Cornwall & Isles of Scilly Comprehensive Child and Adolescent Mental Health Needs Assessment

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Executive Summary

Section 1. Introduction
The aim of this project is to assess the need for emotional wellbeing and mental health services for under 18 year olds in Cornwall & Isles of Scilly and provide recommendations for commissioners to inform local service development, future commissioning of services and future emotional well-being strategy for young people in Cornwall & Isles of Scilly. The identification of priorities for action will support the process of allocating resources to improve health and reduce inequalities.

The main objectives of this needs assessment are to:

- determine the evidence of effective intervention, using national and local policies and guidance
- describe the epidemiology of Mental health problems in Cornwall & Isles of Scilly
- identify current universal, targeted and specialist mental health services available and identify gaps in provision
- identify mental health services that work directly with children and young people, their parents, families, schools and communities
- understand needs and demands by obtaining service users and provider’s views
- identify existing provision and determine commissioning priorities for planning
- provide recommendations based on the gaps, priorities and changes to meet the needs and demands of the population

For the purpose of this needs assessment the term mental health is used to encompass the breadth of experience from emotional and social well-being through to mental ill health, distress and disorder.

Mental health and emotional and social well-being problems in children and young people are associated with a number of factors in relation to: the environment and community in which they live; their parenting and family life; and individual factors such as biology and genetics.

The causes of mental illness are extremely complex; and physical, social, environmental and psychological causes all play their part. We know that problems are unevenly distributed across the population and that some individuals, groups and even communities have an increased likelihood of poor mental health than others. Understanding risk factors can help with targeting resources in numerous ways from prioritising groups to targeting settings for preventative work.

It is recognised, then, that in order to promote mental health and prevent and alleviate mental health difficulties it is vital to help not only the child, but to help their parents, families, schools and communities in which they live, as they all contribute to a child’s development and well-being.

Mental health and mental ill-health can be thought of as occurring on a continuum which requires a continuum of service provision.

This document will make a distinction between universal, targeted and specialist mental health interventions for children and young people.
**Universal interventions** are those which are available to ALL children and young people, promoting and supporting mental health and psychological well-being through the environment and relationships they have with children.

**Targeted interventions** are those which focus on children and young people with specific needs because of the circumstances in which they live; children with additional needs due to physical, learning and sensory disabilities; and children with mild to moderate mental health needs. This includes Children in Need and Children with Disabilities.

**Specialist interventions** are those which focus on children and young people with complex, severe or/and persistent mental health difficulties. It includes children who have been removed from their birth families for their safety and development. Thus, Looked After Children and those living in specialist residential, secure, educational, in-patient and rehabilitation units, within and outside Cornwall.

Assumptions around the continuity of care, multi-agency working and strategic planning are highlighted in order to tackle misunderstandings and provide clarity. It is appreciated that services will have different priorities but finding a shared language is essential.

**Section 2. What Works for Whom?**
The term ‘evidence-base’ is frequently used and can refer to anything from feedback from service users, an expert’s opinion to a meta-analysis.

As we become increasingly dependent on reviews of the evidence base, and good practice guidelines it is important we attend to the details within these reports if we are to remain critical, creative and sensitive to local needs and develop services appropriately.

The evidence for early, whole school and targeted mental health interventions is limited. There is not yet a good research base that demonstrates the effectiveness of: earlier or later interventions; universal, targeted or indicated levels of intervention; and the most robust service provision model required.

Definitions of Evidence-Based Practice (EBP) reiterate the importance of using the evidence base, alongside professionals’ expertise and patients’ contexts and preferences.

Practice-Based Evidence (PBE) involves practitioners and services evaluating their practice by measuring outcomes and modifying their practice as a result of reviewing these evaluations.

There are a number of key policy reports and reviews that provide essential information regarding the provision of services, these are: The Healthy Child Programme, The Targeted Mental Health in Schools project, Early Intervention: The Next Steps, No Health without Mental Health and Talking Therapies: a four-year plan of action.

There are a significant number of National Institute for Clinical Excellence (NICE) guidelines that relate directly to children and young people’s mental health and well-being. Thirty-four guidelines are listed in the report. Although these guidelines are valuable in terms of informing practice, it must be appreciated that psychiatric diagnoses and children’s mental health can be a fraught field with experts and
professionals holding a variety of positions relating to the causes of and best responses to mental health difficulties. Additionally, many children and young people either don’t quite meet the criteria for a specific psychiatric diagnosis or meet the criteria for a number of diagnoses. The ‘disorder-specific’ nature of NICE guidelines can be seen as oversimplifying mental health problems and insensitive to the complexities and messiness of real life.

Drawing together conclusions from the variety of NICE guidelines and being respectful of differences in views and practice to produce a coherent social and emotional well-being strategy is bound to be an ongoing and challenging exercise.

The problem is not lack of information, but firstly finding the time to access and keep abreast with the information; secondly, reflecting on how robust the information is; thirdly, deciding on how to use the information to improve practice; fourthly, how to implement evidence-based practice so that it has every chance of success at a local level; and finally, how to sustain good practice so that it is responsive to a constantly changing environment.

There are a number of universal, targeted and specialist interventions or programmes for which there is a good evidence-base regarding their effectiveness. The impact of any programme, however, can be eroded if fidelity to the programme is not maintained and reviewed.

Section 3. Epidemiological Needs Assessment – population statistics
There are an estimated 102,971 children and young people aged less than 18 years currently resident in Cornwall & Isles of Scilly. Of these children 27,671 (26.9%) are aged 0-4 years; 31,811 (30.9%) are aged 5-10 years; and 43,489 (42.2%) are aged 11-17 years.

According to the ONS population projections, the population of 0-18 year olds in Cornwall & Isles of Scilly is projected to increase by 10.6% for males and 11.84% for females by 2021 from the 2011 base

There are 149 county rankings for the Child Health and Well-being index, with 1 being the best and 149 being the worst in the rankings. Cornwall & Isles of Scilly features in the worst quintile only for the domain of housing at 127 out of 149. Overall, Cornwall and the Isles of Scilly is ranked 69th, so is very much in the middle of the overall rankings.

The 2012 Child Health Profile indicates that 19.1% of young people under the age of 16 live in poverty in Cornwall & Isles of Scilly

Data from the Annual School Census on 19th January 2012 shows that Cornwall and the Isles of Scilly have: 2 nursery schools with 149 pupils; 236 primary schools with 38,083 pupils (of which 27 were academies with 7,354 pupils); 31 secondary schools/academies with 31,315 pupils; 4 special schools with 362 pupils; 12 independent schools with 2,497 pupils.

There were 14,755 young people with Special Educational Need (SEN) in Cornwall & Isles of Scilly schools, of which 1,982 (2.8%) pupils had Statements of SEN.

National subjective well-being surveys indicate that approximately 90% of children are happy with their lives. Age is the strongest predictor of happiness with 4% of eight year olds reporting low well-being compared to 14% of 15 year olds.
Prevalence surveys indicate that approximately 10% of children aged 5 to 16 years of age have a clinically diagnosed mental disorder. Conduct disorders are the most common (6%), followed by emotional disorders (4%). Boys are more likely to report the former and girls the latter. Mental disorders can be fairly persistent with 30% of children continuing to have emotional disorders after three years and 43% of those with conduct disorders.

One fifth of children with mental disorders have multiple disorders (i.e. more than one diagnosis). Almost a third of young people aged 11-16 years with an emotional disorder said that they had tried to harm themselves. Children with mental disorders are also more likely to smoke, drink alcohol and use drugs.

It can be estimated that at any one time C&IOS will have 4,429 children aged 5 to 17 years with a conduct disorder and 2,937 with an emotional disorder.

Some children are more vulnerable or at risk of mental health difficulties, in particular: children who have been abused, children with learning disabilities, young offenders and Children in Care.

It can be estimated that in C&IOS there are 1,029 young people aged 11-16 years who experience severe neglect, 296 of whom are likely to have a mental disorder.

It can be estimated that in C&IOS there are 1,816 children and young people with a learning disability, 654 of whom are likely to have a mental disorder.

It can be estimated that in C&IOS there are 710 young people known to the Youth Offending Service, 220 of whom are likely to have a mental disorder.

It can be estimated that in C&IOS there are 480 Children in Care, 216 of whom are likely to have a mental disorder.

It was identified that nationally research is revealing an increased recognition of problems in the 0 to five year cohort and we should be aware of this.

Both our epidemiological investigation and feedback from the consultation exercise has recognised that self-harm is a significant issue that needs to be addressed.

It must be remembered that approximately 90% of children and young people report they are happy and satisfied with their lives.

**Section 4. Epidemiological Needs Assessment – mapping services in Cornwall and the Isles of Scilly**

Interventions and services were organised in terms of whether they could be classified as universal, targeted or specialist interventions.

Interventions were also organised in terms of whether their focus was on working directly with children and young people, directly with parents or directly with families and wider systems such as schools and local communities.

Service providers were contacted and asked to provide basic information, such as who their service was for, how many staff they employed, how many clients they worked with per annum and the strengths and limitations of service for children and young people.
A total of 43 types of services and interventions were identified that worked directly with children and young people: 11 Universal, 25 Targeted and 7 Specialist.

A total of 32 types of parenting interventions and services were identified: 5 Universal, 26 Targeted and 1 Specialist.

A total of 37 types of interventions and services with a family or whole systems approach were identified: 12 Universal, 19 Targeted and 6 Specialist.

It is difficult to assess the provision and quality of PHSE education across primary and secondary schools.

Many professionals across a variety of services have been trained in evidence based programmes and interventions, but the delivery of these programmes is patchy with the need of better strategic and operational planning.

It is often difficult to establish accurate numbers and statistics around number of children, young people, parents and families who have accessed courses, interventions and programmes.

There is lack of local evaluation – although evidence based programmes are often promoted, fidelity to these programmes is less attended to along with the measuring of outcomes.

It has not been possible to find out more detailed information that may help to establish the quality of programmes (e.g. level of training, supervision, competency).

It is difficult to establish the level of success in working with ‘hard to reach’ families; ‘

It is difficult to establish the extent to which services were ‘hard to access.’

Parenting interventions tend to be Targeted with fewer Universal or Specialist interventions available. This may be experienced as a shortfall of support especially for parents of children with disabilities and severe and complex mental health problems.

Many Targeted interventions are time-limited and only available to children with additional needs.

Many Targeted interventions provided by the voluntary sector are only free of charge to children, young people and families if another service (e.g. the local authority, schools and colleges) agrees to pay for it. These services have limited budgets so often a number of sessions are paid for and anything beyond this may need to be funded by families themselves.

Many Specialist interventions are free of charge, but choice is very limited and progress with developing the psychological therapies strategy within specialist CAMHS is unclear.

Schools take a lead in providing universal services that are directed at children and young people and attending to the context in which children learn - the whole school environment.

Voluntary and private sectors play an important role in providing universal counselling and advice services. However, these services are aimed at young people
(i.e. secondary school aged children) and there little available to younger children outside the school system.

Cornwall Council takes a lead in providing parenting programmes and supporting Children in Need, Children with Disabilities and Children in Care.

NHS Kernow take a lead in commissioning specialist psychological interventions for children and young people with mental health difficulties, which is currently provided by Cornwall Partnership NHS Foundation Trust (CFT).

The following gaps in service provision were identified:

- Universal parenting programmes
- Targeted and specialist interventions for children and young people with learning disabilities and challenging behaviours;
- Longer term or on-going Targeted services for children, young people, parents and families;
- Targeted service for children and young people with mild to moderate mental health problems;
- Specialist mental health services for preschool children (under 5 years);
- Specialist inpatient mental health services for children and young people in Cornwall;
- Specialist rehabilitation provision for young people with substance misuse problems;
- Specialist direct work with Children in Care, especially those in residential settings;
- Specialist parenting programmes for parents with children and young people with severe and complex mental health problems;

Section 5 Corporate Needs Assessment – the views of stakeholders
The views of stakeholders were gathered in a number of different ways:

1) Electronic surveys for young people, parents and professionals;
2) Focus Groups carried out by Hear Our Voice with service users;
3) Consultation events for children and young people and professionals.

The online surveys were publicised in a number of newsletters targeted at young people, parents and professionals. The surveys were live from 18 December 2012 to 28 March 2013. In total, 139 young people, 73 parents and 188 professionals replied to the electronic surveys. These numbers are obviously small and are not representative of the population of Cornwall. It is not possible to provide response rates to the survey as the questionnaires were not sent directly to individuals. It is important that findings from the surveys are treated with caution as it is likely that the sample is biased.

In all three surveys a very small proportion of respondents had direct experience of specialist CAMHS, either as a service user or provider. It must also be noted that children under 11 years of age have not been represented in these surveys. It is also
likely that these surveys were not accessible to children, young people and adults with disabilities and those without computers.

Although electronic surveys may appear to provide easy access to a large groups of people their significant shortcoming is they are a very impersonal approach and by far the majority of people choose to ignore such surveys, which makes any findings from the data difficult to generalise to the whole population.

It would be much more informative to target and sample specific groups of people, using a more personalised approach and follow-up procedures, with the aim of getting good response rates from which we can be more confident about generalising and learning from.

In contrast the second and third ‘Hear Our Voice’ consultation events provided excellent user feedback on a number of services at varying levels of access.

Section 6 Comparative Needs Assessment – the provision of services in Cornwall compared to national recommendations

This section draws together the findings from the previous sections in terms of our understanding of the evidence base, the local population, current service provision and professionals and clients experiences of these and how they can be developed.

It identifies how many recommended interventions, drawn from the evidence-base, are available to the C&IOS population. It also attempts to identify strengths and how these can be further developed and gaps and what interventions to prioritise.

It will reiterate the central message that there is no health without mental health and we all have a part to play in living in communities that sustain our emotional and social well-being.

In terms of interventions that focus on working directly with children and young people, there are few recommended interventions at the universal and targeted levels, but most specialist interventions are available in Cornwall.

In terms of interventions that focus on working with parents, the opposite is the case with a number of recommended interventions available at the universal and targeted levels, but none available at the specialist level. Indeed it was hard to identify a recommended parenting intervention that was geared towards supporting parents with children with severe and complex mental health difficulties or Children in Care.

In terms of interventions that focus on working with the whole family, school or local community, a similar pattern was found with a number of interventions available at the universal and targeted levels, but few at the specialist levels.

Within C&IOS recommended universal services tended to be available at the whole family, school or community level; recommended targeted interventions tend to be available for parents and families as a whole; and recommended specialist services tend to be available for children and young people. There is, then, patchiness in the provision of recommended interventions at different levels of intervention.

The following principles are suggested for any strategic and operational policies and procedures regarding children and young people’s emotional and social well-being and mental health:

- Intervening at multiple levels: universal, targeted and specialist;
• Collaborating with all stakeholders: children/young people, parents/carers and family/school/community;
• Taking a developmental perspective and preparing for transitions at three stages of development: foundation (0-4 years), primary (5-10 years) and secondary years (11-18 years);
• Addressing the service-need gap so that effective interventions reach those most in need;
• Acknowledging that some children, parents and families will require longer-term or on-going support to reach their potential;
• Embedding evaluation into practice so that services are constantly monitoring impact;
• Supporting creative and collaborative practice so that services are sensitive to local needs and real choice is built into systems;
• Focusing on the quality of relationships and respectful engagement of all service providers (private, voluntary and statutory) and the local population.
Section 1: Introduction to Comprehensive Child and Adolescent Mental Health Services Needs Assessment

1.0 Outline of the report
This report consists of six sections. This first section is the introduction and will provide information on the main components of a health needs assessment, the aims of objectives of the report, definitions of mental health and well-being, factors associated with risk and resilience in children’s development, the different levels of service provision (universal, targeted and specialist) and issues around continuity of care and multi-agency working.

The term mental health is used throughout this report to encompass the breadth of experience from emotional and social well-being through to mental ill health, distress and disorder. Each of the sections will follow a similar format and start with well-being, then move on to children and young people with additional and specific needs and end with those where there are concerns about the presentation of specific mental disorders.

The second section provides a review of the evidence-base to assess what is already known about interventions that are effective in supporting children and young people’s mental health and ameliorating mental health difficulties. It starts with a discussion of the evidence-base and evidence-based practice. It then summarises findings from the most recent and key national policy papers, reports and reviews. Reference is made to The Healthy Child Programme, Targeted Mental health In Schools, Early Intervention, No Health without Mental Health and Talking Therapies: a four year action plan. It includes a list of relevant guidelines from the National Institute of Clinical Excellence (NICE) and concludes with some of the strengths and limitations associated using the evidence-base to develop services.

The third section draws on epidemiological research to provide accurate estimates of prevalence of mental health and mental health disorders among children and young people in Cornwall and the Isles of Scilly. Population statistics are combined with prevalence estimates from research in order to calculate the likely level of demand for mental health interventions in Cornwall. Particular attention is also given to the numbers of children and young people who are in groups known to be vulnerable to mental health difficulties, such as those who have been abused, those with learning disabilities, young offenders and Children in Care.

The fourth section details service provision in Cornwall and the Isles of Scilly. It maps out service provision according to level of intervention (Universal, Targeted and Specialist) and the focus of the intervention: direct work with children and young people; direct work with parents; and direct work with families, schools or local communities. It provides an overview of the services available, their strengths and limitations and where gaps in service provision exist.

The fifth section provides evidence from the consultation exercises with stakeholders, which include children and young people, parents and professionals. Stakeholders were approached in a number of ways: electronic surveys, consultation events, personal communications and focus groups. This section summarises the key points raised by stakeholders regarding local needs and service provision.

The sixth section brings together findings from the previous sections. It attempts to identify how many recommended interventions, drawn from the evidence-base, are available to the C&IOS population. It also attempts to identify strengths and how
these can be further developed and gaps and what interventions to prioritise. It also looks at service provision across three age groups – the under 5s (0-4 years), primary school (5-10 years) and secondary school (11-17 years) aged children and young people. It will reiterate the central message that there is no health without mental health and we all have a part to play in living in communities that sustain our emotional and social well-being.

1.1 Health Needs Assessment
Health needs assessment is the systematic review of the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. There are three components to a full healthcare needs assessment, which include:

1. **Epidemiological needs assessment**: This approach uses a wide range of data to determine or estimate the incidence and prevalence of disease, disorders, behaviours etc locally; to assess the effectiveness and cost effectiveness of services or interventions; to identify our existing services and possible gaps.

2. **Corporate needs assessment**: This approach seeks to understand and examine the views of key stakeholders in relation to CAMHS in Cornwall & Isles of Scilly e.g. young people, parents, clinicians etc. These views help to identify gaps and priorities to inform service development and improvement.

3. **Comparative needs assessment**: This approach seeks to compare our services with national guidance on best practice; it may also seek to compare our service provision with other similar areas where possible.

This report will attend to all three components: the epidemiological needs assessment is provided in Sections 3 and 4; the Corporate needs assessment in Section 5; and the Comparative needs assessment in Sections 2 and 6.

1.2 Aim
The aim of this Cornwall & Isles of Scilly Child and Adolescent Mental Health (CAMHS) needs assessment is to assess the need for mental health services for under 18 year olds in Cornwall & Isles of Scilly and provide recommendations for commissioners to inform local service development, future commissioning of services and future emotional well-being strategy for young people in Cornwall & Isles of Scilly. The identification of priorities for action will support the process of allocating resources to improve health and reduce inequalities.

1.3 Objectives
The objectives of this needs assessment are:
- To seek evidence of the effectiveness of interventions for Mental Health (MH) difficulties and identify relevant national and local policies; guidance and evidence of effective interventions
- To describe the epidemiology of MH difficulties among children and young people aged under 18 years of age in the Cornwall & Isles of Scilly
- To identify current MH services available in Cornwall & Isles of Scilly in order to identify any gaps in service provision
- To obtain the views of service users and providers in order to identify felt needs and demands
To identify the resources available and determine priorities for planning and commissioning to improve mental health and well-being in children and young people living in Cornwall & Isles of Scilly

To make recommendations on gaps, priorities and changes needed to optimise the delivery of mental health and well-being services for children and young people living in Cornwall & Isles of Scilly

1.4 Definitions of Mental Health
Mental health is defined by the World Health Organisation as ‘a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’

The term mental health is often used to encompass all aspects from mental well-being through to mental ill health. As such it is not possible to have just one single definition of mental health.

The Foresight reports published in 2008 recognise this complex nature and describe mental health in relation to ‘positive mental health’ and ‘mental ill health.’ They describe positive mental health as:

‘a positive sense of well-being; individual resources including self-esteem, optimism, and sense of mastery and coherence; the ability to initiate, develop and sustain mutually satisfying personal relationships; and the ability to cope with adversity (resilience). Together, these enhance the person’s capacity to contribute to family and other social networks, the local community and society at large. Thus, mental health is more than just the absence of symptoms or distress. It refers to a positive sense of well-being and a belief in our own worth and the dignity and worth of others.’

‘Positive mental health includes the capacity to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary, to think and speak coherently, and to communicate with one another. It also affects our ability to cope with change, transition, and life events such as the birth of a child, unemployment, bereavement or physical ill health. Thus, mental health and physical health are closely interlinked and are both essential components of general health in the individual.’

When adults begin to have concerns about children and young people’s well-being the terminology used can vary from service to service. Thus, the educational service tends to refer to children with behavioural, emotional, social and learning difficulties; social care services tends to refer to children with different levels of need; and mental health services tend to refer to children as having specific mental health disorders. There is an agreement between services that mental health difficulties present on a continuum of severity, need and consequent level of intervention. However, there may be disagreements about the nature of the mental health difficulty (i.e. diagnosis or formulation) and the appropriate level of intervention.

Within Specialist Mental Health Services mental health difficulties are classified according to two diagnostic manuals (ICD-10 and DSM IV), with distinctions made between:

- Disorders of psychological development (e.g. learning disabilities and Autistic Spectrum Disorder)
- Sleep, toileting and somatic problems
- Emotional disorders (e.g. anxiety, phobias, obsessive compulsive disorders, tics and depression)
- Conduct disorders (e.g. oppositional and defiance, anti-social behaviour, aggressive, destructive and/or deceitful behaviours and violation of rules)
- Hyperkinetic disorder (e.g. difficulties with attention, ADHD)
- Attachment disorders (e.g. difficulties with emotional and social development)
- Substance misuse problems (e.g. alcohol and drug misuse)
- Eating disorders (e.g. anorexia nervosa, bulimia nervosa, obesity)
- Trauma disorders (e.g. PTSD, complex trauma, developmental trauma)
- Psychoses (e.g. schizophrenia, drug-related)
- Gender identity disorders of childhood (e.g. gender dysphoria, transgender)

These disorders may first present as emerging behavioural, emotional, social and learning difficulties. It is important to note that there are some very distressing behaviours (e.g. self-harming, suicide attempts, social withdrawal, bullying and abuse), that cause children, young people and adults a great deal of concern that do not have a medical label or diagnosis or quite fit a medical diagnosis. These sorts of behaviours require a multi-agency response, rather than ‘signposting’ to a specific or specialist service provider as no one service is likely to be able to address the factors underpinning these behaviours and the wide-ranging consequences they often have.

1.5 Risk and Resilience Factors
Mental health and emotional and social well-being problems in children and young people are associated with a number of factors in relation to: the environment and community in which they live; their parenting and family life; and individual factors such as biology and genetics. Figure 1.0 highlights both the risk factors associated with poor mental health outcomes and the protective factors associated with good mental health outcomes, as evidenced in research. The likelihood of experiencing poor outcomes increases as the number of risk factors that the child or young person experiences increases.

The causes of mental illness are extremely complex; and physical, social, environmental and psychological causes all play their part. We know that problems are unevenly distributed across the population and that some individuals, groups and even communities have an increased likelihood of poor mental health than others. Understanding risk factors can help with targeting resources in numerous ways from prioritising groups to targeting settings for preventative work. Resilience refers to the way in which individuals or groups navigate stressful and challenging life circumstances and maintain their well-being in spite of threats to their growth or development. It’s about overcoming the odds, coping and recovering and it develops over time.

It is important to understand that even where individuals may share several risk factors they may be very different in terms of their resilience. In other words, some people are better able to manage or bounce back from risk and adversity in their lives than others. Theoretical frameworks that have guided resilience research over the past 40 years include: the three level model which looks at ‘protective and risk’ factors within the community, family or young person; the ecological model that examines the influence of culture and neighbourhood on the young person; and the structural organisational perspective, which views individual choice and self-organisation as important as other factors to building resilience competence over time.
It is recognised, then, that in order to promote mental health and prevent and alleviate mental health difficulties it is vital to help not only the child, but to help their parents, families, schools and communities in which they live, as they all contribute to a child’s development and well-being.

1.6 Child and Adolescent Mental Health Service
Child and Adolescent Mental Health Services (CAMHS) are defined by Wolpert, M as ‘any service provision whose aim is to meet the mental health and emotional well-being of children and young people.’ CAMHS services include both specialist services, where the provision of mental health and well-being care to children is their primary function; and generic services, which are all embracing and cover those providers for whom the delivery of mental health and well-being care is not their primary function. The term CAMHS therefore covers all services provided whether they are specialist or generic.

As already stated, it is agreed that mental health difficulties occur at different levels of severity and may therefore require different levels of intervention. For example, a
child may experience varying levels of anxiety which may: be transitory or chronic, be situation specific or pervasive, they can manage on their own or require additional support; have little effect on their daily function or be extremely disabling and life threatening. Services, then, try to gauge the severity of difficulty or need and develop service pathways which reflect a continuum of services, with the more specialist and intensive for the those with highest levels of need, according to the principle of ‘progressive universalism’ (Statham & Smith, 2005). However, it must be remembered that this linear relationship is not always the case as individual vary considerably in terms of the risk and protective factors available to them.

In addition, there is an appreciation that mental health difficulties are more difficult to understand and are often perceived negatively and can be stigmatising. Consequently, professionals and families vary tremendously in their comfort with labelling and diagnosing medical health difficulties in childhood when there are many significant developmental and contextual issues to take into account. There may, then, be cultural belief systems that get in the way of developing service pathways within and across agencies, especially when the terms different professionals used can appear to emphasise one feature of a mental health difficulty over another.

A number of policy documents have tried to provide strategic frameworks for the delivery of services that take into account these different levels of mental health difficulties, well-being and need. Table 1.0 provides an example of the strategic frameworks used within health, education and social care services. For example, Cornwall’s Local Safeguarding Children’s Board (LSCB) interagency threshold refers to the following levels of need: Universal, Vulnerable, Complex and Acute. The national CAMHS review document refers to tiers of service provision: Universal/primary care, Specialists/uni-disciplinary, Specialised/multi-disciplinary, Highly Specialist/tertiary services. The Improving Access to Psychological Therapies (IAPT) framework makes distinctions between stepped care pathways, which reflect the intensity of psychological therapies provided. Each framework has a slightly different focus (e.g. safety, welfare, well-being and mental health) and refers to different client groups (e.g. people with mental health problems, people with anxiety disorders, vulnerable children) though there is a large degree of overlap.

All focus on children’s well-being and development and make distinctions between different levels, tiers or steps of need and service provision and there are similarities in ways of thinking. Thus, professionals may often feel they are working at similar levels or tiers, but in fact they are referring to two different groups of children. For example, Level 3 within the LCSB system refers to integrated targeted support or Children in Need, and Tier 3 within the CAMHS system, refers to specialist services for children with more severe, complex or persistent disorders. Consequently, movement within and between services can be hard to understand, misconceptions around service provision arise and pathways become obstacle courses.

Additionally, services can be categorised differently across the frameworks. For example, the Children in Care Psychology Team, may regard itself as a Tier 2 service with the CAMHS Review framework and a Level 4 service within LCSB.
<table>
<thead>
<tr>
<th>Service</th>
<th>Public Health</th>
<th>Education</th>
<th>Social Care/ LCSB</th>
<th>Health/ CAHMS Review</th>
<th>Health/ IAPT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Levels of prevention</td>
<td>The 3-waves intervention for children with SEN</td>
<td>The Four Level framework</td>
<td>The Four Tier strategic framework</td>
<td>The Four Stepped care pathway</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Public Health</td>
<td>Ecological – graduated response to SEAL</td>
<td>Holistic - Continuum of Need thresholds</td>
<td>Biopsychosocial – Mental Health emphasis</td>
<td>Psychological – depression and anxiety disorders</td>
</tr>
<tr>
<td><strong>Levels of difficulty/ severity/ service provision</strong></td>
<td>Primary prevention</td>
<td>Universal services for all. Aims to prevent the problem from occurring. Protecting people from ‘disease’. Building resilience</td>
<td>Wave 1 Whole school approaches for ALL children. Promoting learning, well-being &amp; mental health. Involve parents and community</td>
<td>Level 1 – Universal No identified additional needs. Universal services required only</td>
<td>Tier 1 Universal &amp; primary care services Focus on health promotion and prevention Screening &amp; early identification Offer advice</td>
</tr>
<tr>
<td></td>
<td>Secondary prevention</td>
<td>Targeted services for deprived or at-risk populations. Aim to intervene as early as possible, minimise impact and health maintenance.</td>
<td>Wave 2 Skills focused interventions for small groups of children who need help to develop emotional &amp; social skills. Work with parents</td>
<td>Level 2 – Vulnerable (additional needs) Single agency response where needs are not clear/known/being met. May meet Common Assessment Framework threshold</td>
<td>Tier 2 Specialists working in uni-disciplinary way in community. Consultation, assessment &amp; outreach work with children, families and services</td>
</tr>
<tr>
<td></td>
<td>Tertiary prevention</td>
<td>Specialist services which aim to preventing the reoccurrence, escalation, complication of existing problems with recovery and rehabilitation focus</td>
<td>Wave 3 Therapeutic interventions for individual &amp; small groups of children and parents. Placed on School Action, School Action Plus or with Statement of SEN. External agencies involved</td>
<td>Level 3 – Complex Likely to require longer-term integrated targeted intervention from statutory and specialist services. May meet Child in Need threshold</td>
<td>Tier 3 Specialists working in community mental health teams for more severe, complex or persistent disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tier 4 Highly specialist services, for most serious problems, requiring in- and out-patient units and teams. May be out of Cornwall provision.</td>
</tr>
</tbody>
</table>

| Level 4 – Acute | Acute needs requiring statutory intensive support & placement outside birth family. May meet Child in Care threshold | Tier 4 | Tier 4 Highly specialist services, for most serious problems, requiring in- and out-patient units and teams. May be out of Cornwall provision. | Step 4 Specialist Mental Health Services, Psychological therapy services |

Table 1.1 Strategic frameworks used by sectors to organise comprehensive mental health services for children and young people
There is agreement across all services regarding definitions of services at each end of the continuum, whatever the framework. Thus all agree that Tier/Level/Step 1 refers to universal services or services available to all children and young people and Tier/Level/Step 4 refers to the most specialist services for children and young people with severe and complex mental health difficulties and/or require child protection. Problems occur around definitions for Tiers/Levels/Steps 2 and 3.

In order to avoid confusion, this document is guided by the Children’s Workforce Development Council’s (CWDC, 2007) Common Assessment Framework (CAF) for children and young people. The CAF uses a ‘windscreen wiper’ model to describe a continuum of needs and services, with a distinction made between three levels: Universal (services for all children), Targeted (single practitioner and integrated support for children with additional needs) and Specialist (integrated support from statutory or specialist for children with complex needs), as shown in Figure 1.2 below.

**Figure 1.2 The Windscreen of Need**

Source: Development Council’s (CWDC) updated CAF guidance for practitioners and managers. [http://www.cwdcouncil.org.uk/integrated-working/integrated-working-guidance](http://www.cwdcouncil.org.uk/integrated-working/integrated-working-guidance)

Box 1 below provides definitions for universal, targeted and specialist services that will be used in this document.

**Box 1. Definitions of Universal, Targeted and Specialist Mental Health Services for children and Young People**

**Universal services** work with ALL children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include...
early year’s providers and settings such as child minders and nurseries, schools, colleges, youth services and primary health care services such as GPs, midwives and health visitors. Within the educational system a ‘whole school approach’ is often used to ensure well-being is embedded in the curriculum and school’s ethos.

Targeted services work with children and young people who have specific and additional needs and/or mild to moderate mental health problems. Children with specific needs include children who live in circumstances that pose a threat to their mental health (e.g. social deprivation, parents experiencing separation, bereavement, substance misuse, mental health problems, domestic violence or refugee/asylum status). Children with additional needs include those with physical, learning and sensory disabilities. Children with mild to moderate mental health problems include children with emerging mental health difficulties (i.e. behaviour, emotional, social and learning difficulties, including self-harming, trauma, attachment and substance misuse problems). Targeted services include interventions for Children in Need* and Children with Disabilities. These services include specialists often based in community teams. Their specialism can, but do not necessarily have to, be in mental health (e.g. Early Years Service, Educational Psychology Service, Primary Mental Health Workers Service, bereavement counselling service).

Specialist services work with children and young people with complex, severe, and complex mental health difficulties and Children in Care who have been taken away from their birth families to protect them from significant trauma, abuse, neglect and loss that is impacting on their well-being. This includes those children with specific and additional needs, identified above, who have not responded sufficiently to Targeted services or whose circumstances and well-being have deteriorated or changed dramatically. These services include specialist community mental health teams (e.g. Specialist CAMHS) and highly specialist teams (e.g. Early Intervention Team) at Tiers 3 and 4 on the CAMHS conceptual framework. It also includes children who have been removed from their birth families for their own safety. That is, Level 4 within the Social Care conceptual framework which relates directly to Children in Care. These children and young people may require specialist levels of provision across education, social care, youth offending and health services, such as special schools, children’s homes, foster care and other residential or secure settings within and outside Cornwall. A significant proportion of Children in Care will have severe and complex mental health problems, but the majority will have none or mild to moderate mental health problems only.

*Children in Need are defined in law as children who are under the age of 18 years and: need local authority services to achieve or maintain a reasonable standard of health or development; need local authority services to prevent significant or further harm to health or development; are disabled.

1.7 Misconceptions around service provision
Although it is important to have a good understanding of the continuum of service provision, it is also important to be aware of some misconceptions that may arise from using this or any alternative strategic service framework, which are listed below.

Assumption 1. Pathways to mental health services follow the universal, targeted then specialist route.
There may be a perception that services are available to all children, and that children are somehow funnelled along services from universal to targeted to specialist, each level of service working with a smaller number of children as mental health problems become more severe and complex. However, the reality is that
universal services generally are available to all children, targeted services are available to a select group of children (e.g. Children in Need) with additional mental health needs or at-risk due to their circumstances, and specialist services are available to all children, whatever their circumstances only if they have a severe and complex mental health difficulty.

Thus, a group of children and young people will follow the perceived logical route and receive universal, targeted and then specialist services. However, it is likely that a larger group of children will receive universal services, will not be able to access targeted services (by their very nature they are targeted for particularly vulnerable groups known to professionals), but all children will be able to access specialist services if their mental health problems persist. For example, Jigsaw provides a counselling service for children who have been sexually abused. However, this targeted service is only accessible to children who have a named Social Worker. All those children who have been sexually abused and do not have a named Social Worker will not be able to access a targeted service like Jigsaw, but they will be able to access a specialist CAMHS service if they have a severe and complex mental health problem. If they do not, they will only have access to a universal service (e.g. Kooth) or national organisations (e.g. ChildLine).

Specialist CAMHS, then, can have many more referrals than targeted services and many of these referrals are from universal services (e.g. GPs, schools). They are in the unenviable position of meeting children and young people who have experienced similar traumatic events (e.g. domestic violence, sexual abuse), but can only offer a service to children and young people presenting with severe and complex mental health difficulties. Those in distress, but more able to function are not able to access specialist CAMHS service and are often not eligible for targeted services so only have access to universal services.

