8%	11.3%	9.1%
White, as % of all cases	81.9%	88.2%	88.7%	90.9%

Source: ONS, 2012c, Ubido & Winters, 2010 and ChiMat 2012

Police incidents

Liverpool Public Health Observatory recently carried out a Child Safeguarding Needs Assessment for Merseyside (Ubido and Winters, 2010). This work was supported by Merseyside Police, who collected data on police incidents involving safeguarding children. It was found that in 2009, there were more than twice as many individual police incidents involving safeguarding children in Merseyside (3,015) than there were children on child protection plans (1,290). As shown in Table 34, the rate per 10,000 aged under 19 in 2009 was highest in Sefton (100.5) and lowest on the Wirral (77.0) (Halton was not included in this report). More details, including breakdowns by age and sex, are available in the safeguarding report (Ubido and Winters, 2010).

Table 34. Annual police incidents involving safeguarding children, 2009

Local authority	Number of individual cases in 2009	Rate per 10,000 aged under 19	Total cases, including repeated incidents in 2009
Knowsley	345	86.3	429
Liverpool	1007	98.0	1270
Sefton	662	100.5	896
St. Helens	411	94.1	530
Wirral	590	77.0	713
Merseyside total	**3015**	**91.6**	**3838**

Source: Merseyside Police
Halton was not included in this report

As with child protection plans, children from black and ethnic minority (BME) groups – in particular black children – are statistically significantly over-represented in police incidents on Merseyside. This finding was also mirrored in the analysis of attendances at the Rainbow Centre for safeguarding at Alder Hey Children's Hospital. Approximately 69% of incidents involving BME groups on Merseyside were from Liverpool. Of the 1,277 incidents in Liverpool for which ethnic group was recorded, 11.8% (151) involved children from BME groups (Table 33). In the Liverpool population aged under 19 as a whole, there are 9.1% children from BME groups. The proportion of children from BME backgrounds involved in police safeguarding incidents (11.8%) is very similar to the proportion of children from BME groups attending the Rainbow Centre (11.3%) (see Table 33).

Compared to police incidents involving white children, the type of incidents involving children from BME backgrounds were much more likely to be requests for information, neglect and other incidents (including welfare and emotional abuse). Police incidents relating to children from BME backgrounds were statistically significantly less likely to involve sexual abuse and slightly less likely to involve physical abuse. This is similar to patterns of attendance at the Rainbow Centre, where attendances by children from BME backgrounds were slightly less likely to involve sexual abuse and physical abuse (Ubido & Winters, 2010).

Domestic abuse and health service response

The Department of Health published an action plan setting out how it will improve services for women and child victims of domestic abuse in November 2010. Guidance for commissioning services for women and children who experience abuse was published in April 2011. In 2009, the Department of Health published a practical toolkit for front-line practitioners providing information about children, domestic abuse and related issues, along with guidance, sample forms and factsheets.

Government vision for tackling violence against women and girls. Following publication of the government strategy to end violence against women and girls in November 2010, an action plan was published in March 2011. It sets out 88 cross-government actions, including a youth prevention campaign to tackle teenage relationship violence, and a 12 month pilot of Domestic Violence protection notices. A progress review was published in November 2011. Actions completed so far include:

- This is Abuse campaign targeting teenage relationship violence and abuse. It includes resources such as a guide to signs of abuse, a list of services which help both perpetrators and victims and a discussion board.
- The Royal College of General Practitioners has developed an online course for GPs to help them recognise and respond to signs of domestic abuse against women and children.
- Publication of a review of Multi-Agency Risk Conferences (MARACs), looking at how they are working and potential for development. The review was commissioned to inform the development and implementation of the government's call to end violence against women and girls. Findings include: MARACs have potential to improve victim safety and reduce revictimisation, but more robust evaluation is needed

Above taken from NSPCC website;
http://www.nspcc.org.uk/Inform/resourcesforprofessionals/domesticabuse/lggp-england_wda87677.html

Feeling safe

Although now outdated, worrying information from the Tellus2 survey (2007) revealed that the numbers of children who said they felt unsafe at home from being hurt by others ranged from as many as 1 in 12 in St.Helens (8.1) to only 1 in 27 (3.7%) in Liverpool. St.Helens, Wirral, Knowsley and Halton were above the national average of 4% (Figure 35). (S*uch details are not available in the more recent Tellus4 survey. The Tellus surveys were discontinued in 2010 following the change of government*).

Child hospital admissions for injury

Hospital admissions caused by unintentional and deliberate injuries in under 18s are one of the public health indicators in the Public Health Outcomes Framework for England, 2013 – 2016. Although not necessarily linked to violence in the home, child admissions to hospital for injury are recognised as a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experience(s). The Child Accident Prevention Trust note that the inclusion of this indicator is key for cross-sectoral and partnership working to reduce injuries, including child safeguarding (Child Accident Prevention Trust, 2012).

Figure 35

At home I feel a bit/very unsafe from being hurt by other people

'Tellus' survey : Staying safe. % of school age children, Merseyside local authorities, 2007

England 4%

source: CHIMAT

Figure 36

Child hospital admissions due to injury,
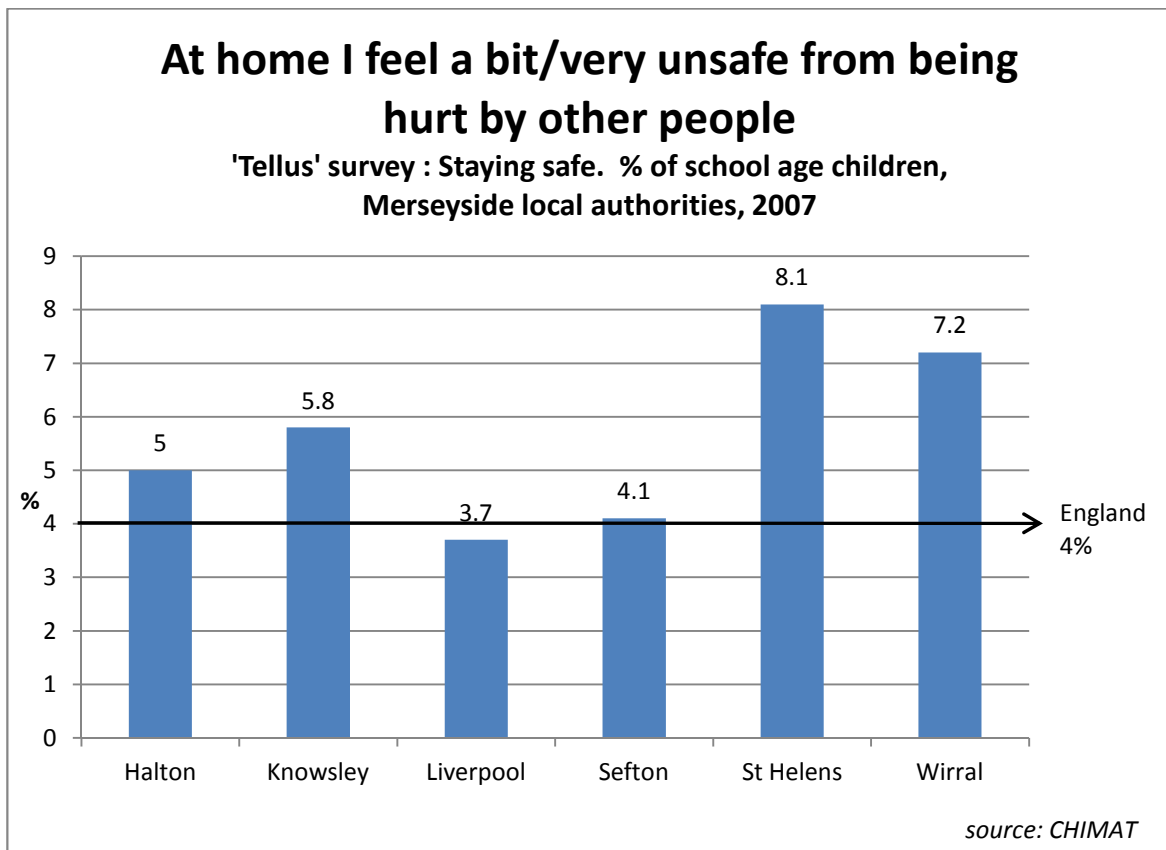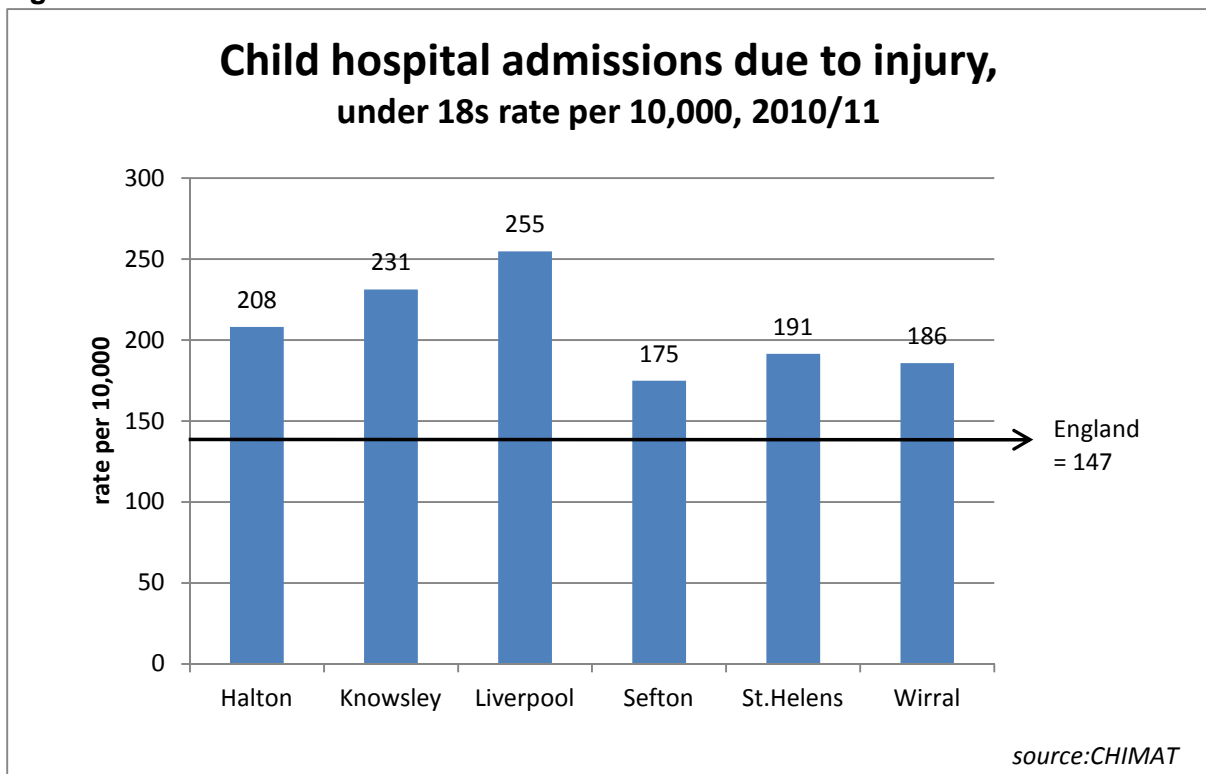### under 18s rate per 10,000, 2010/11

England = 147

source:CHIMAT

On Merseyside, levels of child hospital admissions for injury are higher than the national average in each local authority, as shown in Figure 36. Rates are highest in Liverpool, at 254.8 per 10,000 (about 1 in 40), where there were 2,164 admissions in 2010/11 (Table 35). There were 6,426 admissions across Merseyside in 2010/11.

Data is not routinely available on whether injuries are unintentional or deliberate. It has been estimated that for admissions for under 15s, approximately 89% are a result of unintentional injury and 11% deliberate injury, which could include injury by others and self-harm (Child Accident Prevention Trust, 2012b). Using this figure, it can be estimated that there were 707 hospital admissions for deliberate injury to children in Merseyside in 2010/11. Estimated numbers for each local authority are given in Table 35.
(N.B. the 11% estimate covers a younger age range. If younger children are more likely to suffer deliberate injury, then 1,371 estimated for Merseyside will be an underestimate).

Table 35
Total numbers of child hospital admissions due to injury of which, estimated number due to deliberate injury, Merseyside, 2010/11

	Total number of admissions	Estimated number of deliberate injury admissions (11%)*
Halton	568	62
Knowsley	777	85
Liverpool	2,164	238
Sefton	956	105
St.Helens	721	79
Wirral	1,240	136
Merseyside	6,426	707

Source: ChiMat
*Child Accident Prevention Trust (2012b)

The Trauma and Injury Intelligence Group (TIIG) at Liverpool JMU collect injury data from local emergency departments (EDs), along with ambulance, fire and police services covering the North West. Their Merseyside data does not include Halton. Data on emergency department visits is not routinely available by age and reason for attendance. However, TIIG recently produced such data for 2009 for residents of Liverpool, Knowsley and Sefton. They provided separate data on attendances for home injuries only, which is presented in the pie charts in Figures 37 to 39. Injury type included a large category of 'other' which has not been included in the diagrams.

In Liverpool and Knowsley, the most common type of injury in the home requiring hospital emergency attendance was falls. In Sefton, the most common injury was self-harm. (Section 3, p.119-120 below reports hospital admissions for self-harm amongst children and young people – these were relatively low in Sefton). In the period April 2006-Dec 2009, 366 children and young people in Liverpool had been assaulted in their own home, badly enough for them to require an emergency hospital visit. There were 152 such hospital visits in Sefton, and 73 in Knowsley (data for the rest of Merseyside may be available on special request from TIIG).

It is possible that the high proportion of self-harm emergency attendances in Sefton is due to low levels of other causes. Analysis of rates using population figures is required for a proper analysis of these figures. Early crude analysis would suggest that emergency visit assault rates were higher in Liverpool and lower in Knowsley and Sefton. Rates for falls appear similar in each area. Self-harm emergency attendance rates appear higher in Sefton.

Figure 37

Knowsley
Number of injury attendances for home injuries, ages 0-18, by injury type (excluding 'other'), Apr2006-Dec 2009

- Assault
- Delibrate self harm
- Fall
- Road traffic collision
- Sports injury

other = 5,758

data source: TIIG

Figure 38

Liverpool
Number of injury attendances for home injuries, ages 0-18, by injury type (excluding 'other'), Apr2006-Dec 2009

- Assault
- Delibrate self harm
- Fall
- Road traffic collision
- Sports injury

other = 21,231

data source: TIIG

Figure 39

Sefton
Number of injury attendances for home injuries, ages 0-18, by injury type (excluding 'other'), Apr2006-Dec 2009

- 165
- 152
- 56
- 370
- 285

Legend:
- Assault
- Delibrate self harm
- Fall
- Road traffic collision
- Sports injury

other = 11,147

data source: TIIG
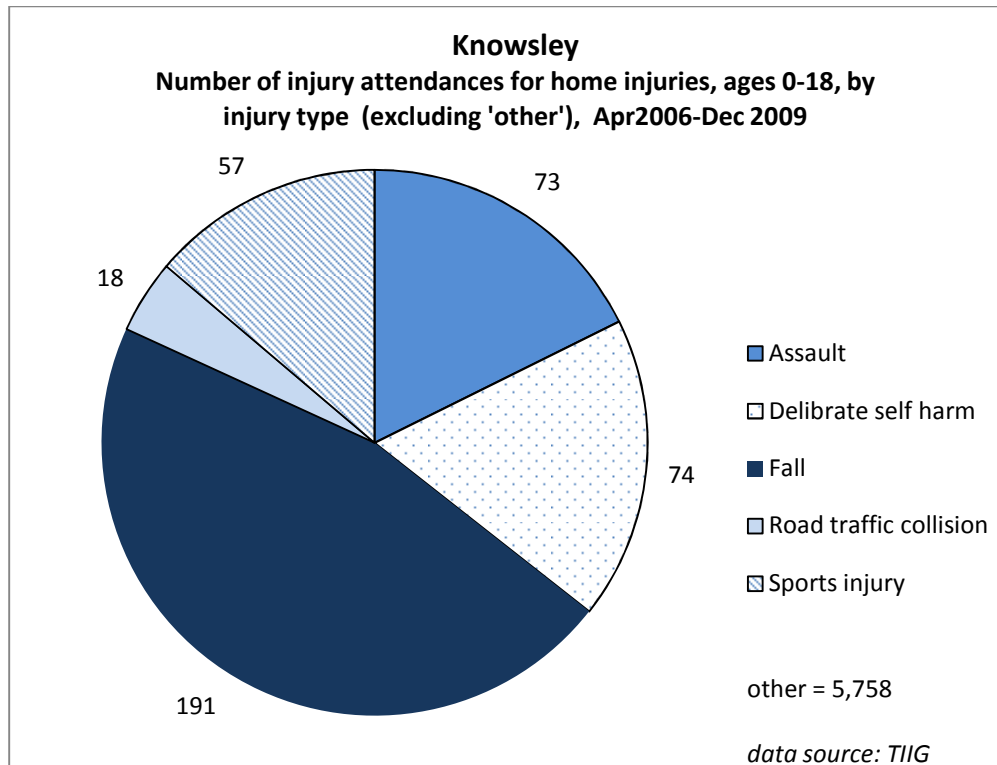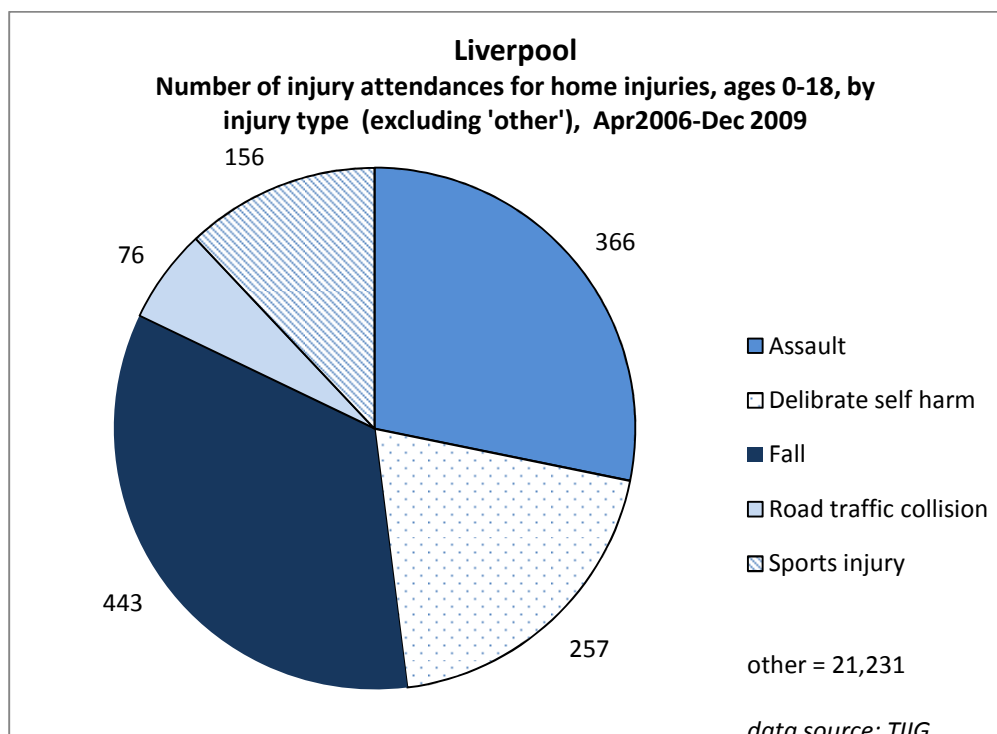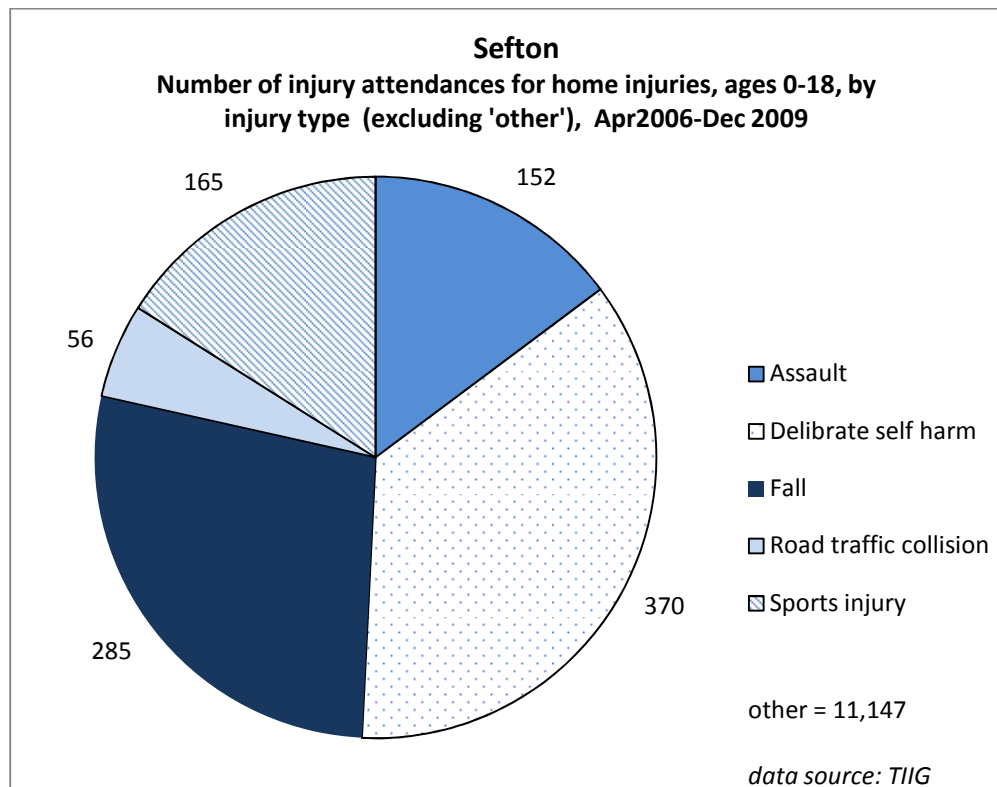
Recommendations

- Consider extending the TIIG definition of Merseyside to include Halton.
- Data on child hospital admissions for injury should be separated into unintentional and deliberate injury.
- Collect data on numbers of attendances at A&E for child injury, in addition to admissions to hospital, to give a better indication of local needs.

