Suffolk County Council

Public Health & Communities

Mental health in children and young people

Part of the Suffolk mental health needs assessment

Published December 2023

Suffolk County Council Public Health & Communities
Knowledge, Intelligence and Evidence team
knowledgeandintelligence@suffolk.gov.uk

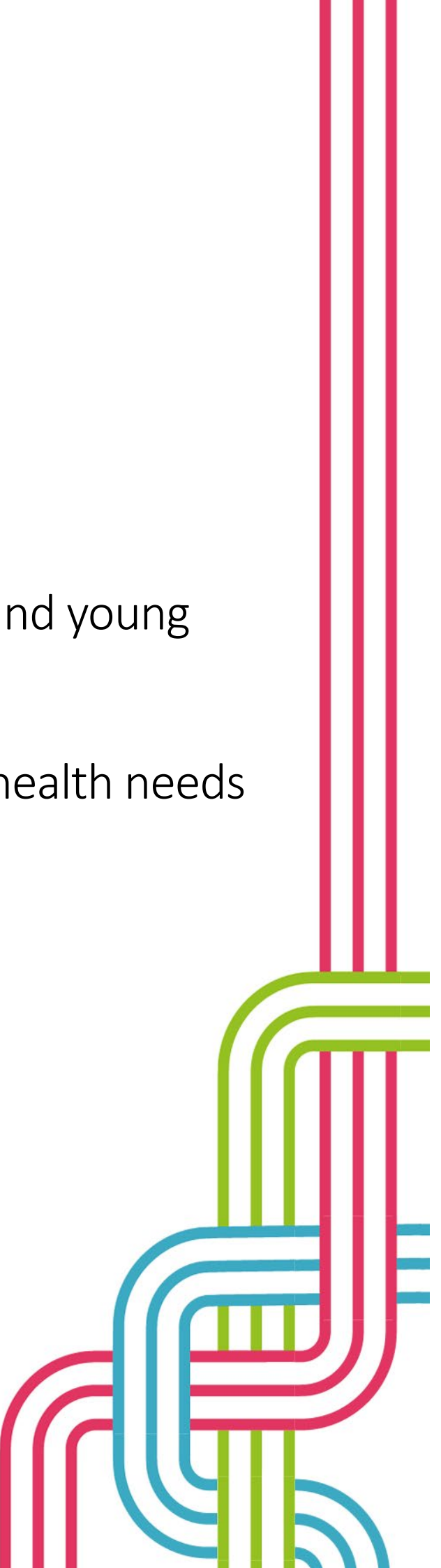


Table of Contents

Five key points

1. In 2021, 2.4% of Suffolk school children had a record of social, emotional, and mental health needs, an increase of 0.8 percentage points from 1.6% in 2015. While this rate is statistically significantly below the national average, the percentage of children with social, emotional, and mental health needs has statistically significantly increased each year since 2018.
2. In 2021/22, Suffolk's self-harm rate for young people aged 10-24 was statistically significantly higher than the national average. The rate is 16.4% higher than the national average.
3. New referrals to secondary mental health services per 100,000 in Suffolk are statistically significantly higher than the national average.
4. In 2021/22, over 3 in 4 (76.2%) children aged 2-2½ years received the Healthy Child Programme or integrated 2 year review, statistically significantly higher than national averages. These reviews are essential to give children the best chance for development and providing opportunities for support (where required), earlier.
5. Children in care in Suffolk may need additional support. Specifically, to support their mental health while in care, but also to support individuals as they transition between services and as care

leavers. Since 2011, there has been a 19.2% increase in the proportion of children in care (52 per 10,000 in 2011, 62 per 10,000 in 2022, n=921).

Context

Type of report

This report is part of a mental health needs assessment in the Suffolk Joint Strategic Needs Assessment. "A health needs assessment is a systematic approach to understanding the needs of a population that can be used as part of the commissioning process to ensure that the most effective support is provided for those in greatest need"[1].

Background - geography

The report covers the Suffolk County Council geography.

Clinical Commissioning Groups (CCGs) ceased to exist on 1 July 2022, when Integrated Care Boards (ICBs) were legally established. "Sub-ICB areas" match the geography of CCGs for data analysis. Suffolk is covered by two ICBs: Suffolk and North East Essex (West Suffolk and Ipswich and East Suffolk CCGs or sub-ICB areas), and Norfolk and Waveney (ICB or CCG). These areas are different sizes in terms of geography and population (March 2023)[2]:

- 1,088,258 Norfolk and Waveney CCG/ICB
- 1,058,560 Suffolk and North East Essex ICB
- 422,283 Ipswich & East Suffolk CCG/sub-ICB
- 265,688 West Suffolk CCG/sub-ICB

Where possible, health information on the Waveney part of Suffolk (including Lowestoft) is given at Primary Care Network (PCN) level. PCNs are groups of GP practices that cover smaller areas than an ICB or CCG.

Note: East Suffolk Lower Tier Local Authority (LTLA) includes the Lowestoft and Waveney area, which is in the Norfolk and Waveney ICB.

Introduction

It is estimated that around half of all mental health conditions start by the mid-teenage years, with 3 in 4 occurring by the mid-20s, although treatment typically begins years later[3]. In 2022, 18.0% of children aged 7 to 16 year and 22.0% of young people aged 17 to 24 years had a probable mental disorder in England. For children aged 7 to 16 years, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020, with rates then remaining stable during 2020, 2021 and 2022[4].

Inequality underpins many of the risk factors for mental ill health in children and young people – linking very closely to the wider determinants of health, outlined in **Environmental Factors** and **Population Factors** within this needs assessment.