It is important, therefore, to consider what targeted services are available to all children with mild to moderate mental health difficulties whether they are a recognised vulnerable group (e.g. have learning disabilities) or not, It is important to bear in mind that many children and young people may be vulnerable (e.g. living in a household with domestic violence) but professionals are not necessarily aware of their status and consequently they do not appear to be eligible for a targeted service.

Assumption 2: Universal, targeted and specialist services are all free of charge to children, young people and families.

It must be appreciated that services provided by Cornwall Council and Cornwall Foundation Trust are generally free of charge to children, young people and families, but they are not necessarily free to all children and young people or unlimited. Thresholds are set to ensure only those most in need receive a service (e.g. children in care). Services provided by voluntary and private sectors may be free of charge to children, young people and families, but another service provider may be paying for this service (e.g. Cornwall Council may pay for counselling provided by CLEAR, a voluntary organisation) and they may only agree to commission a set amount of this service (e.g. 12 sessions of counselling per child) for a specific group of vulnerable children (e.g. children and young people assessed by Independent Domestic Violence Advocates). Voluntary services and private services, then, may not be available to ALL children in Cornwall and if they are, they may or may not be free of charge. This mapping exercise will attempt to capture these differences in access and service limitations.
Assumption 3: Universal, targeted and specialist services offer ongoing support for as long as required.

Generally, universal service are on-going, but it is likely that children and young people who use these services consistently and in the long term may be advised or referred on to more specialist mental health services. Some targeted services work along similar principles and are on-going and remain involved with children, young people and families for as long as support is required (e.g. Children in Need). However, many targeted service are time limited and if children, young people and families do not significantly improve within a specific time they will no longer be offered a service and will be referred on to a more specialist service. Additionally, those that improve may be referred back to universal services. For example, Scallywags is an intensive targeted 6 month intervention for 3-7 year old children and their families. Those families that require support beyond this time will need to be referred elsewhere.

Specialist CAMHS is generally not time-limited and the fact that they focus on children and young people with severe and complex mental health difficulties means that the nature of work is long term, though levels of support required may vary over time. It is also a fact that apart from a very small group of children that may require inpatient care outside of Cornwall specialist CAMHS is the final frontier for children with severe and complex mental health problems! Whereas targeted services may have equal numbers of children entering and leaving their services, specialist CAMHS may have many more entering than leaving. This results in increasing workloads and pressures on the system which tends to be managed by further raising thresholds to access the service. These raised thresholds may be reduced when the pressure is less, resulting in a service that may be perceived by other services as inconsistent, sometimes providing a service to a client group and at other times not.

Obviously, those children within specialist CAMHS who recover or improve sufficiently will be able to access some targeted and most universal services again. For those whose mental health fluctuates and is more resistant to change, specialist CAMHS often acts as a safety net as well as providing specialist interventions.

Assumption 4: Universal, Targeted and Specialist services are equivalent to Tier 1, 2, 3 and 4 services respectively.

Professionals providing comprehensive CAMHS to children and young people tend to have a preference for the terminology they use: either the universal, targeted and specialist or Tiered terminology. They are often seen as interchangeable with Tier 1 services referring to universal services, Tier 2 to targeted services, and Tiers 3 and 4 to specialist CAMHS services. However, this is where misunderstandings may occur and result in gaps in service provision, especially at targeted or Tier 2/3 services.

For example, professionals working within the local authority may be more familiar with the distinctions made between universal, targeted and specialist services. For them targeted services focus on children with additional needs who are known to be more at risk or vulnerable to mental health problems, such as Children in Need. In contrast, professionals working for health services may be more familiar with the distinctions between Tier 1, 2, 3 and 4 services. For them, Tier 2 services focus on children with mild to moderate mental health problems, whatever their circumstances.

A health professional, then, may assume that Targeted services are available to all children when in fact they may only be available to groups of children who are deemed more vulnerable. A local authority professional may assume specialist
CAMHS will prioritise more vulnerable children when in fact they focus on children with **severe and complex** mental health problems, no matter their circumstances. Mental health difficulties, after all are non-discriminatory: anyone, rich or poor, educated or not, with a good social support network or socially isolated can experience trauma and mental health difficulties at some point in their lives.

These differences in perception cause difficulties when professionals wish to refer children and young people up or down Tiers 2 and 3 or between targeted and specialist services. A targeted service may put pressure on a specialist service by indicating they have started to work with a child and family, that they have made as much progress as they can and now require an additional specialist intervention for this family to prevent further breakdown, distress and disruption. A specialist service may reply that they only have limited resources, there are children on their waiting list already and to put these targeted children at the top of the waiting list (i.e. prioritise them) would be unfair to those already on the waiting list who have received little support to date.

Both services are making very valuable points, both are advocating for children's and young people's rights to access a service but both may hold different opinions about which children are most in need and who should be prioritised. When services are under pressure and resources limited these differences in opinion can become acrimonious, personalised and unresolved; joint working and a seamless provision of care becomes difficult and sometimes breaks down; and unhelpful and disrespectful myths about services grow and become ‘ unofficial facts’. For example, specialist CAMHS may say a child has a ‘social problem’ rather than a severe and complex mental health problem and thus is not eligible for their service. In response, a targeted service may say that specialist CAMHS ‘pathologises’ and ‘medicalises’ problems and fails to see the whole child and their social circumstances.

**Assumption 5: Only specialist CAMHS work intensively, long term and systemically with children, young people and families.**

It is fair to say that few professionals work in isolation with children, young people and families. There is an expectation that professionals will be communicating with each other and considering not only the impact of mental health difficulties on children and young people themselves, but on their families, education and community life. Indeed, the Common Assessment Framework with its emphasis on early intervention and maintaining a Team Around the Child (TAC) is an attempt to embed systemic practice across agencies. In addition, universal and targeted services often work intensively with families, though there may be a time limit around the length of time in which they remained involved with a family. If progress is not maintained and concerns remain high, there may be a need to refer children and young people on to more specialist services.

It is also fair to say that specialist CAMHS works intensively (though this may vary over time), longer-term and systemically with children and young people. There is an expectation that this is the sort of work that will need to be provided to make a change that can be sustained. Children and young people who have severe and complex mental health problems will require more than specialist individual therapy. Their families will also need support to understand the roles they play in both exacerbating and improving their children’s mental health difficulties and the impact these sorts of difficulties have on their own well-being and families’ functioning. The longer term nature of specialist CAMHS work means that these relationships need to be maintained, despite challenges especially around levels of engagement and participation.
Individual and family therapy is likely to be one of the hardest pieces of work anyone is expected to do. It requires talking about and making sense of thoughts, beliefs, behaviours, feelings, events and relationships in our lives. Many of us try to protect ourselves from things that make us feel vulnerable and exposed and we develop many useful defence mechanisms or coping strategies to do this, such as avoiding, denying and minimising, numbing and distraction. Specialist CAMHS interventions require professionals to deal directly with these strategies, within the child and young person and within the family, as there is an awareness that these strategies are getting in the way of a young persons’ development and well-being.

There is an awareness that other interventions have not been sufficient and that there will be resistance around doing this sort of work, because it is so challenging. Although, major shifts can occur fairly quickly, it is likely that this work will need to be sensitive to the pace at which a child can work whilst being mindful of the demand for services. This is a very tricky balancing act and professionals are often aware that specialist CAMHS may be one of the few services that are prepared to work for however long it takes to improve a child’s life as there are few options left.

1.8 Conclusion
To conclude, these assumptions are not always appreciated and acknowledged across the agencies and services and consequently cause a great deal of frustrations, communication difficulties and problems with joint working arrangements. Children and young people with mental health difficulties and their families may become aware of these tensions between services. This may add to their distress, result in them losing confidence in the support available to them, reconsider their options and work out which service to ‘side’ with in order to get the help they need. This is the worst case scenario, but it can occur at a locality level between services within Cornwall. Children and young people who live in such a locality will have a very different experience of services to those children and young people who live in a locality where these tensions between services have been properly acknowledged and a consensus reached on how best to support children when there are waiting lists and different service agreed targets to meet.

The opportunity for targeted and specialist services to work together with a family for a short period rather than simply refer on or back and close a case needs to be negotiated so that children and families feel supported when they move from one service to another. These sort of negotiations require a great deal of skill and make all the difference in terms of providing a comprehensive CAMHS service that works for everyone, and not just a specific group.

1.9 Summary
The main objectives of this needs assessment are to:
- determine the evidence of effective intervention, using national and local policies and guidance
- describe the epidemiology of Mental health problems in Cornwall & Isles of Scilly
- identify current universal, targeted and specialist mental health services available and identify gaps in provision
- Identify mental health service that work directly with children and young people, their parents, families, schools and communities
- Understand needs and demands by obtaining service users and provider’s views
- Identify resources and determine commissioning priorities for planning
Provide recommendations based on the gaps, priorities and changes to meet the needs and demands of the population.

Mental health and mental ill-health can be thought of as occurring on a continuum which requires a continuum of service provision.

Within children’s mental health distinctions are often made between the following difficulties:

- Disorders of psychological development (e.g. learning disabilities and Autistic Spectrum Disorder)
- Sleep, toileting and somatic problems
- Emotional disorders (e.g. anxiety and depression)
- Conduct disorders (e.g. oppositional and defiance, anti-social behaviour)
- Hyperkinetic disorder (e.g. difficulties with attention, ADHD)
- Attachment disorders (e.g. difficulties with emotional and social development)
- Substance misuse problems (e.g. alcohol and drug misuse)
- Eating disorders (e.g. anorexia nervosa, bulimia nervosa, obesity)
- Trauma disorders (e.g. PTSD, complex trauma, developmental trauma)
- Psychoses (e.g. schizophrenia, drug-related)
- Gender identity disorders (e.g. gender dysphoria)

For this report the CWDC’s model of service provision and need will be used in which distinctions are made between universal, targeted and specialist services. Some important additions are also made to framework to include those children of particular concern to social care and health services. Thus.

- Universal services work with ALL children and young people, promoting and supporting mental health and psychological well-being through the environment and relationships they have with children.
- Targeted services work with children with specific needs because of the circumstances in which they live; with additional needs due to physical, learning and sensory disabilities; and with mild to moderate mental health needs. This includes Children in Need and Children with Disabilities.
- Specialist services work with children and young people with complex, severe or/and persistent needs and with children who have been removed from their birth families for their safety and development. It includes Children in Care and those living in specialist residential, secure, educational, in-patient and rehabilitation units, within and outside of Cornwall.

These levels of intervention range from ‘doing nothing’ through to monitoring, watchful waiting and educating, guided choices (with incentives or disincentives), restricted choice to statutory regulation where there is little choice due to child protection and safety concerns.

Assumptions around the continuity of care, multi-agency working and strategic planning are highlighted in order to tackle misunderstandings and provide clarity. It is appreciated that service will have different priorities but finding a shared language is essential.

1.9.1 Implications:
- The complexity and diversity of mental health means services will need to address how to meet the demand of a wide range of mental health problems/disorders using current resources.
- Stakeholders and service providers need to work together so that all agencies are involved in the development of communication and referral pathways in order to ensure that there are no gaps between the service levels (tiers) and children have a seamless experience when directed from one service level (tier) to another.
- Stakeholders and services also need to consider how best to provide a seamless transition between children and adult services for those children who are 18 and over.
Section 2: What Works for Whom?

2.0 Introduction
The causes and impact of poor mental health are extremely complex with some children and families needing on-going support while others could have their needs met sufficiently by an earlier intervention. Effective commissioning utilises evidence of what works to improve outcomes for children and young people in order to inform the allocation of resources. In the current climate of cuts to public sector funding this is more important than ever. Work is underway in Cornwall & Isles of Scilly to improve children and young people’s emotional well-being and mental health by ensuring an integrated and timely approach from services.

There have been, and continues to be, numerous changes in the public sector ‘landscape’ including new commissioning arrangements and structures within the NHS plus changes to local authority funding for schools and children’s services. The evidence base behind the new commissioning strategy will be important in informing not only current but also future commissioning decisions some of which will be made by stakeholders such as Kernow Clinical Commissioning Group and, increasingly, head teachers. These stakeholders are likely to be less familiar with the breadth and complexity of the system, from preventative through to acute services, and the interdependence and interconnectedness of the services within it.

Given these changes, it is important to note from the outset that practice has shown that robust, joint commissioning is the most effective mechanism for developing an effective range of targeted services to vulnerable children and young people whilst improving specialist services in parallel with universal servicesvi. The National Support Team (NST) for Children and Young People’s Emotional Well-being and Mental Health reviewed numerous local commissioning and delivery systems and found that well supported, joint commissioning arrangements aimed at ensuring a mix of provision and guided by a shared plan, was a good enabler to progressvi.

2.1 The evidence base
The term ‘evidence-base’ has become so prevalent it is frequently not appreciated that this term can refer to anything from feedback from service users, an expert’s opinion or a meta-analysis. A distinction is usually made between types of evidence, starting from the most rigorous or scientific to the least rigorous, as follows:

- systematic review or meta-analysis (pooling of findings from a number of randomised control trials)
- randomised control trial (RCT)
- case control studies (two groups, one treatment and one non-treatment)
- non-experimental studies (cohort studies, outcomes treatment groups, qualitative studies)
- expert opinions and individual case studies
- personal experiences

A number of organisations are responsible for providing systematic reviews of the evidence base and consequent guidelines on what works for whom within health, education and social care sectors, such as:

- Campbell Collaboration for education, crime and justice and social welfare
- Centre for Evidence-Based Intervention, Oxford University
- Centre for Excellence and Outcomes in Children and Young People’s Services (C4EO) – reviews evidence across sectors with 4 core partners: National Children’s Bureau (NCB), SCIE, NFER and Research in Practice (RiP).
- Cochrane Collaboration for healthcare (Cochrane Database of Systematic Reviews (CDSR))
- National Academy for Parenting Research (NAPR), King’s College, London
- National Foundation of Educational Research (NFER) – reviews evidence to improve education and learning.
- National Institute of Clinical Excellence (NICE) – reviews evidence on interventions for physical and mental health problems – and has now expanded its remit to include work of SCIE (see below) and is renamed National Institute for Health and Care Excellence (NIHCE)
- Social Care Institute of Excellence (SCIE) – reviews evidence to improve practice in child protection and for Looked After Children (LAC)/ Children in Care (CiC).
- Personal Social Services Research Unit (PPSRU), University of Kent
- Social Research Unit (SRU), Dartington

These organisations provide invaluable information and advice. However, it must be appreciated that most were founded in the last 20 years (e.g. NICE was founded in 1999) and there remain many gaps in the research base, particularly in the areas of children’s mental health and emotional and social well-being.

This report draws heavily from a broad range of national guidance and reports which are based on systematic reviews of evidence. Such reviews use a rigorous methodology to search and evaluate academic research and objectively interpret the findings. Reference to systematic reviews should also be treated with caution as these reviews often refer to shortcomings in the evidence base. These shortcomings can be glossed over in policy papers in an attempt to drive the implementation of specific interventions where there is best evidence, though this evidence may be very limited. For example, the NICE guidelines for Eating Disorders (2004) make a number of clear recommendations in their executive summary page, one of which is:

“Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.”

But what does ‘family interventions’ refer to and what is this recommendation for anorexia nervosa (AN) based on? In the full report ‘family interventions’ refers to family therapies though the quantity and type of family therapy is not defined. Regarding the evidence base, the full report states

“Overall the body of research into the treatment of AN is small and inconsistent in methodological quality. The conclusions that can be drawn are limited because many studies have no follow-up data, lack the statistical power necessary to detect real effects and use different study entry criteria and outcome measures” (NCCMH,2004)

More specifically, in relation to research on children and adolescents:

“there is insufficient evidence to determine whether conjoint or separate family therapy is more, or less, effective at the end of treatment or follow-up.”
Indeed all but one of the recommendations in the NICE guidelines for eating disorders is based on Grade C evidence (i.e. evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities). Although these views are based on specialist experience and knowledge, they are not based on systematic reviews or meta-analyses and this should be borne in mind. As we become increasingly dependent on reviews of the evidence base, and good practice guidelines it is important we attend to the details within these reports if we are to remain critical, creative and sensitive to local needs and develop services appropriately.

A closer and more critical inspection of the research literature and evidence base relating to the effectiveness of mental health interventions for children is less developed than for adults (Kelley, Bickman & Norwood, 2010). The evidence for early, whole school and targeted mental health interventions is limited. There is not yet a good research base that demonstrates the effectiveness of: earlier or later interventions; universal, targeted or indicated levels of intervention; and the most robust service provision model required (National Institute for Clinical Excellence, 2009; National Institute for Clinical Excellence, 2008). Researchers have emphasised the “need to take greater heed of the complexity of the issues involved and not expect earlier interventions to act as a 'magic bullet'” (Stratham & Smith 2010, Warrick, Mooney & Oliver, 2009).

2.2 Evidence-Based Practice

Definitions of Evidence-Based Practice (EBP) reiterate the importance of using the evidence base, alongside professionals’ expertise and patients’ contexts and preferences. Thus, evidence-based practice in medicine is defined as follows:

"Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values." (Sackett D et al. 2000)

Within psychology a similar definition is used:

“Evidence-based practice in psychology ....is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006)

EBP entails using the best available evidence, keeping in mind it is not necessarily robust evidence, and that it used alongside an appreciation of professionals’ skills and experience and patients’ abilities and preferences. Unfortunately, EBP has often been interpreted as doing what the best evidence indicates, ignoring the local context and the importance of attending to how an intervention is delivered within and across services.

It is also important to remember that the list of interventions which have been identified within research as effective do not represent the only interventions worth investing in. Some interventions have not been the subject of systematic empirical research but this does not mean they are not effective. Some interventions are difficult to evaluate in terms of outcomes over time when there are a range of other significant contributory factors to take into account. There are also ethical issues with, for example, conducting randomised controlled trials where a control group might mean offering no intervention for some children with the same problems.
Bearing in mind the limitations of the evidence base and misunderstandings around EBP a new concept has gained ground, referred to as ‘practice-based evidence’ (Duncan, Miller, Wampold et al 2010). PBE involves practitioners and services evaluating their practice by measuring outcomes and modifying their practice as a result of reviewing these evaluations. Indeed the Improving Access to Psychological Therapies (IAPT) programme has embedded PBE into the stepped care model with practitioners asking clients to complete outcome measures not only at the beginning and end of therapy but at the end of every session. It is hoped that PBE will encourage practitioners to use best evidence and evaluate their own practice alongside this to ensure their service is sensitive and responsive to the local context.

Evidence from research is an essential part of the process for effective commissioning however it must be considered alongside other information such as local service evaluations and particularly children and young people’s views and feedback. Many interventions arise from local needs and circumstances and work well in that area but may not be as effective in others. In other words, whilst it is best practice to utilise the evidence of what works for children and families and to ensure maximum value for public money, evidence based interventions will not provide one magic approach for every part of the system.

2.3 The case for investing in prevention and earlier intervention

The recent report, Early Intervention; The Next Steps (Allen, 2011) xxviii reiterates “Too few of the Early Intervention programmes currently being tried in the UK have been rigorously evaluated, making it difficult for the public sector and impossible for the private sector to invest with any confidence. “

However, many experts from around the world and epidemiological research indicates that improving emotional well-being and promoting good mental health across the population will result in the following benefits for individuals, communities and populations;vii,xiii

- reduced mental illness and suicide,
- improved physical health and life expectancy,
- better educational achievement,
- reduced health risk behaviour such as smoking, alcohol and drug use,
- improved employment rates and productivity,
- reduced antisocial behaviour and criminality,
- higher levels of social interaction and participation

The case for investment in children and young people’s services however is even stronger as the following evidence clearly indicates;

- Half of all lifetime cases of diagnosable mental illness begin by age 14 and three-quarters of lifetime mental illness arises by mid-twentiesxiv.
- Yet 60–70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunityxv.
- Prevention and intervention in emotional well-being and mental health targeted at children and young people will result in greater benefits and savings than interventions at any other time in the life spanxvi

2.4 The cost of poor mental health

Over the whole life course, the cost of mental health problems to the economy is considerable, both in NHS costs and the impact on wider productivityxvii
In 2010, the annual economic costs of mental illness in England were estimated to be £105.2 billion. Costs in terms of the provision of services which include NHS, social and informal care were £22.5 billion in 2007\textsuperscript{xiii}. The future cost of mental health is forecast to double in real terms over the next 20 years. Mental illness during childhood and adolescence results in costs of between £11,030 to £59,130 annually, per child, in the UK\textsuperscript{xiv}. Yet evidence indicates that these costs could be reduced through a greater focus on whole population mental health promotion and prevention, alongside early diagnosis and intervention – particularly in childhood.

### 2.5 Evidence based national policy and reports

There have been a number of key national policies and reports that underpin or have informed the development of comprehensive CAMHS services more recently. These are:

- Healthy Child Programme: pregnancy and the first five years of life (DOH, 2009)\textsuperscript{xxxiii};
- Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011 (DfE, 2011)\textsuperscript{xxxii};
- Early Intervention: The Next Steps (Allen, 2011);
- No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages (DoH, 2011a)\textsuperscript{xxxiv};
- Talking therapies: a four year plan of action (DOH, 2011b) and Children and Young People’s Improving Access to Psychological Therapies project (DOH, 2011)\textsuperscript{xxxv}.

All these policy documents refer to an evidence base which suggests that intervening earlier, both in terms of stage of emerging problem and age, makes sense not only for the individual but economically too. The main recommendations from these reports will be detailed.

#### 2.5.1 The Healthy Child Programme: pregnancy and the first five years of life

(DoH, 2009) focuses on improving children’s health and well-being, beginning in early pregnancy and ending in adulthood, with a focus on the first 5 years. The programme prioritises:

- Parenting support interventions - which address the transition to parenthood, parents’ relationships with each other, developing parenting skills, fathers’ contributions and parents’ mental health
- Positive parenting and attachment interventions – which start from pregnancy and address the impact mothers and fathers have on children’s development and well-being.
- Use of technology (e.g. internet, helplines, TV, texting) - to improve access to information for parents and improve record keeping on behalf of professionals
- Proactive approach in promoting health and well-being – which helps parents to get the balance right between stimulating their children and managing risk.
- Integrated services – led by Health Visitors and health professionals and delivered by a range of practitioners particularly within Early Years and, Children’s Centres, using Common Assessment Framework to assess children’s needs.
- Increased focus on vulnerable children and families – identify children with high risk and low protective factors to reduce inequalities in health and well-being.
The HCP specifically refers to a number of evidence-based services or approaches which address concerns around parenting and a child’s emotional well-being, such as:

- Sure Start Children’s Centres
- Family Nurse Partnership
- Solihull Approach
- Promotional/motivational interviewing
- One Plus One Brief Encounters
- Family Partnership Model – for vulnerable children and families
- Preparation for Parenting/First Steps in Parenting/One Plus One
- Multimodal approach
- Self-help materials/ Cognitive Behavioural Therapy/Interpersonal Therapy
- Doula programmes
- Baby Express Newsletters/The Social Baby book/video/Brazelton/Nursing Care Assessment Satellite Training
- Mellow Parenting
- Parents in Partnership Parent Infant Network (PIPPIN)
- Baby massage/Interaction Guidance/father-infant groups
- Triple P

The availability of these programmes in Cornwall will be detailed in Section 4 of this report.

2.5.2 Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011 (DfE, 2011) was a national project funded by the former government. The aim of TaMHS was to help schools deliver timely support to those with mental health problems and those at increased risk of developing them, with particular emphasis on promoting evidence based practice and interagency working. The TaMHS projects focused on Children between 5 and 13 years of age. The national evaluation compared children’s well-being in schools involved in the TaMHS project Schools with those not involved in the project over a three year period.

There was a significant reduction in behavioural problems in primary school aged children involved in the TaMHS project, but no significant change in their emotional problems. The provision of self-help booklets on mental health was associated with additional reduction in behaviour problems.

The TaMHS project did not appear to have any significant impact on behaviour or emotional problems in secondary school aged children (11-13 years). However, the following ways of practicing were associated with reduction in behaviour problems

- Use of Common Assessment Framework (CAF)
- Positive links with specialist CAMHS
- Provision of information to pupils around behaviour but not emotional problems

The TaMHS schools implemented a variety of interventions which can be categorised as 1) Social and emotional development of pupils, 2) Creative and physical activity for pupils, 3) Information for pupils, 4) Peer support for pupils, 5) Behaviour for learning and structural support for pupils, 6) Individual therapy for pupils, 7) Group therapy for pupils, 8) Information for parents, 9) Training for parents, 10) Counselling for parents, 11) Consultation for staff, 12) Counselling for staff and 13) Training for staff.
Although evidence-informed practice was one of the major drives of the TaMHS project the majority of both primary and secondary schools reported using approaches developed locally rather that those that had been internationally tested; and no primary or secondary schools reported using approaches that involved following a rigorous protocol or manual. This is an important finding as it suggests that there may be very real practical difficulties in implementing evidence-based interventions.

Schools often used recognised interventions, but they frequently adapted them to take into account local resources and needs and their effectiveness was not always measured. The following interventions were referred to:

- Social and Emotional Skills Development: SEAL/Circle Time/Pyramid Club/Nurture groups, FRIENDS
- Creative and Art Therapy
- Peer Support for pupils – mentors and massage
- Behaviour for learning and structural support - Restorative Justice & Inclusion Units
- Individual Therapy: CBT & Narrative Therapy
- Group Therapy: Art Therapy & FRIENDS
- Information, Training and Counselling for Parents - Parentline Plus/Parent Mentoring/ CBT
- Training, supervision, consultation & support for Staff - Reflective practice training/Child Protection/Every Child Matters/Attachment/Everybodies Business/SEAL workshop training/Well-being course/CAF meetings/Drop Ins

Cornwall was involved in the TaMHS projects from the beginning and carried out its own evaluation, which was reported nationally (Perry & Green, 2012). It concluded that focusing on HOW to provide services is as important as deciding WHAT interventions to implement as:

“We have found that professionals’ attitude or approach to working together is as important as the specific skills they bring with them. It doesn’t matter how knowledgeable and evidence-based your practice is, if you can’t communicate and share your knowledge and skills and be prepared to learn from others your outcomes are likely to be very limited.” (Perry & Green, 2012).xxviii

The local evaluation identified five steps to promoting mental health in schools which were summarised as:

- **Getting Alongside** each other to provide both whole school and targeted approaches;
- **Making it Your Business** to support staff in attending training programmes, consultation and supervision sessions
- **Sharing Resources** so that new ways of supporting students’ mental health could be explored (e.g. PASS, FRIENDS and Solution Focused Communication);
- **Looking for Outcomes** to embed reflective and best practice and have a good understanding of local needs
- **Keeping it Going** by networking and sharing successes.

These findings, alongside the national evaluation confirmed the difficulties with implanting evidence-based interventions. Identifying evidence-based interventions and training staff in these programmes are relatively easy exercises compared to: supporting these staff to deliver these programmes; monitoring the delivery of programmes so that their integrity is maintained (i.e. delivered as they were intended
to be delivered and not ‘watered down.’) embedding evaluation into practice so that the effectiveness of these programmes is evaluated; sharing findings from evaluations with stakeholders to ensure services are sensitive and responsive to local needs.

2.5.3 Early Intervention: The Next Steps (Allen, 2011) is an independent report that promotes greater investment in early years (0-3 years in particular), highlighting a range of universal (for all children) and targeted (for Children in Need) interventions which have been shown to improve social and emotional outcomes for all children and young people. A developmental perspective was taken when reviewing interventions for specific age groups, making a distinction between three stages of development:

- 0-5 years: Readiness for Primary School.
- 5-11 years: Readiness for Secondary School
- 11-18 years: Readiness for Life

This document refers to the mountains of evidence sifted through and makes a real attempt to identify those for which there is the best evidence. A ‘top list’ of nineteen programmes were identified as having the best evidence and these were divided up in terms of the stage of development they are designed for and whether they are universal or targeted interventions. Table 2.0 lists these nineteen interventions.

### Table 2.0. The ‘top list’ of 19 universal and targeted early intervention programmes identified by Early Intervention: The Next Steps (2011)

<table>
<thead>
<tr>
<th>Universal For all children</th>
<th>Targeted For Children in Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curiosity Corner (Success for All)</td>
<td>Early Literacy and Learning Model (ELLM)</td>
</tr>
<tr>
<td>Incredible Years</td>
<td>Incredible Years</td>
</tr>
<tr>
<td>Let’s Begin with the Letter People</td>
<td>Multidimensional Treatment Foster Care (MTFC)</td>
</tr>
<tr>
<td>Ready, Set, Leap!</td>
<td>Nurse Family Partnership</td>
</tr>
<tr>
<td><strong>0-5: Readiness for Primary School</strong></td>
<td>Parent-Child Home Programme</td>
</tr>
<tr>
<td>Incredible Years</td>
<td><strong>5-11: Readiness for Secondary School</strong></td>
</tr>
<tr>
<td>Promoting Alternative Thinking Strategies (PATHS)</td>
<td>Incredible Years</td>
</tr>
<tr>
<td>Success for All</td>
<td>MTFC</td>
</tr>
<tr>
<td>Reading Recovery</td>
<td><strong>11-18: Readiness for Life</strong></td>
</tr>
<tr>
<td>Incredible Years</td>
<td>Functional Family Therapy</td>
</tr>
<tr>
<td>Life Skills Training (LST)</td>
<td>Incredible Years</td>
</tr>
<tr>
<td>Lions Quest Skills for Adolescence</td>
<td>MTFC</td>
</tr>
<tr>
<td>Safe Dates</td>
<td>Multisystemic Therapy (MST)</td>
</tr>
<tr>
<td>Safer Choices</td>
<td>Project Towards No Drug Abuse (Project TND)</td>
</tr>
<tr>
<td>Start Taking Alcohol Risks Seriously (STARS) for Families</td>
<td></td>
</tr>
<tr>
<td>Success for All</td>
<td></td>
</tr>
</tbody>
</table>
The programmes identified in Table 2.0 were rated Level 1, the highest standard. There are also lists of programmes which were rated and Levels 2 and 3 that should also be given consideration.

The report makes the following recommendation:

"I recommend that the 19 ‘top programmes’ identified in my Report should be supported and expanded to demonstrate our commitment to Early Intervention. However, I also recommend that this list of 19 should not be regarded as exhaustive or complete: all should be reviewed and reassessed by the new Early Intervention Foundation (proposed below) before a ‘living list’ is evolved.

This document makes good headway in identifying interventions designed to provide a social and emotional bedrock for current and future generations. It also reiterates two areas of concern regarding the research evidence:

1) There are few UK programmes which have been subject to high-quality evaluation and most of the programmes and policies that meet this test are international (US, Scandinavia and Australasia) and there is a chasm between academic research and clinical practice;
2) The UK has a poor track record in fidelity of implementation – if practitioners do not stick rigorously to a programme it is well known that its impact will be eroded. The dosage and intensity of programmes is important as are continuous programme assessment and quality assurance.

It is essential that these issues are not ignored in the development of interventions in Cornwall and the Isle of Scilly.

2.5.4 No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages (DOH, 2011) was introduced by the Coalition Government, in its first year, alongside the Public Health White Paper Healthy Lives Healthy People. These policies were designed to challenge commissioners and providers of local services to take a longer term view of mental health and the ways in which we can work together to prevent and intervene earlier in emerging problems. They make a clear case for the promotion of emotional well-being, resilience, and earlier intervention for children and families.

"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 (2011)

This policy sets out a clear agenda and priorities:
- Focus on mental health within public health agenda
- Measurement of well-being
- Early intervention
- Life course approach
- Tackling inequalities in health
- Challenging stigma
- Improving access to psychological therapies
- Improving access to mental health services for offenders
- Improving access to mental health services for service and ex-service personnel
- Review service models that best support recovery
- Review service models for health visitors and school nursing
• Support GPs in commissioning effective mental health services
• Suicide prevention strategy
• Cross government response to mental health (e.g. communication between Department of Health and Department of Work and Pensions)

*No health without mental health. Delivering better mental health outcomes* (2011) refers to a number of evidence-based interventions such as:

• Early identification
• Stepped care approaches
• Parent training
• Child social skills training
• Whole school approaches to health promotion
• PSHE guidelines
• School based interventions aimed at preventing violence and abuse
• Multisystemic Therapy (MST)
• Multidimensional Treatment Foster Care.

Many of these programmes include those previously identified in the Early Intervention: The Next Steps document.

**2.5.5. Talking Therapies: A four-year plan of action** is another supporting document to *No Health Without Mental Health*. It details the Government’s commitment to expanding access to psychological therapies, thereby completing the roll-out of Improved Access to Psychological Therapies (IAPT) programme for people who have anxiety and depression disorders, following National Institute for Health and Clinical Excellence (NICE) guidelines. This plan specifically refers to extending the IAPT programme to children and young people, people over 65 years, people with physical long-term conditions and people with severe mental illness.

The recommended stepped care pathway for people with anxiety disorders and depression is as follows:

**Step 1:** Primary Care/Promotion of IAPT service, self-help materials and active monitoring.

**Step 2:** Low-intensity interventions: guided self-help based on CBT, computerised CBT, Behavioural activation (BA), structured physical activity.

**Step 3:** High-intensity interventions: CBT, Couple therapy, Counselling or brief dynamic interpersonal therapy, Interpersonal Therapy (IPT), & eye movement desensitisation and reprocessing therapy (EMDR) for PTSD.

**Step 4:** Specialist mental health services including psychological therapy services

Depression, anxiety disorders, self-harm, eating disorders and conduct disorders make up the majority of referrals to specialist CAMHS and evidence suggest that the similar psychological interventions would be effective in meeting the needs of children and young people. Thus, the CYP IAPT factsheet recommends the following evidence-based therapies:

• CBT
• Parent Training (3-10 year olds)
• Systemic Family Therapy
• Interpersonal Therapy

In addition, CYP IAPT aims to develop interactive e-learning programmes, e-therapy and more collaborative between agencies.
2.6 NICE guidelines

As already mentioned, NICE publish a range of clinical and public health guidelines which make recommendations on appropriate interventions based on the best available evidence. Indeed, many of the previous policy documents have drawn on NICE guidelines. It must be emphasised that NICE guidelines are what they say they are, that is ‘guidelines.’ It is recognised that no one intervention or treatment is effective for all people. An appreciation of the uniqueness of each individual and their own circumstances need to be taken into account, alongside the availability of local resources. It is essential that children, young people, parents and families are offered choices in the interventions available to them.

There are a significant number of NICE guidelines that relate directly to children and young people’s mental health and well-being. Thirty-four guidelines are listed in Table 2.1.

Table 2.1 A list of NICE guidelines that relate directly to children and young people’s mental health and well-being.