Related areas for further investigation:

- *Domestic violence*
  There is no readily available data on local authority-level domestic violence. Crime statistics by local authority break down by sexual offences, violence, robbery etc but no separate analysis for domestic violence.
  According to a recent NSPCC study, 12% of under 11s, 18% of 11-17s and 24% of 18-24s had been exposed to domestic abuse between adults in their homes during childhood. – this could be used to estimate exposure levels. The report looks at child abuse and neglect.
  http://www.nspcc.org.uk/Inform/research/findings/child_abuse_neglect_research_PDF_wdf84181.pdf

  DH recommendations on domestic violence include:
  - Follow local guidelines.
  - Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
  - Provision of information about sources of support for domestic violence.

• Referral to local specialist services as part of a multi-agency strategy.
• The HCP Team to contribute to care package led by specialist service.
• The HCP Team to ensure that any safeguarding concerns are identified and that links are in place to appropriate children's services.
Responsibility: Specialist services, with input from the HCP Team, as appropriate.
(DH/DCSF, 2009)

- *Young people and fighting*
  In the UK, more than 40% of young people age 11, 13 and 15 reported having been involved in fighting in the previous 12 months (2001/02 data) (the UK was the 5th highest out of 21 OECD nations). National numbers in 2008 can be found in section 3.1 of the following report: http://www.education.gov.uk/rsgateway/DB/SBU/b000850/b01-2009.pdf

- *Neighbourhood violence*
  Feeling unsafe in the local neighbourhood can be damaging to emotional health and wellbeing. The Tellus school surveys revealed 1 in 4 children felt unsafe in their local area, with levels slightly higher in Knowsley (28.7%), Wirral (29.2%), Halton (27.1%) and Liverpool (26.2%). Levels in Sefton were around the national average (25.2%) and lower in St.Helens (22.1%) (ChiMat, 2007 data).

Promoting wellbeing in children and young people, priority areas: vi): Opportunities to take part in positive activities to thrive

A healthy balance of time use is important, with choice and autonomy being vital for wellbeing in all aspects of children's lives (Children's Society, June 2012). This would include opportunities to spend time with friends and family, time to oneself, time to do homework, helping at home and the opportunity to be active, with access to a garden or local outdoor space.

### Physical activity and other positive activities

Taking part in social activities, sport and exercise is associated with higher levels of life satisfaction. For example, 76% of those who play sport or exercise at least once a week are satisfied, compared with 70% of those who never or rarely play sport or exercise (MHF, 2007).

Data on physical activity levels appears in the ChiMat child health profiles (ChiMat, 2012). ChiMat point out that all children, whatever their circumstance, should be able to participate in and enjoy PE and sport at school. Physical activity during childhood has a range of benefits including healthy growth and development, maintenance of energy balance, psychological wellbeing and social interaction. Through improved concentration and self-esteem, it can also improve school attendance, behaviour and attainment. The benefits continue well into adulthood by reducing, early in life, some of the key risk factors for diseases such as coronary heart disease, diabetes and osteoporosis. Some evidence also

suggests that participation in physical activity during childhood can help to establish a physically active lifestyle in later life (ChiMat dataset rationale).

ChiMat data gives percentages of schoolchildren who responded to the 2009/10 TNS School Sport Survey who participate in at least 3 hours of high quality PE and out of hours school sport in a typical week. Across Merseyside, in Halton, Sefton, St.Helens and Wirral, physical activity levels were significantly better than the national average (Figure 40). In Knowsley and Liverpool, they were significantly worse.

Figure 40
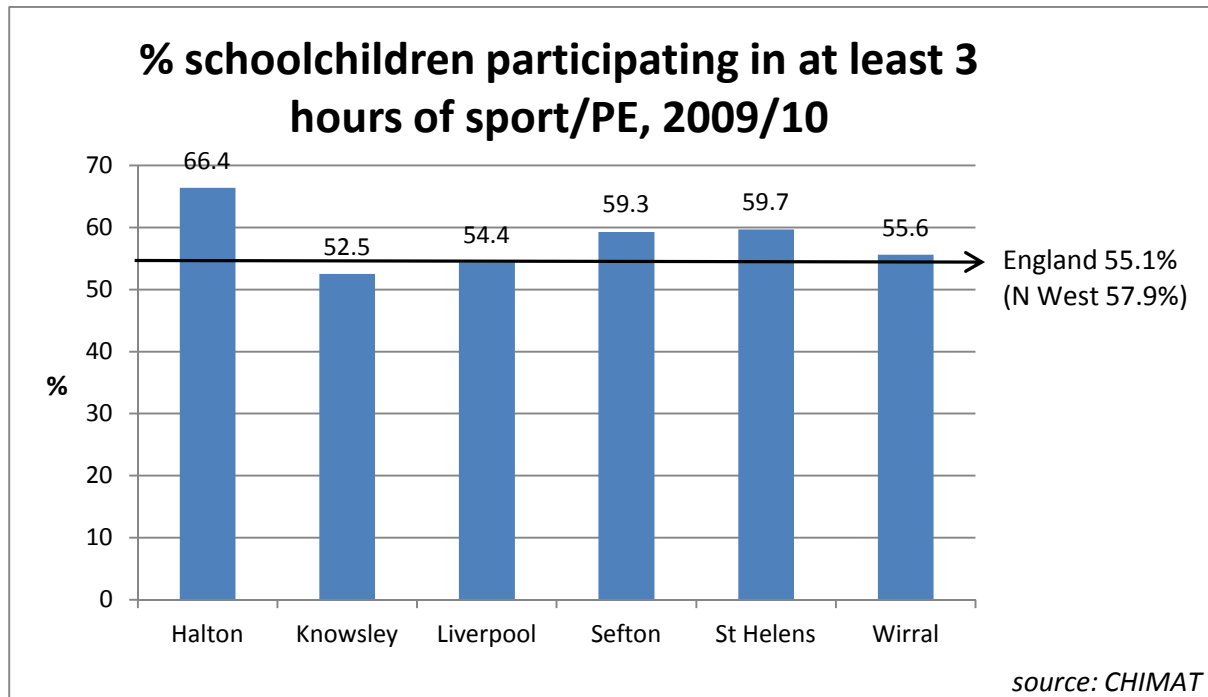
Promoting physical activity for children and young people: Effective interventions

NICE have produced guidance on promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings (NICE, 2009b). They recognised the links between physical activity and mental wellbeing (Box 5) The guidance is aimed at all those involved in promoting physical activity among children and young people, including parents and carers.

The NICE recommendations give advice on:

> **Box 5**
> **Definition of sport (NICE 2009b):**
> *'All forms of physical activity which, through casual or organised participation, aim at expressing or improving physical fitness and **mental wellbeing**, forming social relationships or obtaining results in competition at all levels'.*

- how to promote the benefits of physical activity and encourage participation
- high level strategic planning

- the importance of consultation with children and young people and how to set about it
- planning and providing spaces, facilities and opportunities
- training people to run programmes and activities
- how to promote physically active travel such as cycling and walking.

The guidance is specifically aimed at the following organisations:

- Children's trusts and services
- Community and voluntary groups (running sports and other organised activities)
- Early years providers
- Government departments
- Local authorities (leisure and related services, transport and planning, regeneration)
- Local strategic partnerships
- Organisations offering practitioners education and training
- The police
- Primary care trusts
- Private sector providers
- Schools and colleges.

(NICE 2009b)

Participation in other types of positive social activities such as volunteering is also beneficial to emotional wellbeing.

Access to green space

The importance of access to green space to mental health is becoming more widely recognised (Faculty of Public Health, 2010). Sefton's Green Space Strategy and Liverpool's Green Infrastructure Strategy aim to improve access to and quality of green space, recognising the positive effect this can have on mental health (Sefton MBC, 2009, Liverpool City Council, 2010).

The Faculty of Public Health's 'Action Report' on the 'Great Outdoors' (2010) and their subsequent report on children's mental health and wellbeing (2011) present the evidence for the links between green space and mental health, including:

- Access to and use of green spaces can have a positive effect on mental wellbeing and cognitive function

- Views of the natural environment have been found to have a positive effect on stress levels, promoting a reduction in blood pressure and possibly encouraging faster healing in patients following postsurgical intervention

- Using green space leads to greater social contact and community cohesion

(Faculty of Public Health, 2010 and 2011)

In Liverpool, it was found that green infrastructure is not equally distributed across the city, with 22% of the areas having 80% of the total accessible green infrastructure. Some areas have no accessible green infrastructure. The most affluent areas of the city have 18% more

green infrastructure than the most deprived. Low levels of green infrastructure occur in areas of the city with a higher incidence of coronary heart disease, poor mental health and poor air quality (Liverpool City Council, 2010).

Recommendations

• Increase multi-agency working, recognising the important effects that planning decisions in the design of neighbourhoods and green space initiatives can have on mental health.

• Carry out mapping throughout Merseyside to identify wards/super output areas where green infrastructure is lowest and the incidence of mental health hospital admissions is highest.

Young carers

Young carers are defined as '*children and young people under 18 who provide, or intend to provide, care, assistance or support to another family member who is disabled, physically or mentally ill or has a drug and alcohol misuse problem. They carry out on a regular basis, significant or substantial tasks, taking on a level of responsibility that is inappropriate to their age or development".* (SCIE, 2005)

There is a clear relationship between poor mental health and caring (Liverpool Carers Joint Action Plan). There are an estimated 175,000 young carers in the UK and over 3,000 young carers in Liverpool (estimated by Barnados Liverpool), each experiencing an associated impact on their own life and development.

It is estimated that one third of these young carers care for someone with a mental health problem. We know that children with a parent who has a mental health disorder are known to be more likely to suffer from low levels of mental and emotional health themselves and this group therefore emerges as a particularly vulnerable cohort (see section 2(iv) p.84 on children of parents with mental health and related problems).

ONS estimates that in the UK 250,000 young people are living with parental drug misuse and 1.3 million children live with parental alcohol misuse (see p.86), which indicates another type of caring responsibility children and young people can face at home. In the general population, more than 80% of carers say that caring has damaged their health, and young carers in particular, are likely to miss out on school, friends and childhoods (Liverpool Carers Joint Action Plan). Fox (1995) reports that 10% of all school absence is due to "home responsibilities" although not all of this will be the result of caring. Most young carers are not known to their schools or teachers, so it is therefore imperative that education staff establish ways of identifying this particular group and ensure support mechanisms are in place to allow these young people to achieve their maximum potential.

Barnardos Action with Young Carers group alongside staff from Local Solutions Carers Project held an event in 2007 for young carers with the aim of identifying the impact on caring for them in the school environment, identify support needed and investigate ways in which emergency care services could meet their needs. The group felt it would be useful if

someone in school knew they were a young carer, not necessarily to be given any special treatment, but for flexible solutions to be discussed in relation to homework etc. The young carers felt that their situation could not accommodate emergency situations where routine was likely to be disrupted e.g. breakdown of school mini bus on way home from school trip. It was evident that Young Carers prioritise the needs of the person they care for over their own needs. Emergency situations for Young Carers are compounded by the fact that they do not have tried and tested strategies for coping with crises and they are less likely than other children to have access to extended family. It is likely that if the person they care for was in need of care in an emergency, the Young Carer would need someone to make the arrangements for the replacement care and they would also need someone to care for them.

Dearden & Becker (2004) report some general characteristics of young carers (national data):

- Average age: 12
- 86% compulsory school age
- 57% girls/ 43% boys
- 14% of young carers from BME groups
- 54% are part of a lone parent family
- 12% of young carers care for more than one person

The reasons why children and young people care for adults vary (Dearden & Becker 2004):

    63% care for a physically impaired adult
    29% care for someone with mental health problems
    14% care for someone with a learning disability
    4% of children or young people care for someone with a sensory impairment

Young carers are at risk from a number of educational difficulties which can in turn contribute to their own poor mental health. A study by Marsden (1995) summarized some of these educational difficulties (Table 36):

The government's National Carers' Strategy (DH, 2008) states that 'by 2018 every carer should be: enjoying a life outside caring; mentally and physically well; and that: children will be thriving, protected from inappropriate caring roles'.

Although there is no robust evidence to show long-term emotional or mental health problems associated with caring, it is known that young carers occur more frequently within single-parent families and can often face social exclusion with little support from other family members. Young carers are less likely to discuss their caring responsibilities, with research showing this secrecy may be due to a fear of social service intrusion, associated stigma or through loyalty to parents.

Teenagers who become parents under the age of 18 may be viewed as having caring responsibilities. Teenage mothers are at an increased risk of experiencing poor mental health up to three years after the child is born and are also three times more likely to suffer from postnatal depression (NHS Health Development Agency, 2003).

Table 36
Educational difficulties faced by young carers

Difficulty	Description
Absence	May be regular, protracted or occasional May result in referral to educational welfare services
Lateness	May be persistent or occasional
Tiredness	May be identified by lack of concentration, lack of attention or falling asleep
Difficulty joining extracurricular activities	Due to time constraints as a result of caring
Bullying	May be a direct result of caring/ family disability or unrelated
Restricted peer network in school	May have little in common with same age peers, may be mature beyond their years, may be a result of time constraints due to caring
Poor attainment	May be reflected by lack of qualifications, low grades or underperformance
Homework/coursework	May be poor quality, not submitted on time or at all
Anxiety	Concern over ill/ disabled relative
Behavioural problems	May result in referral to educational psychologist or child and adolescent psychiatrist

(Marsden, 1995)

The mental state of a mother significantly impacts on a child, therefore agencies should ensure pregnant teenagers / teenage mothers in their care are receiving adequate support with depression identified at an early stage.

Recommendations:

- Schools to ensure links are in place with young carer's services
- Children's mental health services to link with young carer's projects
- Young carers to be supported by relevant agencies to ensure they are able to lead a life away from their caring responsibilities
- Agencies to identify any support needs of pregnant teenagers / teenage parents accessing services and ensure appropriate referral pathways are established

Recommendations from report, by Local Solutions and Barnados on young carers in Liverpool included:

- Ensure the school knows which children are young carers, so that flexible solutions can be discussed in relation to homework etc.

– Be aware that the young carer may need help and support in emergency situations such as the breakdown of a school mini bus on the way home from a school trip, or if they themselves need emergency or routine health care.

Teenage parents

It is widely recognised that pregnant teenagers / teenage parents are commonly stigmatised within society. This can often result in a detrimental effect on both the young person and their child and reduce their opportunity to thrive in a positive way.

Teenage mothers and mental health
A government document leading from the teenage pregnancy strategy noted that teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth (DFES, 2006). By the age of 30, they are 22% more likely to be living in poverty and 20% more likely to have no qualifications (compared to older mothers, aged 24+).

The effects are even more damaging for the next generation, with the children of teenage mothers having a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties. These children also have higher mortality rates under 8 and are more likely to have accidents and behavioural problems (DFES, 2006).

Local data
In 2010/11, as many as 3.1% of women giving birth in St.Helens were aged under 18, compared to the national average of 1.5%. Across Merseyside, all areas except Knowsley had a higher proportion of teenage mothers than the national, significantly higher in Halton, St.Helens and Wirral (Table 37).

Table 37

Mothers aged 12-17 as a % of all mothers, 2010/11	
Halton	2.8*
Knowsley	1.5
Liverpool	1.5
Sefton	1.7
St Helens	3.1*
Wirral	2.5*
England	1.5
North west	1.9

Source: ChiMat
*=significantly higher than the national average.

Recommendations:
- Schools and further education settings to offer teenage parents comprehensive package of support to ensure they are able to continue with their education

- Schools and further education settings should aim to identify teenage parents within their organisations to ensure individuals are receiving support reflective of their needs
- Dedicated provision for teenage parents to be established e.g. teenage parent support worker, children's Centre key workers, teenage antenatal clinic, teenage parent groups
- Ensure pathways are in place for information sharing between such agencies to ensure identified needs are met e.g. Family Nurse Partnership
- Regular monitoring of NEET data and Care To Learn uptake to ensure teenage parents are engaging in education, training or employment where possible
- Raise awareness of support for teenage parents through children and young people staff training

Further information on support for teenage parents:
http://tinyurl.com/cg5brbr

3. Prevalence of mental health problems in children and young people

Wellbeing
As mentioned on p.1, UNICEF reported the wellbeing of young people in the UK to be the worst amongst 21 industrialised countries. A Princes Trust survey in 2009 found that amongst 16-25 year olds, 1 in 10 felt that 'life was not really worth living' (in Freer et al 2010 p.243). More than a quarter (27%) said they were always or often depressed and over half (47%) said they were regularly stressed. Those not in work were less likely to be happy. Freer et al note that this is likely to lead to a storing up of mental ill health for large numbers of people who may go on to have more significant problems.

Mental health problems
Mental health problems amongst children and young people are a growing epidemic (Liverpool PCT, 2009, Weare, 2010). Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years (MHF 2007).

One in ten children aged 5-16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14 (ChiMat 2012). ChiMat point out that failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.

Around half of all lifetime mental disorders start by the mid-teens. Less than half are treated appropriately at the time (YoungMinds, 2012). Severe disorders in all ages usually follow a less severe disorder that goes unnoticed by health professionals (Kessler et al, 2007, in Freer et al, 2010 p.243).
Three-quarters (75%) of young people see their GP at least once a year and 1 in 3 of these will be experiencing a mental health problem (Royal College of Paediatrics & Child Health,

2003 in Freer et al, 2010, p.242 &247). Freer et al point out that this means that **primary care services are in regular contact with the majority of young people - a group generally thought to be hard to reach.** Most will present with physical health problems, and up to 50% who feel they have in Freer et al, 2010). **General practice presents an ideal opportunity for screening for high risk behaviours and mental health problems**. Mental health disorders amongst young people attending primary care is higher than in the general community, with around 1 in 3 having a diagnosable mental health problem (38%, reported in Freer et al, 2010, p.248). Young people who go on to commit suicide have a higher rate of consultation with a GP (Appleby et al, 1996 in Freer et al, 2010).

A literature review on the emotional wellbeing mental health needs of young people by TCRU (2007) found the following:
> • Children and young people with emotional wellbeing and mental health problems are more likely to be in contact with statutory services, especially GPs, the police/youth justice system, and education support services.
> • Between one fifth and a quarter of children and young people with a diagnosable mental disorder had still not been seen by CAMHS 18 months and three years on. Furthermore, between 40 and 50 per cent of these children or young people had not been seen by any other services for these specific needs.

TCRU (2007)

Depression: By the age of 18, 1 in 5 (20%) have experienced a diagnosable depressive episode (Freer et al, 2010, p.244). Nearly 80,000 children and young people suffer from severe depression. Over 8,000 children aged under 10-years-old suffer from severe depression (YoungMinds, 2012).

In about 30% of cases, adolescent depression will continue into adulthood. This is linked with a high risk of criminality and 32.3% attempting suicide. (Fombonne et al 2001). Family factors associated with depression in young people include domestic violence and sexual abuse. Outside the family, the most common associated problems are breakdown in friendships and substance abuse (Freer et al, 2010, p.244).

Schizophrenia: For 20% of adults with schizophrenia, the illness starts under the age of 20 and for 5% under the age of 16. The younger the onset, the poorer the outcome (Freer et al, 2010).

National Morbidity Survey
Figure 41 illustrates the findings of the most recent national child mental health morbidity survey, carried out in 2004 (ONS, 2005). It shows that rates of mental health problems among children increase as they reach adolescence and that boys are more likely to have a mental disorder than girls.

