Warrington

Joint Strategic Needs Assessment (JSNA)

Children and Young People Emotional Health and Wellbeing

March 2017

EXECUTIVE SUMMARY

Introduction
This is the second children's and young people's (CYP) emotional health and wellbeing JSNA chapter (the first version produced in 2012) and aims to provide an update to the previous chapter along with a focus on new and emerging CYP mental health priorities in Warrington.

Summary of Key Issues
- Estimated prevalence of mental health disorders in children and young people is dated as current estimates are based on the findings of a 2004 survey (Green et al, 2005), however this survey is scheduled to be updated during 2017;
- Although there are many organisations across Warrington providing emotional and mental health support to children and young people; it is unknown how many people access these services as a central point to consolidate this information is currently not available;
- It is not known how many children and young people in Warrington have a mental health diagnosis. Data has been extracted from GP clinical systems; however it is not known how accurate this figure is;
- Engagement with young people, families and wider partners highlights that locally there is confusion about how to access the right service for the right level of need, with a view that thresholds are too high;
- Commissioning arrangements reflect the findings of 'Future in Mind' (Department of Health, 2015); commissioning arrangements were seen to be disjointed, making accountability unclear and pathways could be confusing for referrers. This could disproportionately affect the more vulnerable groups. This is being addressed through new commissioning arrangements and greater partnership working;
- Locally, the higher than national levels of admission to hospital for mental health conditions, self-harm and the high levels of occupied bed days in Tier 4 specialist mental health inpatient beds suggests that more could be done locally to prevent children and young people going into crisis;
- All schools in Warrington are offered a service from the School Nursing Team. However, it has been identified that there is variation between schools with the emotional health and wellbeing learning and support offered to students.

Recommendations for Commissioning
- A robust process for understanding local levels of need is required. The mental health services minimum dataset should be explored as a method for doing this, however this would require different partners to work together to ensure all activity is reflected;
- Work is already underway to review CAMHS services in line with 'Future in Mind' (Department of Health, 2015). Locally there is now a high level of support for

moving away from a Tiered model to a more needs led, whole system model such as 'THRIVE' (Wolpert et al, 2016). This would shift the focus from diagnostically/severity driven criteria to access support to a more flexible, needs led model of delivery;

- Further reviews of services to be conducted, these will include:
  - o Crisis care and meeting the requirements of the Crisis Care Concordat;
  - o Offering more intensive support to the most vulnerable/risky young people to prevent admission or support them on discharge home to prevent re-presentation in crisis. This will require a joint approach across Health and Children's Services;
  - o Increased access to support those young people at lower levels of need to prevent difficulties from escalating and to enable local services to meet the nationally agreed access target;
  - o Consideration of how specialist services provide support into schools.

- In order to deliver on these recommendations within the resources available, a new model of delivery will be needed. It is recommended that a whole system approach is taken, supported by integrated commissioning and informed by engagement with young people and their families. Consideration should be given to contracting arrangements that enable different providers to work in a more integrated way, to ensure all activity is reflected in the Mental Health Services Minimum Data Set (MHSMDS);
- It is suggested that alongside the development of the MHSMDS, a register of children and young people's mental health is established to create a baseline position of need in Warrington. It is suggest that this is followed up by a data quality audit to ensure that all applicable children and young people are recorded within the register;
- Commissioners to work with schools to support whole school approaches to emotional health and wellbeing;
- Commissioners to develop links between CART (single point of access for referrals for young people experiencing mental health problems) and the Multi Agency Safeguarding Hub (MASH) to support the earlier identification and earlier provision of services.
- Commissioners to continue to work with ADHD service providers to address the current gaps in service provision for 17 year olds.

1) INTRODUCTION

Nationally, children and young people's mental health is high on the agenda and has been identified as a priority for improvement and investment. This is at a time when it is widely agreed the NHS needs to look to financially sustainable new models of integrated care to ensure good quality of care and outcomes. (NHS England, 2014a).

In 2015, the Children and Young People's Mental Health Taskforce report 'Future in Mind' was published (Department of Health, 2015). The taskforce, following wide engagement, highlighted a range of issues in terms of the support that children and young people have been receiving in relation to mental health and makes a wide range of recommendations for improvement. It recognises that investment in children's mental health services has not kept pace with adult mental health; yet if we get it right early we can ensure our children and young people have improved outcomes and potentially reduce demand on adult services.

The report highlights five key themes:
• Promoting resilience, prevention and early intervention
• Improving access to effective support – a system without tiers
• Care for the most vulnerable
• Accountability and transparency
• Developing the workforce

Key recommendations from 'Future in Mind' have been reflected in the 'Five Year Forward View for Mental Health' (NHS England, 2016), which emphasises the need for improved access and waiting times, better crisis care and more intensive support, and better support for vulnerable groups. The 'Crisis Care Concordat' (Department of Health, 2014) also outlines some key recommendations in relation to support that should be received when someone is in mental health crisis; for children and young people this includes not being on an adult ward or detained in a police cell.

Currently, Child and Adolescent Mental Health Services (CAMHS) work within a tiered model as outlined by the Health Advisory Service in 1995, a recommendation following the first CAMHS review and published in the report 'Together We Stand'. 'Future in Mind' advocates moving away from a tiered model in which there are tight thresholds in order to receive the more specialist, more intensive support. In order to deliver real change and improvements in all the areas outlined in national guidance, a whole system approach will be needed.

A model called 'THRIVE' has been proposed by the Anna Freud Centre (Wolpert et al, 2016); the authors outline a more needs led approach to supporting the mental health and wellbeing of our children and young people and provide a framework in which local areas can design services in line with the model and local need. Any design will also need to have embedded within it the principles of 'Delivering With, Delivering Well' (NHS England, 2014b), a document which outlines the principles of high quality, outcomes focussed care for children and young people that have underpinned the 'Improving Access to Psychological Therapies' work that is now being embedded across the country.

2) WHO IS AT RISK AND WHY?

Since the last children and young people emotional health and wellbeing JSNA chapter was written in 2011, there has been very few updates produced estimating the prevalence of specific mental health conditions in children and young people. The survey of the mental

health of children and young people in Great Britain 2004 (Green et al., 2005) continues to provide the most current picture of mental health disorders in children. However, during 2016 the Office for National Statistics (ONS) conducted a consultation asking for opinion about the content of an updated survey; the survey is expected to take place during 2017.

The 2004 survey found that:
- 10% of children and young people aged 5-16 have a mental disorder that is associated with "considerable distress and substantial interference with personal functions", such as family and social relationships, their capacity to cope with day to day stresses and life challenges, and their learning;
- Mental disorders are more common in older than younger children and are more common in boys than girls:
  - 10% of boys and 5% of girls aged 5-10 years were found to have a disorder;
  - 13% of boys and 10% of girls aged 11-16 years were found to have a disorder;
- The prevalence of a mental disorder was greater amongst children that are in lone parent families, living in step-families, in families with no parent working, in low income families, in families from lower socio-economic groups, or living in social or privately rented accommodation;
- Children living in poverty are more likely to suffer behavioural and emotional problems throughout childhood. Conduct disorders are most strongly associated with socio-economic disadvantage, but psychiatric conditions, such as attention deficit hyperactivity disorder (ADHD), also show an association with deprivation;
- Some children and young people who are vulnerable for other reasons, such as those in care, those who have a learning disability, and those with chronic or persistent physical ill-health, are also found to have a higher prevalence of mental health problems.

There are particular groups of children who are much more likely to experience mental health problems. A sample of the children from the Green et al. (2005) survey was followed up over a three-year period, from 2004 to 2007, to find out more about the factors likely to be associated with the onset or persistence of disorders (Parry-Langdon, 2008). This study found that children who face three or more stressful life events, such as family bereavement, divorce or serious illness, were three times more likely than other children to develop emotional and behavioural disorders. Family, household, and social characteristics were strongly linked to persistence of mental and emotional problems (Warrington Council, 2011).

Public Health England (PHE) and the National Child and Maternal Health Intelligence Network (ChiMat) have produced Child and Adolescent Mental Health (CAMHS) needs assessments for all Local Authorities (LA) and Clinical Commissioning Groups (CCGs). Within the needs assessment the following groups have been identified at being particularly at risk of experiencing mental health problems:

Children and young people with learning disabilities: People with learning disabilities are more likely to experience mental health problems, have poorer health and much more likely to live in poverty than the general population. Further analysis of the 2004 survey found that 36% of children and young people with an intellectual disability had a mental health

disorder, whilst 8% of children and young people with no intellectual disability had a mental health disorder (Emerson, 2008 cited in ChiMat 2015).

Looked-after children: Looked-after children are more likely to experience mental health problems. It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic (Meltzer, H. et al, 2003 cited in ChiMat, 2015).

Homelessness and sleeping rough: Homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including acquired immune deficiency syndrome (AIDS) (Vonstanis, P. 2002 cited in ChiMat 2015). Two major studies of this group in London and Edinburgh found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were associated with sexually risky behaviours, substance misuse and comorbid psychiatric disorders, particularly depression (Craig, T. et al, 1996; Wrate, R. et al, 1999, all cited in ChiMat, 2015).

The following section highlights known at-risk groups within specific mental health disorders. These mental health disorders have been included within this JSNA chapter to build further on local knowledge about estimated prevalence and local need within Warrington.

Youth Offending

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. Mapping relevant risk factors associated with youth crime can help inform LA and NHS commissioning of evidence based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. The impact of incorporating these vulnerable children into mainstream commissioning also has the potential benefit of impacting on a young person's wider family now and in the future, particularly when they may already be parents themselves (PHE, 2015).

Perinatal mental health and attachment: Mental ill health during pregnancy and early motherhood, or 'perinatal mental illness', is a serious health issue with potentially harmful consequences for women's life-long mental health and the health and wellbeing of their children and families. For example, postnatal depression is the most common of the potentially serious perinatal mental illnesses and can trigger a relapse or recurrence of previous mental illness. It can also signify the onset of long-term mental health problems and is associated with increased risk of maternal suicide (Oates 2003 and Sullivan et al 2003, cited in Edge, D., 2011).

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"Acute serious perinatal illness usually presents as an emergency and often requires inpatient care. Separation of mother and infant prevents the early development of mother-infant attachment and relationship. This may be difficult to reverse and have longstanding effects on both child and mother. Separation causes great maternal distress and interferes with treatment of the mother as well as preventing breastfeeding" (p6, Joint Commissioning Panel for Mental Health, 2012).

Depression: Depression is a low mood that lasts for a long time, and affects everyday life. In its mildest form, depression can mean just being in low spirits. It doesn't stop a person leading a normal life but makes everything harder to do and seem less worthwhile. At its most severe, depression can be life-threatening because it can make them feel suicidal or simply give up the will to live (Mind, 2013).

There are several ideas about what causes depression. It can vary a lot between different people, and for some people a combination of different factors may cause their depression. Some find that they become depressed without any obvious reason. The following provides possible causes/situations that can increase the risk of depression in children and young people:
- Parents arguing;
- Divorce or separation of parents;
- The death of someone close to them;
- Problems with school work or exam pressure;
- Bullying;
- Physical illness in themselves or a carer;
- Poverty or homelessness.

