Children and young people
Emotional health and wellbeing in Cumbria:
Joint strategic needs assessment [refresh]

Version 1

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Acknowledgements

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Executive summary

This “Children and young people Emotional health and wellbeing in Cumbria: Joint strategic needs assessment” provides a universal, population needs based approach to emotional health and wellbeing for all children and young people in Cumbria. The data and analysis aims to identify patterns and trends in order to understand the emotional health and wellbeing needs of children and young people in Cumbria and protect them against a range of mental ill health conditions.

The focus in this report is on promoting good mental health: identifying risks, protective factors and interventions which will help children and young people build strengths and skills, especially resilience skills, which can be help to help develop coping strategies and manage adversity.

Social and individual resilience may develop naturally, and can also result from good practice in early years: a positive experience of education, strong family and social support, a healthy living environment, and through early intervention when emerging problems are identified. This report explores each of these areas.

1 Aims and objectives

The overall aim of the health needs assessment refresh is to present an updated profile of emotional health and wellbeing of children, young people, families and the communities in which they live in Cumbria.

The needs assessment refresh seeks to inform commissioning plans and support the development of a comprehensive model of service which encompasses:

- broader universal health, social care, education and community services
- specialist services for those with mental health conditions.

Many factors influence the emotional health and wellbeing of children and young people. This joint strategic needs assessment refresh aims to:

- describe levels of need within the population of Cumbria
- describe service provision for child and adolescent mental health in tiers 1 to 4
- review the evidence base of good practice
- assess unmet need to inform commissioning and service model development
- make recommendations for system-wide development.

2 Key statistics about children and young people in Cumbria

- An estimated 9.6% or around 10,000 - 11,000 people aged between 5-16 overall are likely to have an emotional health and wellbeing problem, of whom 3.3% are likely to have an anxiety disorder; 0.9% depression, 5.8% conduct disorder and 1.5% a severe hyperkinetic condition.

- In 2012-13, 2380 referrals were made to child and adolescent mental health services [CAMHS] tier 3 services of whom 943 patients were diagnosed with a mental health condition.
- 61% of children overall have a good level of development by age 5, compared with the national average of 64% [lowest in Allerdale 58.9%; highest in South Lakes 66.5%] at the early years foundation stage.
- Educational achievement: 82% overall achieve level 4 or higher for key stage 2 English and Maths; 55.4% overall achieve 5 or more A*-C grades at GCSE (or equivalent) including English and Maths [Key Stage 4].
- The gap between highest and lowest performing districts is 6.4% at KS2; at KS4 it is 23% for the latest year's figures.
- In 2012, 17.5% or 12,282 overall had special educational needs [SEN] [lowest in Eden 15.5%, highest Barrow 22.7%].
- Approximately 3,000 children with special educational needs are likely to have a mental health condition, of whom around 800 will have a statement of SEN.
- An estimated 5% of 16 to 18 year olds on average were not in education, employment or training [NEET = c794] in 2012-13.
- Carlisle, Barrow and Copeland have under-18 teenage pregnancy rates above the national average.
- Carlisle and Barrow have under-16 teenage pregnancy rates above the national average.
- Hospital admissions for under-18 alcohol consumption are higher than the national average in all districts except Eden; in Barrow the rate is nearly double the national average; in Allerdale and Copeland it is around 2.5 times the national average.

3 Policy development

National policy continues to place firm emphasis on prevention and early intervention in a four-tier pathway of service provision. In this report, prevention and early targeted intervention are broadly described as tiers 1 and 2, whereas more specialist services, mainly provided by the child and adolescent mental health services [CAMHS] are located in tier 3 and patients with the most complex needs are referred to tier 4 mental health services. There are a wide range of professionals and agencies supporting and improving a child or young person's psychological wellbeing – most operating at a universal level, such as midwives, health visitors, teachers, school nurses and community workers. These professionals contribute support for all children and young people's development.

The key factors contributing to positive and negative emotional health and wellbeing in children and young people are explored thematically under six priority area headings in a model developed by the Children's Society and set out in their *Good Childhood Report* (2012 and 2013). The main factors under each heading are described and local population datasets, recommendations from evidence and service activity information are given in the main sections of the report.

Six priority areas for promoting wellbeing in children and young people

1. The conditions to learn and develop.

Children need to be given the conditions to learn and develop, starting early, with support during pregnancy and birth and continuing on to high quality education in school. This section contains information about early years and school-age children.

- ***Peri-natal health:***

The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children a healthy start in life and in establishing their positive health and wellbeing in later life. Across Cumbria there are an estimated 10 to 20% of new mothers with a mental health condition. There is variation in patterns of poor mental health and likely to be a higher percentage of people with problems in more deprived areas.

- ***Good level of development at age 5:***

At early years foundation stage, children in Allerdale generally performed less well than other areas - South Lakes highest at 66.5%. Cumbria overall achieved 61% compared with the national average of 64%.

- ***Key stage assessment:***

82% overall achieve level 4 or higher for key stage 2 English and Maths. 55.4% overall achieve 5 or more A*-C grades at GCSE (or equivalent) including English and Maths [Key Stage 4].
School is particularly important as a social and learning environment and impacting on present and future health and wellbeing. Educational attainment impacts significantly on good mental health: the most positive impact being for individuals who gain GCSEs. Educational attainment, as indicated by GCSEs achieved (5 A*-C including English and Maths), has been improving in each local authority area in Cumbria with Eden (61.4%) and South Lakeland (66%) achieving above the England average of 58.4%.

- ***School absenteeism:***

School absenteeism is a key risk factor for violence, injury, substance use, psychiatric disorders, and economic deprivation. Cumbria has a total of 8.9% of secondary persistent absences, ranging from 6.3% in South Lakeland to 10.9% in Eden: higher than the national average in 2010/11 of 6.1%.

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

Children need to see themselves in a positive light, deserving to feel and be respected by all adults and other children. Factors explored include the impact of disability and vulnerability, such as:

- ***Children with disabilities***

Research suggests that almost 1 in 4 children (24%) who are in receipt of disability benefit are more likely to have an emotional disorder. Census data is used to estimate prevalence of disability in Cumbria at between 4,000 and 4,300.

- ***Learning disabilities/ special educational needs***

Children are considered to have special educational needs if they have a learning difficulty which calls for extra educational support or provision to be made for them: there are strong links between learning disability and emotional health and wellbeing. The latest School Census (January 2013) indicates that there are currently 7,722 children in Cumbria at School Action and 2,636 at School Action Plus.

Nationally, around 1 in 5 children (18.7%) have special educational needs [SEN] (DfE, 2013). In January 2013 there were approximately 12,282 [17.5%] children in Cumbria with special educational needs: Barrow in Furness has the highest proportion of children (22.7%).

One in ten children is likely to have a mental health condition and amongst those with SEN the figure rises to around 25%, ranging from 16% at Stage 1 (mild SEN) to 43% of those with Stage 5 SEN (i.e. those with a statement). Applying population estimates to Cumbria data, there are an estimated 3,118 children with SEN who may have a mental health condition in Cumbria. Of those with SEN statement approximately 825 would be likely to have a mental health condition.

- ***Not in education, employment, or training (NEET)***

Being in education, employment or training between the ages of 16-18 has been shown to increase a young person's resilience and is essential to their future employability and wellbeing. Being NEET between the ages of 16-18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health (ChiMat, 2012). 794 young people were NEET in Cumbria during 2012/13. NEET levels vary across the county with Barrow in Furness having the highest level at 7.5% of young people, South Lakeland the lowest at 3.3%.

- ***Pregnant teenagers***

Although early parenthood can be a positive experience for some young people, low levels of emotional health and wellbeing can often be regarded as both a cause and a consequence of teenage pregnancy (Swann et al, 2003). With a conception rate of 27.0 per 1,000 young women age 15-17 years Cumbria as a whole is below the national average rate of 30.7 conceptions per 1,000. However, Carlisle, Barrow and Copeland districts have teenage pregnancy rates above the national average.

With an under-16 conception rate of 5.9 per 1,000 Cumbria is below the national average rate of 6.7 per 1,000. Carlisle and Barrow districts have under-16 conception rates above the national average.

- ***Asylum seekers, refugees and migrant populations***

Mental health problems in some migrant groups are higher than in the general population. Children in migrant population groups, including asylum seekers and refugees are likely to need extra support for their emotional health and wellbeing. During 2011 there were 14 asylum seekers in Cumbria, some of whom may have dependent families.

- ***Gypsy, Roma and Traveller children***

Gypsy, Roma and Traveller children tend to have the worst educational outcomes of any ethnic group in the UK and higher rates of school exclusion. Countywide there are

approximately 770 families across four official sites in Cumbria - in Carlisle, Eden and Barrow. This figure is likely to underestimate the true population. Estimates from the Cumbria Traveller Family Support Service indicate that there may be up to 5,000 Travellers' staying in Cumbria at any time.

- ***Ethnic minorities***

Evidence on the impact of ethnicity on emotional wellbeing and mental health problems is inconclusive. In Cumbria 2.4% of the population aged 0-19 year can be categorised as non-white. This compares with 21% of the population of England. South Lakeland has the highest proportion with 3.3%, of children and young people from an ethnic background. Allerdale, at 1.6%, has the smallest proportion of non-white children and young people.

3. Have enough of what matters

Children who live in poorer households are twice as likely to have lower levels of wellbeing compared with those in more economically comfortable households. 'Having enough' and 'fitting in' are more important than being very well off. Factors considered under this heading include poverty and deprivation, families most likely to be in need:

- ***Child poverty***

Child poverty is defined as the proportion of children living in families where income is less than 60% of median income. Children in poor households are three times more likely to have mental health problems than those in more affluent households. Barrow has an estimated 22%, compared with neighbouring South Lakeland having an estimated 8% of children living in poverty.

- ***Children in single parent/overcrowded households***

Lone parent families are acknowledged as one of the most disadvantaged groups in society. Children of lone parents are twice as likely to suffer from mental disorders. Children of unemployed lone parents are especially vulnerable. Approximately 25% of children live in single parent households compared to 12% in 1971. Poverty rates for single parents who are working are 23% part time and 18% full time. The 2011 census showed 12,600 lone parent households in the county with Carlisle having the greatest proportion (24%) and Eden the least (8%).

4. Positive relationships with family and friends.

The strongest driver of low subjective wellbeing is when children experience weak, unstable or uncaring relationships with their family or main carer. Stable positive relationships with family and friends are of great importance. Factors explored here include:

- ***Children looked after***

Entering care is strongly associated with poverty and deprivation, poor educational and social outcomes and emotional and mental health problems. Around half of looked after

children may have a mental health condition, with potentially up to three quarters of those in residential care.

- ***Missing children***

Every year, an estimated 200,000 people go missing in the UK, of whom approximately two thirds are under 18. Those aged 15-17 are around one-third of all missing people. Up to two-thirds of young people who run away are not reported. Although many runaways are fleeing abuse, they will often be at increased risk as a result of running away.
In 2010/2011 there were 2008 missing persons in Cumbria, including adults.

- ***Children whose parents have mental health and other problems***

Around 18% of children in the UK live with a parent who has a mental health problem and children whose mothers have mental health problems can be more than twice as likely to develop emotional disorders themselves.

5. A safe and suitable home environment and local area.

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

- ***Homelessness***

Homelessness was 14% higher nationally in 2011 than in 2010. Evidence indicates that many homeless young people suffer from severe mental health problems and behavioural problems have been found to be higher in homeless children living in temporary accommodation. Mental health problems are significantly higher among homeless mothers and children. There were 258 statutory homeless households with dependent children or pregnant women in Cumbria in 2011/12, which was a rate of 1.2 per 1,000 households. This compares to an England average rate of 1.7.

- ***Aggression and violence***

Exposure to abuse and violence in the home – both directly and indirectly – can cause persistent distress and children who live with domestic violence are at increased risk of behavioural problems, emotional trauma and mental health difficulties in adult life.

- ***Child hospital admissions for injury***

Although not necessarily linked to violence in the home, child admissions to hospital for injury are recognised as a cause of premature mortality and long-term health conditions. There were 8,417 A&E attendances in children aged 0-4 years in Cumbria in 2010/2011. There were 4116 A&E attendances in Cumbria of 0-18 year olds in 2012/13 for injury in the home.

6. Opportunity to take part in positive activities to thrive.

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

- ***Teenage parents***

It is recognised that teenage parents can experience poor social circumstances with subsequent detrimental effects on the family. Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth. By the age of 30, they are 22% more likely to be living in poverty and 20% more likely to have no qualifications (compared to older mothers, aged 24+).

- ***Young carers***

There are an estimated 175,000 young carers in the UK and there is a clear relationship between poor mental health and caring. 2011 census data shows 3,378 carers in Cumbria aged under-24, though this figure may not include those looking after family members with mental health or substance misuse problems.

- ***Healthy weight, physical activity and other positive activities***

Taking part in social and voluntary activities, sport and exercise is associated with higher levels of life satisfaction. Access to green spaces can have a positive effect on mental wellbeing and cognitive function as well as greater social contact and community cohesion.

Cumbria has a higher percentage of children in reception (aged 4-5years) and Year 6 (aged 10-11 years) classified as obese or overweight compared to the England average. In reception Cumbria's level is 10.1% (England average 9.5%) and in year 6 Cumbria's level is 20.3% compared with the England average of 19.2%.

Summary of findings and recommendations

The following key findings are preceded with a general caveat that children's services in Cumbria are undergoing rapid change as a result of the external inspections. . Therefore It will be necessary to update information in the JSNA as improvement plans are implemented. Some of the improvement activity centres on safeguarding and other interventions, other activity focusses on data and surveillance capacity.

Key findings:

- In overall terms, the emotional health and wellbeing of children and young people in Cumbria appears to follow national average trends, however in many areas of observation and analysis there is evidence of wide disparity between geographical districts. This is consistent with national projections which suggest that younger populations in more socio-economically deprived areas have a poorer start in life, are more likely to suffer lower levels of emotional health and wellbeing through their life course and in consequence experience higher levels of mental ill health than the general population.

- There is evidence of unmet need, under capacity and lack of accurate service and surveillance data across agencies and disciplines: e.g. diagnostic data is unavailable from the main mental health provider. Despite the unavailability of robust referral data it is likely that the highest proportions of unmet need are in the poorest areas.

- There is no comprehensive four-tier integrated service at present – though commissioners and clinical leads are working towards this objective.

- Children and young people with problems are more likely to present in early years, school or primary health care, though they may also have contact with non-statutory and third sector services. Improvement in prevention and early detection of problems requires appropriate capacity particularly within primary care, education, social and community based care.

- Better communication and links between agencies – particularly CAMHS, schools and primary care would improve support for children and families. Anecdotal evidence from primary care is of a need for capacity to help general practitioners manage caseload at an earlier stage, provide support and to ensure appropriate referrals to specialist CAMHS.

- Children with emotional health conditions ranging from conduct or behavioural problems to more extreme needs such as safeguarding or child protection are often identified by adults with differing areas of responsibility for them. Development of a joint multiagency data hub to enable 'real time' early warning and tracking of these children and their interventions would be beneficial.

- Parental concerns and parents' ability to identify a developing problem with their child are very important. Parents need the confidence and capacity to communicate the needs of their child to professionals, and have confidence that their concerns will be acted upon. Successful early detection of developing problems often depends on the tenacity of the help-seeking response of parents. It is essential therefore to ensure that the signs and symptoms parents report are acted upon effectively.

- There are some areas where data appears to indicate a need for further investigation and possibly action. These include:

    - Free school meals uptake. Current data suggests that over 2000 families in Cumbria may be entitled to free school meals for their children and are currently not receiving them.
    - Educational attainment. The disparity between the best and worst performing districts appears to widen between KS2 and KS4. The data needs further examination.
    - Alcohol admissions. Some districts are significantly worse than the England average and this requires urgent attention.

- There are some areas where data is needed to be able to assess service provision and referrals including:
    - Primary care - GP practice profiles. An audit of presentations and referrals in GP practices would be helpful.
    - CPFT. Diagnostic coding and caseload analysis will help to identify capacity issues.
    - Schools. An audit of services and interventions in primary and secondary schools would allow further examination of services at tiers 1 and 2.

    - Community and voluntary organisations. Activity data would allow assessment of available services, particularly at tier 1.

- Schools. An audit of support for emotional health and wellbeing in schools, including independents and academies would be helpful.

- Early years providers, schools and colleges need to be aware of the services offered at all levels including by local CAMHS and how children, young people and their families can access them.

- School nurses have a pivotal role in identifying and supporting children in need of mental health services. Their service specification for the new school nursing service will specify their responsibilities.

- Cumbria's teenage pregnancy and suicide prevention strategies are in development and their implementation will be essential to improving emotional health and wellbeing.

- Support in primary care. An exercise to audit primary care activity via PRIMIS would be helpful, and a practice profile approach to support early identification and diagnosis of child and adolescent mental health conditions within practice populations. Support from the new strategic clinical networks may be available.

- Training in emotional health and wellbeing is particularly important for non-mental health professionals; and more general public awareness campaigns around signs, symptoms and how to access help are needed to support early help-seeking.

- More in-depth needs assessments for some of the more vulnerable groups identified for whom there is a lack of readily available data may be required, as well as further analysis to explore particular needs of small areas within districts such as social factors of poor housing, fuel poverty and neighbourhood crime/safety.

- Further work is needed to explore stakeholder views, particularly concerns arising from the schools and young people's surveys (see appendix 1).

Conclusions and recommendations

Many factors associated with child wellbeing are inter-linked, with children and young people often facing more than one adverse experience and life situation. This joint strategic needs assessment refresh identifies evidence-based good practice, protective factors and areas of risk. It is possible to identify a significant level of population need in Cumbria, some of the service activity to meet these needs and areas of good practice. It is recommended that further work is considered by the joint commissioners to ensure that more complete intelligence is available and good practice disseminated.

More precise identification, analysis and surveillance data, particularly of children and young people in greatest need, are recommended with a central hub to support key agencies. High level datasets exist to a large extent, and local information-sharing protocols are in place. Further development is now needed to ensure more localised intelligence is shared in a timely way.

In comparing district local authorities with each other or with a national benchmark, it is necessary to note that there are inequalities in need within their boundaries. The limited amount of data readily available by small areas suggests nationally that the distribution of low levels of child wellbeing follows a similar pattern to that of high levels of school absenteeism, child poverty, and disability. Further exploration of small area data is needed to understand causal and correlating factors. It is recommended that qualitative studies are undertaken to explore these relationships.

There are many more factors associated with the emotional health and wellbeing of children and young people that were not included here, either because of a lack of readily available data, or because it was beyond the scope of this project. Research data on protective factors associated with emotional health and wellbeing tends to be incomplete and often rely on the results of self-reported surveys. Areas for further investigation have been listed in the main report.

Introduction

A universal, population needs based approach to emotional health and wellbeing for all children and young people will help to protect them against mental ill health. The focus in this report is on promoting good mental health: identifying risks, protective factors and interventions which will help children and young people build strengths and skills, especially resilience skills, which can help them to manage adversity. Social and individual resilience may develop naturally, and can also result from good practice in early years. A positive experience of education, strong family and social support, a healthy living environment, and through early intervention when emerging problems are identified.

1 Aims and objectives

The overall aim of the health needs assessment refresh is to present an updated profile of emotional health and wellbeing of children, young people, families and the communities in which they live in Cumbria. Inequalities in emotional health and wellbeing have been identified where possible, with particular reference to the demography of the local population and those groups most at risk of poor mental health. The factors that can contribute to positive and negative emotional health and wellbeing are explored, for example having the conditions to learn and develop and a safe and suitable home environment.

The needs assessment refresh seeks to update population data inform commissioning plans and support the development of a comprehensive model of service which will include:

- broader universal health, social care, education and community services
- specialist services for those with diagnosable mental health conditions.

Evidence based interventions - including examples of local good practice - are highlighted where possible. Local population and service activity data is also included where available in order to estimate unmet need or gaps in service provision. Where data is not available, need has been estimated from national statistics where possible. There are significant issues with data availability, which are commented on in the text.

Many factors influence the emotional health and wellbeing of children and young people. This joint strategic needs assessment refresh aims to:

- describe levels of need within the population of Cumbria
- describe service provision for child and adolescent mental health in tiers 1 to 4
- review the evidence base of good practice
- assess unmet need to inform commissioning and service model development
- make recommendations for system-wide development.

2 Mental health problems in children and young people: the national picture

Mental health problems in children and young people appear to be increasing. Around one in ten children aged 5-16 years is estimated to have a mental health condition and in adults with long-term mental health problems, half may have experienced their first symptoms before age 14.
Less than half the mental health problems are diagnosed and treated during adolescence, which can have a profound effect on later life chances. [YoungMinds 2012]

Approximately 75% of young people see their GP at least once a year, of whom 1 in 3 is likely to experience an emotional health problem. Freer et al [2010] point out that this indicates that primary care services have contact with the majority of young people - a group generally thought to be ‘hard to reach’ – which can provide opportunities for detecting mental health problems. Box

1 shows estimated prevalence of the main mental health conditions experienced by children and young people. Around 9.6% of all children and young people aged 16 and under are likely to experience some level of disorder: the most prevalent appear to be conduct disorders, affecting nearly 6% aged 16 and under, and anxiety, affecting just over 3%.