Box 6 shows the prevalence of different types of mental health condition (ONS, 2005). Overall, 9.6% of all children and young people aged 16 and under will have some form of mental disorder The most prevalent forms of childhood mental health condition are conduct disorders, which affect around 5.8% of all children and young people aged 16 and under, and anxiety, affecting 3.3%.

Figure 41

Prevalence of mental health disorders in children and young people
(ONS, 2005)
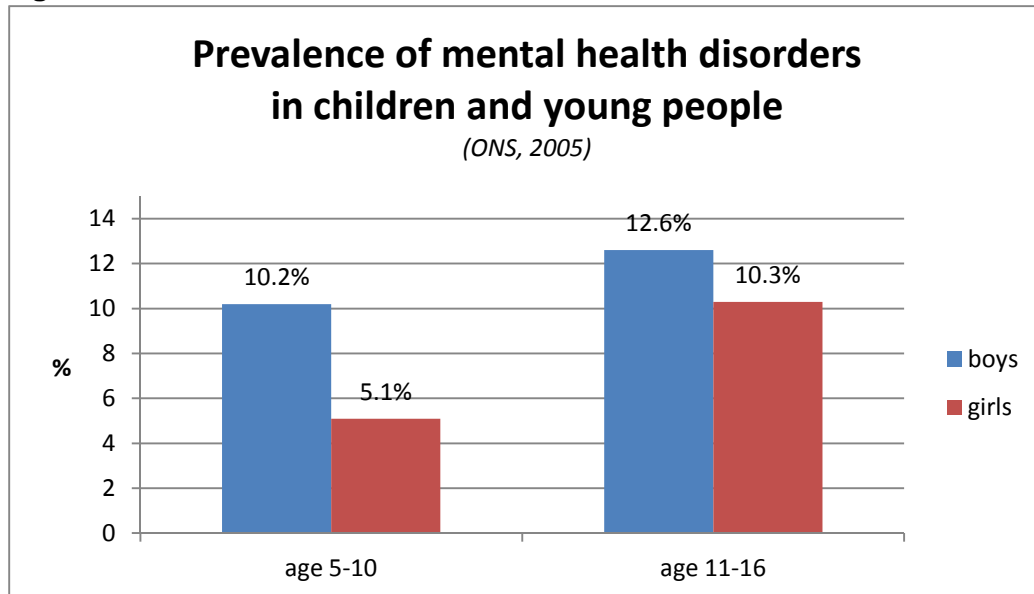
Total boys and girls: *ages 5-16 = 9.6%; ages 5-10 = 7.7%; ages 11-16 = 11.5%*

Box 6
Prevalence of Mental Disorders in children and young people

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

Anxiety
3.3% or about 290,000 children and young people have an anxiety disorder
2.2% or about 96,000 children aged 5-10 have an anxiety disorder
4.4% or about 195,000 young people aged 11-16 have an anxiety disorder

Depression
0.9% or nearly 80,000 children and young people are seriously depressed
0.2% or about 8,700 aged 5-10 year-olds are seriously depressed.
1.4% or about 62,000 aged 11-16 year-olds are seriously depressed.

Conduct Disorders
5.8% or just over 510,000 children and young people have a conduct disorder
4.9% or nearly 215,000 children aged 5-10 have a conduct disorder
6.6% or just over 290,000 young people aged 11-16 have a conduct disorder

Hyperkinetic Disorder (Severe ADHD)
1.5% or just over 132,000 children and young people have severe ADHD
1.6% or about 70,000 children have severe ADHD
1.4% or about 62,000 young people have severe ADHD

source: YoungMinds 2012, based on the finding of the latest ONS Child and Adolescent Mental Health Survey, published in 2004: ONS (2005)

In 2007, the ONS carried out a follow-up survey aiming to identify the persistence and onset of childhood mental disorders. Of those with an emotional disorder in 2004, 30% were found to still have one in 2007. For those with conduct disorders in 2004, 43% persisted until 2007. Between 2004 to 2007, a further 3% of children had developed an emotional or conduct disorder (ONS, 2008).

Local estimates
Figures 42 and 43 show the estimated numbers of children and young people suffering from mental health problems across Merseyside. This is based on estimates from the national prevalence survey which were applied to mid-2010 local population figures. Even in Halton, the local authority with the smallest child population, there are still likely to be as many as 453 boys and 219 girls aged 5-10 with mental health problems, and a further 564 boys and 445 girls aged 11-16. Table 38 gives further details for each local authority.

Figure 42

Prevalence of mental disorders amongst males & females aged 5-10,

Estimated number in each local authority on Merseyside, 2010

source: based on estimates in Figure P40 (ONS,2005), applied to 2010 ONS populations
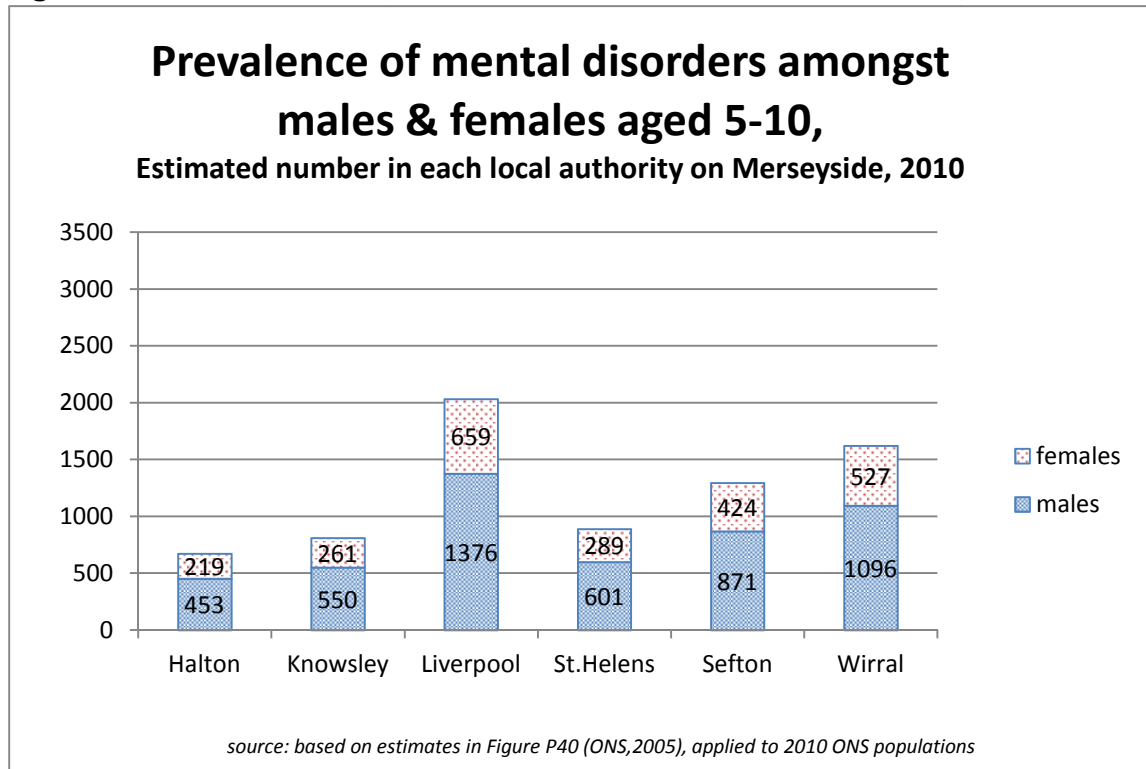
Mersey totals: *boys=4,964; girls=2,379*

Figure 43

Prevalence of mental disorders amongst males & females aged 11-16,

Estimated number in each local authority on Merseyside, 2010

source: based on estimates in Figure P40 (ONS, 2005) , applied to 2010 ONS populations
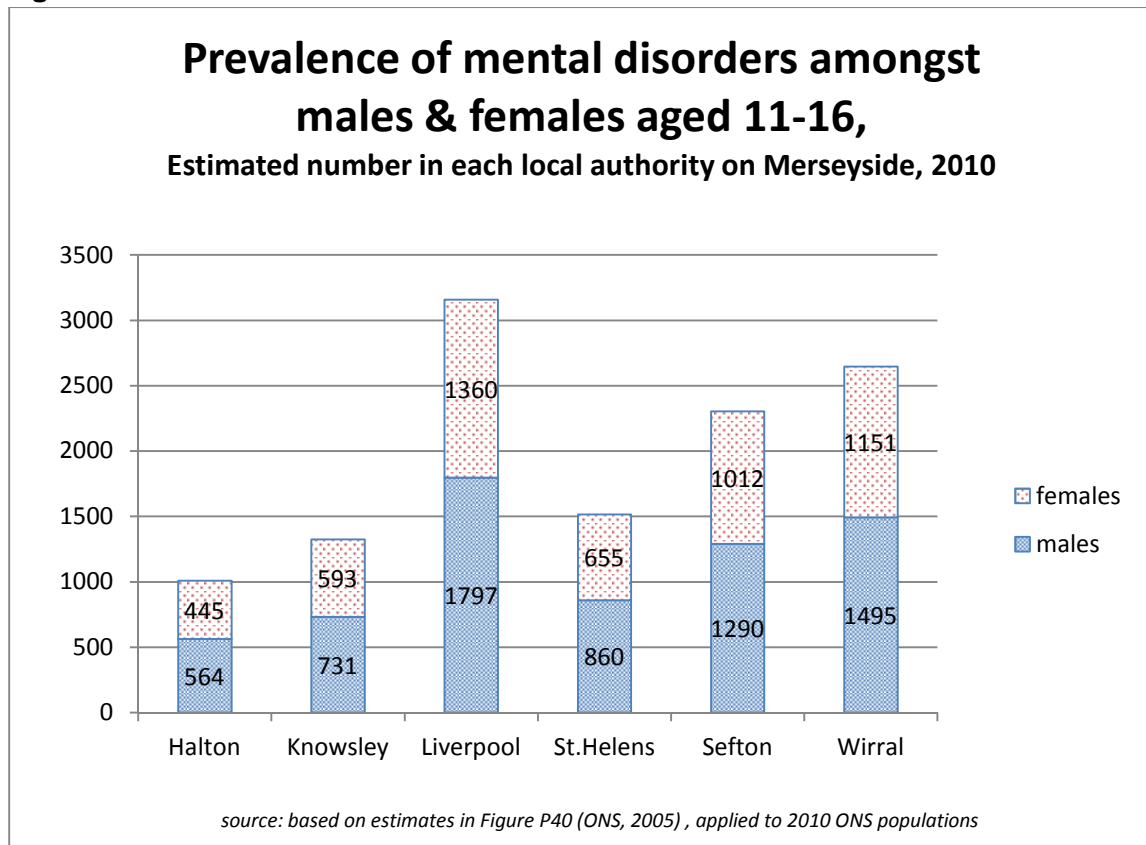
Mersey totals: *boys=6,737, girls=5,218*

Table 38

Estimated prevalence of any mental disorder amongst children and young people in Merseyside (numbers)

Males	age 5-10	age 11-16	tot 5-16
Halton	453	564	1016
Knowsley	550	731	1282
Liverpool	1376	1797	3172
St Helens	601	860	1461
Sefton	871	1290	2161
Wirral	1096	1495	2591
MERSEYSIDE Total	*4946*	*6737*	*11683*
Females	**age 5-10**	**age 11-16**	**tot 5-16**
Halton	219	445	664
Knowsley	261	593	853
Liverpool	659	1360	2019
St Helens	289	655	945
Sefton	424	1012	1437
Wirral	527	1151	1678
MERSEYSIDE Total	*2379*	*5218*	*7596*
All Persons	**age 5-10**	**age 11-16**	**tot 5-16**
Halton	672	1004	1676
Knowsley	809	1208	2017
Liverpool	2033	3037	5070
St Helens	890	1329	2219
Sefton	1298	1939	3237
Wirral	1623	2425	4048
MERSEYSIDE total	*7326*	*10941*	*18266*

Source: based on estimates in ONS (2005), applied to mid-2010 ONS populations

Figures 42 and 43 and Table 38 above have presented estimates of mental health conditions based on a national survey. For more severe mental health problems requiring hospital admission, actual numbers are available in the ChiMat child health profiles for those aged 0-17. Figure 44 shows that rates of hospital admission for children and young people are higher than national and North West averages in each local authority in Merseyside. In Liverpool, Halton, Sefton and St.Helens, they are significantly higher than the national rate of 109.4 per 100,000 aged 0-17. Actual numbers are shown in Table 39. There were a total of

520 young people aged 0-17 admitted to hospital with mental health conditions during 2010-11.
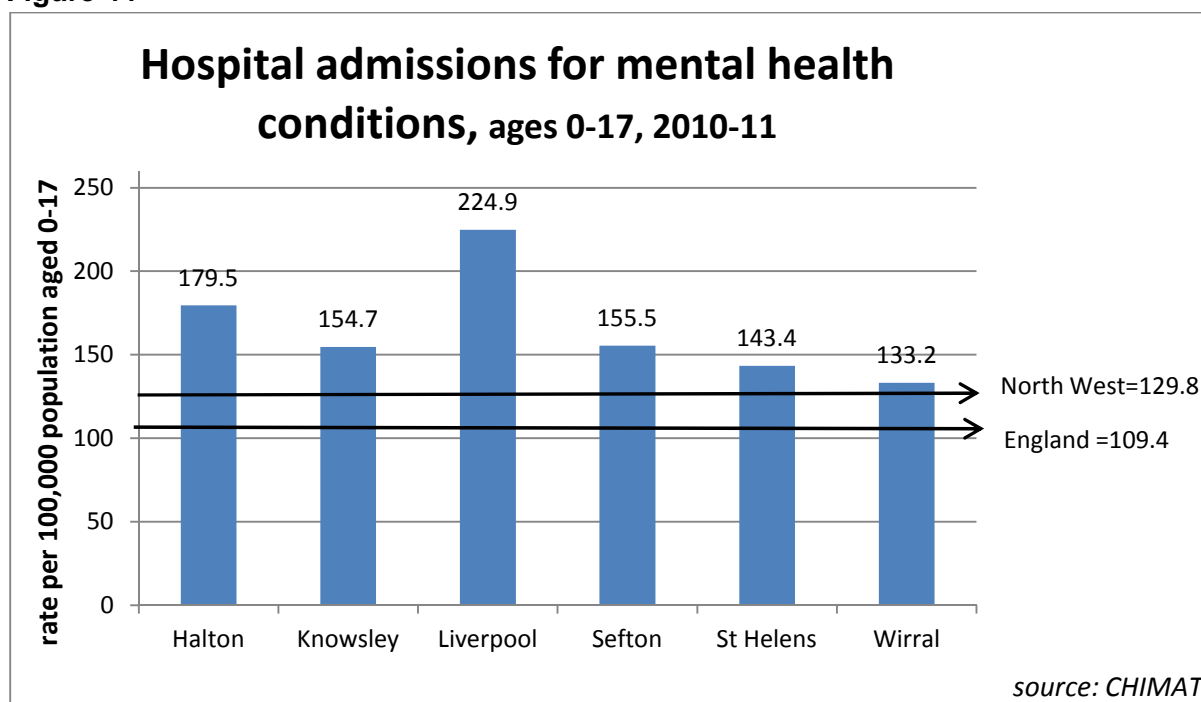
Figure 44

Hospital admissions for mental health conditions, ages 0-17, 2010-11

source: CHIMAT

Table 39
Hospital admissions for mental health conditions 2010-2011, ages 0-17

	Admission rate per 100,000	number
Halton	179.5	49
Knowsley	154.7	52
Liverpool	224.9	191
Sefton	155.5	85
St Helens	143.4	54
Wirral	133.2	89
Mersey		520
North West	129.8	
England	109.4	

Source: ChiMat

Eating disorder and body image

There is a lack of data detailing how many people in the UK suffer from an eating disorder, especially lacking is detailed information on how many children and young people may be suffering from an eating disorder. Simon et al. (2005) reviewed studies which estimated the cost of eating disorders to the national health service (NHS). Although this data is now out of date, it was estimated that in 1990 the cost to the NHS was likely to exceed £4.2 million.

This figure will have dramatically increased in more recent years alongside the increase in prevalence in eating disorders, especially amongst young children. Simon et al concluded that to be able to estimate the net cost, more comprehensive data on the current health-care resource use pattern of patients with eating disorders and more trials with good health economic components are urgently required. If service support provision is to match the needs of the local population it is important for these statistics to be available. Access to high-quality mental health care, based on the best available evidence and delivered by staff with an appropriate range of skills and competencies, is critical to meeting the specific needs of this group of young people (DH, 2011b).

The most accurate figures of the numbers of people in the UK with eating disorders are those from the National Institute of Health and Clinical Excellence (NICE). These suggest that 1.6 million people in the UK are affected by an eating disorder, of which around 11% are male. More recent research from the NHS Information Centre showed that up to 6.4% of adults displayed signs of an eating disorder (McManus et al, 2009). This survey also showed that a quarter of those showing signs of an eating disorder were male, a figure much higher than previous studies had suggested. Importantly, 81% of those screened positive for possible eating disorder were not currently receiving any treatment for an emotional or mental problem.

"A General Practitioner's Guide to Eating Disorders" produced definitions of different types of eating disorders and estimates of prevalence:

> **Anorexia nervosa** (10% of sufferers are anorexic):
> Weight <85% median body mass index/age.
> Determined food avoidance.
> Weight and shape concerns.
> Compensatory behaviours – optional but confirmatory.
> If reached menarche, must have amenorrhoea.
>
> **Bulimia nervosa** (40% bulimic) :
> >85% ideal body weight.
> Bingeing.
> One or more compensatory behaviour.
> Weight and shape concerns.
>
> **Eating disorder not otherwise specified (EDNOS)** (approximately 50% of sufferers fall into this category)
> (a) Binge eating (binge eating disorder)
> Bingeing but no compensatory behaviours or food avoidance.
> Weight and shape concerns present.
> (b) EDNOS
> All other cases not meeting criteria above but with the presence of weight and shape concerns.

(King's College London)

Anorexia has the highest mortality rate of any psychiatric disorder, from medical complications associated with the illness as well as suicide. Research (NICE 2004a) has found that 20% of anorexia sufferers will die prematurely from their illness. Bulimia is also

associated with severe medical complications, and binge eating disorder sufferers often experience the medical complications associated with obesity. In every case, eating disorders severely affect the quality of life of the sufferer and those that care for them.

Multiple factors contribute to the development of an eating disorder, but research suggests that genetics do play a role in this. Some research has found (reported in NICE 2004a) that female relatives of anorexia sufferers were 11.4 times more likely to suffer from anorexia compared to relatives of unaffected participants. For female relatives of those with bulimia, the likelihood of developing bulimia was 3.7 times that of those with unaffected relatives. This and other research does suggest a link between family members, although it is not yet totally clear how much of this influence is genetic and how much is due to environmental factors. We do know that many other factors also affect the development of an eating disorder (Micali 2011), including cultural and family pressures and emotional and personality disorders. Genetics and biological factors also play a role.

The National Eating Disorder Association in the USA report that anorexia is the third most common chronic illness among adolescents and 50% of girls between the ages of 11 and 13 see themselves as overweight. Studies show that 80% of all children have been on a diet by the time they've reached fourth grade (age 9 or 10). Furthermore, 86% of people with eating disorders report onset of an eating disorder by age 20 with 10% reporting onset at ten years or younger (South Carolina DMH). However, data from other countries should be generalised to the UK population with caution as other social, economic and cultural factors can influence study results.

The British newspaper, the Guardian, reported some headlines about childhood eating disorders (Guardian 2011, from a study conducted by Nicholls et al. 2011 - see Box 7). Nicholls et al. (2011) defined childhood eating disorder onset as before the age of 13 and found that there were approximately 3 cases of eating disorders per 100,000 children under age 13. They concluded that for a minority of children this episode of eating disorder may "be the start of a severe and enduring illness, with a mortality comparable with some forms of leukaemia" (Nicholls et al, 2011), highlighting the severity of eating disorders and the importance of treating children and young people timely and with the best evidence based treatment.

> **Box 7** Headlines reported in the Guardian (from a study conducted by Nicholls et al. 2011, British National Surveillance Survey)
>
> Data from 35 NHS hospitals suggests:
>
> - More than 2,000 children treated for eating disorders in past 3 years
> - 600 children under age 13 treated in England, including 197 between ages 5-9. 98 of these were aged 5-7 and 99 children aged 8 or 9 years old.
> - 82% female, 18% male,
> - 86% white British, 3% Irish, 5% Asian, 1% Black.
>
> *Guardian, 2011*

Local data

Data on those with eating disorder who are in contact with health services will be the 'tip of the iceberg', as eating disorders are regarded as a hidden illness that is often un-detected and under-reported (Liverpool PCT 2012, personal correspondence).

There was limited data available on children and young people with eating disorders known to the health service on Merseyside. Data was obtained from Cheshire and Wirral Partnership NHS Trust on their current caseload of under 18s with eating disorders (Table 40).