(Young Minds, 2016b)

Anxiety: Anxiety is the term used to describe feelings of unease, worry and fear. It incorporates both the emotions and the physical sensations that might be experienced when worried or nervous about something. Although it is usually unpleasant, anxiety is related to the 'fight or flight' response – the normal biological reaction to feeling threatened (Mind, 2013b).

However, some people find it hard to control their worries. Their feelings of anxiety are more constant and can often affect their daily lives. Anxiety is the main symptom of several conditions, including: panic disorder, phobias, post-traumatic stress disorder (PTSD) and social anxiety disorder (social phobia) (NHS Choices, 2016a).

The possible causes/situations that can increase the risk of anxiety are:
- Personality type – some children are born more anxious or 'nervous' than others;
- Frequently moving house or schools;
- Parents arguing;
- Divorce or separation of parents;
- The death of someone close to them;
- Physical illness in themselves or a carer;
- Problems with school work or exam pressure;

- Bullying.
(Young Minds, 2016c)

Obsessive Compulsive Disorder (OCD): OCD is an anxiety-related disorder. Obsessions are intrusive thoughts, images or ideas that come into people's minds when they do not want them to. They can be distracting and distressing. Compulsions are things that people feel they have to do to neutralise or 'get rid of' the obsessions, even when they do not want to - for example repeatedly checking the light is switched off - and they feel frustrated or worried unless they can finish them (Young Minds 2016d).

Conduct disorders: People with conduct disorders tend to display repetitive and continued patterns of antisocial, aggressive or defiant behaviour (NICE 2013a). Based on findings produced by ONS (Green et al., 2005), the following demographic and socio-economic characteristics of children with conduct disorder were identified:

- More likely to be male and more likely to be in the older age group of 11 to 16 years;
- Children with conduct disorders were more likely than other children to have parents with no educational qualifications and more likely to live in low-income families;
- About one-third of children with a conduct disorder had another clinically recognisable disorder;
- About a half of children with conduct disorders were considered by their teachers to have special educational needs;
- Young people with conduct disorders were much more likely than other young people to smoke, drink and take drugs.

Emerging Personality disorders

People with emerging personality disorders tend to think, feel or react differently from other people and their reactions may become worse when they are stressed. Most people tend to change and modify their behaviour to different circumstances as they go through different experiences in life to cope better with different situations. People with an emerging personality disorder find this more difficult and they may have a more limited range of emotions, attitudes and behaviours with which to cope with everyday life (Young Minds 2016a).

Emerging personality disorders typically emerge in adolescence and continue into adulthood. They may be mild, moderate or severe, and people may have periods of "remission" where they function well. Emerging personality disorders may be associated with genetic and family factors, and experiences of distress or fear during childhood, such as neglect or abuse, are common (NHS Choices 2014).

Psychotic disorders

Psychosis and schizophrenia: Psychosis is a symptom of serious mental illness. A person experiencing psychosis loses touch with what is usually accepted as reality. They may feel paranoid, hallucinate, hear voices or have delusions, or have confused thoughts. People who develop psychosis often have their first episode in their teens or early twenties. They may only have one episode, or can go on to have them throughout their lives (Young Minds, 2016e). Schizophrenia is a mental illness which affects thinking and behaviour, a person

diagnosed with schizophrenia may experience psychosis, but not everyone with a diagnosis of psychosis will have schizophrenia as there can be other causes for the psychosis (Young Minds, 2016f).

Possible causes/situations that can increase the risk of psychotic disorders are:
- Severe stress or depression;
- Drug or alcohol use, especially cannabis use;
- History of family mental illness;

(Young Minds, 2016e)

When a diagnosis of psychosis or schizophrenia is made in childhood/adolescence, there tends to be a worse outcome for that person. Approximately 20% of children and young people with schizophrenia have a good outcome, with only a mild impairment; however, approximately one third will have a severe impairment resulting in the need for intensive social and psychiatric support. Psychosis and schizophrenia can have a damaging effect on children and young people's personal, social, educational and occupational functioning, placing a heavy burden on them and their parents and carers (NICE, 2016a).

Self-Harm: Self-harm is the action of intentionally damaging or injuring their body. This can be done by cutting or burning their skin, punching or hitting themselves, poisoning themselves, misusing alcohol or drugs, deliberately starving themselves or excessively exercising. Self-harm is usually a way of coping with or expressing overwhelming emotional distress (NHS Choices, 2015).

Possible causes/situations that can increase the risk of self-harm are:
- Bullying;
- Difficulties at school/with family/with friends;
- Coming to terms with sexuality;
- Physical or sexual abuse;
- The death of someone close to them;
- Psychological causes.

(NHS Choices, 2015)

Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorders (ADHD)
The causes of ASD remain unknown, although ongoing research is offering some insight into the probable reasons as to why some people develop this lifelong condition. Many experts believe that the pattern of behaviour from which ASD is diagnosed may not result from a single cause. There is strong evidence to suggest that ASD can be caused by a variety of physical factors, all of which affect brain development. There is evidence to suggest that genetic factors are responsible for some forms of ASD. Scientists have been attempting for some years to identify which genes might be implicated in ASD (The National Autistic Society, 2014).

In the United Kingdom it is estimated that 1% of the population have ASD (Baird et al, 2006), this equates to approximately 700,000 people nationally (The National Autistic Society, 2014). Numerous studies have found that ASD is more prevalent in males than females (The

National Autistic Society, 2014). Data presented by the Health and Social Care Information Centre (HSCIC, 2009) estimate that the prevalence of ASD in males is 1.8% compared to 0.2% in females. Further information about ASD can be found in the Warrington Autism JSNA Chapter (https://www.warrington.gov.uk/info/201145/joint_strategic_needs_assessment/1918/joint_strategic_needs_assessment_jsna)

Attention deficit hyperactivity disorder (ADHD) encompasses a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. The symptoms of ADHD tend to be noticed during childhood, and may become more obvious during a life changing situation, for example when a child starts school. Diagnosis is often made between the ages of 6 and 12 years (NHS Choices, 2016b).

It is estimated there are between 2% and 5% of school-aged children may have ADHD. The exact cause of the condition is unknown, but there does appear to be a genetic link as is can run in families. It has also been suggested that the following can increase the risk of developing ADHD:

- Being born prematurely (before 37 weeks gestation);
- Having a low birthweight;
- The mother consuming substances during pregnancy (tobacco, alcohol and drugs).

Those with ADHD are at greater risk of experiencing anxiety disorders.
(NHS Choices, 2016)

3) THE LEVEL OF NEED IN WARRINGTON

Child Poverty and children living in socio-economic disadvantage
As mentioned in section 2, children and young people exposed to poverty and socio-economic disadvantage are at increased risk of developing mental health disorders. Currently child poverty is defined as the number of children living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or are in receipt of Income Support or (Income-Based) Job Seeker's Allowance. The latest data from 2013 shows that nationally 18.6% of children aged less than 16 live in poverty. Locally in Warrington the percentage is significantly lower at 14.5%, however approximately 5,500 children in Warrington live in poverty.

In addition to this poverty measure, the Indices of Deprivation 2015 (Department of Communities and Local Government, 2015) provides a supplementary index, which considers the percentage of children aged under 16 who are living in families in receipt of Income Support or income-based Jobseekers Allowance, Pension Credit (Guarantee), or families in receipt of Working Tax Credit and Child Tax Credit whose income is below 60% of
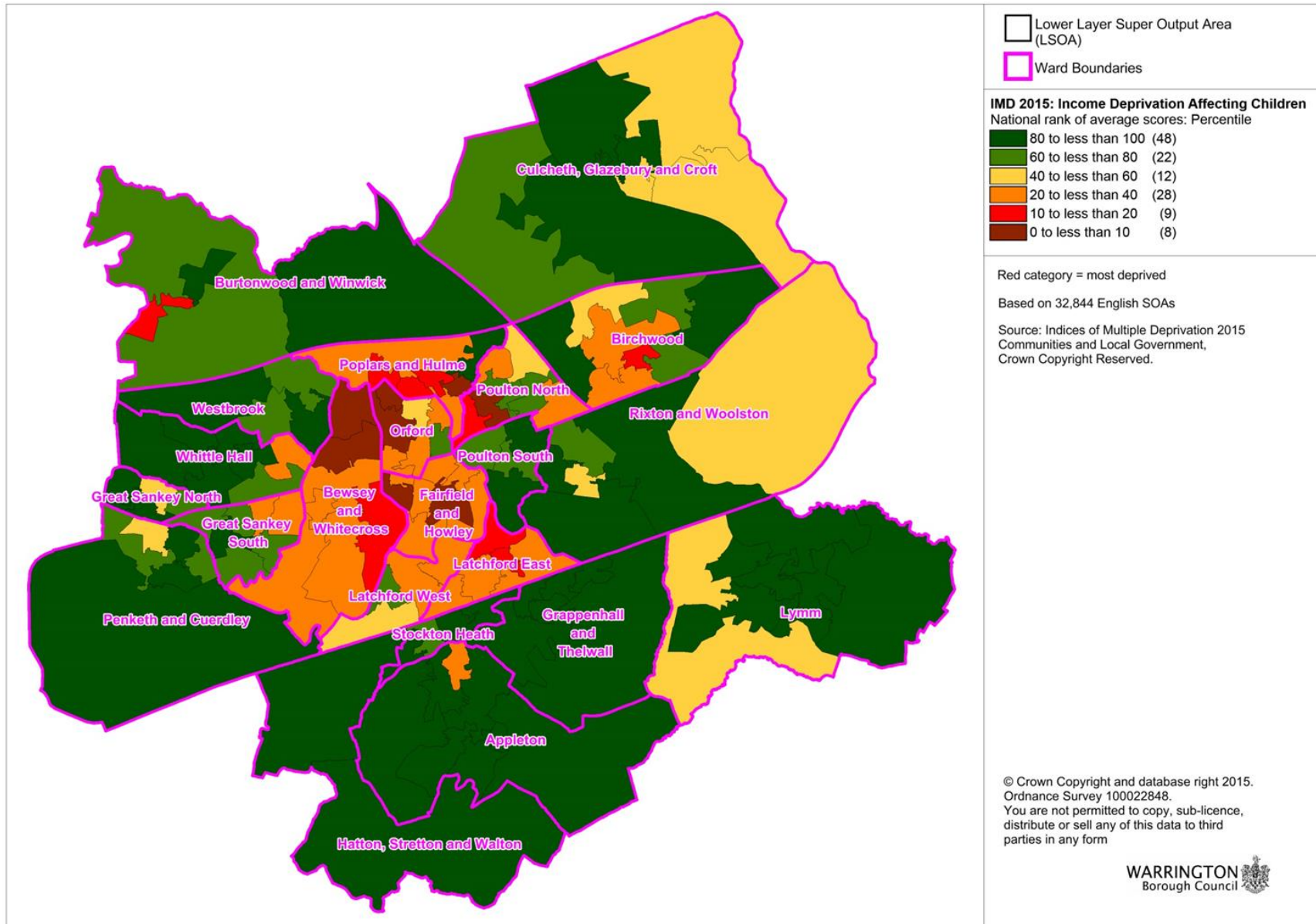
median before housing costs. Please see the JSNA Chapter on Deprivation for further details.