<table>
<thead>
<tr>
<th>NICE Guideline</th>
<th>Year first published</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eating disorders</strong>: core interventions in the treatment and management of</td>
<td>2004</td>
</tr>
<tr>
<td>anorexia nervosa and bulimia nervosa and related eating disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Self-harm</strong>: the short-term physical and psychological management and</td>
<td>2004</td>
</tr>
<tr>
<td>secondary prevention of self-harm in primary and secondary care</td>
<td></td>
</tr>
<tr>
<td><strong>Depression</strong> in children and young people: identification and management in</td>
<td>2005</td>
</tr>
<tr>
<td>primary, community and secondary care</td>
<td></td>
</tr>
<tr>
<td><strong>Post-traumatic stress disorder</strong> (PTSD): The management of PTSD in adults</td>
<td>2005</td>
</tr>
<tr>
<td>and children in primary and secondary care</td>
<td></td>
</tr>
<tr>
<td><strong>Obsessive-compulsive disorder</strong>: Core interventions in the treatment of</td>
<td>2005</td>
</tr>
<tr>
<td>obsessive-compulsive disorder and body dysmorphic disorder</td>
<td></td>
</tr>
<tr>
<td><strong>Postnatal care</strong>: routine postnatal care of women and their babies</td>
<td>2006</td>
</tr>
<tr>
<td><strong>Bipolar disorder</strong>: the management of bipolar disorder in adults, children</td>
<td>2006</td>
</tr>
<tr>
<td>and young people in primary and secondary care</td>
<td></td>
</tr>
<tr>
<td><strong>Parent-training/education programmes</strong> in the management of children with</td>
<td>2006</td>
</tr>
<tr>
<td>conduct disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Obesity</strong>: guidance on the prevention, identification, assessment and</td>
<td>2006</td>
</tr>
<tr>
<td>management of overweight and obesity in adults and children</td>
<td></td>
</tr>
<tr>
<td><strong>Community-based interventions to reduce substance misuse</strong> among</td>
<td>2007</td>
</tr>
<tr>
<td>vulnerable and disadvantaged children and young people</td>
<td></td>
</tr>
<tr>
<td><strong>Interventions in schools to prevent and reduce alcohol use</strong> among children</td>
<td>2007</td>
</tr>
<tr>
<td>and young people</td>
<td></td>
</tr>
<tr>
<td><strong>Antenatal and postnatal mental health</strong>: clinical management and service</td>
<td>2007</td>
</tr>
<tr>
<td>guidance</td>
<td></td>
</tr>
<tr>
<td><strong>Behaviour change</strong> at population, community and individual levels</td>
<td>2007</td>
</tr>
<tr>
<td><strong>Prevention of sexually transmitted infections and under 18 conceptions</strong></td>
<td>2007</td>
</tr>
<tr>
<td><strong>Promoting children’s social and emotional well-being</strong> in primary education</td>
<td>2008</td>
</tr>
<tr>
<td><strong>Attention deficit hyperactivity disorder</strong>: diagnosis and management of</td>
<td>2008</td>
</tr>
<tr>
<td>ADHD in children, young people and adults</td>
<td></td>
</tr>
<tr>
<td><strong>Antenatal care</strong></td>
<td>2008</td>
</tr>
<tr>
<td><strong>Maternal and child nutrition</strong></td>
<td>2008</td>
</tr>
<tr>
<td><strong>Promoting young people’s social and emotional well-being</strong> in secondary</td>
<td>2009</td>
</tr>
<tr>
<td>education</td>
<td></td>
</tr>
<tr>
<td><strong>When to suspect child maltreatment</strong></td>
<td>2009</td>
</tr>
<tr>
<td><strong>Anti-social personality disorder</strong>: treatment, management and prevention</td>
<td>2009</td>
</tr>
</tbody>
</table>
The list of guidelines is not necessarily complete. There are also a number of guidelines in progress (e.g. conduct disorder, domestic violence) and others are being updated. As can be seen the guidelines cover a wide range of conditions, some broad (e.g. social and emotional well-being) and others very specific (e.g. psychoses and schizophrenia); some are child focused and others cover the lifespan. Most of the guidelines refer to the management of conditions (e.g. primary, community and secondary services) as well as specific interventions (e.g. CBT). The guidelines vary in terms of how up-to-date they are and some have been overtaken by other reviews of the evidence and new health and social care policies and government agendas. NICE has now expanded its remit and is now known as the National Institute for Health and Care Excellence.

Although these guidelines are valuable in terms of informing practice, it must be appreciated that psychiatric diagnoses and children’s mental health can be a fraught field with experts and professionals holding a variety of positions relating to the causes of and best responses to mental health difficulties. Additionally, many children and young people either don’t quite meet the criteria for a specific psychiatric diagnosis or meet the criteria for a number of diagnoses. The ‘disorder-specific’ nature of NICE guidelines can be seen as oversimplifying mental health problems and insensitive to the complexities and messiness of real life. Drawing together conclusions from the variety of NICE guidelines and being respectful of differences in views and practice to produce a coherent social and emotional well-being strategy is bound to be an ongoing and challenging exercise.

### 2.7 Conclusions
A number of policy papers and NICE guidelines have consistently identified interventions with the best evidence for specific groups of children and young people. It will be important to identify how many of these interventions are available in Cornwall in the mapping exercise of service provision, outlined in the next section.
These policy documents also highlight difficulties around implementing evidence-based practice and reiterate that the evidence base is far from robust. All policy documents encourage further research, service evaluation and practice-based evidence so that

"a growing number of excellent well-regarded UK programmes should be assisted in joining the list as proven programmes able to help our children the most." (Allen, 2011)

A number of papers have demonstrated real problems around the implementation of evidence-based programmes, the gap between research and practice and ensuring fidelity to programmes and embedding evaluation into everyday practice. A recent discussion paper, Technique is Not Enough. A framework for ensuring that evidence-based parenting programmes are socially inclusive (Davis, McDonald & Axford, 2012)raises an additional issue: the need-service gap. The need-service gap addresses the fact that effective evidence-based parenting programmes are not reaching those most in need of them. They question whether families are ‘hard to reach’ or services are ‘hard to access.’ The paper outlines four Techniques is Not Enough (TINE) principles:

Principle 1. Access: Recruitment and retention;
Principle 2. Cultural sensitivity: Programme adaption through co-production with parents;
Principle 3. Building social capital: social support for knowledge and skills transfer;

These principles indicate that evidence-based parenting programmes will only reach those most in need of them and be effective if they respectfully engage disadvantaged and excluded families from the outset and are adapted accordingly.

Naomi Eisenstadt, in the foreword to the paper makes a stark comment:

"The best programme in the world is of little value if no one who needs it participates. Poor programmes that are successful in attracting parents may at worst do harm, and at best waste precious resources. “

Maintaining fidelity to a programme and adapting it to suit local need requires a high level of skill, commitment and energy and it is these aspects of service delivery that have probably been underestimated previously.

2.8 Summary

This section has looked at the evidence base around what works for whom in terms of building resilience and well-being and supporting those with mild to severe mental health difficulties. A number of interventions or approaches have been identified and recommended (based on the best available evidence) that focus on working directly with children and young people (e.g. cognitive behavioural therapy), their parents (e.g. Triple P parenting programme) and with the family as a whole (e.g. multisystemic therapy).

Indeed there is a plethora of guidelines, policy documents, reviews of the literature and published research. The problem is not lack of information, but firstly finding the time to access and keep abreast with the information; secondly, reflecting on how robust the information is; thirdly, deciding on how to use the information to improve practice; fourthly, how to implement evidence-based practice so that it has every chance of success at a local level; and finally, how to sustain good practice so that it is responsive to a constantly changing environment.
Section 3: Epidemiological Needs Assessment: What do we know about the mental health of children and young people in Cornwall and the Isles of Scilly?

3.0. Introduction
The aim of this section is to use national prevalence data on the estimated and registered population of Cornwall to estimate the number of children and young people likely to have good mental health and the number with mental health difficulties.

3.1. Demography

3.1.1. Profile of children and young people living in Cornwall & Isles of Scilly
There are an estimated 102,971 children and young people aged less than 18 years of age currently resident in Cornwall & Isles of Scilly. Table 3.0 highlights the breakdown by one year age bands and the percentage of each year group as a percentage of the under 18 years and as a percentage of the total population. In total 27,671 (26.9%) are aged 0-4 years; 31,811 (30.9%) are aged 5-10 years; and 43,489 (42.2%) are aged 11-17 years.

Table 3.0: Number of children less than 18 years old by selected age groups in C&IOS.

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>% of &lt;18 years</th>
<th>% Total Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5,723</td>
<td>5.56</td>
<td>1.07</td>
</tr>
<tr>
<td>1</td>
<td>5,417</td>
<td>5.26</td>
<td>1.01</td>
</tr>
<tr>
<td>2</td>
<td>5,527</td>
<td>5.37</td>
<td>1.03</td>
</tr>
<tr>
<td>3</td>
<td>5,426</td>
<td>5.27</td>
<td>1.01</td>
</tr>
<tr>
<td>4</td>
<td>5,578</td>
<td>5.42</td>
<td>1.04</td>
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<tr>
<td>5</td>
<td>5,479</td>
<td>5.32</td>
<td>1.02</td>
</tr>
<tr>
<td>6</td>
<td>5,255</td>
<td>5.10</td>
<td>0.98</td>
</tr>
<tr>
<td>7</td>
<td>5,210</td>
<td>5.06</td>
<td>0.97</td>
</tr>
<tr>
<td>8</td>
<td>5,166</td>
<td>5.02</td>
<td>0.96</td>
</tr>
<tr>
<td>9</td>
<td>5,208</td>
<td>5.06</td>
<td>0.97</td>
</tr>
<tr>
<td>10</td>
<td>5,493</td>
<td>5.33</td>
<td>1.02</td>
</tr>
<tr>
<td>11</td>
<td>5,780</td>
<td>5.61</td>
<td>1.08</td>
</tr>
<tr>
<td>12</td>
<td>6,026</td>
<td>5.85</td>
<td>1.12</td>
</tr>
<tr>
<td>13</td>
<td>6,176</td>
<td>6.00</td>
<td>1.15</td>
</tr>
<tr>
<td>14</td>
<td>6,399</td>
<td>6.21</td>
<td>1.19</td>
</tr>
<tr>
<td>15</td>
<td>6,455</td>
<td>6.27</td>
<td>1.20</td>
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<tr>
<td>16</td>
<td>6,231</td>
<td>6.05</td>
<td>1.16</td>
</tr>
<tr>
<td>17</td>
<td>6,422</td>
<td>6.24</td>
<td>1.20</td>
</tr>
<tr>
<td>&lt; 18 years</td>
<td>102,971</td>
<td>100.00</td>
<td>19.21</td>
</tr>
</tbody>
</table>

Source: ONS Mid 2011 Population Estimates

In comparing the Cornwall & Isles of Scilly 0-18 population structure with the South West, Cornwall & Isles of Scilly has a slightly lower proportion of 0-17 year olds than the South West, which itself is lower than the England proportion of 0-17 year olds (Table 3.1) at 21.35%.
Table 3.1: Mid-2011 Population estimates of the resident less than 18 years population in Cornwall & Isles of Scilly, the South West and England

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Cornwall and Isles of Scilly</th>
<th>% of all age population</th>
<th>SW Region</th>
<th>% of all age population</th>
<th>England</th>
<th>% of all age population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5,723</td>
<td>1.07</td>
<td>60,582</td>
<td>1.14</td>
<td>679,102</td>
<td>1.28</td>
</tr>
<tr>
<td>1</td>
<td>5,417</td>
<td>1.01</td>
<td>59,494</td>
<td>1.12</td>
<td>669,858</td>
<td>1.26</td>
</tr>
<tr>
<td>2</td>
<td>5,527</td>
<td>1.03</td>
<td>58,921</td>
<td>1.11</td>
<td>661,891</td>
<td>1.25</td>
</tr>
<tr>
<td>3</td>
<td>5,426</td>
<td>1.01</td>
<td>60,006</td>
<td>1.13</td>
<td>669,484</td>
<td>1.26</td>
</tr>
<tr>
<td>4</td>
<td>5,578</td>
<td>1.04</td>
<td>58,723</td>
<td>1.11</td>
<td>648,411</td>
<td>1.22</td>
</tr>
<tr>
<td>5</td>
<td>5,479</td>
<td>1.02</td>
<td>57,267</td>
<td>1.08</td>
<td>635,925</td>
<td>1.20</td>
</tr>
<tr>
<td>6</td>
<td>5,255</td>
<td>0.98</td>
<td>55,324</td>
<td>1.04</td>
<td>608,280</td>
<td>1.15</td>
</tr>
<tr>
<td>7</td>
<td>5,210</td>
<td>0.97</td>
<td>54,832</td>
<td>1.03</td>
<td>597,679</td>
<td>1.13</td>
</tr>
<tr>
<td>8</td>
<td>5,166</td>
<td>0.96</td>
<td>54,209</td>
<td>1.02</td>
<td>579,791</td>
<td>1.09</td>
</tr>
<tr>
<td>9</td>
<td>5,208</td>
<td>0.97</td>
<td>52,823</td>
<td>1.00</td>
<td>568,460</td>
<td>1.07</td>
</tr>
<tr>
<td>10</td>
<td>5,493</td>
<td>1.02</td>
<td>54,815</td>
<td>1.03</td>
<td>583,192</td>
<td>1.10</td>
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<tr>
<td>11</td>
<td>5,780</td>
<td>1.08</td>
<td>57,425</td>
<td>1.08</td>
<td>599,021</td>
<td>1.13</td>
</tr>
<tr>
<td>12</td>
<td>6,026</td>
<td>1.12</td>
<td>59,651</td>
<td>1.12</td>
<td>617,326</td>
<td>1.16</td>
</tr>
<tr>
<td>13</td>
<td>6,176</td>
<td>1.15</td>
<td>60,712</td>
<td>1.14</td>
<td>625,128</td>
<td>1.18</td>
</tr>
<tr>
<td>14</td>
<td>6,399</td>
<td>1.19</td>
<td>63,216</td>
<td>1.19</td>
<td>642,744</td>
<td>1.21</td>
</tr>
<tr>
<td>15</td>
<td>6,455</td>
<td>1.20</td>
<td>63,103</td>
<td>1.19</td>
<td>643,838</td>
<td>1.21</td>
</tr>
<tr>
<td>16</td>
<td>6,231</td>
<td>1.16</td>
<td>62,945</td>
<td>1.19</td>
<td>643,625</td>
<td>1.21</td>
</tr>
<tr>
<td>17</td>
<td>6,422</td>
<td>1.20</td>
<td>65,883</td>
<td>1.24</td>
<td>666,996</td>
<td>1.26</td>
</tr>
<tr>
<td>&lt; 18 years</td>
<td>102,971</td>
<td>19.21</td>
<td>1,059,931</td>
<td>19.98</td>
<td>11,340,751</td>
<td>21.35</td>
</tr>
<tr>
<td>All Ages</td>
<td>535,984</td>
<td>100.00</td>
<td>5,306,025</td>
<td>100.00</td>
<td>53,107,169</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: ONS Mid-2011 Population Estimates

3.1.2. Population Projections for under 18 Year Olds
According to the Office of National Statistics (ONS) population projections, the population of 0-18 year olds in Cornwall & Isles of Scilly is projected to increase by 3 3.1).
Figure 3.1: Projected population for males and females aged 0-17 years in Cornwall & Isles of Scilly 2011-2021

Source: ONS 2011 Based National and Subnational Population Projections

3.1.3. ONS Estimates of Ethnicity

ONS experimental population estimates by ethnic group,\textsuperscript{\textcopyright} indicate that 89.9% of the 0-15 year olds in Cornwall & Isles of Scilly are White, compared to 83% in England. According to the ONS estimates after White British, the next most populated group of 0-15 year olds in C&IoS are in the White Other group. The estimated total number of BME non-white of 0 – 15 year olds is 1,464, while the BME non-white 16 to 24 year olds is estimated at 648. These figures have probably increased since the 2001 census.

Table 3.2: Estimated % of the 0-15 year old and 16 to 24 year old population by ethnic group in Cornwall & Isles of Scilly, based on 2001 census.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Cornwall and Isles of Scilly 0 - 15 years</th>
<th>% 0 - 15 years</th>
<th>16 -24 years</th>
<th>% 16 – 24 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>T13:1 All People</td>
<td>501,267</td>
<td>92,603</td>
<td>18.5</td>
<td>45,081</td>
</tr>
<tr>
<td>T13:2 White - British</td>
<td>486,635</td>
<td>89,951</td>
<td>18.5</td>
<td>43,673</td>
</tr>
<tr>
<td>T13:3 White - Irish</td>
<td>2,216</td>
<td>102</td>
<td>4.6</td>
<td>94</td>
</tr>
<tr>
<td>T13:4 White - Other White</td>
<td>7,448</td>
<td>1,086</td>
<td>14.6</td>
<td>630</td>
</tr>
<tr>
<td>T13:5 Mixed - White and Black Caribbean</td>
<td>603</td>
<td>286</td>
<td>47.4</td>
<td>101</td>
</tr>
<tr>
<td>T13:6 Mixed - White and Black African</td>
<td>313</td>
<td>119</td>
<td>38.0</td>
<td>67</td>
</tr>
<tr>
<td>T13:7 Mixed - White and Asian</td>
<td>804</td>
<td>373</td>
<td>46.4</td>
<td>101</td>
</tr>
<tr>
<td>T13:8 Mixed - Other Mixed</td>
<td>580</td>
<td>227</td>
<td>39.1</td>
<td>88</td>
</tr>
<tr>
<td>T13:9 Asian or Asian British - Indian</td>
<td>411</td>
<td>63</td>
<td>15.3</td>
<td>28</td>
</tr>
<tr>
<td>T13:10 Asian or Asian British - Pakistani</td>
<td>149</td>
<td>30</td>
<td>20.1</td>
<td>23</td>
</tr>
<tr>
<td>T13:11 Asian or Asian British - Bangladeshi</td>
<td>231</td>
<td>68</td>
<td>29.4</td>
<td>37</td>
</tr>
<tr>
<td>T13:12 Asian or Asian British - Other Asian</td>
<td>178</td>
<td>44</td>
<td>24.7</td>
<td>17</td>
</tr>
<tr>
<td>T13:13 Black or Black British - Black Caribbean</td>
<td>307</td>
<td>30</td>
<td>9.8</td>
<td>19</td>
</tr>
</tbody>
</table>
### 3.2. Deprivation

#### 3.2.1. Child and Well-being Index

- The Child and Well-being Index (CWI) was first published in 2009 and has seven domains, which each have a range of indicators within them:
  - **Material well-being** – captures the proportion of children experiencing income deprivation (this is the same as the Income Deprivation Affecting Children domain contained within the Indices of Deprivation) and relates to those aged under 16.
  - **Health** – focuses on illness, accidents and disability and relates to those aged under 19.
  - **Education** – covers a range of educational outcomes including attainment, attendance and destinations at age 16.
  - **Crime** – focuses on the four main volume crime types, which impact on communities and individuals i.e. burglary, theft, criminal damage and violence.
  - **Housing** – incorporates two elements, access to housing and the quality of housing.
  - **Environment** – captures aspects of the environment that affects children’s physical well-being; it has two elements, environmental quality and environmental access.

There are 149 county rankings for the Child Health and Well-being index, with 1 being the best and 149 being the worst in the rankings. Cornwall & Isles of Scilly features in the worst quintile only for the domain of housing at 127 out of 149. Overall, Cornwall and the Isles of Scilly is ranked 69th, so is very much in the middle of the overall rankings (See Table 3.3).

#### Table 3.3: Cornwall & Isles of Scilly scores for 2009 Child and Well-being index.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average score</td>
<td>156.08</td>
<td>69</td>
</tr>
<tr>
<td>Material well being</td>
<td>0.19</td>
<td>55</td>
</tr>
<tr>
<td>Health</td>
<td>0.17</td>
<td>90</td>
</tr>
<tr>
<td>Education</td>
<td>19.45</td>
<td>57</td>
</tr>
<tr>
<td>Crime</td>
<td>-0.48</td>
<td>14</td>
</tr>
<tr>
<td>Housing</td>
<td>36.86</td>
<td>127</td>
</tr>
<tr>
<td>Environment</td>
<td>22.30</td>
<td>91</td>
</tr>
<tr>
<td>Children in need</td>
<td>0.03</td>
<td>51</td>
</tr>
</tbody>
</table>

**Notes:**
- Table 3.3 demonstrates that the Children in Need score for Cornwall & Isles of Scilly is 0.03, placing it in the 51st rank out of 149. This indicates a relatively low level of children in need compared to other areas.
- The Material well-being score for Cornwall & Isles of Scilly is 0.19, ranking 55th, suggesting a relatively low level of income deprivation compared to other areas.
- The Education score for Cornwall & Isles of Scilly is 19.45, ranking 57th, indicating a relatively high level of educational attainment compared to other areas.
- The Crime score for Cornwall & Isles of Scilly is -0.48, ranking 14th, indicating a relatively low level of crime compared to other areas.
3.2.2. South West Public Health Observatory March 2012 Child Health Profile

The 2012 Child Health Profile indicates that 19.1% of young people under the age of 16 live in poverty in Cornwall & Isles of Scilly compared to 17.2% for the South West region and 21.9% for England.

There is obviously a strong correlation between child poverty and benefit dependency. According to Cornwall’s Child Poverty Strategy 14,314 children between the ages of 0-15 are currently living in benefit dependent families, which is 15.7% of the total population of children of this age. In addition to this, in certain areas of Cornwall the issue is far more severe. This is only highlighted when the situation is analysed at a lower super output area level, showing that in one area 66% of families are in a benefit dependent situation, when the national average is only 21%.

The rural nature of Cornwall creates an isolation that can magnify the impact of poverty beyond its immediate effect. This, with a relatively low wage economy mean that even for families that are in work they may remain within the poverty thresholds. At a national level figures show that the same number of children exist in low wage poverty as do in benefit dependent families.

3.3.3. March 2012 CIOS Health Visitor Survey

The 2012 Health Visitor survey looks at the number of need factors for each family in Cornwall with children of 3 years and younger. Data from the 13,852 families showed that 16% of families had 4 or more risk factors; 5% had 8 or more need factors, while 1% had 12 or more risk factors (see Table 3.4). It is the children in families with a high number of risk factors that are more susceptible to emotional health problems.

Table 3.4: Health Visitor Survey 2012 for all families with children under the age of three years.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Universal</th>
<th>Targeted</th>
<th>Complex</th>
<th>Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>7,691</td>
<td>2,742</td>
<td>2,251</td>
<td>1,157</td>
</tr>
<tr>
<td>% cases</td>
<td>55.57</td>
<td>19.81</td>
<td>16.26</td>
<td>8.36</td>
</tr>
</tbody>
</table>

To triangulate the information on child poverty the survey showed that 4,226 (32.2%) of families were on low incomes and 2,501 (18.1%) of families had the major wage earner unemployed. It was also identified that 3,082 (22.3%) of families in the survey had one or both parents with a mental health problem.

3.3 Children and young people and Education

Data from the Annual School Census on 19th January 2012 shows that Cornwall and the Isles of Scilly have:

- 236 primary schools with 38,083 pupils (of which 27 were academies with 7,354 pupils).
- 2 nursery schools with 149 pupils.
- 31 secondary schools with 31,315 pupils (of which 13 were academies with 14,305 pupils). Of the 31,315 pupils 28,184 were in Years 7-11 and 3,131 were post-16 in 15 schools with sixth forms.
- 4 special schools with 362 pupils (of which 1 academy with 110 pupils). Of the 362 pupils 97 were primary age and 265 were secondary age.
- Total 273 schools with 69,909 pupils.
There were also 2,497 pupils on roll across 12 Independent schools in Cornwall (January 2011 School Census).

In January 2012 in Cornwall, 14.7% of primary pupils and 12.2% of secondary pupils (10-15) claimed (were eligible for) a free school meal in comparison with 19.2% of primary pupils and 15.9% of secondary pupils respectively in England in January 2011. In January 2011 in Cornwall, 14.7% of primary pupils and 11.7% of secondary pupils (10-15) claimed (were eligible for) a free school meal in comparison with 19.2% of primary pupils and 15.9% of secondary pupils respectively in England.

There has been an increase in take up (eligibility measured through claiming Free School Meals) within the last year, which is greater than the national increase. There has been a significant amount of publicity on this issue, although it is thought this is still not a true reflection of entitlement in Cornwall. The percentage of pupils eligible for Free School Meals, used historically for benchmarking by the DfE and OFSTED, has in the past been viewed as an unfair measure of social deprivation.

Research conducted by the DfE, highlighted potential problems with the take up of free school meals and suggests that up to 1 in 5 children entitled to receive free school meals do not take up this benefit.

Having Special Educational Needs (SEN) is strongly associated with onset and persistence of conduct disorders in particular. In Cornwall & Isles of Scilly's LA maintained schools in (School census January 2011 – 69,801 pupils in total) there were 14,755 young people with SEN in Cornwall & Isles of Scilly schools altogether; (school action, school action plus or statement). 1,982 (2.8%) pupils with statements and 12,773 (18.3%) pupils with school action or school action plus. In January 2011, some 224,210 (or 2.8 per cent) pupils across all schools in England had statements of SEN. This percentage has remained unchanged in recent years. In 2011 there were some 1,449,685 pupils in England with SEN without statements representing 17.8 per cent of pupils across all schools. This is a decrease of 0.4 percentage points from 2010, following increases in the years prior to this. Most of the decrease is in pupils at School Action.

Those with SEN are 16 times more likely to have a persistent mental disorder and 4 times more likely to develop a disorder compared to those who do not have an SEN. This would suggest that a substantial proportion of those young people in Cornwall & Isles of Scilly with SEN are also likely to have some kind of mental disorder or at increased risk of developing one.

There were 18 (0.06% of secondary school population, none from primary school population) permanent exclusions from Cornwall & Isles of Scilly schools in 2010/11. In the same year there were 253 fixed period exclusions from primary schools and 1471 from secondary schools (0.67% and 4.65% of primary and secondary schools’ population respectively). Nationally there were 5,740 permanent exclusions from maintained primary, state-funded secondary and special schools (0.08% of the total school population in England). In total, there were 331,380 fixed period exclusions (4.46% of the total school population in England)

Of the 331,380 (4.46% of the total school population) fixed period exclusions in England, 179,760 pupils (2.42%) had 1 or more episodes of fixed period exclusion compared to Cornwall – 1,740 fixed period exclusions (2.49% of the Cornwall schools population) and 1,060 pupils (1.52%) had 1 or more episodes.
It has been found that children and young people with persistent emotional disorder and persistent conduct disorder were more likely to be excluded from school. Those children, who had developed conduct disorder during the three years, were more likely to have been excluded from school (ONS, 2007).

Those with any persistent disorder were 19 times more likely to be excluded from school and 12 times more likely to develop a disorder compared to those with no disorder. Those with a conduct disorder were 47 times more likely to be excluded than those with no disorder. Again this would suggest that a substantial proportion of those who have been excluded from Cornwall & Isles of Scilly schools have some kind of mental disorder and are at much greater risk of developing one.
3.4 Children and young people and subjective well-being

In the UNICEF (2007)\textsuperscript{d} international report on children’s subjective well-being across 21 rich countries, the United Kingdom ranked the bottom on 3 dimensions of subjective well-being (personal well-being; behaviours and risks; and family and peer relationships); was fourth from the bottom for material well-being; and fifth from the bottom for educational well-being. The exception to this pattern was for health and safety with children in the UK ranking 12 out of a possible 21 countries. It is not surprising then the well-being of children and young people has become an important issue in this country, although the position had improved by the 2013 survey.

The Office for National Statistics’ (ONS) \textit{Measuring National Well-being} programme is investigating the well-being of children, young people and adults in Britain. The surveys on children’s subjective well-being have included questions on general happiness and life satisfaction as well as happiness with a number of aspects of their lives, such as family, friends, school and appearance. Nearly 90% of children aged 10 to 15 year olds said they were completely happy, somewhat happy or happy with their life as a whole (Knies, 2012)\textsuperscript{xvi}. About 15% of 10-12 year olds had high happiness scores, compared to 6% of 13-15 year olds. Smoking and drinking, high consumption of unhealthy foods and decreased consumption of fruit and vegetables were negatively associated with high happiness. Increased participation in sport was positively associated with high happiness. Children were happiest with family and friends and least happy with school and appearance.

Subjective well-being was measured slightly differently for young people aged 16 years or more and adults (Potter-Collins & Beaumont, 2012). Young people (16-24 years) consistently ranked the highest in terms of satisfaction with life, life being worthwhile, happiness, optimism and volunteering, compared to adults. For example, 85% of 16-19 year olds reported medium to high levels of optimism in the next 12 months.

These findings are consistent with the surveys carried out by the Children’s Society, using The Good Childhood Index. (Children’s Society,2012)\textsuperscript{xvii}. In their most recent survey of children aged 8 to 16 years old, 91% of children reported they were happy with their lives. The Good Childhood Index measures 10 aspects of life:

- Relationships with family
- Relationships with friends
- Time use
- Health
- The future
- Home
- Things (money and possessions)
- School
- Appearance
- Amount of choice in life.

Children and young people reported greatest happiness with family, health, home and friends and least happiness with appearance, choice and the future. Age is the strongest predictor of happiness with 4% of eight year olds reporting low well-being and 14% of 15 year olds. Individual and family factors (e.g. family structure) only explained a minority (less than 10%) of the variation in well-being.
The quality of children’s relationships and stability in their lives appeared to be important factors in terms of understanding well-being. For example, family conflict and changes in family structure had stronger associations with well-being than family structure itself. Similarly, experiences of bullying and stressful life events are known to have significant associations with well-being (Children's Society, 2012).

The Children’s Society conducted a Good Childhood Conversation in Cornwall in 2012 (Maitland, 2012). As part of this work, 1337 children and young people aged 8 to 17 years old from 5 locations (Helston, Camelford, Torpoint, Liskeard and Portreath) completed the Good Childhood Index. Findings from Cornwall were very similar to the findings from the national survey and children and young people were found to be happiest with family, friends and home. There were some small differences between the Cornish study and the national survey: on the positive side, Cornish children were more likely to be happy about where they lived and had a greater sense of safety and freedom; on the negative side, they were slightly less happy with their school and appearance.

When asked what would improve the area they live in the Cornish children and young people in the sample suggested more shops, whereas national samples referred to better youth facilities, parks and playgrounds. The Good Childhood Conversation in Cornwall also noticed that children in Cornwall sometimes referred to a dilemma about their future: should they leave Cornwall to seek better jobs or stay and accept poorly paid jobs. There are, then, some aspects of subjective well-being that are specific to the locality.

3.5. The prevalence of mental disorders in children and young people

Research has shown that early experience influences later development and can account for individual differences in aspects such as cognition, behaviour, social skills, emotional responses and personality. Early experiences, especially emotionally or affectively charged experiences with other humans, induce and organize the patterns of structural growth that result in the expanding functional capacities of a developing individual.

Attachment is the emotional bond that individuals form with their caregivers over the course of their infancy. The quality and timing of attachment could determine the quality of later development. Young children who do not have a relationship with at least one emotionally invested, predictably available, caregiver, even in the presence of adequate physical care and cognitive stimulation, display an array of developmental deficits that they endure over time. Some children develop intense emotional ties to parents and other caregivers who are unresponsive, rejecting, highly erratic or frankly abusive, and these relationships can be a source of serious childhood impairment.

It is believed that maternal deprivation can have the following consequences in children: dwarfism (retarded growth), aggressiveness, dependency anxiety (being ‘clingy’), intellectual retardation, social maladjustment, affectionless psychopathy (showing no feelings for others), depression and delinquency.

Children with problems related to insecure attachment begin to soak up statutory resources from early on when 'externalizing' behaviour (aggression, non-compliance, negative and immature behaviours, etc.) demands a response (Speltz et al., 1990). This is probably the largest group of children that Social Services, Special Education and the Child and Adolescent Mental Health Services are expected to deal with. The social and economic costs of these types of disorders are huge.
While maternal mental health has received increased attention in recent years, recognition of early problems in the under-five age group and how to deal with these problems is still in its infancy.

However, for the over five years there have been two national surveys of mental disorders in children and young people in Great Britain. The first was carried out in 1999\textsuperscript{xvi} and the second in 2004.\textsuperscript{xvii} There was little difference between the results of the 2004 survey and those found in 1999. The surveys use the term ‘mental disorders’ as defined by OCD-10, to imply a clinically recognisable set of symptoms and behaviours associated in most cases with considerable distress and substantial interference with personal functions. These surveys, then, focus on children and young people with moderate to severe mental health difficulties.

The 2004 survey of mental health in children and young people aged 5-16 years indicated that nationally:

- 1 in 10 (10%) children and young people aged 5-16 years had a clinically diagnosed mental disorder
- 4% had an emotional disorder.
- 6% had a conduct disorder.
- 2% had a hyperkinetic disorder.
- 1% had a less common disorder (including autism, tics, eating disorders and selective mutism).

Conduct disorders were more prevalent in boys and emotional disorders in girls. One in five children were diagnosed with more than one of the main categories of mental disorder. This represents 1.9% of all children. The most common combination was either conduct and emotional disorder or conduct and hyperkinetic disorder.

There have not been any specific surveys carried out in Cornwall & Isles of Scilly to identify the prevalence of mental disorders in children and young people. Therefore, national prevalence figures have been applied to local data on the population aged 5-17 years to provide estimates of the numbers of young people with specific disorders resident in Cornwall.

The national surveys undertaken only look at the population aged 5-16 years due the difficulties involved in calculating prevalence rates for those aged less than 5 years. This is because the assessment methods used in under 5s are different and less well developed compared to those used in assessing 5-16 year olds. As the population of interest is under 18 years, the 17 year old population have been included in the 5 to 16 years and rates extrapolated for 5 to 17 years of age.

Table 3.5 below provides the estimated numbers of children and young people aged 5-17 years with specific disorders and highlights that girls were more likely to have an emotional disorder than boys. Boys were more likely than girls to have any other type of disorder. Conduct disorders affect the greatest number of children.
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Great Britain prevalence (%)</th>
<th>Estimated Number of Young People (5-17 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>Emotional Disorders</td>
<td>3.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>2.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Social phobia</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Panic</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Post-traumatic stress</td>
<td>0</td>
<td>0.3</td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>0.6</td>
<td>1</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>0.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Depression</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Depressive episode (full ICD criteria)</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Other depressive episode</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Conduct Disorders</td>
<td>7.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Unsocialised conduct disorder</td>
<td>1.1</td>
<td>0.5</td>
</tr>
<tr>
<td>Socialised conduct disorder</td>
<td>1.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Other conduct disorder</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Hyperkinetic Disorder</td>
<td>2.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Less Common Disorders</td>
<td>1.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td>1.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Tic disorders</td>
<td>0</td>
<td>0.1</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Mutism</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>11.4</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Source: Mental Health of Children and Young People in Great Britain 2004 and Mid 2011 ONS Population Estimates

The identified prevalence rates per 1,000 population for the key overarching disorder categories outlined in the 2004 ONS survey (Table 3.6) shows that the estimated prevalence rate of emotional disorders and conduct disorders increases with age, whilst the rate of hyperkinetic and less common disorders remains fairly stable between the age groups.
Table 3.6: Prevalence rate (percentage) for population aged 5-16 years with mental health problems.

<table>
<thead>
<tr>
<th>Category of Disorder</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5-10 year olds</td>
</tr>
<tr>
<td>Emotional Disorders</td>
<td>2.4</td>
</tr>
<tr>
<td>Conduct Disorders</td>
<td>4.9</td>
</tr>
<tr>
<td>Hyperkinetic Disorders</td>
<td>1.6</td>
</tr>
<tr>
<td>Less Common Disorders</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Source: ONS 2004 survey

Table 3.7 shows the estimated numbers expected in C&IOS from the prevalence figures shown in Table 5.6b.