Table 40
Caseload of under 18s with eating disorders, 3/10/12

PCT of patient	Aged 10-15	Aged 16-17	Total
Halton & St Helens		1	1
Liverpool	1	1	2
Sefton	1	1	2
Wirral	4	3	7

Source: Cheshire & Wirral Partnership NHS Trust

NHS Merseyside are currently undertaking a Merseyside health needs assessment on eating disorders.

Recommendations
Prevention: Schools and other agencies dealing with children have an important role to play in encouraging positive body image amongst young people.
Identification and treatment: A full set of clinical guidelines have been produced by NICE (2004a). Family based interventions are recommended, including sharing of information, advice on behavioural management and encouraging communication. These should take place alongside individual appointments with a specialist for the child.

Data: More comprehensive data on the current health-care resource use pattern of patients with eating disorders are required. If service support provision is to match the needs of the local population it is important for these statistics to be available (Simon et al, 2005).

Children and young people who self-harm

In the UK rates of deliberate self-harm appear to be rising among young people, especially amongst girls. There is evidence to suggest that rates of self-harm in the UK are higher than anywhere else in Europe (MHF, 2006). Hospital admissions for self-harm in children have increased in recent years, with admissions for young females being much higher than admissions for young males. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment' (ChiMat child health profiles, 2012).

It is estimated that one in fifteen young people in the United Kingdom have deliberately harmed themselves, suggesting that around two people in every secondary school classroom have self-harmed at some time (MHF, 2006). Self-harm amongst young people is more common between the ages of 11 and 25, although occasionally, self-harm can occur in

children as young as 7. Although it is increasing, the NSPCC report (2009) concluded that of all the 175,000 children they counselled in 2007-2008, only a small proportion spoke about self harm (2210 directly, and a further 3883 mentioned it alongside other issues).

There is a strong and direct association between suicide attempts and childhood sexual and/or physical abuse (Evans et al. 2005). It is also clear that depression, substance abuse, sexual and physical abuse, hopelessness, poor coping, suicidal behaviour by family and friends and in the media increase the risk of suicidal phenomena among children and adolescents (Fortune et al. 2005). There also appears to be a significant and direct relationship between antisocial behaviours and self-harm among girls, although perhaps surprisingly, the relationship is less clear for boys (Evans 2004). Among female adolescents there appears to be a relationship between poor body image, subtle forms of disordered eating and suicidal phenomena (Evans 2004). Motives reported by children and young people suggest that wanting to die, self punishment, escape from bad state of mind or to stop bad feelings, generate feelings e.g. of pain and hopelessness are also important factors in considering why children and young people self harm (Shaffer et al. 1996).

There is a strong link with deprivation, with children and young people from more deprived areas significantly more likely to be admitted to hospital for self-harm (Figure 45).

Figure 45
Hospital admissions for self-harm in the North West, by deprivation level.
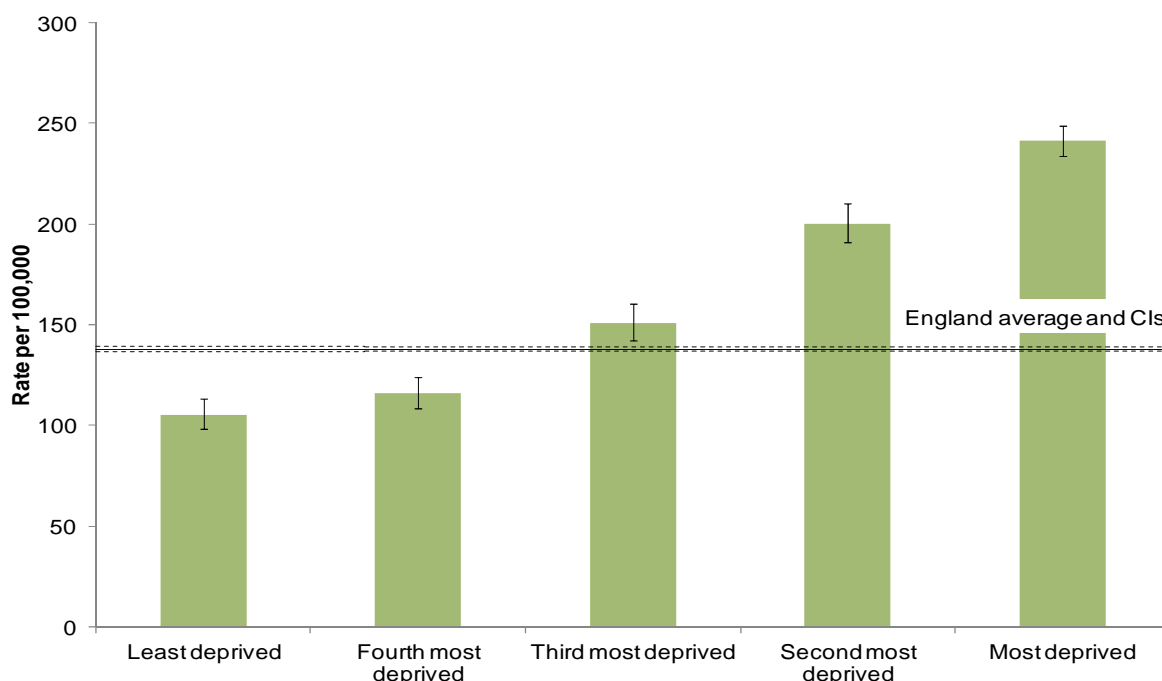
Chart taken from Deacon, 2012: 'Self-harm among children and young people in the North West: the data'

Local data

The only source of local data available on levels of self harm is hospital admissions. This will perhaps only provide an indication of the more extreme cases of self-harm, or those for which help has been sought. In Merseyside, the crude rate per 100,000 aged 0-17 of emergency admissions for self-harm is shown in the Figure 46 below (taken from the ChiMat

child health profiles). Rates are worse than the national average of 158.8 per 100,000 in each local authority on Merseyside. They are significantly worse in St.Helens, Halton, and Wirral. However in Knowsley, Liverpool and Sefton, rates are well below the North West average of 207.7 per 100,000.

Table 41 gives actual numbers with a total of 675 admissions for self harm amongst young people aged under 18 across Merseyside in 2010-11.

Figure 46
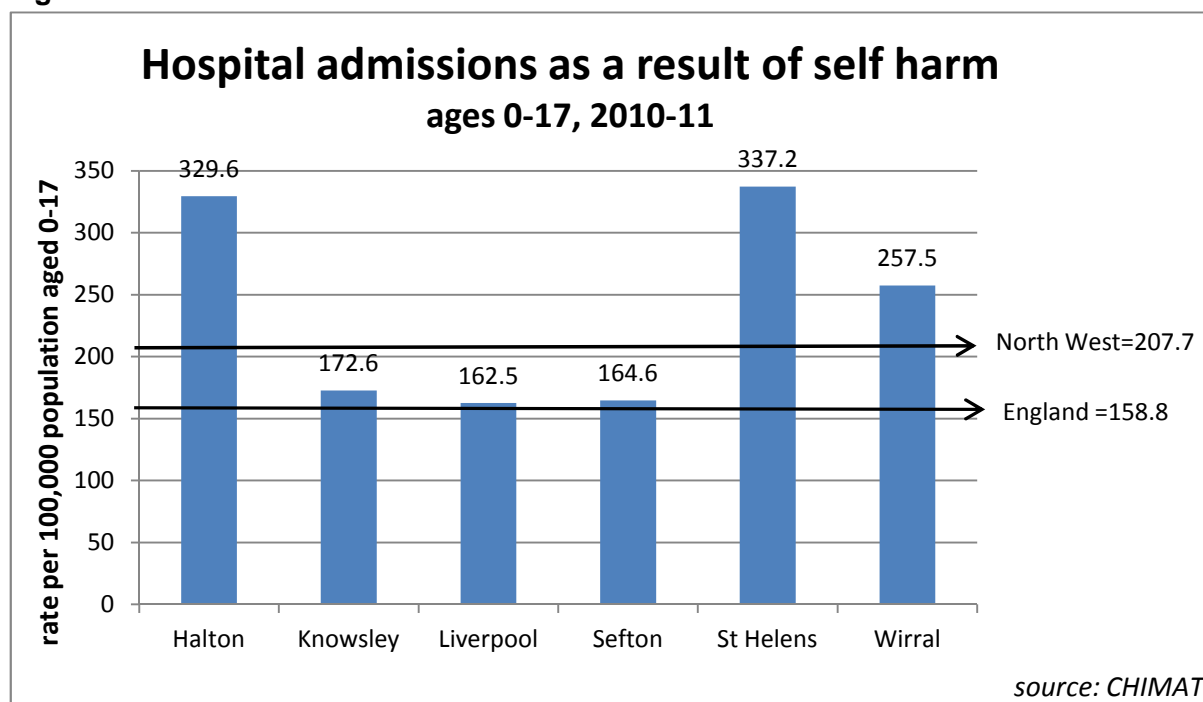
Table 41
**Hospital admissions as a result of self-harm,
2010-2011, ages 0-17**

	Hospital admission rate per 100,000	number
Halton	329.6	90
Knowsley	172.6	58
Liverpool	162.5	138
Sefton	164.6	90
St Helens	337.2	127
Wirral	257.5	172
Mersey		675
North West	207.7	
England	158.8	

Source: ChiMat

It should be noted that levels of admission may relate to the particular policy of individual hospitals rather than reflecting levels of need.

Recommendations:

Management: NICE (2004b) have produced clinical guidelines for the short term management of self harm with a specific section on children and young people. They suggest that children and young people be kept in hospital overnight to be assessed the following day and factors such as accommodation, age of the child, circumstances of the child and family, time of presentation to the service, child protection issues, physical and mental health of child including child or adolescent psychiatric inpatient unity, where necessary, be taken into account. In 2011, guidelines for longer-term management were issued, which included psychological, psychosocial and pharmacological interventions (NICE, 2011).

Prevention: Several practice guidelines have been published to improve the management of patients presenting with self-harm. However, barriers to help seeking, particularly among high-risk young people and especially males, need to be further understood so suicide prevention strategies can be tailored to address these populations. Contagious influences on self-harm and the positive and negative role of the Internet are also areas for future research (Fortune 2005).

In order to reduce the risk of self-harm amongst children and young people who may be at risk or who have a history of self-harming, the Mental Health Foundation (MHF, 2006) make a number of recommendations which professionals should consider. These include:

- ensuring the young person is receiving a healthy, balanced diet and is participating in regular, physical activity;
- encouraging the young person to seek help from their family and friends;
- ensuring the young person is avoiding alcohol or only consuming this in moderation
- encouraging the young person to take up a hobby or pursue an activity they are good at.

Young et al (2007) make several recommendations for professionals when tackling self-harm in children and young people. These include developing personal coping skills with the individual and targeting young people who are not in education, employment or training (NEETs) as they are known to be at greatest risk from chronic self-harm (see p.46 for more on NEETs). It was also found that a large number of young people who self-harm are known to their GP's, therefore, additional training and support for GP's may help to provide support for these young people.

In 2011, the National CAMHS Support Service produced a *"self-harm in children and young people"* handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond (National CAMHS Support Service, 2011).

NHS Knowsley/ Knowsley MBC have commissioned Salford University to look into issues around self-harm and suicide in more detail, with a report due in 2013. The project involves consultation with young people and their families who have experienced self harm and relevant multi-disciplinary professionals. A risk assessment tool will be developed and implemented.

Suicide

A new government strategy was launched in September 2012 focusing on suicide prevention (DH, 2012d). This strategy identifies several priority groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced. Amongst others, children and young people are named as one of the priority groups, which includes young men and young people from particularly vulnerable groups e.g. looked after children, care leavers and those in the youth justice system.

A 2009 NSPCC report based on case notes from ChildLine, identified potential risk factors which may increase a young person's risk of attempting suicide. They found that young people who had experienced sexual or physical abuse were at greater risk, as were those who were being bullied at school, those who were experiencing relationship difficulties, those in care and those who were suffering from increased stress. Several other studies have also found a strong link between suicide in young people and a family history of suicide attempts (Hawton et al, 2006).

Those bereaved by suicide are at an increased risk of suicide themselves. For every suicide it is claimed that on average six people suffer intense grief, with those affected including parents, partners, children, siblings, friends, colleagues at work, and also clinicians (Hawton and Simkin, 2003). Counselling and self-help groups such as Survivors of Bereavement by Suicide (previously known as SOBs) provide invaluable 'postvention' support. Hawton and Simkin note that other factors which might help reduce distress include specialised training for professionals who have contact with people bereaved by suicide, modifications to those aspects of coroners' inquest procedures that the bereaved report finding most stressful, and more sensitive media coverage of suicides.

Suicide statistics for children and young people do not necessarily reflect levels of wellbeing amongst this population. Research suggests that suicide is more to be seen as a rare event related to particular circumstance than as an indicator of overall mental health among a nation's young people (UNICEF, 2007).

There were 10 child deaths in the North West in 2009/10 provisionally identified as an apparent suicide (CMACE, 2011).

The Government recognises the concern around misuse of the internet to promote suicide and suicide methods and will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. This will involve ensuring that parents are able to recognise the risk factors and have the necessary tools to prevent their children from accessing harmful suicide-related content online (Department of Health, 2012).

Recommendations:
The Department of Health (2012) states that schools, social care and the youth justice system, and charities highlighting problems such as bullying, low body image and lack of self-esteem, all have an important contribution to make to suicide prevention among children and young people.

Local services can develop systems for the early identification of children and young people with mental health problems in different settings, including schools. Stepped-care approaches to treatment, as outlined by NICE, can be effective when delivered in settings that are appropriate and accessible for children and young people. The Department of Health's *You're Welcome* quality criteria self-assessment toolkit may be helpful in ensuring that services and settings are genuinely acceptable and accessible to children and young people.

The non-statutory programmes of study for Personal, Social, Health and Economic (PSHE) education provide a framework for schools to provide age–appropriate teaching on issues including sex and relationships, substance misuse and emotional and mental health. This and other school-based approaches may help all children to recognise, understand, discuss and seek help earlier for any emerging problems.

The consensus from research is that an effective school-based suicide prevention strategy would include: the following;
- a co-ordinated school response to people at risk and staff training;
- awareness amongst staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems and risk;
- clear referral routes to specialist mental health services.

4. Children and young people in contact with mental health services

Child and adolescent mental health provision (CAMHS) is organized across four tiers which reflect differing levels of need. Figure 1 on p.3 above summarises the range of provision across the tiers, from Tier 1, which promotes emotional wellbeing for all children and adolescents, through to Tier 4, which supports those with more complex needs.

CAMHS referrals
Children referred to the specialist CAMHS teams are those with more complex needs. Requests were sent for data on CAMHS referrals in each area within Merseyside. It would appear that such data is not readily available for all areas within Merseyside. Five Boroughs Partnership NHS Trust reported that to produce such data would be a lengthy and time-consuming process. They hope to procure a new system in the near future that can assist in all such data requests.

Data was received on referrals in Liverpool (referrals across targeted and specialist services) and Sefton. Figure 47 shows that emotional disorders are the most common reason for referral to CAMHS amongst children and young people in Liverpool and Sefton. Emotional disorders are the main presenting problem in just over half of referrals in Liverpool (53%) and just under half in Sefton (44.3%).

Conduct disorders and self-harm are the next most common main presenting problems in Sefton and Liverpool. In Sefton, more than 1 in 10 referrals are for conduct disorder (12.6%) and the same for self-harm (12.2%). In Liverpool, the proportions are slightly lower, with 9% presenting with conduct disorder and 7.1% with self-harm.

There may be some discrepancies in the data, as there are large differences in total numbers of referrals between Liverpool (4,962) and Sefton (621). Liverpool data covers a 12 month period and it is possible that Sefton data covers 9 months, but this would not account for such a large difference.

Figure 47

Main presenting problem as % of all referrals, Liverpool and Sefton CAMHS, 2011

source: Liverpool and Sefton CAMHS
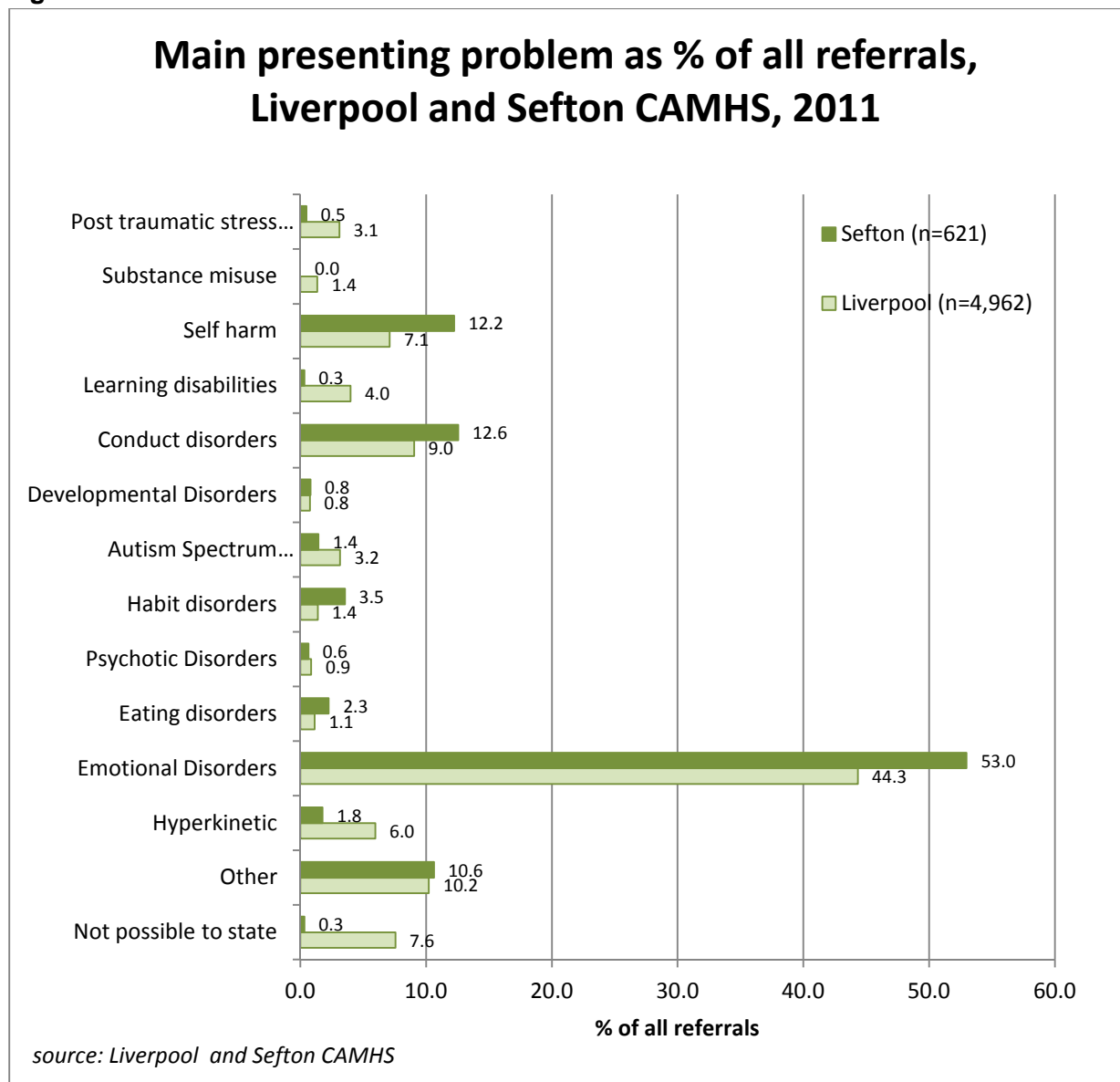
Note: -Sefton totals may be for ¾ year, rather than full year
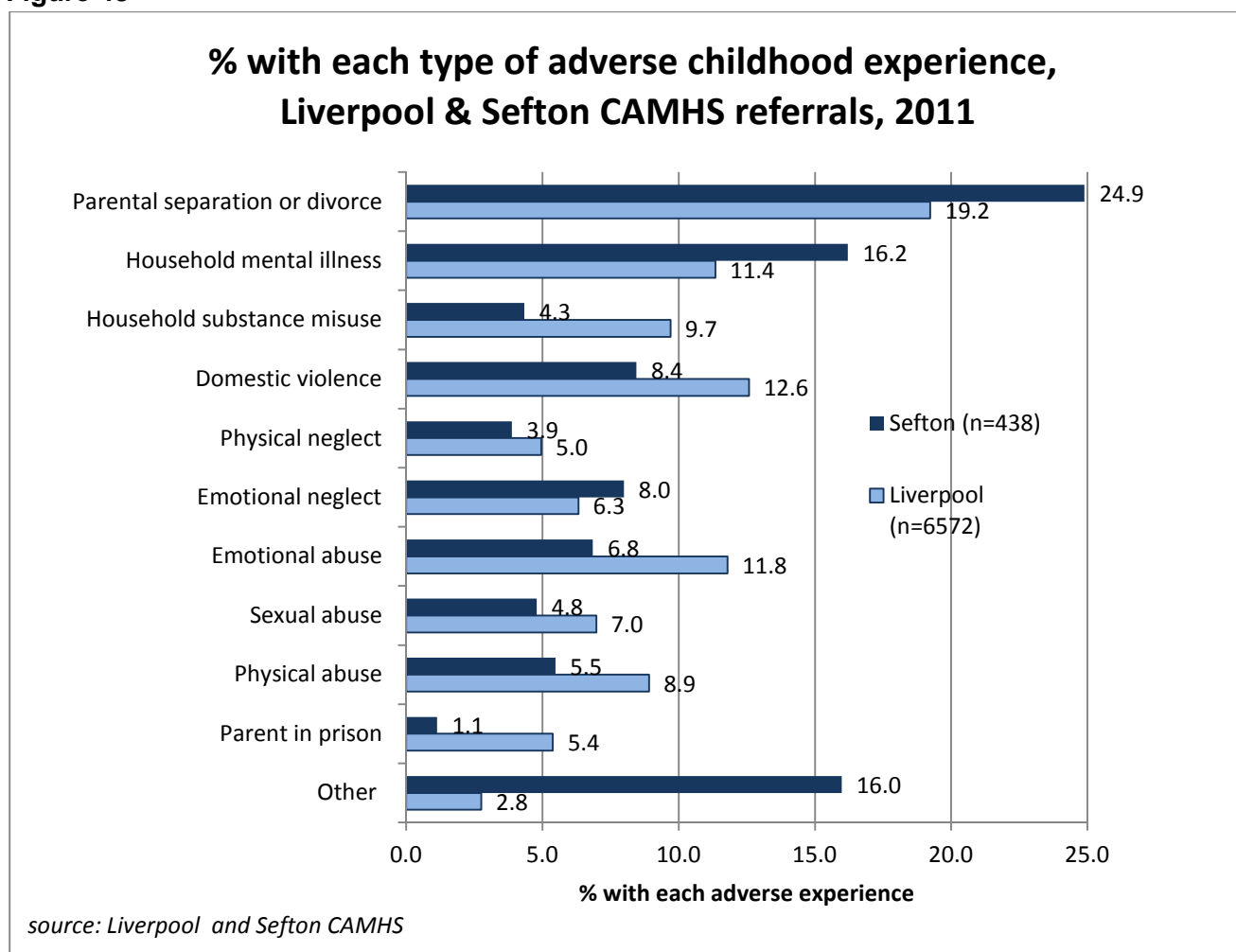*-numbers with learning disability in Sefton may be higher*

Figure 48 shows the adverse childhood experiences of children and young people referred to CAMHS. In Sefton and Liverpool, the most commonly recorded adverse experience was parental separation and divorce, affecting as many as 1 in 4 (24.9%) of referrals in Sefton

and 1 in 5 (19.2%) in Liverpool. (Section 2.iii above, p.73, explores the links between single-parent households and mental health).