Scores are available at a very local area level, and enable comparisons to be made at a sub-Warrington level. As Map 1 shows, there is considerable variation within Warrington. 17 of the 127 Lower Super Output Areas (LSOAs[1]) within Warrington are within the most deprived quintile nationally for income deprivation affecting children. Within these LSOAs, the proportion of children affected ranges from 31% to 54%.

Based on the national evidence, which highlights the higher prevalence of mental health and emotional problems amongst children from more disadvantaged backgrounds, it is likely that there may be increased need in these communities.

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[1] LSOAs are small geographical areas. Every LSOA in England has had a deprivation score calculated and are ordered by overall deprivation score. They are split into 5 evenly sized groups, with quintile 1 being the most deprived quintile.

Map 1: ID 2015:– Income Deprivation Affecting Children

Lower Layer Super Output Area (LSOA)

Ward Boundaries

IMD 2015: Income Deprivation Affecting Children
National rank of average scores: Percentile

- 80 to less than 100 (48)
- 60 to less than 80 (22)
- 40 to less than 60 (12)
- 20 to less than 40 (28)
- 10 to less than 20 (9)
- 0 to less than 10 (8)

Red category = most deprived

Based on 32,844 English SOAs

Source: Indices of Multiple Deprivation 2015
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Estimated prevalence of diagnosable mental health conditions
Perinatal mental health disorders
Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point, many women will experience both. Depression and anxiety also affect 15 to 20% of women in the first year after childbirth. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth (NICE 2015a).

It is unknown how many women from Warrington become pregnant each year, however there were approximately 2,400 births to mothers living in Warrington during 2015. Therefore, it would be expected that each year during their pregnancy, approximately 288 women will develop depression and 312 develop anxiety. In the first year after birth between 360 and 480 mothers will develop depression and/or anxiety whilst approximately 4 women will experience postpartum psychosis.

Additionally, teenage mothers are more likely to have a higher risk of poor mental health than older mothers, during 2015, approximately 3% of births in Warrington were to mothers aged 19 years and under (approximately 79 births).

Pre-school aged children
There is very little information available about the prevalence of mental health conditions in pre-school aged children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H et al, 2006 cited in ChiMat 2015). The review focussed on the 5 most common groups of childhood psychiatric disorders: attention deficit hyperactivity disorders (ADHD), oppositional defiant and conduct disorders, anxiety disorders and depressive disorders. However, caution should be applied with the applicability of this prevalence figure to Warrington as the studies included in the literature review were conducted in the United States of America. Applying this average prevalence rate to the estimated population within Warrington (2015 mid-year population estimates), gives a figure of 2,031 children aged 2 to 5 years inclusive living in Warrington who have a mental health disorder.

Children and young people aged 5 to 16 years
As discussed in Section 2, robust, consistent and comparable data on the emotional wellbeing of children and young people is not routinely available. At a local level, there is also a lack of robust prevalence information on 'diagnosable mental health conditions'. This section utilises the nationally available prevalence estimates and applies them to the latest local estimates of the number of children and young people aged 5 to 16 years (2015 mid-year population estimates). This provides an indication of the likely numbers of children and young people experiencing a mental health problem in Warrington. The following table presents the estimated prevalence of any mental health disorder in Warrington for those aged between 5 and 16 years. The estimated prevalence (8.9%) was based on the 2004 ONS survey (Green et al, 2005) and then adjusted by Public Health England to take into account the age, sex and socio-economic classification of children resident in the area. It is estimated that there may be approximately 2,600 children and young people aged 5 to 16 years experiencing a diagnosable mental health problem in Warrington.

Table 1: Estimated Warrington prevalence rates applied to population aged 5-16

Diagnosis	Prevalence (all)	Estimated Number (all)
Emotional Disorders[2]	3.5%	1,030
Conduct Disorders[3]	5.3%	1,560
Hyperkinetic Disorder	1.5%	441
Any Disorder	8.9%	2,619

Source: Public Health England, 2016
Note: an individual may have more than one disorder

Data extracted from GP Clinical systems estimates there to be 2,026 children and young people with emotional disorders, conduct disorders or autism[4] in Warrington. Caution should be applied to the interpretation of this figure; it could be assumed that the number of children and young people diagnosed with a mental health condition is much lower than expected; especially as the figure extracted from GP practices relates to a wider age group than the estimated prevalence produced by PHE. It may be true that all children and young people who have an existing mental health condition may not have received a diagnosis. They may not have received a diagnosis as the condition does not affect their daily routine, or they could feel apprehensive about receiving an official diagnosis.

Mental health services are reluctant to provide a child or young person with a definitive diagnosis (which is then reported back to the GP) but rather take a 'formulation' approach which gives account of the factors which have contributed to a young person's difficulties and those which maintain them, in addition to protective factors (those which promote resilience and coping). This approach is usually much more helpful to children and families and so a mental health diagnosis is not needed. Additionally, a mental health diagnosis is recorded within GP clinical systems when an official diagnosis has been received from mental health services; Psychiatrists are the only professional in CAMHS who can give a young person a diagnosis. As only a small proportion of young people require Psychiatry, many young people will not have an official diagnosis.

The estimated figure has been based on a limited number of mental health conditions, the list of codes used to extract this data is not exhaustive, and therefore some uncommon conditions may be excluded (see footnote 4). It is unknown how complete coding of mental health conditions are within GP Practices, this may also reduce the number of children and young people reported as having a mental health condition.

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[2] Includes: Separation anxiety, specific phobia, social phobia, generalised anxiety and depression.
[3] Includes: Oppositional defiant disorder, unsocialised and socialised conduct disorder.
[4] Data extracted in September 2016 for emotional disorders and conduct disorders (0-17 years inclusive), autism estimate was extracted in 2014 (0 to 19 years inclusive). The estimate does not include ADHD and any other mental ill health conditions.

Nationally a new comprehensive mental health services minimum dataset (MHSMDS) has been developed and is currently being populated by mental health services. Data is expected to be made available during 2017.

Emerging Personality Disorders: The prevalence of personality disorders in the general population is estimated to be between 0.7% and 2%, however under current diagnostic systems, antisocial personality disorder is not formally diagnosed before the age of 18 but the features of the disorder can manifest earlier as conduct disorder (NICE 2013b). Borderline personality disorder is often not formally diagnosed before the age of 18, but features of the disorder can be identified earlier (NICE 2009).

As symptoms of personality disorders tend to emerge during adolescence, the following estimates are based on children and young people aged 12 to 17 years. It is estimated that there are between 101 and 289 young people aged 12 to 17 years with an emerging personality disorder living in Warrington.

Psychotic disorders
The prevalence of psychotic disorders in children aged between 5 and 18 years has been estimated to be 0.4% (NICE 2016). However, the first episodes of psychotic disorders are not normally experienced until adolescence/teenage years. Therefore the following estimates are based on population estimates covering 12 to 17 year olds. Based on the prevalence of 0.4%, it is estimated there are 58 children aged 12 to 17 years with a psychotic disorder living in Warrington.

Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorders (ADHD)
The Warrington Autism JSNA Chapter (written in 2015) estimated there to be approximately 500 people with autism who are aged 19 years and under (1% prevalence based on 2013 population estimates).

It is estimated there are between 2% and 5% of school-aged children may have ADHD. When applying these percentages to the Warrington population aged between 5 to 18 years, it is estimated there are between 687 and 1,718 children and young people with ADHD.

Additionally, caution should be used with the prevalence figures stated above for ASD and ADHD as it is possible that some children and young people experience/received a diagnosis for both conditions.
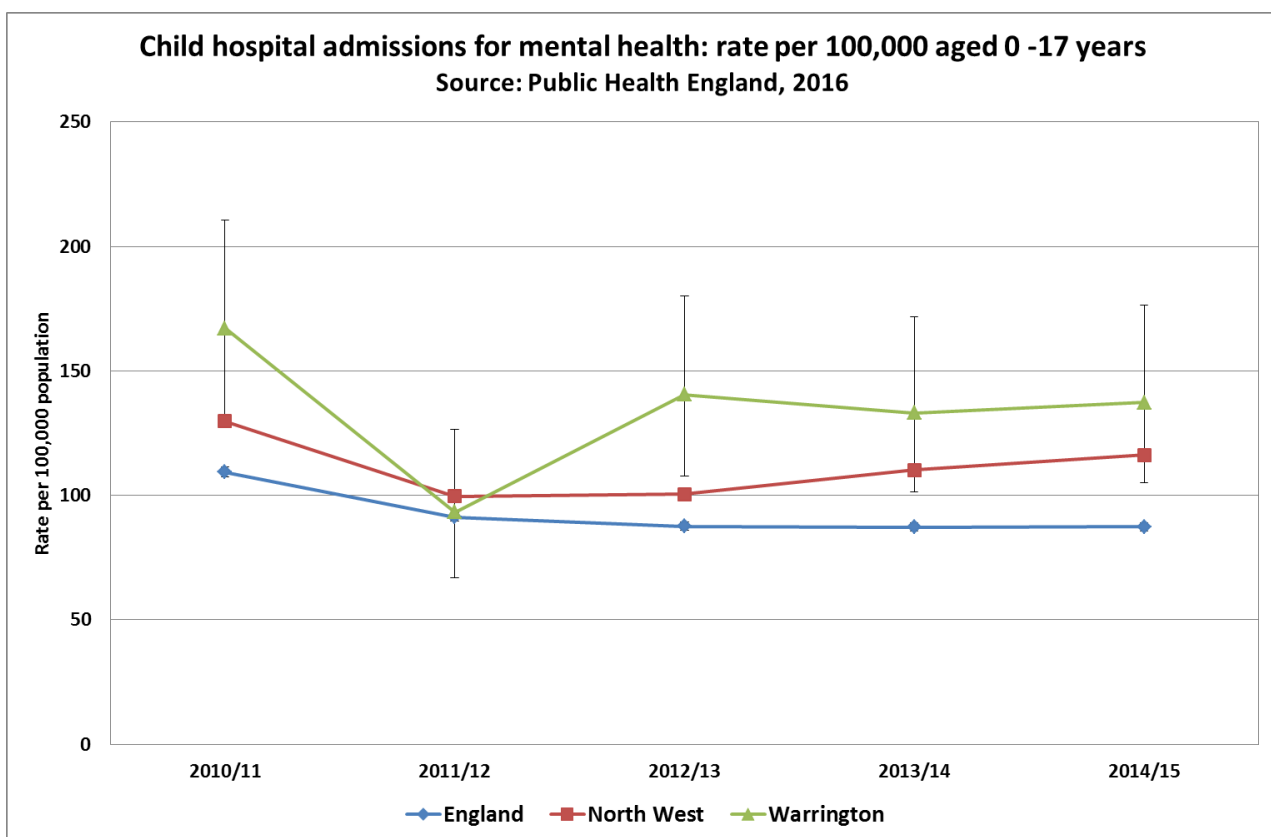
Hospital Admissions
The PHE Children's and Young People's Mental Health and Wellbeing profile draws together various mental health (and related known risk factors) data sets to present a picture of mental health need by Local Authority. As presented in section 2, children and young people who consume alcohol or drugs are at increased risk of developing mental health disorders, as are children exposed to abuse. The PHE profile presents hospital admissions where the primary cause of admission was due to alcohol for those aged less than 18 and due to substance misuse in those aged between 15 and 24 years. For both of these indicators, Warrington had admission rates that were significantly higher than England

(admissions made between 2012/13 and 2014/15). Hospital admissions due to unintentional and deliberate injuries in children (aged 0 to 14 years) and young people (aged 15 to 24 years) were both significantly higher than England from 2010/11 through to 2014/15.