Table 3.7: Estimated numbers for mental health problems aged 5-10 years and extrapolated 11 to 17 years (using 11 to 16 prevalence rates) in Cornwall & Isles of Scilly

<table>
<thead>
<tr>
<th>Category of Disorder</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5-10 year olds</td>
</tr>
<tr>
<td>Emotional Disorders</td>
<td>763</td>
</tr>
<tr>
<td>Conduct Disorders</td>
<td>1,559</td>
</tr>
<tr>
<td>Hyperkinetic Disorders</td>
<td>509</td>
</tr>
<tr>
<td>Less Common Disorders</td>
<td>414</td>
</tr>
</tbody>
</table>

The prevalence of mental disorders was higher in children:
- In lone parent families (16%).
- In reconstituted families (14%).
- Whose interviewed parent had no educational qualifications (17%).
- In families with neither parent working (20%).
- In families with a gross weekly household income of less than £100 (16%).
- In households in which someone received disability benefit (24%).
- In families where the reference person was in a routine occupational group (15%).
- Living in the social or privately rented sector (17% and 14% respectively).
- Living in deprived areas (15%).

The 2004 mental health survey was followed up three years later with another survey in order to have a better understanding of the persistence of mental disorders and related risk and resilience factors. The three year follow up survey found that:
- 30% of the young people that were found to have an emotional disorder in 2004 continued to have one in 2007.
- 43% of the young people that were found to have a conduct disorder in 2004 continued to have one in 2007.
• 3.4% of those young people who did not have a disorder in 2004 had developed an emotional disorder by 2007 (170/4,926).
• 2.8% of those young people who did not have a disorder in 2004 had developed a conduct disorder by 2007 (140/4,926).

The report goes on to present the results of their analysis of the factors most likely to affect onset, persistence and resilience. They focus on emotional and conduct disorders as the numbers of young people with hyperkinetic disorders and less common disorders were low. They grouped their findings in relation to the following key overarching themes:

- **Child characteristics** – age, sex, ethnicity, physical illness, has Special Educational Needs (SEN), smoking, drinking and cannabis use.
- **Family characteristics** – one or two parent family, reconstituted family (contains step children), mother’s educational qualifications and number of children and young people in the family.
- **Household characteristics** – working status of household, socio-economic class (NS-SEC), tenure and household gross income.
- **Social factors** – psychological distress of mother and number of stressful life events.

The key risk factors affecting onset, persistence and resilience have been outlined in figure 3.1. The complexity of the relationship between the onset, persistence and resilience factors gives an indication of the difficulties inherent in seeking to reduce mental disorders in children and young people.
Figure 3.1: Risk factors affecting onset, persistence and resilience in relation to mental disorders in young people aged 5-16 years

### Onset – Emotional Disorders
- **Age** – being older (14-16 years) OR=2.2
- **Physical illness** – OR=1.7
- **Gender** – being a girl OR=1.8
- **Change in number of parents** – going from 2 parents to 1 OR=4.5
- **Employment** – no parent working, persistent unemployment OR=4.4
- **Number of children** – 2 children in the family reduced risk of onset compared to only 1 OR=0.6
- **Mother’s mental health** – high GHQ12 scores especially persistently high scores OR=3.5
- **Number of significant life events** – 3+ stressful life events OR=2.7

### Onset – Conduct Disorders
- **Gender** – being a boy, odds reduced if a girl OR=0.7
- **Physical illness** – OR=2.9
- **SEN** – OR=3.7
- **Change in number of parents** – going from 2 parents to 1 OR=2.87
- **Reconstituted families** – compared to ‘traditional’ families (6% Vs 2%)
- **Rented accommodation** – continued living in rented accommodation OR=3.5
- **Mother’s mental health** – high GHQ12 scores especially persistently high scores OR=3.3
- **Number of significant life events** – 3+ stressful life events OR=2.7

### Persistence – Emotional Disorders
- **Mother’s mental health** – high GHQ12 scores especially persistently high scores OR=3.3
- **Social status** – living in households defined as ‘intermediate’ and ‘small employers’ OR=5.3 compared to ‘higher/lower managerial and professional’
- **Accommodation type** – living in rented accommodation increased the likelihood of persistence
- **Number of significant life events** – 3+ stressful life events OR=2.7

### Persistence – Conduct Disorders
- **Age** – being older (11-13) OR=1.9
- **Gender** – being a boy
- **SEN** – OR=2.1
- **Number of children in household** – 3+ children increased likelihood of persistence OR=2.5
- **Social status** – lower supervisory / semi-routine / routine OR=2.2
- **Education** – mother having no qualifications
- **Rented accommodation** – OR=5.9
- **Income** – living in household with ≤ £400 a week OR=2.1
- **Mother’s mental health** – high GHQ12 scores especially persistently high scores OR=6.9

### Resilience
- Rated high on child strengths
- Rated high on social aptitudes
- Higher number of friends
- Parental approval of friends
- Parents did not think their child’s friends got into trouble
- Good social support networks
- Positive views about the neighbourhood in which they live
- Trust others
- Helping others
- Participation in clubs / groups

Source: Three years on: Survey of the development and emotional well-being of children and young people, 2008.
3.6. Mental disorders, self-harm and suicide

In the previous section it was noted that one fifth (20%) of children and young people with a mental disorder have multiple disorders (i.e. more than one mental disorder). It is also recognised that young people with mental health problem often experience problems around self-harm and suicide. The ONS report on the mental health of children and young people in 2004 asked all parents whether their child had ever tried to hurt, harm or kill themselves. The same question was also asked directly to those aged 11-16 years. The prevalence of self-harm was higher when based on the child’s self-report compared to the parent’s report in relation to 11-16 year olds. Almost a third of young people aged 11-16 years with an emotional disorder said that they had tried to harm themselves. This is around four and a half times higher than those with no disorder (table 3.8).

Table 3.8: Prevalence of deliberate self-harm in young people aged 5-16 years by mental disorder and no mental disorder for 5-16 year olds

<table>
<thead>
<tr>
<th></th>
<th>Emotional disorder</th>
<th>Conduct disorder</th>
<th>Hyperkinetic disorder</th>
<th>Autistic spectrum disorder</th>
<th>No disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-16 year olds</td>
<td>14%</td>
<td>16%</td>
<td>14%</td>
<td>25%</td>
<td>2%</td>
</tr>
<tr>
<td>(parent reports)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-16 year olds</td>
<td>19%</td>
<td>18%</td>
<td>14%</td>
<td>NA</td>
<td>2%</td>
</tr>
<tr>
<td>(parent reports)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-16 year olds</td>
<td>28%</td>
<td>21%</td>
<td>18%</td>
<td>NA</td>
<td>6%</td>
</tr>
<tr>
<td>(self-report)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Mental Health of Children and Young People in Great Britain 2004 and Mid 2010 ONS Population Estimates

Table 3.10 indicates that there could be over 3,000 16-19 year olds in Cornwall & Isles of Scilly who have ever self-harmed and potentially just over 130 who may have attempted suicide in the last year. 16-24 year olds had the highest prevalence of suicidal thoughts, attempts and self-harm compared to all other age groups.

The Adult Psychiatric Morbidity in England, 2007 identifies a self-harm rate for 16 to 24 year old males to be 7.9% while for females it is a staggering 17%. The majority of those who self-harm will not be known to services.

In a survey undertaken by ‘Hear Our Voice’ self-harm was recognised by young people as a prevalent and growing concern, particularly for looked after young people. These young people were less likely to turn to families or professionals for support with self-harm, and more likely to talk to friends or cope alone.

Factors preventing young people asking for help with self-harm included fears around ‘overreaction’, judgement or other unhelpful responses, stigma and fears around confidentiality and that self-harm is not well understood by parents, or a number of professionals. It was felt that professionals need better training and awareness around self-harm, particularly in how to respond appropriately.

So as identified previously, it is unlikely that most young people that self-harm are engaged with professional help. However, a percentage of those who self-harm end up at A&E or a minor injury unit, and in extreme cases, become an inpatient.
At A&E at Treliske in the years October 2009 to and inclusive of September 2012 there were around 112 presentations for self-harm in the 10 to 14 age group, and 188 presentations for self-harm in the 15 to 19 year age groups. In comparison for the whole of Cornwall and the Isles of Scilly primary Care Trust in a similar period of the years March 2009 to March 2012 there were around 52 admissions for self-harm in the 10 to 14 age group, while there were around 290 admissions for self-harm in the 15 to 19 year age groups. It must be remembered that the Treliske catchment area is far smaller than the whole of Cornwall, IE: does not take into account Plymouth hospitals, North Devon and the Community hospitals.

The highest inpatient group were the 20 to 24 year olds with around 325 admissions. In these age groups for males and females the main diagnosis was ICD10 T36 to T65 which describes poisoning at 75% and 87% respectively. The remaining cases were mainly ICD10 S000 to T35, which describes wounding.

Table 3.9: Prevalence of suicidal thoughts, attempts and self-harm in young people aged 16-24 years.

<table>
<thead>
<tr>
<th></th>
<th>% Prevalence 16-24 year olds (Men)</th>
<th>% Prevalence 16-24 year olds (Women)</th>
<th>% Prevalence 16-24 year olds (All)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal thoughts (past year)</td>
<td>5.4</td>
<td>8.5</td>
<td>3.4</td>
</tr>
<tr>
<td>Suicide attempts (past year)</td>
<td>1</td>
<td>2.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Self-harm (lifetime)</td>
<td>7.9</td>
<td>17</td>
<td>12.4</td>
</tr>
</tbody>
</table>


NB: The prevalence for 16-24 year olds has been used as a proxy for 16-19 year olds and has then been applied to the Cornwall & Isles of population aged 16-19 years to ascertain the estimated numbers of 16-19 year olds with each condition.

Data from the South West Public Health Observatory on Suicide and Self-harm in the South West (2012) indicates that suicide rates in Cornwall and the Isles of Scilly are consistently higher than the national average. The directly standardised rates of suicides and undetermined death (per 100,000 population), for persons of all ages in South West local authorities for 2007 to 2009 inclusive were 7.9 per 100,000 compared to Cornwall at 9.7 per 100,000, and England at 7.9 per 100,000.

Table 3.10: Estimates of suicidal thoughts, attempts and self-harm in young people aged 16-19y ears, for Cornwall & Isles of Scilly (extrapolated from 16-24 years data).
<table>
<thead>
<tr>
<th></th>
<th>19 year olds (Men)</th>
<th>16-19 year olds (Women)</th>
<th>16-19 year olds (All)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal thoughts (past year)</td>
<td>718</td>
<td>1,091</td>
<td>889</td>
</tr>
<tr>
<td>Suicide attempts (past year)</td>
<td>133</td>
<td>308</td>
<td>131</td>
</tr>
<tr>
<td>Self-harm (lifetime)</td>
<td>1,051</td>
<td>2,183</td>
<td>3,242</td>
</tr>
</tbody>
</table>

Between 50-60 people living in Cornwall and Isles of Scilly die each year by suicide. Research suggests that certain groups are more vulnerable or are regarded as high risk groups. They are:
1. Young and middle aged men
2. People in the care of mental health services, including inpatients
3. People with a history of self-harm
4. People in contact with the criminal justice system
5. Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

The South West Suicide Audit 2010 (DH, 2012) shows at a regional level a very strong gradient of increasing suicide rate with higher levels of deprivation. The report also shows an upward trend in the South West for admissions to hospital for self-harm between 2001/2 and 2008/9. Males increased from 2,457 to 3,425, while females increased from 3,239 to 5,169. The peak of admissions for females is in the 15 to 19 years age group, while males have a bi-modal peak at 20 to 24 years and again 35-39 years age group.

3.7 Mental disorders and substance misuse
The 2004 ONS survey also investigated the relationship between mental disorder and substance misuse. Table 3.11 presents the prevalence of smoking drinking and drug use among children with mental disorders.

Table 3.11 Prevalence of smoking, drinking and drug use by disorder in young people aged 11-16 years (1999 and 2004 data combined)

<table>
<thead>
<tr>
<th></th>
<th>Emotional Disorders</th>
<th>Conduct Disorders</th>
<th>Hyperkinetic Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Smoking</td>
<td>23%</td>
<td>8%</td>
<td>34%</td>
</tr>
<tr>
<td>Drinking</td>
<td>13%</td>
<td>9%</td>
<td>19%</td>
</tr>
<tr>
<td>Drug use</td>
<td>20%</td>
<td>8%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: The mental health of children and young people, 2004

Given the prevalence figures above, there could be the following numbers of young people in Cornwall & Isles of Scilly with mental disorder who also smoke (either occasionally or regularly), drink alcohol regularly (at least once a week) or use illegal drugs (mainly cannabis):

- The Health and Social are Information Centre Report (2011) suggests that in 2010 five per cent of pupils smoked. Extrapolating this to the CIOS 11 to 16 years population would equate to 1,833 smokers (422 with emotional disorders; 632 with conduct disorders; 385 with hyperkinetic disorders).
- The Health and Social are Information Centre Report (2011) suggests that in 2009 eighteen per cent of 11 to 15 yr. old pupils had had a drink in the last week, a proxy for a definition of regular drinker. In CIOS this would equate to
6,598 regular drinkers (857 with emotional disorders; 1,253 with conduct disorders; 857 with hyperkinetic disorders).

- The Health and Social Care Information Centre Report (2011) suggests that the proportion of 11 to 16 year olds who regularly take drugs is 2% or 733 pupils. This equates to 146 with emotional disorders; 205 with conduct disorders; 169 with hyperkinetic disorders).

The adult psychiatric morbidity study provides prevalence information for those aged 16-24 years in relation to alcohol use and dependence and drug dependence. Table 3.12 outlines these prevalence rates and estimates the possible numbers for Cornwall & Isles of Scilly young people aged 16-19 years based on this.

**Table 3.12: Prevalence of alcohol use and dependence and drug dependence in young people aged 16-24 years, with estimated numbers of Cornwall & Isles of Scilly young people aged 16-19 years.**

<table>
<thead>
<tr>
<th></th>
<th>% Prevalence 16-24 year olds (Men)</th>
<th>% Prevalence 16-24 year olds (Women)</th>
<th>% Prevalence 16-24 year olds (All)</th>
<th>Estimated numbers of 16-19 year olds in Cornwall &amp; Isles of Scilly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing risk drinking</td>
<td>33.6</td>
<td>27.2</td>
<td>30.4</td>
<td>7,948</td>
</tr>
<tr>
<td>Higher risk drinking</td>
<td>8.8</td>
<td>4.8</td>
<td>6.8</td>
<td>1,778</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>12.6</td>
<td>9.8</td>
<td>11.2</td>
<td>2,928</td>
</tr>
<tr>
<td>Severe alcohol dependence</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>157</td>
</tr>
<tr>
<td>Moderate alcohol dependence</td>
<td>1</td>
<td>0.3</td>
<td>0.6</td>
<td>157</td>
</tr>
<tr>
<td>Mild alcohol dependence</td>
<td>11.6</td>
<td>9.6</td>
<td>10.6</td>
<td>2,771</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>13.3</td>
<td>7</td>
<td>10.2</td>
<td>2,666</td>
</tr>
</tbody>
</table>


NB: The prevalence for 16-24 year olds has been used as a proxy for 16-19 year olds and has then been extrapolated to the Cornwall & Isles of Scilly population aged 16-19 years to ascertain the estimated numbers of 16-19 year olds with each condition.

Given that young people with mental health problems are more likely to undertake risky behaviours such as drinking, smoking and drug use, there is a need to ensure that services are available for those young people where more specialist substance misuse services are required. In addition, all young people in contact with CAMHS services should also be exposed to information and activities around healthy lifestyles in order to support reductions in prevalence amongst these groups.

### 3.8. Children and young people vulnerable or ‘At Risk’ of mental health difficulties

There are a number of groups of children and young people who may be at greater risk of developing a mental disorder or having a persistent mental disorder. This section looks at some of the key themes / groups in a little more detail to attempt to ascertain what this might mean for Cornwall & Isles of Scilly’s children and young people. Particular attention is given to the following groups of children and young people, starting with the largest to smallest groups in terms of number of children affected:
3.8.1. Children who have been abused

The National Society for the Prevention of Cruelty to Children (NSPCC) indicates on their website\textsuperscript{xix} that:

- 1 in 10 (9.8%) children aged 11-17 years have experienced severe neglect\textsuperscript{xx}.
- 1 in 14 (6.9%) children aged 11-17 years have experienced severe physical violence at the hands of an adult as per bullet above.
- 1 in 20 (4.8%) children aged 11-17 years have experienced contact sexual abuse as above.
- 31% of children experienced bullying by their peers during childhood\textsuperscript{xxi}.
- There is a strong correlation between domestic violence and child maltreatment as per bullet above.
- 6% of young people aged 18-24 years said that they had experienced frequent and severe emotional maltreatment during childhood as above.
- Almost two thirds of children killed at the hands of another person in England and Wales are aged under 5\textsuperscript{xxii}.

In Cornwall & Isles of Scilly at May 2012 there were 454 children with a Child Protection Plan. They are likely to have a complex needs in relation to emotional health and well-being. In addition, given the prevalence figures outlined by the NSPCC, there could be a large number of children and young people who have experienced some significant life events, which may impact on their mental and emotional well-being.

If we use the mid-2010 ONS 11-17 year old Cornwall & Isles of Scilly population (36,453), there could be as many as:

- 3,572 young people who have experienced severe neglect.
- 2,515 young people who have experienced severe physical violence.
- 1,750 who have experienced contact sexual abuse.
- 2,787 who have experienced frequent and severe emotional maltreatment.

The 2004 ONS survey estimated that 12% of 11-16 year olds have a mental disorder and the 2007 ONS follow up survey indicated that overall the odds of developing a mental disorder where 2.4 times higher in those children who had experienced 3 or more stressful life events. It can therefore be estimated that 28.8% of children who have experienced abuse may have a significant mental disorder, which is:

- 1,029 young people who have experienced severe neglect.
- 724 young people who have experienced severe physical violence.
- 504 who have experienced contact sexual abuse.
- 794 who have experienced frequent and severe emotional maltreatment.

3.8.2. Children with Learning Disabilities

The White Paper, ‘Valuing People’ published in 2001 included the following definition of learning disabilities.
Learning disability includes the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

In the UK the terms mild, moderate, severe and profound have been used, which have been linked to IQ test scores. IQ is one way of classifying learning disability, with mild classified as having an IQ of 50-70; moderate having an IQ of 35-50; severe having an IQ of 20-35; and profound having an IQ of below 20. The problem with relying on IQ scores only is that it does not take into account a person’s personal growth and development; does not take into account our individual strengths and abilities; and importantly does not take into account the degree of social functioning and adaptation.

Learning disability differs from learning difficulty in that the latter is often used to refer to someone with specific learning problems e.g. dyslexia and does not take into the wider facets of learning disability such as intellectual impairment.

A recent study by Emerson and Hatton in 2007 found that, consistent with other previous studies, the prevalence of learning disabilities amongst children and young people was 3.5%. It also indicated that over 1 in 3 people with learning disabilities have a diagnosable psychiatric disorder and are just 6 times more likely to have such disorders compared to those with no learning disability.

Using the study prevalence of 3.5% of children and young people having a learning disability, there could be an estimated 3,771 nought to 18 year olds with some form of learning disability in Cornwall & Isles of Scilly. This contrasts with Glover et al (2011) estimates, using school based data of 1,816 children with a learning disability. The estimates in Table 3.13 are based on the Glover estimates.

**Table 3.13. Prevalence estimates for children with learning disabilities and mental health problems.**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Children with learning disabilities</th>
<th>Children without learning disabilities</th>
<th>Odds ratio</th>
<th>Estimated number of people with learning disabilities who may have a mental disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any psychiatric disorder</td>
<td>36%</td>
<td>8%</td>
<td>6.5</td>
<td>654</td>
</tr>
<tr>
<td>Any emotional disorder</td>
<td>12%</td>
<td>4%</td>
<td>3.6</td>
<td>218</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>11%</td>
<td>3%</td>
<td>3.9</td>
<td>200</td>
</tr>
<tr>
<td>ADHD</td>
<td>8%</td>
<td>1%</td>
<td>8.4</td>
<td>145</td>
</tr>
</tbody>
</table>
### 3.8.3 Young Offenders and Mental Disorder

Children and young people in contact with the Youth Justice System are at least three times more likely to have mental health problems compared to those in the general population.\(^{xxv}\)

In a study published by the Youth Justice Board for England and Wales in 2005\(^{xxvi}\) they found that:

- 31% of young offenders had a mental health need.
- 18% had problems with depression.
- 9% had a history of deliberate self-harm within the last month.
- 10% had anxiety problems.
- 9% had post-traumatic stress.
- 7% had hyperactivity.
- 5% had psychotic like symptoms.

Female offenders had significantly higher levels of mental health need:

- Depression – 35% females; 13% males.
- Deliberate self-harm ever – 17% females; 7% males.
- Post-traumatic stress – 19% females; 6% males.

In 20010/11 there were 710 young people covered by the Youth Offending Team in Cornwall & Isles of Scilly and in 2011/12 there were 579 young people. This was a reduction of 18%, but with a reported greater complexity of caseload. It can be estimated that approximately, 220 will have a severe mental disorder.

### 3.8.4. Children in Care

In 2002, ONS carried out a survey, which looked at the mental health of young people looked after by local authorities, otherwise referred to as Children in Care (CIC).\(^{xxvii}\) It indicated that of children in care:

- 45% of CIC aged 5-17 years were assessed as having a mental disorder
- 37% had clinically significant conduct disorders.
- 12% had emotional disorders.
- 7% were rated as hyperactive.
- 4% had less common disorders.
- The overall prevalence includes some children who had more than one type of disorder.
- CIC aged 5-10 years were around 5 times more likely to have a mental disorder (42%) compared to those children living in private households.
- CIC aged 11-15 years were almost 5 times more likely to have a mental disorder (49%) compared to those children living in private households (11%).

### Table: Mental Health Conditions among Young Offenders and Autistic Spectrum Disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Young Offenders</th>
<th>Autistic Spectrum Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any conduct disorder</td>
<td>21%</td>
<td>8%</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>5.7</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>381</td>
<td>145</td>
</tr>
</tbody>
</table>


\(^{xxv}\) xxv

\(^{xxvi}\) xxvi

\(^{xxvii}\) xxvii
• 68% of CIC living in residential care were assessed as having a mental disorder compared to 33.8% of those in foster care; 41.9% of those living with their natural parents; and 51.3% of those living independently.

• The prevalence of mental disorder decreased with the length of time in their ‘current placement’ (from 49.4% less than a year to 31.1% over 5 years).

• CIC with a mental disorder were more likely to have difficulty with reading, writing and mathematics; to be three or more years behind; to have SEN; to smoke; to drink alcohol; to use drugs.

The Children in Care service in Cornwall & Isles of Scilly have on average between 470 and 490 looked after children each month, with a turnover of about a third each year. In addition, there is on average another 150 to 160 children placed into Cornwall from other local authorities. The service also has input to children who have short break provision exceeding 75 nights, which is currently between 80 and 90 children and a small number of children who are in hospital exceeding 90 nights. Whilst all these children have emotional health needs, a number are likely to have significant mental health needs. It can be estimated that at any one time between 211 and 220 Children in Care may have a severe mental disorder.

3.9. Summary of the epidemiological information on Cornwall & Isles of Scilly’s CAMHS

This section has brought together epidemiological information in order to assess the level of need in Cornwall and Isles of Scilly. In other words, enable a reliable estimation about the number of children and young people who require support around their emotional and social well-being and mental health. Figure 5.8 attempts to summarise some of the information gathered and relates this to the provision of universal, targeted and specialist services. Thus, it can be estimated that in Cornwall and the Isles of Scilly there are:

• 102,971 children and young people aged 0-17 years
• 69,547 are in nursery, primary and secondary education
• 14,755 have Special Educational Needs of which 1,982 have a Statement of SEN
• 12,970 live in poverty
• 7,265 have moderate mental health difficulties
• 3,241 are Children in Need
• 1,998 have severe and complex mental health difficulties
• 1,816 have Learning Disabilities
• 710 are Young Offenders
• 479 are Children in Care

These figures must be treated with some caution as they are not comparable (i.e. refer to different age ranges and time periods). Thus, approximately 1 in 10 children (5-15 years) will have a clinically diagnosed mental disorder and the most common
disorder will be conduct disorders (experienced by 3,669 children and young people), followed by emotional disorders (experienced by 2,341 children and young people). Conduct disorders are more common in boys and emotional disorders in girls. Conduct and emotional disorders can be persistent with 30% to 43% of children continuing to report symptoms over a three year period.

There is good evidence that certain groups of young people are more at risk of developing mental health problems. In particular, children who have been abused, children with learning disabilities, young offenders and Children in Care.

We also know that mental health problems do not exist in isolation as one in five children and young people experience multiple mental health difficulties and a significant proportion are also engaging in self-harming behaviours, including suicide and experimenting with drugs and alcohol. The risks associated with these groups of children and young people, then can be high and it is essential that a multi-agency approach is taken as no-one agency can attend to these multiple aspects of risk and resilience.

There are gaps in the epidemiological evidence, in particular:

- Reliable estimates of mental health difficulties in 0-4 year olds
- Reliable estimates of mental health difficulties across infancy, childhood and adolescence (e.g. different definitions of mental disorder for 16+ years)
- Reliable estimates of attachment difficulties in 0-17 year olds
- Reliable estimates of trauma and loss among 0-17 year olds

By 2021 the number of 0-17 year olds will have increased by 10.6% and this will put additional demand for emotional well-being and mental health services. These epidemiological statistics have focused on the mental health difficulties and risk factors. It must be remembered that approximately 90% of children and young people report they are happy and satisfied with their lives.

Figure 5.8 Summary of epidemiological information on children and young people in Cornwall and the Isles of Scilly.
Section 4: Mapping Comprehensive CAMHS Services for children and young people in Cornwall

4.0. Introduction
This section will document comprehensive CAMHS services for children and young people within Cornwall and Isles of Scilly. It is appreciated that children, young people, parents and professionals have access to national organisations and services (e.g. Young Minds, Child Line, National Autistic Society) that support children and young people’s mental health, but these will not be included in this report. The aims of this section of the report are to identify:

- what services are provided;
- who provides and commissions them;
- who they are for;
- how widespread they are across Cornwall;
- their strengths and limitations; and
- gaps in service provision.

The emphasis is on mapping service provision and current service use. A brief assessment of strengths and limitations will be based largely on the availability and accessibility of these services. It will not be possible to comment on the quality of the services provided, how efficient and effective they are, standards of practice, how ‘joined up’ services are and how much they are valued by service users and professionals. These aspects relate to the quality of a service provision and will be captured in Section 5 of this report.

In order to understand what mental health services are available to children and young people in Cornwall it is important to have an appreciation of the culture in which professionals, services and agencies work. This is not an easy task when mental health policies and commissioning arrangements change, services undergo reorganisation and budgets are reduced or prioritised resulting in the loss of some services and the development of others in the public, private and voluntary sectors. In other words, change is constant and mapping what is available within Cornwall is in reality a snapshot.

The geographic isolation of Cornwall and the Isles of Scillies also means that there is less through put of professionals coming into and leaving services. Consequently professionals often move from one service or sector to another and there is often a perception that one service’s gain is another’s loss. These sorts of dynamics can both help and hinder multi-agency working, depending on the reputation of professionals, the circumstances of these moves and changes in role and how these are managed.

In addition, Cornwall has a large self-employed and small businesses sector and rural community. On the positive side, there is a lot of independent thinking and creativity - people tend to make things happen. On the negative side, liaison and joint working requires much more investment and projects can pop up and disappear when funding is short-term and limited and the potential to expand limited. There are also access to services issues for those children and young people living on one of the islands in the Isles of Scilly.

Bearing in mind these difficulties, this section will attempt to provide a broad overview of Comprehensive CAMHS in Cornwall and Isles of Scilly, with a particular focus on Universal, Targeted and Specialist services, as previously defined.
4.1 Organisation of mapping exercise
For reasons of clarity, this mapping exercise will make distinctions between
universal, targeted and specialist interventions, as defined in Section 1. Universal
services are available to ALL children and young people. Targeted interventions are
available to those with specific and additional needs, children with mild to moderate
mental health needs, Children in Need and Children with Disabilities. Specialist
interventions are for those with severe and complex mental health difficulties,
Children in Care and children requiring residential, secure, rehabilitation and inpatient
services.

Services providing support to children and young people around their emotional and
social well-being and mental health always consider the context in which children live
and develop (i.e. their parenting, families, schools and communities). Interventions
then, are often at multiple levels: for children and young people, their parents and
families and wider systems (e.g. school and local communities). A distinction will be
made between interventions that primarily focus on working directly with:
1) **Children and young people** – focusing on children’s and young people’s well-
being, resilience, development and skills and supporting their emotional and social
well-being and mental health.
2) **Parents** – focusing on parents’ well-being and parenting skills and helping parents
to support their children’s emotional and social well-being, development and mental
health;
3) **Families, schools and wider community** – focusing on families’ well-being and
functioning and how related systems and communities support children’s emotional
and social well-being and mental health.

These three levels of intervening are not mutually exclusive. It is likely that the more
severe and complex mental health difficulties will require input at all these different
levels. There may also be difference across the age range. Thus, after assessing a
very young child’s development (i.e. preschool) services are likely to focus on
parental and family interventions to ensure this child is able to develop in a safe and
good enough environment with parents who are able to meet their child’s needs. As
children become older (i.e. secondary school age) interventions may focus more on
working directly with young people, ideally with the involvement of their parents and
family, but this may be less important as a young person learns to be more
independent and manage their difficulties appropriately.

This way of mapping services and levels of interventions (i.e. children and young
people, parents and families) is compatible with more recent policy documents and
NICE guidelines which address early interventions and improving access to
psychological therapies for children and young people. For example, the Children
and Young People’s IAPT is a service transformation project which aims to embed
evidence based practice across services. This project makes distinctions between
psychological therapies for children (e.g. Cognitive Behavioural Therapy and
Interpersonal Therapy), parent training (e.g. Webster Stratton for parents with
children 3-10 years of age) and Family interventions (e.g. Systemic Family Therapy).
Interesting, CYP IAPT is focusing on psychological therapies for children and
parenting strategies in the first instance, followed by systemic family therapy,
perhaps indicating how much more complicated and complex the latter is.

The information summarised in the Tables that follow were gathered directly from
service providers. Service providers were asked very basic information about the
services they provided in terms of:
• who their service was for (i.e. any eligibility criteria)
• how many professionals were employed to deliver the service and their professional roles
• how many children, young people, parents and/or families were referred to their service, were assessed and received an therapeutic intervention over a one year period.
• Strengths and limitations of their services
• Gaps in service provision

It has not been possible to check on the accuracy of the data provided and sometimes it is difficult to make comparisons across services as different agencies collect a variety of statistics and performance indicators.

The Tables are not complete as it was not possible to gather all the required information in the time frame of the project. Cornwall Partnership NHS Foundation Trusts’ Psychological Therapies Strategy (Burgess and Hunter, 2012) provided useful information on specialist service provision within Cornwall and the Isles of Scilly. The engagement and consultation exercises will address some of the gaps in knowledge. The tables are ‘live’ as of the time of producing this report and it is likely that they will need updating on an ongoing data to reflect changes in service development and provision. The Tables provide a good overview of the variety of interventions available.

4.2 Mapping Interventions for children and young people
Table 1 lists direct interventions for children and young people around their emotional and social well-being and mental health difficulties. Universal services tend to be delivered in most towns and many villages in Cornwall, through health centres, schools, children’s and youth centres. Many universal services provide face to face support as well as access via telephone helplines and the internet. Although some universal service carry out home visits (e.g. Health Visitors), most are based in local centres and schools. For the Isles of Scilly, these services are available on St Mary’s.