Levels of household mental illness were high, featuring in 16.2% of all referrals in Sefton and 11.4% in Liverpool. (Section 2.iv above, p.84, explores the links between parents with mental health problems and child mental health).

In Liverpool, domestic violence, emotional abuse, household substance misuse and physical abuse were associated with around 1 in 10 referrals.

Figure 48

% with each type of adverse childhood experience, Liverpool & Sefton CAMHS referrals, 2011

Adverse experience	Sefton	Liverpool
Parental separation or divorce	24.9	19.2
Household mental illness	16.2	11.4
Household substance misuse	4.3	9.7
Domestic violence	8.4	12.6
Physical neglect	3.9	5.0
Emotional neglect	8.0	6.3
Emotional abuse	6.8	11.8
Sexual abuse	4.8	7.0
Physical abuse	5.5	8.9
Parent in prison	1.1	5.4
Other	16.0	2.8

■ Sefton (n=438)
□ Liverpool (n=6572)

% with each adverse experience

source: Liverpool and Sefton CAMHS

Note: -Sefton totals may be for ¾ year, rather than full year

As reported in Section 3 on prevalence, the TCRU (2007) noted that historically, there has been a gap between prevalence of emotional wellbeing and mental health problems and access to specialist support within CAMHS. However, as the development of emotional wellbeing and mental health support has been receiving increasing attention and funding from national government recently, it is likely that the situation has started to improve. On the other hand, it is possible that on occasions there are inappropriate referrals to CAMHS that could have been dealt with by other professionals more directly in contact with the child or young person, such as teachers or school nurses. There is a need for more training and awareness raising amongst those involved with children and young people on what can be

done to help them achieve emotional wellbeing and when to recognise the need to refer on to more specialist services.

Recommendations:
Interventions such as family based programmes and psychological therapies have been discussed in Section 2 (i) above.

Facilitating access to CAMHS - the role of non-CAMHS professionals
Summary of recommendations from TCRU literature review (TCRU, 2007):
> • Given that children and young people with emotional wellbeing and mental health problems are more likely to have had contact with statutory services; it would be beneficial for non-CAMHS services to be able to make more appropriate referrals
> • Links between CAMHS and GPs have resulted in training for primary care staff and the development of consultation services for professionals as well as direct support provision for children and young people; however measures are needed to improve GPs' ability to identify problems of emotional wellbeing and mental health and to increase referral rates.
> • Increasingly, social (care) services are developing emotional wellbeing and mental health support provision, but clearer and quicker referral pathways to specialist CAMHS are still needed.
> • Increasing links between schools and CAMHS have been noted in the form of consultation to staff and direct support to children and young people, but more training for school staff is needed, specifically in making appropriate referrals.

> *The role of parents:*
> • Barriers identified by parents to accessing support for their children include: the fear of being blamed, not knowing where to go, and concerns that the support would make no difference.
> • Relatively high numbers of children and young people with significant emotional wellbeing and mental health problems are seen by GPs; detection by GPs has been suggested to be significantly increased if parents express concern about their child's emotional wellbeing and mental health during the consultation itself.
> • More parental education should take place to improve early identification in the primary care settings.

TCRU (2007)

5. Discussion and recommendations

Discussion

The Mental Health Foundation (MHF, 2007) noted the significant economic effect on society of childhood mental health. They quoted research estimating that a child with a conduct disorder will, by the age of 28, have generated costs (such as to the health, education, benefits and criminal justice systems) ten times as high as a child without conduct problems.

For those children known to the health service, in 2003, it was estimated that depression in children and young people could cost the NHS up to £3.5m annually for Fluoxetine treatment, £113m for cognitive behavioural therapy and £149m for these treatments combined (Thomas & Morris, 2003, in Freer et al, 2010, p.245).

Promoting positive mental health in children through earlier intervention can result in large benefits (human and economic) with relatively little expenditure. For example, it has been estimated that:

- promoting positive mental health in those children with moderate mental health would yield benefits over the life course of around £75,000 per case
- in comparison the intervention cost, per child, for parenting programmes would be in the range £1,350 to £6,000
- preventing conduct disorders in those children who are most disturbed would save around £150,000 per case in lifetime costs

(LSE, 2011, Liverpool PCT, 2009)

With the current financial crisis, it is more important than ever to promote emotional resilience. Preventive, population based work such as that being undertaken in schools should continue to be given a high priority (Weare, 2010).

The Healthy Child Programme (HCP) is the government's universal early intervention and prevention public health programme. It is evidence-based and brings together the wide range of recommended programmes and interventions for local areas to consider. There are two documents, covering pregnancy and the first five years (DH HCP, 2009) and ages 5 to 19 (DH/DCSF HCP, 2009).

The HCP recognises that to reduce inequalities in children's health, wellbeing and achievement, in addition to universal approaches, there is a need to focus on the most vulnerable children and families who are at risk of poor outcomes, and allocate resources accordingly. Those at risk need to be identified, as detailed in Section 2 of this needs assessment (for example predictors may include overcrowded housing, being looked after, or having a parent with mental health problems). There also needs to be an acknowledgement of protective factors such as strong parenting and educational achievement.

Deprivation and multiple risks: There is clear evidence in the literature of inequalities, with those from more deprived backgrounds significantly more likely to suffer poor emotional and mental health. Many of the factors associated with child wellbeing are inter-linked, with children and young people often facing more than one adverse experience. For example

some children and young people with a parent who has a mental health or substance abuse problem may also be living in poverty, in a lone parent household and in poor housing. It is recognised that those who have suffered four or more adverse childhood experiences are especially at risk of poor emotional and mental wellbeing (DH, 2011a&b). Where numbers with mental health conditions have been estimated in this report, the high levels of mental health risk factors on Merseyside, such as deprivation, mean that figures are likely to be underestimates.

Universal health and development reviews to help identify those at risk are a key feature of the HCP. Interventions such as introducing the use of interpreters, understanding different childcare practices, and taking services to the homeless and to travelling families are mentioned as key features of local programmes. The HCP calls for an end to the separation of maternity and child health services. It encourages better integration and information sharing between maternity services and the HCP team, school health teams and adolescent services, including child and adolescent mental health services

Consider varying degrees of need within vulnerable groups: This report has included a consideration of the emotional and mental health needs of vulnerable groups of children and young people. The Department for Health (DH, 2008) noted that service provision that is focused on specific groups of children needs to be undertaken cautiously. Even within a particular vulnerable 'group', the needs of children and young people are not all the same. These issues need to be considered carefully to ensure that these children and young people have access not only to a full range of provision but also the specific expertise and knowledge that may be required to successfully meet their needs. The DH noted that services are often not being commissioned systematically and in co-ordination with other relevant services.

Awareness raising and training: Within primary level services (Universal, Tier 1), those in contact with children and young people need to be able to have sufficient knowledge of children's mental health to be able to identify those who need help, offer advice and support to those with mild or minor problems and have sufficient knowledge of specialist services to be able to refer on appropriately when necessary (Maughan, 2010).

Child mental health workers (Targeted, Tier 2) need to be available to support, train, liaise with, consult to and provide direct work with other agencies providing services for children (Maughan, 2010). This would help to avoid inappropriate referrals to CAMHS. Also, at the universal level, training in how to build up resilience in children and young people would help to prevent some problems from developing.

Merseyside:
This needs assessment has identified some of the protective factors and areas of risk across Merseyside and should be regarded as a working document, for local authorities and other related agencies to take away and use to identify areas for action and further exploration. Data presented was the most recently readily available at the time of writing.

Across Merseyside, on the whole there were low levels of resilience and high levels of risk factors relating to emotional health and wellbeing. There were some exceptions and Sefton compared well to the national average on more factors than any other local authority in Merseyside, for example on levels of GCSE attainment, family homelessness and pregnant

teenagers. There were different patterns of need in each local authority, for example Halton had relatively low levels of children looked after and on child protection plans, but high levels of hospital admissions for substance abuse and self-harm. Even where local authorities compare well with each other or to the national picture, there will be inequalities in need within their boundaries, as illustrated in the small area ward maps in the report. The limited amount of data readily available by small areas shows that the distribution of low levels of child wellbeing follows a very similar pattern to that of high levels of school absenteeism, to levels of child poverty, and to a lesser extent, children under 16 on disability allowance. Further exploration of small area data is required.

Current research on Merseyside includes the following:
Young Offenders: Liverpool Public Health Observatory is currently carrying out a needs assessment of young offenders, with a report due out early in 2013.

Eating disorders: a Merseyside Eating Disorders Health Needs Assessment is currently being undertaken by NHS Merseyside.

For future investigation
There are many factors that impact on the emotional health and wellbeing of children and young people, and it was not possible to cover everything here. Areas for future consideration include:

- Children with a limiting long term illness (using 2011 census data once it becomes available).
- Additional social factors such as poor housing, fuel poverty and neighbourhood crime/safety.

There is a shortage of data on the protective factors associated with emotional health and wellbeing, which mainly rely on the results of surveys (Hicks and Newton, 2011).

For some areas where there was a lack of readily available data, further investigation might involve contacting various community and voluntary organisations and health agencies and undertaking surveys and focus groups to understand the emotional health needs of vulnerable groups. Such areas include the following:

- Transition: The effects of being in transition from child to adult services, for looked after children; children with physical health needs; and children in touch with child mental health services.
- Children with an absent parent (bereaved children; those with a parent in hospital; children of prisoners; children of service personnel).
- Children who are overweight/ obese.
- The effects of bullying.

The needs of the following groups were considered in this needs assessment but require further investigation due to a lack of data:

- Young carers.
- CAMHS referrals.
- Children of asylum seekers and travellers/gypsies.
- Children with autism (considered here under the broad 'SEN' heading).

- Sexual orientation.

Recommendations

There are many factors that can influence the emotional wellbeing of children and young people. An attempt has been made to cover the main factors in this needs assessment, painting a picture of need across Merseyside. Details of recommendations and interventions available relating to these areas can be found within the subsections of the main report.

Following on from the CAMHS Review (DH, 2008), the latest DH mental health strategy paper made recommendations detailing what each agency could do to improve the mental health and wellbeing of the population, including specific action around children and young people (DH, 2012c). These in many cases mirrored the recommendations from the Children and Young People's Mental Health Outcomes Forum sub-group on Mental Health (CYP Health Outcomes Forum, 2012), which are in turn based around the six objectives of the DH Mental Health Outcomes Strategy (DH, 2011b). The main recommendations relating to children and young people are presented here, with additions from the results of this needs assessment:

Summary of recommendations

Local authorities:

- Support whole school approaches that build on strengthening the protective factors associated with the emotional wellbeing of children and young people.

- Consider the mental health impact of wider services and initiatives, such as providing good quality family housing, opportunities for NEETs and opportunities for exercise and access to green spaces.

- *Appoint an elected member as 'mental health champion.'* This role might include raising awareness of mental health issues, including the impact of stigma and discrimination, across the full range of the authority's work and with other elected members, including lead members for children.

- Support action on child poverty, as outlined in the Liverpool City Region Child Poverty Strategy (Liverpool City Region, 2011).

- Encourage all schools across Merseyside to carry out the same standard, consistent school survey covering emotional health and wellbeing (as proposed in Scotland).

Local Public Health Service:
- Develop a clear plan for public mental health, incorporating the tiered approach to improving public mental health: *Universal* interventions to build resilience and promote wellbeing for all ages*; targeted* prevention and early intervention for people at-risk of mental health problems, for example early intervention with children, young people and families. Examples of effective interventions include the Healthy Child Programme 0-19 (DH HCP, 2009).

- Establish a public health lead for the emotional health and wellbeing of children and young people. This would assist in improved integration of public health with others who lead in this area, including social services, schools, CAMHS and the community and voluntary sectors.

- Together with local clinical commissioning groups (CCGs), work with maternity and child health services to identify and meet the needs of their local population.

- Commission or provide evidence-based mental health training for non-mental health professionals. Training builds awareness of mental health issues, addresses myths and stigma, and enables professionals to support and signpost to the right services. This could include training for midwives, health visitors, police and probation staff, school and college staff, housing and hostel staff, youth workers, and health staff in acute and community settings.

- Support Clinical Commissioning Groups (CCGs) to consider and commission mental health promotion, prevention and early intervention.

- Support positive parenting through commissioning Family Nurse Partnership and Health Visiting services.

- Consider carrying out more in-depth needs assessments for some of the more vulnerable groups identified for whom there is a lack of readily available data. This would involve contacting various community and voluntary organisations and health agencies for information and consulting with the young people involved.

- Carry out further analysis to explore the particular needs of small areas within local authorities.

- Encourage related agencies to collect the data that can be used to assist in planning and commissioning, for example number and type of CAMHS referrals. Feed this work into the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategies.

Children's Trust Board:
- Work alongside CCGs, schools and wider children's services to focus on early intervention and integrated support.

- Offer evidence-based parenting interventions to families with children at risk of conduct disorder and those experiencing conduct problems. Effective parenting support also needs to include the development of effective referral routes and awareness-raising, for example with local GPs, maternity services, health visitors and other services working with young families.

- Improve emotional support for children on the edge of care, looked after and adopted children. This can include establishing links with CAMHS to make appropriate referrals and offer integrated support, including support for adoptive parents of children with mental health problems. The children and young people's IAPT

programme will ensure that more children have timely access to evidence-based psychological therapies.

Clinical Commissioning Groups (CCGs)

- *Consider the mental health needs of their whole population when commissioning, including seldom-heard groups.* This includes commissioning for effective transitions between Child and Adolescent Mental Health Services (CAMHS) and adult services.

- *Commission to intervene early.* Evidence-based and cost-effective early interventions include early treatment of childhood conduct disorder and early intervention in psychosis teams. CCGs may wish to commission some of these jointly (Tier 2).

- Provide information and intelligence from commissioning into JSNAs and Health and Wellbeing Strategies.

- Commission CAMHS and other providers to promote an awareness of local services available to schools and other professionals working with children and young people. Offer clear guidance and training on the appropriate support for different situations.

- Ensure increased access to primary care for vulnerable groups. This includes children in care, homeless people, some BME communities, lesbian, gay, bisexual and transgender people, offenders, victims of violence (including domestic violence and sexual violence) and those from gypsy and traveller communities.

- Increase awareness amongst GPs and primary care staff of the ideal opportunity that general practice presents for screening for high risk behaviours and mental health problems amongst children and young people.

- Ensure that commissioning requires providers to report numbers and types of referrals to child mental health services (including inappropriate referrals).

- Data on child hospital admissions for injury should be separated into unintentional and deliberate injury.

- Collect data on numbers of attendances at A&E for child injury, in addition to admissions to hospital, to give a better indication of local needs.

Children's health services (including CAMHS, and independent agencies)

- Encourage links with schools, primary care staff and other professionals working with children and young people, developing consultation services to:
    - ° promote awareness of what support CAMHS and others can provide for children and young people,
    - ° promote awareness of what support CAMHS and others can provide for school staff and other professionals,

- provide training and clear guidance for schools and other professionals on which support is the most appropriate for different situations.

- Improve access for children, young people and their families to mental health support through universal service provision.

- Improve access to mental health services for at risk children and young people (such as children in care, those with disabilities and those with behavioural, emotional and social difficulties) (a statutory requirement).

- Ensure that parents and carers can access advice and support when they are concerned about their children's mental health.

- Improve data collection so that information on numbers of referrals, and reasons for referral and related factors, is routinely available to assist in planning and commissioning decisions.

Schools and colleges:

- Understand the link between emotional wellbeing and good educational and wider outcomes and ensure children who need professional health support are able to access services. Good schools recognise the link between emotional wellbeing and good educational and wider outcomes and have effective systems in place for monitoring and responding to children and young people's issues.

- Have a 'whole school' approach to supporting all pupils' wellbeing and resilience, with an emphasis on strengthening the associated protective factors. This includes both universal approaches, and targeted services for children and young people with, or at risk of developing, behavioural difficulties or emotional problems. Evidence-based interventions to improve wellbeing and build resilience include behavioural support, school-based counselling and parenting interventions.

- Address bullying. Bullying puts children and young people at significant risk of developing mental health problems.

- Ensure staff are aware of how mental health relates to their work. Mental health awareness can help staff recognise signs of mental ill-health and understand the link between mental health and behaviour, attendance and attainment, and will know when a child needs extra help.

- Access the e-learning packages for non-health professionals, being developed as part of the Children and Young People's IAPT programme. This will help staff recognise and support children and young people with mental health problems. The e-portal will also include specific support materials in relation to self-harm, suicide and risk in children and young people.

- Know what specialist mental health support is available. Schools and colleges can ensure they are aware of the services offered by local CAMHS and by the

independent and voluntary sector, and of how children, young people and their families can access them. They can contribute to shaping specialist provision through input to JSNA and commissioning processes.

- Promote the role of school nurses in helping schools to identify those children and young people in need of specialist interventions.

- Know when to intervene early to tackle mental health problems. Schools and colleges can proactively seek to identify children and young people with the risk factors for, or the early signs of, behavioural problems and intervene early by securing access to evidence-based support. School leaders can support this through creating a whole-school culture and ethos which supports good outcomes through a strong focus on high-quality teaching and learning, enriching extra-curricular activities and good pastoral care.

- Challenge mental health stigma by ensuring students and staff know about mental health, how and when to seek help, and how to improve their own mental health and wellbeing. Time to Change are piloting approaches to tackling mental health stigma and discrimination amongst young people. They provide useful resources that can help schools and youth groups in overcoming stigma.

Across all areas, young people's voices should be central to the process of informing the commissioning, planning, delivery and evaluation of services

(recommendations are based on: DH, 2012c; CYP, 2012; Stansfield, 2012; DH, 2011b; Children and Young People's Mental Health Coalition, 2012; DH, 2008; and this needs assessment):

A matrix table in Appendix 7 summarises the main evidence for these interventions available at each level/ tier of need relating to the emotional health and wellbeing of children and young people. Links to further details of other evidence based interventions that are relevant to the emotional wellbeing of children and young people, but not all covered in this report are also given in the table. These include guidelines around the following:
- pregnancy and complex social factors
- schools-based interventions on alcohol
- substance misuse in children and young people
- the management of attention deficit hyperactivity disorder (ADHD)
- recognition, referral and diagnosis of children and young people on the autism spectrum
- when to suspect child maltreatment
- the management of children with conduct disorders
- depression in children and young people

References

NOTE: Publically available URLs have been given here, rather than URLs that can only be accessed through the university library. These links may therefore not always lead to the full article.