Mental health conditions: The PHE profile presents an indicator illustrating the rate of hospital admissions for those aged less than 18 years where the main cause of admission is due to a mental health condition. This indicator illustrates that there were 61 admissions made by Warrington residents during 2014/15, this resulted in a rate of 137.2 per 100,000 population; this rate was significantly higher than England (87.4 per 100,000). What is unknown from this dataset is if the admissions were made by 61 individuals or a smaller cohort being repeatedly admitted into hospital.

Chart 1: Child hospital admissions for mental health

Chart title: Child hospital admissions for mental health: rate per 100,000 aged 0 -17 years
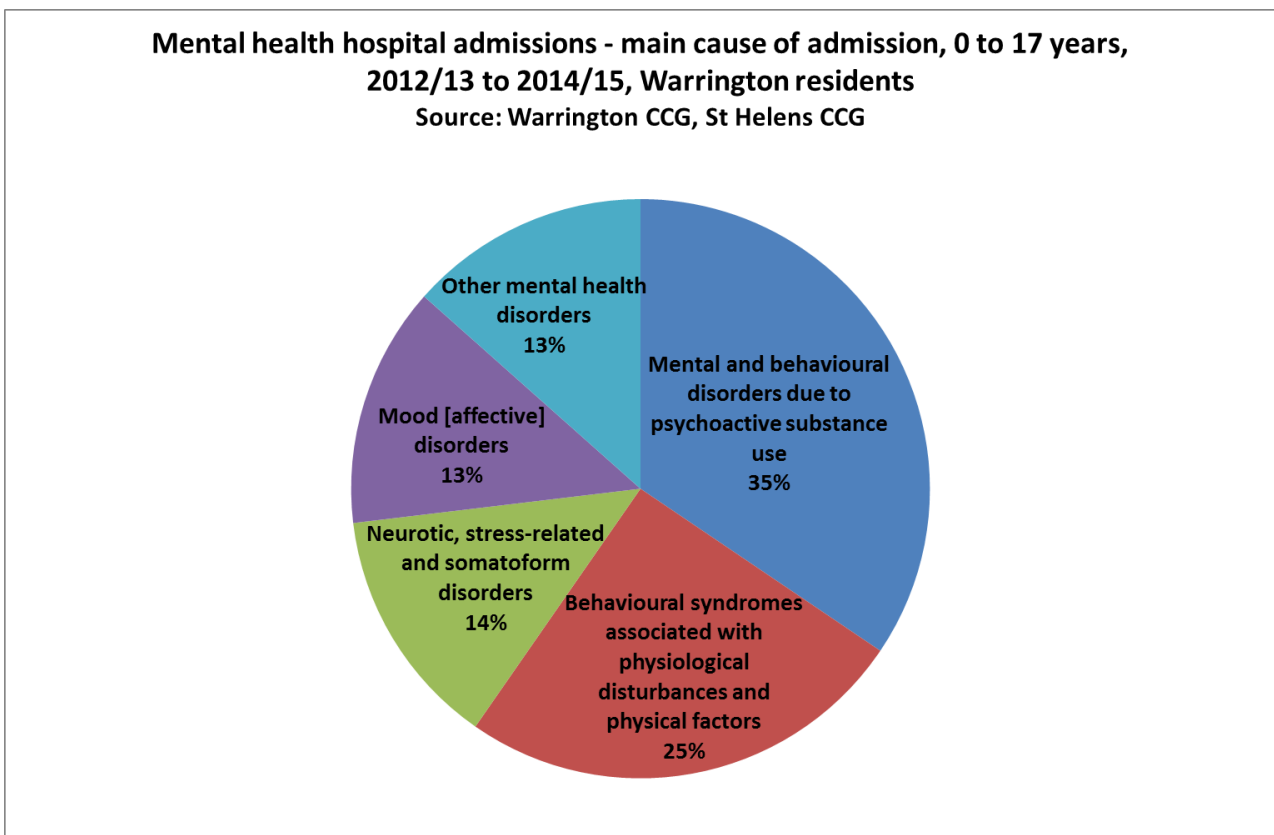Source: Public Health England, 2016

To gauge an indication of the numbers of young people being admitted into hospital due to mental health conditions on more than one occasion, further analysis of a local hospital admissions dataset[5] revealed that of those admitted to hospital over a three year period (2012/13 through to 2014/15), approximately 15% of the admissions were made by patients who had been admitted on more than one occasion (over the three year period there were 119 admissions made by 101 individuals).

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[5] Direct comparisons between data sourced from PHE and the local hospital admissions dataset should not be conducted as slightly differing search queries were conducted when extracting the datasets. The PHE dataset is based on first finished episodes for each financial year, whilst the local hospital admissions dataset is based on the date of admission falling within the three year period of 2012/13, 2013/14 and 2014/15.

The most common cause of admission was due to *mental and behavioural disorders due to psychoactive substance use* (41 admissions); more specifically, the majority of these admissions were due to acute intoxication from alcohol. The second most common cause of admission was due to *behavioural syndromes associated with physiological disturbances and physical factors* (30 admissions); the majority of these admissions were due to eating disorders.

The following pie chart illustrates the main causes of mental health admissions made between 2012/13 to 2014/15 for Warrington residents aged 0 to 17 years.

Chart 2: Mental health hospital admissions - main cause of admission

Mental health hospital admissions - main cause of admission, 0 to 17 years, 2012/13 to 2014/15, Warrington residents
Source: Warrington CCG, St Helens CCG

- Mental and behavioural disorders due to psychoactive substance use 35%
- Behavioural syndromes associated with physiological disturbances and physical factors 25%
- Neurotic, stress-related and somatoform disorders 14%
- Mood [affective] disorders 13%
- Other mental health disorders 13%

Self-Harm: Nationally, admissions to hospital due to self-harm have increased in recent years, with admissions for young women being much higher than admissions for young men (PHE 2016). The following chart examines the rate of hospital admission due to self-harm for those aged between 10 and 24 years. Between 2012/13 and 2014/15, Warrington consistently had significantly higher rates of admission when compared to England and the North West. During 2014/15 there were 293 admissions made by Warrington residents. As with mental health admissions, it is unknown from this dataset if there were 293 individuals admitted to hospital or a small group being repeatedly admitted to hospital.

Chart 3: Hospital admissions as a result of self-harm

Hospital admissions as a result of self-harm (10-24 years), DSR per 100,000
Source: Public Health England, 2016
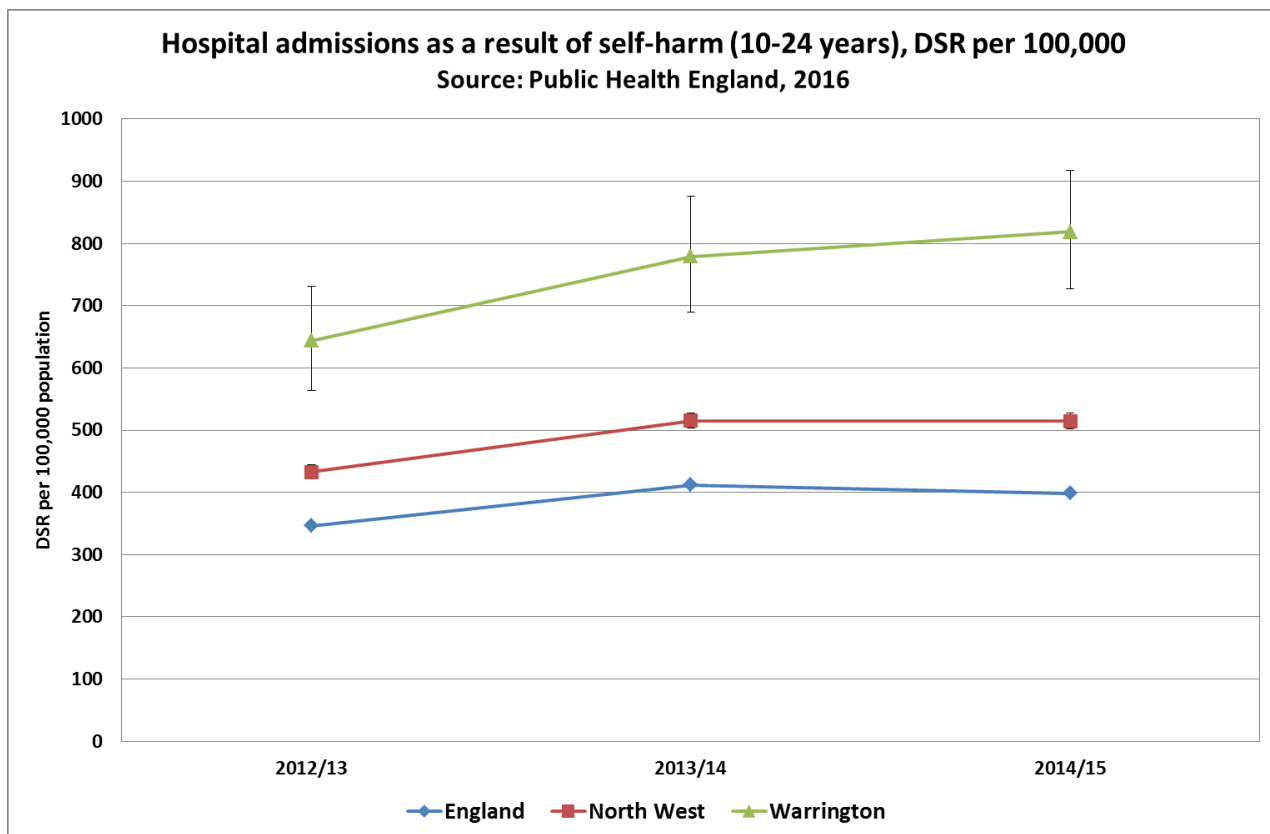
As with mental health admissions, further analysis has been conducted to understand the scale and causes of admission in Warrington[6]. The analysis showed that over the three year period of 2012/13 through to 2014/15, approximately 36% of admissions were made by patients who had been admitted on more than one occasion (over the three year period there were 778 admissions made by 497 individuals).

The most common cause of admission was due to *Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics* (318 admissions); these include substances such as pain medication, aspirin and medications used to treat rheumatoid arthritis. The second most common cause of admission was due to *Intentional self-harm by sharp object* (142 admissions). The third most common cause of admission was due to *Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified* (127 admissions); these include sedatives/tranquillisers, mood/behaviour altering medication and medications used to treat epilepsy and Parkinson's disease.

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[6] Direct comparisons between data sourced from PHE and the local hospital admissions dataset should not be conducted as slightly differing search queries were conducted when extracting the datasets. The PHE dataset is based on the number of finished admission episodes for each financial year, whilst the local hospital admissions dataset is based on the date of admission falling within the three year period of 2012/13, 2013/14 and 2014/15.

An initial audit has been conducted between Warrington CCG, Warrington Council and Five Boroughs Partnership NHS Trust that has identified that a high proportion of children and young people who repeatedly attend hospital Emergency Departments (ED) due to a mental health condition (a child or young person in crisis) are also known to social services (a vulnerable child or young person).