Targeted services are often available in the same venues as universal services, as well as being available in their own premises. Some Targeted services work hard at engaging with young people and provide interventions in children’s homes or in places where they feel more comfortable in the community (e.g. youth clubs, leisure centres) whichever is the most appropriate.
<table>
<thead>
<tr>
<th>Name of intervention</th>
<th>Service Providers</th>
<th>Professionals involved</th>
<th>Description of service</th>
<th>Availability within Cornwall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nurseries, schools and colleges</strong></td>
<td>Providers: Cornwall Council and Academies</td>
<td>Head Teachers, Teachers, Teaching Assistants, Mentors, Monitors/Supervisors</td>
<td>Educational provision for children and young people, including mainstream, independent, pupil referral units (PRUs), and special schools</td>
<td>Cornwall wide 2 nurseries, 236 primary schools, 31 secondary schools, 4 special schools, 7 PRUs, 16 independent schools</td>
</tr>
<tr>
<td><strong>School counsellors</strong></td>
<td>Provider: Schools and Academies</td>
<td>Counsellors</td>
<td>Provide individual sessions and drop in support</td>
<td>Cornwall wide though differences in provision across schools Approximately 0.2 counsellor per secondary school</td>
</tr>
<tr>
<td><strong>Integrated Health Centres</strong></td>
<td>Provider: Schools</td>
<td></td>
<td>Health and well-being support, drop in sessions and appointments</td>
<td>Budehaven, Penair and Hayle secondary schools</td>
</tr>
<tr>
<td><strong>General Practitioner Practices</strong></td>
<td>Providers: Private sector</td>
<td>GPs</td>
<td>Provision of primary care</td>
<td>Cornwall wide Approximately 70 independent practices available in most towns and some villages in Cornwall</td>
</tr>
<tr>
<td><strong>Healthy Relationships Programme</strong></td>
<td>Provider: CLEAR Commissioned by IDVA</td>
<td>Therapists &amp; Counsellors</td>
<td>Training programmes for young people in secondary school raising awareness of domestic violence, abusive and acceptable behaviour and where to go for support</td>
<td>In 2012/13: delivered to all Y9 pupils in 11 secondary schools in 8 ‘hotspot’ towns in Cornwall</td>
</tr>
<tr>
<td><strong>Safe relationships and friends for everyone</strong></td>
<td>Provider: SaFE Commissioned by IDVA</td>
<td></td>
<td>Training programmes for young people in secondary schools, raising awareness of abusive and safe relationships and where to go for support</td>
<td>In 2012/13 delivered to pupils in secondary schools in Cornwall</td>
</tr>
<tr>
<td><strong>Kooth</strong></td>
<td>Provider: Private Commissioned by CSF, Cornwall Council</td>
<td>Counsellors</td>
<td>Online, telephone &amp; and face to face counselling, support and advice to young people aged 11-25 years</td>
<td>Cornwall wide 15 staff and volunteers. 287 young people used Kooth July-Sept 2012: 153 received online &amp; 76 face to face counselling, 990 counselling sessions in total</td>
</tr>
<tr>
<td><strong>Youth Cornwall</strong></td>
<td>Provider: CSF, Cornwall Council</td>
<td>Youth workers</td>
<td>Information, Advice and Guidance for young people age 13 to 19 years and up to 24 years if have additional needs.</td>
<td>Cornwall wide 32 Youth Centres, Clubs, Projects and Forum</td>
</tr>
<tr>
<td><strong>SHARE</strong></td>
<td>Provider; CSF, Coordinator</td>
<td></td>
<td>Drop in service in Information, advice,</td>
<td>Cornwall wide, Share shops in 8 localities</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Cornwall Council</strong></td>
<td>Outreach workers, Youth workers, Volunteers</td>
<td>guidance and mentoring</td>
<td>For 2012, 13667 young people accessed service, 3318 relating to personal support, 510 referrals to Kooth, 158 to Mentoring &amp; 144 advice for mental health difficulties in particular</td>
<td></td>
</tr>
<tr>
<td><strong>Brook Advisory Service</strong></td>
<td>Provider: voluntary sector</td>
<td>Helpline, advice and support about sexual health for young people under 25 years of age</td>
<td>Cornwall wide</td>
<td></td>
</tr>
<tr>
<td><strong>Careers South West</strong></td>
<td>Provider: Voluntary</td>
<td>Information, advice, guidance practical support around preparing for adult and working life for 13-19 years</td>
<td>Cornwall wide</td>
<td></td>
</tr>
<tr>
<td><strong>Youth Offending Service</strong></td>
<td>Provider: Cornwall Council</td>
<td>YOS case workers and secondments from health, police, social work, education and probation. Work with young people aged 10 to 17 years</td>
<td>Cornwall wide 2011/12: YOS had 44 members of staff, including two part-time nurse specialists. YOS worked with 749 young people, 348 of these received an offense outcome and 74 of these were referred to YOS specialist nurse for holistic health assessment. In total 43 of these identified as having mental health difficulties, 20 of whom were referred to specialist CAMHS.</td>
<td></td>
</tr>
<tr>
<td><strong>Pyramid Kernow</strong></td>
<td>Provider: CSF, Cornwall Council</td>
<td>Pyramid Co-ordinator who provides training and resources for club leaders. Therapeutic group work for children aged 7 to 14 years. 10 week clubs for children who show early signs of mental health problems such as social withdrawal, somatic disorders, anxiety &amp; depression</td>
<td>Limited. 1 co-ordinator In 2012, there were 44 club leaders who provided 16 clubs in 14 schools (1 secondary and 13 primary) for 143 children</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Mental Health Workers</strong></td>
<td>Provider: CFT</td>
<td>Primary Mental Health Workers Short term therapeutic support (approx 3 months) for children aged 0 to 18 years. Trained in CBT, SF, Mellow Parenting Solihull, Video Interaction Guidance</td>
<td>Cornwall wide 7.9 WTE staff each with caseload of approximately 35 children at any one time.</td>
<td></td>
</tr>
<tr>
<td><strong>Outlook Southwest</strong></td>
<td>Provider: Private sector</td>
<td>Personal Well-being Advisors, Counsellors &amp; Psychologists Short term Cognitive Behavioural Therapy and Interpersonal Therapy for young people and adults aged 16+years with mild to moderate mental health problems</td>
<td>Cornwall wide In 2011/12 received 693 referrals for 16-18 year olds, 323 attended first appointment, 17 referred to AMHS</td>
<td></td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>BEME</td>
<td>Provider: CFT</td>
<td>Nurses, Councillors, Therapists</td>
<td>Short term Cognitive Behavioural Therapy and Interpersonal Therapy for young people and adults aged 16+ years with mild to moderate mental health problems</td>
<td>Cornwall wide New service available from January 2013</td>
</tr>
<tr>
<td>Aspires</td>
<td>Provider: Dreadnought</td>
<td></td>
<td>Socialisation project for young people with diagnosis of an ASD aged 13-17. Weekly groups and outreach work</td>
<td>Penzance, Redruth, Bodmin &amp; Launceston</td>
</tr>
<tr>
<td>People First</td>
<td>Provider: Voluntary</td>
<td>Project Manager, Co-ordinator &amp; Outreach Workers</td>
<td>Advocacy, young people and adults with learning disabilities</td>
<td>Cornwall wide Small Team of 10 staff</td>
</tr>
<tr>
<td>Hear Our Voice</td>
<td>Provider: Voluntary Commissioned by CFT, PCT and others</td>
<td>Youth workers, volunteers</td>
<td>Support to young people aged 11 to 25 years with mental health problems. One to one support (up to 12 hours), advocacy, group work, CAMHS Shadow Board, training in schools</td>
<td>Cornwall wide 200 referrals and work with 150 young people per annum. Heads Up training to 600 young people in schools per annum</td>
</tr>
<tr>
<td>Jigsaw</td>
<td>Provider: CSF, Cornwall Council Commissioned by CSF, Cornwall Council</td>
<td>12 Counsellors offering therapeutic support</td>
<td>10 sessions of counselling for children and young people who have experienced sexual abuse</td>
<td>Cornwall wide Approx 140 referrals per annum</td>
</tr>
<tr>
<td>CLEAR</td>
<td>Provider: Voluntary Commissioned by IDVA</td>
<td>Counsellors, Therapists, Art, Music and Drama Therapists</td>
<td>12 sessions of Individual counselling for children aged 0 – 25 years who have experienced domestic violence. Service user group, CLEAR Voices.</td>
<td>Cornwall wide, 12 Therapists Approx 140 referrals per annum with most receiving an intervention</td>
</tr>
<tr>
<td>Penhaligon’s Friends</td>
<td>Provider: Voluntary Sector</td>
<td></td>
<td>Individual, group and family support to children and young people who have experienced bereavement. Training and support to professionals on bereavement issues</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Foyer Projects</td>
<td>Provider: Independent Futures, part of Devon &amp; Cornwall Housing</td>
<td>Housing support</td>
<td>Young people aged 16+ years...</td>
<td>Cornwall wide 8 projects provide accommodation and support for 79 young people in Cornwall</td>
</tr>
<tr>
<td>CRASAC</td>
<td>Provider:</td>
<td>Counsellors</td>
<td>Telephone and face to face counselling for</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------</td>
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<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Cornwall Rape &amp; Sexual Abuse Centre</td>
<td>Voluntary Sector</td>
<td></td>
<td>young people aged 13+years and adults</td>
<td></td>
</tr>
<tr>
<td>WRASAC</td>
<td>Provider: Voluntary sector</td>
<td>Counsellors</td>
<td>Telephone and face to face counselling for 13+years, women only.</td>
<td>Bodmin</td>
</tr>
<tr>
<td>The Dreadnought Centre</td>
<td>Provider: Voluntary Commissioned by CC and YOS</td>
<td>Project Manager, Office Manager, Project Coordinators, Project Workers</td>
<td>Support for children and young people aged 8 to 19 years with emotional and behavioural problems. Provide 1:1 and 12 week group programmes around variety of issues, such as anger management, socialisation, self-esteem, DV, mentoring, befriending, and activity groups</td>
<td>Cornwall wide. Team of 8 staff, 10 sessional workers and 75 volunteers. 160 children and young people receiving a Dreadnought service across Cornwall in 1 week, 58 attend 1:1 or groups at Pool Centre, 13 1:1 Outreach in West and 31 in North &amp; East</td>
</tr>
<tr>
<td>Aspires</td>
<td>Provider: The Dreadnought Centre</td>
<td></td>
<td>Young people aged 13-17 years with a diagnosis of an Autistic Spectrum Condition Weekly evening groups</td>
<td>Cornwall wide – 5 towns in Cornwall</td>
</tr>
<tr>
<td>SPLAT club</td>
<td>Provider: The Dreadnought Centre</td>
<td></td>
<td>Children aged 7 to 11 years with a diagnosis of ADHD, ADD meet once a week</td>
<td>Cornwall wide. There is a charge for the service of £16.50 per session</td>
</tr>
<tr>
<td>Hot Spot</td>
<td>Provider: The Dreadnought Centre</td>
<td></td>
<td>One to one sessions for young people aged 8-19 years who are playing with fire or involved in hoax calls. 12 week course if further support required</td>
<td>Training delivered to 1073 young people in schools to raise awareness of</td>
</tr>
<tr>
<td>BF Adventure</td>
<td>Provider: Voluntary</td>
<td>Management Instructors, volunteers</td>
<td>Outdoor activity centre for disadvantaged, disaffected and disabled children aged 7+ years. One off holiday activities to minimum of 6 sessions+ and ongoing support</td>
<td>Cornwall wide. Team of 50 members of staff, including volunteers and instructors. Funding required for all activities. Work closely with Behaviour Support Team and schools</td>
</tr>
<tr>
<td>Kernow Young Carers</td>
<td>Provider: Action for Children</td>
<td></td>
<td>Children and young people who provide regular care and support for a member of their family</td>
<td>Cornwall wide though small team of 5 WTE staff. 281 young carers on database, 45 referrals and 8 discharges between April &amp; September 2012.</td>
</tr>
<tr>
<td>Wave Project</td>
<td>Provider: Voluntary</td>
<td>Project Manager Coordinator Instructors Volunteers</td>
<td>Surfing instruction for children and young people aged 8+ years who face exceptional challenges in their lives. The aim is to build confidence and self-esteem.</td>
<td>Cornwall wide service, Team of 1.5 staff and 10-15 surfing instructors for various projects, 160 trained and registered volunteers 100 referrals in 2011/12. Ongoing surf club with 40 members</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
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<tr>
<td>Phoenix Project</td>
<td>Provider: Cornwall Fire and Rescue Service</td>
<td></td>
<td>1 and 5 day courses for young people aged 13 to 17 years who have not fulfilled their potential aimed at building self-esteem and confidence</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>YZUP</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Young Person’s Substance Misuse Workers Manager Administrator</td>
<td>Harm reduction, information, education, drug &amp; alcohol information &amp; work around causes of substance use for young people aged 11-18 years with substance misuse problems</td>
<td>Cornwall wide, 6 YPSMW 1 Manager 2011/12: 225 young people referred and assessed, 127 received Tier 3 intervention and 98 Tier 2 intervention, 215 discharged from service</td>
</tr>
<tr>
<td>Young Addaction</td>
<td>Provider: Addaction - voluntary sector</td>
<td>Youth workers</td>
<td>Education, Aspire Project, Family work, Young Addaction Plus for young people aged less than 18 years</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Pentreath Ltd</td>
<td>Provider: Voluntary sector</td>
<td>Community development workers, Outreach workers, Family Support workers</td>
<td>Promote mental health through personal development, education and employment for people aged 14+years with mental health difficulties. Generally work up to 6 months</td>
<td>Cornwall wide Team of 44 WTE staff, 6 of whom work specifically with young people. Worked with 120 young people in the last 12 months.</td>
</tr>
<tr>
<td>Specialist CAMHS</td>
<td>Provider: CFT</td>
<td>Community Nurses, Clinical Psychologists, Art Therapists, Family Therapists, Psychotherapist, CBT Therapist, Child Psychiatrists, Specialist doctors</td>
<td>Therapeutic, support and advice for children aged 0 to 18 years with severe and complex mental health difficulties, including Cognitive Behavioural Therapy, Systemic Family Therapy, Psychoanalytic Psychotherapy, Eye Movement Desensitisation Reprocessing (EMDR), Integrative psychological therapy, Applied Behavioural Intervention and medication.</td>
<td>Cornwall wide 28.5 WTE staff. 2472 referrals per annum, 1712 assessment, telephone consultations</td>
</tr>
<tr>
<td>Specialist CAMHS/LD</td>
<td>Provider: CFT</td>
<td>Community Nurses, Clinical Psychologists, Child Psychiatrists, Art Therapists, Psychotherapists</td>
<td>Therapeutic, support and advice for children aged 0 to 18 years with learning disabilities and severe and complex mental health difficulties</td>
<td>Cornwall wide 9.3 WTE staff 256 new assessments per annum,</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
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</tr>
<tr>
<td><strong>Eating Disorders Service</strong></td>
<td>Provider: CFT</td>
<td>Community Nurse, Family Therapists, Clinical Psychologists</td>
<td>Therapeutic support for children and young people with eating disorders</td>
<td>Cornwall wide 1 dedicated Nurse Specialist, Access to 3 Family Therapists, 4 Psychologists, 1 CBT therapist. 61 referrals in last 6 months and 44 in receipt of service</td>
</tr>
<tr>
<td><strong>Early Intervention Service</strong></td>
<td>Provider: CFT</td>
<td>Team Manager, Psychiatrist, Community Psychiatric Nurses, Occupational Therapists, Support Workers, Administration</td>
<td>Young people aged 14 – 35 years experiencing first episode of psychosis</td>
<td>Cornwall wide Team of 21 staff. 2011/12: 59 referrals and assessments aged 14-18 years, 12 on current caseload.</td>
</tr>
<tr>
<td><strong>Voice4Us</strong></td>
<td>Provider: Barnardos</td>
<td>Youth Workers</td>
<td>Children in Care</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td><strong>Carefree</strong></td>
<td>Provider: Voluntary sector</td>
<td>Youth workers</td>
<td>Young people in care aged 11-25 years, particularly those leaving care. Build confidence and skills, provide peer mentoring, group, holiday activity programmes and Edulink</td>
<td>Cornwall wide, based at Redruth Team of Youth Workers -5 full-time and 2 part-time. In last 12 months, approximately 80 young people have received 50-100 hours of support, some considerably more.</td>
</tr>
<tr>
<td><strong>CICSS Children in Care Education Support Service</strong></td>
<td>Provider: CSF, Cornwall Council</td>
<td>Virtual School comprises of Head Teacher, Education Officers, Teachers, Higher Level Teaching Assistants, Administrator, FAB reading project coordinator</td>
<td>Improve attainment and achievement for Children in Care</td>
<td>Team of 10 members of staff. Virtual school consists of 334 Cornish CIC. Worked with and supported 426 CIC in 2010/11.</td>
</tr>
</tbody>
</table>
Specialist services tend to be delivered in Child and Family Centres easily identified as health and/or local authority property, across 6–8 localities in Cornwall. Although specialist services may carry out outreach work, they are more likely to require a building that can provide therapeutic spaces where children and young people can work on issues without distraction and interruption.

Universal services are provided by a variety of providers (statutory, voluntary and private), targeted services are largely provided by the voluntary sector (though may be paid by the statutory sector) and statutory sectors and specialist services by the statutory sector, with Cornwall Council focusing on Children in Care and Cornwall Foundation Trust on children with severe and complex mental health problems. There appears to be less diversity in the provision of services as mental health difficulties become more severe and complex.

Targeted services are more likely to focus on children with additional needs and there are much fewer Targeted services for children and young people with mild to moderate mental health problems with no additional needs. There appears to be more universal and targeted services for young people (11+ years/secondary school aged) compared to younger children (primary school aged).

A total of 43 services and interventions were identified: 11 Universal, 25 Targeted and 7 Specialist.

4.3 Mapping interventions for parents
Table 2 details services that focus on working directly with parents in order to improve children and young people’s well-being and development. These interventions include informal parenting support groups (e.g. Oasis), more structured parenting programmes (e.g. Mellow Parenting, Incredible Years), counselling and creative therapies groups (e.g. Parent Counselling service), personal development and advocacy work (e.g. WILD) and longer term outreach support work (e.g. Family Nurse Partnership). Many of these interventions are delivered in Children’s and Community Centres. Some of these interventions are well established (e.g. Penhaligon’s Friends) and others are new projects (e.g. Partner’s Group), still at their pilot stage and there is uncertainty around their future provision.

The parenting interventions have been listed in terms of how they are often talked about or referred to (e.g. Solihull Approach). Consequently, some of the interventions listed refer to particular programmes or interventions (e.g. Early Bird, Video Interaction Guidance) and some to particular teams or services (e.g. Special Parenting service). It is easier to grasp the coverage of a service than an intervention. For example, the WILD young parents’ project is a Cornwall wide service delivered by approximately 9 members of staff who work with approximately 450 families per annum. In contrast Video Interaction Guidance is an intervention which 32 professionals across Cornwall Council and CFT have received training in, but access to this intervention and the number of parents that have received this service is unclear.

What is immediately apparent from Table 2 is the limited availability of universal and specialist support for parents, with most parenting interventions being Targeted and available to parents of children with additional needs. There are some parenting interventions for children with specific mental health difficulties (e.g. ADHD, conduct problems), but these are short-term in nature with few providing longer term or ongoing support. Parenting programmes for parents with children receiving specialist services are rare.
Although many staff in health, social care and education statutory sectors have been trained in evidence based parenting programmes it is unclear how many actual programmes are being delivered within Cornwall and whether there is equal access to these programmes.

Many parenting programmes appear to be focused on parents with young children (less than 3 years of age), with an emphasis on preventative practice, early intervention and raising awareness around child development. Parenting interventions tend to be group based rather than provided at an individual level, thereby encouraging the development of local support networks. There are a number of programmes for young and disadvantaged parents (e.g. WILD, YMWA, FNP).

There are few Universal and Targeted parenting interventions for parents with older children (i.e. adolescents) with challenging behaviour, emotional and social difficulties and disabilities. Targeted interventions for parents who may be regarded as more difficult to reach are more available within the domestic violence arena than for parents with substance misuse and/or mental health problems.

A total of 32 types of parenting interventions and services were identified: 5 Universal, 26 Targeted and 1 Specialist
<table>
<thead>
<tr>
<th>Name of intervention</th>
<th>Service Providers</th>
<th>Professionals involved</th>
<th>Description of service</th>
<th>Availability within Cornwall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal, perinatal and postnatal support</td>
<td>Providers: CFT</td>
<td>Midwives</td>
<td></td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Solihull Approach</td>
<td>Providers: CFT</td>
<td>PMHW, Health Visitors &amp; School Nurses</td>
<td>10 week course for parents of children aged 0 – 18 years with universal to complex needs</td>
<td>Evidence based programme. Cornwall wide. All PMHW trained. 49 Health visitors and school nurses trained</td>
</tr>
<tr>
<td>Here’s Looking At You trilogy: Bump, Baby and Little One</td>
<td>Providers: CSF, Cornwall Council CFT Commissioners: CSF, Cornwall</td>
<td>Parenting coordinators Play Workers Play Supervisors FSW, PMHW, Youth Worker, Children’s Centre staff</td>
<td>6 week courses available to parents with children up to 3 years of age.</td>
<td>Cornwall wide. Approx 80 staff trained</td>
</tr>
<tr>
<td>Parents and Children Together</td>
<td>Provider; CSF, Schools</td>
<td></td>
<td>Training programme for parents to help them talk to their children about personal relationship</td>
<td>Limited service. Approx 12 staff trained No groups commissioned in last 12 months</td>
</tr>
<tr>
<td>Mellow Parenting</td>
<td>Providers: CSF, Cornwall Council &amp; CFT Commissioners: CSF, Cornwall</td>
<td>Parenting coordinators Family Support Workers PMHW</td>
<td>14 week course for parents with mental health problems with children 1-5 years</td>
<td>Cornwall wide Approx 30 staff trained</td>
</tr>
<tr>
<td>Incredible Years</td>
<td>Providers: CSF, Cornwall Council &amp; Parenting coordinators, FSW, CSF, Cornwall</td>
<td></td>
<td>12 week courses for parents with children from 3-12 years with conduct problems.</td>
<td>Cornwall wide Approx 30 staff trained</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
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</tr>
<tr>
<td>Positive Parenting</td>
<td>Providers: CSF, Cornwall Council CFT Commissioners: CSF, Cornwall</td>
<td>Parent Support Advisor, Family Support Worker, Play/Creche supervisor</td>
<td>10 week specialist ‘Time Out’ courses for parents with children with special needs, ADHD or ASC.</td>
<td>Very limited service, approx 5 staff trained</td>
</tr>
<tr>
<td>Take 3</td>
<td>Providers: CSF, Cornwall Council CFT Commissioners: CSF, Cornwall</td>
<td>Youth Offending Officers, Youth Workers/Coordinators, FSW, PSA</td>
<td>10 week course for parents of children aged 10-18 years, with additional 10 optional sessions.</td>
<td>Cornwall wide service, approx 45 staff trained</td>
</tr>
<tr>
<td>Oasis</td>
<td>Providers: CSF, Cornwall Council CFT Commissioners: CSF, Cornwall</td>
<td>FSW, Play/Creche Supervisor</td>
<td>Informal sessions on a weekly or monthly basis for parents, carers and grandparents. Can bring children along.</td>
<td>Limited service, approx 5 staff trained</td>
</tr>
<tr>
<td>Early Bird</td>
<td>Providers: Cornwall Council</td>
<td>Educational Psychologists</td>
<td>3 month programme for parents of children of preschool age with diagnosis ASD. Includes group training and home visits, 2½ hours support per week.</td>
<td>Unclear how widespread</td>
</tr>
<tr>
<td>Early Bird Plus</td>
<td>Providers: Cornwall Council</td>
<td>Educational Psychologists</td>
<td>8 week programme for parents of children aged 4 to 8 years with diagnosis of ASD. Includes 2 home visits and 6 month follow-up.</td>
<td>Unclear how widespread</td>
</tr>
<tr>
<td>RESERVE</td>
<td>Providers: Addaction, CADA</td>
<td>Addaction, CADA workers</td>
<td>4 sessions for parents with children aged 8-16 years focusing on prevention of harm from substance misuse.</td>
<td>Limited service, Penwith and Kerrier</td>
</tr>
<tr>
<td>Suzie Project</td>
<td>Provider: Women's Refuge, Truro, Voluntary sector</td>
<td>FSW, Children’s Centre Managers, PSA</td>
<td>12 week Recovery Toolkit course, drop in support groups and 1:1 outreach work</td>
<td>Cornwall wide, Approx 15 staff trained in Tool Kit</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
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</tr>
<tr>
<td>Women's Refuge</td>
<td>Provider: Voluntary Sector</td>
<td>Counsellors and Outreach Workers</td>
<td>12-20 week Group Therapy, creative skills groups. 1:1 counselling and outreach work, Helpline</td>
<td>Penzance</td>
</tr>
<tr>
<td>ESTEEM WAVES</td>
<td>Provider: Women's Refuge, Truro, Voluntary Sector</td>
<td>WAVES counselling for women. ESTEEM, counselling for male,</td>
<td></td>
<td>Truro</td>
</tr>
<tr>
<td>Partner's Group</td>
<td>CSF, Cornwall Council</td>
<td>2 Counsellors</td>
<td>12 week course.</td>
<td>Very limited, delivered in two centres, St Austell and Camborne for less than 15 mothers.</td>
</tr>
<tr>
<td>WILD Young Parents Project – disadvantaged And socially excluded</td>
<td>Providers: Voluntary Sector Commissioners, CSF, Cornwall Council and PCT</td>
<td>Approx 9 members of staff: Manager Youth Workers Project Workers Skills Co-ordinator Children’s work Co-ordinator</td>
<td>Skills development, parenting, education, support for mothers less than 23 years with children less than 5 years of age</td>
<td>Cornwall wide, 11 groups in children’s centres. Approx: 450 families per annum, 60% single mums. 80% housing &amp; benefits help 70% help with DV 70% help with mental health 50 young dads</td>
</tr>
<tr>
<td>YMWA Young Mums Will Achieve</td>
<td>Providers: Cornwall Council, Cornwall College and Fit n Fun Kids Limited</td>
<td>Support, guidance and learning. One year programme for young mums aged 14-19 years. Meet two days per week</td>
<td>Cornwall wide – 8 towns across Cornwall</td>
<td></td>
</tr>
<tr>
<td>Cornwall One Parent Support</td>
<td>Providers: Voluntary sector</td>
<td>Support networks, weekly groups, activities &amp; outings, workshops for parents in one parent families</td>
<td>Cornwall wide</td>
<td></td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>Providers: CFT Commissioners: PCT</td>
<td>Supervisor and Family Nurses</td>
<td>All first time mothers aged 19 years and under. Beginning with weekly, fortnightly then monthly visits from pregnancy until child’s 2nd birthday.</td>
<td>Cornwall wide 1 supervisor and 8 Family Nurses. For 2011/12 there were 228 referrals. Maximum caseload of 25 clients. 48 clients graduated.</td>
</tr>
<tr>
<td>Video Interaction</td>
<td>CSF Cornwall Council</td>
<td>Educational Psychologists (9)</td>
<td>Therapeutic work</td>
<td>Very limited, 4 members of staff qualified &amp; 28 in training.</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
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<tr>
<td>Guidance (VIG)</td>
<td>CFT</td>
<td>PMHW (6) Early Years workers (5) Clinical Psychologist (CIC Team) (4) Scallywags (2) Social Workers (3) Teachers/school staff (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PACE group</td>
<td>CSF, Cornwall Council CFT</td>
<td>SW (CIC team), CIC Psychology Team</td>
<td>6 week course for foster carers only. Referral by CIC Psychology Team and/or Social Worker. Up to 12 FC in a group. Two groups provided to date.</td>
<td>Very limited 2 groups run in Truro to date.</td>
</tr>
<tr>
<td>Carers Group</td>
<td>CFT</td>
<td>Family Therapists Clinical Psychologists</td>
<td>Monthly support meetings for parents with children with eating disorders</td>
<td>Limited’ meetings based in Truro on</td>
</tr>
<tr>
<td>Special Parenting Service</td>
<td>CFT</td>
<td>Consultant Clinical Psychologist Clinical Psychologist Community Psychiatric Nurse</td>
<td>Assessment, intervention and support to parents with learning disabilities and those in the borderline range</td>
<td>Limited as team of 3 members of staff. 2011-12: 74 parents referred and 54 accepted, including 91 children</td>
</tr>
<tr>
<td>Penhaligan’s Friends</td>
<td>Penhaligan’s Friends Voluntary Sector</td>
<td>Bereavement workers Befriending facilitators</td>
<td>Parents drop in groups for surviving parents within a family</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Outlook Southwest Post natal depression groups</td>
<td>Provider: Private sector</td>
<td>Counsellors</td>
<td>5 session which offer support and skills building for mothers with post natal low mood</td>
<td>Cornwall wide, six areas, Falmouth, Camelford, Truro, Camborne, Penzance &amp; Liskeard</td>
</tr>
<tr>
<td>Small Steps Big</td>
<td></td>
<td></td>
<td>Parents of children with additional needs aged 0-4 years</td>
<td></td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Professionals involved</td>
<td>Description of service</td>
<td>Availability within Cornwall</td>
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<tr>
<td>achievements</td>
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<tr>
<td>Face to Face</td>
<td></td>
<td>Parents with children with learning disabilities</td>
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</tr>
<tr>
<td>S.P.A.C.E</td>
<td>Provider: Action for Children</td>
<td>Parenting groups for parents with children with disabilities and additional needs</td>
<td></td>
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</tr>
<tr>
<td>Parent Carer Council for Cornwall PCCC</td>
<td>Provider: voluntary</td>
<td>Advice, support, information for parents with children with disabilities</td>
<td>Cornwall wide</td>
<td></td>
</tr>
<tr>
<td>Parent Counselling Service</td>
<td>Provider: CFT</td>
<td>Psychoanalytic Psychotherapist Parent Counsellors</td>
<td>Individual counselling for parents with children with mental health difficulties.</td>
<td>Very limited Only available to parents whose child is in receipt of specialist CAMHS service: 0.46 WTE Psychoanalytic Psychotherapist who supervises work of 5 Highly Specialist Parent Counsellors employed on sessional basis. For 2011/12, parents from 71 families were provided with face to face therapy sessions</td>
</tr>
</tbody>
</table>
4.4 Mapping Interventions for Families

Table 3 details a variety of family, school and community based interventions available across Cornwall. These interventions are harder to define because they include whole directorates (e.g. Children in Need, Children in Care, Disabled Children and Therapy Services) and services (e.g. specialist CAMHS). They focus on working with the whole family (e.g. Family Intervention Project, Family Therapy), with whole communities (e.g. Cornwall Neighbourhood for Change) and working across systems (e.g. educational services, housing services, child and adult mental health services) that impact on families’ functioning. Universal services are often school based, targeted services tend to be home and community based and specialist services tend to be based in Child and Family Centres, hospitals and residential homes.

Targeted services often have procedures that underpin this more systemic way of working (e.g. Common Assessment Framework and Team Around the Child (TAC) meetings). Specialist services use Child Protection and Care Programme Approach with legal requirements and regular review meetings to ensure progress is being monitored and a recovery model supported.

The family level interventions listed in Table 3 again cover a wide range of services from one off holiday activities for families with children with additional needs to longer term risk management, child protection and therapeutic work. These approaches tend to be more labour intensive as they entail working with whole systems, from the smallest system which is the family unit to larger systems, such as educational, health, social work and youth justice services.

There are a variety of whole school interventions pitched at the universal level of intervention (e.g. anti-bullying strategies, SEAL, R-Time). Targeted services focus on those where there is statutory and legal responsibility to safeguard children and promote their well-being and development and ensure children with additional needs are not excluded and discriminated against. This way of working requires building good relationships and networks within and across services;

It is difficult to establish the use of whole school interventions across schools within Cornwall and the extent to which social and emotional aspects of well-being are embedded in school’s curriculum and ethos.

Targeted services tend to be restricted to those most at risk or those with additional needs rather than those with mild to moderate mental health problems. Building good relationships and networks liaisons takes time, more organisation, planning and maintaining – it is, then, more labour intensive.

Specialist interventions for children and young people with severe and complex mental health difficulties tend to be provided by Cornwall Foundation Trust. The Local Authority (CSF, Cornwall Council) tend to provide support to Children in Care. There is no specialist in-patient or rehabilitation mental health provision for children and young people in Cornwall