The NHS Long Term Plan (2019) made the commitment for more than 345,000 children and young people under the age of 25, to have access to support through NHS funded mental health services or school/college mental health support teams by 2023/24. This comes with the commitment to invest in new mental health support teams across 20%-25% of schools and colleges nationally, and to ensure that crisis care is universally available all day, every day, by 2023/24. More information is available within NHS Mental Health Implementation Plan – 2019-2020 to 2023-2024, providing details of a new framework to achieve the mental health specific commitments.

The Department for Education (DfE) has produced guidance in September 2021 on Relationships and sex education (RSE) and health education. This guidance addresses mental health and internet use, including targets for what children should understand by the end of primary and secondary school[5]. Emotional wellbeing and building resilience are also core elements of the Healthy Child Programme (5 to 19) which is implemented within schools[6].

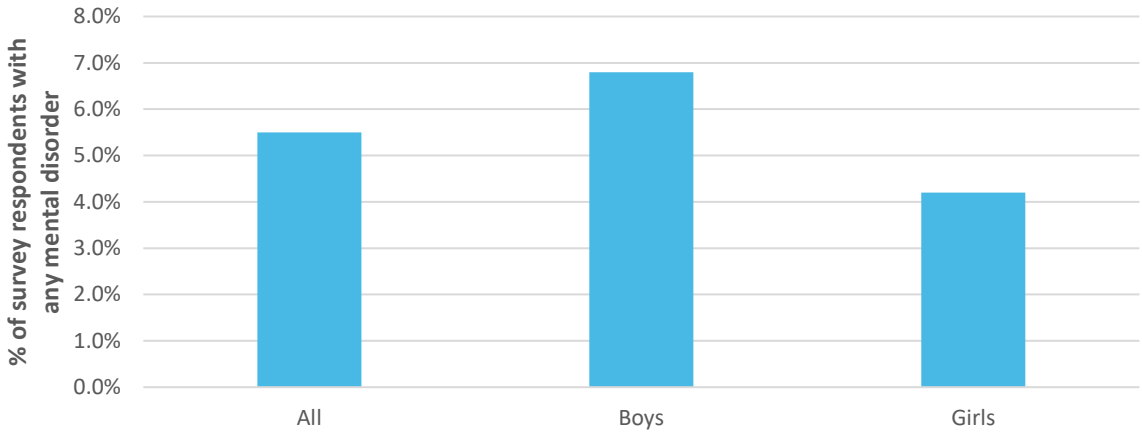
This follows the government's green paper on Transforming children and young people's mental health provision, published by the Department for Health and Social Care (DHSC) and the DfE. The paper proposed designated mental health leads within all schools, and mental health support teams working with children experiencing mild to moderate mental ill health[7].

This has been built on the foundations set out in The Five Year Forward View for Mental Health (2016), which aimed for parity of esteem between physical and mental health for all people, of all ages, while making the case to train existing staff and recruit 1,700 more people in Children and Young People's (CYP) mental health services[8].

Children under 5

In 2017, data was first published on the mental health of children aged 2 to 4 years. As the survey follows the same cohort, data is used from the 2017 version for children under 5 years. Figure 1 shows that 6.8% of boys (1 in 15) aged 2 to 4 years had any mental disorder, higher than girls (4.2%, 1 in 25).

Figure 1: Percentage of 2–4-year-olds nationally, with any mental disorder, by sex, 2017[4]



Source: Mental Health of Children and Young People in England 2022

Children who have been neglected are more likely to experience mental ill health including depression, post-traumatic stress disorder, and attention deficit and hyperactivity disorder. In later life, they may also find it difficult to maintain healthy social relationships, including with their own children[9].

A child's mental wellbeing is influenced by parental styles, interpersonal relationships, and family functioning. Loving and trusting relationships, feeling supported, and having a sense of connection all have a positive association, with maternal mental ill health, family discord, hostility and breakup negatively associated with child mental wellbeing[9].

The Universal Health Visiting Service is part of the Healthy Child Programme, which includes home visits focused on assessing family needs, and providing early intervention if required[6]. The review at

age 2 to 2 ½ years uses the Ages and Stages Questionnaire (ASQ) to assess child development outcomes, including:

- Communication
- Skills
- Problem solving
- Social-emotional development
- Aspects of physical development

Any development delays identified within the ASQ are associated with poorer long-term outcomes including mental health, and general wellbeing. Services are available in all areas, however there is significant geographic variation in access and uptake – 90.3% are receiving the ASQ nationally, with Suffolk statistically significantly higher at 94.9%.

Early years risk factors – overview

When looking at Suffolk's child and maternal health profile, several areas are identified where Suffolk performs worse than the England average – many of these areas influence mental wellbeing. Figure 2 is a summary of the Office for Health Inequalities and Disparities (OHID) Fingertips measures early years risk factors in the child and maternal health profile. Suffolk is statistically significantly worse than the England average for these measures:

- Emergency admissions (aged 0-4)
- Proportion of New Birth Visits (NBVs) completed within 14 days
- Proportion of children receiving a 12-month review
- School readiness: percentage of children achieving a good level of development at the end of Reception
- School readiness: percentage of children achieving at least the expected level of development in communication, language, and literacy skills at the end of Reception.

Suffolk is statistically significantly better than national averages for:

- Smoking status at time of delivery
- A&E attendances (0-4 years)
- Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years)
- Children with one or more decayed, missing or filled teeth
- Proportion of infants receiving a 6 to 8 week review
- Proportion of children who received a 2-2 ½ year review
- Proportion of children receiving ASQ-3 as part of the Healthy Child Programme or integrate review
- Several child development indicators – however these all have data quality concerns.