Children and Young People emotional health and wellbeing surveys
What about YOUth survey
The What about YOUth (WAY) survey is a newly established survey to collect robust Local Authority level data on a range of health behaviours amongst 15 year olds, the survey took place during 2014/15. The survey included a number of questions about wellbeing, life satisfaction and bullying.

A set of questions were asked which formed the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). WEMWBS is formed of 14 statements covering a range of feelings and attitudes towards life. Participants were asked to rate how often they felt like each of the 14 statements, ranging from 'None of the time' to 'All of the time', which are scored from 1 to 5. Each participant is given a single score based on their responses to the 14 statements which ranges from 14 – 70 (a sum of their scores to the individual statements). 70 is the highest possible score of wellbeing, while 14 the lowest.

The mean (average) score for Warrington was 47.7; this was very similar to the North West (47.8) and England score (47.6).

The WAY survey asked the following question about life satisfaction: 'Overall, how satisfied are you with your life nowadays?' 12.4% of respondents from Warrington reported low life satisfaction; this percentage was slightly lower than the North West (13.3%) and England (13.7%).

Questions were also asked about bullying (either being bullied or being a bully). In Warrington 56.4% reported that they had been bullied in the past couple of months, this percentage was slightly higher than both the North West (54.2%) and England (55%). 8.3% of respondents admitted that they had bullied someone in the past couple of months; this percentage was similar to the North West (8.5%) but significantly lower than England (10.1%).

Strengths and Difficulties Questionnaire for looked after children
Children who are looked after by Local Authorities are required to have completed a Strengths and Difficulties Questionnaire (SDQ). This is a tool used for assessing a child's emotional wellbeing, looking at the likelihood of problems being already present or of developing in the future. During 2015/16, 62% of children completed the questionnaire, whilst for England as a whole, it was 75%.

Subsequently, one of the outcomes from the SDQ is the identification of 'a cause for concern'. As with WEMWBS, each child is given a single summary figure (the total difficulties score), ranging from 0 to 40. A higher score indicates greater difficulties (a score of under 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a

cause for concern). During 2015/16, 46% of children in Warrington recorded a score which gave 'a cause for concern'; this percentage was higher than both the North West (33%) and England (38%).

Warrington children and young people survey
The Warrington children and young people survey was ran during the spring/summer 2014. A questionnaire was provided to students in Year 6 (age 10/11), Year 8 (age 12/13) and Year 10 (age 14/15) and was completed by 926 primary school pupils and 2,553 pupils in secondary schools. Detailed findings of the survey can be found on the Public Health page of the Warrington Council website.

Happiness/unhappiness: Positively, on the whole the majority of respondents said they were very/quite happy. However, only 46% of Year 8 girls, and 29% of Year 10 girls, said they felt quite/very happy about their appearance. Appearance by far was the main reason girls felt very/quite unhappy, the proportion feeling unhappy about their appearance increased with age (20% in Year 6, 29% in Year 8 and 43% in Year 10). Boys were also unhappy about their appearance (but in much lower proportions), boys were also unhappy about school. 7% overall said they felt very/quite unhappy about the overarching "Unhappy with their life as a whole". The group with the highest proportion who said this were Year 10 girls (12%).

Worrying: A high percentage of pupils reported worrying a lot/quite a lot from a list of reasons provided in the questionnaire (63% of Year 6, 60% of Year 8 and 74% of Year 10); girls were more likely to report worrying a lot/quite a lot when compared to boys. The main causes of worry for all year groups were exams/tests/SATS and older pupils reporting worries about careers and plans for the future.

Bullying: Over half of pupils had experienced some form of bullying in the previous month (57% of Year 6, 60% of Year 8 and 56% of Year 10, these percentages reflect the findings from the WAY survey); a lower proportion responded that they had been a victim of cyberbullying (7% of Year 6, 11% of Year 8 and 12% of Year 10). Over a quarter responded that they had been afraid to go to school due to bullying at least sometime in the previous month (29% of Year 6, 31% of Year 8 and 23% of Year 10).

Youth Offending
During 2015 there were 29 first time entrants to the youth justice system in Warrington. This resulted in a rate of 149.6 per 100,000 population; this rate was significantly lower than England (368.6 per 100,000) and the North West (336.1 per 100,000). The trend in the rate of first time entrants has been steadily reducing in Warrington since 2010 when there were 167 first time entrants (814.7 per 100,000) (PHE, 2015a).

A Young Offender Health Needs Assessment (HNA) conducted across Halton, Warrington, Cheshire West and Chester during 2015 identified that young offenders in the sample population had higher levels of health need compared to their peers who are not engaged with offending services in relation to several areas – mental health, learning difficulties, substance misuse and social issues. It was also identified that this population also

experienced high levels of dual diagnosis, in which young people experienced both mental health and substance misuse needs.

Within the sample population who resided in Warrington (47):
- 36% had their functioning impacted by mental health;
- 9% had received a formal mental health diagnosis;
- 19% were in contact with mental health services;
- 19% had either in the past or currently self-harmed or attempted suicide.

(The Centre for Public Innovation, 2015).

3) CURRENT SERVICES IN RELATION TO NEED

Health Visiting

The Health Visiting Service forms part of the 0-19 Integrated Public Health Service commissioned by Warrington Borough Council. The responsibility of commissioning the 0-19 service commenced in October 2015, therefore service data is not available before this date.

All families/children are offered a universal health visiting service from birth to 5 years and comprises of 5 mandated assessments[7], health promotion and the early identification of additional needs. During Quarter 1 of 2016/17, 541 women received their 6-8 week health review, of these women, 49 were identified with a mental health need and required further assessment and intervention from the health visiting service.

'Time for me' is a creative arts group for antenatal and postnatal mothers with children under two years of age who are experiencing mild to moderate perinatal depression and/or anxiety. The aim is to encourage and support women in ways that will help to improve their mental health and well-being through creative activities. The 'time for me' programme consists of 8 sessions aiming to provide support for up to 10 women per session facilitated/supported by and Art Worker and a Health Visitor. The programme has been funded for 1 year by Warrington CCG. The first group commenced during May 2016 with 10 women offered a place and 8 attending. The second group started in September 2016 with 10 women attending and a final programme will be offered in January 2017 (Bridgewater Community Healthcare NHS Foundation Trust, 2016).

The Universal Plus offer to parents provides expert timely advice, guidance and support when needed for issues such as attachment, behaviour management, toilet training and infant feeding. During Quarter 1 of 2016/17 (between April and June 2016), there were 533 families receiving the Universal Plus offer (Bridgewater Community Healthcare NHS Foundation Trust, 2016).

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[7] Pre-birth assessment, new birth assessment, 6-8 week health assessment and review of maternal mental health, 12 month child health review and 2½ years child health review.

Universal Partnership Plus work in collaboration with other health, social care and education professionals where health needs are identified and co-ordinate tailored packages of additional care as required. This could include young people and families with mental health, substance misuse problems, risk taking behaviours, child protection or safeguarding issues and children with complex needs (Warrington Borough Council, 2015).

School Health
The School Health service forms part of the 0-19 Integrated Public Health Service commissioned by Warrington Borough Council. As mentioned previously, the responsibility of commissioning the 0-19 service moved to Public Health during April 2014, this has resulted in limited service activity data for the remainder of 2015/16 and is therefore not presented below. Each primary and secondary school has a named School Nurse who is supported by their team to promote health and emotional wellbeing in schools. (Bridgewater Community Healthcare NHS Foundation Trust, 2015).

Health screening questionnaires are sent to all parents/carers of children in Reception class (aged 4 and 5 years), the aim of the questionnaire is for parents/carers to highlight any concerns they have about their child regarding a wide range of health issues, the response rate to the questionnaire is 77% (2,658 questionnaires sent out, 2,037 returned). In total, 95 parents/carers have identified that behaviour is a concern with their child. A further 86 parents/carers had identified multiple issues which required input from the school nurse, out of this cohort 11 children are being seen for a package of care for behaviour issues.

School Nurse 'drop in' sessions are currently offered at 13 high schools across Warrington. The purpose of drop in sessions is for students to speak with a school nurse about health and wellbeing issues that are troubling them. Between April and June 2016 there were a total of 192 students seen by school nurses, of these contacts, 97 were due to emotional health and wellbeing issues[8] (51%).

Family Nurse Partnership
Family Nurse Partnership (FNP) forms part of the 0-19 Integrated Public Health Service commissioned by Warrington Borough Council and is an innovative and evolving evidence-based, preventive programme for vulnerable first time parents, providing primary prevention for babies and early intervention for some of the most vulnerable young people in Warrington.

The programme is designed for first time mothers, aged 19 and under and their partners. This reflects evidence about which groups will benefit most from FNP; and also whose children are shown to be at high risk of poor developmental outcomes. The aim is to enrol clients on the programme as early as possible in pregnancy, ideally before 16 weeks and always no later than 28 weeks gestation, to deliver the programme until the child is two years of age.

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[8] Emotional health and wellbeing issues include: eating disorders, self-harm, anxiety, low mood and 'other EHWB'.

As well as delivering the five mandated health assessments as part of the Healthy Child Programme, the family nurse plays an important role in any necessary safeguarding arrangements, alongside statutory and other partners, to ensure children are protected.

FNP uses in-depth methods to work with young parents on attachment, relationships and psychological preparation for parenthood, helping them to overcome adverse life experiences, strengthen their parenting capacity and enable babies to have a positive start in life and achieve all their developmental milestones and be school ready.

All clients are asked a number of questions about their life experiences at intake onto the programme. Clients report:
- 37.5% reported ever being abused by someone close to them;
- 29.3% report having a history of mental health problems;
- 2.4% report receiving mental health services;
- 40.5% report living away from their parents for more than 3 months while under the age of 18 years;

Parental and Infant Mental health Pathway (0-2 years)
Good parental mental health, positive parenting and a secure parent infant relationship can result in better outcomes for a child. This can be achieved through early interventions to prevent problems from developing or deteriorating and promoting effective evidence based and timely interventions. The Integrated perinatal and infant mental health (IPIMH) pathway aims to promote a seamless, flexible and high quality responsive care for all families; this is due to be implemented from March 2017 by Bridgewater Community Healthcare NHS Foundation Trust.
The Integrated Parent Infant Mental Health Care pathway has been developed in order to:
- Promote good parent/care giver and infant mental health well-being in order to reduce the incidence of early relationship difficulties and improve subsequent children and young people's mental health;
- Identify parents at increased risk of developing perinatal mental health conditions;
- Identify parent/care givers and or infants at risk of developing attachment and bonding difficulties;
- Provide early recognition and comprehensive assessment of parental/care giver mental health and parent/care giver infant relationship difficulties;
- Provide seamless interventions to support parents/care giver and parent infant relationships;
- Provide evidence based services to meet the needs of parents/care givers who require support;
- For parent/carer givers and infants identified at increased risk should have a personalised care plan/early help.

Kooth.com
Kooth is an online counselling and emotional well-being support service for 11 to 19 year olds and is available free at the point of use. Warrington CCG commissioned the service in early 2016, between February and September 2016 1,805 young people from Warrington registered on the Kooth website. Young people log on to Kooth through their smart phone, tablet or computer to access counsellors online up to 10pm, 365 days a year, along with

self-help materials co-produced by other young people, live moderated forums and fully-moderated peer-to-peer support. XenZone's (the organisation who manage Kooth) team of accredited counsellors, therapists and support workers provide guided and outcome-focused support for each individual (XenZone, 2016).