A total of 37 types of interventions and services with a family or whole systems approach were identified: 12 Universal, 19 Targeted and 6 Specialist.
<table>
<thead>
<tr>
<th>Name of intervention</th>
<th>Service Providers</th>
<th>Who trained/qualified to deliver</th>
<th>Description</th>
<th>Availability within Cornwall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social and Emotional Aspects of Learning (SEAL)</td>
<td>Provided by schools.</td>
<td>Schools led, may commission other providers to deliver aspects of the curriculum</td>
<td>School based intervention</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Personal Social Health and Economic Education (PSHEE)</td>
<td>Provided by Schools</td>
<td>Schools led, may commission other providers to deliver aspects of this curriculum</td>
<td>School based intervention</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>R-Time Relationships to improve education</td>
<td>Provider: Pyramid Kernow, CSF, Cornwall Council</td>
<td>No dedicated staff, Coordinator of Pyramid Kernow is an R-Time trainer and with a freelance trainer and national service promotes this programme in the South West</td>
<td>Programme to improve relationships, social skills, self-confidence and general behaviour. The programme is ongoing, year on year.</td>
<td>Cornwall wide In 2012, training workshops provided to 300 staff (including 150 midday supervisors) with 127 schools having some involvement with R-Time. 4 R-Time accredited schools.</td>
</tr>
<tr>
<td>Cornwall Healthy Schools</td>
<td>Provider: Health Promotion Service, NHS</td>
<td>School based support, information, advice, &amp; training, such as Resilience and Self-Esteem toolkit (ReSET), The Christopher Winter Project’s Drug and Alcohol and Sex and Relationships educational resources, Mindfulness for schools, Stop Stigma, Promoting Active Democracy Loudly (PADL)</td>
<td>Difficult to establish how many schools have accessed various levels of support</td>
<td></td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
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</tr>
<tr>
<td>Cornwall Anti-Bullying Harassment Services Consortium</td>
<td>Provider: Victim Support Commissioned by: Cornwall Council</td>
<td></td>
<td>Freephone helpline to, provide advice and support to children, young people and parents around bullying issues. Peer support training and support around anti-bullying policies</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Cornwall Neighbourhood for Change CN4C</td>
<td>Provider: voluntary</td>
<td></td>
<td>Strengthening Families Strengthening Communities 12 week programme for parents</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Family Information Service (FIS)</td>
<td>Provider: Cornwall Council</td>
<td></td>
<td>Provides information on local and national services for children, young people, parents and families</td>
<td>Cornwall wide – website</td>
</tr>
<tr>
<td>Children’s Centres</td>
<td>Provider: CSF</td>
<td></td>
<td>Support, information, advice, training, creche and play facilities for children less than 5 years and their families</td>
<td>Cornwall wide 18 Children’s Centres</td>
</tr>
<tr>
<td>Multi-agency Referral Unit</td>
<td>Provider: multi-agency</td>
<td></td>
<td>Single point of access for concerns around safeguarding</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>General Practitioner Practices</td>
<td>Provider: private General Practitioners Primary Care professionals</td>
<td></td>
<td>Information, advice, support, assessment, treatment for children 0-18 years and their families</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Health Visiting Team</td>
<td>Provider: CFT Health Visitors Community Nurses Community Nursery Nurses Health Care Support Worker</td>
<td></td>
<td>Provides support and advice to families and monitors child development for 0-4 year olds. Work with pregnant women from 28 weeks. Discharged at 3-4 month post natal review if assessed as Universal.</td>
<td>Cornwall wide 90 WTE Health Visitors with target of 122 by 2015. Approx 5800 babies born per annum.</td>
</tr>
<tr>
<td>School Nursing Team</td>
<td>Provider CFT School Nurses Community Nurses Student Nurses</td>
<td></td>
<td>Provide advice and information to children, young people, parents &amp; teachers. Carry out annual health assessments</td>
<td>Cornwall wide Approx 34 WTE nurses</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
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</tr>
<tr>
<td>The Equality and Diversity Service</td>
<td>Provider: Cornwall Council</td>
<td>Advisory Support or Lead Teachers Cultural Diversity Support Workers (CDSW)</td>
<td>Promote equality and diversity in Cornwall. Deliver Cornwall’s Ethnic Minority Achievement Service and Traveller Education service. Specialist interests, BME, Gypsy, Roma and Traveller and Additional Language inclusion.</td>
<td>Cornwall wide: 6 WTE Lead teachers and CDSW.</td>
</tr>
<tr>
<td>Referral and Assessment Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager Team Managers Social Workers Trainee Social Workers Contact Workers</td>
<td></td>
<td>Cornwall wide. Team of 49 staff</td>
</tr>
<tr>
<td>Supporting Families Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td></td>
<td>8 locality teams whose work includes children’s centres, youth work and family and parent support programmes</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Children’s Specialist Social Work Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager Team Managers Social Workers Trainee Social Workers Contact Workers</td>
<td></td>
<td>Cornwall wide. Team of 114 staff.</td>
</tr>
<tr>
<td>Children in Need (CIN)</td>
<td>Providers: CSF, Cornwall Council</td>
<td>Manager Team Managers Social Workers Youth Workers Family Support Workers</td>
<td>Focus on children at risk</td>
<td>Cornwall wide. Team of 46 staff.</td>
</tr>
<tr>
<td>Family Intervention Project (FIP)</td>
<td>Provider: Action for Children Commissioned by CSF, Cornwall Council</td>
<td>Service Manager and Coordinators Social Worker Family Support Practitioners</td>
<td>Children &amp; young people at risk, particularly arising from parenting mental health problems, substance misuse and domestic violence</td>
<td>Cornwall wide Approx team of 19 staff, 15 Family Support Practitioners. 2 Coordinators, 1 SW, 1 Manager 185 referrals per annum, 85 families</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Family Assessment Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Manager Social Workers Support Workers Night Supervisors</td>
<td>6 week residential family assessment for high risk families</td>
<td>Team of 14 staff. 50-60 referrals and 18 assessments per annum</td>
</tr>
<tr>
<td>Family Group Conferencing</td>
<td>Provider: Cornwall Council</td>
<td>Family Group Conferencing workers</td>
<td>FGC workers facilitate meetings to help families’ find their own solutions</td>
<td>Cornwall wide 9 members of staff employed on casual basis, each hold 1-4 cases at any one time. 105 referrals for 226 children in 11 months. 51 went to conference</td>
</tr>
<tr>
<td>Scallywags</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Educational Psychologists Support Workers</td>
<td>6 month intensive programme for children aged 3-7 years with complex emotional and behavioural difficulties</td>
<td>Cornwall wide 9 Support Workers and 1 Educational Psychologist. 219 children referred, 63 assessed, receive intervention and discharged per annum</td>
</tr>
<tr>
<td>Education Behaviour Support Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Behaviour Support Advisors</td>
<td>Supporting schools in the management of social and emotional needs that lead to challenging behaviour for children aged 5 to 16 years.</td>
<td>Cornwall wide 3.5 Behaviour Support Workers &amp; 3 Advisors Free to maintained primary schools only, other schools will need to buy in support.</td>
</tr>
<tr>
<td>Specialist Support Team</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager Outreach Workers</td>
<td>Work with Children in Need and Children in Care</td>
<td>Cornwall wide. Team of 22 staff</td>
</tr>
<tr>
<td>Crisis Support Team</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager Senior Support Workers Support Workers</td>
<td>Work with children aged 0 to 18 years with a named Social Worker</td>
<td>Cornwall wide Team of 21 staff. 270 families for safe and well visits, 1900 home visits, 120 for intensive family support, 36 children visited Out of Hours</td>
</tr>
<tr>
<td>Children’s Disability and Therapy Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Senior Manager Team Managers Occupational Therapists (OT) Coordinators</td>
<td></td>
<td>Cornwall wide. Team of 50 staff.</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
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</tr>
<tr>
<td>Residential Short Breaks Services</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager Centre Managers Residential Centre Workers Care Assistants Nightcare Assistants Ancillary Staff</td>
<td>Residential support of children and young people with disabilities</td>
<td>Cornwall wide. Team of 104 staff.</td>
</tr>
<tr>
<td>Short Break Services</td>
<td>Provider; CFT</td>
<td></td>
<td>Disabled children</td>
<td>Cornwall wide 3 home with 1789 overnight 2011/12</td>
</tr>
<tr>
<td>Autistic Spectrum Team</td>
<td>Provider: CSF, Cornwall Council</td>
<td></td>
<td>Children with diagnosis on ASD</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Early Years Inclusion Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Educational Psychologists SENCOs Autism workers Portage workers</td>
<td>Work with families with children 0-5 years with SEN and disabilities.</td>
<td>Cornwall wide service 25 WTE staff 368 referrals &amp; 94 Statutory Assessment per annum</td>
</tr>
<tr>
<td>SPACE</td>
<td>Provider: Action for Children</td>
<td></td>
<td>Holiday activities for disabled children and young people aged 5 to 18 years</td>
<td></td>
</tr>
<tr>
<td>A.S.K Activities for Special Kids</td>
<td>Provider: Voluntary</td>
<td></td>
<td>Activities, support and information to families with disabled children</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Children’s Hospice South West</td>
<td></td>
<td></td>
<td>Family support</td>
<td></td>
</tr>
<tr>
<td>Breaking the Cycle EMPACT</td>
<td>Provider: Addaction</td>
<td>Counsellors</td>
<td>Family Group work for parents with substance misuse problems</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
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<tr>
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</tr>
<tr>
<td>Community Children's and Diana Nurses</td>
<td>Provider: CFT</td>
<td>Nurses</td>
<td>Support children with complex health needs, disabilities, life limiting and threatening conditions and their families</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Short Break and Home Care Service</td>
<td>Provider: CFT</td>
<td>Nurses, Care Assistants</td>
<td>Short breaks and respite for families with children aged 3-18 years with learning disabilities &amp; physical health needs</td>
<td>Limited 3 homes: 2 in Camborne and 1 in Liskeard</td>
</tr>
<tr>
<td>Speech &amp; Language Therapy Team</td>
<td>Provider: CFT</td>
<td>Speech &amp; Language Therapist</td>
<td>Provide support, advice, assessments and interventions for children aged 0-19 years who have difficulties with communication, eating, drinking or swallowing</td>
<td>Cornwall wide</td>
</tr>
<tr>
<td>Child Health Team</td>
<td>Provider: Royal Cornwall Hospital Trust</td>
<td>Community Paediatricians, Consultants and Associate Specialists</td>
<td>Work with children with learning disabilities, physical disabilities, communication disorders and other long-term disabilities</td>
<td>Cornwall wide: Based at Treliske 6 consultants 5 Associate Specialists</td>
</tr>
<tr>
<td>Children's Community Therapy</td>
<td>Provider: Royal Cornwall Hospital Trust</td>
<td>Physiotherapist, Occupational Therapists, Dieticians</td>
<td>Assess and provided interventions for children with physical or sensory difficulties, developmental delay, under-nutrition &amp; excessive weight gain and their families</td>
<td>Cornwall wide: Based at Treliske</td>
</tr>
<tr>
<td>Gweres Kernow</td>
<td>Provider: CSF, Cornwall Council, CFT</td>
<td>Clinical Psychologists, Social Worker, YOS Worker</td>
<td>Assesses and supports to children and young people who have sexually harmed others and the systems around them</td>
<td>Cornwall wide service: Team of 4 staff. In last six months Gweres received 28 referrals which resulted in direct work and 21 enquiries required consultation and mentoring.</td>
</tr>
<tr>
<td>Psychology Associates</td>
<td>Provider: Private</td>
<td>Clinical Psychologists</td>
<td>Assessments, consultation, expert witness and therapeutic work for children and young people within school, domestic violence, Children in Care and adoption arenas</td>
<td>Cornwall wide: 10 employed psychologists and 20-30 self-employed psychologists from counselling, clinical, forensic and educational specialisms.</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Specialist CAMHS</td>
<td>Provider: CFT</td>
<td>Community Nurses, Clinical Psychologists, Child Psychiatrists, Art Therapists, Psychotherapists, Family Therapist, CBT Therapist, Psychiatrists, Specialist doctors</td>
<td>Therapeutic, support and advice for children aged 0 to 18 years with severe and complex mental health difficulties including Cognitive Behavioural Therapy, Systemic Family Therapy, Psychoanalytic Psychotherapy, Integrative psychological therapy and Applied Behavioural Intervention.</td>
<td>Cornwall wide&lt;br&gt;28.5 WTE staff.&lt;br&gt;2472 referrals per annum, 1712 assessment, telephone consultations</td>
</tr>
<tr>
<td>Paediatric Liaison</td>
<td>Provider: CFT</td>
<td>Clinical Psychologists</td>
<td>Any child/family with mental health issues resulting primarily in relation to a physical health problem. Provide assessments, therapeutic interventions and consultation.</td>
<td>Limited: Treliske Hospital and community&lt;br&gt;1.2 Clinical Psychologists: 0.2 dedicated to Cleft Lip and Palate and associated syndromes and 0.2 to Cystic Fibrosis &amp; 0.8 to all other physical health problems, excluding obesity and enuresis/encopresis unless in isolation. Approximately 140 referrals per annum</td>
</tr>
<tr>
<td>Children in Care (CIC)</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Social Workers, Support Workers</td>
<td>Children aged 0 to 25 years</td>
<td>On 31 October 2012 there were 500 Children in Care in Cornwall</td>
</tr>
<tr>
<td>Family Placement Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager, Social Workers, Family Placement Workers, Crisis Support Workers</td>
<td></td>
<td>Cornwall wide. Team of 52 staff. Provides between 350-70 foster care placements and 38 residential home placements at any one time for children and young people up to 25 years.</td>
</tr>
<tr>
<td>Residential Service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Service Manager, Home Managers, Children’s Home Workers, Ancillary staff</td>
<td>Provides 5 residential homes in Cornwall</td>
<td>Cornwall wide&lt;br&gt;Team of 73 staff</td>
</tr>
<tr>
<td>Name of intervention</td>
<td>Service Providers</td>
<td>Who trained/qualified to deliver</td>
<td>Description</td>
<td>Availability within Cornwall</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>The 16+ (Leaving Care) service</td>
<td>Provider: CSF, Cornwall Council</td>
<td>Team Manager, Social Workers, Personal Assistants, Housing Officer</td>
<td>Cornwall wide. Team of 18 staff. Supports 126 16-18 year olds and 210 care leavers over 18 years at any one time.</td>
<td></td>
</tr>
<tr>
<td>CIC Psychology Team</td>
<td>Provider: CSF, Cornwall council &amp; CFT</td>
<td>Clinical Psychologists, Art Psychotherapist, Assistant Psychologist, Trainee Psychologist</td>
<td>Children in Care and children who have been adopted</td>
<td>Cornwall wide 3.8 Clinical Psychologists and 0.8 Art Therapist. 156 referral in last 12 months, 236 open cases</td>
</tr>
</tbody>
</table>
4.5 Mapping services - Areas of encouragement and concern

The process of mapping comprehensive CAMHS services across Cornwall was a complex and complicated exercise as many services can claim to support children and young people's social and emotional well-being and mental health. This is, after all a broad term and it is appreciated that a holistic understanding of mental health and recovery is increasingly being valued. Thus, it is recognised that any service that provides creative and social activities, support, advice and guidance, training and education and therapeutic services can confidently state that they are supporting children and young people's well-being and mental health.

Service that work with particular groups of young people, such as the Youth Offending Service, recognise that to promote prosocial behaviour and reduce further offending it is often important to understand a young people’s strengths and limitations and where they may need some additional support (e.g. in school). Although the provision of additional support in this area may not be regarded as directly related to reducing their offending behaviour, it may encourage them to consider their own aspirations and options in life and promote more socially acceptable behaviour. Attending to children and young people’s emotional and social well-being, then, have multiple benefits on individual, family, community and society levels.

The Tables are not complete, but provide a good starting point for further engagement and consultation exercises. The mapping exercise focused on those interventions that are more explicit about attending to children’s and young people’s well-being and mental health. Many professionals and services were extremely helpful in providing information about their services and were prompt in responding to inquiries as part of this mapping exercise. In addition, some services wished to be open and transparent about the interventions they provided and how they hoped to develop and others were more suspicious about providing information and were concerned about how it was going to be used. Indeed some services appeared to have embedded service evaluation into their working model and could easily access statistics, whereas others regarded this as a time consuming task that required additional resources that they were not able to commit to or prioritise.

Not all the services listed in the Tables were contacted and asked for information, so it is important not to make judgements about a service where there is little information. Some services had annual or performance reports that they were able to refer to, some provided access to these reports on their websites and others felt that permission needed to be sought from higher management before a report could be made public. Professionals’ and agencies’ responses to information sharing then, varied greatly and it cannot be assumed that those who are more guarded have something to hide. People are very aware of the limitations of statistics and how they can be used to both hide and reveal mental health issues and levels of service provision.

There were some consistent themes across all levels of service provision that can be summarised as areas of concern, as follows:

- Many professionals across a variety of services have been trained in evidence based programmes and interventions, but the delivery of these programmes is patchy;
- It is often difficult to establish accurate numbers and statistics around number of children, young people, parents and families who have accessed courses, interventions and programmes.
- There is lack of local evaluation – although evidence based programmes are often promoted, fidelity to these programmes is less attended to along with the measuring of outcomes.
- It has not been possible to find out more detailed information that may help to establish the quality of programmes (e.g. level of training, supervision, and competency).
- It is difficult to establish the level of success in working with ‘hard to reach’ families;
- It is difficult to establish the extent to which services where ‘hard to access.’
Parenting interventions tend to be Targeted with fewer Universal or Specialist interventions available. This may be experienced as a shortfall of support especially for parents of children with disabilities and severe and complex mental health problems.

- Many Targeted interventions are time-limited and only available to children with additional needs.
- Many Targeted interventions are not free of charge and are paid for by other services (e.g. the local authority, schools and colleges). These services have limited budgets so often a number of sessions are paid for and anything beyond this may need to be funded by families themselves.
- Many Specialist interventions are free of charge, but choice is very limited and progress with developing the psychological therapies strategy within specialist CAMHS is unclear.

4.6 Gaps in service provision

Table 4.4 lists all those services identified in Tables 1, 2 and 3 in order to provide an overview of universal, targeted and specialist services that are directed mainly at children and young people, parents and families. Table 4 is useful for identifying gaps in service provision.

In terms of Universal services, schools appear to take a lead in providing services that are directed at children and young people and attending to the context in which children learn - the whole school environment. Voluntary and private sectors play an important role in providing universal counselling and advice services. However, these services are aimed at young people (i.e. secondary school aged children) and there little available to younger children outside the school system. Cornwall Council takes a lead in providing parenting programmes and health services take a lead in providing specialist psychological interventions for children and young people with mental health difficulties. Interestingly, there are very few Universal services that focus on working directly with parents.

There appears to be more Targeted Services than Universal and Specialist services. It must be remembered though, that the number of Targeted services reflects the diverse groups of children and young people with additional needs (e.g. learning disabilities, Children in Need, young offenders, young carers, experienced domestic violence, bereavement etc). Indeed, Targeted services across the board are more focused on children with additional needs rather than children with mild to moderate mental health problems. Targeted services are much more parent focused than Universal services and these tend to be provided by Cornwall Council and the voluntary sector. Targeted services for children and young people are generally provided by the voluntary sector and interventions for families tend to be provided by Cornwall Council and the Cornwall Partnership Foundation NHS Trust and Royal Cornwall Hospitals NHS Trust.

As would be expected, there are fewer Specialist Services than Targeted and Universal. Interestingly, Cornwall Partnership NHS Foundation Trust provides the majority of Specialist services that are directed at children and young people, parents and families. Specialist parenting interventions are very limited and there is a greater focus on working with families. Cornwall Council takes a lead in providing residential, family and short break placements within Cornwall for Children in Care and Children with Disabilities. NHS Kernow also commissions Cornwall Partnership NHS Foundation Trust to a limited number of short break placements for Children with Learning Disabilities and Physical needs, but they do not provide specialist mental health hospital, residential or rehabilitation placements within Cornwall. NHS England is responsible for commissioning the highly specialist inpatient services, including eating disorders.

In addition professionals were asked where they thought there were gaps in service provision. The following were identified:

- Specialist mental health services for preschool children (under 5 years);
- Specialist inpatient mental health services for children and young people in Cornwall;
- Specialist rehabilitation provision for young people with substance misuse problems
- Specialist direct work with Children in Care, especially those in residential settings
- Specialist parenting programmes for parents with children and young people with severe and complex mental health problems;
- Targeted and specialist interventions for children and young people with learning disabilities and challenging behaviours;
- Longer term or ongoing Targeted services for children, young people, parents and families;
- Targeted service for children and young people with mild to moderate mental health problems;

It is hoped that this mapping exercise, along with evidence provided in other chapters of this report will inform the development of comprehensive CAMHS strategy for Cornwall.
<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Children &amp; young person focused</th>
<th>Parent focused</th>
<th>Family and community focused</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal</strong></td>
<td>Nurseries, Schools &amp; Colleges: School counsellors Integrated Health Centres Healthy Relationships programme Kooth Youth Cornwall SHARE Brook Advisory Service Careers Southwest</td>
<td>Children’s Centres: Here’s Looking at You trilogy Positive Parenting for Parents, Dads, Juniors and Teenagers Parent and Children Together</td>
<td>Family Information Service Schools and Colleges: SEAL PHSE Cornwall Anti-bullying Harassment Services Consortium R-Time Healthy Schools Stop Stigma Health Centres: GPs Midwives &amp; Health Visitors School Nurse CN4C: Strengthening Families Strengthening Communities</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>YZUP Young Addiction Specialist CAMHS: Specialist CAMHS/LD Eating Disorders Service Early Intervention Service CBT, Psychoanalytic Psychotherapy, Art &amp; Creative Therapies, Integrative Therapy</td>
<td>Specialist CAMHS: Parent Counselling Service -</td>
<td>Children in Care Team Family Placement Service Residential Service The 16+ Service CIC Psychology Team Specialist Support Team Specialist CAMHS: Systemic Family Therapy</td>
</tr>
</tbody>
</table>
Section 5: Corporative needs assessment - consultation exercise

5.0 Introduction
This section will provide an overview of the consultation exercises undertaken to gather the views of stakeholders (children, young people, parents and professionals) in relation to the provision of comprehensive CAMHS services across Cornwall and the Isles of Scilly.

The views of stakeholders were gathered in a number of different ways:
- Electronic surveys for young people, parents and professionals;
- Focus Groups carried out by Hear Our Voice with service users;
- Consultation events for children and young people and professionals.

5.1 Electronic Online Surveys
The online surveys were publicised in a number of newsletters targeted at young people, parents and professionals. These newsletters represented a number of organisations, including schools, Children’s Centres, Health Centres, Cornwall Voluntary Sector Forum, Cornwall Partnership NHS Foundation Trust and Royal Cornwall Hospital Trust. It was hoped that these newsletters would reach a wide variety of stakeholders. The surveys were live from 18 December 2012 to 28 March 2013.

5.1.1. Responses to the surveys
In total, 139 young people, 73 parents and 188 professionals replied to the electronic surveys. These numbers are obviously small and are not representative of the population of Cornwall. It is not possible to provide response rates to the survey as the questionnaires were not sent directly to individuals. It is important that findings from the surveys are treated with caution as it is likely that the sample is biased (i.e. those very satisfied or dissatisfied with local services may be more likely to complete the survey). For example, of the 139 children who completed the online survey, 84 provided information on which school or college they attended and of these all were from secondary schools and 63 (75%) reported they studied at Penair School. This suggests that this school promoted the completion of the survey, whereas other schools did not.

Table 5.1 provides some information on the characteristics of respondents to the surveys. The Young People’s survey tended to be answered by white heterosexual females with an average age of 15 years, no disabilities and no reported religion. The Parents survey was completed mainly by white heterosexual mothers without disabilities and reported religion as Christian. Professionals were not asked questions relating to their demographic characteristics so it is not possible to provide these.

Table 5.1 Demographic characteristics of respondents to the surveys.

<table>
<thead>
<tr>
<th></th>
<th>Young People’s survey</th>
<th>Parents survey</th>
<th>Professionals survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents</td>
<td>139</td>
<td>73</td>
<td>188</td>
</tr>
<tr>
<td>Gender</td>
<td>53 Female 38 Male</td>
<td>42 Female 6 Male</td>
<td>Not asked</td>
</tr>
<tr>
<td>Numbers by Age (years)</td>
<td>1 under 11 5 = 12 y 9 = 13 y 26 = 14 y 27 = 15 y 17 = 16 y</td>
<td>Not asked</td>
<td>Not asked</td>
</tr>
</tbody>
</table>
5.1.2. The questionnaires
The questionnaires included a variety of questions which captured respondents’ knowledge of mental health and wellbeing issues, local services around children and young people’s emotional health and wellbeing, their own use and experience of these services, their ratings of service provision in Cornwall and Isles of Scilly and what they believe are the priorities for service development.

Many of the questions on the questionnaire were not mandatory and only relevant if a respondent had used a service. Consequently the number of respondents who responded to questions was often much lower than the total number who had completed the survey. For example, 139 young people completed the survey but the response rate to individual questions ranged from 6% (n=8) to 97% (n=135). Numbers (where possible) rather than percentages are provided to avoid drawing spurious conclusions based on very small numbers. Percentages are sometimes reported when more than fifty percent of respondents answered the question.

5.1.3 Findings from the Young People’s survey’
Out of the 27 questions in the survey, 11 were completed by the majority and these relate to the 6 demographic questions already presented in Table 5.0. The remaining 5 questions relate to young people’s understanding of mental health issues and can be summarised as follows:

- 83% agreed/strongly agreed that they understand what is meant by mental health;
- 76.4% agreed/strongly agreed that any young person can suffer from mental health problems;
- 60.5% agreed/strongly agreed that they understand how to have good mental health;
- 50.7% agreed/strongly agreed that they wouldn’t want people to know if they had mental health problems;
- 30% agreed/strongly agreed that young people are generally caring and sympathetic to other young people with mental health problems;
- 20.3% agreed/strongly agreed that they would find it hard to talk to another young person with mental health problems.

The majority of respondents reported they have an understanding of mental health and appreciate that anyone can experience mental health problems. However, there were concerns around sharing this sort of information and how their peer group would respond to these sorts of issues.
When asked who they would go to first for help for a number of different sorts of worries and problems the most frequently reported source of support was family followed by friends. Young people talked to the family first about problems around school work, friendships, feelings, physical aggression, being bullied, sexual abuse, amount they are eating, thinking about sexuality and if someone asked you to do something they felt wasn’t right. They were more likely to talk to their friends first about problems around relationships with girlfriends and boyfriends, how they look, and difficulties with parents, parental relationships, divorce and separation and parental substance misuse.

The majority of young people went to family or friends first. It was not possible to establish who in the family they may turn to first (i.e. parents, siblings, other relatives). After this, someone at school or college (teacher or other adult) was where they would go first. Youth workers, doctors, nurses, mental health professionals, Hear Our Voice/Kooth, books and magazines, telephone help-lines and the internet were mentioned by less than 10% of young people as where they would go first. The exceptions were as follows:

- 10% of respondents reported going first to youth workers/group leader/personal advisor when parents/carers weren’t getting on with them;
- 11% of respondents reported going first to their doctor, GP, school nurse or other health worker if their parent was taking drugs or drinking a lot.
- 16% of respondents reported going first to their doctor, GP, school nurse or other health worker about the amount they were eating;

Most respondents were able to identify someone they would go to for help. However, between a third and nearly one half of young people reported that they would go to no one or they didn’t know who to go to for problems about the way they look, sexual abuse, the amount they were eating and thinking about their sexuality.

In total, 33.6% (40/119) of respondents reported they had ever met with a professional person or specialist service to discuss a worry that has been affecting their emotional wellbeing and mental health. The reason for not ever meeting with a specialist service or professional person to discuss a problem or worry that was affecting their wellbeing most (59/71) responded they didn’t feel they needed them. The remainder (18/71) replied they were afraid their parents would have to know or that they may have an illness. A similar number (17/71) said they weren’t aware of where they could go. A small number (3/71) a bad experience in the past which led them to think a service would not be helpful. The majority of respondents who hadn’t met with a specialist or professional person (48/71) said their school had a school counsellor and a third said their school didn’t have a school counsellor or they didn’t know about this service.

The remainder of the questions were only answered by those (n=40) who said they had accessed a specialist service or professional person about their emotional wellbeing and mental health. Figure 5.1 presents information on which services they used. Support at school and GP were the most frequently reported services they used. About one half of these respondents reported that their parents/carers had arranged for them to meet with these people/service, followed by teachers, themselves or doctors. Most were positive about their appointments with professionals/services. For example, 17/31 of respondents agreed or strongly agreed that the people/services helped me to deal with their worries and problems. Before seeking help talking to friends or family and looking on websites were the most frequently reported self-help activities. Getting help earlier was reported by the greatest number of respondents as being a very useful change to services.
Figure 5.1 Responses to Q5. Which of these emotional wellbeing and mental health services have you used? (n=34)
Box 5.1 presents the verbatim response young people gave when asked “Are there any other improvements you would like to see for young people?"

**Box 5.1 Young people’s responses to Q19. Are there any other improvements you would like to see for young people? (n=13)**

<table>
<thead>
<tr>
<th>If a counsellor suddenly has to cancel an appointment, for them to make sure that as well as letting you know they have cancelled it, that they then make sure to ring/text you when they next can so that you can at least talk to them for a bit and not feel so alone with worries etc when you really need someone to talk to.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The same CPN where possible-I have had three in 11 months and one of them didn't even tell me at our last appointment that he wouldn't be seeing me again. Not shuffling young people around with workers to fit the 'areas' the workers cover-I was told I would lose my counsellor because she doesn't strictly cover my area but had taken me on because of high caseloads and her manager doesn't like her coming from Bude to where I live. Telling my story over again to different workers in the same role successively has made me feel like quitting treatment sometimes but mum encourages me to be patient and promises she will drive me wherever I need to go to see the same worker.</td>
</tr>
<tr>
<td>A separate place for teenagers</td>
</tr>
<tr>
<td>People talking about it more readily. People I know with health issues are ashamed to talk about it because they feel ashamed. If they knew that people actually respect them and do not think any less of them then it would be much easier for them. We don't talk about it enough. I only know a lot because of personal experiences, otherwise I would know nothing.</td>
</tr>
<tr>
<td>Don't worry about people the heart u</td>
</tr>
<tr>
<td>People being diagnosed, not being left to suffer in silence.</td>
</tr>
<tr>
<td>Help them more</td>
</tr>
<tr>
<td>Better facilities, closer drop in too schools which are not too obvious.</td>
</tr>
<tr>
<td>More well known anonymous phone line?</td>
</tr>
<tr>
<td>Information for yourself about the signs of problems eg depression, bi polar etc</td>
</tr>
<tr>
<td>I would like doctors to generally check (properly) on the emotional wellbeing of their patients when treating a physical condition.</td>
</tr>
<tr>
<td>Ways to make sure people won't judge people with issues, so they feel safe</td>
</tr>
<tr>
<td>More online services</td>
</tr>
</tbody>
</table>

**5.1.4 Findings from the Parents’ survey**

Of the 23 questions in the Parents’ survey, 14 questions were completed by the majority (i.e. at least 36 parents), 8 out which were demographic questions. The remainder questions were specific to those who had ever met with a specialist service or professional person to discuss a problem or worry affecting their child’s emotional health and mental wellbeing.

Parents who completed the survey were geographical spread across Cornwall and Isles of Scilly. Their understanding of emotional and mental health problem problems and services can be summarised as follows:

- 25% of respondents agree/strongly agreed that if their child was suffering from mental health problems they wouldn’t want people to know;
- 28% of respondents agreed/strongly agreed that they don’t really understand enough about mental health and emotional wellbeing;
63% of respondents agreed/strongly agreed that they would be able to recognise the signs of emotional distress and mental health problems;
64% of respondents agreed/strongly agreed that they would be able to support their child if they had these sorts of problems;
95% of respondents agreed/strongly agreed that it would be helpful to have more information as a parent.

It appears then that parents would like more information about these sorts of issues. About one third of parents were concerned about their ability to recognise and support their children with these sorts of problems.

When asked if they had ever met with a specialist service or professional person to discuss a problem or worry that was affecting their child’s emotional health and mental wellbeing the majority (40/63 respondents, 63.5%) reported they had. Awareness and use of services were closely related to service use and Figure 5.2 provides information on the services respondents said they had used. Most indicated they had used more than one service. Of the services/professionals listed, doctors (GP and Paediatricians) and a worker from CAMHS were used the most frequently. Interestingly, 14/37 parents reported they had used specialist CAMHS.

**Figure 5.2 Response to Q5: Have you used any of the following for information, advice or guidance to help with concerns about your child's emotional and mental health (n=37).**

The majority of respondents (18/31) reported that another professional had recommended or arranged for their child to meet with one of the services listed. The remainder said they had made their own arrangements. The majority of respondents (29/33) reported they went with their child to the appointment with the service or professional. There were mixed and discrepant findings regarding respondents’ views of these appointments and the support they received. This mixed picture is probably a result of parents referring to a variety of services.
and professionals and it is difficult to extrapolate which service they have a more favourable experience of and which not.

In addition respondents tended to be more positive about the appointment itself (i.e. the process of meeting with a professional) and less positive about the additional information and support received (i.e. the outcome of the meeting). Thus, regarding the appointment itself:

- 20/25 respondents agreed/strongly agreed they felt welcome when they arrived;
- 23/25 respondents agreed/strongly agreed they could understand the questions asked;
- 17/24 respondents agreed/strongly agreed they felt able to ask questions;
- 17/24 respondents agreed/strongly agreed they felt able to discuss things

However, when asked about the outcomes of the appointment:

- 3/27 respondents agreed/strongly agreed that the availability of emotional and mental wellbeing services is excellent;
- 6/28 respondents agreed/strongly agreed the quality of services is high;
- 6/28 respondents agreed/strongly agreed that services had a positive impact on solving their problem;
- 7/25 respondents agreed/strongly agreed that they were told where they could find more information to help;
- 7/27 agreed/strongly agreed it is easy to get help from a professional;
- 8/28 respondents agreed/strongly agreed the people/services helped me to deal with my worries and problems;
- 8/28 respondents agreed/strongly agreed it was quick to get help or contact once I had raise it with someone;
- 11/28 agreed/strongly agreed they felt supported as a parent with emotional wellbeing of their child;

When asked to rate how useful a variety of changes to services would be, the changes endorsed as very useful by the majority (i.e. 25 or more respondents) were as follows:

- Clearer communication about services
- More information about the services available
- Being able to see someone as soon as possible and not waiting for an appointment
Box 5.1 presents verbatim respondents answers to Q16 which asked about what other improvements parents would like to see made in services.

**Box 5.1 Parents responses to Q16. Are there any other improvements you would like to see made in emotional wellbeing and mental health services for children and young people in Cornwall and the Isles of Scilly? (n=23)

<table>
<thead>
<tr>
<th>Year</th>
<th>Less secrecy, more support, quicker service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A greater culture of compassion and integrity. The Child and Adolescent mental health service was rude, abrupt, they didn't listen to us, they were late and they said that they not only couldn't help but that they didn't know who else could. My daughter went on to have several psychotic episodes and admissions to hospital and cannot be persuaded to see another helping organisation as a result.</td>
</tr>
<tr>
<td></td>
<td>All teams working together. Not being over looked, resulting in phone calls to see what's happening. Local groups for children &amp; parents to meet.</td>
</tr>
<tr>
<td></td>
<td>More stability and consistency in teams and continuous access to same CPN etc where possible. Less requirement for patients to fit the needs of the service because of staffing/resource cuts etc (good luck with that!) More localised working.</td>
</tr>
<tr>
<td></td>
<td>Easier transport for young people who are trying to be independent and go to college but find public transport difficult. Teachers at primary schools should be trained to recognize common disorders early on in a child's education. Mentoring help in High schools for children with needs comes to an end in year 10 which is disastrous for some children needing this help and support.</td>
</tr>
<tr>
<td></td>
<td>A more co-ordinated approach - like a 1 stop shop for advice. I have had no support from GP and found it hard to access services on behalf of my child. 3 months after asking for help he has seen someone for one half hour session...</td>
</tr>
<tr>
<td></td>
<td>More support for parents involved in the process</td>
</tr>
<tr>
<td></td>
<td>These emotional wellbeing should be linked with physical conditions. Instead as part of a medical assessment the emotional wellbeing is not considered</td>
</tr>
<tr>
<td></td>
<td>More contact with social services.</td>
</tr>
<tr>
<td></td>
<td>A follow up after the initial 3 session evaluation</td>
</tr>
<tr>
<td></td>
<td>No I have no current need to access this service but if I did need too, I would not know where I should go to get the best help for my child.</td>
</tr>
<tr>
<td></td>
<td>It's a mess quite frankly, no joined up working, no sharing of information, no inpatient facilities designated for young people in difficulty who require more longer term support (eg the adult model of home treatment teams) etc etc. Access to services take a long time, the people you see are often not the right people and signpost to someone else with a further wait. Access to Community Paediatricians in schools or other school based health staff would be much better, local clinics etc.</td>
</tr>
<tr>
<td></td>
<td>Drop in facilities for all the family with family issues and publicity</td>
</tr>
<tr>
<td></td>
<td>I feel that emotional health and wellbeing impacts children of all ages and that the demand for the service far out strips the number of people able to offer the appropriate help.</td>
</tr>
<tr>
<td></td>
<td>CCC website was out of date (I'm talking about 2011). It was hard to get information about any kind of support if your child wasn't suffering from frank mental illness. Didn't see GP as he had retired. How do you get counselling and parental support for teenagers with problems?</td>
</tr>
<tr>
<td></td>
<td>More cognitive behavioural therapy options for tourettes, food issues etc</td>
</tr>
</tbody>
</table>
|      | I think it would be great to have a specialist mental wellbeing unit/centre. If young people have support and treatment for mental illness sooner it would contribute to them becoming healthier adults. Those
that self harm are viewed as attention seeking rather than being in distress. In my own experience, as an adult, unless you hit crisis there's not a lot of support available. I had the option of 6 weeks counselling via my GP with a generic counsellor or seek help through charities when the realisation of childhood abuse became overwhelming. Childhood abuse cannot be disclosed and worked on in just 6 weeks. Fortunately, the emergency mental health team put me in touch with CRASAC who gave me long term one to one and group therapy. I am a much healthier individual thanks to CRASAC.

Parenting classes or speakers at local schools for parents. For example our local school offers short teaching sessions to parents on how to help with reading and maths. They could have speakers attend the school to offer tips / teaching sessions that parents are invited to, to learn more about emotional and mental wellbeing, especially considering our increasingly materialistic culture and lack of spirituality in society today.

Emphasis on promoting good diet and exercise, which helps with self esteem (combating weight problems) and gives a sense of achievement. This can also help young people meet others in the same situation.

When more than one agency is involved, each one arranges their appointments with the child and/or parents & then meetings e.g. school pastoral team, social care, CAMHS. This can sometimes result in more than 1 meeting/appointment a week so a better awareness of when other agencies are organising things & can they sometimes coalesce e.g. have a general meeting but then continue with the CAMHS team for a specialist meeting. As a parent, you feel that you are the only one going through what you are with your child. I haven't looked for Carer's groups but neither has it been suggested. Sometimes you're so bound up with the day to day effort of caring for someone that behaves unpredictably that your own needs get put into the background.

Essentially more info as when my daughter had a problem (post traumatic stress syndrome incl. panic attacks) the help was all outside of the NHS services. The help came from my daughter's independent school and the solicitor involved in the court case against person causing the accident

Child and Family Services at RCHT is unsupportive and dismissive, my child has continuing problems because they decided he was fine........I in turn have had mental health issues with the worry.

5.1.5 Findings from the Professionals’ survey

Of the 30 questions within the online survey for professionals, just over one half were answered by the majority of respondents. The first 10 questions asked about respondents’ job/role. Most respondents did not identify themselves with any of the jobs listed on the questionnaire, in particular Youth Workers (n=16), Speech and Language Therapists (n=13), Careers and Personal Advisors (n=11), and various nursing professionals (e.g. community nursery nurse, general nurse, family nurse). Although professionals were represented from across Cornwall working for variety of agencies (e.g. health, social care, education, voluntary), it is notable that no General Practitioners completed the survey. Eighteen respondents indicated they worked for Specialist CAMHS or were a PMHW.

The most common location for respondents to see children and young people was in school (61/155), followed by clinic (33/155). When asked how many children and young people they see with emotional, behavioural or mental health problems per week, 78.2% (122/156) of respondents reported 10 or less children per week, though most (72/122) of these professionals saw 5 or less children per week. When asked which age groups they most commonly worked with, the most frequently reported was 11-16 year olds, followed by 6-10 year olds and 16+ year olds. Only 19 respondents reported they work with 1-5 year olds and 2 less than one year olds. The majority of respondents (61/158, 51.3%) reported they had not received training in understanding the mental health of children. When asked if they felt adequately experienced to provide best care to children and young people with these sorts of problems, a similar proportion (66/150, 50.6%) reported they didn’t. Not surprising, nearly all respondents (97.4%) said they would attend training if offered.
The remainder questions asked professionals for their views and experiences of service for children and young people. Questions that were answered by the majority of respondents can be summarised as follows:

- 81.3% of respondents felt there wasn’t enough early intervention for children at risk to prevent referrals to specialist CAMHS;
- 61.5% of respondents felt there were vulnerable groups that they struggled to get help for or refer appropriately;
- 59.5% of respondents felt there wasn’t enough provision for improving self-esteem and resilience;
- 51.9% of respondents had discussed difficult cases with specialist CAMHS if they needed support and 54/69 had found CAMHS supportive.

There were a number of open-ended questions in the online survey that were answered by a minority of respondents and were more difficult to summarise so these have been left out of this section. However, verbatim answers to one question are provided to illustrate some of the concerns raised by professionals (See Box 5.2).