Box 1

Prevalence of mental health conditions in children and young people

Prevalence of mental health conditions in children and young people

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

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

Depression
- 0.9% or nearly 80,000 children and young people with severe depression
- 0.2% or about 8,700 aged 5-10 year-olds
- 1.4% or about 62,000 aged 11-16 year-olds

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

Hyperkinetic disorder
- 1.5% or just over 132,000 children and young people have severe ADHD
- 1.6% or about 70,000 children have severe ADHD
- 1.4% or about 62,000 young people have severe ADHD

Source: YoungMinds 2012

3 National policy

National policy focusses on early detection and intervention, support for individuals and families at key life stages and training for non-specialists in mental health.

The *Children and Young People's Health Outcomes Framework* outlines key strategic themes of prevention, early detection and intervention. The policy framework underlines that those who work with children outside the healthcare system, such as teachers, social and youth workers, have an important contribution to make to improving health outcomes, and that their training in emotional health and wellbeing is vital. [DH 2013]

This policy framework builds on previous programmes such as *Every Child Matters* in placing emphasis on early development, safety and partnership working.

'Giving every child the best start in life' is the highest priority recommendation in the national '*Strategic review of health inequalities'* led by Sir Michael Marmot who notes that disadvantage starts before birth and accumulates throughout life: action to reduce health inequalities must start before birth and be followed through the life of the child. [Marmot 2010]
The White Paper *Healthy Lives, Healthy People* adopts a life-course perspective to address wider social factors affecting people's mental health at different stages of their lives, starting in early childhood. [DH 2010]
Good peri-natal health in women is highlighted as a critical factor, as is identifying, treating and preventing health problems, and creating resilience and self-esteem, as children negotiate the transition into adulthood. The national mental health strategy *No Health without Mental Health* emphasises that mental health is everyone's business, and that early detection and intervention is essential to prevent more serious problems in later life. [DH 2011]

4 Emotional health and wellbeing

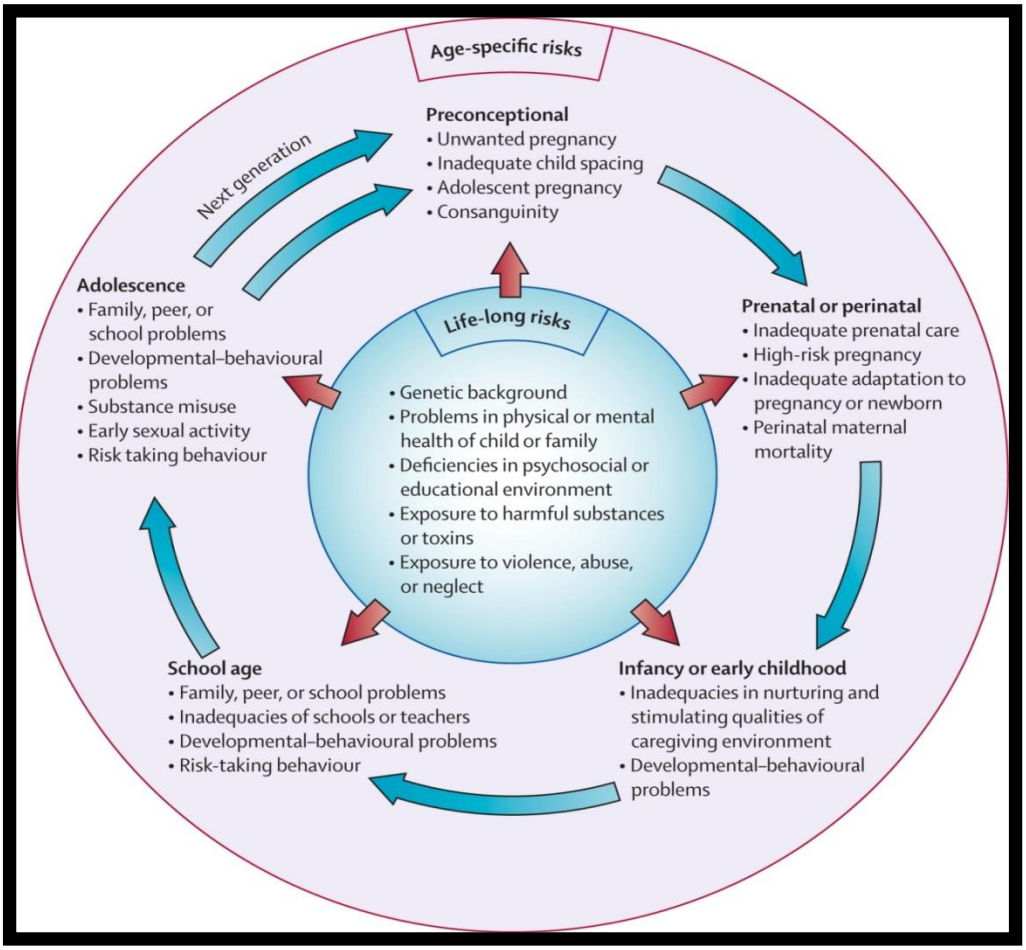
Wellbeing has been defined as *'more than just happiness. As well as feeling satisfied and happy, wellbeing means developing as a person and being fulfilled'.* [New Economics Foundation 2008]

Populations with high levels of wellbeing are more likely to be protected from mental ill-health than populations with lower levels, and wellbeing is subject to many influencing factors. For example, the incidence of mental health problems in young people and adults can increase in times of economic and employment uncertainty, as can the rate of suicide. [DH 2011]
UNICEF reported the wellbeing of young people in the UK to be the lowest of 21 industrialised countries and a Princes Trust survey in 2009 found that among 16-25 year olds, 1 in 10 felt that 'life was 'not really worth living'; 27% said they were 'always or often' depressed and 47% said they were 'regularly stressed'. Those without work were least likely to be happy.
It is more likely that children and young people who are emotionally healthy achieve more, participate more fully with their peers and their community, engage in less risky behaviour and cope better with adversity. [Freer et al 2010]

'Subjective wellbeing focuses on how people are feeling…whereas objective wellbeing focuses on the conditions which affect those feelings, such as health or education. Both these perspectives are valuable for understanding children's wellbeing'. [Children's Society 2012]

4.1 Levels of need

Emotional health and wellbeing needs arise at different times of life and with differing levels of severity. These needs may be met within a supportive environment of family or friends, or may require external intervention: from social, community or educational sources, or from one or more clinical services. Box 2 shows the interaction of factors throughout the life course that may lead to poor emotional health and wellbeing.



Box 2: Kieling C et al *Child and adolescent mental health worldwide: evidence for action*

Source: The Lancet 2011; 378:1515-1525 (DOI:10/1016/S0140-6736(11)60827-1

4.2 An integrated model of care

An evidence-based comprehensive model of child and adolescent emotional health and wellbeing service provision would typically be organised across four tiers reflecting the diversity of potential support for differing levels of need. An integrated model of care describes an ideal range of provision from tier 1 universal community provision, which should promote good emotional wellbeing for all children and adolescents, through to tier 4, which is designed to support those with the most complex needs.

The description of child and adolescent mental health services or CAMHS is usually associated with specialist tiers 3 and 4. However, CAMHS professionals can also work in other settings such as schools and GP practices, alongside social services, and in children's centres. There is also a range of staff and groups operating at a universal level such as midwives, early years and school teachers, school nurses and community staff. The lower tiers of this model include mainly community provision, but for more severe and acute conditions the specialist services also include in-patient care. For further detail refer to table in appendix 2.

4.3 Cumbria demography: 0-19 age group

Just over one-fifth of Cumbria's population is aged under-19. As table 1 below shows, there is variation between the six district council area populations, with Barrow in Furness having the highest proportion and South Lakeland the lowest.

Table 1: Population aged 0-19 years in Cumbria, by District Council area

	0-4	5-9	10-14	15-19	0-19	0-19 age group as % of all ages
Allerdale	4,900	4,700	5,200	5,700	20,500	21.3
Barrow in Furness	3,700	3,700	3,900	4,300	15,600	22.8
Carlisle	6,200	5,700	5,400	6,500	23,800	22.0
Copeland	3,700	3,700	3,700	4,100	15,200	21.6
Eden	2,300	2,600	2,800	2,900	10,600	20.1
South Lakeland	4,500	4,800	5,200	5,700	20,200	19.5
Cumbria	**25,400**	**25,200**	**26,200**	**29,200**	**106,000**	**21.2**

Source: Office for National Statistics (ONS): Mid-2012 Estimates - Rounded to the nearest 100

Nationally by 2021 there is a projected 9% growth in this population group, which contrasts with a projected decrease of 1% overall in Cumbria. Allerdale is the only area to forecast a small increase of 1%; the remaining districts, with the exception of Carlisle showing no change, all are projected to have a falling population for this age group.

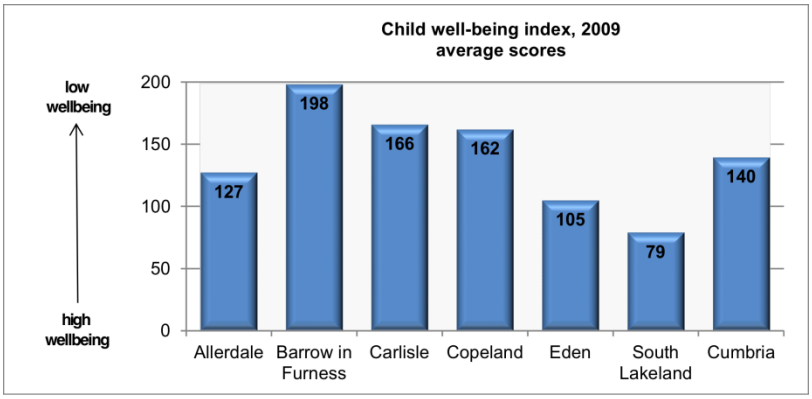
4.3 How do young Cumbrians feel?

Young people face many pressures and challenges and many factors influence them such as family and friends, availability of money, media, social and school environments. Social media

and networks play a huge part from a relatively early age. Measurement of a general level of wellbeing is by means of qualitative survey [health related behaviour survey, schools survey] and quantitative indicators such as family income [the child wellbeing index] in district council areas.

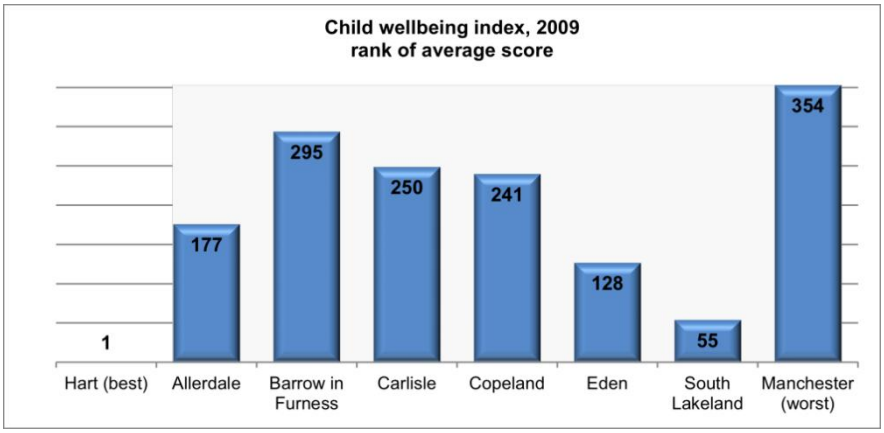
The surveys show a pattern of overall wellbeing in primary and secondary schools which is broadly similar to the national average of just over half respondents reporting a good level of wellbeing. The child wellbeing index average scores in figures 1 and 2 below show average scores: at district level there is considerable variation, with Furness ranked at 295th in the lowest quintile nationally whereas South Lakeland at 55th is in the top 20%.

Figure 1: Child wellbeing index, 2009, average scores



Source: Communities and Local Government, Child Wellbeing Index, 2009

Figure 2: Child wellbeing index, 2009, ranking of average scores



Source: Communities and Local Government, Child Wellbeing Index, 2009

4.4 Services in Cumbria

Local services for children and families are commissioned and provided by a number of key agencies:

- Cumbria County Council children's services directorate
- District councils and housing associations
- Cumbria Clinical Commissioning Group
- Cumbria Partnership Foundation Trust

- North Cumbria University Hospitals Acute Trust; University Hospitals Morecambe Bay
- Children's centres
- General practitioners in six localities
- Schools and nurseries, including academies and independent sector
- Further education centres
- Third sector – voluntary, community and charity organisations.

The healthy child programme 5-16 years, school age pathway:
The school health service is undergoing change in order to deliver the healthy child programme. This includes a new school entry health and wellbeing review, as part of "The Lancaster Model". It will commence in the autumn term for children in schools in Furness and South Lakes and rolled out in the other localities next year. There is a section on emotional health and wellbeing based on the strengths and difficulties questionnaire. This will enable public health school nurses to assess, analyse, and respond swiftly, to the emotional health needs of children and young people.it is hoped this will expand to include this type of assessment at year 6 and mid-teens. The data gathered from these questionnaires will also provide trends and inform services of local need.

Figure 3 shows the referrals to CAMHS in Cumbria in 2012-2013 (more specific data can be seen in appendix 3).

Figure 3: Referrals to CAMHS in Cumbria 2012-2013: source CPFT

Indicator	Period	Cumbria
		Current Period
Number of referral to CAMHS Tier 3 for mental health conditions	2012/13	2380
Number of CAMHS Tier 4 referrals	2012/13	17
Number of children diagnosed with a mental health condition	2012/13	943

Children's services in general and those providing specialist emotional health and wellbeing support have been subject to external review and inspection since the original joint strategic needs assessment was published. As a result of these exercises, multi-agency plans for improvement are being implemented and the full details of these are beyond the scope of this refresh report. However a broad summary of key themes includes:

- disparity between population estimates of mental health conditions and access to appropriate support services: this appears to be the case with universal as well as targeted and specialist services
- the requirement to review pathways, thresholds of case management and appropriateness of referrals to specialist CAMHS services
- re-commissioning of specialist services to meet the needs of those requiring clinical support at tiers 3 and 4
- greater precision about volume and quality of activity of professionals in various settings – such as in primary and community health, schools and other community and voluntary groups: especially where data is insufficient or inaccessible

- evidence of underdevelopment of lower tier services, which increases demand and can impact negatively on the quality and capacity of specialist services
- ensuring high quality training, awareness-raising and empowerment of professionals involved with children and young people, to enable them to perform their roles in early detection and manage interventions to established standards

Six priority areas for promoting wellbeing in children and young people

Based upon concepts of risk and resilience, and incorporating interlinked factors related to these, the Children's Society '*Good Childhood Report'* identified six priority areas for promoting wellbeing in children - summarised in box 3 below.

In the following sections, the needs assessment refresh follows these themes: presenting information on each of the priority areas where data is available, or extrapolated from national data where possible. It is important to acknowledge that many factors are interlinked, and some cohorts of children have cross-cutting needs across several sections.

Box 3: Six key themes for a good childhood: Children's Society

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

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

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

4 **Positive relationships with family and friends**, where stable and caring relationships are important

5 **A safe and suitable home environment and local area,** such as feeling safe, privacy, good local facilities, stable home life

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

(Children's Society, 2012, 2013)

1 The conditions to learn and develop – pregnancy, birth and beyond

Children need to be given the conditions to learn and develop in a safe and secure environment, with good attachment and nurturing, access to play, healthy, stress-free early years and high quality education in school. This section considers indicators of levels of wellbeing including the foundations for good development that are laid at birth, measures of 'good level of development' at age 5, educational achievement and school attendance.

1.1 Perinatal health

The peri-natal health and wellbeing of women is a critical factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing in later life. [Royal College of Midwives, 2011]

It is estimated that around 10-15% of new mothers suffer some peri-natal mental health difficulties which can lead to cognitive and emotional disturbance in the baby alongside the effects on the mother. Children of depressed mothers are more likely to need access to support services, and to experience mental health problems as older individuals. Social isolation is a known risk factor for postnatal depression and reducing this may have a range of clinical and psycho-social benefits.

The 2011 report '*Supporting Families in the Foundation Years'* recognises the importance of early years for future emotional and mental health. After age three it becomes much more difficult to make changes in a child's development and in parental behaviour. Interventions under the *Healthy Child Programme* can help prevent problems in the firs years. [DfE 2011]

Support for mothers with postnatal depression and improvements to maternity care in 2012 included, for example, an additional 4,200 health visitors nationally. For vulnerable young first time mothers, the Family Nurse Partnership (FNP) scheme offers intensive and structured home visiting until age two. FNP is designed to benefit the neediest families across a wide range of outcomes helping improve social mobility and reduce the effects of disadvantage. [DH 2012]
NICE guidelines outline that women with complex social factors may have additional needs, such as for peer group social support. [NICE 2010]

Cumbria's perinatal services:

- The health visiting service follows NICE guidelines for perinatal mental health. Staff are trained in the Solihull approach which promotes parent-infant interaction and bonding
- New processes, assessment and systems have been implemented in children's services to identify and manage risk and escalate in a timely fashion
- Joint working has begun between health and early years to support the early years strategy
- Pathway development across maternity and health is underway
- The Family Nurse Partnership programme is offered in Furness, Carlisle and Workington to teenage parents. The programme commences at 16 weeks gestation in the antenatal period up to 2 years old
- Positive outcomes have been recorded in child health and development, smoking cessation, hospital admissions, A&E attendances
- Health visitors in post at the end of August 13=74.51 WTE
- School nurses in post at the end of August 13=20.86 WTE.

[Source: CPFT]

1.2 Cumbria data – new mothers with mental health needs

Table 2 shows an estimated prevalence of between 10 and 15% of new mothers with a mental health problem. In more deprived areas the proportion can be 25%.

Table 2: Estimated numbers of new mothers with a mental health problem, 2011: source ONS

	Live births	Estimated numbers of new mothers with a mental health problem	
		from 10%	**to 15%**
Allerdale	941	94	141
Barrow in Furness	712	71	107
Carlisle	1,310	131	197
Copeland	771	77	116
Eden	426	43	64
South Lakeland	873	87	131
Cumbria	**5,033**	**503**	**755**

1.3 Early years development: good level of development at age 5

The early years foundation stage profile records each child's achievements at the age of 5 in six areas of learning and development:

- Personal, social and emotional development
- Communication, language and literacy
- Problem solving, reasoning and numeracy
- Knowledge and understanding of the world
- Physical development
- Creative development

The 'good level of development' score describes each child's development and learning achievements at the age of five. [DfE 2010]

Cumbria early years outcomes:

The early years foundation outcomes for 5 year olds are as follows:

- Overall attaining the good level of development in 2010-11: 49.4% (national average = 52%).
- Children qualifying for free school meals: 30.8% successful
- Children looked after: 11.1% successful

The profile for early years foundation stage in 2011-12 changed therefore comparison with previous years is problematic. Cumbria's performance compared to the national average was 61% compared with a national average of 64% [see table 3 below].

Table 3: Achievement of a Good Level of Development at Early Years Foundation Stage, 2011-12
Source: Children's Services Information & Performance Team, Cumbria County Council

District	Percentage
Allerdale	58.9%
Barrow in Furness	57.3%
Carlisle	62.2%
Copeland	54.1%
Eden	62.6%
South Lakeland	66.5%
Cumbria	**61.0%**

1.4 School

School is particularly important as a social and learning environment impacting on present and future health and wellbeing. Young people who are not engaged with learning or who have poor relationships with peers and teachers are more likely to engage in risk-taking and socially disruptive behaviours, report anxiety/depressive symptoms, have poorer adult relationships and fail to complete secondary school. [Bond et al, 2007]

Cumbria education levels of achievement

Table 4: Educational achievement by key stage, academic year 2011-12
Source: Children's Services Information & Performance Team, Cumbria County Council

	Level of Achievement	
District	**Key Stage 2**	**Key Stage 4 (GCSE)**
Allerdale	82.9%	53.8%
Barrow in Furness	77.5%	42.2%
Carlisle	79.8%	53.1%
Copeland	82.5%	52.7%
Eden	81.8%	61.4%
South Lakeland	83.9%	66.0%
Cumbria	**82.0%**	**55.4%**

Notes: Key Stage 2 – achievement of Level 4 or above for English and Maths
Key Stage 4 – achievement of 5 or more A*-C grades at GCSE (or equivalent) including English and Maths

Educational attainment impacts significantly on good mental health: the most positive impact being for individuals who do well at key stages 2 and 4 and who gain GCSEs. Education can directly affect health outcomes through income, employment, working conditions or family relations and by enabling individuals to be more health-conscious, by increasing help-seeking behaviour or by adhering to therapy. Current data suggests that disparities between the best and worst performing districts tend to widen between KS2 and KS4, however data over several years is needed in order to analyse such a trend.
Eligibility for free school meals is an important indicator of family income levels. Table 5 below shows eligibility and uptake across districts. It is clear that a significant number of children entitled to free school meals especially in some districts are not receiving them.