APPG (2012) *The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers: Report from the joint Inquiry into children who go missing from care.* All Party Parliamentary Group, June 2012.http://tinyurl.com/bvd5du7

Atkinson, A., Bellis, M., Hughes, K., Hughes, S., Smallwaite, L (2009) *Smoking behaviour in north west schoolchildren: a study of 15 & 16 year olds.* Centre for Public Health, Liverpool John Moores University in collaboration with Trading Standards.

Barnados, Liverpool (2012) *Personal correspondence*, 19/9/12, Louise Wardale, Keeping the Family in Mind Coordinator, Barnardos Action with Young Carers, Liverpool.

Becker J, Roe S (2005) Drug use among vulnerable groups of young people. Findings from the 2003 Crime and Justice Survey. *Home Office Research Findings* 254. London: Home Office.

Berg I (1992) Absence from school and mental health. *The British Journal of Psychiatry* (1992) *161: 154-166* http://bjp.rcpsych.org/content/161/2/154.short

Bremner, P., Burnett, J., Nummey, F., Ravat, M., Mistral, W (2011) *Young people, alcohol and influences: A study of young people and their relationships with alcohol.* Joseph Rowntree Foundation.

Bond L, Butler H, Thomas L, Carlin J, Glover S, Bowes G, Patton (2007) Social and School Connectedness in Early Secondary School as Predictors of Late Teenage Substance Use, Mental Health, and Academic Outcomes. *Journal of Adolescent Health* 40 357.e9 –357.e18. http://tinyurl.com/corja2f

Burnett, A & Peel, M (2001) Asylum seekers & refugees in Britain: Health needs of Asylum seekers and refugees, *BMJ*, 322 (7285): 544-547. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119741/

Caan W (2012) *personal correspondence* with Dr. Alex Scott-Samuel, 23/4/11.

Caestecker L, Killoran-Ross M (2010) Early years and public health: a case study from the Glasgow experience. In Goldie I (ed) *Public Mental Health Today. A handbook* (pp.121-134). Brighton, Pavilion Publishing/Mental Health Foundation.

Cancer Research UK website children and smoking: webpage, accessed Sept 2012: http://www.cancerresearchuk.org/cancer-info/healthyliving/smokingandtobacco/childrenandsmoking/

Carey-Wood J, Duke, K, Karn, V, Marshall, T (1995) *The settlement of refugees in Britain.* Home Office Research Study 141. HMSO. London. http://tinyurl.com/ccam38a

CHaMPs (2012) *September 2012 - ChaMPs e-Bulletin.* Cheshire & Merseyside Public Health network http://www.champspublichealth.com/writedir/57deSeptember_ChaMPs_e-bulletin1.pdf

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

Child Accident Prevention Trust (2012) website news Jan 2012, accessed 29/8/12. http://www.makingthelink.net/node/469

Child Accident Prevention Trust (2012b) *'Hospital admissions data - by local authority'*, accessed 29/8/12 http://www.makingthelink.net/data-source/hospital-admissions-data-local-authority

Children and Young People's Mental Health Coalition (2012) *Resilience and Results: How to improve the emotional and mental wellbeing of children and young people in your school.* http://tinyurl.com/93qpvuh

Children's Society (2012a) *The Good Childhood Report: A review of our children's wellbeing.* The Children's Society, London. http://tinyurl.com/d6g9zad

Children's Society (2012b) *New charter to protect runaways, missing children from harm and exploitation.* Press release, 10th July. http://tinyurl.com/buoesw2

Children's Society (June 2012) *Promoting positive wellbeing for children: A report for decision-makers in parliament, central government and local areas.* The Children's Society, London.
http://www.apho.org.uk/resource/item.aspx?RID=118165

ChiMat (2012) *Child Health Profiles 2012.* Child and Maternal Health Observatory.
http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES

Clarke, GN., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W., E O'Connor, E., Seeley, J (2001) A randomised trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archive General Psychiatry.* 58 (12): 1127-1134

CMACE (2011) *North West Report of Child Deaths 2009/10.* Centre for Maternal and Child Enquiries.
http://www.cumbrialscb.com/contents/images/File/NW%20Report%20of%20Child%20Deaths%202009-10.pdf

Coleman PK (2006) Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: Individual and Family Predictors and Psychological Consequences. *Journal of Youth and Adolescence,* 35 n6, 903-911. http://tinyurl.com/cq3bw4l

Communities and Local Government (2009) *Local Index of Child Well-Being.Summary Report.*
http://www.communities.gov.uk/documents/communities/pdf/1126232.pdf

Communities and Local Government (2011) *The English Indeces of Deprivation 2010.* Department for Communities and Local Government, London.
http://www.communities.gov.uk/publications/corporate/statistics/indices2010

Connelly, N., Forsythe, L.A., Njike. G & Rudiger, A (2006) *Older refugees in the UK: A literature review.* London: Age Concern & Refugee Council. http://tinyurl.com/bp82n8w

ContinYou (2011) *About Pyramid Clubs.* Online, accessed May 2012:
http://www.continyou.org.uk/what_we_do/pyramid/about

Craig,T., Hodson, S.,Woodward, S. and Richardson, S. (1996) *Off to a Bad Start: A longitudinal study of homeless young people in London.* London: The Mental Health Foundation

Crawley, H (2010) *Chance or choice? Understanding why asylum seekers come to the UK.* London: Refugee Council. http://www.refugeecouncil.org.uk/Resources/Refugee%20Council/downloads/chancechoice.pdf

CYP Health Outcomes Forum (2012) *Report of the children and young people's health outcomes forum – mental health sub-group.* Department of Health, July 2012.
http://www.dh.gov.uk/health/files/2012/07/CYP-report.pdf

DCSF (2010) *Change in Wellbeing from Childhood to Adolescence*:Research Brief. Departmentr
Risk and Resilience. https://www.education.gov.uk/publications/eOrderingDownload/DCSF-WBL-10-01.pdf

Deacon L (2012) *Self-harm among children and young people in the North West: the data.* Presentation by Lynn Deacon, North West Local Specialist, Child and Maternal Health Observatory.
http://www.northwest.nhs.uk/whatwedo/improvingservices/ch/Self-Harm-and-Suicide-in-the-North-West.html

Dearden, C & Becker, S (2004) *Young carers in the UK: the 2004 report.* London: Carers UK.
http://www.carersuk.org/professionals/resources/research-library/item/492-young-carers-in-the-uk

De Leo D, Heller TS (2004) Who are the kids who self-harm? An Australian self report school survey. *Med J Aust* 181:140–144.

Department for Communities and Local Government (2012*) Housing Research, Table 770.*
www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livetables

DfES (2006) *Teenage Pregnancy: Accelerating the Strategy to 2010. Every child matters: Change for children.* Department for Education and Skills, London. http://tinyurl.com/bon3wl3

DfES (2007) *Care Matters: Time for Change.* White paper. Department for Children, Schools and Families.
https://www.education.gov.uk/publications/eOrderingDownload/Cm%207137.pdf

DfE (2010) *Achievement of Children in the Early Years Foundation Stage Profile. Research Report* DFE-RR034, Schools Analysis and Research Division, Department for Education.
https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR034.pdf

DfE (2011) *Supporting Families in the Foundation Years*. Department for Education, London.
http://media.education.gov.uk/assets/files/pdf/s/supporting%20families%20in%20the%20foundation%20years.pdf

DfE (2012) *Special Educational Needs from Schools in England*, January 2012. Statistical First Release.
Department for Education. http://www.education.gov.uk/rsgateway/DB/SFR/s001075/index.shtml

DfE (2012b) *Support and Aspiration: A new approach to Special Educational Needs and Disability. Progress and next steps.* Department for Education, May 2012. http://tinyurl.com/d4r2plh

DH (1989) *Statutory Instrument no. 306: The National Health Service (charges to overseas visitors*) Regulations *1989.* Department of Health, London. http://www.legislation.gov.uk/uksi/1989/306/contents/made

DH (2001a) *Making It Happen: A guide to delivering mental health promotion*. Department of Health.
http://www.publications.doh.gov.uk/pdfs/makingithappen.pdf

DH (2001b) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. Department of Health White Paper. http://www.archive.official-documents.co.uk/document/cm50/5086/5086.pdf

DH (2002) *Promoting the health of looked-after children. Revised statutory guidance.* London: Department of Health. http://tinyurl.com/ydqwcy7

DH (2004) *CAMHS Standard, National Service Framework for Children, Young People and Maternity Services.* Department of Health. http://tinyurl.com/c8qo3lf

DH (2008) *Children and young people in mind: the final report of the National CAMHS Review*. Department of Health. http://tinyurl.com/646udg

DH (2009) *Promoting the health and wellbeing of looked after children - revised statutory guidance*. Department of Health, London. http://tinyurl.com/ydqwcy7

DH (2010*) Healthy lives, healthy people: our strategy for public health in England*. Department of Health White Paper. http://tinyurl.com/32nt3sr

DH (2011a) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.* Department of Health. http://www.dh.gov.uk/health/2012/07/mentalhealthframework/

DH (2011b) *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages.* Department of Health. http://tinyurl.com/6hd4sdj

DH (2011c) *Preparation for birth and beyond: a resource pack for leaders of community groups and activities.* Department of Health, London. http://tinyurl.com/bqja9r7

DH (2011d) *Talking therapies: a four year plan of action*. Department of Health.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123759

DH (2011e*). Healthy Lives, Healthy People: A Tobacco Control Plan for England.*

DH (2012a) *Government pledges support for women with postnatal depression and improvements to maternity care*. Department of Health website, 16th May. Last accessed 26/9/12:
http://www.dh.gov.uk/health/2012/05/postnatal-depression-maternity-care/

DH (2012b) *The Family Nurse Partnership Programme. Information leaflet.* Department of Health.
http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

DH (2012c) *No Health Without Mental Health: Implementation Framework*. Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point.
http://tinyurl.com/9zheym4

DH (2012d). *Preventing suicide in England : a cross government outcomes strategy to save live*s. Department of Health.

DH CNO (2012) *Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and Call to Action.* Department of Health, Chief Nursing Officer Professional Leadership Team. http://tinyurl.com/7rutw5g

DH HCP (2009) *Healthy Child Programme – Pregnancy and the first five years Department of Health*, October 2009. http://tinyurl.com/35qrkj7

DH/DCSF HCP (2009) *Healthy Child Programme: From 5–19 years old.* Department of Health and Department for Children, Schools and Families. October 2009. http://tinyurl.com/bsj62bw

Doyal L, Cameron A, Cemlyn S,Nandy, Shaw M (2002) *The health of Travellers in the South West region: a review of data sources and a strategy for change.* South West Public Health Observatory http://www.swpho.nhs.uk/resource/item.aspx?RID=9043

Edwards D and Forbes G (2009) *Emotional Health and Mental Wellbeing Needs Assessment of Children and Young People in Halton & St Helens.* NHS Halton & St Helens Public Health Team.

End Child Poverty (2011) *Child Poverty Map of the UK, Part 1: England.* End Child Poverty, Child Poverty Action Group, March 2011. http://endchildpoverty.org.uk/files/child-poverty-map-of-the-uk-part-one.pdf

Evans E, Hawton K, Rodham K. (2004) Factors associated with suicidal phenomena in adolescents: a systematic review of population-based studies. *Clin Psychol Rev*; 24:957–979.

Evans E, Hawton K, Rodham K. (2005) Suicidal phenomena and abuse in adolescents: a review of epidemiological studies. *Child Abuse Neglect*; 29: 45–48.

Faculty of Public Health (2010) *Great Outdoors:How Our Natural Health Service Uses Green Space To Improve Wellbeing: An action report.* A Faculty of Public Health report In association with Natural England http://www.fph.org.uk/uploads/r_great_outdoors.pdf

Faculty of Public Health (2010) *Thinking ahead: Why we need to improve children's mental health and wellbeing.* A Faculty of Public Health report. http://www.apho.org.uk/resource/item.aspx?RID=109540

Fombonne, E., Wostear, G., Harrington, R., Rutter, M. (2001) The Maudsley long term follow up of child and adolescent depression. 2. Suicidality, criminality and social dysfunction in adulthood. *The British Journal of Psychiatry.* 179: 218-223

Fortune, S.A & Hawton, K (2005) Deliberate self-harm in children and adolescents: a research update. *Current Opinion in Psychiatry* 18: 401-406

Fox, N.J (1995)Professional models of school absence associated with home responsibility. *British Journal of Sociology of Education.* 16: 2: 221-42. http://www.tandfonline.com/doi/abs/10.1080/0142569950160206

Freer M, Shiers D, Churchill D, Friel J (2010) Meeting the mental health needs of young people: a GP's perspective. In Goldie I (ed) *Public Mental Health Today. A handbook* (pp. 241-258). Brighton, Pavilion Publishing/Mental Health Foundation.

Gordon, L., Tinsley, L., Godfrey, C. and Parrott, S. (2006) ‗The economic and social costs of Class A drug use in England and Wales, 2003/04'. In: Singleton, N., Murray, R. and Tinsley, L. eds. *Measuring different aspects of problem drug use: methodological developments.* Home Office Online Report 16/06, pp.41-45 [online]. http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr1606.pdf

GOV.UK (2012) *Emergency housing if you're homeless.* Government services and information website, accessed 31/10/12. https://www.gov.uk/emergency-housing-if-homeless

Government Office for Science (2008*) Foresight Mental Captial and Wellbeing Project. Final Project report.* Mental Capital and Wellbeing: Making the most of ourselves in the 21st century. London.

Guardian (2011) Children's eating disorder figures cause alarm. *The Guardian,* Monday 1 August 2011 http://www.guardian.co.uk/society/2011/aug/01/children-eating-disorder-figures-alarm

Guasp A (2009) The teachers' report: Homophobic bullying in Britain's schools. Stonewall. http://www.stonewall.org.uk/documents/the_teachers_report_1.pdf

Grenier, P. (1996) *An update of Crisis' 1992 investigation into the links between homelessness, health and mortality.* London: Crisis.

Hagiliassis N, DiMarco M, Gulbenkoglu H, Iacono T, Larkin H, Watson J (2005) The bridging project : physical disability and mental health. *In-psych : the bulletin of the Australian Psychological Society* , 27, 4, 22-24 http://www.psychology.org.au/publications/inpsych/bridging/

Hawton K, Hall S, Simkin S, et al. (2003) Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990–2000. *J Child Psychol Psychiatry*; 44:1191–1198.

Hawton K, Rodham K, Evans E. (2006). *By their own young hand: deliberate self-harm and suicidal ideas in adolescents.* London: Jessica Kingsley.

Hicks S and Newton J (2011*) Measuring Children and Young People's Wellbeing*. Office for National Statistics. http://www.chimat.org.uk/resource/item.aspx?RID=111308

HM Revenue and Customs (2011) *Technical information for the revised local child poverty measure.* http://www.hmrc.gov.uk/stats/personal-tax-credits/child-poverty-stats09-sept11.pdf

Homeless link: http://homeless.org.uk/

Home Office (2011) *Missing children and adults: A cross government strategy.* London. http://tinyurl.com/bowyx66

House of Commons (2000) *Health Committee Fourth Report. Provision of NHS mental health services.* London. The Stationery Office. http://www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/373/37307.htm

Hunt R and Jensen J (2007) *The School Report: The experiences of young gay people in Britain's schools.* Schools Health Education Unit and Stonewall. http://www.stonewall.org.uk/documents/school_report.pdf

Joloza T, Evans J, O'Brien R (2010) *Measuring Sexual Identity: An Evaluation Report*. Integrated Household Survey, Office for National Statistics, September 2010 http://tinyurl.com/7nabdt5

JRF (2008) *Monitoring Poverty and Social Exclusion*. Joseph Rowntree Foundation. http://www.jrf.org.uk/publications/monitoring-poverty-and-social-exclusion-2008

Kearney CA (2008) School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review*, 28, 3, 451–471 http://tinyurl.com/dyak2yu

Keenan K, Loeber R, Green S (1999) Conduct disorder in girls: A review of the literature: *Clinical Child and Family Psychology Review:* Vol2, No 1.

Kessler, R.C et al (1997) Social Consequences of Psychiatric Disorders, II: Teenage Parenthood, *American Journal of Psychiatry*: 154: 1405-1411

King's College London. Website accessed 23/10/12. *A General Practitioner's Guide to Eating Disorders* http://tinyurl.com/afhj8pv

Knowsley NHS (2011) *Knowsley Children and Young People's (C&YP's) Emotional Health, Wellbeing and Mental Health Needs Assessment*. DCFS Partnership Intelligence & Performance Team. Knowsley Children and Young People's Services.

Knowsley MBC (2012) *Risk taking behaviour: Final Report*. Knowsley MBC's Rights and Participation Team, Knowsley Young Advisors.

Levenson, R. & Sharma, A. (1999) *The Health of Refugee Children. Guidelines for Paediatricians.* Royal College of Paediatrics and Child Health. London http://tinyurl.com/ccn294f

LHO (2011) *Marmot Indicators for Local Authorities in England*. London Public Health Observatory and Marmot Review Team. http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

Liverpool Carers Joint Action Plan (available via google, 18/9/12)

Liverpool City Council (2010) *Liverpool City Green Infrastructure Strategy*. http://www.greeninfrastructurenw.co.uk/liverpool/

Liverpool City Employment Strategy (2012) http://www.liverpoolcitystrategyces.org.uk/

Liverpool City Region (2011) *Child poverty and life chances strategy 2011-2014.* http://www.liverpoolcitystrategyces.org.uk/projects/overview-of-what-is-being-done-to-tackle-child-poverty/

Liverpool PCT (2009) *Mental Health is Everyone's Business. The Joint Strategic Framework for Public Mental Health 2009–2012.* Department of Public Health, Liverpool PCT and Liverpool City Council. http://www.liverpoolpct.nhs.uk/Library/Your_PCT/Publications/JSFMH.pdf

Liverpool PCT (2012) *personal correspondence*. Tony Mercer/ Andrew Liu, 11/9/12

LSE (2011) *Mental health promotion and mental illness prevention: The economic case*. London School of Economics and the Department of Health. http://tinyurl.com/cpvh5sn

Local Solutions Link: http://www.localsolutions.org.uk/projects/Homelessness/

Manning V, Best DW, Faulkner N &Titherington E (2009) New estimates of the number of children living with substance misusing parents: results from UK national household surveys *Journal ofPublic Health* , 9 (1); 377-389 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2762991/pdf/1471-2458-9-377.pdf

Marmot (2010) *Fair Society, Healthy Lives*. The Marmot Review. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Marsden, R (1995) *Young carers and Education*. London Borough of Enfield, Education Department.

Maughan K (2010) *Halton and St Helens CYP Mental health and Emotional Wellbeing Strategy*. NHS Merseyside.

McAteer S (2011) *Housing & Health – Part 1. Evidence review – impact of housing on health and interventions to improve health through housing*. Halton and St.Helens NHS

McAteer S (2012) *Joint Strategic Needs Assessment: Looked After Children (Draft)*. NHS Halton & St Helens.

McAuley, C. & Davis, T (2009) Emotional wellbeing and mental health of looked after children in England. *Child & Family Social Work,* 14: 147–155.

McManus, S. et al., (2009). *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*., The NHS Information Centre for Health and Social Care. http://discovery.ucl.ac.uk/164862/.

Meltzer H, Gatward R; Corbin T, Goodman R, Ford T (2003) *The mental health of young people looked after by local authorities in England*. Office for National Statistics, London. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019442

MHF (1999) *Bright Futures: Promoting Children And Young People's Mental Health*. London: Mental Health Foundation. http://www.mentalhealth.org.uk/publications/bright-futures/

MHF (2006*). Truth hurts: report of the National Inquiry into self-harm among young people*. London: Mental Health Foundation http://www.righthere.org.uk/home/assets/pdf/Truth_Hurts.pdf

MHF (2007) *Fundamental facts. The latest facts and figures on mental health.* Mental Health Foundation, London. http://www.mentalhealth.org.uk/publications/fundamental-facts/

MHF (2002) *The Mental Health Needs of Homeless Young People; Bright Futures, Working with Vulnerable Young People*. Mental Health Foundation and Barnardos. http://tinyurl.com/cotjl4x

Micali, N et al. (2011) Is childhood Obsessive Compulsive Disorder a risk factor for eating disorders later in life? A longitudinal study. *Psychological Medicine* 41: 12 pp2507-2513

Moilanen, I. & Rantakollio,P. (1998) The single parent family and the child's mental health. *Social Science and Medicine* 27: 2 pp181-186.