Box 5.2 Respondents’ verbatim answers to Q18. What additional support would you require? (n=36)

<table>
<thead>
<tr>
<th>Additional Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7/support local unit so such patients didn’t sit on an acute ward</td>
</tr>
<tr>
<td>A more flexible and responsive service to meet the needs of the child or YP rather than feeling that the yp had to fit around their organisational structure.</td>
</tr>
<tr>
<td>A timely, helpful and constructive response, with follow through,. rather than the defensive unhelpful response, or lack of response one gets persistently.</td>
</tr>
<tr>
<td>Accepting referrals at a less critical stage</td>
</tr>
<tr>
<td>Attendance/reports at TACS</td>
</tr>
<tr>
<td>Better access to advice</td>
</tr>
<tr>
<td>CAMHs can only provide support for mental health conditions rather than emotional difficulties. They do not have the resources to provide early intervention for emotional/behavioural difficulties. They cannot process referrals for diagnosis of ASC from school. They are unwilling or unable to support those with low learning. I need more support for emotional difficulties which was provided by specialist social workers in the past. I need diagnosis pathways for secondary school students.</td>
</tr>
<tr>
<td>Continuity of workers and more workers</td>
</tr>
<tr>
<td>Diagnosis and more availability</td>
</tr>
<tr>
<td>Easier and quicker access to professional help and more consistent communication.</td>
</tr>
<tr>
<td>Easy rapid referral pathway for assessment/documentation and intervention</td>
</tr>
<tr>
<td>Faster referral to appointment times. more consistent, accessible support to families For them not to just reject referrals</td>
</tr>
<tr>
<td>Greater communication, feedback when referrals are made. Training in schools. Hard to say as I am not too sure what is on offer from them!</td>
</tr>
<tr>
<td>I think that the psychology provision for children is inadequate</td>
</tr>
<tr>
<td>infant mental health service Primary mental health care provision for the under 5's</td>
</tr>
<tr>
<td>More access/time for them to see individuals. It is difficult to get children taken on.</td>
</tr>
</tbody>
</table>
More accessibility

More availability of specialist mental health practitioners

More CAMHS staff, quicker response times

More communication, easier access

More consultations

More information and link up with CAMHS

More of their time. More CAMHS workers. More follow ups to initial appointments. More time for one to one sessions

More regular support

More resources in Specialist CAMHS to be able to offer more support to staff in Gwyn Dowr and to parents and schools.

More support for young people with eating disorders. Better access to child and family support services

More timely response More dialogue with CamHs professional, including their contribution to MDTs More training about services

Not having to jump through hoops to prove a child has mental health problems...usually they have...what comes 1st the conditions the child is living in or the illness

Quick response to referrals. Alternatives to CAMHS if their service does to support the child's needs. trust that our choice to refer is not done on a whim, but is a culmination of professional views; consequently at least a discussion with staff and an initial assessment would be appreciated.

Specialist support when needed without having to wait for long periods More clear guidance on how to obtain help and who to ask More face to face meetings and not just conversations over the phone Consistent timetabled support for children, and training for adults involved

Supervision or the opportunity to have mini sessions where we could discuss common referrals. The service is so stretched at present meaning they cannot provide required therapy. I would like more advice and support in meeting children's needs at school.

There is an issue about access for both service users and practitioners - given their geographical location and the difficulties in travel. More effective video conferencing would be helpful, and better access so that young people and their families can have the intervention they require in the timescales they require - without having to have so much time out of school for example.

<table>
<thead>
<tr>
<th>5.1.6 Findings from the first Hear Our Voice consultation with service users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hear Our Voice (HOV) is a voluntary organisation that supports young people aged 11 to 25 years with mental health problems. They were asked to promote the online survey to their service users so that the views and experiences of young people with mental health problems were captured in the consultation exercise.</td>
</tr>
</tbody>
</table>

HOV did not find the online survey very accessible for their service users and made a number of adaptations to the content and administration of the survey. This involved three steps:

1) Summarising the questions in the online survey and grouping them into themes;

2) Arranging focus groups of young people to discuss these themes;

3) Redesigning the questionnaire again and using this with small groups of young people or individual young people.
Due to mixed methods and various versions of the questionnaire it is not possible to report accurately on responses to specific questions. Indeed many of the themes covered in the online surveys were complex and not easy to understand. Young people wanted clarity around the concepts used in the questionnaire, such as what ‘mental health’ might refer to. In this way it was appreciated that many of the questions in the survey were open to multiple interpretations (e.g. definition of a specialist service).

In total, 162 young people aged between 13 and 21 years took part in the HOV consultation exercise, with the majority being female (60%) from the following areas: Torpoint, St Austell, Truro, The Clays, Bodmin, Camborne and Redruth. Those consulted included young people with diagnosed mental health issues, young carers, LGBTQ (lesbian, gay, bisexual, transgender, queer and/or questioning their sexuality), young people who are looked after and those living in rural isolation, poverty and with multiple indicators of ‘disadvantage’. The focus groups were conducted in specialist and generic youth centres and with school groups as part of the Heads Up workshops.

Response to some of the themes in the online surveys are shown in Table 5.2.

Table 5.2 Young peoples’ responses to themes in online surveys

<table>
<thead>
<tr>
<th>Theme</th>
<th>YES (N)</th>
<th>NO (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand what is meant by mental health</td>
<td>56</td>
<td>34</td>
</tr>
<tr>
<td>I know how to have good mental health</td>
<td>55</td>
<td>29</td>
</tr>
<tr>
<td>If I have mental health problems I don’t want people to know about it</td>
<td>59</td>
<td>44</td>
</tr>
<tr>
<td>I understand anyone can have a mental health problem</td>
<td>74</td>
<td>18</td>
</tr>
<tr>
<td>I would find it hard to talk to other young people with mental health problems</td>
<td>61</td>
<td>47</td>
</tr>
<tr>
<td>People are generally sympathetic if they know some has mental health issues</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>I would know where to go for support</td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td>There needs to be better support for young people</td>
<td>54</td>
<td>35</td>
</tr>
</tbody>
</table>

Young people said they would CHOOSE to talk to the following people if they were concerned about anything:

- Doctor/GP
- Student Support – easy to book appointments
- Friends
- Parents
- Social Workers
- Youth Workers
- Teachers
- Connexions Workers based in school.

When young people were shown a list of professionals and asked if they would ever use them for support/to talk to the following numbers of young people said they would, in descending order:

- School/college counsellor 69
- Teacher 63
- Service to help at school 56
- School Nurse 53
- Doctor 48
- Youth Worker 38
- Walk in services – Brook, Share 35
- Other counselling 31
28 – Specialist counselling e.g. Penhaligon’s Friends
20 – CAMHS worker
17 – Family Therapy and support services
17 – Hear Our Voice
16 – Other support e.g. texting services
13 – Kooth
12 – Education or child psychologist
11 – Young Carers Support Service
  7 – Paediatrician
  2 – Primary Mental Health Worker
  2 – Specialist Support Domestic Violence

Young people said they had concerns and worries about growing up and becoming an adult, dying, drugs and alcohol, relationships, moving away, their identity and sexuality.

When asked how support could be improved the following suggestions were made:

- More information
- More drop-in services
- Posters and more publicity
- People visiting in schools and actually meeting people
- Days off the school timetable
- Talks in schools and youth groups
- Regular attendance at student support
- Clear explanations about how to book health/counselling appointments
- Knowing a youth worker.

5.1.7. Report from the second Hear Our Voice consultation

Hear Our Voice carried out a second, more in-depth consultation exercise, which was held at Young People Cornwall’s (YPC) Zeb’s Youth Centre in Truro on May 11th, and interviews/discussions were carried out by HOV youth workers. Some young people – who were more likely to have accessed mental health services were invited to take part. Other young people were able to ‘drop in’ on the day and additional outreach sessions with groups at Carefree (looked-after young people) and Wild (young mothers) were undertaken, so the consultations included young people who would access ‘targeted’ and ‘specialist’ services, as well as those accessing universal services. A further consultation around PHSE provision was carried out during the same week at Penair School in Truro, through the ‘Heads Up’ programme which delivers emotional resilience training in schools across Cornwall.

While a broad range of young people were involved, the consultation was not fully representative with certain ‘harder to reach’ groups missing from the research. The groups that were not targeted were; BME groups; refugees, asylum seekers and those with English as a second language; young people with physical disabilities; gypsy and traveller communities, and those living in very rural areas. In any future research or consultation, developing ways to involve these groups should be included in the early stages of planning.

62 young people, aged between 12 and 23 years took part in the second consultation exercise, with 30 young men and 32 young women. Approximately half were ‘invited’ to take part and included young people who had been in contact with mental health and alcohol/substance misuse services, LGBTQ young people, looked after young people, young carers and young parents, often living in rural isolation, poverty or with multiple indicators of ‘disadvantage’. These young people are members of YZUP, Hear Our Voice, Carefree, Wild, YAY and Penhaligon’s friends. Others dropped in to the event on the day, or were regular participants at YPC’s ‘Zebs’ youth centre, many of whom were also living with multiple indicators of ‘disadvantage’ and increased vulnerability.
The majority of those consulted live in the Truro area, others are from Devoran, St Austell, Portreath, Bude, Launceston, Par, Camborne, Pool, Hayle, Newquay and Falmouth.

A further 100 young people from Penair School in Truro were consulted about PHSE provision.

Summary of findings:

1. Family and friends were the first port of call for young people experiencing mental health difficulties. Young people in contact with youth workers and support workers would also turn to them for help. The presence of a trusting relationship was the most significant factor in this.

2. Young people in contact with social workers said they would not choose to talk to them about their mental health.

3. Young people over 16 years were more likely to see their GP with mental health concerns than their younger counterparts.

4. Reasons for not seeing the GP included lack of trust/relationship, fears around confidentiality and feeling that GPs did not understand young people’s mental health.

5. Young people believe that early intervention is most helpful and can prevent mental health difficulties from escalating and impacting on school/home life.

6. Some young people felt that behavioural problems in school meant that their mental health difficulties were not recognised – delaying or preventing access to specialist support. Some of these young people were subsequently diagnosed with ASD or ADHD.

7. Experiences of referral into specialist services were mixed – some received assessment and support quickly while others experienced long waiting lists and/or were discouraged from attending appointments.

8. For some young people the involvement of parents in CAMHS assessment processes limited what they felt able to disclose/discuss.

9. The role of VCS organisations in promoting access and supporting referral into specialist services, particularly for young people with less family/school support, was also highlighted.

10. Those who had received support from CAMHS services largely felt this was positive and helpful.

11. Some young people felt frustrated that they or friends had not received appropriate support when they felt they needed it.

12. Self harm was recognised by most young people as a prevalent and growing concern. This was particularly true for looked after young people.

13. Young people were less likely to turn to families or professionals for support with self harm, and more likely to talk to friends or cope alone.

14. Factors preventing young people asking for help with self harm included fears around ‘overreaction’, judgement or other unhelpful responses, stigma and fears around confidentiality.

15. Young people feel self harm is not well understood by parents, professionals – particularly in schools, or other young people. Young people who self harm experience stigma and bullying.
16. Young people feel that they need more information and education around self harm – to increase understanding, reduce stigma and to help them to develop coping strategies and manage stress/emotions.

17. Young people feel that professionals need better training and awareness around self harm, particularly in how to respond appropriately.

18. Young people want more confidential support for self harm, particularly in school.

19. Young people say they would like more information about mental health problems, including self harm, and more awareness of where and how to access support. Leaflets, posters and online resources are most useful.

20. Findings suggest that PHSE provision across Cornwall is patchy and inconsistent. Young people felt that there was too much emphasis on sexual health and drugs and alcohol awareness and would like to cover a wider range of topics including: body image, identity, relationships, race awareness and LGBTQ, politics and voting, first aid and physical health, making choices and planning for the future, CV writing and preparing for employment.

21. Most young people said they received little or no mental health or emotional wellbeing education through their PHSE lessons. Many believe it would be helpful to cover this more.

22. Some young people felt that self harm should be covered in school, but some suggested that small, targeted group work was a safer environment in which to deliver this.

23. Young people and teachers say they prefer PHSE sessions to be delivered by outside agencies/speakers who have ‘expertise’ and with whom young people feel more comfortable talking about sensitive issues.

24 – Young people’s recommendations:

Young people’s suggestions to improve mental health support and wellbeing for young people in Cornwall include:

- more access to confidential services
- more accessible, drop-in or self referral services
- earlier access to specialist support
- more availability of information about mental health and about support services
- improvements in transitions between child and adult services and between inpatient and community services.

The findings in detail can be read in Appendix C.

5.1.8. Hear Our Voice Isles of Scilly consultation

Hear Our Voice was also asked to carry out a consultation with young people living on the Isles of Scilly (IOS), and help to facilitate this was given by the Five Islands School and Mundesley Boarding House on St Mary’s.

As the Isles of Scilly was not involved in earlier consultations, Hear our Voice asked young people to complete the initial short questionnaire used on the mainland to establish levels of mental health awareness among a wider group. These were completed by all students from Years 7 to 10 who were present on the day. Small group (4 – 6 per group) discussions were
carried out with students from Years 7 to 10, a group of young people who live on other islands and board at Mundesley during the week, and a larger group (10) from Year 6.

Questions were included around PHSE provision. The detail of questions around self harm was reduced as Hear Our Voice were not aware of any existing mental health difficulties among young people or of their support networks. Questions on self harm were omitted from discussions with students from Years 6 and 7. Young people were also told that they could speak to their Key Stage leader with any concerns that arose as a result of the consultation process.

Children below Year 6 were not included at this stage. Members of the CAMHS young people’s board have expressed an interest in developing and co-facilitating this work in the future.

As an organisation Hear Our Voice is not known by young people, school staff or parents who may have limited what young people would reveal. In addition, consulting with a whole school population, within the school environment and in larger groups may also have limited what young people felt able to disclose or discuss. This was particularly relevant in light of an acknowledged ‘culture of silence’ on Scilly and young people’s evident concern about lack of confidentiality. There was not an opportunity to consult with older young people and those not in education who may have different levels of involvement with support services for example.

The consultation was seen as a useful opportunity to build links and relationships that would inform future consultation and research with young people on the islands.

A total of 87 young people were involved in the consultation process. 77 young people, aged between 11 and 15 years, with 40 young women and 37 young men. 72 described themselves as White British, White Cornish or White Scillonian, 1 was White African, 3 Mixed Race and 1 described their ethnicity as Other. 51 said they lived on St Mary’s, 11 on other islands and 15 did not specify.

38 young people took part in further more detailed, small group discussions; this included 10 young people from Year 6 who did not complete the questionnaire with representation from St Martins, St Agnes, Bryher and Tresco.

Summary of findings:

1. The young people consulted were aware of mental health and most understand the terms mental health and emotional wellbeing, however, almost half of those consulted felt that they did not know how to look after their mental health.

2. Most young people said they would not find it easy to talk about mental health and would not want people to know if they were experiencing problems with their mental health.

3. The most frequently reported causes of stress or concern were pressures from school, homework and/or exams, followed by problems with family or friends. Other issues mentioned included physical health problems, worrying about money, the future, bullying, lack of confidentiality and homesickness (off islanders).

4. Parents and friends would be the first port of call for young people experiencing concerns about mental health. The House Parent at Mundesley Boarding House is also an important and highly valued source of support for ‘off-island’ young people who live there during the week.

5. Other sources of support include the school, the primary mental health worker (PMHW) (no longer in post), and the practice nurse at the Health Centre.

6. Lack of confidentiality is the main barrier that would prevent young people asking for help or accessing services, and is a significant problem for young people.
7. Stigma, embarrassment and a perception that mental health is not well understood on IOS would also deter young people from accessing support.

8. The majority of young people had not heard of specialist CAMHS but were aware of the PMHW role. Some had received one to one support from her and many had been involved in group sessions in school and at the boarding house. Young people were not generally aware of any other counselling services available.

9. Young people were not aware of online counselling services but many felt that this could be a useful source of confidential support.

10. Most young people who had accessed support from the PMHW found this to be positive and helpful. Some young people expressed regret that she was no longer in post. Young people did not generally find it easy to talk to teachers about mental health concerns.

11. Young people access information about mental health and emotional wellbeing from leaflets, websites including Childline, Brook, Frank and the NHS, and from parents and visiting agencies from the mainland – Brook, Yzup and Devon and Cornwall Police were mentioned.

12. Young people have learned about mental health and wellbeing through SEAL (Social and Emotional Aspects of Learning) provision in primary school.

13. Young people say they have learnt about sexual health, drugs and alcohol, bullying and the Law through PHSE sessions, but say that business and enterprise has now become the main focus of sessions (PHSE).

14. Young people said there was less emphasis on mental health in PHSE in secondary school, and most said that it would be helpful to cover this in more depth – in particular why people develop mental health problems, how to protect against this and when, where and how to access support.

15. Young people had some understanding of self harm, although there was a perception that it is ‘all about attention seeking’. They did not believe that self harm is a significant or prevalent issue on IOS.

16. Young people are unsure of where they could access support for self harm. They would be reluctant to talk to parents about this and were concerned that school staff would ‘overreact’ and may not maintain confidentiality.

17. Underage drinking was identified by some as a significant problem on IOS – related to a ‘drinking culture’ and lack of out of school youth provision.

18. **Young People’s Recommendations:**

Young people’s suggestions for improving mental health support and young people’s wellbeing on IOS included having:

- More access to confidential and safe support.
- More choice of support services.
- A dedicated person in school to offer confidential support (named, consistent, not a teacher).
- Access to support without having to tell parents.
A dedicated ‘chill out space’ for young people – suggestions included their own ‘shed’ (chalet type space) –and/or more informal youth club provision (the ‘Hub’ youth club only runs one night a week and is mainly used by younger age groups – up to Yr 9).

More information/education about mental health.

More visits from mainland agencies.

School nurse back in post.

The findings in detail can be seen in Appendix D.

5.2. Summary from Consultation exercises
Although the electronic surveys have produced some interesting findings these must be treated with caution as the numbers of respondents are small and it is likely that the sample is not representative of the population of Cornwall and the Isles of Scilly. In all three surveys a very small proportion of respondents had direct experience of specialist CAMHS, either as a service user or provider. It must also be noted that children under 11 years of age have not been represented in these surveys. It is also likely that these surveys were not accessible to children, young people and adults with disabilities and those without computers.

Although electronic surveys may appear to provide easy access to a large groups of people their significant shortcoming is they are a very impersonal approach and by far the majority of people choose to ignore such surveys, which makes any findings from the data difficult to generalise to the whole population. Indeed, we can conclude that people who respond to electronic surveys are a very unusual group in themselves!

It would be much more informative to target and sample specific groups of people, using a more personalised approach and follow-up procedures, with the aim of getting good response rates from which we can be more confident about generalising and learning from.

The second and third ‘Hear Our Voice’ surveys have proved very useful in providing feedback from young people on their perception of a number of services at varying levels. Their views expressed have helped to form the recommendations from this needs assessment.
Section 6: Comparative needs assessment – gaps and recommendations

6.0 Introduction
This section draws together the findings from the previous sections in terms of
- the understanding of the evidence base,
- the local population,
- current service provision and
- professionals and clients experiences of these and how they can be developed.

It will begin with a summary of those interventions with the best evidence base that have been consistently recommended in guidelines, reviews and policy documents. It will then identify the availability of these interventions in Cornwall and the Isles of Scilly. This exercise will provide an overview of the strengths of current service provision and where there are gaps. It will raise questions about those interventions that are not available in Cornwall and Isles of Scilly and whether there are any equivalents and whether new service developments need to be prioritised, such as the Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) transformation project.

This section will also identify those interventions that are available at the universal, targeted and specialists levels for children, young people, parents and families and considers the extent to which early intervention and a stepped care approach is supported at all levels across the lifespan. Graham Allen’s report on Early Intervention (2011) recommends that services are organised around three age groups: pre-school, primary school and secondary school aged children to ensure their readiness for primary school, secondary school and life respectively. These three developmental phases are times of transition and most require additional support when dealing with significant changes in life.

6.1 The availability of interventions in Cornwall and Isles of Scilly with the best evidence base regarding their effectiveness in supporting children and young people’s emotional well-being and mental health
Table 6.1 provides a summary of those interventions which have been recommended in a number of guidelines, reviews and policy documents as there is evidence that they are effective in supporting children and young people around their emotional well-being and mental health (see Section 2). These interventions have been classified according to the definitions used throughout this report. Thus, distinctions have been made between, universal, targeted and specialist services and those that focus mainly on working directly with children and young people, parents and families. It is appreciated that these distinctions are not always easy to make and some interventions work on many different levels. For example, the Life Skills Training programme could be categorised as a direct intervention for young people and a whole school intervention. It was decided that specific programmes would be categorised as direct interventions with young people and broader curriculum subject areas (e.g. PHSE education) would be categorised as a whole school intervention.

The recommended evidence-based interventions that are available in Cornwall and Isles of Scilly have been identified in bold in Table 6.1. Section 4 provided some information on the accessibility, quality and effectiveness of these interventions, but this information and practice-based evidence is limited. It must also be remembered that the interventions in themselves are only as good as the professionals delivering them: their belief in the approach, their competency and the organisational framework to support these ways of working (e.g. Continual Professional Development, supervision and management). There are often tensions between demand and supply, breadth and depth working, medical, psychological, educational and social models and fidelity to and adaption of evidence-based interventions.
In terms of the availability of services that focus on working directly with children and young people, there are few recommended interventions available at the universal and targeted levels, but most specialist interventions are available.

The opposite is the case for interventions that focus on working directly with parents only, with a number of recommended interventions available at the universal and targeted levels but none available at the specialist level. Indeed it was hard to identify a recommended parenting intervention that was geared towards supporting parents with children with severe and complex mental health difficulties or Children in Care. A similar pattern was found for interventions that focus on supporting the whole family, school or community, with a number of interventions available at the universal and targeted levels, but few at the specialist levels. Within C&IOS, recommended universal services tended to be available at the whole family, school or community level; recommended targeted interventions tend to be available for parents and families as a whole; and recommended specialist services tend to be available for children and young people. There is, then, patchiness in the provision of recommended interventions at different levels of intervention.

Table 6.1: The availability of interventions in C&IOS with the best evidence base regarding their effectiveness in supporting children and young people’s well-being and mental health

<table>
<thead>
<tr>
<th>Focus of intervention</th>
<th>Universal For all children and young people</th>
<th>Targeted For children and young people with additional and specialist needs and children with mild to moderate mental health difficulties</th>
<th>Specialist For children and young people with severe and complex mental health needs and Children in Care</th>
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</thead>
<tbody>
<tr>
<td>Direct work with children and young people</td>
<td>Let’s Begin with the Letter People Life Skills Training (LST) Lions Quest Skills for Adolescence Project Towards No Drug Abuse (Project TND) Promoting Alternative Thinking Strategies (PATHS) Ready, Set, Leap! Safe Dates Safer Choices</td>
<td>CBT Early Literacy and Learning Model (ELLM) Interpersonal Psychotherapy Reading Recovery Self-help literature Success for All Start Taking Alcohol Risks Seriously (STARS) for Families</td>
<td>CBT Interpersonal Psychotherapy Psychodynamic Psychotherapy Creative Therapies</td>
</tr>
<tr>
<td>Direct work with parents and primary carers</td>
<td>Baby Express Newsletters Baby massage Incredible Years One Plus One Brief Encounters Preparation for Parenting PIPPIN First Steps in Parenting Solihull Approach Success for All</td>
<td>Baby massage Incredible Years Mellow Parenting Parent-Child Home Programme Triple P Video Interaction Guidance</td>
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</table>

Table 6.1: The availability of interventions in C&IOS with the best evidence base regarding their effectiveness in supporting children and young people’s well-being and mental health.

<table>
<thead>
<tr>
<th>Focus of intervention</th>
<th>Universal For all children and young people</th>
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<th>Specialist For children and young people with severe and complex mental health needs and Children in Care</th>
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Focus of intervention

<table>
<thead>
<tr>
<th>Universal</th>
<th>Targeted</th>
<th>Specialist</th>
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</thead>
<tbody>
<tr>
<td>For all children and young people</td>
<td>For children and young people with additional and specialist needs and children with mild to moderate mental health difficulties</td>
<td>For children and young people with severe and complex mental health needs and Children In Care</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Direct work with whole family or whole school or community</th>
<th>Family Partnership Model</th>
<th>Common Assessment Framework</th>
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<tbody>
<tr>
<td>Motivational Interviewing</td>
<td>PHSE curriculum</td>
<td>Family Partnership Model</td>
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<tr>
<td>Sure Start Children’s Centres</td>
<td>Motivational Interviewing</td>
<td>Nurse Family Partnership</td>
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<td></td>
<td></td>
<td>Strengthening Families</td>
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<tr>
<td></td>
<td></td>
<td>Strengthening Communities</td>
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<tr>
<td></td>
<td></td>
<td>Functional Family Therapy</td>
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<td></td>
<td></td>
<td>Multidimensional Treatment Foster Care</td>
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<td></td>
<td></td>
<td>Multisystemic Therapy</td>
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<td></td>
<td></td>
<td>Systemic Family Therapy</td>
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</table>

NOTE: Interventions in **bold** are currently available in Cornwall and Isles of Scilly.

It is also hard to establish what package of support a child, parent and family may receive. For example, if a professional was beginning to be concerned about a child’s conduct and disruptive behaviour, their substance misuse, poor concentration and decline in academic work what interventions would be offered to the child, parent and family and in what order? Would there be a preference to intervene at one level and gradually build up levels of intervention as required?

This stepped approach is often recommended as best practice. However, NICE guidelines tend to focus on specific interventions for specific disorders. In real life, children and young people may experience multiple problems and have access to multiple levels of intervention. There are fewer guidelines about dealing with the complexities of these sorts of interactions and what interventions should be prioritised under certain circumstances. The Common Assessment Framework may be the process by which a package of care is arranged which takes into account clients’ preferences, professionals’ views and the availability of services locally. Although packages of care will need to be individualised there is also a need to having some clear service pathways to ensure an equitable and transparent service for all.

6.2. Recommendations

This needs assessment will be used to develop a five year Comprehensive CAMHs Strategy for Cornwall and the Isles of Scilly. From it there are several principles that need to be reflected in the strategy and also a number of key areas that it needs to address i.e. the priorities.

6.2.1 Key Principles

These principles are recommended in the development of strategic and operational policies and procedures regarding children and young people’s emotional and social well-being and mental health:

1. Focusing on the quality of relationships and respectful engagement of all service providers (private, voluntary and statutory) and the local population.
2. Intervening at multiple levels: universal, targeted and specialist;
3. Collaborating with all stakeholders: children/young people, parents/carers and family/school/community;
4. Taking a developmental perspective and preparing for transitions at three stages of development: foundation (0-4 years), primary (5-10 years) and secondary years (11-17 years);
5. Acknowledging that some children, parents and families will require longer-term or ongoing support to reach their potential;
6. Supporting creative and collaborative practice so that services are sensitive to local needs and real choice is built into systems

6.2.2 Priorities
1. The voice of the children and young people and their families needs to be captured in a way that can feed into service developments and also feedback to them
2. The number of parenting courses should be reviewed to ensure that only evidence based courses are available; that they are consistently offered across Cornwall and the Isles of Scilly; and there is appropriate coverage at all levels from Universal to Specialist
3. That the development of a parenting course for families of children with complex needs and those in care is explored
4. To review the gap in services for children and young people with mild to moderate mental health difficulties,
5. The services available for the most vulnerable groups e.g. CIC and children with complex needs should be reviewed to assess the level of capacity versus demand
6. Specialist CAMH Services should be reviewed to assess the level of capacity versus demand
7. Evaluation should be embedded into practice so that services are constantly monitoring impact
8. Activity data should be collected in a standardised format to ensure that future demand/capacity planning can be undertaken
9. The range of services available should be assessed to better understand their capacity, offer and quality
10. The skills of the workforce across the Comprehensive CAMHs provision should be reviewed to ensure that they constantly reviewed and updated and fit for purpose
11. There should be a mechanism in place to ensure all targeted providers can meet and discuss developments across Cornwall and Isles of Scilly
12. That there is some level of support to commissioners, including schools, on the to ensure the quality of commissioned mental health services including workforce standards; liaison with other services and support
13. Taking a lifespan perspective and acknowledging that mental health issues relates to each and every one of us requires joined up thinking – so other interlinking and overlapping strategies should be reviewed to ensure that this can happen including the wider determinants of health and social wellbeing e.g. housing, PHSE offer
14. Clear pathways into service provision are in place and understood by referrers and providers
15. Step up/step down protocols between the steps or tiers need to be in place to ensure a seamless service
16. Transition to adult mental health services should be re-assessed and monitored to ensure it is working as best as it can
17. Poor mental health should not be stigmatised and better understood by the wider community
18. Professionals in contact with children and young people should be trained to better understand mental health and how they can offer early help
19. Data sharing is enabled to ensure that there are no barriers to children and young people's mental health, education and social needs being met across statutory agencies and the voluntary sector
20. The commissioning of mental health services should be joined up across the Councils, schools/academies and NHS Kernow, and stronger links made with the voluntary sector and that service specifications, where appropriate are shaped based on the 3 age ranges and 3 tiers of need.
21. In line with national policy, there should be an increased emphasis in the recognition of possible behavioural and mental health problems in the under five year olds.
22. More needs to be done to improve the recognition of, and access to, non-discriminatory services for self-harm.


viii Department of Health (2011). The economic case for improving efficiency and quality in mental health


xi Department of Health (2011). Delivering better mental health outcomes for people of all ages


xvi Meltzer, H; Gatward, R; Goodman, R; Ford, T (2000). Mental health of children and adolescents in Great Britain. TSO:


xix www.nspcc.org.uk/whatwedo/aboutthenspcc/keyfactsandfigures/keyfacts_wda33645.html
NSPCC (2011). Child cruelty in the UK 2011 – An NSPCC study into Childhood abuse and neglect over the past 30 years. NSPCC.


Harrington, R; Bailey, S et al. (2005). Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community. Youth Justice Board for England and Wales

Meltzer, H; Gatward, R; Corbin, T; Goodman, R; Ford, T (2003). The mental health of young people looked after by local authorities in England. Crown Copyright


Department of Health (2009). Healthy Child Programme: pregnancy and the first five years of life. DOH.

Department of Health (2011a). No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages. DOH.

Department of Health (2011b). Talking therapies: A four-year plan of action. DOH.


### Appendix A

#### List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD/ADD</td>
<td>Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder</td>
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<tr>
<td>ASB</td>
<td>Anti-Social Behaviour</td>
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<tr>
<td>ASC/ASD</td>
<td>Autistic Spectrum Condition/Autistic Spectrum Disorder</td>
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<tr>
<td>BA</td>
<td>Behavioural Activation</td>
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<td>BPS</td>
<td>British Psychological Society</td>
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<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<td>CC</td>
<td>Cornwall Council</td>
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<td>CD</td>
<td>Conduct Disorder</td>
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<td>CFT</td>
<td>Cornwall Foundation Trust</td>
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<td>CIC</td>
<td>Children in Care</td>
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<tr>
<td>CIN</td>
<td>Children in Need</td>
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<tr>
<td>CSF</td>
<td>Children, Schools and Families</td>
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<tr>
<td>CWDC</td>
<td>Cornwall’s Workforce Development Council</td>
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<tr>
<td>DCSF</td>
<td>Department for Children, Schools and Families</td>
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<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DSM IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders (4th edition)</td>
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<tr>
<td>EBP</td>
<td>Evidence-Based Practice</td>
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<td>EDS</td>
<td>Eating Disorders Service</td>
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<td>EYS</td>
<td>Early Years Service</td>
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<td>Educational Psychologist</td>
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<td>Family Group Conferencing</td>
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<td>Family Intervention Project</td>
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<td>FIS</td>
<td>Family Information Service</td>
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<td>FNP</td>
<td>Family Nurse Partnership</td>
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<td>FSW</td>
<td>Family Support Worker</td>
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<td>HV</td>
<td>Health Visitor</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>ICD-10</td>
<td>International Classification of Diseases and Related Health Problems (10th edition)</td>
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<tr>
<td>IDVA</td>
<td>Independent Domestic Violence Advocates</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LCSB</td>
<td>Local Children’s Safeguarding Board</td>
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<td>LD</td>
<td>Learning Disabilities</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>Parents and Children Together</td>
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<td>PBE</td>
<td>Practice-Based Evidence</td>
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<td>PSHE</td>
<td>Personal Social Health and Economic education</td>
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<td>PND</td>
<td>Post Natal Depression</td>
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<tr>
<td>RCHT</td>
<td>Royal Cornwall Hospital Trust</td>
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<td>RCP</td>
<td>Royal College of Psychiatrists</td>
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</table>
SaLT = Speech and Language Therapists
SDQ = Strengths and Difficulties Questionnaire
SEAL = Social and Emotional Aspects of Learning
SEN = Special Educational Needs
SENCo = Special Educational Needs Coordinator
TaMHS = Targeted Mental Health in Schools
YOS = Youth Offending Service
VIG = Video Interaction Guidance
## Appendix B

**Professionals and organisations contacted for information for the Comprehensive CAMHS Needs Assessment**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alison Cook</td>
<td>CAMHS, CFT</td>
</tr>
<tr>
<td>Linda Bennetts</td>
<td>CAMHS, CFT</td>
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Appendix C

HOV report from 2nd needs assessment consultation, May 2013.

Process:

Hear Our Voice (HOV) was asked to carry out a second, more in-depth consultation exercise, in response to priorities identified through initial consultations and the CYP Emotional Wellbeing and Mental Health consultation event for professionals that took place at the Eden Project on 24th April.

HOV was sent a list of broad priorities, out of which we developed a list of questions to ask young people through individual interviews or small group discussions. Priorities included looking at young people’s access to information, the PHSE offer around mental health and wellbeing, access to and experiences of referral into specialist mental health services and self harm. Consultation questions were designed to be accessible, or ‘friendly’, and safe, given that the consultation environment was not confidential and we were asked to reach a fairly large number of young people. With this in mind young people were told they could answer the questions with reference to friends if they did not feel comfortable talking about their own experiences.

The consultation event was held at Young People Cornwall’s (YPC) Zeb’s Youth Centre in Truro on May 11th, and interviews/discussions were carried out by HOV youth workers. Some young people – who were more likely to have accessed mental health services – were invited to take part, through our own projects and through our wider local networks. Other young people were able to ‘drop in’ on the day. In addition we carried out outreach sessions with groups at Carefree (looked-after young people) and Wild (young mothers). This meant that we were able to consult with young people who would access ‘targeted’ and ‘specialist’ services, as well as those accessing only universal services. A further consultation around PHSE provision was carried out during the same week at Penair School in Truro, through our ‘Heads Up’ programme which delivers emotional resilience training in schools across Cornwall.

Limitations of the consultation: while a broad range of young people were involved, the consultation was not fully representative and we recognise that certain ‘harder to reach’ groups are missing from the research. For example, BME groups; refugees, asylum seekers and those with English as a second language; young people with physical disabilities; gypsy and traveller communities, and those living in very rural areas were not targeted, and may have found it difficult to access the consultation event. In any future research or consultation, developing ways to involve these groups, perhaps through outreach sessions, should be included in the early stages of planning.

Profile:

62 young people, aged between 12 and 23 years took part in the second consultation exercise. Those consulted included 30 young men and 32 young women. Approximately half were ‘invited’ to take part and included young people who had been in contact with mental health and alcohol/substance misuse services, LGBTQ young people, looked after young people, young carers and young parents, often living in rural isolation, poverty or with multiple indicators of ‘disadvantage’ – these young people are members of YZUP, Hear Our Voice, Carefree, Wild, YAY and Penhaligon’s friends. Others dropped in to the event on the day, or are regular participants at YPC’s ‘Zeb’s’ youth centre, many of whom are also living with multiple indicators of ‘disadvantage’ and increased vulnerability.
The majority of those consulted live in the Truro area, others are from Devoran, St Austell, Portreath, Bude, Launceston, Par, Camborne, Pool, Hayle, Newquay and Falmouth.

A further 100 young people from Penair School in Truro were consulted about PHSE provision.