Figure 2: Suffolk's child and maternal health – early years risk factors[10]

Better 95% Similar Worse 95% Not applicable Data quality concerns

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Suffolk			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18s conception rate / 1,000	2020	↓	143	11.6	11.8	13.0	30.4		2.7
Smoking status at time of delivery	2021/22	↓	483	7.6%	8.5%	9.1%	21.1%		3.1%
Low birth weight of term babies	2021	→	169	2.8%	2.5%	2.8%	5.0%		1.5%
Infant mortality rate New data	2019 - 21	–	66	3.1	3.4	3.9	7.5		1.2
Breastfeeding prevalence at 6-8 weeks after birth - current method	2021/22	↑	3,235	49.7%	51.6%	49.3%	-	*Insufficient number of values for a spine chart*	-
Reception: Prevalence of overweight (including obesity)	2021/22	↑	1,580	22.3%	20.9%	22.3%	28.7%		13.7%
A&E attendances (0-4 years) New data	2021/22	–	18,645	503.0	634.0	762.8	2,080.6		387.2
Emergency admissions (aged 0-4)	2020/21	→	4,335	110.9	95.3	91.2	193.7		40.5
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years) New data	2021/22	–	325	87.7	95.5	103.6	204.5		42.0
Children with one or more decayed, missing or filled teeth	2016/17	–	-	17.0%	18.0%	23.3%	47.1%		12.9%
Population vaccination coverage: MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2021/22	↑	7,555	90.8%	89.2%	85.7%	58.9%		95.6%
Proportion of New Birth Visits (NBVs) completed within 14 days	2021/22	→	4,878	75.7%	70.6%	82.6%	9.5%		99.0%
Proportion of infants receiving a 6 to 8 week review	2021/22	→	5,938	91.3%	65.3%	81.5%	5.6%		99.8%
Proportion of children receiving a 12-month review	2021/22	↓	5,013	75.4%	77.6%	81.9%	22.2%		99.1%
Proportion of children who received a 2-2½ year review	2021/22	→	5,489	76.2%	60.7%	74.0%	6.9%		98.8%
Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2021/22	↓	5,210	94.9%	96.8%	90.3%	31.5%		100%
Child development: percentage of children achieving a good level of development at 2 to 2½ years ⚠	2021/22	→	4,252	81.6%	83.8%	81.2%	43.5%		95.3%
Child development: percentage of children achieving the expected level in communication skills at 2 to 2½ years ⚠	2021/22	→	4,789	91.9%	89.5%	86.5%	52.5%		95.6%
Child development: percentage of children achieving the expected level in gross motor skills at 2-2½ years ⚠	2021/22	↑	5,109	98.1%	94.8%	93.5%	62.9%		98.8%
Child development: percentage of children achieving the expected level in fine motor skills at 2-2½ years ⚠	2021/22	→	4,962	95.2%	95.9%	93.3%	59.3%		99.5%
Child development: percentage of children achieving the expected level in problem solving skills at 2-2½ years ⚠	2021/22	→	5,043	96.8%	94.5%	92.7%	66.2%		99.1%
Child development: percentage of children achieving the expected level in personal social skills at 2 to 2½ years ⚠	2021/22	→	4,598	88.3%	91.8%	91.2%	60.8%		100%
School readiness: percentage of children achieving a good level of development at the end of Reception	2021/22	–	-	62.3%	64.6%	65.2%	53.1%		74.4%
School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	2021/22	–	-	80.1%	80.1%	79.5%	68.0%		90.0%
School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	2021/22	–	-	64.8%	66.7%	67.1%	54.5%		76.5%

Source: Fingertips, Child and Maternal Health

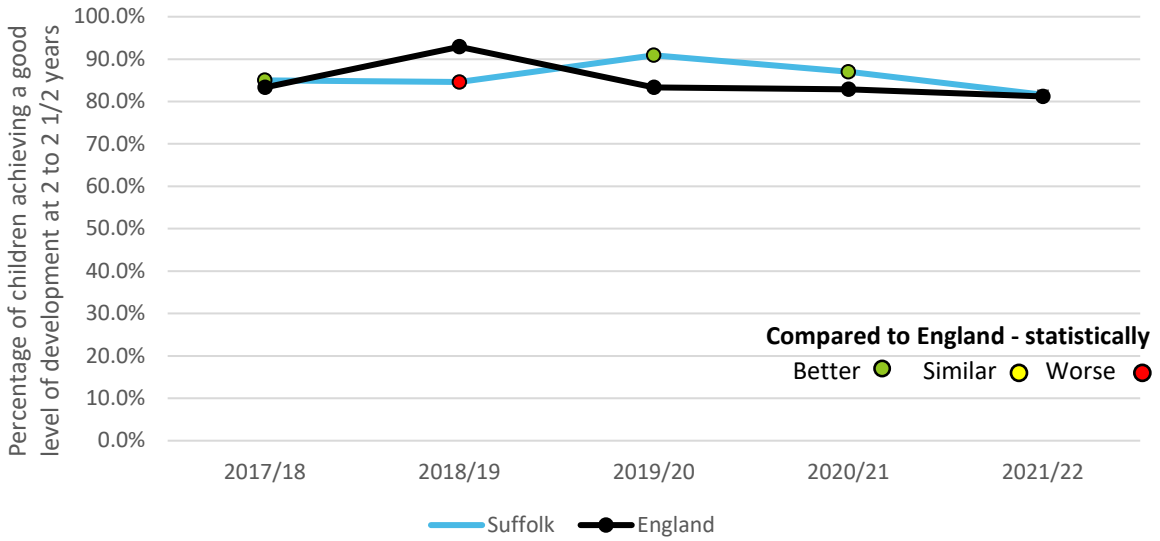
Child development and school readiness

Disparities in child development are recognisable in early years and have an impact by the time children enter school. If left unsupported, these children are less likely to achieve their full potential. ASQ-3 provides an objective measur e of development and allows comparisons to be made to help identify children who are not developing as expected and supporting decisions on closer monitoring of progress or early intervention services. Domains of development which are tested include communication, gross motor, fine motor, problem solving and personal-social skills.