Table 5: Free school meal eligibility and uptake, January 2013

	Free school meal eligibility and uptake		
	Eligibility	**Take Up**	**%**
Allerdale	1792	1535	85.7
Barrow in Furness	1767	1299	73.5
Carlisle	1845	1118	60.6
Copeland	1342	1007	75.0
Eden	423	266	62.9
South Lakeland	772	392	50.8
Cumbria	**7941**	**5617**	**70.7**

Source: Children's Services Information & Performance Team, Cumbria County Council

1.5 School absences and exclusions

Absenteeism from school is a risk factor for violence, injury, substance misuse, psychiatric disorders and economic deprivation. It is linked with suicide attempts, risky sexual behaviour and teenage pregnancy. Conditions related to extensive school absences primarily include anxiety, depressive and disruptive behaviour disorders. Children who refuse to attend school tend to have more socially deprived backgrounds, have significant difficulties relating to peers, and a family life containing conflict and stress. Higher levels of absenteeism are indicated for children with special educational needs, especially those with learning disabilities. [Kearney, 2008, Place et al, 2000]

Within Cumbria levels of unauthorized absence from school remains comparatively low: performance is better than the national average and that of the county's statistical neighbours. A data tool enables schools to self-assess performance against OFSTED benchmarks on a termly basis. This data indicates where targeted support and advice to schools is required. Enforcement requires a robust response to individual cases of poor attendance. 'School Attendance Promotion Days' take place in partnership with Cumbria Constabulary across the county several times a year.
Children Missing education officers identify pupils without a school place to support access to education and safety of the child. Procedures are in place to address missing children as a priority.

Cumbria performs comparatively with other authorities in fixed term exclusions and above the national average for permanent exclusions. Re-integration co-ordinators attempt to identify alternative options
Tables 6 and 7 show exclusion data

Best practice indicates that targeted approaches are required for children with early signs of emotional and social difficulties. Targeted approaches in schools can be delivered by third sector organisations, for example after school clubs. A recent initiative was Targeted Mental Health in Schools, (TaMHS) a three year project established in 2008, running in selected schools in each local authority.

Table 6: Pupil absence by type of school, 2011-12: Source: Department for Education

	Percentage of persistent absence by type of school	
	Primary	**Secondary**
Allerdale	3.1%	7.8%
Barrow in Furness	2.9%	9.7%
Carlisle	3.8%	10.7%
Copeland	3.0%	9.8%
Eden	2.9%	10.9%
South Lakeland	2.4%	6.3%
Cumbria	**3.1%**	**8.9%**

Table 7: Pupil exclusions by exclusion and type of school, 2011-12

	Percentage of fixed term and permanent exclusions			
	Primary (fixed)	**Secondary (fixed)**	**Primary (permanent)**	**Secondary (permanent)**
Allerdale	0.39%	5.07%	0.00%	0.10%
Barrow in Furness	0.17%	21.23%	0.00%	0.07%
Carlisle	1.27%	11.08%	0.00%	0.02%
Copeland	0.77%	5.20%	0.00%	0.07%
Eden	0.13%	2.41%	0.00%	0.00%
South Lakeland	0.19%	7.53%	0.00%	0.05%
Cumbria	**0.47%**	**9.49%**	**0.00%**	**0.05%**

Case study – Targeted Mental Health in Schools

The Targeted Mental Health in Schools Programme (TaMHS) was a three year, national pathfinder programme, funded through the DCSF, 2008 - 2011. The TaMHS programme built upon the work of the Social and Emotional Aspects of Learning (SEAL) and Healthy Schools programmes.

Cumbria was one of 72 'phase 3' areas that received funding for one year (£215,000).

TaMHS aimed to support the development of innovative models of therapeutic and holistic mental health support in schools for children and young people aged five to thirteen at risk of, and / or experiencing, mental health problems, and their families. The TaMHS Steering Group included senior leads from Children's Services, NHS and voluntary agencies.

The project ran from April 2010 to March 2011 and eighteen schools participated. Schools were clustered in three geographical areas and included fourteen primary schools, three secondary schools and one PRU. School leads participated in regular cluster meetings.

Support for schools included universal, whole school training in promoting positive mental health, whole school 'health days', workshops for parents and funding for joint working projects. Targeted, tier 2 provision included small group work for children and young people and 1 – 1 consultations with CAMHS workers. Some teachers also accessed counselling. A group of primary school head teachers and secondary school pastoral leaders undertook accredited, outsourced training. Action for Children was commissioned to provide parent / child activity sessions and away days for 'vulnerable' young people.

864 children aged from 5 to 13 completed student questionnaires:

- 77% of respondents felt happy about life (at the moment), only 3% felt this statement was untrue.
- 95% of students felt that they had one or more good friends, only 1% felt that this statement was untrue.
- If they were worried 75% of students felt that they could talk to their parents, 72% could talk to their friends and 66% felt that they could talk to another adult.

Questionnaires also included questions related to worries, bullying and feeling safe in school. Schools received individual feedback. The project was independently evaluated by the University of Cumbria*: 'Synthesis of the data revealed that the TaMHS project in Cumbria was, on the whole, very well received by professionals in education and mental health alike, and produced concrete positive impacts'*

A TaMHS report and toolkit were made available to all schools in Cumbria in January 2012. TaMHS training was provided for school leaders in summer term 2012; this training was very well attended and received.

2 A positive view of themselves and an identity that is respected

Children and young people need to see themselves in a positive, confident way, needing to feel accepted and respected by adults and their peer groups. Possible negative influences on this aspect of wellbeing are considered in this section, including disability; having problems with weight, body image or other aspects that may set them apart from their peer group; not being in education employment or training (NEET); being pregnant; smoking and drinking; belonging to a vulnerable group, such as gypsy and traveller communities, asylum seekers or an ethnic minority; and those with sexual identity issues. Bullying is an important factor, with children from more vulnerable groups being especially susceptible. [Children's Society 2012]

2.1 Children with disabilities, ill-health and special educational needs

Childhood disability prevalence is not consistently defined between health and social care agencies. There is variation between definitions of disability, therefore national estimates and survey data are used to extrapolate local disability prevalence. According to the Office for National Statistics [ONS] there are an estimated 0.7 million disabled children in the UK Boys are more likely than girls to be disabled. Children under five are less likely to be counted. ONS estimates 42.3 per 1,000 children who are disabled. The Thomas Coram Research Unit [TCRU] estimate is slightly lower, at 40.3 per 1,000. Using these figures and the 2011 census population the prevalence of under-18 disability in Cumbria is estimated to be between 4,100 and 4,300.

2.1.1. Cumbria disability prevalence

Table 8: Disability prevalence estimates, 0-18 years

	ONS	TCRU
Estimated rate	***42.3/1,000***	***40.3/1,000***
Allerdale	840	800
Barrow in Furness	640	610
Carlisle	950	900
Copeland	620	590
Eden	440	420
South Lakeland	830	790
Cumbria	4,310	4,100

Source: ONS population data/TCRU

The TCRU survey estimates nationally different types of disability: however this data is from 2008.

Table 9: Type of disability, rates per 1,000 children under 18

Type of disability	Rate per 1,000
Physical disability	2.7
Sensory impairment	1.8
Chronic illness	1
Life limiting illness	4.7
Other disability	
Interaction and communication	6.1
Cognition and learning	12.3
Emotional/behavioural	5.3
Mental Health	6.5
Total	40.3

Source: TCRU, 2008

Data on disability benefits claimed is available, however this information should be treated cautiously as claimant data usually underestimates disabled children within families and the 2013 welfare reforms will change the basis of entitlement. It has been suggested that almost 1 in 4 children whose family are in receipt of disability benefit (24%) are believed to have an emotional disorder [ONS, 2005].

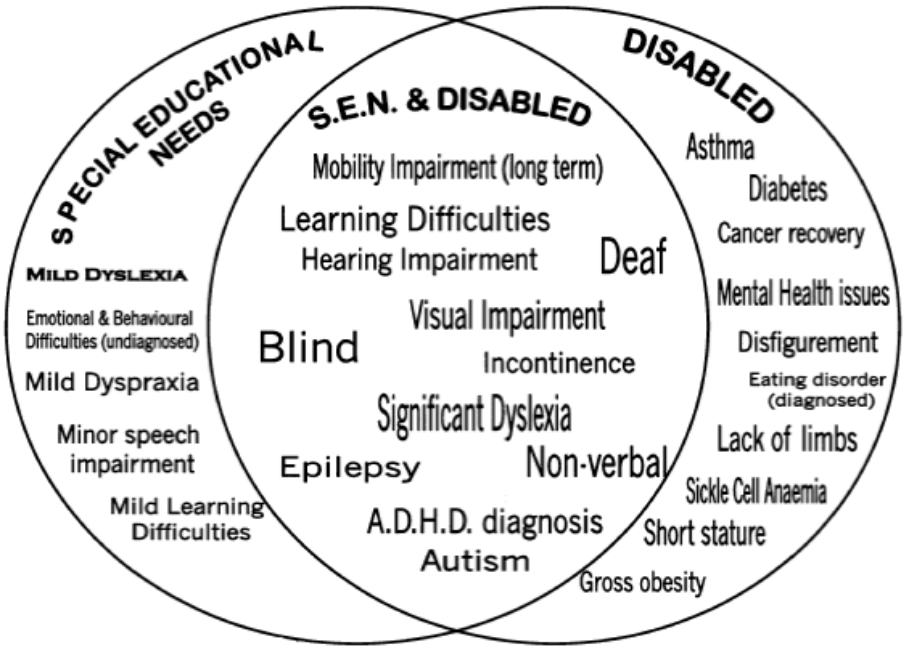
2.1.2. Learning disability and children with special educational needs (SEN)

The definition of learning disability is the presence of significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence), reduced ability to cope independently (impaired social functioning) commencing before adulthood and with a lasting effect on development. [DH, 2001] Learning disability is the category with the greatest proportion of people and aJSNA exercise dedicated to learning disability in Cumbria is being undertaken.

Children are considered to have special educational needs if they have a learning difficulty which requires extra educational support or provision to be made for them. Figure 3 illustrates the relationship between special educational needs and disability. Many children with special needs will also be disabled as defined by the Disability Discrimination Act (DDA). However, not all children with special educational needs are defined as learning disabled, e.g. those with mild learning difficulties. Similarly, not all those defined as disabled under DDA have special educational needs.

Some children with the most severe special educational needs have statements which formally describe the special help the child should receive – mostly by increased existing support already available in a mainstream school. This support is provided at two levels: School Action (SA) and School Action Plus (SA+). In Cumbria, the children's services inclusion team provides support and advice to schools and to parents of children with SEN. The team includes educational psychologists and specialist advisory teachers as well as officers receiving advice and input from partner agencies, notably health, to determine the additional support to be provided for children with a statement.

Figure 3: The relationship between special educational need and disability



Evidence suggests significant links between learning disability and emotional health and wellbeing, such as:

- children with learning disabilities are three to four times more likely to have behavioural problems than peers without a disability
- around 40% prevalence of diagnosable mental disorder within the learning disabled population of children, young people and adults
- 10% of children with referred mental health problems have a learning disability; around 50% of whom live in poverty
- learning disability is more prevalent among some minority ethnic groups
- Higher levels of absenteeism are likely among children with special educational needs, [TCRU, 2007, Redmond and Hosp, 2008]

2.1.3. Cumbria data: special educational needs

Nationally, around 1 in 5 children (19.8%) have special educational needs (DfE, 2012; ONS, 2000).
In Barrow there are more children with SEN as a proportion of all school children than the national average. Table X. shows that in Allerdale, Carlisle, Copeland and South Lakeland proportions are lower than the national average and the North West average of 19.2%. In children with more severe special educational needs (i.e. SEN with a statement): proportions are higher than the national average and North West averages in Barrow in Furness and South Lakeland.

The proportions who have SEN but without a statement are higher than national average (17%) and North West (16.4%) averages in Barrow in Furness ,but less than the national and North West averages in Allerdale, Carlisle, Copeland and South Lakeland .

For primary school pupils with statements of SEN or at School Action Plus by type of need, Cumbria is below the national (20.3%) and North West (22.0%) average for pupils with moderate

learning difficulties at 13.9%. Cumbria is below the national (18.4%) and North West (18.5%) average for pupils with behavioural, emotional and social difficulties at 16.1%. Cumbria follows the national (1.3%) and North West (1.5%) average for pupils with a visual impairment at 1.3%; and follows the national average (2.3%) and North West average (2.0%) for pupils with a hearing impairment at 2.5%. Cumbria is in line with the national average (4.2%) and North West average (5.3%) for pupils with physical difficulties at 4.1%, and also follows the national (30.6%) and North West (26.2%) average for pupils with speech, language and communication difficulties at 29.2%. Cumbria is above the national average (7.8%) and North West average (6.8%) for pupils with an autistic spectrum disorder at 8.8%; and is above the national (1.3%) and North West (1.3%) average for pupils with severe learning difficulties at 2.8%. Cumbria is above the national (9.1%) and North West average (11.0%) for pupils with specific learning difficulties at 13.4%.

For secondary school pupils with statements of SEN or at School Action Plus by type of need, Cumbria is below the national (21.6%) and North West (23.0%) average for pupils with moderate learning difficulties at 12.0%. Cumbria is also below the national (15.8%) and North West average (17.0%) for pupils with specific learning difficulties at 8.2%. Cumbria is below the national (27.7%) and North West (25.2%) average for pupils with behavioural, emotional and social difficulties (at 25.0%. Cumbria is below the national (1.5%) and North West (1.6%) average for pupils with a visual impairment at 0.9%. Cumbria is above the national average (2.9%) and North West average (3.0%) for pupils with a hearing impairment at 3.7%; and above the national average (3.9%) and North West average (4.2%) for pupils with physical difficulties at 6.1%. Cumbria is above the national (10.1%) and North West (8.5%) average for pupils with speech, language and communication difficulties (at 14.8%. Cumbria is above the national average (9.8%) and North West average (8.7%) for pupils with an autistic spectrum disorder at 18.5%; and also above the national (0.9%) and North West (1.0%) average for pupils with severe learning difficulties at 4.6%.

Table 10: Special educational needs, January 2012, numbers: source: Cumbria County Council

	Special Educational Needs					
District	**No SEN**	**School Action**	**School Action+**	**Statemented**	***All SEN***	**Total pupils**
Allerdale	11,962	1,754	455	291	*2,500*	14,462
Barrow in Furness	7,871	1,298	461	360	*2,119*	9,990
Carlisle	12,206	1,743	587	393	*2,723*	14,929
Copeland	7,828	1,005	414	260	*1,679*	9,507
Eden	5,948	905	229	161	*1,295*	7,243
South Lakeland	12,204	1,362	530	453	*2,345*	14,549
Cumbria Total	58,019	8,067	2,676	1,918	*12,661*	70,680

Table 11:		SEN by classification			
District	**No SEN**	**School Action**	**School Action+**	**Statemented**	***Any SEN***
Allerdale	82.7	12.1	3.1	2.0	*17.3*
Barrow in Furness	78.8	13.0	4.6	3.6	*21.2*
Carlisle	81.8	11.7	3.9	2.6	*18.2*
Copeland	82.3	10.6	4.4	2.7	*17.7*
Eden	82.1	12.5	3.2	2.2	*17.9*
South Lakeland	83.9	9.4	3.6	3.1	*16.1*
Cumbria Total	82.1	11.4	3.8	2.7	*17.9*

2.1.4. Links between special educational needs [SEN] and mental health conditions

One in ten children in the general population is likely to have a mental health condition: in those with SEN around a quarter are likely to suffer poor mental health. Applying these proportions to the local population shows an estimated 3,118 children with SEN who are likely to have a mental health condition in Cumbria, [see table 12 below]. Of those with SEN statement approximately 825 would be likely to have a mental health condition.

Table 12: Estimated prevalence of mental disorders amongst pupils with SEN in Cumbria

	Statemented		**Any SEN**	
	Number	**Estimated number with a mental disorder (43%)**	**Number**	**Estimated number with a mental disorder (24.63%)***
Allerdale	291	125	2,500	616
Barrow in Furness	360	155	2,119	522
Carlisle	393	169	2,723	671
Copeland	260	112	1,679	414
Eden	161	69	1,295	319
South Lakeland	453	195	2,345	578
Cumbria	**1,918**	**825**	**12,661**	**3,118**

Source: DfE 2012, ONS, 2000

*calculated using ONS, 2000 table 8.3 and totalling the prevalence form all SEN stages

2.2 Evidence based good practice

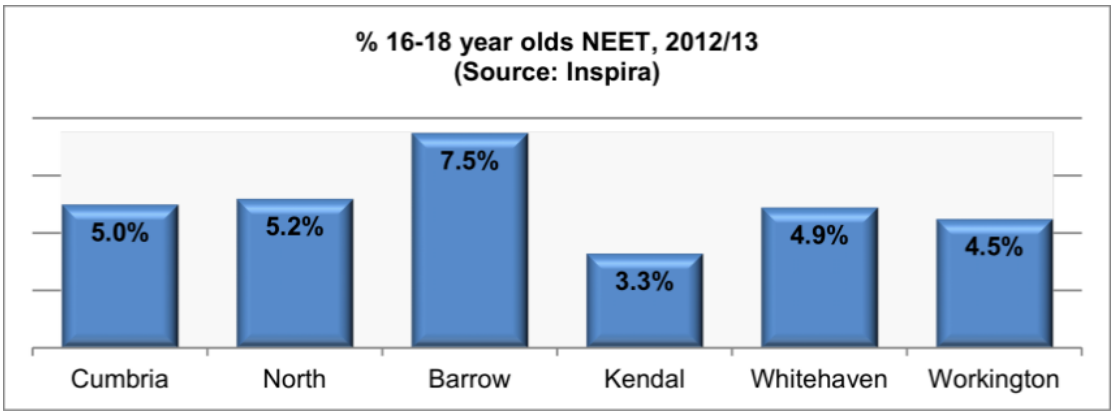
Planning and improving services for disabled children requires accurate, comprehensive data that all agencies can share.

A Children and Families Bill that builds on the Green Paper "*Support and Aspiration: A new approach to special educational needs and disability*" [DfE, 2011] is currently in parliament. This is intended to provide the most significant change to the way we support children with SEN for 30 years. Key changes proposed include the replacement of School Action and School Action Plus with a single category of SEN. Statements are due to be replaced by education, health and care plans, and local authorities will need to produce a local offer of what they *expect* to be available for children with SEN. Health services will also have a duty to make provision and new rights and protections for young people up to the age of 25 are envisaged.

Young people not in education, employment or training (NEET)

Being in education, employment or training between the ages of 16-18 has been shown to increase a young person's resilience and is essential to their future employability and wellbeing. Conversely, having NEET status can be a predictor of later unemployment, low income, teenage motherhood, depression and poor physical health. [ChiMat 2012]. Figure 4 shows young people who were NEET in Cumbria during 2012/13: levels vary across the county with Furness having the highest level at 7.5% and South Lakeland the lowest at 3.3%.

Figure 4: proportion of young people NEET, 2012/13:



Source: Inspira

2.3 Pregnant teenagers

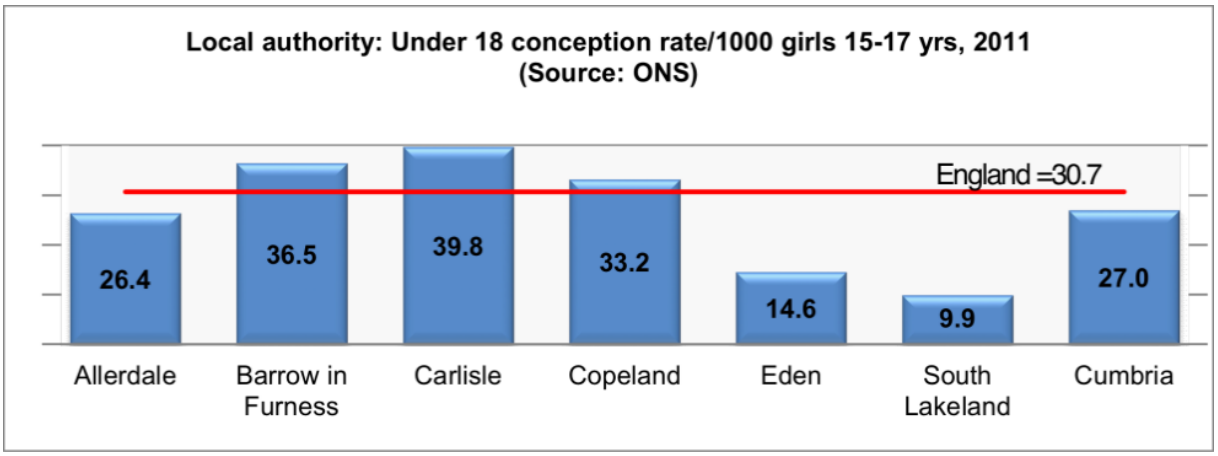
Low levels of emotional health and wellbeing are both a cause and a consequence of teenage pregnancy, which can have a detrimental effect on long term outcomes. [Swann et al, 2003]

Particularly vulnerable groups include:

- Looked after children: at greater risk than other groups
- People with mental health problems have rates more than twice those of their peers
- Young people in the youth offending system: twice as likely to become a teenage parent
- Pregnancy terminations: Coleman [2006] found that adolescent girls who abort unintended pregnancies are more likely to seek help for emotional problems.