**Summary of findings:**

1. Family and friends are the first port of call for young people experiencing mental health difficulties. Young people in contact with youth workers and support workers will also turn to them for help. The presence of a trusting relationship was the most significant factor in this.

2. Young people in contact with social workers said they would not choose to talk to them about their mental health.

3. Young people over 16 years were more likely to see their GP with mental health concerns than their younger counterparts.

4. Reasons for not seeing the GP included lack of trust/relationship, fears around confidentiality and feeling that GPs did not understand young people’s mental health.

5. Young people believe that early intervention is most helpful and can prevent mental health difficulties from escalating and impacting on school/home life.

6. Some young people felt that behavioural problems in school meant that their mental health difficulties were not recognised – delaying or preventing access to specialist support. Some of these young people were subsequently diagnosed with ASD or ADHD.

7. Experiences of referral into specialist services were mixed – some received assessment and support quickly while others experienced long waiting lists and/or were discouraged from attending appointments.

8. For some young people the involvement of parents in CAMHS assessment processes limited what they felt able to disclose/discuss.

9. The role of VCS organisations in promoting access and supporting referral in to specialist services, particularly for young people with less family/school support, was also highlighted.

10. Those who had received support from CAMHS services largely felt this was positive and helpful.

11. Some young people felt frustrated that they or friends had not received appropriate support when they felt they needed it.

12. Self harm was recognised by most young people as a prevalent and growing concern. This was particularly true for looked after young people.

13. Young people were less likely to turn to families or professionals for support with self harm, and more likely to talk to friends or cope alone.

14. Factors preventing young people asking for help with self harm included fears around ‘overreaction’, judgement or other unhelpful responses, stigma and fears around confidentiality.
15. Young people feel self harm is not well understood by parents, professionals – particularly in schools, or other young people. Young people who self harm experience stigma and bullying.

16. Young people feel that they need more information and education around self harm – to increase understanding, reduce stigma and to help them to develop coping strategies and manage stress/emotions.

17. Young people feel that professionals need better training and awareness around self harm, particularly in how to respond appropriately.

18. Young people want more confidential support for self harm, particularly in school.

19. Young people say they would like more information about mental health problems, including self harm, and more awareness of where and how to access support. Leaflets, posters and online resources are most useful.

20. Findings suggest that PHSE provision across Cornwall is patchy and inconsistent. Young people feel that there is too much emphasis on sexual health and drugs and alcohol awareness and would like to cover a wider range of topics including: body image, identity, relationships, race awareness and LGBTQ, politics and voting, first aid and physical health, making choices and planning for the future, CV writing and preparing for employment.

21. Most young people say they receive little or no mental health or emotional wellbeing education through their PHSE lessons. Many believe it would be helpful to cover this more.

22. Some young people felt that self harm should be covered in school, but some suggested that small, targeted group work was a safer environment in which to deliver this.

23. Young people and teachers say they prefer PHSE sessions to be delivered by outside agencies/speakers who have ‘expertise’ and with whom young people feel more comfortable talking about sensitive issues.

24. Young people’s recommendations:

Young people’s suggestions to improve mental health support and wellbeing for young people in Cornwall include:

- more access to confidential services
- more accessible, drop-in or self referral services
- earlier access to specialist support
- more availability of information about mental health and about support services
- improvements in transitions between child and adult services and between inpatient and community services.
Findings in detail:

Where do young people go for support with mental health and wellbeing?

1. First port of call - family, carers and friends were the most frequently reported source of support for young people facing difficulties with mental health and wellbeing (32/62). Having a trusting relationship appears to be an important factor in where young people turn for help. Those young people consulted who were in regular contact with youth support organisations (VCS/LA), also said they would turn to their youth workers or support workers for help and advice (29). Hear Our Voice, Young People Cornwall, Penhaligon’s Friends, YZUP, YOS workers, Carefree, Voice for Us and Share were mentioned.

15 young people said they would ask for help from teachers or pastoral care staff in schools, and a further 10 said they would go to a school counsellor or school health centre. In schools with an integrated health centre (Penair in Truro and Budehaven in Bude) this was largely valued as a source of safe, confidential and easily accessible support which students were aware of.

2. Looked-after young people, and those in contact with social workers, all stated that they would not choose to talk to their social workers about mental health difficulties – this was due to not having positive or trusting relationships with social workers, frequent changes in worker, feeling let down or feeling that social workers don’t care.

3. GPs: 20 young people said they would see their GP with concerns about their mental health. These were mostly young people 16 years and over – who are perhaps more able to access GP surgeries independently.

4. Some young people said they would definitely not talk to a GP due to lack of trust, fears around confidentiality – particularly if the Dr knew the family well, not feeling able to talk to a stranger about sensitive issues, and difficulties accessing GPs out of school hours or without parent’s support/knowledge. Among those young people who did see their GP for support with mental health, including self harm, numbers of those reporting positive experiences (4) and those reporting negative experiences or lack of understanding (5) were roughly equal. Some young people felt that GPs did not understand how to respond to young people’s mental health issues: “I wouldn’t talk to my GP about my mental health, I find it hard to talk to people I don’t know” (YW, 15) “GPs need more understanding of young people’s mental health, they are not sympathetic ... sometimes they are judgemental” (YW,17).

Access and referral to specialist services:

The main themes around access to services include young people not being aware of services or not understanding them; stigma and/or fear discouraging young people from attending mental health services; needing support through the referral process and to attend appointments; long waiting times or not being offered the support they or families feel they need.

5. Early intervention - the majority of young people who took part suggested that having access to specialist support services during early (22) or moderate (27) stages of mental health difficulties is most helpful, and can prevent problems from escalating and affecting school outcomes for example. However many believe that this is not available to them and some have experienced difficulties
accessing services and/or long waiting times for assessment and support from specialist CAMHS services: “you should be able to get help when you first start feeling low; before it gets really bad, but this generally doesn’t happen, it’s pretty unlikely to happen” (YW, 16) “it’s better to tackle it early, when you notice a change; when signs are showing, earlier intervention is better.” (YW, 17)

6. Some of those consulted had experienced great difficulty in accessing the support they and their parents/carers felt they needed. They talked about parents/carers having to ‘fight for services’, often over several years. Some of these young people had received support from their school, while others felt that behavioural issues meant that they were ‘labelled’ as ‘naughty’ or ‘bad’ from a young age, and that as a result of this their mental health difficulties were either not recognised or not taken seriously, and referrals for appropriate support were delayed. “The CMHT only took me on this time because of safeguarding and I was suicidal” (YW, 23yrs); “I had an assessment from CAMHS for my autism but only last year after we asked for it for years and years. And that’s the only time I saw them … My foster carers tried to get support for me for years. They managed to get it in the end. The PRU helped with this too.” (YM, 18)

ASD/ADHD: Some of these young people were subsequently diagnosed with ASD or ADHD, or other learning difficulties. They felt strongly that schools needed more training in recognising mental health difficulties and learning disabilities, and suggested that schools and healthcare professionals should take young people more seriously when they ask for help: “I got kicked out of school for my behaviour, but it’s because they didn’t understand I had autism and they didn’t get me assessed and they never gave me extra support … I feel I have been really let down by everyone – school and social workers … Schools and social services need to be more proactive over autism, it would have been much better for me if I had a diagnosis when I was younger because then I would have got more support at school and I might not have got kicked out ” (YM, 18)

Experiences of referral:

Of those consulted, 24 said they had been referred to CAMHS at some point, and 19 said they had seen counsellors, including Kooth, Clear, Jigsaw, FCA and Outlook SW. Of these, 11 had been referred by their GP, 11 by a youth or support worker, 7 by their school and 3 by social workers. Others were unsure who had made the referral. 4 young people said they were under the care of community mental health teams (adult services).

7. Experiences of referral were mixed. Some young people reported timely and straightforward referral and assessment processes. Several young people mentioned that they had experienced long waiting times before assessment, which had discouraged some from accessing the service altogether. Some said they had found their first appointments intimidating or scary.

8. In addition, some young people said they found it difficult attending with parents as they felt this limited what they were able or willing to discuss/disclose, and for some, the fact that parents would be involved in the assessment process discouraged them from accessing support at all.

9. The important role of VCS organisations (working with young people) in promoting access and supporting referral into specialist services for certain groups was also highlighted. As noted, youth workers and support workers are often the ‘first port of call’ for young people who do not have so much support from family or school. Young people reported that they made them aware of the specialist services available, made referrals, and then supported them into services by preparing
them for appointments, encouraging them to attend, liaising with services on their behalf and sometimes providing transport or accompanying young people to appointments. Several of those who took part suggested that without this support they would not have continued to access support: “Hear Our Voice and Share helped me to access CAMHS the second time. CAMHS referred me to Early Intervention. I didn’t stick with CAMHS at first because it was too difficult, even the waiting room was intimidating, but then I really need help again so I asked HOV for support and they referred me again.” (YW,16) “I wouldn’t have known where to go without [support from] YZUP ... they have given me ongoing support and help me with transport and things” (YM, 17).

Experiences of services:

10. Experiences of services was not specifically consulted on, however, those who had received support from CAMHS were largely positive about the impact of this on their mental health and wellbeing, and on their lives more generally. “CAMHS have been really helpful, they stand up for us and don’t give up on us” (YW, 17); “I don’t see my CAMHS worker any more but have been told I can go back to them if I want to in the future. My referral was quick but others have had to wait a really long time.” (YM, 15); “I went to CAMHS for 8 months a couple of years ago, I still have an open invitation to go back until I’m 18 if I need to, I just have to call them which is good. CAMHS wasn’t helpful at first, but after a while it really helped and now I’m a different person.” (YM, 16)

These young people were more likely to recommend earlier intervention, and some suggested that if they had received support earlier they believe their mental health problems would have been less serious and would have had less impact on their education and relationships for example.

11. Difficulty accessing support - others had less positive experiences of specialist services, or felt frustrated that they or friends had not received support when they needed it: “Because my friend wasn’t at risk of serious harm she didn’t get enough support. CAMHS only saw her for one session because she wasn’t a suicide risk. They should have carried on with her, she is still self harming” (YW,17) “ Early Intervention were not so helpful, they asked really difficult, personal questions, and it was quite distressing being told I didn’t have psychosis, because now I have no answers.” (YW,16);

Self harm:

12. Self harm was recognised as a very prevalent and growing issue among the young people who took part. Of those consulted 53/62 had either self harmed themselves and/or had friends who self harmed. This was particularly evident at certain schools where young people reported that self harm was very common and increasing, particularly among girls in Years 8 – 10, and among looked after young people, some of whom reported having up to 15 or 20 friends who self harmed. “Lots of people at school self harm. It’s very common, especially the girls in Yrs 8 and 10. Also, people using aerosols is common at school.(YW, 13+ 15)

Most young people consulted understood what was meant by self harm, although for some there was a perception that self harm was all about ‘attention seeking’, ‘drama’ or ‘copycatting’.

13. Support -young people said they were less likely to turn to family (particularly parents) for support with self harm (10/62) and several mentioned that this was because they feared parent’s reactions and worried about upsetting them. The majority of those consulted said they would turn to friends for support (23) or cope alone (13). Some also said they would speak to a youth worker (12), someone at school (15) or their GP (14): I’ve had no one to talk to when I’ve felt like doing it ...
future I think I would talk to friends and people I trust (YM 17); “parents and teachers don’t understand, parents overreact, they get angry and punish you.” (YW, 13 +15).

14. The most commonly reported barriers to asking for help were fears around professionals ‘overreacting’ or ‘blowing things out of proportion’, and around confidentiality – some believed schools or healthcare professionals would inform their parents or make safeguarding alerts: “I didn’t tell anyone as I was worried about their reactions – I thought they might overreact or be angry.” (YW, 15); “I didn’t tell people because I was worried they would blow it out of proportion – worrying about reactions stopped us asking for support – it probably would have been helpful if I did tell someone though” (YW, 16); “We wouldn’t go to teachers because it’s not confidential.”(YW, 13+ 15).

When those who did ask for help from schools, GPs or parents were asked if the response was positive or negative the numbers were fairly even, suggesting that some schools and GPs have a good understanding of self harm, but that this is not consistent. “Teachers sometimes overreact and confiscate sharp objects! It’s quite mixed, sometimes they know and are helpful, sometimes they panic.”(YM, 15); “my GP told me I would grow out of it, it wasn’t taken seriously” (YW, 22).

15. The young people consulted generally felt that self harm was not well understood, particularly by school staff and other young people, and that there was not enough support available: “people don’t have enough access to services or know how to get support” (YW, 16)“the school were judgemental and asked to see my self harm” (YW,16); “the teachers didn’t understand, there should be help in schools, but it’s too strict and controlled, you can’t speak to anyone” (YM, 17); “reactions at school, among other young people, are bad, it can lead to more bullying, people don’t understand” (YM, 15).

Young people felt that youth workers and CAMHS workers generally did have a good understanding of self harm.

Several young people mentioned offering peer support around self harm to their friends: “Sometimes they talk to friends or to me, I tell friends who self harm that they can always ask me for help when they need it, I feel I can support them now that I don’t do it anymore.” (YM,16) “I support people at school who self harm, I think I listen well and support them, people trust me now, I used to be really out of control, but now I’ve matured I think they trust me, I was like them once and can give them advice about how I coped.” (YM, 15).

Some recognised that they needed support and information in order to help their friends: “Services where we could get help and advice for our friends, anonymously, if they didn’t want to go, would be good – so we could help them.”(YW, 12 + 13).

**Changes to improve support for self harm:**

16. When asked what changes could be made to improve support for self harm, some (25/62) suggested that young people needed more information and increased understanding of self harm. They suggested that this could be taught in school (21) and/or that information leaflets/booklets or online should be more widely available (19). “Schools don’t provide enough education on mental health and self harm” (YW, 17); “Young people need more awareness too, and young people in care especially should have education about mental health and self harm because it’s even more important for them.” (YM,18).
Several young people who had self harmed reported that they regularly experienced stigma, misunderstanding, judgement and sometimes bullying - from other young people, families and professionals. They suggested that talking about self harm more may help to improve this: “... there needs to be less stigma, sometimes you get bullied for admitting you self harm or see a counsellor or have problems.” (YW, 13+ 15) “all teachers and pastoral staff and youth workers should have awareness. There is lots of stigma and misunderstanding, it should be more talked about in schools and youth centres.” (YM, 17) “There should be more discussion about why people self harm, it shouldn't be a taboo subject, there should be workshops in school.” (YW, 16)

17. Many also felt that professionals, and particularly staff working in schools need better training and awareness– in particular around why young people self harm, and how to respond appropriately in ways that are helpful and do not increase distress: “Parents, carers and teachers need education about self harm, especially about how to respond to it – often they get angry or panic or over react. For example - My foster carers took everything sharp away thinking they were doing the right thing, but actually that made it worse because I was going to do it anyway and so then I had to use things like pens and pencil sharpeners that are more dirty and dangerous to use.” (YM,16); “Professionals need to be calm and relaxed when you tell them about self harm, the last thing you need is for them to be anxious or panic, they need to be easy to talk to and not shocked.” (YM,15); “counsellors sometimes say there is nothing wrong with you, I’m sure they’re trying to reassure you but it can be the worst thing to say because then people don’t know why they are self harming and feel so bad and you can feel like it’s not taken seriously” (YM,16)

18. They also suggested that schools should maintain confidentiality unless there was risk of significant harm, rather than immediately escalating the issue or informing parents. Access to confidential support was a theme that repeatedly arose throughout the consultation: “There should be more confidential places for young people to go to for help – schools tell your parents or carers – my sister was self harming, and she told the school and they told my dad even though she asked them not to and when they knew that I was in care because he had been violent to me when he found out that I self harmed ...” (YW,18)

In addition, some young people suggested that parents/carers needed education around self harm; and some felt that there should be more access to psychological therapies or to self harm support groups.

Information/education:

19. Information: young people generally suggested that they would like more information about mental health, in particular around self harm, and also about where, when and how to access support if they needed it. They mentioned that support and groups available from VCS organisations should be more widely publicised. They suggested that information in the form of leaflets and posters available in schools and community settings was most useful, followed by workshops/teaching in schools and online resources.

PHSE:

Earlier consultations suggested a need to establish a clearer picture of PHSE provision in Cornwall, particularly with regard to the mental health and emotional wellbeing education that young people received. This was discussed with some groups through the consultation events, and with a further 100 young people through the ‘Heads Up’ programme.
20. Consultation findings suggest that there is little consistency between schools’ PHSE offer, with some young people saying they had regular sessions, others saying PHSE was delivered only once or twice a year through ‘collapse days’, and one young woman reporting that she had received only one PHSE lesson in her entire school career. Young people had generally covered sexual health and drugs and alcohol awareness, but some felt there was too much focus on this and that it was often repetitive. Other topics they would like to cover more include – body image, identity, relationships, race awareness and LGBTQ, politics and voting, first aid and physical health, making choices and planning for the future – college, university, employment, gap years, CV writing and preparing for employment.

21. Of those consulted about this, the majority said they had received little or no education around mental health through their PHSE lessons. When asked, many felt that it would be helpful to cover mental health in PHSE lessons, in particular general mental health awareness, stress management, depression and anxiety, eating disorders and how to get help: “young people need more education about coping with stress and how to get help or who to get help from.” (YM, 16); “mental health and self harm should be covered in PHSE, as well as LGBT issues they’re not really covered at all” (YW, 16).

22. At the consultation event 21/62 young people suggested that self harm should be covered in PHSE, and that this should focus on increasing understanding of why young people self harm, reducing stigma, and educating young people about managing emotions, developing alternative coping strategies, and how/where to access support. However, some of those who had self harmed felt that mainstream classes may not be the safest place to discuss self harm and that this could trigger young people or increase bullying or distress. They suggested that someone should always be available to support young people, and felt that small, targeted group work may be safer and more effective. “Mental health should be in PHSE, but don’t make it a big deal and don’t be personal – and there should be someone there to talk to if you need to” (YW, 12 +13) “you need to be careful teaching mental health/self harm in PHSE as it can be hard if you have experiences of this and people know about it – they look at you and can bully you more – it can make you feel worse or trigger you.” (YW, 15+ 13); “Young people need more information about mental health and self harm – in lessons general information about mental health and stress would be helpful, but I don’t think class is the best place to talk openly about self harm, because it can make young people anxious, and if people know you self harm then you might get bullied.” (YM, 16)

23. Young people also said that they preferred PHSE delivery from outside speakers, particularly around issues such as mental health, sexual health and drugs and alcohol. They did not always feel comfortable talking to teachers about sensitive topics and also felt that outside speakers had more expertise. Teachers also fed back that they often did not feel equipped to teach these topics, and were aware that students gained more from agencies and outside ‘experts’ coming in.

24. Young People’s recommendations:

When asked about changes and recommendations to improve mental health support and wellbeing for young people in Cornwall the most frequently reported suggestions were:

- More confidential services for young people.
- Easily accessible drop-in services, or services they could self access without referrals or parent’s support – these should be on school/college sites or within youth or community centres.

“there needs to be more confidential drop in support, but not from teachers – although in school
would best as its easy then. I don’t know about any support in my school that isn’t teachers – I don’t know if there are learning mentors or anything.” (YM,15); “there should be more drop in services for young people – where you can go in and talk to someone about mental health and get advice”(YW, 15+ 13); “It’s better when services are in schools and colleges because it’s really difficult to get to clinics and GP etc, especially if you live in a rural area – and especially if you don’t want your carers to know – but you can’t get there without transport” (YW,15)

- Earlier access to specialist support, before difficulties ‘get out of hand’. “you need help younger, before you get labelled or become suicidal” (YW, 22).

- More availability of information about mental health and services (see above): “there should be more publicity and posters about services that we can access directly ourselves – and not have to go through Mum or school or GP …” (YW,15);

- Improved transitions between services.

Difficulty with service transitions was not highlighted in the priorities and therefore not consulted on, but was raised by some young people– lack of continuity of support and communication between hospital and community services meant that some young people found themselves without support after discharge from inpatient units; and the significant differences between CAMHS and AMHS services meant that young people found it hard to navigate this transition and sometimes stopped accessing support: “there should be better communication between hospital and community services [because you can get good support in hospital and then it doesn’t continue in the community and things don’t get passed on].” (YW,16); “there’s no half way point, adult services are too old and people’s issues are really serious.” (YM,17).

HOV Comments:

Themes arising from this 2nd consultation would suggest that:

The availability of support and information for families/carers supporting young people with mental health difficulties should be a priority, including clear information about specialist referral routes, VCS support available for young people and carers’ support.

Skills mapping and training for workers who are in regular contact with young people and are likely to be a first or early port of call – youth workers, social workers, family or housing workers, support staff in schools for example – is important.

Specific training around young people’s mental health and self harm, and clear service availability and referral routes, for GPs and other healthcare professionals should be a priority. (For example – recently a GP made a referral to HOV rather than CAMHS for a young person experiencing suicidal thoughts as it was felt that we would be a ‘good starting point’ – we subsequently made the CAMHS referral.)

More awareness and a better understanding of the role of VCS organisations by NHS and local authority services, a commitment to more partnership working between the two sectors, and a commitment by NHS services to involve VCS organisations in providing holistic support for young people, would benefit those young people and their families.

A clear ‘offer’ to young people, outlining different support available, specialist service thresholds, a clear referral and assessment process and likely waiting times, would be helpful for young people and families and also for organisations/professionals referring in.
As far as we are aware a PHSE working group has been established and is currently mapping provision across the county. Ensuring that mental health and wellbeing are included in any future curriculum should be a priority, and planning to involve more NHS staff in delivery of PHSE could also be considered.

In addition, HOV believes that developing a clear, participatory, action-research approach to engaging young people in future consultation and research would enable more meaningful and youth-led involvement and would improve the breadth, rigour and quality of future engagement work. HOV will develop this in collaboration with the CAMHS Young People’s Board and with support from members of the EWMH Partnership Board.
Appendix D


Process:

HOV was asked to carry out a further consultation with young people living on the Isles of Scilly (IOS), this took place on 4th/5th July, 2013. As HOV has not previously worked on IOS we approached the Five Islands School and Mundesley Boarding House on St Mary’s to help us facilitate the consultation.

Two HOV youth workers travelled to St Mary’s and carried out the consultation over two days. As the IOS was not involved in earlier consultations, we asked young people to complete the initial short questionnaire used on the mainland to establish levels of mental health awareness among a wider group. These were completed by all students from Years 7 to 10 who were present on the day. We also carried out small group (4 – 6 per group) discussions with students from Years 7 to 10, a group of young people who live on other islands and board at Mundesley during the week, and a larger group (10) from Year 6.

The questions used on the mainland consultation were developed and refined to ensure they were succinct and relevant. We also included questions around PHSE provision and, in order to ensure the safety of the exercise, we reduced the detail of questions around self harm as we were not aware of any existing mental health difficulties among young people or of their support networks. Questions on self harm were omitted from discussions with students from Years 6 and 7. Young people were also told that they could speak to their Key Stage leader with any concerns that arose as a result of the consultation process.

We did not involve young people below Year 6 at this stage as we felt that a separate consultation process, designed for primary age children, was more appropriate. Members of the CAMHS young people’s board have expressed an interested in developing and co-facilitating this work in the future.

Limitations of the consultation: As an organisation HOV is not known by young people, school staff or parents which may have limited what young people would reveal to us. In addition, consulting with a whole school population, within the school environment and in larger groups may also have limited what young people felt able to disclose or discuss. This is particularly relevant in light of an acknowledged ‘culture of silence’ on IOS and young people’s evident concern about lack of confidentiality – described below. We did not have an opportunity on this occasion to consult with older young people and those who are not in education who may have different levels of involvement with support services for example.

The consultation was a useful opportunity to build links and relationships on IOS that will inform future consultation and research with young people on the islands.

Profile:

A total of 87 young people were involved in the consultation process.

77 young people, aged between 11 and 15 years completed the short questionnaire (approx 20 from each Year group 7 – 10). Of these 40 were young women and 37 young men. 72 described themselves...
as White British, White Cornish or White Scillonian, 1 was White African, 3 Mixed Race and 1 described their ethnicity as Other. 51 said they lived on St Mary’s, 11 on other islands and 15 did not specify.

38 young people took part in further more detailed, small group discussions, this included 10 young people from Year 6 who did not complete the questionnaire. Groups were comprised as follows:

Mundesley Boarding House – x 5 young people - 4 female, 1 male. Aged 11 – 15yrs, from St Martins (2), St Agnes (1), Bryher (1), Tresco (1).

Year 6 – x 10 young people – 6 female, 4 male. Aged 10 – 11.
Year 7 – x 6 young people – 3 female, 3 male. Aged 11 – 12.
Year 9 – x 6 young people – 5 female, 1 male. Aged 13 – 14.
Year 10 – x 5 young people – 1 female, 4 male. Aged 15.

Of these 4 young people lived on other islands – St Agnes, St Martins and Bryher.

Summary of findings:

1. The young people consulted are aware of mental health and most understand the terms mental health and emotional wellbeing, however, almost half of those consulted felt that they did not know how to look after their mental health.

2. Most young people said they would not find it easy to talk about mental health and would not want people to know if they were experiencing problems with their mental health.

3. The most frequently reported causes of stress or concern were pressures from school, homework and/or exams, followed by problems with family or friends. Other issues mentioned included physical health problems, worrying about money, the future, bullying, lack of confidentiality and homesickness (off islanders).

4. Parents and friends would be the first port of call for young people experiencing concerns about mental health. The House Parent at Mundesley Boarding House is also an important and highly valued source of support for ‘off-island’ young people who live there during the week.

5. Other sources of support include the school, the primary mental health worker (PMHW) (no longer in post), and the practice nurse at the Health Centre.

6. Lack of confidentiality is the main barrier that would prevent young people asking for help or accessing services, and is a significant problem for young people.

7. Stigma, embarrassment and a perception that mental health is not well understood on IOS would also deter young people from accessing support.

8. The majority of young people had not heard of specialist CAMHS but were aware of the PMHW role. Some had received one to one support from her and many had been involved in group sessions in school and at the boarding house. Young people were not generally aware of any other counselling services available.
9. Young people were not aware of online counselling services but many felt that this could be a useful source of confidential support.

10. Most young people who had accessed support from the PMHW found this to be positive and helpful. Some young people expressed regret that she was no longer in post. Young people did not generally find it easy to talk to teachers about mental health concerns.

11. Young people access information about mental health and emotional wellbeing from leaflets, websites including Childline, Brook, Frank and the NHS, and from parents and visiting agencies from the mainland – Brook, Yzup and Devon and Cornwall Police were mentioned.

12. Young people have learned about mental health and wellbeing through SEAL (Social and Emotional Aspects of Learning) provision in primary school.

13. Young people say they have learnt about sexual health, drugs and alcohol, bullying and the Law through PHSE sessions, but say that business and enterprise has now become the main focus of sessions (PHSEE).

14. Young people say there is less emphasis on mental health in PHSE in secondary school, and most say that it would be helpful to cover this in more depth – in particular why people develop mental health problems, how to protect against this and when, where and how to access support.

15. Young people have some understanding of self harm, although there is a perception that it is ‘all about attention seeking’. They do not believe that self harm is a significant or prevalent issue on IOS.

16. Young people are unsure of where they could access support for self harm. They would be reluctant to talk to parents about this and were concerned that school staff would ‘overreact’ and may not maintain confidentiality.

17. Underage drinking was identified by some as a significant problem on IOS – related to a ‘drinking culture’ and lack of out of school youth provision.

18. Young People’s Recommendations:

Young people’s suggestions for improving mental health support and young people’s wellbeing on IOS included having:

- More access to confidential and safe support.
- More choice of support services.
- A dedicated person in school to offer confidential support (named, consistent, not a teacher).
- Access to support without having to tell parents.
- A dedicated ‘chill out space’ for young people – suggestions included their own ‘shed’ (chalet type space) –and/ or more informal youth club provision (the ‘Hub’ youth club only runs one night a week and is mainly used by younger age groups – up to Yr 9).
- More information/education about mental health.
- More visits from mainland agencies.
- School nurse back in post.

Findings in detail:
Findings from the questionnaires show that:

1. Young people on IOS have a fairly good awareness of mental health - 83% (64/77) young people feel they understand what is meant by the terms mental health and wellbeing, and 87% agreed that any young person could experience mental health problems. However, only 57% (44/77) felt they knew how to look after their mental health.

2. Most young people consulted (81%) said they would not find it easy to talk about mental health problems, and 38% (30/77) strongly agreed that they would not want people to know if they were experiencing problems, a further 36% (28/77) were unsure about this.

3. The most frequently reported causes of stress or concern were pressures from school, homework and/or exams, followed by problems with family or friends. Other issues mentioned included physical health problems, worrying about money, worrying about the future, bullying, lack of confidentiality and homesickness (off islanders).

Findings from group discussions:

4. First port of call – parents and friends were the most frequently reported sources of support for mental health and emotional wellbeing. Young people living at Mundesley all said that they would also turn to Ann Pearson – House Parent who runs the boarding house - and indicated that she was an important and highly valued source of support and advice for them. Some of these young people felt they were better supported than those living at home as they had additional support outside of the family. Young people at the boarding house are also given a list of confidential helpline numbers they can call.

5. Other sources of support - Some young people said they would go to someone in school, particularly the head teacher. The practice nurse at the health centre and the previous primary mental health worker (PMHW) and school nurse -Carol Green - were also mentioned frequently as sources of support and advice.

Young people felt they would be likely to ask for help with feeling sad a lot, stress, alcohol problems, bullying, anger, suicidal thoughts or not feeling in control. Most felt that it was better to get help early (although questionnaire results indicated that they would be reluctant to ask for help).

6. Barriers - the main barrier to asking for help or accessing services was lack of confidentiality. Young people said that things spread very quickly around the school and wider community, and often became magnified, blown out of proportion and/or distorted – “like Chinese whispers”. This stopped some from talking to friends and made them less likely to ask for help from professionals. “Everything gets spread around, three minutes later it’s all over the Island” (YW, Yr 10). “Things get back to your parents before you even get home … you have to be open here, if you don’t tell someone else will …” (YM, Yr 10).

7. Young people also suggested that the felt there was a general lack of understanding about mental health issues on the islands, and stigma and embarrassment were other widely reported barriers to accessing help. “I don’t think people here are very well informed [about mental health], and we don’t get much education about it.” (YM, Yr 10). “Older kids might find out and give you a hard time.” (YW, Yr 7)
8. Specialist services - most young people had not heard of specialist CAMHS services. However, the majority were aware of the previous PMHW /school nurse and several had worked with her on a 1 to 1 basis. Some young people believed friends had received counselling, but they were not aware of who had provided this, if it was a service from the mainland, or how to access counselling if they needed it. “We had Carol, the ‘feelings lady’, she taught us how to take control of our feelings.” (YW x 2, Yr 8).

Young people at Mundesley believed their House Parent would be able to refer them for specialist support if they needed it. “We would go to Ann and she would sort that sort of thing out for us.” (YW x 2, Yr 8).

9. Online services - those consulted were not aware of online counselling services, but of those asked, most felt that this could be a useful source of support as it would offer them confidentiality and some choice of worker and service, which was not currently available to them.

10. Experiences of support - most of the young people who had accessed support from the PMHW reported that they found this positive and helpful. Some expressed frustration that there was no choice of worker if they did not get on with her. Young people believed that the PMHW was no longer in post and many expressed regret about this.

Other young people found that support from parents and friends’ parents was most helpful. Most said that they did not find it easy to talk to teachers and were not aware of an identified person in school who they could ask for support.

11. Information - young people said they accessed information about mental health and emotional wellbeing from leaflets available at the health centre and online from sources including Childline, Brook, Frank and the NHS. They were not aware of Kooth, and teachers believed that the Kooth service was not available on IOS.

Most young people also said that their parents were an important source of information and advice. Some said they talked to the youth worker at the ‘Hub’, but felt that this would not be confidential. Young people said that the most useful sources of information were parents, the internet, visiting agencies and leaflets. “Parents are most helpful, because you know them and can trust them.” (YW, Yr 6).

12. PHSE - when asked about PHSE provision in their school most young people said they had learnt about mental health and wellbeing through dedicated ‘SEAL’ (Social and Emotional Aspects of Learning) sessions during primary school, delivered by the PMHW, where they had covered stress, relaxation, friendships, bullying and ‘feelings’ for example.

13. Young people said they had covered sexual health, drugs, alcohol, the law and bullying through PHSE in secondary school, mostly delivered by agencies visiting from the mainland – Brook and Yzup were mentioned. Some mentioned that PSHE now included business and enterprise (PHSEE) and felt that this had largely become the focus of sessions. Some young people said they would like more PHSE sessions. “We think we actually need more PHSE, we have less than we used to and we like PHSE” (YW, Yr 6).
14. Most young people said that there had been less emphasis on mental health through PHSE sessions in secondary school. Many felt that it would be useful to learn more about mental health and wellbeing, particularly as it felt increasingly relevant as they grew older and had to cope with exam stress and navigating friendships and relationships for example. They wanted to include why people developed mental health problems, how to protect against problems and when to get help, managing stress and learning about the types of support and services available for young people. “We’d like to know more about mental health because you might come across it. It would be good to know what is serious and what’s not, and what you should get help for.” (YW, Yr 9).

15. Self harm – young people had some understanding of self harm, although some expressed a belief that it was all about ‘attention seeking’. Young people believed that there were a few people who self harmed at the school but felt that it was not a common problem on IOS. One young woman who had recently moved to IOS said she believed it was not nearly as prevalent as on the mainland.

16. Support for self harm - young people were unsure about where they would be able to access support for self harm. They didn’t believe that there was anywhere confidential enough to talk about self harm and said they would be reluctant to tell anyone in school as they were concerned that teachers would ‘overreact’ and that parents would be informed. While parents were mentioned as the primary source of support for mental health more generally, young people were unsure of how parents would react to self harm and would be more reluctant to disclose this.

17. Alcohol - this was not consulted on but several young people (and staff at Mundesley) commented that underage drinking was a significant problem for young people on IOS. They described how the pub was often the centre of community life and young people grew up around pub and drinking culture, often drinking with parents, so that it became ‘normalised’. Young people talked about peer pressure in relation to alcohol and also felt that lack of other youth provision meant young people were more likely to drink. They did not feel that other drugs were much of a problem on IOS.

18. Young People’s Recommendations:

When asked about changes and recommendations to improve mental health support and wellbeing for young people on IOS, the most frequently reported suggestions through questionnaires and group discussions were:

- More access to confidential and safe support.
- More choice of support services.
- Having a dedicated person in school to offer confidential support (named, consistent, not a teacher).
- Having access to support without having to tell parents.
- A dedicated ‘chill out space’ for young people – suggestions included their own ‘shed’ (chalet type space) –and/ or more informal youth club provision (the ‘Hub’ youth club only runs one night a week and is mainly used by younger age groups – up to Yr 9).
- More information/education about mental health.
- More visits from mainland agencies.
- School nurse back in post.
HOV Comments:

HOV has established that the KOOTH counselling service has not been commissioned for IOS. It would seem that the online counselling service would address many of the issues highlighted by young people – offering them independent and confidential support, and making a choice of workers and services available.

Consultation findings suggest that the PMHW role was very successful and was valued by young people on the islands – is this being replaced? or is there an opportunity to provide individual IAG (information, advice and guidance) sessions at the youth ‘Hub’ and/or in school, similar to the Share service in Cornwall?

HOV will continue to involve young people from IOS in future engagement work, and plans to develop links between the CYPB and young people representatives on IOS, from September 2013. We will also investigate ways of reaching older young people and those out of education, although we recognise that many post-16s leave the islands.