There are inequalities in the number of children who achieve the expected level in their development, with children living in more deprived areas and boys less likely to be at expected levels.

The percentage of children achieving a good level of development between age 2 to 2 ½ years in Suffolk (81.6%) is statistically similar to the national average (81.2%) in 2021/22. However, since 2019/20, Suffolk was statistically significantly 7.6 percentage points higher than the national average – with 90.1% of 2 to 2 ½ years achieving a good level of development. This figure has fallen over the last 3 years, now statistically similar to the national average.

Figure 3: Child development: percentage of children achieving a good level of development at 2 to 2 ½ years (2017/18 to 2021/22)[10]

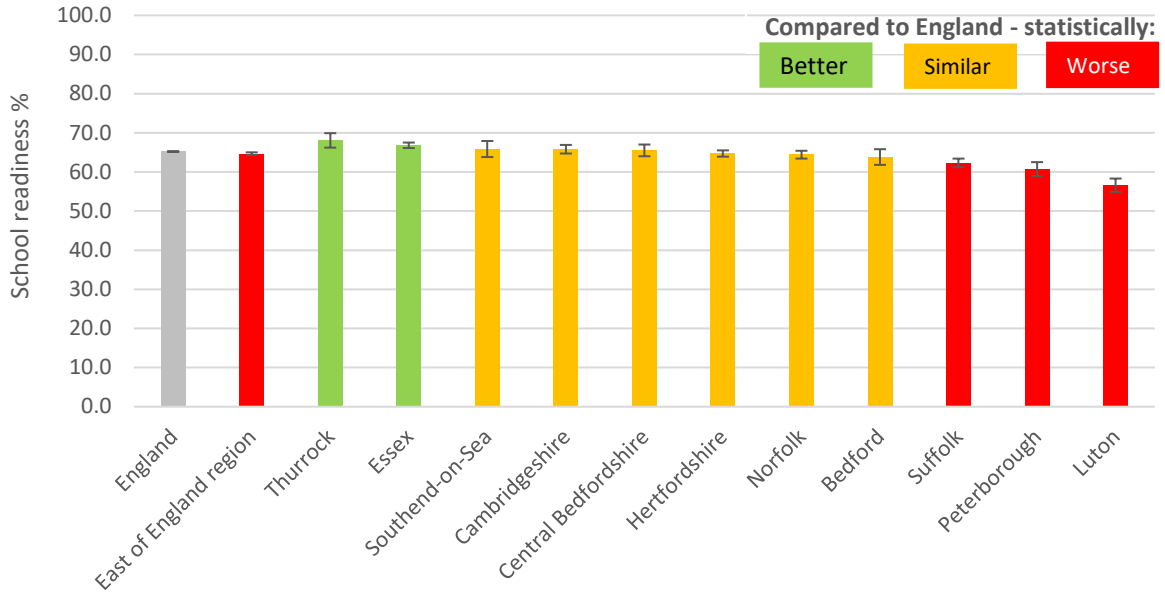


Source: Fingertips, Child and Maternal Health

School readiness is a key measure of early years development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and differences by social background emerge early in life.

Figure 4 compares Suffolk in 2021/22 to other counties within the eastern region for Reception school readiness. 6 out of 10 children in Suffolk achieve a good level of development at the end of Reception - a statistically significant lower percentage (61.2%) - meaning Suffolk's schoolchildren are already at a disadvantage prior to starting primary education.

Figure 4: School readiness: percentage of children achieving a good level of development at the end of Reception for Suffolk and eastern counties, 2021/22, compared to England[11]



Source: Early years foundation stage profile results

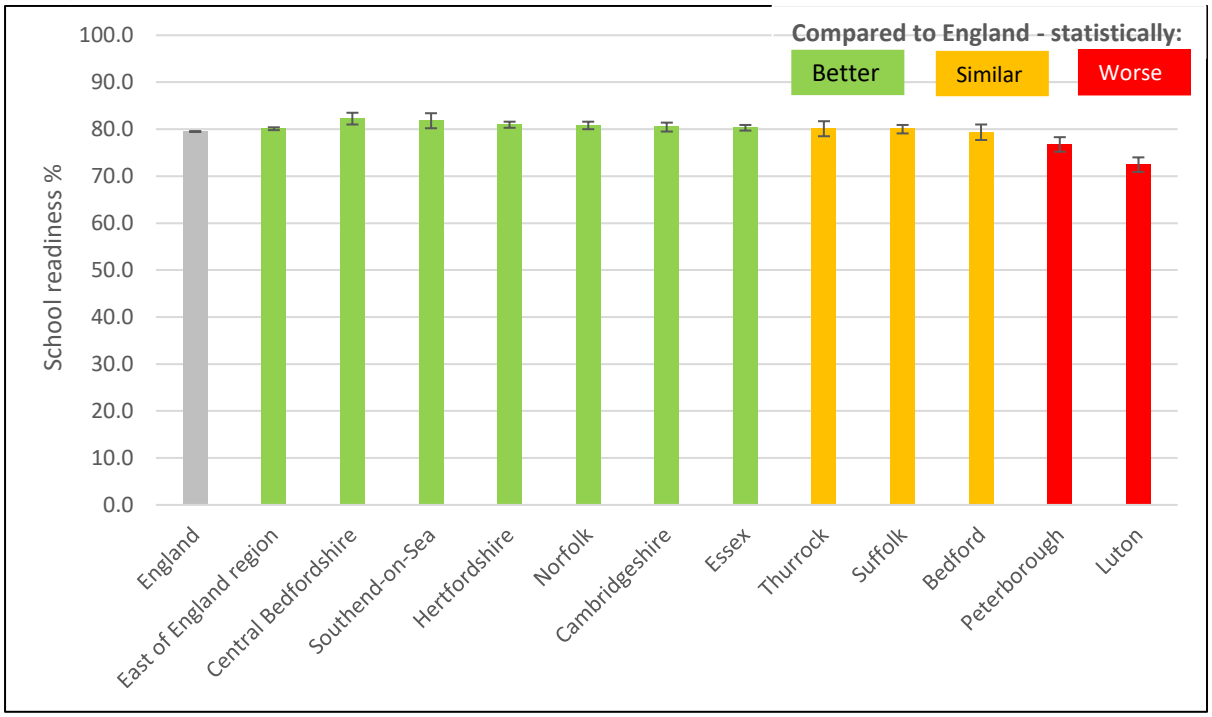
Disparities in child language capabilities are recognisable in the second year of life and have an impact by the time children enter school. If left unsupported, these children are likely to fall behind their peers and not reach their full potential.