Mooney, A., Oliver, C., Smith, M. Thomas (2009) Impact of Family Breakdown on Children's Well-Being. *Thomas Coram Research Unit, I*nstitute of Education, University of London, 2009

National CAMHs Support Service (2011) *Self-harm in children and young people handbook.* National CAMHs Support Service, National Workforce Programme. www.chimat.org.uk/resource/view.aspx?RID=105602

NEPHO (2008) *North East Public Health Observatory report on alcohol* http://www.nepho.org.uk/topics/Alcohol

New Economics Foundation (2008) *National Accounts of Wellbeing: bring real wealth onto the balance sheet.* http://www.nationalaccountsofwellbeing.org/learn/download-report.html

NHS Health Development Agency (2003) *Teenage pregnancy and parenthood: a review of reviews.* February 2003. http://tinyurl.com/btkpmyy

NHS (2008) *Statistics on Smoking, England 2008*. The NHS Information Centre for Health and Social Care. Health Survey for England 2007. Volume One Healthy Lifestyles: Knowledge, Attitudes and Behaviour.

NHS (2011) *Statistics on Smoking, England 2011.* The NHS Information Centre for Health and Social Care. Smoking, drinking and drug use among young people in England in 2010. http://www.ic.nhs.uk/pubs/smoking09

NICE (2004*) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.* National Clinical Practice Guideline Number CG9.. http://www.nice.org.uk/nicemedia/live/10932/29220/29220.pdf

NICE (2004) CG16 *Self harm: The short term physical and psychological management and secondary prevention of self harm in primary and secondary care.* Developed by the National Collaborating Centre for Mental Health. http://www.nice.org.uk/CG16

NICE (2005) *Health Needs Assessment: A practical guide.* National Institute for Health and Clinical Excellence. http://www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf

NICE (2006*) Routine postnatal care of women and their babies.* National Institute for Health and Clinical Excellence, Clinical guideline 37. http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf

NICE (2007a) *Antenatal and postnatal mental health: Clinical management and service guidance.* National Institute for Health and Clinical Excellence, Clinical guideline 45. http://www.nice.org.uk/nicemedia/live/11004/30432/30432.pdf

NICE (2007b) PH7 *School based interventions on alcohol; Interventions in school to prevent and reduce alcohol use among children and young people.* http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7

NICE (2007c) PH4 *Interventions to reduce substance misuse among vulnerable young people*: community based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. http://publications.nice.org.uk/interventions-to-reduce-substance-misuse-among-vulnerable-young-people-ph4

NICE (2008) PH12 *Promoting children's social and emotional wellbeing in primary education.* National Institute for Health and Clinical Excellence (NICE) http://www.nice.org.uk/nicemedia/pdf/PH012Guidance.pdf

NICE (2009a) PH20 *Social and emotional wellbeing in secondary education.* National Institute for Health and Clinical Excellence (NICE) http://tinyurl.com/brjojnz

NICE (2009b) PH17 *Promoting physical activity for children and young people.* National Institute for Health and Clinical Excellence. http://tinyurl.com/cyyrhns

NICE (2010a) *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors.* NICE clinical guideline 110. http://tinyurl.com/42wjnux

NICE (2010b*) Promoting the quality of life of looked-after children and young people*. NICE public health guidance 28. http://www.nice.org.uk/guidance/PH28

NICE (2011) *Self-harm: Longer term management.* National Institute for Health and Clinical Excellence. CG133 http://publications.nice.org.uk/self-harm-longer-term-management-cg133

Nicholls, D.E., Lynn, R., Viner, R.M (2011) Childhood Eating Disorders: British National Surveillance Survey. *The British Journal of Psychiatry.* 198: 295: 301.

NPIA (2011) *Missing Persons Data and Analysis Report 2009-10.* National Policing Improvement Agency Missing Persons Bureau. http://www.npia.police.uk/en/docs/Missing_Persons_Data_and_Analysis_2009-10.pdf

NSPCC (2009) *Child Protection research briefing: young people who self harm: implications for public health practitioners.* http://www.nspcc.org.uk/Inform/research/briefings/youngpeoplewhoselfharmpdf_wdf63294.pdf

NSPCC (2012) *Returning home from care: what's best for children.* http://tinyurl.com/d6clu4n

NSPCC*. Reunification of children home from care.* Weblink accessed 20/7/12: http://tinyurl.com/c7rl8ld

ONS (2000) *The mental health of children and adolescents in Great Britain.* Office for National Statistics on behalf of the Department of Health. http://www.dawba.info/abstracts/B-CAMHS99_original_survey_report.pdf

ONS (2005) *Mental health of children and young people in Great Britain 2004*, Office for National Statistics, London. http://www.esds.ac.uk/doc/5269/mrdoc/pdf/5269technicalreport.pdf

ONS. (2007)*Family resources survey: United Kingdom 2005 – 06.* London: Department for Work and Pensions

ONS (2008) *Three years on: Survey of the development and emotional well-being of children and young people.* Office for National Statistics, London. http://tinyurl.com/8b48hy4

ONS (2012a) General lifestyle survey overview: A report on the 2010 general lifestyle survey.

ONS (2012b) Lone parents with dependent children. http://www.ons.gov.uk/ons/rel/family-demography/families-and-households/2011/sum-lone-parents.html

ONS (2012c) *Measuring national well-being: Households and families.* Office for National Statistics. http://www.ons.gov.uk/ons/dcp171766_259965.pdf

Parkinson J (2012) *Establishing a core set of national, sustainable mental health indicators for children and young people in Scotland: Final Report.* NHS Scotland; Scot PHO; Healthier Scotland, The Scottish Government. http://www.healthscotland.com/documents/5878.aspx

PACT (2005) *Every Five Minutes: A Review of the Available Data on Missing Children in the UK.* Parents and Abducted Children Together. http://www.pact-online.org/images/stories/Documents/E5M.pdf

PATHS (2012) PATHS (Promoting Alternative THinking Strategies) Program. Online, accessed May 2012: http://www.channing-bete.com/prevention-programs/paths/paths.html

Perry G (2011) *Summary report on Pupil Perception Survey.* Sefton Borough Council and NHS Sefton

Place M, Hulsmeier J, Davis S, Taylor E (2000) School Refusal: A Changing Problem Which Requires a Change of Approach? *Clin Child Psychol Psychiatry,* 5, 3, 345-355. http://ccp.sagepub.com/content/5/3/345.abstract

Princess Royal Trust (2012) *Princess Royal Trust for Young Carers: Young Carer's Charter,* 2012 http://professionals.carers.org/young-carers/articles/young-carers-charter,3069,PR.html

RCM (2011) *Response to the Department of Health consultation - Healthy Lives, Healthy People: Transparency in outcomes. Proposals for a Public Health Outcomes Framework.* Royal College of Midwives, London.

Ridge M (2010) *Developing a mental health strategy for Gypsy Roma traveller communities.* Haringey Travelling Peoples Team, London.

Redmond SM, Hosp JL (2008) Absenteeism Rates in Students Receiving Services for CDs, LDs, and EDs: A Macroscopic View of the Consequences of Disability. *Language, Speech, and Hearing Services in Schools,* 39, 97-103 http://tinyurl.com/dxq2wx4

Refugee Council (2009) *Tell it like it is: The Truth about Asylum.* London: Refugee Council http://www.refugeecouncil.org.uk/Resources/Refugee%20Council/downloads/aboutus/Tell_it_like_it_is_23_March.pdf

Refugee Council (2010*) Refugee council briefing August 2010: Recent Developments Relating to the plans to return unaccompanied children to Afghanistan.* London: Refugee Council. http://tinyurl.com/bpxhz6x

Rohde, P., Noell, J.,Ochs, L. and Seeley, J. (2001) Depression, suicidal ideation and STD-related risk in homeless older adolescents.' *Journal of Adolescence*, 24, pp. 447 – 460.

Salmon G, Portwood J, Shabbaz A (2005) *Child and Adolescent Mental Health Services: A Health Needs Assessment for the City and County of Swansea.* http://tinyurl.com/d63upn9

Saunders JB, Aasland OG, Babor TF, De La Fuente JR, Grant M (1993) Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption-II. *Addiction*, 88, 6, 791–804. http://tinyurl.com/chd6sec

Save the Children (2012) *Child Poverty in 2012: it shouldn't happen here.* Save the Children, London.

SCIE (2004) *Preventing Teenage Pregnancy in Looked After Children.* SCIE Research briefing 9. Social Care Institute for Excellence, August. http://www.scie.org.uk/publications/briefings/files/briefing09.pdf

SCIE (2005) *Practice guide 5: Implementing the Carers (Equal Opportunities) Act 2004.* Social Care Institute for Excellence. http://lx.iriss.org.uk/content/practice-guide-5-implementing-carers-equal-opportunities-act-2004

Sefton MBC (2009) *Green Space Strategy for Sefton.* Sefton Metropolitan Borough Council. http://www.sefton.gov.uk/default.aspx?page=8817

Shaffer D, Gould MS, Fisher P, Trautman P. (1996) Psychiatric diagnosis in child and adolescent suicide. *Arch Gen Psychiatry*; 53:339–348

Shelter (2005) *Building for the futures-2005 update*. Shelter housing investment project series.

Simmonds, J., & Merredew, F (2009?) *The Health Needs of unaccompanied Asylum seeking children and young people*. British Association for Adoption and Fostering. NICE expert paper, EP23-LAC9.4.

Simon J, Schmidt U, Pilling S (2005) The health service use and cost of eating disorders. *Psychological Medicine*, 35 , pp 1543-1551

Sinclair S (2011) *My Views about Children and Young Peoples' Mental Health and Emotional Well Being (August -September 2011).* Liverpool City Council, Liverpool PCT.

Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H (2001) *Psychiatric Morbidity among adults living in private households, 2000*. London: The Stationery Office. http://tinyurl.com/d6o6p4j

Skuse D (2008) *Mental Capital and Wellbeing:Making the most of ourselves in the 21st century. State-of-Science Review: SR-D9. Social Cognition and School Exclusion*. Foresight Mental Capital and Wellbeing Project. Government Office for Science. http://www.bis.gov.uk/assets/foresight/docs/mental-capital/sr-d9_mcw.pdf

Stonewall (2010) *Education for all: Supporting lesbian, gay and bisexual young people* http://www.stonewall.org.uk/at_school/education_for_all/quick_links/education_resources/4534.asp

South Carolina DMH (Department of Mental Health). *Eating disorder statistics*. Website accessed 23/10/12 http://www.state.sc.us/dmh/anorexia/statistics.htm

Stansfield J (2012) *ChaMPs Mental Health Implementation Framework.* Cheshire and Merseyside Public Health Network. http://tinyurl.com/9uvng7p

Swann C, Bowe K, McCormick G & Kosmin M (2003) *Teenage pregnancy and parenthood: A review of reviews.* Health Development Agency. http://tinyurl.com/d5m8qay

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

TCRU (2008) *Disabled children: Numbers, Characteristics and local service provision*. Thomas Coram Research Unit, Institute of Education, University of London. http://tinyurl.com/bn7vgd8

Teenage Pregnancy Unit (2005) *Implementation of the teenage pregnancy strategy: progress report*, March 2005. Department for Education and Skills: London

Tellus4 (2010). *Tellus 4 survey for 2009. Summary.* National Foundation for Educational Research (NFER), 11th Feb. http://www.nfer.ac.uk/nfer/research/projects/tellus4/tellus4_home.cfm

The Learning Trust (2009) *Disability and Discrimination Guidance for Schools: What the Legislation Means for the School. How Schools Implement their Duties. Preparing Accessibility Plans*. The Learning Trust, Hackney. http://tinyurl.com/cz5nogb

TSO (2003) *Every Child Matters*. The Stationery Office. Green paper Cm5860. http://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf

Ubido J, Winters L (2010) *Healthcare needs assessment: Specialist intervention in safeguarding children across Merseyside - Final Report*. Liverpool Public Health Observatory report series no.75. http://tinyurl.com/d5gxhj7

UNICEF (2007). *Child poverty in perspective: An overview of child well-being in rich countries.* Innocenti Report Card 7. The United Nations Children's Fund (UNICEF) Innocenti Research Centre, Florence. http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf

Van Cleemput PV and Parry G (2001) Health Status of Gypsy Travellers. *Journal of Public Health Medicine*, 23, 2, 129-134. http://jpubhealth.oxfordjournals.org/content/23/2/129.full.pdf+html

Velleman R &Templeton L (2007) Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment* 13; 79–89 http://apt.rcpsych.org/content/13/2/79.full.pdf+html

Weare K (2010) Promoting mental health and preventing mental health problems through school settings. In Goldie I (ed) *Public Mental Health Today. A handbook* (pp 135-146). Brighton, Pavilion Publishing/Mental Health Foundation.

Whitehead, M., Burstrom, B., Diderichsen, F (2000) Social policies and the pathways to inequalities in health: a comparative analysis of lone mothers in Britain and Sweden. *Social Science and Medicine* 50 255-270 http://tinyurl.com/93r2r9x

Whitehead, M & Holland, P (2003) What puts children of lone parents at a health disadvantage? *The Lancet* 361, 9354, p271 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)12362-8/fulltext#article_upsell

WHO (2004) *Prevention of Mental Disorders, Effective Interventions And Policy Options.* World Health Organisation, Geneva. http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

Wrate, R. and Blair, C. (1999) 'Homeless Adolescents'. In: Vostanis, P. and Cumella, S. (eds), *Homeless Children: Problems and Needs* pp. 83-96. Jessica Kingsley, London.

Young R, Van Beinum M, Sweeting H, west P. (2007) Young People Who self-Harm. *British Journal of Psychiatry*; 191:44-49 http://bjp.rcpsych.org/content/191/1/44.short

Young Minds (2006) *Looking after Looked After Children: Sharing Emerging Practice.* Young Minds, London.

Youngminds (2012) *Young adults Statistics. Statistics about young adults with mental health problems.* http://www.youngminds.org.uk/training_services/policy/useful_statistic/young_adults_statistics

Youth Justice Board (2011) website accessed 14/9/12: http://tinyurl.com/bmhkxbs

Appendices

Appendix 1 Map indicator descriptions
Brief Description of Indicators used for Children's HNA Mapping – October 2012

Children in Poverty
Definition: The proportion of children living in families in receipt of out-of-work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income. To concur with National Statistics procedures all of the estimates within the publication have been independently rounded to the nearest 5 claimants.
Full guidance: http://www.hmrc.gov.uk/stats/personal-tax-credits/child-poverty-stats09-sept11.pdf

Child Wellbeing Index
Each of the 32,482 LSOAs in England has been assigned a score and rank for the CWI index; the seven domain indices; and the two sub domains. Each local authority district is assigned a score and a rank using a population weighted average of the score and rank for each LSOA within the local authority. Each (social service authority) is assigned a score and rank based on the population weighted score and rank for each LSOA within the social service authority.
Full guidance: http://www.communities.gov.uk/documents/communities/pdf/1126232.pdf

DLA claim rates among under 16s
The information in these datasets refer to numbers of claimants of individual DWP benefits and is derived from a 100% data source; the Work and Pensions Longitudinal Study (WPLS). Depending on the actual benefit, the datasets provide counts of total claimants of the main DWP benefits then desegregations by age, gender, duration on benefit and some benefit specific information. The data refer to a snapshot in time, and these snapshots are taken at quarterly intervals at the end of February, May, August and November.

All counts have been adjusted using a variant of controlled rounding to avoid the disclosure of any personal information. All cells have been rounded to base 5 and the total equals the sum of the disaggregation shown. Please note that any counts that are shown as zero may not be a 'real' zero.
Full guidance: http://83.244.183.180/NESS/BEN/Metadata%20for%20ORC.htm

Persistent Absenteeism
The figures presented here provide information about the absence of day pupils of compulsory school age (5-15 at the start of the school year) in maintained primary schools, maintained secondary schools, City Technology Colleges, Academies and maintained and non-maintained special schools (excluding general hospital schools) in England and who are resident in England. The dataset includes the total number of enrolments in all schools, the percentage of half days ('pupil sessions') missed due to authorised absence, unauthorised absence and overall absence, and the percentage of enrolments that are persistent absentees (PA) in all schools. Figures are also shown for maintained primary and maintained secondary schools and for boys and girls separately. Pupils who are boarders are not included in the dataset.

The definition of what constitutes a persistent absentee pupil has changed this year to be defined as a pupil who is absent for 46 or more sessions during the year. The previous definition was any pupil who was absent for 64 or more sessions during the year.
Full guidance:
http://www.neighbourhood.statistics.gov.uk/dissemination/MetadataDownloadPDF.do?downloadId=29927

Children in out-of-work benefit households
Data for children in out-of-work benefit households are derived by matching DWP benefit data with HMRC Child Benefit data. Children are matched through the Child Benefit claimant (i.e. parent or guardian), a customer of HMRC, where the Child Benefit claimant or the partner of a Child Benefit claimant is also a DWP benefit claimant. Care should be exercised in interpretation of the term out-of-work benefit household, which means that as least one parent or guardian is claiming an out-of-work benefit. A distinction needs to be drawn between households where no one in the family unit is working. For smaller geographies such as Ward and Lower Layer Super Output Area, figures are

independently rounded to five. The DWP strongly advise against creating proportions that include the age group 16-18, because for Child Benefit, entitlement for a particular child often ends at the age of 16. As a result, fewer young people aged 16-18 years are subsequently matched to DWP claimants. Therefore the under16 population is used.
Full guidance: http://statistics.dwp.gov.uk/asd/asd1/ben_hholds/cb_hholds_guidance.pdf

Income Deprivation Affecting Children (IDACI)
This covers only children aged 0-15 living in income deprived households, defined as either families receiving Income Support or income-based Jobseeker's Allowance or Pension Credit (Guarantee) or those not in receipt of these benefits but in receipt of Child Tax Credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs. The Income Deprivation Affecting Children Index is expressed as the proportion of all children aged 0-15 living in income deprived families.
http://www.communities.gov.uk/documents/statistics/pdf/1870718.pdf

Becky Williams, NHS Sefton, Oct 2012

Appendix 2: Sefton and Wirral school surveys

Sefton's school survey
Pupil Perception Survey (INTEC) 2011
The Sefton Pupil Perception Survey was based on Every Child Matters headings (TSO, 2003). There were 45 schools that completed the survey; 38 primary and 8 secondary, with a total of over 8,600 pupils (2800 secondary and 5800 primary). Sefton scored around or above national average for all aspects of the survey.

Locally and nationally a large proportion of pupils do not feel safe from other people when not at school (Sefton: 15.9% primary, 13.7% secondary) and when in school (5.6% primary, 12.3% secondary).

Bullying does not appear to be a significant issue in Sefton. Of all primary school pupils, 10.8% reported being bullied, which was less than the 14.5% nationally. When these cases were followed up, the majority were not serious. As pupils get older they do not report being bullied as much. In primary schools, more pupils from minority ethnic backgrounds report being bullied, with a figure higher than the national average.

The percentage of pupils who report feeling stressed or worried increases with age. By years 10 &11 approximately 40% of pupils are reporting that they feel stressed. This is not surprising due to the pressures of GCSEs and just being a teenager. Most pupils are able to cope with these levels of stress but there will be some who find it difficult and may need additional support.

Amongst secondary school pupils, 13.4% do not usually feel happy or content, compared with 12.9% nationally.

Even though nearly one third of pupils responding live in an area of deprivation, 91.2% primary & 80% secondary answered 'yes' to *'do you think you live in a nice place to grow up?'* (nationally 88.4% primary &, 82.9 secondary).

(Perry, 2011)

Wirral School HELP Survey
Health, Education and Lifestyle Profile Survey, 2012

3,792 children completed the survey (compared to 1,460 in the previous year). Results related to emotional wellbeing are summarised as follows:

Worries (all schools):
17.3% of girls and 27.6% of boys say 'nothing worries them'.
The top worry was school work and exams.

Feeling happy about life (secondary schools):
Girls: 61.7%
Boys: 69.9%

Feeling unsafe in the area they live:
17.8% felt a bit or very unsafe.

Bullying
Primary schools: 40% said they had been bullied at some time in school; 23.9% had been bullied in the last 4 weeks.
Secondary schools: 32.3% said they had been bullied at some time in school; 16.5% had been bullied in the last 4 weeks. 53.9% said the school deals quite or very well with bullying.

Appendix 3 IMD map

Index of Multiple Deprivation 2010 by Lower Layer Super Output Area

Index of Multiple Deprivation 2010 Score
- 56.3 to 83.1
- 38.4 to 56.3
- 22.8 to 38.4
- 12.8 to 22.8
- 2.9 to 12.8

Electoral Ward Boundaries (see table for labels)

Note: The higher the Score, the more deprived an area is.

Data Source: Department for Communities & Local Government.