During quarters 1 and 2 (April to September) of 2016/17 there were 1,760 new registrations on Kooth, 60% were girls and 40% boys. The most frequent age at registration was 14/15 years during quarter 1 and 12/13 years during quarter 2; 83% of new registrations had heard about the service from their school. The most common issues presented during online chat, message, forum, articles and Ask Kooth were:
- Anxiety/stress (132 individuals);
- Family relationships (83 individuals);
- Friendships (79 individuals).

St Joseph's Family Centre
St Joseph's provide a service that aims to improve the emotional health and wellbeing of their clients by providing an evidence-based therapeutic service for children and adults, and is part of the local IAPT partnership. They operate a brief intervention model of 6 weeks using the most suitable intervention following assessment. The service offers interventions to children and young people with a low / medium level of emotional/mental health issues, operating at a tier 2 or targeted level. For children, the service delivers to Warrington's integrated pathway for emotional and wellbeing for children and young people.

Children and young people are offered 1:1 counselling, anger management group sessions and family therapy sessions. Warrington CCG is the main commissioner of St Joseph's, some additional counselling services are commissioned by Warrington Council specifically for children in care. Referrals to the centre can be received from CAMHS, CART[9], Mental Health Matters[10] for those aged between 16 and 18, GP's, schools, and self-referral.

The following table illustrates the number of referrals made to St Joseph's for the 3 previous financial years (children aged between 0 and 18 only) presented by commissioner. The table illustrates that through the Warrington CCG contract, the number of Warrington children referred to St Joseph's has increased year on year. During the 7 months from April to October 2016 there have been 269 referrals to St Joseph's for children and young people. Over this time period there have been 82 children and young people who have successfully completed counselling.

The table also shows that during 2015/16 there were 228 referrals made to St Joseph's where the child or young person was a child in care. No data was available for the previous 2 time periods.

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[9] The single point of referral and assessment for all urgent and routine mental health referrals.
[10] Mental Health Matters is a national organisation supporting people with mental health needs, learning disabilities, drug and alcohol and other problems through a range of evidence based and innovative services.

Table 2: Number of children referred to St Joseph's Family Centre

	2013/14	2014/15	2015/16
Number of referrals (through Warrington CCG contract)	325	357	443
Number of referrals (through Warrington council contract)	No data available	No data available	228

ADHD Diagnostic Pathway

The ADHD diagnostic pathway is managed by Bridgewater Community Healthcare NHS Foundation Trust and has been developed for children aged 4 year and above. Universal behavioural issues are managed by parents, if parents are particularly concerned about their child's behaviour and advice is needed, it can be obtained from Children's Centre staff, Health Visitors and School Nurses. These professionals can offer advice to parents and refer families to behavioural advice programmes.

Where a school age child has behavioural issues, an Individual Behaviour Plan is developed with the child that includes specific and measurable targets and expected outcomes a child is expected to achieve both at home and in the school setting. This is sufficient to manage most behaviour problems.

If the strategies put into place to manage behaviour at this initial phase are not producing suitable results, a referral to specialist services may be required. A full assessment with a health professional will be instigated if appropriate. If a medical diagnosis is indicated it will be made by a Paediatrician, Specialist Psychiatrist or other experienced and trained health professional.

Following a medical diagnosis of ADHD, the ongoing treatment, support and prescribing of medication in line with NICE guidelines is putting additional demands on services; this has led to an increase in waiting times, particularly for review appointments. For children and young people, this service is provided by Community Paediatrics and the Child Development Centre. The CCG have recently agreed funding for a waiting list initiative around diagnoses and review. In addition the CCG had funded two additional staff to support nurse prescribing and improve outcomes of this vulnerable group in respect to their emotional health and wellbeing. There is also a gap in provision for 17 year olds and commissioners are currently working with providers to address this.

Core Assets

Core Assets have very recently been awarded a 1 year contract by Warrington Council and Warrington CCG to provide counselling services to Children in Care (CiC) whose SDQ score gave a cause for concern. The aim of this service is to provide a range of appropriate preventative and responsive interventions that support children and young people with emotional and mental health needs. The service will provide 'Tier 2' level interventions, for children who do not meet the criteria for specialist CAMHS provision. The contract was awarded in October 2016.

As the contract has been very recently awarded, no service level data is available to present current service usage. As at March 2016, there were 1,687 children supported by

Warrington Council through a Child In Need Plan, Child Protection Plan, or Family Support Plan. As presented in section 3, approximately 42% of looked after children had an SDQ score that was a cause for concern in 2014/15. If this percentage remained consistent for 2015/16, it could be estimated that approximately 709 children and young people could be referred into this service (assuming that this cohort are not receiving any other mental health service support).

The Child and Adolescent Mental Health Service (CAMHS) (Tiers 2, 3 and 4)
CAMHS supports young people with complex mental health problems. It is a specialist service, which means the child or young person can only be referred into CAMHS by their GP, or another health professional such as a Social Worker or a School Health Advisor. CAMHS provides comprehensive assessment and evidence-based therapeutic intervention to children, young people and their families who are experiencing complex, persistent and severe emotional and psychological problems.

There are different services provided by CAMHS depending on the severity and complexity of mental health conditions experienced by the child or young person. The different services are grouped into Tiers (Tiers 2, 3 and 4), with the intensity of support provided to the child or young person increasing with each Tier.

Tier 2: Function of Tier 2 CAMHS (p142, Health Advisory Service, 1995):
- "Provision of support, advice and education to, and consultation with, professionals working with children and young people with the intention of normalising children's experiences, avoiding crises and preventing family breakdown";
- "Working closely with other agencies which provide services to children and young people";
- "Provision of a perspective on child and adolescent mental health problems and disorders which derives from education and training…";
- "Provision of new perspectives on a child's mental health problems which lead to care and treatment strategies being redesigned where appropriate";
- "Offering specialist treatment and interventions".

Tier 2 CAMHS is delivered through networks of individual practitioners or small teams based in separate services.
In Social and Education Services, may be delivered by:
- Social Workers;
- Pupil Support Teachers;
- Educational Psychologists.

In Child Health, may be delivered by:
- Paediatricians;
- Specialist Nurses.

Voluntary organisations also contribute to Tier 2 provision, for example, St. Joseph's, NSPCC, School Nurses delivering emotional health and wellbeing interventions, School Counsellors and 5 Borough Partnership (5BP) Tier 2 CAMHS Team

Limited data from 5BP Tier 2 services has been provided for inclusion within this report; during 2015/16, activity data was provided by CAMHS to Warrington Council (as the commissioner of Tier 2 services at the time) covering the months of April 2015 through to September 2015. During this 6 month period a total of 121 children and young people had direct contact with the Tier 2 service. Over the same time period, there were no inappropriate referrals from Tier 2 to Tier 3 services.

Tier 3: This involves specialist assessment, which may include diagnosis, and the provision of psychological, systematic and/or pharmacological therapy. Intervention at this step is provided to children and young people who are experiencing severe and enduring mental health problems which are having a significant impact on daily psychological/social/educational functioning. Intervention at this level is normally provided through specialist multi-disciplinary teams (The Centre for Public Innovation, 2015).

- **CART** is the CAMHS Assessment and Response Team – single point of access for referrals for young people experiencing mental health problems;
- **Community CAMHS** refers to the specialist team who provide assessment and intervention.

During 2015/16 there were a total of 5,444 seen contacts within the Tier 3 service; 963 contacts through CART and 4,476 through community CAMHS. The total number of seen contacts was approximately a third higher (33%) than the target set for the year (4,083 total seen contacts). As at March 2016, there were 206 children and young people active to the CART service, whilst in community CAMHS there were 244 active clients.

Tier 4: This is the highest level of care provided to children and young people and is usually provided through an in-patient mental health care facility. NHS England commissions this service. One Tier 4 facility is located in Warrington (Fairhaven Young People's Unit) and is designed specifically for teenagers, however a young person can be admitted to any facility across the country depending on specialised need and facility capacity. During 2015/16 there were a total of 26 admissions made by Warrington CCG patients, it is not known if the number of admissions relates to 26 individuals or if a smaller number of individuals were admitted on more than 1 occasion.

Across all Cheshire and Merseyside CCGs, Warrington had the highest rate of admission during 2015/16; the rate for Warrington (58.3 per 100,000 population aged 0 to 17 years) was significantly (statistically significant) higher than the average rate for the Cheshire and Merseyside region (32.1 per 100,000).

CAMHS Parenting Pilot
The significant positive impact that parenting interventions can have on children and families across a range of outcomes have now been widely demonstrated. Robustly delivered and evidence-based parent group programmes are the identified first-line best practice intervention in the treatment of conduct, anti-social behaviour problems and ADHD (NICE, 2008; 2013a), as well as being a recommended intervention for early identified attachment difficulties in at risk groups (NICE, 2015). And, in addition to these specific

applications, parenting interventions have the potential to support children's cognitive and socio-emotional development and school readiness and, more generally, to foster resilience (by reducing risk factors for averse outcomes whilst promoting protective factors) and therefore contribute to the prevention of later mental health problems. Moreover, parenting interventions have been identified as amongst the most cost-effective treatments with convincing evidence of long-term economic returns (Department Of Health, 2011). Finally, in the context of a shift towards a needs-led approach to service delivery for children and families (for example, the THRIVE model (Wolpert et al., 2014)), parenting support bridges universal provision and targeted evidence-based practice.

The CAMHS parenting pilot project aims to enhance and expand the existing offer of parenting support in Warrington through resourcing a small dedicated team to robustly and strategically deliver high-quality parenting interventions with an early/preventative focus and to strengthen working relationships with all partners. At the outset of the project, which commenced in August 2016, an agreed delivery plan for the pilot project year was developed in partnership with Local Authority leads and health commissioning input. The pilot project team, which comprises a lead clinician and specialist parenting practitioner, have also developed a positive working relationship with the Local Authority parenting co-ordinators and, in addition to significantly contributing to the capacity for the delivery of parent programmes in Warrington, they have engaged in joint development work and practice-sharing.

The pilot is expected to deliver 5 parent group programmes with projected target of approximately 46 families completing parent programmes. To date, with one group programme completed and one nearing completion (as per the project timeline), 14 parents (with 28 resident children) have received/continue to receive input. A retention rate of 90% was achieved for the first completed group and at session 12 of 14 there is 100% retention for project group 2.

Warrington CAMHS Self-Harm Pilot Project
The Warrington CAMHS self-harm pilot project is a 12 month project which aims to improve the quality and timeliness of support of young people under the age of 18 living in Warrington who self-harm. The pilot builds on self-harm training that CAMHS have been co-delivering since November 2014 with experts-by-experience, which has reached approximately 200 professionals working with children and young people in Warrington. As per the THRIVE model (Wolpert et al., 2014) through Commissioning for Quality and Innovation (CQUINS) set by commissioners there is a strong focus in this project of providing training, supervision and consultation to schools to support young people who self-harm. The project also looks at the pathway from referral into CAMHS to treatment for young people who self-harm. Another area of development is the availability of information and resources for professionals working with young people who self-harm and making this more readily available.