The Office for Health Improvement and Disparities (OHID) has been allocated funding to train Health Visitors in the use of a new communication and language assessment tool to identify problems at 2 to 2 ½ years of age, and to arrange interventions where children are below expected level of development in this area. This is an outcome indicator used to measure the impact of early years services (including the universal and non-universal aspects of health visiting) and regarded as an important social determinant of longer-term health, education, and life chances.

For children to meet the criteria of achieving at least the expected level, they have to satisfy 'expected' or 'exceeding' levels of development within all three communication and language early learning goals (listening and attention, understanding, speaking).

Again, for school readiness regarding pupils achieving the expected level in communication and language skills – 80.1% of Suffolk's reception-aged children meet the expected level in communication and language skills. Just under 2 in 10 fail to meet the target, statistically similar to the national average (79.5%).

Figure 5: School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of reception, for Suffolk and Eastern counties, compared to England, 2021/22[11]



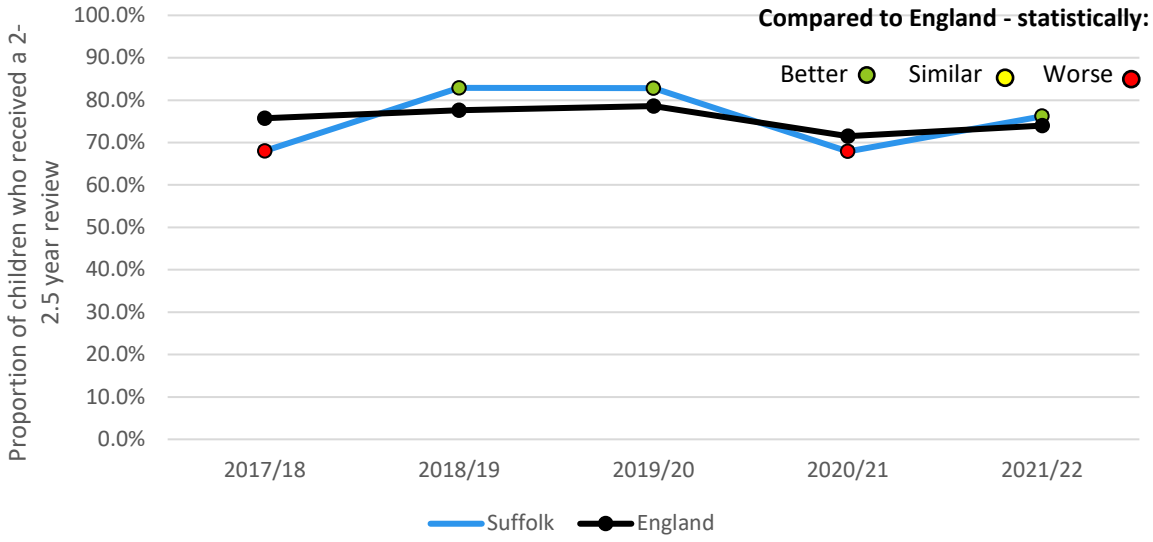
Source: Early years foundation stage profile results

Service delivery

All children and families should receive a review when the child reaches 2 to 2½ years. This allows for an integrated review of their health and development. In addition, it presents an opportunity to discuss preconception health with parents before any future pregnancy, and an opportunity to support the parents with issues such as access to a nursery place (including free provision), and a reminder of the importance of the pre-school immunisation booster.

For Suffolk, in 2022 over 3 in 4 (76.2%) 2 year old children received their review, which was statistically significantly higher than the national average. Suffolk's proportion of children receiving these reviews has been statistically significantly higher than the national average since 2018/19, apart from during 2020/21, where 67.9% of eligible children received reviews – 8.3 percentage points lower than the 2021/22 figure.