Produced by Colin Wilson
Liverpool Public Health Intelligence Team

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Appendix 4: Deprivation in parishes

Small area analysis of deprivation factors – an example using parish areas.
The Church of England dioceses of Liverpool covers the whole of Merseyside, with the possible exception of Runcorn and is made up of 250 parishes. A recent Church Urban Fund (CUF) report found that nearly half (45%) of the Liverpool parishes are ranked in the 10% most deprived in England (Church Urban Fund, 2012, based on the Index of Multiple Deprivation 2010).

The CUF argue that parishes are arguably more 'natural' communities than local authority wards or census output areas used in most small area analyses. They noted that Britain is one of the most unequal countries in the western world, where children born within just a few miles of one another can have widely differing life chances and even life expectancies. For example in Widnes (part of Halton), levels of child poverty in Farnworth are 7%, while less than a couple of miles down the road in St.Pauls (Kingsway), nearly half (45%) of children are in poverty. Figure A1 gives further details.
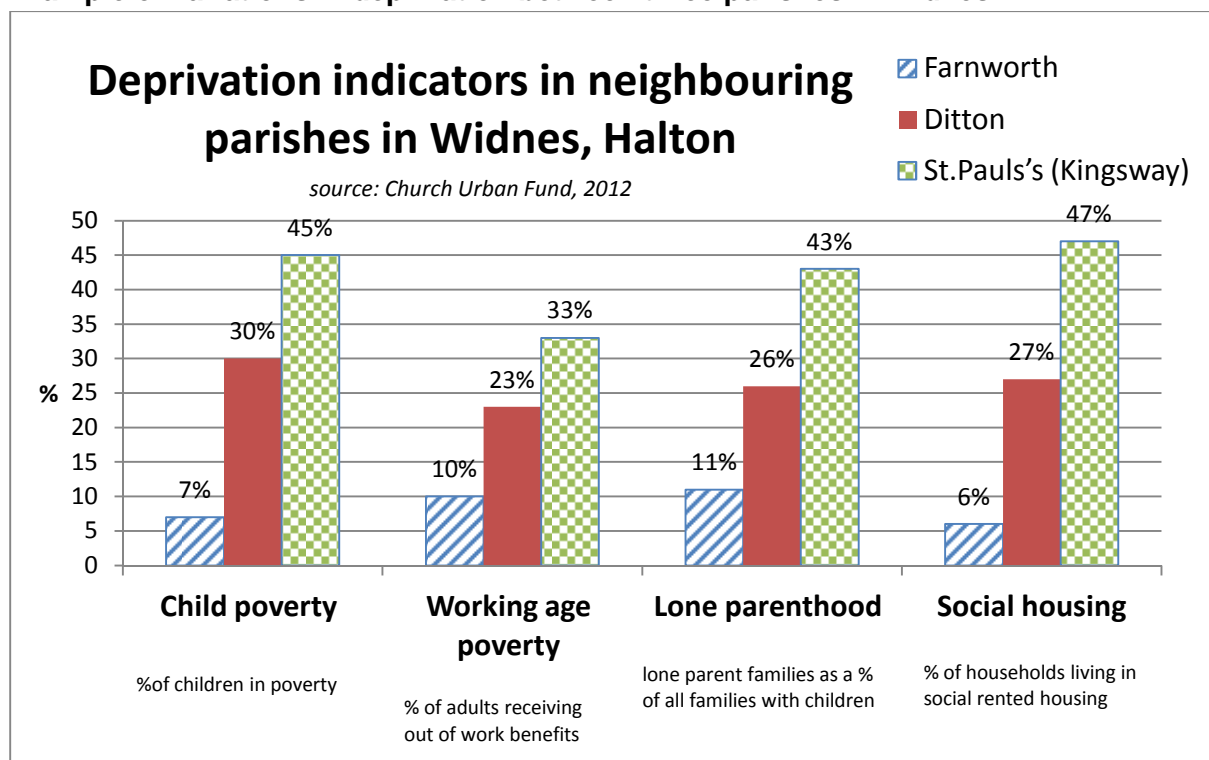
Figure A1
Example of variations in deprivation between three parishes in Widnes

Estimated populations: Farnworth 13,200; Ditton 15,000; St.Paul's 5,900.

It would be possible to do a chart like this for each parish/deanery in Merseyside. There are other indicators available, such as life expectancy; no qualifications (adults), etc.

Source:
Church Urban Fund (2012) Poverty in numbers: On-line poverty lookup for parishes in England. Church Urban Fund, England
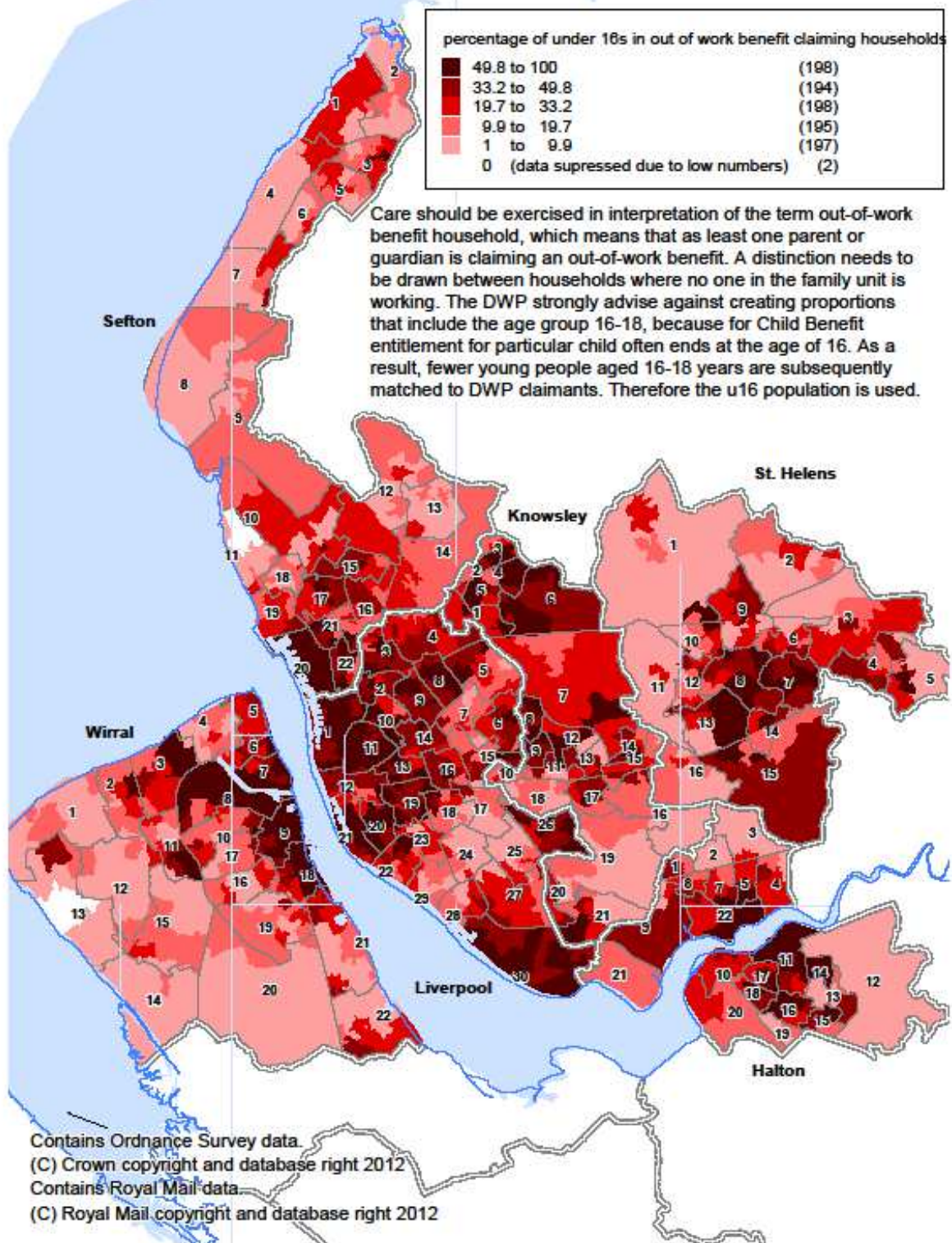*http://www.cuf.org.uk/sites/default/files/documents/Poverty_in_numbers_May12.pdf*

Appendix 5: Map of children in out-of-work benefit households

(key to wards on next page)

Percentage of children in out of work benefit claiming households by LSOA in Merseyside May 2011
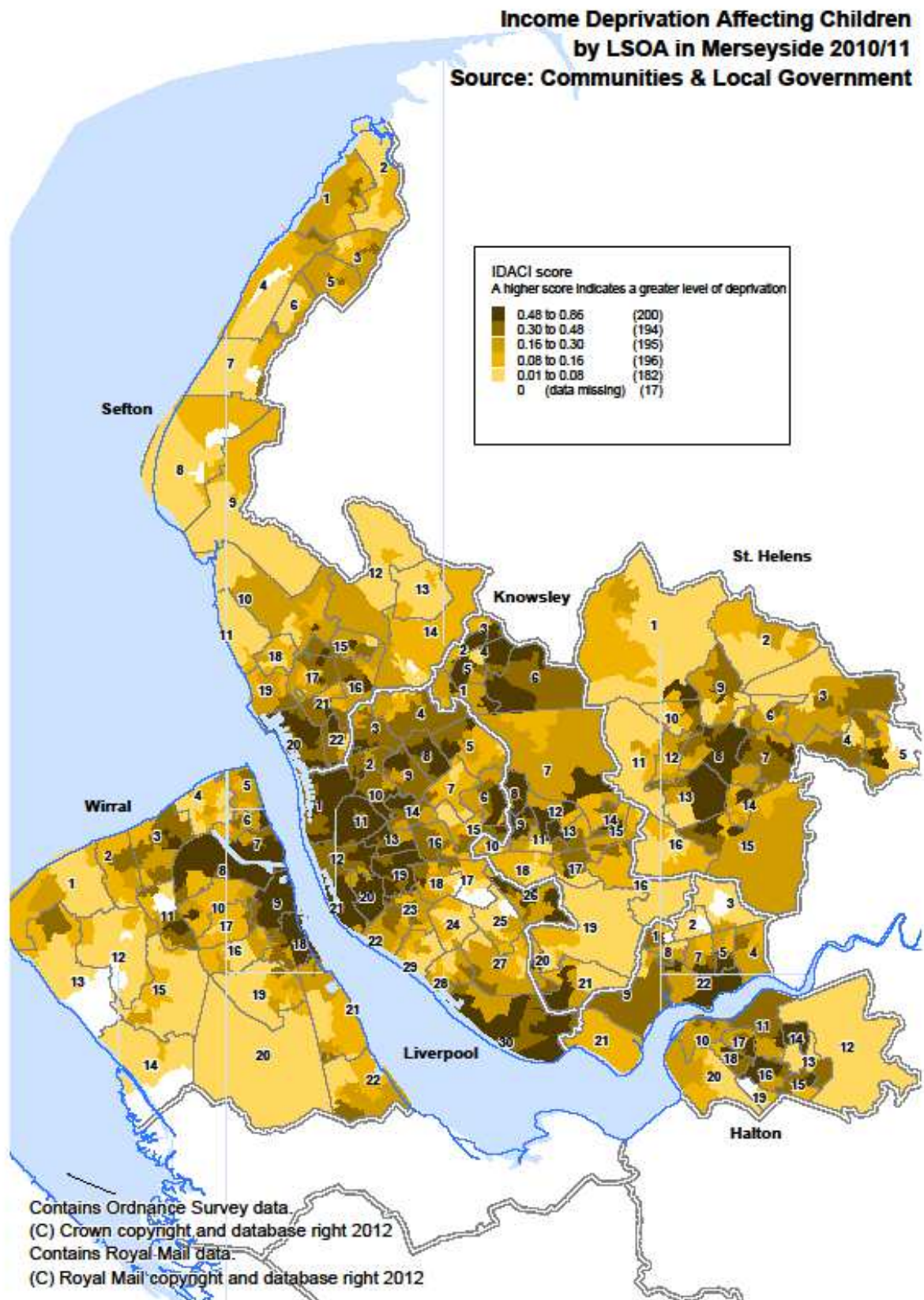Source: HMRC

Map Key for Appendices 5 & 6: Electoral wards in the Merseyside area

	Halton		**Liverpool**		**Sefton**
1	*HOUGH GREEN*	1	KIRKDALE	1	CAMBRIDGE
2	BIRCHFIELD	2	COUNTY	2	MEOLS
3	FARNWORTH	3	WARBRECK	3	NORWOOD
4	HALTON VIEW	4	FAZAKERLEY	4	DUKES
5	APPLETON	5	CROXTETH	5	KEW
7	KINGSWAY	6	YEW TREE	6	BIRKDALE
8	BROADHEATH	7	WEST DERBY	7	AINSDALE
9	DITTON	8	NORRIS GREEN	8	HARINGTON
10	MERSEY	9	CLUBMOOR	9	RAVENMEOLS
11	CASTLEFIELDS	10	ANFIELD	10	MANOR
12	DARESBURY	11	EVERTON	11	BLUNDELLSANDS
13	NORTON NORTH	12	CENTRAL	12	PARK
14	WINDMILL HILL	13	KENSINGTON AND FAIRFIELD	13	SUDELL
15	NORTON SOUTH	14	TUEBROOK AND STONEYCROFT	14	MOLYNEUX
16	HALTON LEA	15	KNOTTY ASH	15	ST OSWALD
17	HALTON BROOK	16	OLD SWAN	16	NETHERTON AND ORRELL
18	GRANGE	17	CHILDWALL	17	FORD
19	BEECHWOOD	18	WAVERTREE	18	VICTORIA
20	HEATH	19	PICTON	19	CHURCH
21	HALE	20	PRINCES PARK	20	LINACRE
22	RIVERSIDE	21	RIVERSIDE	21	LITHERLAND
	Knowsley	22	ST MICHAEL'S	22	DERBY
1	CHERRYFIELD	23	GREENBANK		**Wirral**
2	PARK	24	CHURCH	1	HOYLAKE AND MEOLS
3	SHEVINGTON	25	WOOLTON	2	MORETON WEST AND SAUGHALL MASSIE
4	NORTHWOOD	26	BELLE VALE	3	LEASOWE AND MORETON EAST
5	WHITEFIELD	27	ALLERTON AND HUNTS CROSS	4	WALLASEY
6	KIRKBY CENTRAL	28	CRESSINGTON	5	NEW BRIGHTON
7	PRESCOT WEST	29	MOSSLEY HILL	6	LISCARD
8	STOCKBRIDGE	30	SPEKE-GARSTON	7	SEACOMBE
9	PAGE MOSS		**St.Helens**	8	BIDSTON AND ST JAMES
10	SWANSIDE	1	RAINFORD	9	BIRKENHEAD AND TRANMERE
11	ST BARTHOLOMEWS	2	BILLINGE AND SENELEY GREEN	10	CLAUGHTON
12	LONGVIEW	3	HAYDOCK	11	UPTON
13	ST MICHAELS	4	EARLESTOWN	12	GREASBY FRANKBY AND IRBY
14	PRESCOT EAST	5	NEWTON	13	WEST KIRBY AND THURSTASTON
15	WHISTON NORTH	6	BLACKBROOK	14	HESWALL
16	WHISTON SOUTH	7	PARR	15	PENSBY AND THINGWALL
17	ST GABRIELS	8	TOWN CENTRE	16	PRENTON
18	ROBY	9	MOSS BANK	17	OXTON
19	HALEWOOD NORTH	10	WINDLE	18	ROCK FERRY
20	HALEWOOD WEST	11	ECCLESTON	19	BEBINGTON
21	HALEWOOD SOUTH	12	WEST PARK	20	CLATTERBRIDGE
		13	THATTO HEATH	21	BROMBOROUGH
		14	SUTTON	22	EASTHAM
		15	BOLD		
		16	RAINHILL		

Appendix 6: Map of Income deprivation affecting children (IDACI)

(key to wards on previous page)

Income Deprivation Affecting Children
by LSOA in Merseyside 2010/11
Source: Communities & Local Government

IDACI score
A higher score indicates a greater level of deprivation

	0.48 to 0.86	(200)
	0.30 to 0.48	(194)
	0.16 to 0.30	(195)
	0.08 to 0.16	(196)
	0.01 to 0.08	(182)
	0 (data missing)	(17)

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Appendix 7 Matrix of evidence based interventions

<table>
<tr>
<td colspan="6" align="center">Children and Young People's Emotional Health and Wellbeing Needs Assessment
Evidence Based Interventions Matrix</td>
</tr>
<tr>
<td></td>
<td colspan="4" align="center">Age Range</td>
<td></td>
</tr>
<tr>
<td align="center">Level of Need</td>
<td align="center">0-4 years</td>
<td align="center">5-10 years</td>
<td align="center">11-15 years</td>
<td align="center">16-19 years</td>
<td align="center">Source of Evidence</td>
</tr>
<tr>
<td rowspan="5" align="center">Tier 1 (universal)</td>
<td align="center">Healthy Child Programme 0-5</td>
<td colspan="3" align="center">Healthy Child Programme 5-19</td>
<td align="center">Ages 0-5:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf
Ages 5-19:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107566</td>
</tr>
<tr>
<td align="center">Routine postnatal care of women and their babies (includes 'mental health & wellbeing')</td>
<td colspan="3"></td>
<td align="center">http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf</td>
</tr>
<tr>
<td align="center">NICE CG110 Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors</td>
<td colspan="3"></td>
<td align="center">http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110</td>
</tr>
<tr>
<td align="center">Positive parenting -</td>
<td colspan="3"></td>
<td align="center">http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf</td>
</tr>
<tr>
<td></td>
<td colspan="3" align="center">NICE PH7 Schools-based interventions on alcohol</td>
<td align="center">http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7</td>
</tr>
</table>

	0-4 years	5-10 years	11-16	Source of Evidence
	'Resilience and Results: How to improve the emotional and mental wellbeing of children and young people in your school'. Guide for schools from the Children and Young People's Mental Health Coalition (2012).			http://tinyurl.com/93qpvuh
		NICE PH12 social and emotional wellbeing in primary education	NICE PH 20 social and emotional wellbeing in secondary education	http://publications.nice.org.uk/social-and-emotional-wellbeing-in-primary-education-ph12 http://publications.nice.org.uk/social-and-emotional-wellbeing-in-secondary-education-ph20
			NICE PH4 Interventions to reduce substance misuse among vulnerable young people	http://publications.nice.org.uk/interventions-to-reduce-substance-misuse-among-vulnerable-young-people-ph4
	NICE PH17 Promoting physical activity for children and young people			http://publications.nice.org.uk/promoting-physical-activity-for-children-and-young-people-ph17
	Training for non-mental health professionals			http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
	NICE CG45: Antenatal and postnatal mental health/depression *(overlaps into Tier 2)*			http://publications.nice.org.uk/antenatal-and-postnatal-mental-health-cg45
Tier 2 (targeted)	Family Nurse Partnership Programme			http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf
	NICE CG89 When to suspect child maltreatment			http://publications.nice.org.uk/when-to-suspect-child-maltreatment-cg89
	NICE TA102 Parent-training/education programmes in the management of children with conduct disorders			http://publications.nice.org.uk/parent-trainingeducation-programmes-in-the-management-of-children-with-conduct-disorders-ta102

5-10 years	5-19	Source of Evidence
NICE PH28 Looked After Children		http://publications.nice.org.uk/looked-after-children-and-young-people-ph28
NICE CG128 Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum		http://publications.nice.org.uk/autism-diagnosis-in-children-and-young-people-cg128
NICE CG28: Depression in children and young people: Identification and management in primary, community and secondary care		http://publications.nice.org.uk/depression-in-children-and-young-people-cg28
Talking therapies: A four-year plan of action. Department of Health, 2011:		http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123759
Tier 3 (specialist)	Family Nurse Partnership Programme		http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf
	NICE CG16 Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	http://www.nice.org.uk/guidance/CG16 *note on short & long term self harm guidance:* no age group given although likely to cover from 11years onwards mostly. Guidance covers any age of person who self harms, child or adult.
Tier 4 (highly specialist)	NICE 131 Self-harm: longer-term management		http://publications.nice.org.uk/self-harm-longer-term-management-cg133
	NICE CG77 Antisocial personality disorder. Although mostly about treatment of adults it does include prevention amongst children & adolescents	http://publications.nice.org.uk/antisocial-personality-disorder-cg77
NICE CG72 Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults		http://publications.nice.org.uk/attention-deficit-hyperactivity-disorder-cg72

Hopefully you have found the report useful and informative. Once you have had time to look at it, we would really appreciate your feedback - please answer four very quick questions by clicking this link:

http://www.surveymonkey.com/s/KP86DMZ

Liverpool Public Health Observatory

Department of Public Health and Policy
Whelan Building
Quadrangle
University of Liverpool
Liverpool L69 3GB

Tel: 0151 794 5570/81
Fax: 0151 794 5588
E-mail: obs@liv.ac.uk
WWW: http://www.liv.ac.uk/PublicHealth/obs

UNIVERSITY OF
LIVERPOOL