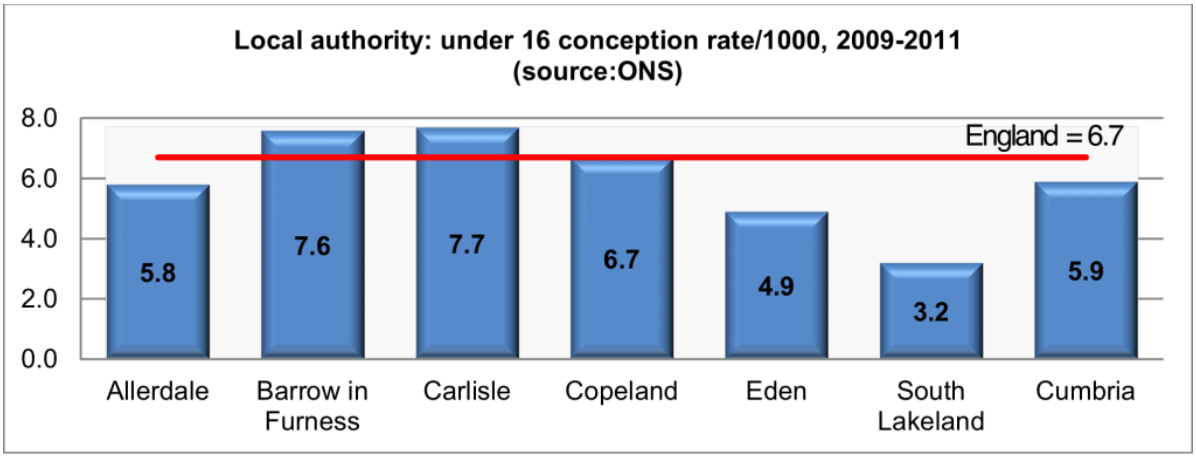
Figure 5 below shows the under-18 conception rate per 1,000 for 2011. With a rate of 27.0 per 1,000 Cumbria is below the national average rate of 30.7 conceptions per 1,000. However, Carlisle, Barrow and Copeland districts have teenage pregnancy rates above the national average.

Figure 5: Under 18 conception rates/1000, 2011



The under-16 conception rate per, 1000 for 2009-2011 is shown in figure 6 below. With a rate of 5.9 per 1,000 Cumbria is below the national average of 6.7 per 1,000. Carlisle and Barrow districts have under-16 conception rates above the national average.

Figure 6: Under-16 conception rates/1,000 2009-2011



Under-18 conceptions in Cumbria during 2011 are shown in table 13 below. Alongside is the proportion of conceptions that were terminated. Overall slightly less than half (49%) pregnant under-18s terminate the pregnancy, a figure similar to the national average.

Table 13: Number of conceptions and % leading to abortion in those aged under-18, 2011

	Number of conceptions in 2011	% of conceptions leading to abortion	Number conceptions leading to abortion in 2011
Allerdale	46	50.0	23
Barrow in Furness	49	30.6	15
Carlisle	72	55.6	40
Copeland	39	46.2	18
Eden	13	*	*

South Lakeland	18	*	*
Cumbria	**237**	**49.0**	**116**
England		49.0	
*figures base on counts of less than 5 have been suppressed by ONS			

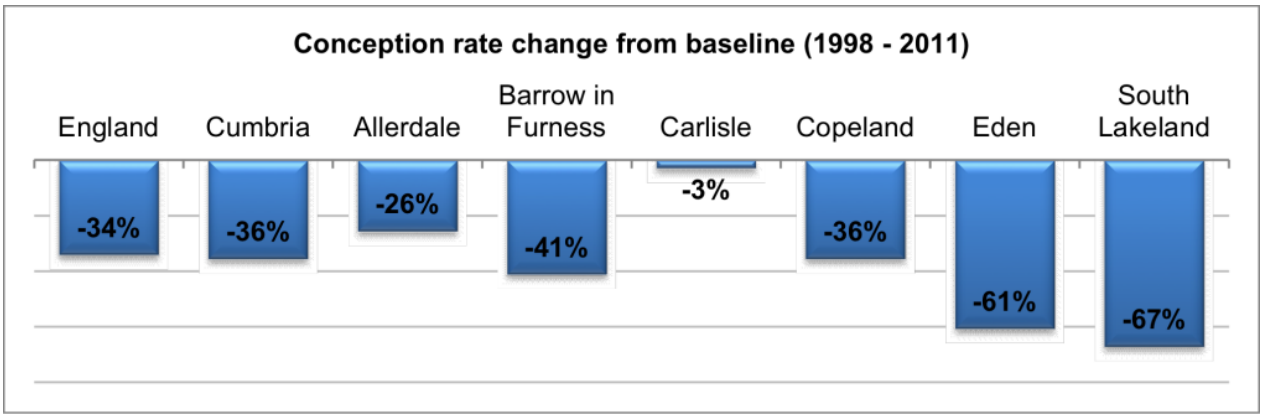
Under-16 conceptions in Cumbria between 2009-2011 are shown in table 14. Alongside this is the proportion of conceptions that were terminated. In Cumbria 61% of young women under 16 terminated their pregnancy: broadly similar to the national average. Allerdale district has the highest abortion rate of 72.4%; Barrow has the lowest at 53.3%.

Table 14: Number of conceptions and % leading to abortion in those aged under-16, 2009-11

	Number of Conceptions Between 2009-11	**Percentage of conceptions leading to abortion**	**Number of conceptions leading to abortion between 2009-11**
Allerdale	29	72.4	21
Barrow in Furness	30	53.3	16
Carlisle	40	55.0	22
Copeland	24	*	*
Eden	13	*	*
South Lakeland	18	61.1	11
Cumbria	154	61.0	94
England		61.1	
*figures base on counts of less than 5 have been suppressed by ONS			

Figure 7 shows the trend in under-18 conceptions since the '*National Teenage Pregnancy Strategy*' was launched in 1999. In Cumbria the rate has generally been below the national average and shows a downward trend: all areas show a decrease in conceptions when 2011 is compared with the baseline year of 1998. However reductions in conception rates are not evenly distributed.

Figure 7: Conception rate change, 2011 compared with baseline (1998)



The Cumbria multi-agency teenage pregnancy strategy partnership group has produced a draft strategy due for approval in 2014.

2.4 Migrant populations

Migrant populations such as asylum seekers are likely to experience poverty, and a lack of cohesive social support. Children and young people could be in vulnerable situations with adults unfamiliar to them. They may have experienced extreme violence or cruelty. [Connelly et al. 2006] Such factors can undermine both physical and mental health. Communication is also likely to be a barrier in accessing health care. Rates of mental health problems in particular migrant groups, and subsequent generations, can be higher than in the general population. [DH, 2011]

During 2011 there were 14 asylum seeker families in Cumbria: some may have dependent children.
NICE recommends:

- Good assessment of emotional health and wellbeing and access to specialist services
- Primary prevention including high quality placements, establishing meaningful and long lasting relationships with adults, establishing friendships networks, culturally relevant networks including those that meet religious, dietary, dress beliefs and needs
- Advice, advocacy and links with community networks, contact with or information about family and friends in the country of origin may also be crucial.

2.5 Gypsy, Roma and Traveller children

Gypsy, Roma and Traveller children have the worst education outcomes of any ethnic group in the UK and high rates of school non-attendance and exclusion. This is likely to have an impact on social inclusion, achievement and mental health across the life course. [Ridge, 2010]
There is little published literature on the mental health needs of travelling children. A study of the health status of adult Gypsy/Travellers in Sheffield found that the proportion reporting any problems with 'nerves' or 'feeling fed up' was significantly greater than a matched comparison group of urban deprived residents (35% compared to 19%). Communities have cultural identity, and traditions such as gender roles: for example boys may begin to work in their early teens. There are cultural and societal values around many aspects of health and education. [Van Cleemput and Parry, 2001]

A 2009 health needs assessment of Cumbria Gypsy and Traveller communities in Cumbria highlights significantly poorer health with prevalence of mental health problems appearing

considerably higher than in the North West region and England. The report highlights access to education as a significant issue, and relatively good registration with GPs.
Countywide there are approximately 770 families across four official Traveller sites: two in Carlisle, one in Eden and one in Furness. This is likely to underestimate the true population. Estimates from the Cumbria Traveller Family Support Service indicate that there may be up to 5,000 Travellers staying in Cumbria at any given time.

2.6 Sexual orientation

The School Report found that 60% of lesbian, gay and bisexual young people feel there are no adults with whom they can discuss their sexual orientation. Homophobic bullying was found to be the most frequent form of bullying, being three times more prevalent than bullying due to religion or ethnicity, causing absence from school and lowering self-esteem, attainment and aspirations. There are wide variations in prevalence estimates of sexual orientation in adults. Around 1.5% to 6% of the adult population is estimated to be lesbian, gay or bi-sexual; whereas sexual orientation in adolescents is considered to be less stable. [Joloza et al, 2010]
Recommendations for adults supporting those who are lesbian, gay and bisexual include:

- avoid making assumptions about young people's sexuality
- positive response when young people reveal their sexuality
- work with parents and carers to protect young people from bullying and aggression
- provide access to resources and information. [Stonewall 2007]

2.7 Ethnicity

ONS indicates some variation in mental health by ethnicity: children aged 5-10 who are white, Pakistani or Bangladeshi appear more likely to have a mental disorder. Indian children are least likely to have such problems. Overall estimated prevalence rates for ages 5-16 are shown in table 15.

Table 15: Prevalence of mental disorders by ethnicity, ages 5-16

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

Source: ONS, 2005

Cumbria data: ethnicity

Table 16: ethnic population aged 0-19 years

	Allerdale	Barrow in Furness	Carlisle	Copeland	Eden	South Lakeland	Cumbria	England
White	20,553	15,524	23,222	14,980	10,718	19,752	104,749	
% white	***98.4%***	***97.8%***	***97.3%***	***97.7%***	***98.3%***	***96.7%***	***97.6%***	***78.9%***
Mixed/multiple ethnic group	215	158	238	146	108	336	1201	
Asian/Asian British	103	160	349	195	67	272	1146	
Black/African/ Caribbean/Black British	8	16	38	6	2	44	114	
Other ethnic group	8	15	24	7	9	27	90	
Non-white total	**334**	**349**	**649**	**354**	**186**	**679**	**2,551**	
% non-white	***1.6%***	***2.2%***	***2.7%***	***2.3%***	***1.7%***	***3.3%***	***2.4%***	***21.1%***
Total	20,887	15,873	23,871	15,334	10,904	20,431	107,300	

Source: Census 2011

In Cumbria 2.4% of the population aged 0-19 can be categorised as non-white. This compares with 21% of the population of England. South Lakeland has the highest proportion, 3.3%, of children and young people from an ethnic background: Allerdale at 1.6% has the smallest proportion.

Evidence based good practice

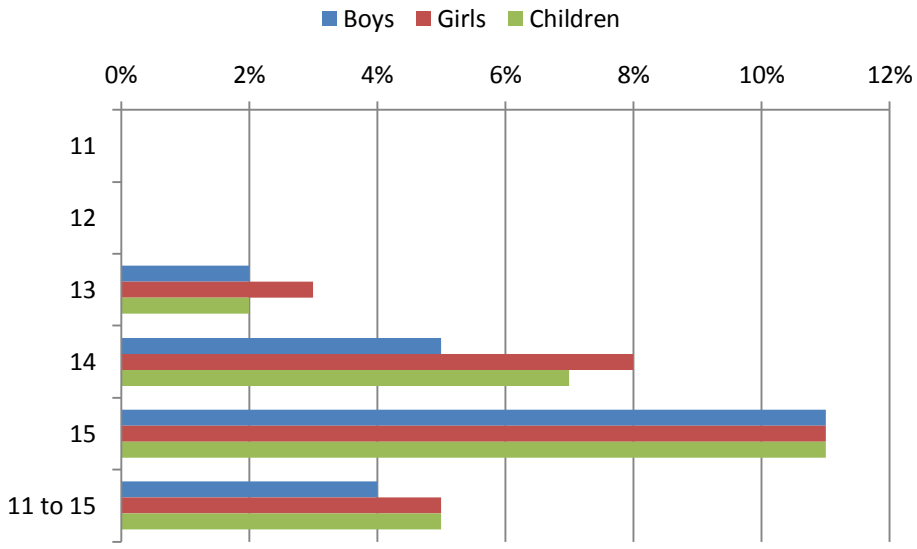
- Provide support to children and young people relevant to specific cultural situations
- Compile profiles based on ethnicity and assess service availability and appropriateness. [TCRU, 2007]

2.8 Risk-taking behaviour

2.8.1 Smoking

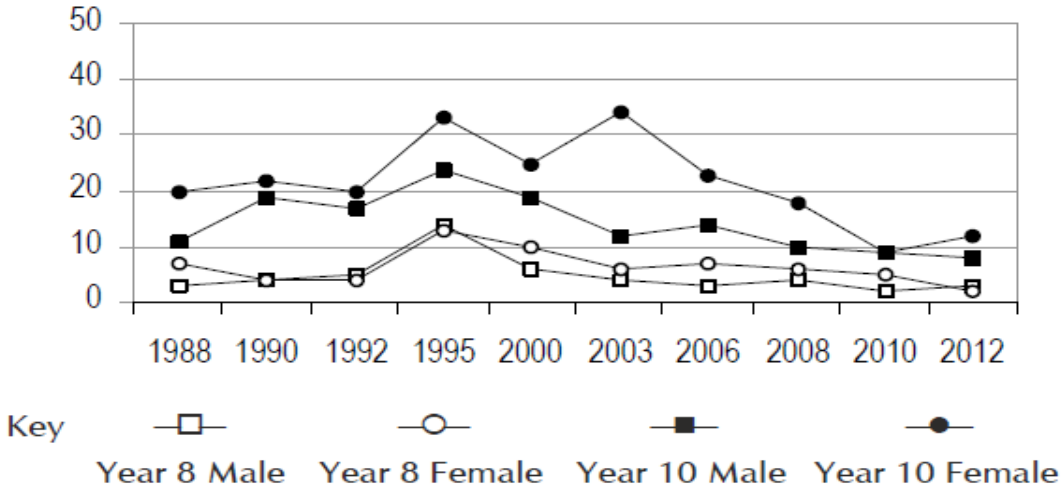
It is estimated that every year more than 200,000 children in the UK start smoking (*Childhood smokers*, Cancer Research UK, 2013). Regular smoking is defined as at least one cigarette a week. Occasional smokers consumed on average 3.5 cigarettes a week. By the age of 15, approximately 11% of children in England report being regular smokers [see fig 7]. Figure 8 shows the self-reported smoking status to be slightly lower in boys and higher in girls.

Figure 7: Percentage of children smoking regularly by age, England, 2011



Source: The NHS Information Centre for Health and Social Care. Smoking, Drinking and Drug Use among Young People in England in 2011. 2012.

Figure 8: Percentage of secondary pupils smoking in the last week, 1988-2012



Source: Cumbria Health related behaviour survey 2012

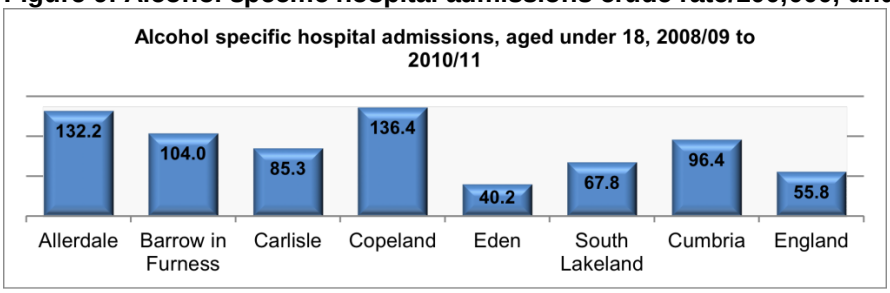
Having parents, siblings and peers who smoke is a factor that encourages children to smoke. Other factors include school truancy, exclusion, and deprivation. Of 11-15 year olds who smoke regularly, it is estimated that 41% could have a mental disorder, as well as 24% of those who drink alcohol at least once a week and 49% of those who use cannabis a least once a month. [MHF, 2007] Those aged 11-15 who smoke are 6 times more likely to develop serious psychological distress. [Freer et al, 2010]

2.8.2 Alcohol

Problem or harmful drinking has implications for physical and mental health: 24% of 11-15 year olds drinking alcohol at least once a week are likely to have a mental disorder. [MHF 2007] Children whose parents regularly drink are twice as likely to consume alcohol. [Bremmer et al, 2011].

Local data is from the Local Alcohol Profiles for England: shown in figure 9. This suggests that the numbers of under-18s admitted to hospital with an alcohol specific condition indicates a significant public health concern particularly in Allerdale and Copeland.

Figure 9: Alcohol specific hospital admissions crude rate/100,000, under 18, 2008/09-2010/11:



Source: Local Alcohol Profiles England

2.8.3 Substance misuse

Nationally, the prevalence of drug use by young people aged 11 to 15 is estimated to have declined from 29% in 2001 to 17% in 2011. [NTA 2011] In 2003, 24% of vulnerable young people reported using illicit drugs frequently during the preceding 12 months, compared with 5% of their less vulnerable peers. There were significantly higher levels of drug use in those who identify with more than one vulnerable group. Persistent substance use is associated with significant mental health risks including anxiety, depression, memory or cognitive loss, psychosis.

Young people using cannabis by the age of 15 are 3 times more likely to develop serious mental health conditions including schizophrenia. Of those aged 11-15 who use cannabis at least once a month, around half (49%) are likely to have a mental health condition. [MHF 2007]

Figure 10: percentages of pupils who had 'ever tried drugs'

	Cumbria	Reference sample
Year 8	3%	1%
Year 10	14%	11%

Source: Cumbria Health Related behaviour survey 2012

Cumbria action on drug and alcohol use

There is a clear need to reduce hospital admissions in some parts of the county, where Cumbria's rate is significantly higher than the England average and the countywide multiagency alcohol strategy seeks to improve prevention, detection and early intervention services for young people.

NICE recommendations for alcohol misuse include: education, school-based interventions and specialist referral where young people are considered at risk of harmful drinking. [NICE 2007]

2.9.4 Eating disorder and body image

Prevalence of eating disorders and related body image problems is difficult to estimate, due to poor data, though survey results from Nicholls et al [2011] giving a snapshot of treatment in 35 acute hospitals in England indicate that around 2000 children of whom 600 were under 13 were treated in these centres between 2008-2011 . Anorexia has the highest mortality rate and suicide is also a high risk. NICE [2004] suggest that 20% of anorexia sufferers will die prematurely from their illness. Bulimia is also associated with severe medical complications, and binge eating disorder sufferers often experience the medical complications associated with obesity.

NICE clinical guidelines [2004] recommend family-based interventions, with schools having an important role in promoting positive body image.

2.9.5 Deliberate self-harm

Deliberate self-harm is considered an expression of distress, with a significant and persistent risk of future suicide following an episode of self-harm. NICE defines self-harm as any act of self-poisoning or self-injury irrespective of motivation, not including harm arising from excessive consumption of alcohol or recreational drugs, from starvation arising from anorexia nervosa, or accidental harm Self-harm can be divided into two broad groups: self-poisoning and self-injury. About 80% of people presenting in A&E following self-harm events will have taken an overdose of prescribed or over the counter medicine. [Horrocks et al 2003] Self-injury is present in the teenage population however. Cutting is the most common means; however less common methods include burning, hanging, stabbing, swallowing objects, insertion, shooting and jumping from heights or in front of vehicles. [Hawton et al 2002]

It is estimated that one in fifteen young people in the UK have deliberately harmed themselves. Self-harm is more common between the ages of 11 and 25, although occasionally it can occur in children under 10. [MHF, 2006]
Since many acts of self-harm are unreported and untreated, hospital attendance rates will not reflect true prevalence, however, UK rates of deliberate self-harm appear to be rising: there is also evidence to suggest that rates of self-harm in the UK are higher than anywhere else in Europe. [MHF 2006] Hospital admissions for self-harm in children have increased in recent years, with admissions for girls being much higher than for boys. With links to other mental health conditions such as depression, the '*emotional causes of deliberate self-harm may require psychological assessment and treatment'* (ChiMat child health profiles, 2012).