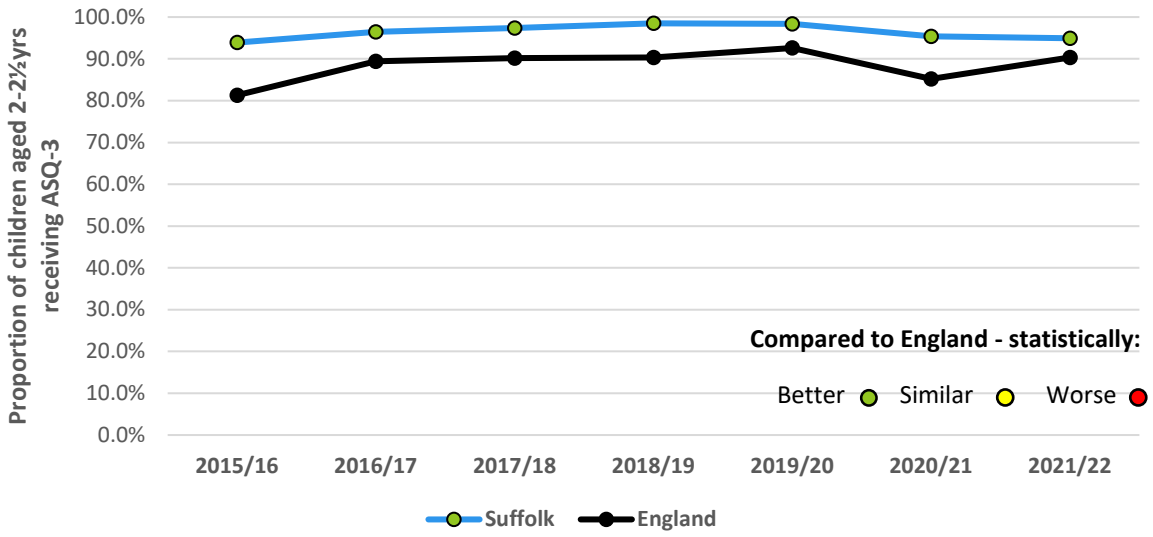
Figure 6: Proportion of children who received a 2-2 ½ year review, Suffolk and England, 2017/18 to 2021/22[10]



Source: Fingertips, Child and Maternal Health

The Department of Health is developing an outcome measure of child development at 2 years of age. The measure will help monitor child development across England to observe changes in population health from year to year, and potentially use the data to track children's outcomes as they grow up. The Ages and Stages Questionnaire-3 (ASQ-3) covers five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development. Health visiting teams should have been using ASQ-3 as part of HCP two-year reviews from April 2015. Since 2015/16, Suffolk has had a statistically higher proportion of children receiving the ASQ-3 than national averages over the same period.

Figure 7: Proportion of children aged 2-2 ½ years receiving ASQ-3 as part of the Healthy Child Programme or integrated review, Suffolk and England, 2015/16 to 2021/22[10]



Source: Fingertips, Child and Maternal Health

Children and young people aged 5 to 17

The report by OHID in 2015 on promoting children's emotional health and wellbeing, states that doing so will positively impact the child's cognitive development, learning, physical health, mental health, and social and economic prospects in adulthood[12]. Poor mental wellbeing in childhood and youth increases the likelihood in later life of:

- poor educational attainment
- antisocial behaviour
- drug and alcohol misuse
- teenage pregnancy
- involvement in criminal activity
- mental ill health[13]

Risk factors that may increase childhood vulnerability and reduce childhood mental wellbeing include:

- being in social care (looked after children)
- homelessness
- youth offending
- low household income
- family disharmony/parental breakup
- domestic violence and abuse
- parental substance misuse
- parental mental ill health and school absence and exclusions

Conversely, there are protective factors which can reduce vulnerability and increase mental wellbeing, including:

- high self-esteem
- good education

- someone from the family being in work
- development of good oral language skills
- positive relationships with parents
- social/community inclusion
- sport and physical activity

A child's resilience (ability to 'bounce back' from adversity) is also an important factor[14]. The presence of risk factors can be countered when a child is more resilient because they also have several protective factors, such as the presence of a supportive adult.

Adverse Childhood Experiences (ACEs) are important to consider in the context of children and young people who may need extra support. ACEs are a specific set of childhood experiences that are comparable with outcomes in later life:

ACEs directly relating to the child:

- psychological abuse
- physical abuse
- sexual abuse

ACEs relating to a child's household:

- parental separation
- domestic violence
- mental illness
- alcohol abuse
- substance misuse
- imprisonment

When compared to experiencing no ACEs during childhood, adults who experienced four or more were:

- 4 times more likely to be a high-risk drinker
- 6 times more likely to be a current smoker
- 6 times more likely to have sex under 16 years of age
- 11 times more likely to have smoked cannabis
- 16 times more likely to have used heroin or crack cocaine[15]

While ACE approaches to target interventions towards the most vulnerable children can be effective, they will not address all vulnerabilities.

Cyberbullying is an emerging issue – one survey estimated 18% of 11–15-year-olds experienced a form of bullying via electronic communication during a 2-month period[16]. Use of the internet and social media can adversely impact the mental health of children and young people, with more users becoming addicted to social media and other addictions[17]. It is also estimated that 91% of 16–24-year-olds use the internet for social networking, with this suggested to link to increased rates of anxiety, depression, and poor sleep[18].

If risks and protective factors can be quantified, this can help commissioners understand of the needs of children in Suffolk who are at higher risk of developing mental ill health, and to plan and implement appropriate prevention and early intervention services to meet said needs.

The March 2023 report by the Children's Commissioner on children's mental health services between 2021-22 summarised children's access to these services nationally. The report found that in England, 1.4 million children are estimated to have a mental health disorder, and of those 1.4 million:

- 48% received at least 1 contact with CYP mental health services
- 34% received at least 2 contacts with CYP mental health services[19]

A systematic review also highlighted the differences in adolescent depression to adult depression, highlighting that adolescents with depression experience considerable distress and may be confused about what is happening to them, ultimately trying to hide their symptoms – making diagnosis increasingly difficult. As a result, the review recommended in order to recognise and understand adolescent depression, we need to move away from viewing adolescents as smaller versions of adults[20].