A Dialectical Behaviour Therapy (DBT) coping skills group has been running for Warrington children and young people for nearly two years. As part of this project it is hoped this service provision can be extended by training a number of CAMHS professionals and clinicians from external agencies in DBT skills and developing a full DBT programme with Tier

3 CAMHS which consists of individual therapy, phone consultation, skills group and a therapists' consultation group. DBT teaches young people the skills necessary to regulate emotions, control self-destructive behaviours and improve interpersonal relationships.

Early Help Division
The Warrington Borough Council Early Help Division offers information, advice and support to children, young people and their families as soon as possible in their lives. The Early Help Division consists of a number of services providing different levels of support depending on the need of the child or young person and their family[11]. At present the services provided are structured based on the level of need of the child or young person. Each of these services offer an element of support regarding the emotional health and wellbeing of a child or young person. The Early Help Division are currently working in partnership with Warrington CCG to explore how THRIVE (Wolpert et al, 2016) can be integrated into this service.

Youth Offending
Cheshire West, Halton and Warrington Youth Offending Service provide youth justice services to the boroughs of Cheshire West, Halton and Warrington for young people aged 10 to 17 (Warrington Borough Council, 2016). For young people from Warrington and Halton, the YOS have a referral pathway in place with the Five Boroughs Partnership NHS Trust who provide specialist child and adolescent mental health services. In addition, consultation is available to YOS staff by telephone via a named person in the CAMHS team. Where a young person and/or family do not consent to a specialist CAMHS intervention, the YOS Case Manager are able to benefit indirectly through anonymous clinical consultation to seek advice/ guidance (The Centre for Public Innovation, 2015).

Based on the findings from the Young Offender HNA, there is a Speech and Language Therapist working into the YOS team on a pilot basis.

Schools
Schools are ideally placed to support students in being resilient and mentally healthy. The National Institute for Health and Care Excellence (NICE) advises that primary schools and secondary schools should be supported to adopt a comprehensive, 'whole school' approach to promoting the social and emotional wellbeing of children and young people (PHE, 2015b). The 2013 Ofsted report on Personal, Social, Health and Economic (PSHE) education identified associations between outstanding PSHE and outstanding whole school inspections (PSHE Association, 2016a). However, Ofsted's most recent review of provision noted that PSHE provision was 'not yet good enough' in schools, pointing to a lack of confidence among teachers, who are often not trained in the subject (PHSE Association, 2016b).

Many services described within this section are located within the school setting; additionally, further support for children and young people is provided by PSHE staff,

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[11] Services provided by the Early Help Division: Services for everyone - Families Information Service (FIS); Free Early Year Entitlement (FEYE); Children's Centres; Early Years Quality Team; Play Team. Early help services – Free Childcare for 2 year olds; 2 year old Outreach; Early Years SEN; Warrington SEND, Information and Support Service; Family Outreach Team; Brighter Futures Team; Youth Service;

pastoral support staff and any additional external services invited or commissioned by schools to support students with mental health and wellbeing issues.

Findings from a PSHE audit conducted with 12 high schools across Warrington during March 2016 found that the delivery of the PSHE curriculum was not consistent within all schools as 3 schools reported that PSHE was not a timetabled lesson (PHSE was a timetabled lesson in 9 of the schools).

All schools in Warrington are given the opportunity to achieve the Committed to Inclusion Award, a scheme organised by the Warrington Inclusion Hub (Warrington Council). The Committed to Inclusion scheme provides training and learning opportunities for school staff to learn/build upon existing knowledge regarding children and young people's mental health, challenging behaviours and emotional health and wellbeing. To achieve the Committed to Inclusion Award, schools are expected to attend a minimum number of events during the academic year (15 events have been arranged for 2016/17). In addition, to re-enforce learning outcomes, schools are also expected to submit a case study describing how the training sessions has improved inclusive practice within the school.

The Warrington Association of School and College Leaders (WASCL) group comprises of leaders of secondary schools/colleges and academies from across the Warrington area. The group leads a range of collaborative work to ensure that the outcomes for young people across Warrington schools continually improves and that secondary education provision for Warrington continues to be of the highest standards. During 2016/17 funding was made available to run the WASCL Future in Mind project by Warrington CCG. The aim of the project is to promote, protect and improve children and young people's mental health and wellbeing.

The key services listed above are not intended to be an exhaustive list of services in place to support the emotional health and wellbeing of children and young people in Warrington. There are a number of other services/teams who work with children and young people where their primary role is not to address their emotional and wellbeing needs, but these are addressed as a secondary outcome. These services include young carers' services, educational psychology, Catch 22, Playability, Children's Society domestic abuse services, Warrington Youth Club, advocacy provision for children in care, NSPCC, Warrington Wolves, Footsteps, The Verve and LiveWire.

4) PROJECTED SERVICE USE AND OUTCOMES

Introducing the THRIVE Framework to Warrington

The current model of children and young people mental health care offered in Warrington is a tiered system, as each tier increases, the intensity of health care provided increases (as described in the previous section). The tiered system was developed during the mid-1990's to help differentiate between the different level of support that could be offered to children

and young people. However, the tiered model has been critiqued as each tier is seen as a separate, distinct service (Wolpert et al, 2016).

Presently, work is progressing in Warrington to move away from a tiered system of health care services towards a new model called THRIVE. The THRIVE framework moves away from a tiered approach of offering health care, to a whole system approach. The framework outlines groups of children and young people, and the sort of support they may need and which service(s) are best placed to provide this, and tries to draw a clearer distinction between treatment on the one hand and support on the other (Wolpert et al, 2016).

The THRIVE framework is based on 5 needs-based groupings for young people with mental health issues and their families. The image on the left describes the input that is offered for each group; that on the right describes the state of being of people in that group (Wolpert et al, 2016).

Figure 1: THRIVE Framework
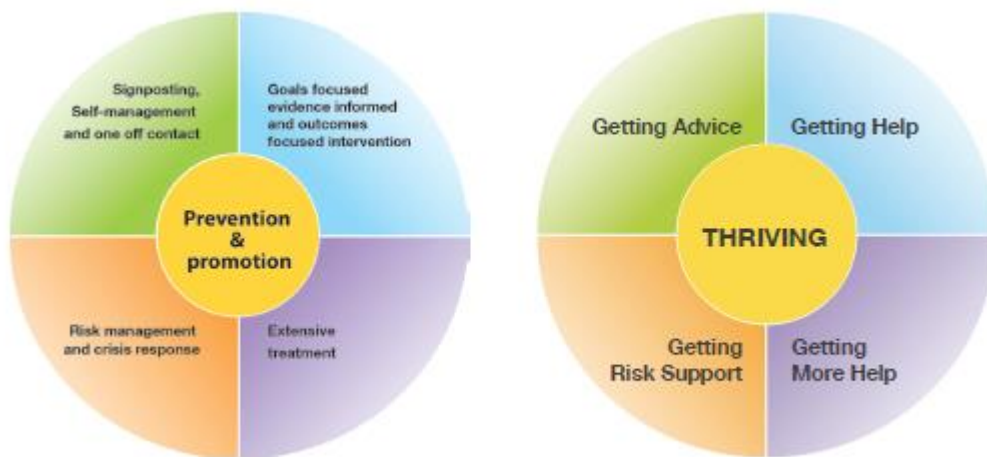
(Wolpert et al, 2016)

Thriving: The THRIVE Framework authors have estimated that at any one time, approximately 80 to 90% of the total population of children and young people will fall within this needs based group (based on findings from Green et al, 2005). This group will receive universal and selective prevention messages.

Children and young people who do not fall within the Thriving category (between 10% and 20%) will fall into one of the following 4 needs based groups:

Of the 10-20% approximately:

30% will belong to **Getting Advice**: This group will contain children and young people who are dealing with mild or temporary difficulties. Interventions will be community based or through self-support; this could include receiving support through education settings or digitally based support.

60% will belong to **Getting Help**: This group will contain children and young people who would benefit from focussed, evidence-based treatment, with clear aims and criteria to assess when these have been achieved. Health services will be the lead provider of care.

5% will belong to **Getting More Help**: This group will contain children and young people who require more extensive long-term treatment. For example, young people with psychosis, eating disorders and emerging personality disorders. Health services will be the lead provider of care.

5% will belong to **Getting Risk Support**: This group will contain children and young people who are unable to benefit from evidence-based treatment but remain a significant concern or risk. For example, children and young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference; who self-harm; or ongoing issues that have not yet responded to treatment. Social care may be the lead provider of care with input from health specialists.

The following table[12] estimates the number of children and young people who could fall within each of these groupings at present (using 2015 mid-year resident population estimates) and for future years based on any changes in population size (using 2014 population projections)[13].

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[12] The table has been based on analysis produced by The Centre for Public Innovation

[13] Populations have been based on children and young people aged 5 to 17 years (inclusive). This age range has been selected as the estimates of the population falling within each THRIVE grouping was based on the Green et al. 2005 survey which questioned 5 to 16 year olds. The age range has been extended to 17 years as children and young people health services will treat this age group. Populations for children aged 0 to 4 years have been excluded as it is not common for children in this age range to receive mental health and wellbeing support and services.

Table 3: Estimated number of children and young people presented by THRIVE groupings

	90% of children and young people thriving			
	% in each grouping	2015	2020	2025
Thriving	90%	28,686	30,185	31,409
Getting Advice	3%	956	1,006	1,047
Getting Help	6%	1,912	2,012	2,094
Getting More Help	0.5%	159	168	174
Getting Risk Support	0.5%	159	168	174
Total	100%	31,873	33,539	34,899
	80% of children and young people thriving			
	% in each grouping	2015	2020	2025
Thriving	80%	25,498	26,831	27,919
Getting Advice	6%	1,912	2,012	2,094
Getting Help	12%	3,825	4,025	4,188
Getting More Help	1%	319	335	349
Getting Risk Support	1%	319	335	349
Total	100%	31,873	33,539	34,899

The table illustrates that at present, somewhere between 3,187 and 6,375 children and young people may fall within one of the THRIVE groupings where some form of mental health intervention would be of benefit to the individual. By 2025 this is expected to increase to somewhere between 3,490 and 6,980 children and young people.

Further analysis has been completed by The Centre for Public Innovation for Warrington and Halton CCGs, the report looks at existing CAMHS provision in Warrington and how this will translate to the THRIVE framework. Based on the number of clients in service[14] as at March 2016 (1,641), it is expected that:

- 492 will fall within 'Getting Advice';
- 985 will fall within 'Getting Help';
- 82 will fall within 'Getting More Help';
- 82 will fall within 'Getting Risk Support'.

(The Centre for Public Innovation, 2016)

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[14] CAMHS Tier 2, CAMHS Tier 3, St Joseph's Family Centre

Between 2015 and 2025, the 5 to 17 year population is expected to increase by 9.5%; therefore if current service usage remains consistent, it could be expected that by 2025 there will be 1,797 clients in service with the following numbers presenting in each THRIVE category:

- 539 will fall within 'Getting Advice';
- 1,078 will fall within 'Getting Help';
- 90 will fall within 'Getting More Help';
- 90 will fall within 'Getting Risk Support'.