There is strong association between suicide attempts and childhood sexual and/or physical abuse. [Evans et al. 2005] It is also suggested that depression, substance abuse, deprivation, poor coping and resilience skills, suicidal behaviour by family and friends and in the media increase the risk of suicidal phenomena among children and adolescents. [Fortune et al. 2005] There also appears to be a significant relationship between antisocial behaviours and self-harm among girls, although the relationship is less clear for boys. Among young girls there appears to be a relationship between poor body image, some forms of disordered eating and suicidal phenomena. [Evans 2004] Motives reported by children and young people suggest that wanting to die, self-punishment, and 'escape from bad state of mind' or to stop bad feelings are also important reasons for harming themselves. [Shaffer et al 1996]. Figure 11 shows hospital admissions for self-harm in the North West.

Figure 11: Hospital admissions for self-harm in the North West

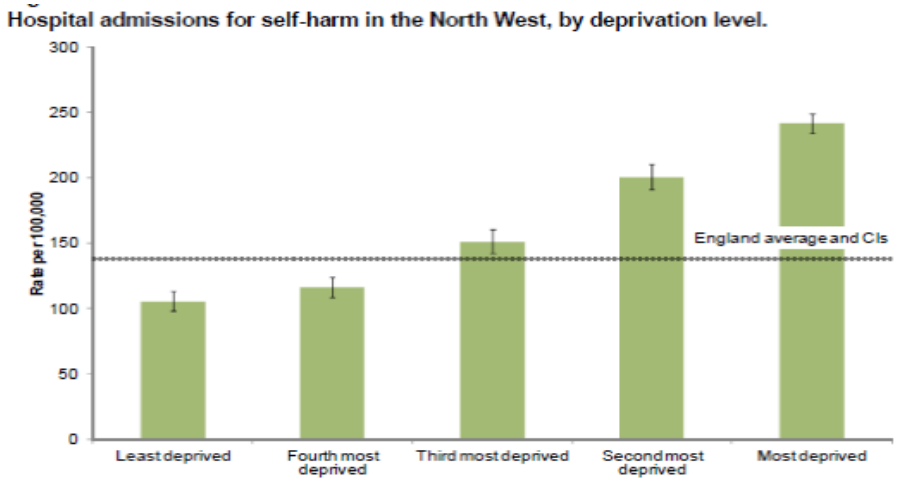


Chart taken from Deacon, 2012: 'Self-harm among children and young people in the North West: the data'

Cumbria self-harm data in under-19s

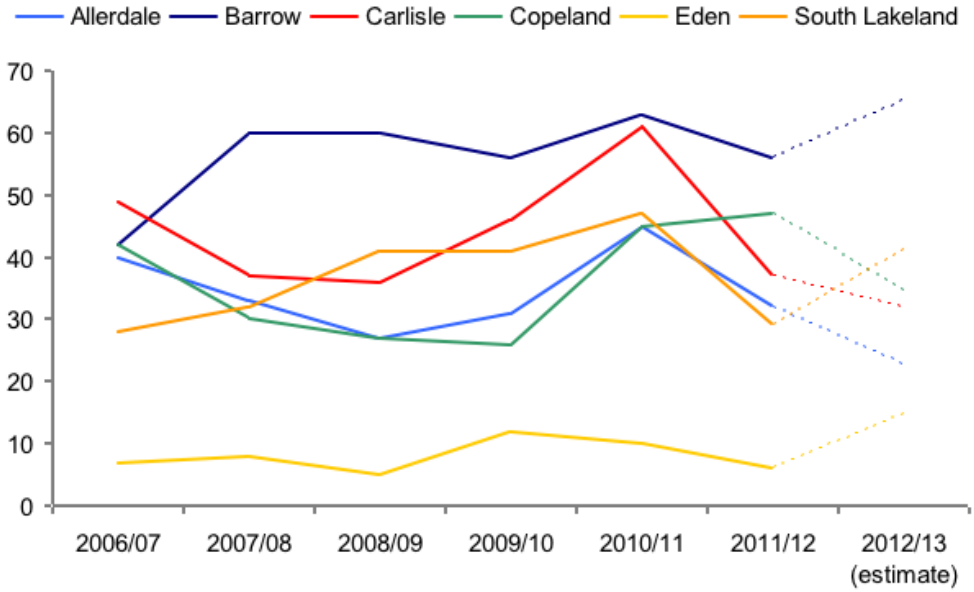
- Hospital admission rate 219/100,000 in 2010/11: by 2012/13 is estimated 175/100,000
- Barrow highest rate in 2011/12 at 307.4 per 100,000
- In 2011/12, 70% of all self-harm admissions were female
- Copeland had the highest rate of female admissions; Barrow of male admissions.
- The most common cause of admission was self-poisoning between 2006/07 and 2011/12
- The general trend of over the counter drug related poisoning is declining
- Most deprived are 2.4 times more likely than least deprived to be admitted to hospital
- Urban areas had a higher rate of admission for self-harm than rural areas
- In 2011/12 there were 299 A&E attendances: a 20% decrease from the previous year.
- Copeland had the highest A&E attendance rate across all localities in 2011/12
- Estimated A&E attendance rates for 2012/13 are likely to show a slight decrease

As shown in figure 12 below, the trend in admissions for self-harm by locality can fluctuate considerably. For example in Carlisle the number increased considerably between 2008/09 and then sharply decreased in 2011/12. Conversely in Copeland, admissions decreased steadily between 2006/07 and 2009/10, and then sharply increased over the next two years.
The estimated numbers of admissions are also included and highlight a predicted increase of admissions in Barrow and South Lakeland.

Evidence based good practice

NICE guidelines for the short and longer term management of self-harm: children and young people need to be assessed for factors such as accommodation, age of the child, circumstances of the child and family, time of presentation to the service, child protection issues, physical and mental health of child including child or adolescent psychiatric inpatient.
Young et al [2007] recommend developing personal coping skills with the individual, and targeting young people who are not in education, employment or training as they are likely to be at greatest risk. It was also found that a large number of young people who self-harm are known to their GP: therefore, additional training and support for GPs is recommended.

Figure 12: Trend of the number of hospital admissions for self-harm in Cumbria by locality, 0-19 years, 2006/07 to 2012/13 (estimate)



Caveat: numbers for 2012/13 are estimates based on nine months of data.
Source: NHS Cumbria Admitted Patients Database

2.9.6 Suicide

The national suicide prevention strategy identifies priority groups for whom a tailored approach is necessary to reduce suicide risk. Children and young people are considered priority particularly young men, looked after children, care leavers and those in the youth justice system. [DH, 2012]

A 2009 NSPCC report based on case notes from *ChildLine*, identified potential risk factors which may increase a young person's risk of attempting suicide. They found that young people who had experienced sexual or physical abuse were at greater risk, as were those bullied at school, experiencing relationship difficulties, in care and those suffering from increased stress. There appears to be a link between suicide in young people and a family history of suicide attempts (Hawton et al, 2006).
Those bereaved by suicide are considered to be at increased risk of suicide - for every suicide it is possible that on average six people suffer intense grief, including children, siblings and friends. This can be intensified and extended in a close environment such as school/college. Counselling, peer support and self-help groups can reduce distress as can training for professionals, modifications to aspects of coroners' inquest procedures that the bereaved find most stressful, and reduced media coverage of suicides. [Hawton and Simkin, 2003]

Suicide statistics do not necessarily reflect levels of wellbeing in a population. Research suggests that suicide continues to be a relatively rare event related to particular circumstance than as an indicator of overall mental health. [UNICEF, 2007] Concern around use of the internet (violence; suicide and suicide methods) and social media raises issues of a safer online environment. Parents, relatives and other adults with responsibility need to be able to recognise and reduce risk. National policy aims to ensure parents have the necessary tools to guard against and protect their children from harmful digital content and supporting them to be safe online. [DH 2012]

Evidence based good practice

Schools, social care organisations, youth justice system, third sector agencies can contribute to suicide prevention. Early intervention is essential to address issues such as bullying, poor body image and low self-esteem. Responsive services such as support for bereaved individuals can be helpful in school settings. Personal, Social, Health and Economic (PSHE) education can provide a framework for schools to provide age–appropriate teaching on issues including sex and relationships, substance misuse and emotional and mental health. This and other school-based approaches may help all children to recognise, understand, discuss and seek help earlier for any emerging problems. [DH 2012]

An effective school-based suicide prevention strategy would include:

- a co-ordinated school response to people at risk and staff training
- awareness to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond
- signposting to sources of information on signs of emotional problems and risk
- clear referral routes to specialist mental health services.

There were 10 child deaths in the North West in 2009/10 provisionally identified as an apparent suicide [CMACE, 2011].

Cumbria's suicide prevention strategy is being refreshed in 2013 and extracts from the draft document are included below:

Suicides in children and young people, while rare, are particularly tragic and have far-reaching effects on families, friends, communities, and those providing support and care. Cumbria's Local Safeguarding Children's Board (LSCB) has identified emotional health and wellbeing, suicide prevention and self-harm as priorities.

Recent actions to help prevent suicides in Cumbria, with particular reference to young people, include:

- *In response to a serious case review, information and good practice guidance about suicide and self-harm in children and young people was produced by a multi-agency task and finish group from the NHS, children's services and the third sector. This was posted on the Cumbria LSCB website and is available at: www.cumbrialscb.com/newsdetails.aspx?newsid=76*

.

- *CPFT CAMHS have recently been reviewed and are undergoing significant re-structure.*
- *Improving Access to Psychological Therapies (IAPT) – CPFT First Step Service is planning to extend its service to children and young people.*
- *Cumbria County Council children's services launched a new county triage service in 2012, which provides a single point of access for reporting safeguarding concerns about children and young people.*
- *CCC children's services senior education psychologist has recently delivered suicide/self-harm training sessions across the county for front-line workers and school staff.*
- *after consultation with schools and third sector organisations, CCC children's services commissioned Young Minds to deliver training sessions for school staff and front-line workers around self-harm, suicide, parental mental health and its impact on children.*
- *Use (and abuse) of social media is an area of increasing concern. Cumbria Constabulary regularly monitor internet and new media content for anything that may put children and young people at risk of suicide. They have also initiated dialogues with young people (either directly or using friends as third party intermediaries under police supervision) when a friend or contact has noticed that they are in distress on Facebook, to help identify their whereabouts.*

 Some secondary schools in South Lakeland are looking to set up 'Cybermentors', a national initiative established by BeatBullying (the UK's leading bullying prevention charity). Young people aged 11-17 receive two days intensive face-to-face training by BeatBullying staff which gives them the skills and confidence to mentor offline (in their school or community) and online (on the Cybermentors website). Once graduated, they mentor, guide, and support other young people on issues of bullying, cyberbullying and wellbeing. More information about the initiative can be found at http://archive.beatbullying.org/dox/whatwe-do/cybermentors.html.

Post suicide intervention response
The tragic death of a school pupil in early 2013 triggered immediate concerns about possible suicide contagion (or 'copycat' suicides) within the local and wider community. A multi-agency emergency response included the following:
 ***Establishing 'circles of vulnerability'.** A mapping exercise was carried out to systematically identify vulnerable individuals at increased risk of suicide, self-harm or destructive behaviour as a consequence of the incident. This was then used as a tool to target and prioritise interventions and support.*
 ***Enhanced service support: k**ey support agencies (both statutory and third sector) increased their capacity and/or availability to support young people, parents and school staff impacted by this tragic incident.*
 ***Providing national and local resources and further sources of support: i**nformation and advice on issues such as bereavement, self-harm, bullying, eating disorders and exam stress. The Department of Health booklet, Help is at Hand: a resource for people bereaved by suicide and other sudden, traumatic death was also made available.*
 ***Enhanced data surveillance.** In order to assess the on-going level of suicide risk in Cumbria, 'real-time' information was gathered and shared with responding agencies. This was a short-term measure, but it may be incorporated into the development of a future protocol for post suicide intervention in Cumbria.*

Cumbria children's services directorate commissioned resilience projects in 2012 and 2013 and the details of these programmes are in appendix 4.

3 Having enough of what matters

Children's wellbeing is affected by 'having enough' and 'fitting in' rather than being materially affluent. As part of their national child wellbeing survey, a 'deprivation index' was developed by the Children's Society, consisting of items with the strongest associations with wellbeing, such as:

- having access to a garden or outdoor space
- clothes and belongings to 'fit in' with friends
- excursions with the family.

Children lacking three or more of these items are three times more likely to experience low levels of wellbeing. [Children's Society, 2012, 2013]

3.1 Child poverty

Child poverty is one of the key risk factors for poor emotional health and wellbeing and is defined as the proportion of children living in families in receipt of out-of-work benefits or tax credits where income is less than 60% of median income. [HMRC 2011] Children in poor households are three times more likely to have mental health problems than those in more affluent households. [MHF,

2007] UK children living in "severe poverty" rose by 260,000 in 2004-08, to 1.7million. Currently there are an estimated 3.5 million children living in poverty in the UK, a figure expected to rise by 400,000 by 2015. [Save the Children, 2012]

A national survey of low income families, found that children with low income families tend to lack material items: daily essentials such as food, warm homes, clothes and shoes and also family holidays, access to leisure, internet and social interaction:

- one in seven of the poorest children go without a winter coat and new shoes
- nearly a fifth of children living in poverty miss school trips
- children worry about their family not having enough money
- almost 25% of poor parents argue or snap at their children because of money trouble
- in households where neither parent is working one in five children has emotional disorder [ONS, 2005] [Save the Children, 2012]

3.1.1 Cumbria child poverty data

Cumbria's child poverty estimates are shown in table 17 with Barrow having an estimated 22%, compared with South Lakeland's estimated 8% of children in poverty. Caution must be exercised when interpreting because changes to benefits as a result of the welfare reforms in 2013.

Table 17: Children by age group living in all out-of-work benefit claimant households, May 2011: source ONS

	0-4	5-10	11-15	16-18	0-15	0-18	Number of Households
Allerdale	1,020	950	770	400	2,750	3,150	1,780
Barrow-in-Furness	1,070	1,070	930	420	3,070	3,500	1,950
Carlisle	1,250	1,160	840	350	3,250	3,600	2,030
Copeland	830	760	640	280	2,230	2,510	1,460
Eden	210	270	190	70	670	740	410
South Lakeland	440	450	380	190	1,270	1,450	830
Cumbria	4,820	4,660	3,750	1,710	13,240	14,950	8,460

3.1.2. Children in single parent households

Lone parent families are among the most disadvantaged groups in society. [Whitehead et al, 2000]: Approximately 25% of all dependent children live in single parent households compared to 12% in 1971. Poverty rates for single parents who are working are 23% part time and 18% full time; 41% of children in single parent households are poor compared to 2% of children in families with two adults;43% of social housing tenants are single parents, compared with 12% of couples with children. [ONS 2011, DWP, 2010]

Children from single-parent family units are considered to be twice as likely to suffer mental health problems. A family's type of accommodation is also influential, with 17% in the social sector, 14% in the private rented sector and 7% of home owners affected by poor mental health within the family. [ONS, 2005]
Table 18 shows lone parent households with dependent children in Cumbria: a higher proportion overall than the English average. The 2011 census shows 10.7% or nearly 12,600 lone parent households in the county with Carlisle having the greatest proportion (24%) and Eden the least

(8%). In terms of gender there are slightly more male lone parents at 10.7% compared with the national average of 9.7%. At 12.7% Eden district has the highest proportion of lone male parents.

Clearly poverty and material deprivation are significant issues in some parts of Cumbria. The areas of higher socio-economic deprivation are shown on the population map in appendix 5. However smaller areas of deprivation within relatively affluent districts, and the complex factors linked to rural deprivation are important considerations for service provision. It is expected that the greatest need for all tiers of service are present in these areas.

Although precise referral, diagnostic and caseload data are not available, it is expected that the link between poverty and poor emotional health and wellbeing causes demand to be higher and that gaps in some services leads to significant unmet need.

Case study: Love Barrow Families

Love Barrow Families is a two year pilot working with 60 complex families to improve their life outcomes whilst reducing the resources to support those families in the medium /long term. Also to provide a catalyst for the future integration of services between Health and social care: from cooperation at senior management level to coproduction of services with families, professionals and the local community.
The project will provide a whole team approach “think family" to work with families who face complex problems including safe guarding. Love Barrow Families has been codesigned by Barrow families and workers. The project will join together adult and children's services in one location. We work with assets ... expecting families to give as well as receive

Table 18: Lone parent households with dependent children: source ONS

	All lone parent households with dependent children					
	Male	*% of total*	Female	*% of total*	**Total**	***% of household in Cumbria***
Allerdale	253	*10.1%*	2,254	*89.9%*	**2,507**	*20%*
Barrow in Furness	259	*10.9%*	2,111	*89.1%*	**2,370**	*19%*
Carlisle	330	*10.8%*	2,725	*89.2%*	**3,055**	*24%*
Copeland	181	*10.1%*	1,607	*89.9%*	**1,788**	*14%*
Eden	126	*12.7%*	867	*87.3%*	**993**	*8%*
South Lakeland	197	*10.5%*	1,683	*89.5%*	**1,880**	*15%*
Cumbria	**1346**	***10.7%***	**11,247**	***89.3%***	**12,593**	
England	151,744	*9.7%*	1,412,937	*90.3%*	**1,564,681**	

Table 19: Lone parent households with dependent children by employment status: source ONS

	Part time		Full time		Unemployed		Total
	No	***% of total***	**No**	***% of total***	**No**	***% of total***	No
Allerdale	1,023	*41%*	602	*24%*	882		2,507
Barrow in Furness	888	*37%*	533	*22%*	949	*35%*	2,370
Carlisle	1,226	*40%*	782	*26%*	1,047	*40%*	3,055
Copeland	637	*36%*	422	*24%*	729	*34%*	1,788
Eden	464	*47%*	321	*32%*	208	*41%*	993
South Lakeland	885	*47%*	563	*30%*	432	*21%*	1,880
Cumbria	5,123	*41%*	3,223	*26%*	4,247	*23%*	12,593
England	522,789	*33%*	407,873	*26%*	634,019	*34%*	1,564,681

4 Positive relationships with family and friends

The Children's Society [2012] finds the strongest link with poor mental health and wellbeing to be when children experience weak attachment, bonding and lack of nurturing relationships within their family or with their principal carers. Stable positive relationships with family and wider social group are of paramount importance to good mental health. Children at greatest risk of experiencing problems include those looked after and those whose parents cannot establish a strong bond from early in their lives: such as those with mental health or related problems. Also at greater risk are young children whose parents are absent from their lives for extended periods such as those in prison.

4.1 Looked after children

The national mental health strategy '*No health without mental health'* [DH, 2011] notes that in England 0.5% of all under 18 year olds are looked after, with 72% living in foster placements. The most common reason for a child being looked after is abuse or neglect, which accounted for nearly 60% of all cases nationally in 2011. The next most common reason is 'family dysfunction' (14%). Disability or illness of child or parent causes 7.5% of care cases.

Entering care is strongly associated with poverty and deprivation and effects often persist into adulthood. Many who are looked after experience significant health inequalities throughout childhood: on leaving the care system they are likely to experience continuing poor health, educational and social outcomes. They are five times less likely to achieve five good GCSE grades, nine times more likely to be excluded from school and six times less likely to enter higher education that their peers. [DH, 2011; DfES, 2007]

On leaving care the most common outcome for children is to be returned home to their family. However it is considered that around 50% abused and neglected children are likely to suffer repeated abuse or neglect when they return home. [NSPCC 2012]
Many have positive experiences in the care system: though entering care is strongly associated with poverty and deprivation. Looked after children are estimated to have a five-fold increased risk of mental disorders (42% compared with 8% in the general population in ages 5-10); a six-to-seven-fold increased risk of conduct disorder; and a four-to-five fold increased risk of attempting suicide in adulthood. NICE/DH suggest around 45-60% of looked after young people have emotional and mental health problems, increasing to 72% for those in residential care. [DH 2011]

Cumbria LAC data

In Cumbria as of Dec 2013 there were 639 looked after children. This equates to a rate of 67.6 per 10,000 0-17 year olds. The rate of looked after children varies across Cumbria and in Allerdale and Copeland the rate is 77.5 per 10,000 where as in Barrow and South Lakeland it is 61.6 per 10,000. The number of children entering care and receiving a health assessment is an improving picture compared to 2012/13 and recent November 2013 data suggests 81.5% of children entering care had received a health assessment.