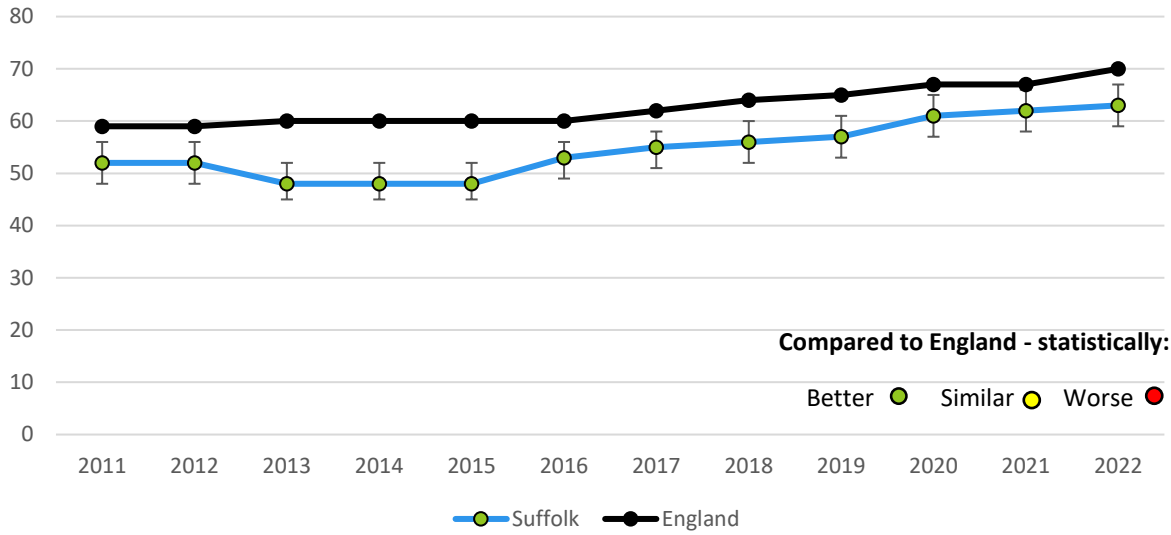
Understanding local population: data sources

Risk factors

Children and young people in care experience inequalities in health and social outcomes compared with all children, and these contribute to poor health and social exclusion of care leavers later in life[21].

Suffolk has statistically significantly fewer children in care (per 10,000) than the national average, at 62 per 10,000 in 2021 (n=921). The rate has been statistically significantly lower each year since 2011, however the rates of children in care per 10,000 have statistically significantly risen from 52 per 10,000 in 2011 to 62 per 10,000 in 2021.

Figure 8: Children in care, rate per 10,000, 2011-2022[21]

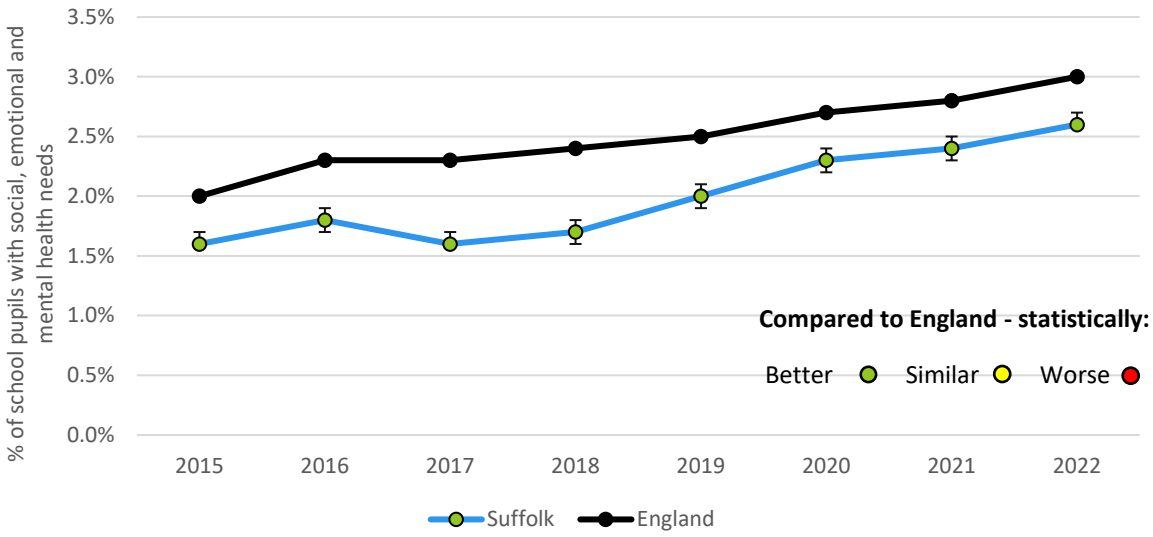


Source: Fingertips, Mental Health and Wellbeing

The National Clinical Practice Guidelines published by the British Psychological Society state that children with learning or physical disabilities have a greater risk of developing a mental health condition compared to the national population[22].

The recent trend for school pupils with social, emotional and mental health needs is increasing both within Suffolk, and nationally – with statistically significant increases from 2015 (1.6%) to 2021 (2.4%).

Figure 9: Suffolk and England's percentage of school pupils with social, emotional, and mental health needs, 2015–2022[21]



Source: Fingertips, Mental Health and Wellbeing

The figure below displays the rates of juveniles receiving their first conviction, caution, or youth caution per 100,000 10-17-year-old population by area of residence. Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. This indicator is included to ensure that vulnerable children and young people (aged 10 to 17) at risk of offending, are included in mainstream planning and commissioning.