5) EVIDENCE OF WHAT WORKS

Equitable provision of emotional health and wellbeing learning within schools
As identified in section 3, schools are ideally placed to offer children and young people emotional health and wellbeing support; all schools receive a school nursing offer and many secondary schools provide emotional health and wellbeing learning and support through PSHE lessons. However, the content and frequency of PSHE in schools is not consistent and the following provides suggestions for ensuring all children and young people receive equitable learning opportunities and support.

The National Institute for Health and Care Excellence (NICE) has produced guidelines to support schools and local government to promote emotional health and wellbeing to children and Young People. Local Government Briefing 12 (LGB 12, 2013) summarises NICE's recommendations for local authorities and partner organisations on social and emotional wellbeing for children and young people, specifically, vulnerable children aged under 5 years and all children in primary and secondary education. Whilst Public Health guideline 12 (PH12, 2008) and Public Health guideline 20 (PH20, 2009) provides guidance for teachers and school governors, and for staff in local authority children's services, primary care and CAMHS by specific school setting (either primary or secondary school).

Public Health England has produced key actions for headteachers and college principals to embed a whole school approach to promoting emotional health and wellbeing. The document includes 8 key principles to promote emotional health and wellbeing:

1. Leadership and management that supports and champions efforts to promote emotional health and wellbeing;
2. An ethos and environment that promotes respect and values diversity;
3. Curriculum, teaching and learning to promote resilience and support social and emotional learning;
4. Enabling student voice to influence decisions;
5. Staff development to support their own wellbeing and that of students;
6. Identifying need and monitoring impact of interventions;
7. Working with parents/carers;
8. Targeted support and appropriate referral.

(PHE, 2015b)

Self-Harm

As presented in section 3, the rate of hospital admissions due to self-harm in young people from Warrington is significantly high when compared to England and it appears the rate of admissions in Warrington is increasing year on year. To help support these young people, a 12 month self-harm pilot project led by CAMHS aims to improve the quality and timeliness of support of young people under the age of 18 living in Warrington who self-harm (as mentioned in section 4). As this project commenced in August 2016, no measureable outcomes are available as of yet.

A Cochrane review of interventions for self-harm in children and adolescents (2015) found that there have been surprisingly few investigations of treatments for self-harm in children and adolescents, despite the size of this problem in many countries. Only one therapeutic approach, mentalisation, was associated with a reduction in frequency of repetition of self-harm. However, the effect was modest and the trial was small, therefore it was difficult to make firm conclusions about the effectiveness of this treatment. It has been recommended that therapeutic assessment, mentalisation, and dialectical behaviour therapy (DBT) warrant further investigation (Hawton et al, 2015).

There are published NICE guidelines relating to self-harm and children and young people:
- Self-harm in over 8s: long-term management CG133, November 2011;
- Self-harm in over 8s: short-term management and prevention of recurrence CG16, July 2004;
- Self-harm QS34, June 2013;
- Depression in children and young people: identification and management CG28, March 2015.

Transition

Transition from children's mental health services to adult mental health services has been cited by commissioners as being problematic; this is not a unique occurrence in Warrington. The National CAMHS Review found that the transition from CAMHS to Adult Mental Health Services (AMHS) caused children, their families and service providers the most concern (Murcott, 2014). The process of transitioning can be a daunting experience for young people, especially if the young person does not receive the same level of support within adult services, as they received within children's services, with some young people not being eligible for any AMHS.

Young Minds (2016g) has produced a series of recommendations of what should happen during the transition process:
- Young people need to receive a continuity of care with no delay in receiving services;
- The transfer to adult services should be negotiated and supported to make sure that the young person does not leave services only to experience great difficulty in another aspect of their life;
- AMHS budgets need to shift to focus more on the 16-19 age group;
- The style of service needs to change within AMHS so it is more holistically focused, as in the CAMHS model;

- Young people's care plans need to involve a multi-agency approach;
- Young people need to have a more central role in deciding their care plans.

(Young Minds, 2016g)

In December 2016, NICE published a Quality Standard (QS140) about how transition from children's to adult's services should be implemented (NICE, 2016c).

A systematic review of academic literature (Embrett et al, 2015) aimed to assess the peer reviewed evidence on services and programmes aimed at addressing youth to adult transitions in mental health services. Findings suggest few studies exist on the effectiveness of transition services and programmes. Available evidence supports meetings between youth and youth caseworkers prior to transitions occurring; it also verifies that this is not common practice. Other identified barriers to effective transitions were categorised as logistical (ineffective system communication), organisational (negative incentives), and related to clinical governance (Embrett et al, 2015).

Young people with a diagnoses of conditions such as ADHD, autism or emerging personality disorders are either not referred to adult care or if referred, are not accepted (Vyas, Birchwood and Singh, 2014). These young people can feel abandoned by health services and may be less inclined to engage with health services in the future. It is important that agencies work together to signpost to other services and to ensure that the young person is still in contact with their GP or their local primary care team (Royal Collage of Psychiatrists, 2016, NICE, 2016b).

6) (TARGET) POPULATION/SERVICE USER VIEWS

During July 2016 an engagement event discussing children and young people's emotional health and wellbeing took place in Warrington[15]. The event covered each of the THRIVE categories: getting advice, getting help, getting more help and getting risk support. The main outcome themes of the event were:
- Develop and support resilience in children and young people helping young people cope with the ups and downs of life;
- Schools and families need to know how to understand triggers/behaviours and do the right things to help;
- There is a need for easier access to advice/guidance/preventative approaches for schools when difficulties are still mild;
- Professionals need to feel more able, with support, to manage issues at an earlier stage to try to avoid the need for more specialist help, by having improved relationships, joined up ways of working and a preventative focus.

The full report can be accessed here

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[15] The event was organised by Warrington CCG and Warrington Council with input from 5 Boroughs Partnership NHS Foundation Trust, The Children's Society and Warrington Parents and Carers.

7) UNMET NEEDS AND SERVICE GAPS

As indicated in the introduction, it has been recognised that children's mental health services have not received adequate investment, though this is currently a national priority. It is unknown whether current services are meeting the expected level of need in the population. The total number of children and young people supported with their emotional and mental health needs is unknown; a variety of organisations across Warrington offer support to children and young people, however a central point to consolidate this information does not currently exist. In addition, the estimated prevalence of mental health disorders is based on dated survey data (2004); this may not reflect current levels of need in the population. However, this survey is due to be updated during 2017.

It is not known how many children and young people in Warrington have a mental health diagnosis. Data has been extracted from GP clinical systems; however it is not known how accurate this figure is. Accurate data is required to ensure that all children and young people who need care and support receive it; and also to ensure that current service provision (capacity) meets the needs of this specific population.

Engagement with young people, families and wider partners highlights that locally there is confusion about how to access the right service for the right level of need, with a view that thresholds are too high. It is also highly likely that the same young people are accessing different types of support without different parts of the system being aware leading to duplication and inefficient use of resources.

Commissioning arrangements reflect the findings of 'Future in Mind' (Department of Health, 2015); commissioning arrangements were disjointed, making accountability unclear and pathways could be confusing for referrers. This could disproportionately affect the more vulnerable groups. This is being addressed through new commissioning arrangements and greater partnership working.

It has also been identified that there are currently gaps in service provision for 17 year olds who have been diagnosed with ADHD. This is currently being addressed by commissioners and service providers.

Local engagement confirmed these findings with 2 particular cohorts of young people reported to be 'falling through the gaps'. Some of the vulnerable groups with chaotic circumstances who wouldn't typically meet current criteria to access support are one of these groups. Despite these young people being at risk for some of the poorest outcomes, engagement indicates these young people's mental health needs are escalating significantly before they can access support, often requiring high levels of intervention from health and social care and putting huge cost pressures on the system as a whole.

In addition, local engagement indicates young people experiencing neurodevelopmental difficulties find it much harder to access support for mental health concerns.

Locally, the higher than national levels of admission to hospital for mental health conditions, self-harm and the high levels of occupied bed days in Tier 4 specialist mental health inpatient beds suggests that more could be done locally to prevent children and young people going into crisis.

Local areas are required to increase access to appropriate evidence based support for children and young people. These national access targets will need to be considered when developing plans for improvement. In addition, a new comprehensive mental health services minimum dataset (MHSMDS) has been developed and offers an opportunity to have much more robust and detailed information about local need.

All schools in Warrington are offered a service from the School Nursing Team who are trained by the local CAMHS team to provide support for children and young people's emotional health and wellbeing concerns. However, it has been identified through a survey conducted with high schools during March 2016, that schools are not consistent with the emotional health and wellbeing learning and support offered to students, PSHE lessons are not timetabled into learning in 3 of the 12 high schools who completed the survey.

8) RECOMMENDATIONS FOR COMMISSIONING

Having robust information to make informed commissioning decisions continues to be problematic. Locally, a more robust process for understanding local levels of need is required. The mental health services minimum dataset should be explored as a method for doing this, however this would require different partners to work together to ensure all activity is reflected.

Work is already underway to review CAMHS services in line with 'Future in Mind'. Locally there is now a high level of support for moving away from a tiered model to a more needs led, whole system model such as 'THRIVE' (Wolpert et al, 2016). This would shift the focus from diagnostically/severity driven criteria to access support to a more flexible, needs led model of delivery.

This review of services should include:
- Crisis care and meeting the requirements of the Crisis Care Concordat;
- Offering more intensive support to the most vulnerable/risky young people to prevent admission or support them on discharge home to prevent re-presentation in crisis. This will require a joint approach across Health and Children's Services;
- Increased access to support those young people at lower levels of need to prevent difficulties from escalating and to enable local services to meet the nationally agreed access target;
- Consideration of how specialist services provide support into schools.

In order to deliver on these recommendations within the resources available, a new model of delivery will be needed. It is recommended that a whole system approach is taken, supported by integrated commissioning and informed by engagement with young people and their families. Consideration should be given to contracting arrangements that enable

different providers to work in a more integrated way, to ensure all activity is reflected in the MHSMDS.

It is suggested that alongside the development of the MHSMDS, a register of children and young people's mental health is established to create a baseline position of need in Warrington. It is suggest that this is followed up by a data quality audit to ensure that all applicable children and young people are recorded within the register.

Commissioners to work with schools to support whole school approaches to emotional health and wellbeing.

Commissioners to develop links between CART (single point of access for referrals for young people experiencing mental health problems) and the Multi Agency Safeguarding Hub (MASH) to support the earlier identification and earlier provision of services.

Commissioners to continue to work with ADHD service providers to address the current gaps in service provision for 17 year olds.

9) RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

It is recommended that a programme of needs assessment work is conducted to fully understand the population of children and young people currently experiencing issues with their mental health. It is suggested that once data from the MHSMDS has been made available, and a CYP mental health register created, this data is analysed to fully understand the population on this register. This analysis can be shared with CYP mental health services to ensure that the development of the THRIVE model will meet the needs of children who may appear within the 4 needs-based groupings of getting advice, getting help, getting more help and getting risk support.

It is also recommended that an evaluation of the implementation of THRIVE in Warrington is conducted.

It is recommended that a whole system dashboard to be developed with input from Warrington CCG, Five Boroughs Partnership NHS Trust and Warrington Local Authority.

Work to be further developed between Warrington CCG, Warrington Local Authority and 5BP which focus on identifying and supporting vulnerable children and young people who present to services during crisis.

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