Evidence based good practice

National policy emphasises improving outcomes for looked after children: through more effective assessment and detection of mental health problems and use of referral protocols.
Local authorities are required to ensure the voices of looked after children are heard. [DH 2011]
YoungMinds (2006) report that young people want a service that is about their specific needs, easily accessible and flexible, that understands and provides support.

NICE guidance on promoting the quality of life of looked after children and young people includes recommendations covering local strategy and commissioning, multiagency working, care planning and placements, and timely access to appropriate health and mental health services. [*NICE 2010]*

4.2 Missing and runaway children

Children looked after are three times more likely to run away than children living at home. Around half the children living in residential homes are placed outside their own local authority. Placed far from home, family and friends, these are the children more likely to run away, with the attendant increased risk of emotional and physical abuse and other dangers. [APPF, 2012]
The majority of missing children are' hidden' and therefore unable to access the help they need. Additionally, there is discrepancy between agency-held data: with police data showing consistently higher estimates of young people missing each year compared to other agency figures. [APPG, 2012)]

Every year, there are an estimated 200,000 episodes of people being missing in the UK, of whom approximately two thirds are under 18. Up to two-thirds of young people who run away are not reported, and many cases are repeat episodes. [Home Office, 2011; NPIA, 2011 APPG, 2012]

Factors linked to the decision to run away include family, school or substance problems. Although many runaways are fleeing abuse, they will often be at increased risk as a result of running away. Missing children are at great risk of physical and/or sexual abuse; one in six may be sleeping rough and one in eight needs to beg or steal food. They are more likely to suffer mental health problems such as depression, as both cause and effect of being missing. Repeatedly going

missing from home is recognised as an indicator that a child may be the victim of sexual abuse. [Children's Society, 2012; Home Office, 2011]
Table 20 shows estimated missing person episode data for all missing persons in Cumbria in 2010/11

Table 20: Missing persons episodes 2010/11

Police Force	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Rate per 1000 population
Cumbria number of missing persons	653	573	361	421	2,008	4.1

Source: NPIA Missing persons data & analysis

The Missing Children and Adults Strategy 2011 requires national and local agencies to prioritise prevention, protection and support for families. Training and awareness, information sharing, advice and support are among good practice recommendations. [APPG 2012; Home Office 2011]

4.3 Children of parents with mental health, substance misuse and related problems

Around 18% of children in the UK live with a parent who has a mental health problem. In most cases, parents with mental health problems are able to bring up their children effectively, however up to 70% of children whose parents have mental health problems could develop problems either in childhood or adult life; and children of depressed parents have a 50% risk of developing depression before the age of 20. [DH 2011]

Parents with alcohol or substance misuse problems can have significant negative effects on health and behavioural patterns in their children: which can result in the children's' developing drinking and associated risk-taking behaviours in adolescence. Children in these family circumstances may experience social isolation due to a reluctance to interact socially, or as a result of caring responsibilities. Between a quarter and a third of children under-16 are estimated to live with at least one adult who regularly consumes alcohol over the recommended safe limits. [Manning et al, 2009]

The World Health Organisation recommends interventions to prevent generational transfer of mental health problems:

- post natal home visiting focusing on improving early parent–infant interaction
- school-based screening and early intervention programmes
- group programmes for adolescent children of depressed parents
  [WHO, 2004]

5 A safe and suitable home environment and local area

Children need safe and suitable environments at home and in their local area. Feeling safe, privacy, and good local facilities are important to health and wellbeing, Factors such as poor quality or overcrowded housing or moving house frequently are risk factors for low emotional wellbeing. However, the existence of positive caring relationships can to an extent counterbalance such negative influences. [Children's Society, 2012]

5.1 Housing accommodation

Good-quality, affordable, safe housing is essential to wellbeing. Poor housing or homelessness can contribute to mental ill health or exacerbate mental distress. [MIND 2007] Lack of good quality, affordable housing is a persistent problem. Social housing has improved but is associated with poorer, more deprived areas and overcrowding: children growing up in social housing have, on average, seven square metres less space in which to play and develop, than the national average. [Shelter 2007] Children living in social sector housing are considered to be at greater risk of developing mental health problems. [MHF 2007]

Possible interventions include:

- Educating families about health risks and appropriate referrals to local health providers
- More insulation; improved warmth and reduced damp
- Modifying houses to address health and disability needs
- Ensuring access to help with energy costs. [McAteer 2011]

5.2 Homelessness

Homelessness was 14% higher nationally in 2011 than in 2010. Changes to housing benefit entitlement introduced by the welfare reforms in 2013 may affect homelessness but there is no data at the time of this report.

Evidence indicates that many homeless young people suffer from severe mental health problems and that such problems are eight times as high for people living in hostels and bed and breakfast accommodation and eleven times higher for those who sleep rough, compared to the general population. [MHF, 2002]

Self-neglect may result from a combination of practical barriers and the manifestation of mental health problems. Self-harming is thought to be relatively common among young homeless people and suicide is the greatest single cause of death among the street homeless. There is a relatively high prevalence of sexual risk behaviour among the young homeless population. Rohde et al. (2001) found that '*depression is frequent in homeless older adolescents and has a complex association with STD-related behaviours*'. The risks associated with such behaviour include sexually transmitted infections, unplanned pregnancy and potential for abuse or exploitation.

Homelessness can instigate or compound existing mental health problems and/or drug misuse problems, and there is a strong association between homelessness and withdrawing from education, low levels of social capital, poor sense of identity and exposure to dangers. Poverty and worklessness, family breakdown and exposure to violence are associated with homelessness.
Table 21 shows statutory homeless households with dependent children or pregnant women per 1,000 households in Cumbria, 2011/12.

Table 21: Statutory homeless households with dependent children: source ONS

Indicator	Cumbria no. per year	Statutory homeless households with dependent children or pregnant women per 1,000 households,	England average
Family homelessness	258	1.2	1.7

Evidence based good practice recommendations:

- *Practical support:* while specific clinical help is essential, many emotional problems may be alleviated by the simple and reliable provision of practical help
- *Listen to young people:* it is critical that young people's voices are heard, not just to map their routes into homelessness and its impact on their mental health, but also to help workers assess the availability and appropriateness of supportive provision
- *Active intervention:* early and pro-active, with multiple and intense support services; more assertive outreach work for those with the most severe problems
- *Improve access:* access to services for runaways paying attention to physical proximity and timing to ensure access to benefits, day centres and other essential services
- *Improved inter-agency working* increase services' capacity to deal with needs
- *Preventive housing measures:* includes more secure tenancies and better regulation
- *Accommodation provision:* a range of secure and flexible accommodation will have both preventive and healing effects on psychiatric morbidity; supported accommodation and half-way houses can be crucial resources for young people
- *Preventive familial measures:* including family mediation and respite services.
- Support care-leavers: support for care-leavers' independence.
  [MHF 2002, JRF, 2008]

5.3 Exposure to domestic abuse, aggression and violence

Exposure to abuse and violence in the home environment – even indirectly – can cause persistent distress. People who have been abused or are victims of domestic violence have higher rates of a range of mental health problems. Domestic abuse (both in childhood and in adult life) is often the main factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse. Children who live with, are subjected to or witness domestic abuse are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life. [Women's Aid, 2012]

Serious case reviews of child deaths have consistently found histories of violence and abuse in the home, often with evidence of similar behaviour in perpetrators' childhood environment.

Studies have shown that women abused in childhood are more likely to develop depression in adulthood, and that people experiencing childhood sexual abuse are almost three and a half times as likely to be treated for psychiatric disorders in adulthood as the general population. [MHF, 2007]

Child hospital admissions for injury

Hospital admissions caused by unintentional and deliberate injuries in under-18s. Although not necessarily linked to violence in the home, child admissions to hospital for injury are recognised as a cause of premature mortality and long-term health conditions.

There were 4116 A&E attendances in Cumbria of 0-18 year olds in 2012/13 for injury in the home. 93.9% of attendances were due to other injury, 0.6% assault, 3.3% deliberate self harm, 0.4% road traffic collision and 1.7% sports injury. Data supplied by Trauma and Intelligence Injury Group.

Evidence based good practice

- Data on child hospital admissions should categorise unintentional and deliberate injury.
- A&E attendance data for child injury should be included
- Areas for further investigation:
  - Domestic abuse
  - Neighbourhood violence and individual events of fighting and aggression

6 Opportunities to take part in positive activities to thrive

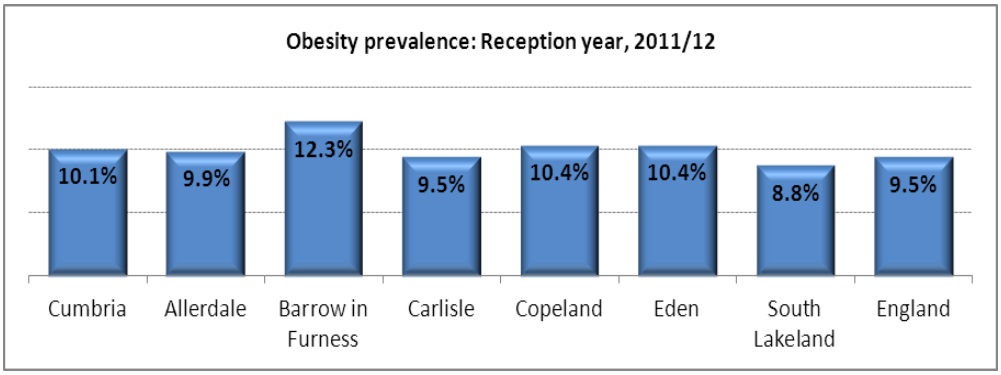
A healthy balance of time use is important, with choice and autonomy being vital for wellbeing in all aspects of children's lives. This would include opportunities to spend time with friends and family, time to oneself, time to do homework, helping at home and the opportunity to be active, with access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

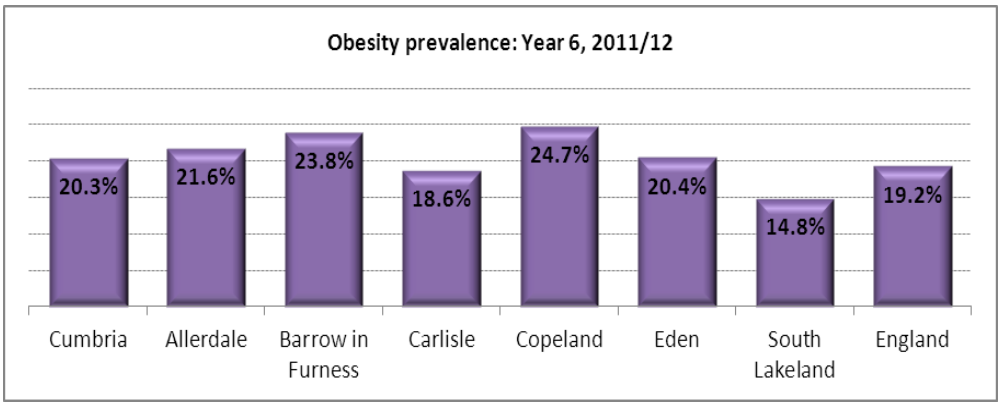
6.1 Physical activity and other positive activities

Taking part in social activities, sport and exercise is associated with higher levels of life satisfaction. Child and maternal child health profiles indicate that all children should be able to participate in and enjoy PE and sport at school. Physical activity during childhood has a range of benefits including healthy growth and development, maintenance of energy, psychological wellbeing and social interaction. Through improved concentration and self-esteem, it can also improve school attendance, behaviour and attainment. [ChiMat, 2012]

Tables 22 and 23 show the percentage of children classified as obese or overweight in reception (aged 4-5 years) and year 6 (aged 10-11 years) by area. Cumbria has a higher percentage both in reception and Year 6 classified as obese or overweight compared to the England average.

Tables 22 and 23: Obesity prevalence reception year/ Year 6 2011/12





Cumbria's healthy weight strategy is being refreshed and includes an implementation plan to address overweight and obesity in children and adults. The *Cool4Life* programme commenced in September 2013 and offers structured interventions for children and families.

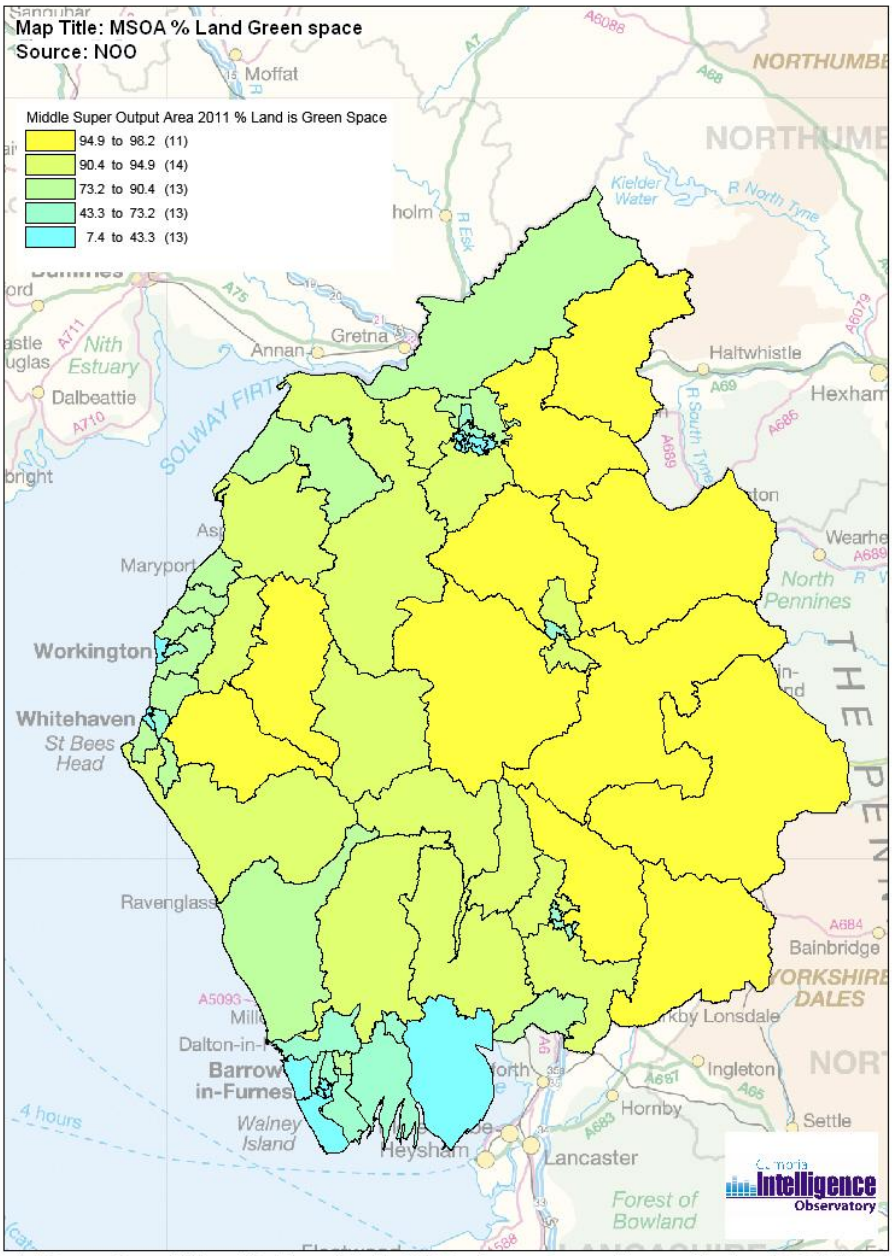
6.2 Access to green space

The importance of access to green space to good mental health is widely recognised. The Faculty of Public Health's '*Great Outdoors'* suggests that access to green spaces can have a positive effect on mental wellbeing and cognitive function as well as greater social contact and community cohesion. [Faculty of Public Health, 2010 and 2011]
Mapping of green space throughout Cumbria:

Cumbria data

The % of green space as expected for a rural county is high in most areas however in some urban areas there are much smaller percentages of green space.

Figure 13: % of green space in Cumbria



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Evidence based good practice

NICE guidance on promoting physical activity, active play and sport for preschool and school-age children and young people in family, pre-school, school and community settings links between physical activity and mental wellbeing Participation in other types of positive social activities such as volunteering is also beneficial to emotional wellbeing. Increase multi-agency working, recognising the important effects that planning decisions in the design of neighbourhoods and green space initiatives can have on mental health. [NICE, 2009]

Good practice in Cumbria

Barrow community gym
LDNPA activities
DC activities

6.3 Young carers

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

There is a clear relationship between poor mental health and caring. There are an estimated 175,000 young carers in the UK. Young carers are at risk of social isolation, bullying, underachievement, poor physical and mental health, exclusion and absenteeism from school.

ONS estimates that in the UK 250,000 young people are living with parental drug misuse and 1.3 million children live with parental alcohol misuse. However, many young carers are not known to their schools or teachers: it is important therefore that education establishments find ways of identifying and supporting them.
The national *Carers' Strategy* has the aim that '*by 2018 every carer should be: enjoying a life outside caring; mentally and physically well; and that: children will be thriving, protected from inappropriate caring roles'.* [DH, 2008]

Teenagers who become parents under the age of 18 may also be considered to be young carers. Teenage mothers are at an increased risk of experiencing poor mental health up to three years after the child is born and are also three times more likely to suffer from postnatal depression [NHS Health Development Agency, 2003]

Cumbria data

2011 census data shows 3,378 carers in Cumbria aged under-24 though this figure may not include those looking after family members with mental health or substance misuse problems.

Evidence based good practice

- Schools to ensure links are in place with young carer's services
- Children's mental health services to link with young carer's projects
- Young carers to be supported by relevant agencies to ensure they are able to lead a life away from their caring responsibilities
- Agencies to identify any support needs of pregnant teenagers / teenage parents accessing services and ensure appropriate referral pathways are established
- Young carers should be identified early and intervention should support resilience building
- Young carers policy and nominated lead should be established in every school
- Monitoring systems should be in place for example to track effects of welfare reforms and other social policy changes

Case study – Young Carers

Cumbria County Council has a statutory duty to provide a carer's assessment and inform carers of their right to an assessment [Carers Recognition and Services Act 1995, Carers and Disabled Children Act 2000, Carers Equal Opportunities Act 2004]. The authority must also consider if a young carer is in need or at risk of harm [Children Act 1989 and Children Act 2004]

What action was taken?

Cumbria county Council commissions five young carer organisations across the county (Carlisle, Eden, South Lakes, Barrow including Ulverston and the West which incorporates Copeland and Allerdale) to offer assessments to all young people who may be potential young carers.

- Young Carers Strategy in place linked to Children and Young People's Plan
- Memorandum of understanding "*Working together to support Young Carers"*
- Joint working with Adult Social Care to review and implement new questions in assessments and reviews to identify young carers and signpost to young carer organisation
- Partnership working with children's service equality officer for young carers and young carer organisation to raise awareness
- Model policies available to schools to support schools in recognising young carers and to demonstrate that young carers are treated with equity
- Children's service ICT system in working progress to ensure young carer organisations and children's service can share accurate and up to date information
- Quarterly monitoring of young carer organisation to ensure young carers have equality of access, their needs are met through reasonable adjustment and to identify and remove any additional barriers that young carers may face.

What difference did it make?

- Children's services are aware of this vulnerable group and have real data which will enable us to track and offer additional support if necessary
- Young carers are recognised and offered support and all in receipt of service have an individual support plan.
- 333 new assessments undertaken and 278 young carers identified over the last year
- 741 young carers known and currently receiving support (23% of young carers are supporting a family member with emotional and mental health issues) (22% of young carers are supporting a sibling with a disability) 6% of young carers are known as a child in need or have a child protection plan in place
- Improved emotional wellbeing and resilience of young carers through access to young carer projects.
- Schools will make reasonable adjustments for a young carer and this enables young carer to be successful and happy in school
- Young carers have real breaks from caring, hours of respite offered

How will this impact be sustained?

- Children's services will continue to commission services and work in partnership to raise awareness of young carers.
- Children's services equality officer to work alongside contract management to monitor young carer organisations to ensure intervention is targeted and young carer's role remains manageable and safe and that young carers have equality of access.
- Liaison worker engaging with GP practices

6.4 Teenage parents

It is recognised that teenage parents can experience poor social circumstances with subsequent detrimental effects on the family. Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth of their child. By the age of 30, they are 22% more likely to be living in poverty and 20% more likely to have no qualifications (compared to older mothers, aged 24+).

Children of teenage mothers have increased risk of being born into poverty compared to babies born to mothers in their twenties. These children also have higher mortality rates under 8 and are more likely to have accidents and behavioural problems. [DFES, 2006]

Evidence based good practice

- Schools and further education settings should offer teenage parents comprehensive package of support to ensure they are able to continue with their education
- Targeted provision for teenage parents e.g. through children's centres; family nurse partnership programme
- Ensure pathways are in place for information sharing between agencies
- Regular monitoring of NEET data and Care To Learn uptake to ensure teenage parents are engaging in education, training or employment where possible
- Raise awareness of support for teenage parents through staff training

7 Summary of key findings

The following key findings are preceded with a general caveat that children's services in Cumbria are undergoing rapid change as a result of the external inspections outlined above. It will be necessary therefore to update information in the JSNA as improvement plans are implemented. Some of the improvement activity centres on safeguarding and other interventions, other activity focusses on data and surveillance capacity.

Key findings:

- In overall terms, the emotional health and wellbeing of children and young people in Cumbria appears to follow national average trends: however in many areas of observation and analysis there is evidence of wide disparity between geographical districts. This is consistent with national projections which suggest that younger populations in more socio-economically deprived areas have a poorer start in life, are more likely to suffer lower levels of emotional health and wellbeing through their life course and in consequence experience higher levels of mental ill health than the general population

- There is evidence of unmet need, under capacity and lack of accurate service and surveillance data across agencies and disciplines: e.g. diagnostic data is unavailable from the main mental health provider. Despite the unavailability of robust referral data it is likely that the highest proportions of unmet need are in the poorest areas

- There is no comprehensive four-tier integrated service at present – though commissioners and clinical leads are working towards tis objective

- Children and young people with problems are more likely to present in early years, school or primary health care, though they may also have contact with non-statutory and third sector services. Improvement in prevention and early detection of problems requires appropriate capacity particularly within primary care, education, social and community based care

- Better communication and links between agencies – particularly CAMHS, schools and primary care would improve support for children and families. Anecdotal evidence from primary care is of a need for capacity to help general practitioners manage caseload at an earlier stage, provide support and to ensure appropriate referrals to specialist CAMHS

- Children with emotional health conditions ranging from conduct or behavioural problems to more extreme needs such as safeguarding or child protection are often identified by adults with differing areas of responsibility for them. Development of a joint multiagency data hub to enable 'real time' early warning and tracking of these children and their interventions would be beneficial

- Parental concerns and parents' ability to identify a developing problem with their child are very important. Parents need the confidence and capacity to communicate the needs of their child to professionals, and have confidence that their concerns will be acted upon. Successful early detection of developing problems often depends on the tenacity of the help-seeking response of parents. It is essential therefore to ensure that the signs and symptoms parents report are acted upon effectively

- There are some areas where data appears to indicate a need for further investigation and possibly action. These include:

    - Free school meals uptake: current data suggests that over 2000 families in Cumbria may be entitled to free school meals for their children and are currently not receiving them
    - Educational attainment: the disparity between the best and worst performing districts appears to widen between KS2 and KS4: data needs further examination
    - Alcohol admissions: some districts are significantly worse than the England average and this requires urgent attention

- There are some areas where data is needed to be able to assess service provision and referrals including:
    - Primary care: GP practice profiles: an audit of presentations and referrals in GP practices would be helpful
    - CPFT: diagnostic coding and caseload analysis will help to identify capacity issues
    - Schools: an audit of services and interventions in primary and secondary schools would allow further examination of services at tiers 1 and 2
    - Community and voluntary organisations: activity data would allow assessment of available services, particularly at tier 1.

Appendix 1

Health Related Behaviour Survey 2012 -
http://www.cumbriaobservatory.org.uk/elibrary/Content/Internet/536/671/4674/4144212282.pdf

Appendix 2

CAMH services are organised into Tiers, but these are not hierarchical tiers. The tiered system is one of organisational structure that supports such a method of service delivery, each CAMHS professional having the potential to work at, or with, more than one tier.

Table 1: CAMHS Tier Structure

CAMHS professionals and associated partners are organised into a structure comprising four tiers	
Tier 1	This tier comprises contact with professionals who are not necessarily employed for the prime purpose of promoting mental health, but who directly and indirectly influence the mental health of children through their work with them, .e.g. Health Visitors, school teachers, social workers, GPs
Tier 2	Individual specialist mental health workers who work with children, adolescents, and their families with mild to moderate difficulties
Tier 3	Services that are more specialised and deal with complex problems. In this tier are members of multi-disciplinary mental health services, often working in therapeutic teams,to ensure that the co-ordinated interventions of several professionals can be used to help children with moderate to severe problems.
Tier 4	This tier provides for highly specific and complex problems that require considerable resources, e.g. in-patient psychiatric provision, secure provision, and very specialised services

Source: Review of Child and Adolescent Mental Health Services [CAMHS] in Cumbria, October 2012

Appendix 3

Length of Stay (711 Discharges) (1/4/12 - 31/3/13)							
Days	1	2	3	4	5	6	7
Number of Discharges	3	1	0	2	0	0	0

Diagnosis (711 Admissions) (1/4/12 - 31/3/13)	
Primary diagnosis mental/behavioural ICD10 F admission 0-19	0
Any diagnosis with mental/behavioural ICD10 F admission	3
Diagnosis Code F321	2
Diagnosis Code F323	1

CAMHS Caseload By Referral Source (Snap-shot at 31/3/13)		
Referral Source	Number	%
General Medical Practitioner	1196	57.67%
Consultant (non-A+E)	191	9.21%
Staff Team	191	9.21%
Community Nursing	128	6.17%
Local Auth Social Services	71	3.42%
Cons resp for OP - Other	62	2.99%
Internal	41	1.98%
Educational Establishment	32	1.54%
Specialist Nurses - Secondary Care	32	1.54%
Community Health Services - other	30	1.45%
Other	24	1.16%
Local Authority - other departments	21	1.01%
Health Visitor	10	0.48%
Cons resp OP - foll Emerg Adm	8	0.39%
Private-Voluntary Sector	7	0.34%
Cons Resp OP foll A+E Attend	6	0.29%
Self Referral	5	0.24%
Family / friend / neighbour	4	0.19%
Allied Health Professional	3	0.14%
General Dental Practitioner	3	0.14%
Speech Therapists	2	0.10%
Probation Service	2	0.10%
Consultant referral request	1	0.05%
Carer	1	0.05%
Emergency Services	1	0.05%
Police	1	0.05%
Accident and Emergency Dept	1	0.05%
Total	2074	100.00%

CAMHS Waiting List (Snap-shot at 31/3/13)										
Team	0 - 2 weeks	2 - 4 weeks	4 - 6 weeks	6 - 8 weeks	8 - 10 weeks	10 - 12 weeks	12 - 14 weeks	14 - 16 weeks	16 - 18 weeks	Over 18
Child and Adolescent Mental Health East			1	1	4	6	1	3	3	3
Child and Adolescent Mental Health South	1	3	4	5	4	5	7	5	8	66
Child and Adolescent Mental Health West				4	1		3		4	10
Total	1	3	5	10	9	11	11	8	15	79

Snapshot As At 31/3/13 Clients with mental disorder in contact with services by CAMHS locality age and sex																					
			Age																		
Locality	Sex	CORC Diagnosis	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	21	Grand Total
Allerdale	Female	01 Hyperkinetic Disorders			1	6	1	2	1	1		4	4	12	13	18	12	4				79
		02 Emotional Disorders			1		1						3	2	1	5	4	3				20
		04 Eating Disorders												1				2				3
		06 Deliberate Self Harm														1	2					3
		12 Not Possible To State										2										2
		Not Specified / Missing													1			2				3
		NULL		2			2	2	6	8	2	6	11	10	13	17	8	6				93
	Female Total			2	2	6	4	4	7	9	2	12	18	25	28	41	26	17				203
	Male	01 Hyperkinetic Disorders		2	1	7	10	3	8	7	2	9	9	5	6	7	6	2				84
		02 Emotional Disorders				1					1	2	2	1	2	1	1	1				12
		03 Conduct Disorders										1	1			1	1					4
		09 Habit Disorder						1														1
		10 Autism Spectrum Disorder													2		1					3
		12 Not Possible To State											1									1
		Not Specified / Missing		1									1	1								3
		NULL	1	2	5	5	17	19	17	14	15	12	13	21	18	16	12	9	1		1	198
	Male Total		1	5	6	13	27	23	25	21	18	24	27	28	28	25	21	12	1		1	306
	Female	01 Hyperkinetic Disorders				1	1			1	1		5	7	11	13	7	6				53
		02 Emotional Disorders			1	2	1		1		2	1	2	5	3	13	5					36

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Carlisle		03 Conduct Disorders				1			1			1		2	4	1	1					11
		04 Eating Disorders												1								1
		06 Deliberate Self Harm												1	1		1	1				4
		07 Substance Abuse													1							1
		10 Autism Spectrum Disorder						1								1						2
		11 Development Disorder							1													1
		12 Not Possible To State										1	1	2	2		5					11
		13 Other														3						3
		Not Specified / Missing							1							2	2					5
		NULL	1		2		2	2	1	1	1	5	4	6	6	4	13	4				52
	Female Total		1		3	4	4	3	5	2	4	8	12	24	28	37	34	11				180
	Male	01 Hyperkinetic Disorders			1	2	9	5	4	5	7	5	4	4	2	2	2	2				54
		02 Emotional Disorders					2	1		2	3	3	4	1	2	3	2					23
		03 Conduct Disorders					1			1	1	2		1		1						7
		06 Deliberate Self Harm											1									1
		09 Habit Disorder									1		1									2
		10 Autism Spectrum Disorder					1			1					1							3
		13 Other				1					1		2		1	2	1					8
		Not Specified / Missing									1		2		3	1						7
		NULL			2	5	2	11	5	8	8	6	6	8	10	3	3	2				79
	Male Total				3	8	15	17	9	17	22	16	20	14	19	12	8	4				184
Copeland	Female	01 Hyperkinetic Disorders				1		2	1	1		2	4	5	8	13	15	6				58
		02 Emotional Disorders							1		2			5	2	1	2					13
		04 Eating Disorders												1								1
		06 Deliberate Self Harm															1					1
		09 Habit Disorder									1											1
		10 Autism Spectrum Disorder												1								1
		Not Specified / Missing															1					1
		NULL				2	1	2	4	7	2	5	2	4	15	17	10	4	1			76
	Female Total					3	1	4	6	8	5	7	6	16	25	31	29	10	1			152
	Male	01 Hyperkinetic Disorders				7	7	2	9	6	5	5	6	3	4	3	7	3				67
		02 Emotional Disorders							1				2	1	2	4						10
		03 Conduct Disorders						1	1				1									3
		04 Eating Disorders													1	1						2
		06 Deliberate Self Harm							1						1							2
		08 Learning Disability											1									1
		09 Habit Disorder											1		1	1						3
		10 Autism Spectrum Disorder						1							1							2
		11 Development Disorder											1									1
		Not Specified / Missing						2		1												3
		NULL	2	1	4	11	9	11	17	16	13	13	9	11	8	15	9	3				152
	Male Total		2	1	4	18	16	17	29	23	18	18	21	15	18	24	16	6				246
Eden	Female	01 Hyperkinetic Disorders				1		1	2	2	1	1	1	3	2	7	4	1				26
		02 Emotional Disorders								1		1	2	1	2	8	3	1				19
		03 Conduct Disorders										1										1
		06 Deliberate Self Harm										1			1	4						6
		09 Habit Disorder											1		1							2
		12 Not Possible To State													3							3
		13 Other										1				1						2
		Not Specified / Missing										1			1	1	2					5
		NULL			1				1	1					2	1	1	1				8
	Female Total				1	1		1	3	4	1	6	4	4	12	22	10	3				72
	Male	01 Hyperkinetic Disorders					3		3	2	6	1	2	1	2		2	1				23
		02 Emotional Disorders							1		1		3		1		2	1				9
		03 Conduct Disorders									1						1					2
		06 Deliberate Self Harm															1					1
		10 Autism Spectrum Disorder											1									1
		11 Development Disorder											1									1
		12 Not Possible To State						1									1					2
		13 Other											2									2
		Not Specified / Missing								1							1					2
		NULL					3	1	5	1	1	2	3		1		1	2				20
	Male Total						6	2	9	4	9	3	12	1	4		9	4				63
Furness	Female	01 Hyperkinetic Disorders											1			4	5					10
		02 Emotional Disorders										1	1									2
		04 Eating Disorders														1						1
		06 Deliberate Self Harm										1										1
		13 Other				1																1
		NULL					2	3	5	2	6	6	4	15	21	25	21	15		1		126
	Female Total					1	2	3	5	2	6	8	6	15	21	30	26	15		1		141
	Male	01 Hyperkinetic Disorders					1	2	2	2	1	5	2	3	3	4	1	1				27
		02 Emotional Disorders									1											1
		08 Learning Disability													1							1
		10 Autism Spectrum Disorder												2								2
		Not Specified / Missing							1													1
		NULL			1	2	7	10	14	13	22	11	23	25	24	33	23	10	2			220
	Male Total				1	2	8	12	17	15	24	16	25	30	28	37	24	11	2			252
Lancaster	Male	NULL														2						2

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Lancaster	Male Total														2					2
Out of Area	Female	01 Hyperkinetic Disorders											1		4		1			6
		02 Emotional Disorders									2									2
		04 Eating Disorders															1			1
		06 Deliberate Self Harm									1									1
		NULL						1	1	1		2		4	3		3	4		19
	Female Total							1	1	1	3	2	1	4	7		3	6		29
	Male	01 Hyperkinetic Disorders			1	1	1	1		1			1	1	1					8
		02 Emotional Disorders									1	1								2
		NULL		2		6	1	1	6	2	2	4	2	2	3	4	3	1		39
	Male Total			2	1	7	2	2	6	3	3	5	3	3	4	4	3	1		49
South Lakes	Female	01 Hyperkinetic Disorders						1		1	1	2			1					6
		02 Emotional Disorders														1				1
		04 Eating Disorders														1				1
		NULL				1				1	1	2	5	10	15	29	21	10	1	96
	Female Total					1		1		2	2	4	5	10	16	31	21	10	1	104
	Male	01 Hyperkinetic Disorders								2				1		2				5
		02 Emotional Disorders														1				1
		03 Conduct Disorders															2			2
		06 Deliberate Self Harm															2			2
		NULL		1			2	2	4	2	9	4	5	7	10	12	11	9	1	79
	Male Total			1			2	2	4	4	9	4	5	8	10	15	15	9	1	89
	Not Specifie	07 Substance Abuse													1	1				2
	Not Specified Total														1	1				2
Grand Total			4	11	21	64	87	92	126	115	126	133	165	197	249	312	245	119	6	1	1	2074

Appendix 4

PLANNING & COMMISSIONING - HEALTH GAIN TRANSITION PROJECTS - ACTION PLAN

Last Updated: 27/08/2013

ID	Project	Budget	Theme	Team Participants	Delivered by/Contact Name	Partners (incl Partner Lead)	Strategy / Policy	Delivery	Outcomes	Milestones	Start Date	End Date	Evaluation	Sustainability	RAG	GAA	Perf Inds	HWS Priorities Ref
1	Breast Feeding Peer Support	£39,000	Healthy Lifestyles and Healthy Weight	Eileen Teasdale / Jacqui Sullivan	Christine Clark, Public Health	Midwifery & infant feeding coordinators, health visitors, Children's Centres staff, peer mentors. Public Health Target. (Liz Strickland)	Healthy Child Programme. Cumbria Healthy Weight Strategy. Cumbria Breast Feeding & Infant Feeding Strategic Group.	Use of Breast Feeding Peer Support workers to support initiation and continued BF. 3 projects: Carlisle Whitehaven & Barrow	Improved rates at 6-8 wks in areas where there is current concern. Longer term: fewer hospital admissions. Fall in obesity rates.	Improvement at 6-8 wks	Delay in starting Barrow project (Dec12). Strategic group proposal to extend all projects for further 6 mths.	31/03/2013 (funding ends)	Each project will undertake their own evaluation to be supplemented by Qualitative audit from CS P&C team by brief survey via baby clinics	Further partnership funding required to run projects to sufficient length to evaluate the differences between models and look at the needs of different communities. Longer term sustainability requires roll out across all areas.	G	pending	Public Health Target - ChiMat data.	Priority 1
2	HENRY roll out	£17,713	Healthy Lifestyles and Healthy Weight	Eileen Teasdale	Eileen Teasdale	HENRY North West, Children's Centres, PVI Early Years Sector, Parents.	Healthy Child Programme. Cumbria Healthy Weight Strategy.	Health Exercise and Nutrition for the really young - roll out of training for practitioners and parent facilitators.	Better parental understanding importance of healthy eating, exercise for pre school age. Improved workforce skills in working with parents & families.		June 2012	31/03/2013 (funding ends)	HENRY North West are undertaking the evaluation - expected end of March.	HENRY North West are working in partnership with Barnardos from April 2013 and have made some proposals about the continuation of the programme in Cumbria.	B	pending	NI055i, CSA statutory. ChiMat indicator.	Priority 1
2.1	HENRY Sustainability 2013-14	£8,857	Healthy Lifestyles and Healthy Weight	Eileen Teasdale		HENRY National Team and Barnardos	Healthy Child Programme. Cumbria Healthy Weight Strategy.	Core training plus facilitator training if budget allows.			April 2013?	31/03/2014 additional funding)	To be agreed	Addressed as above	A			Priority 1
3	Nutrition Training Childminders	£19,000	Healthy Lifestyles and Healthy Weight	Eileen Teasdale	Eileen Teasdale	Nutritionists, PVI providers and predominantly childminders latterly, public oral health.	Healthy Child Programme. Cumbria Healthy Weight Strategy. Oral Health.	Nutrition trainers delivering training to early years settings and childminders.	Improved knowledge and understanding of healthy weight and oral health across the early years workforce.	Feedback from childminders. End of programme report.	April 2012	31/03/2013 (funding ends)	Nutrition trainers are undertaking evaluation supported by CS Planning & Commissioning Team.	Future/further development to be reviewed by Cumbria Healthy Weight Strategy Group as part of ongoing strategy implementation.	G	√		Priority 1
4	Family Weight Management - including Cool4Life	£60,000	Healthy Lifestyles and Healthy Weight	Eileen Teasdale / Jacqui Sullivan	Public Health. Contact Christine Clark, 01228 603075	Public Health (Lead), school nursing, health visiting, Children's Services, Leisure providers, Nutritionists, families. (Christine Clark)	Cumbria Healthy Weight Strategy Action Plan.	Accessible family weight management programme delivered by leisure providers and nutritionists with other agency support over 12 weeks. Aimed at 8-12 yr olds.	Sustained long term movement towards and maintenance of a healthy weight for adults and children in obesogenic families. Increased activity and improved emotional wellbeing of both parents and children.		March 2013	May 2013 (slow uptake). Revised end date August 2013	Height, Weight and BMI measured at start/finish of each cohort. Physical activity take-up will be monitored by the activity centres/ sports centres. Self esteem evaluations along with anxiety and wellbeing. Evaluation carried out by University of Cumbria.	Further development to be reviewed by Cumbria Healthy Weight Strategy Group as part of ongoing strategy implementation at the end of the project. Depending on impact results this programme may be expanded and include other partners in future.	A	√	Health Target, ChiMat. NI056 (Yr 6 weight)	Priority 1, 2, 3
6	Young People Consultation Sexual Health	£13,900	Risk Taking Behaviour	Lindsey Ormesher / Julie Mattock	Contact Christine Clark, 01228 603075	Public Health (Lead), Cumbria Youth Alliance, Children's Services Planning & Commissioning Team (Christine Clark/Jane Muller)	Cumbria Sexual Health and Teenage Pregnancy Strategy. Cumbria SH &TP Strategic Partnership Group.	Delivered by Cumbria Youth Alliance and Journey of Youth project. Collation of views of YP service provision.	Increased awareness of SH Targeted needs analysis.		Dec 2012	May 2013	Extensive survey data to inform commissioning.	To be considered as part of countywide review & changes to commissioning practice, post NHS restructure and move to CCC of Public Health. Opportunity to properly integrate commissioning to support sustainability.	G			Priority 2

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7	Promoting Emotional Resilience Parent Newborn Targeted Support	£30,000	Emotional Wellbeing and Mental Health	Lindsey Ormesher		Mental Health, Midwives, Family Nurse Team Lead, Children's Centre Providers	Perinatal & Infant Mental Health Strategy Group, Early Years Strategy Group, HCP, EYFS	Training for acute & community Midwives. Use of DVD resource in antenatal classes and home visits.	Improved knowledge in practitioners of attachment and infant brain development. Parents more aware and supported.		Jan 2013	March 2014	Being formulated with support of Family Nurse Practitioner Team and Supervisor	Improved practitioner skills and knowledge to be sustained and rolled out through development of integrated workforce development learning framework. (EYSG)	A			Priority 3
8	Promoting Emotional Resilience (PER) Workforce Development Building Capacity in the Third Sector	£148,087 (total allocation relates to the 6 district projects below)	Emotional Wellbeing and Mental Health	Lindsey Ormesher	See below for district details	YOUNG MINDS (BOND) Children & YP workforce across CCC and NHS providers, Third Sector Commissioned Youth Services, Schools, Cumbria LSCB	Cumbria Health & Wellbeing Strategy, Emotional Wellbeing & Mental Health CQC Core Group, OFSTED Improvement Programme, Suicide Prevention Leadership Group	6 district based projects to promote emotional resilience in CYP and build capacity in 3rd Sector. YOUNG MINDS training at 2 levels: Training the Trainer, Focussed training on Parental Mental Health & Self-harm & Suicide. YOUNG MINDS support to Third Sector via BOND Programme	Improved knowledge / skills within workforce. Earlier identification and intervention to support CYP mental health and promote resilience. Increased capacity to meet mental health needs in Universal/Targeted Services.		Jan 2013	March 2014	Under development.	Risks to sustainability: interventions at Tiers 1 and 2 requires support from Tier 3. Models and Care Pathways to provide this need to be developed **now** as part of the improvement programme.	A			Priority 3
8.1	Carlisle District	£24,090	Emotional Wellbeing and Mental Health		Pam Hutton pam@eastcumbriafamilysupport.org.uk	ECFSA (lead), Brathay Trust, ECO, Carlisle Young Carers, CADAS	See above	Through delivery partners and network members	See above		April 2013	March 2014	To be developed via outcome based monitoring of grant award agreements.		A	✓		Priority 3
8.2	Eden District	£24,500	Emotional Wellbeing and Mental Health		Pam Hutton pam@eastcumbriafamilysupport.org.uk	ECFSA (lead), Brathay Trust, ECO, Carlisle Young Carers, CADAS					April 2013	March 2014	To be developed via outcome based monitoring of grant award agreements.		A	✓		Priority 3
8.3	South Lakes District	£24,933	Emotional Wellbeing and Mental Health		Kathleen Newson kathleennewson@youngcumbria.org.uk	Young Cumbria (lead), Brathay Trust, CAMHS, Youth Clubs, New Beginnings network					April 2013	March 2014	To be developed via outcome based monitoring of grant award agreements.		A	✓		Priority 3
8.4	Furness District	£25,384	Emotional Wellbeing and Mental Health		Joyce Hawthorn joyce.hawthorn@actionforchildren.org.uk	Furness Childrens Centre (lead), Inspira, Health Visitors, CAMHS, Millom network centre, SERIS workers, Young Carers, Kidsafe Barrow					April 2013	March 2014	To be developed via outcome based monitoring of grant award agreements.		A			Priority 3
8.5	Copeland District	£25,000	Emotional Wellbeing and Mental Health		Andrea Hardie-Knight andrea.hardie-knight@howgill-centre.co.uk	Howgill Family Centre (lead), NACRO, Young Cumbria, Brathay Trust, Safety Net, CAMHS, Health Visitors, Local schools,					April 2013	March 2014	To be developed via outcome based monitoring of grant award agreements.		A			Priority 3
8.6	Allerdale District	£24,180	Emotional Wellbeing and Mental Health		Anne Cartner, annec@impacthousing.org.uk	Impact Housing (lead), Inspira, NACRO, Childrens Centre, Brathay Trust, Youth Clubs					April 2013	March 2014	To be developed via outcome based monitoring of grant award agreements.		A	✓		Priority 3

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8.7	**Young Minds Training Programme** (Promoting Emotional Resilience Workforce Development Mental Health Training Programme)	£54,000	Emotional Wellbeing and Mental Health	Lindsey Ormesher / Sue Milner	Contact Lindsey Ormesher, lindsey.ormesher@cumbria.gov.uk	YOUNG MINDS, Educational Psychology Workforce Development Team, Schools (Jo Gaffney)		YOUNG MINDS Training Programme			April 2013	March 2014			A		NI051 C.Govt statutory	Priority 3
9	Promoting Emotional Resilience (PER) Peer Mentor Educator Programme	£50,000	Emotional Wellbeing and Mental Health	Lindsey Ormesher		Children's Services, Schools, Commissioned Providers, NHS / CPFT	Cumbria Health & Wellbeing Strategy, Emotional Wellbeing & Mental Health CQC Core Group, OFSTED Improvement Programme, Suicide Prevention Leadership Group	Funding to enable Third Sector organisations to train peer mentors and educators.	Increased community capacity and development promoting Emotional Resilience and supporting mental health of CYP.		April 2013??	March 2014	To be developed	Requires development of support systems to sustain peer mentors / educators.				Priority 3
10	Nutrition Training Foster Carers (READY4Life)	£10,000	Emotional Wellbeing and Mental Health	Sue Milner / Eileen Teasdale>Lisa Hignett	Nutrition Training Consortium. Contact Eileen Teasdale	Nutritionists, Fostering Social Workers, CLA Senior Practitioners, Health of CLA Nurses, Foster Carers (Anne Hood)	MALAP Be Healthy Group, Health of Children Looked After Guidance	Cumbria foster carers receive training on nutrition. Development of resources toolkit (READY4Life). Public Health England involved with dental/oral health.	Foster carers have increased knowledge of nutrition and related food issues often rooted in emotional difficulties and trauma		March 2013 (programme start Oct/Nov 2013)	March 2014	Being developed by Sue Milner in consultation with Public Health	Through local foster carer networks and by support from multi-agency practitioners.	A			Priority 3
11	Emotional First Aid Kits for CLA (Nurture Packs)	£21,000	Emotional Wellbeing and Mental Health	Sue Milner	Contact Sue Milner, sue.milner@cumbria.gov.uk	CLA & Adoption Support Teams, Health of CLA Team, Health Visitors, Fostering Teams, Foster Carers, Independent Reviewing Officers	MALAP Be Healthy Group, Health of Children Looked After Guidance, Adoption Support Regs, OFSTED & CQC Improvement Plans	Roll-out of Emotional First Aid Kits (Nurture Packs) to help staff recognise and respond to the needs of children in care and adopted	Improved practice, workforce development, foster carers and practitioners more able to support children affected by grief, loss, trauma, dissociation and emotional literacy problems.		August 2012	April 2014	Being developed by Sue Milner in consultation with Public Health	Inclusion in all annual reviews. Provision of information sessions for managers. Embed in workforce development programmes for all practitioners.	A	✓		Priority 2, 3
12	Early Years Wellbeing & Involvement	£57,000	Emotional Wellbeing and Mental Health	Lindsey Ormesher	Amanda Macdonald, EY Kendal	Early Years specialists in Children's Services, Providers of 2yr old care, Health Visitors, Parents, Child & Family Workers (Amanda Macdonald)	Early Years Strategy Steering Group and Action Plan, HCP, EYFS	Builds on former work to focus on meeting the emotional needs of 2yr olds accessing Early Education funding.	Resources available to enable settings to deliver one to one interventions with vulnerable children to support improved emotional and social development.		Jan 2013	March 2014	Undertaken by Early Years Specialists and Commissioning Officer	Embed in practice the use of the FL scales to measure emotional wellbeing and involvement across all early years settings. Roll-out to Children's Centres (?).		?		Priority 2, 3
13	Open Door Targeted Support Eden	£19,350	Emotional Wellbeing and Mental Health	Sue Milner / Jacqui Sullivan	Delivered by Young Cumbria. Contact Liz Cornford, tel 01768 867456	Young Cumbria, Eden Mind, CAMHS / First Steps, Children's Services Social Care, Planning & Commissioning	Positive for Youth Outcomes Framework, Cumbria Health and Wellbeing Strategy, Children's Services Plan	Direct work with YP at risk and excluded. Training Youth Workers in Mental First Aid. Programme & provision of structured activity and personal development opportunities.	Increased activities for young people supported by appropriately trained staff. Improved life skills and positive relationships resulting in improved mental health. Greater understanding of issues of rural isolation.		March 2013	April 2014	To be developed with partners. The evidence of impact of this project has a direct bearing on sustainability.	The outcomes and evaluation will inform future commissioning decisions in relation to youth services and mental health. Young Cumbria has actively identified potential future funders beyond the life of this Eden pilot project.	A	✓		Priority 3

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14	Alcohol Misuse Awareness Raising	£89,766	Risk Taking Behaviour	Anne Sheppard / Lindsey Ormesher	Helen Davies, CADAS helend@cadas.co.uk	Cumbria Alcohol Strategy Steering Group, Public Health, Children's Services P & C Team, CADAS, Brathay Trust, CYA, Young Cumbria, Community Safety Partnerships	Health and Wellbeing Strategy, Cumbria Alcohol Harm Reduction Strategy, Safer Communities, Positive for Youth.	Grant awards of up to £15k per project to local initiatives to improve awareness of impact of alcohol misuse on CYP and families.	Better understanding of impact of parental behaviour on CYP alcohol consumption. Greater awareness of harm and risk. Direct targeted support.		April 2013	April 2014	To be developed with partners, providers and young people.	Outcomes and evaluation to inform future commissioning practice in relation to Risk Taking Behaviour. Ensure links with other Health Gain Projects eg Peer Mentor/educator project (ID 9)	A	√	Health Target, ChiMat	Priority 2
15	Children with Disabilities - Access to Sport	£75,084	Children & Young People with Disabilities	Julie Mattock / Jacqui Sullivan [prev Jon Parnaby]	Bruce Lawson - Active Cumbria, bruce.lawson @cumbria.gov .uk	Active Cumbria (Bruce Lawson), Seashell Trust, Schools, Sports Clubs, Parents and Carers, LA Sport Development Officers, English Federation for Disability Sport, CS Planning & Commissioning Team.	Aiming High' Positive for Youth, Health and Wellbeing Strategy.	Delivery of the Children's Able and Disabled Sports Programme. Events to provide access to competitions and festivals not already in place.	Disabled CYP are offered the opportunity to compete in sport. Young disabled people and non-disabled people will be brought together to develop understanding and mutual respect in a safe and secure environment. The emotional & physical health of CYP is promoted and supported to improve.		Jan 2013	March 2014	To be developed with partners, providers and young people.	Effective signposting for ongoing future participation. Link with National Talent Pathway for those demonstrating performance potential. CYP will be supported and encouraged at a local level to continue involvement in sport.	A	√		Priority 2
15.1	Young People with Learning Disabilities / Difficulties (LDD) Peer Mentoring Scheme	£10,000	Children & Young People with Disabilities	Julie Mattock / Jacqui Sullivan [prev Jon Parnaby]	Juan Shimmin, CYA, 01900 822110, juan@cya.org.uk	Cumbria Youth Alliance	'Aiming High' Positive for Youth Health and Wellbeing Strategy	LDD specialist providers doing youth work with YP throughout the county will support CYA	Raise awareness of risk taking behaviour. Train peer educators and health champions	Year 1 funding sourced, including 3 year funding from some charitable trusts. Years 2 and 3 will require 'top up' funding to ensure project can continue.	Feb 2013	Dec 2015 (dependent on funding)			A	√		Priority 2
16	Up in Smoke	£15,000	Risk Taking Behaviour	Sue Milner / Jacqui Sullivan	delivery in primary schools - contact Su Sear, 01593 797867 (Cumbria PCT)	NHS Cumbria, Schools, Headzup Theatre Company	Health and Wellbeing Strategy, Public Health Target	Through Headzup Theatre Company - anti smoking play staged in primary schools (Years 5 and 6)	Continuation of preventative focus - repeat of effective strategy 2 years ago which had a significant impact	Schools contacted for sign up. Update of stage performance. Theatre delivered in schools	March 2013	Dec 2013	The theatre company return to schools 6-10 months after the project to evaluate the impact	No ongoing costs after project ends.	A	√	Health Target, ChiMat	Priority 2
17	Cumbria Outdoors	£40,169	Emotional Wellbeing and Mental Health	Sue Milner	Delivered by Cumbria Outdoors - contact Deborah Hunter (deborah.hunter@cumbria.gov.uk)	W Cumbria Young Carers, Inspira, CLA Team, Cumbria Outdoors (Deborah Hunter)		Extend the reach of the Allstars Passport Project to vulnerable groups in Allerdale	To provide an extensive range of opportunities to improve the physical and mental wellbeing of YP who are most at risk of not making healthy lifestyle choices	Plan programme content and delivery. Meet and recruit partner agencies and delivery partners. Delivery partners engage participants. Delivery of activites.	July 2013	March 2014	Monitoring and evaluation reports will be prepared in Dec and April	Development of a toolkit for use by other providers working with vulnerable young people in Cumbria and beyond. Cumbria Outdoors received notification in August 2013 of further funding that will ensure another project can be run aimed at vulnerable CYP	A	√		Priority 1, 2, 3
18	Self Harm & Suicide	£18,000	Emotional Wellbeing and Mental Health	Lindsey Ormesher	Delivered by our County Psychological Service - contact Sue Sanderson, 01229 407425, sue.sanderson @cumbria.gov .uk	Education Psychologists with links to CAMHS, Young Minds		Training sessions for practitioners delivered by internal Education Psychologists. Funding pays for CPS staff backfill.	Raising awareness. Understanding the risk. Identification of support measures.		Sept 2013	March 2014			A			Priority 1, 2, 3
19	Attachment Conference	£8,000	Emotional Wellbeing and Mental Health	Sue Milner	Bev Redfern	Kate Cairns Associates, Virtual School Team for Children Looked After/Vulnerable Children		Training event delivered by key speaker (Kate Cairns) plus additional trainers for workshops aimed at designated teachers, school staff, Health Visitors, CLA Nurses, Third Sector Providers, and Social Care/Fostering/ Adoption colleagues.	Improve the understanding of staff in schools of the impact of trauma and abuse on vulnerable children including CLA. The conference will be followed up by Virtual School Team with training inputs, advice and support.	Spring 2014 Conference (Feb or March). Ongoing support and advice in 2014/15.	Sept 2013	July 2015	The impact of the project will be done through an evaluation of the conference and of follow-up training delivered in individual schools plus case studies relating to individual children.		A			
20	Smoke Free Pregnancy Project	£39,000	Healthy Lifestyles and Healthy Weight	Sue Milner	Su Sear, Cumbria PCT	Cumbria PCT, University Hospitals of Morecambe Bay, Cumbria Children's Centres		Provide carbon monoxide monitors to midwives. A couple of monitors for children's centres use coupled with cessation training		Purchase of CO monitors and additional equipment. Training & distribution to children's centres. Training & distribution to midwives.	Sept 2013	March 2014		Exit strategy will ensure no further HGT funding required.	A	pending		

Appendix 4

21	Identifying and providing early help in schools (pilot)	£14,460	Emotional Wellbeing and Mental Health	Anne Sheppard	Jo Gaffney	Richmond Hill Primary School, CDEC, CCC, school nurse, pastoral staff from partner secondary schools, Childrens Centre, Young Minds		Pilot in Richmond Hill School. Identifying early on CYP at high risk of emotional health/wellbeing. System to be developed, whole school approach.	Increase the knowledge / understanding of whole school staff and governors to emotional wellbeing and resilience of children. Sustainable increase in school's capacity to support vulnerable children.		Sept 2013	March 2014			A	pending		
22	Think Good Feel Good (Carlisle)	£10,176	Emotional Wellbeing and Mental Health	Anne Sheppard	Debra Brewer			Multi agency project to promote emotional resilience. Educational Psychologist group intervention.			Sept 2013	March 2014	Pre and post intervention questionnaires. Written report produced		A			
23	CAF Team Proposal	£150,000	Emotional Wellbeing and Mental Health	Deb	Jane Williamson	Cumbria Local Safeguarding Children's Board, Children's Trust Board, District Delivery Groups, County Triage Team, Early Help Project Team	Working Together to Safeguard Children.	Result of Ofsted Improvement Plan. Fresh launch to adopting CAF, aligned to Focus Family initiative. County Early Help Strategic Manager + 3x Early Help Officers (district based)	To improve the early identification and assessment of children's needs and ensure consistent partnership working to improve the outcomes for the child	Set up project team and recruit staff. Develop network and engagement with partners, agencies, local community. Complete and analyse a survey on Triage contacts. Monitor and audit CAF and Early Help measures. Introduction and implementation of e-CAF system to include training development.	Sept 2013	March 2014	Establish regular reports on CAF usage, outcomes and impacts. Review and evaluate effectiveness to ensure sustainability and fit for purpose.		A			
24	CAMHS/EHW Project Manager	£100,000	Emotional Wellbeing and Mental Health	Deb				May need to be included in above role so funding committed - still under discussion. Part funded by CCG & HWB.							A			
OTHER HEALTH PROJECTS PENDING CONFIRMATION / UNDER REVIEW																		
tbc (HGT)	Solihull Programme	?	Project may now be aimed for next financial year	Anne Sheppard / Lindsey Ormesher	Margaret Watson	Children's Centres		Training in parenting skills etc for Centre staff			Oct 2013?	Oct 2015?			on hold			

ID Key:

	Healthy Lifestyles and Healthy Weight
	Risk Taking Behaviour
	Emotional Wellbeing and Mental Health
	Children & Young People with Disabilities

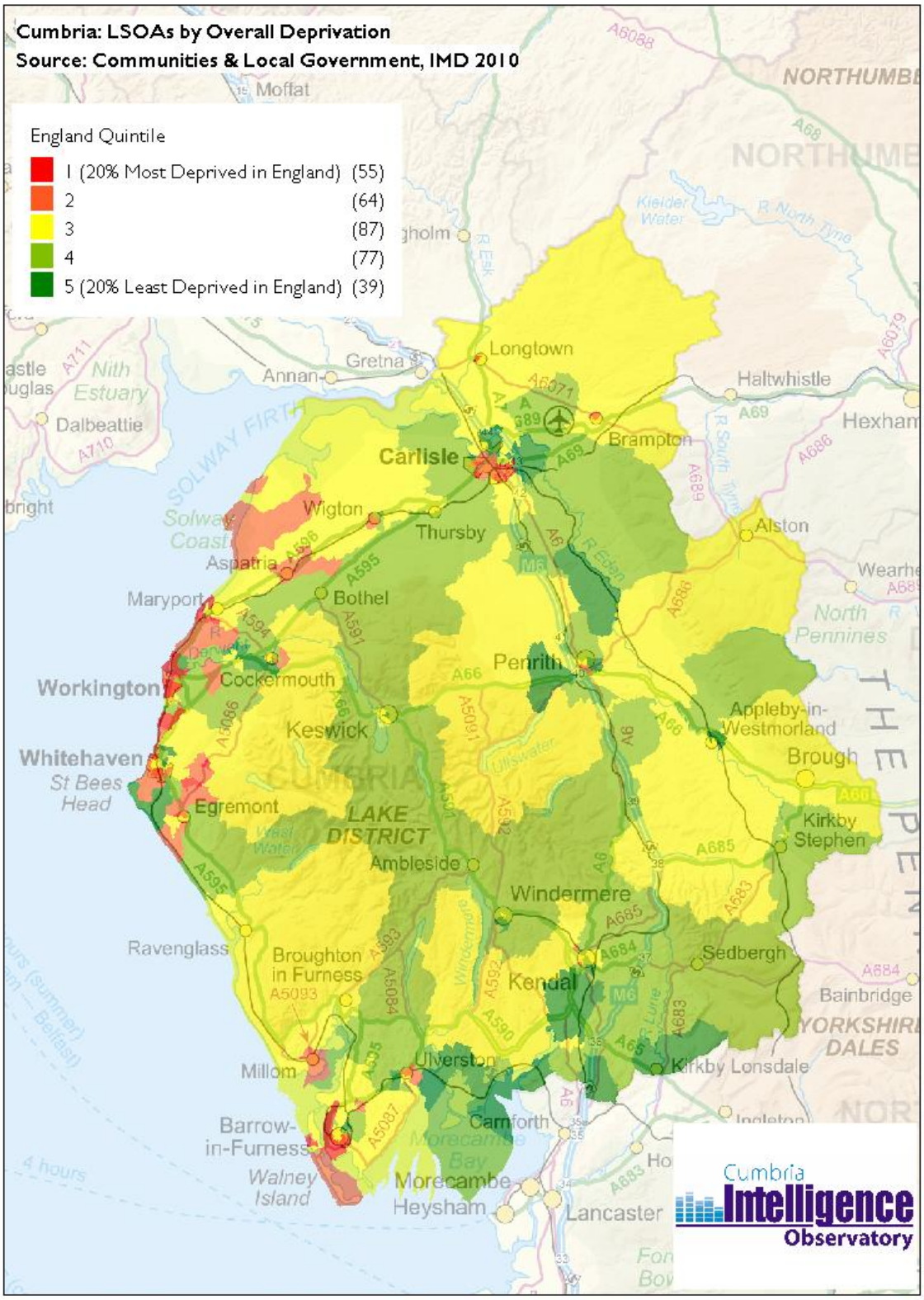
RAG Key:

Y	Proposed
A	In Development
A/G	On track
G	Completed
B	Evaluated

Priority Key Health & Wellbeing Strategy 2012-2015 Priorities

1) health inequalities
2) children and young people
3) mental health and wellbeing
4) ageing population

Appendix 5



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