Suffolk has a statistically similar rate of youth offending compared to national averages at 163.9 per 100,000. Many of Suffolk's nearest neighbours (other counties/unitary authorities that have similar socio-economic characteristics to Suffolk) report statistically significantly lower than national average rates of youth offending, with their figures decreasing year on year. Suffolk's rate of youth offending has had no significant change, remaining statistically similar and consistent over the last 5 years.

Figure 10: Suffolk's compared to children's services nearest neighbours, first time entrants per 100,000 to the youth justice system, 2021[21]

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

First time entrants to the youth justice system 2022

Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,984	148.9	145.6	152.2
CYP nn 2023	–	-	-	-	-
Dorset	–	58	177.4	134.8	229.1
Suffolk	–	121	176.5	146.5	211.0
Devon	–	90	131.3	105.6	161.4
Worcestershire	–	65	118.6	91.6	151.1
Norfolk	–	83	108.3	86.3	134.2
East Sussex	–	51	105.9	78.9	139.0
Lincolnshire	–	68	101.0	78.5	128.0
Cornwall	–	50	100.7	74.6	132.9
Gloucestershire	–	47	80.4	59.1	106.7
Shropshire	–	10	37.2	18.1	67.7
Somerset UA	–	-	-	-	-

Source: Fingertips, Mental Health and Wellbeing

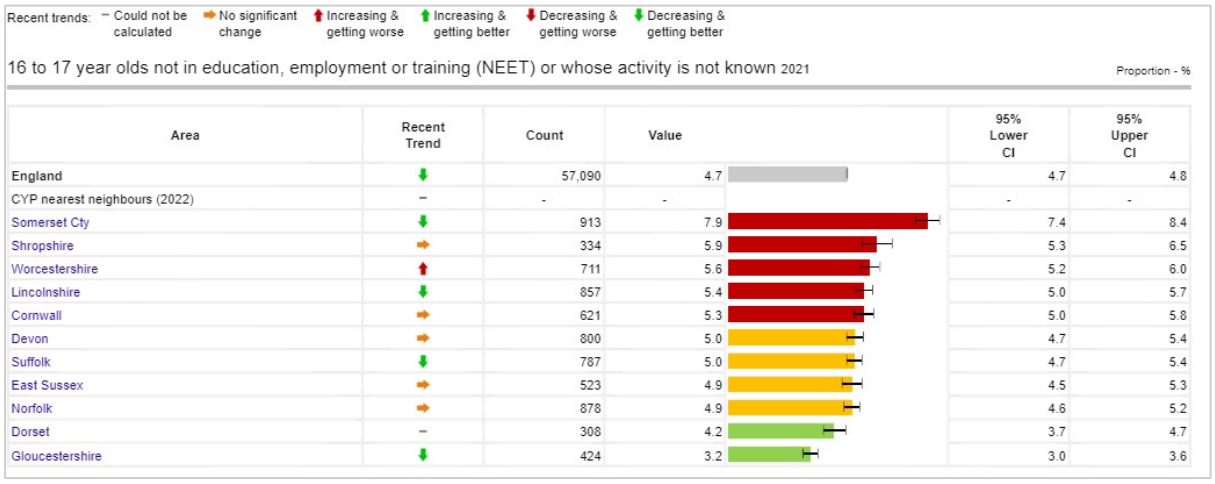
Young people who are not in education, employment, or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression, or early parenthood. The indicator is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training, and work.

The Government believes that increasing the participation of young people in learning and employment makes a difference to individual lives and improves social mobility and stimulate economic growth.

To support more young people to study and gain the skills and qualifications that lead to sustainable jobs, reducing the risk of young people becoming NEET, legislation was included in 2013 to raise the participation age as contained within the Education and Skills Act 2008. This required that from 2013 all young people remain in some form of education or training until the end of the academic year in which they turn 17.

Between 2016 to 2018, Suffolk had a statistically significantly higher proportion of young people not in education, employment or training compared to England. This percentage has since fallen, with 5.0% (1 in 20) Suffolk 16/17-year-olds not in education, employment, or training in 2021. Rates for Suffolk's children's services neighbours range from 7.9% (Somerset) to 3.2% (Gloucestershire).

Figure 11: 16 to 17 year olds not in education, employment, or training (NEET) or whose activity is not known, 2021[21]



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	57,090	4.7	4.7	4.8
CYP nearest neighbours (2022)	–	-	-	-	-
Somerset Cty	↓	913	7.9	7.4	8.4
Shropshire	→	334	5.9	5.3	6.5
Worcestershire	↑	711	5.6	5.2	6.0
Lincolnshire	↓	857	5.4	5.0	5.7
Cornwall	→	621	5.3	5.0	5.8
Devon	→	800	5.0	4.7	5.4
Suffolk	↓	787	5.0	4.7	5.4
East Sussex	→	523	4.9	4.5	5.3
Norfolk	→	878	4.9	4.6	5.2
Dorset	–	308	4.2	3.7	4.7
Gloucestershire	↓	424	3.2	3.0	3.6

Source: Fingertips, Mental Health and Wellbeing

Protective factors

Children's education and development of skills are important for their own wellbeing and for that of the nation. Learning ensures that children develop the knowledge and understanding, skills, capabilities, and attributes that they need for mental, emotional, social, and physical wellbeing now and in the future.

Children with poorer mental health are more likely to have lower educational attainment and there is some evidence to suggest that the highest level of educational qualifications is a significant predictor of wellbeing in adult life; educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing, and other material resources. Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances.

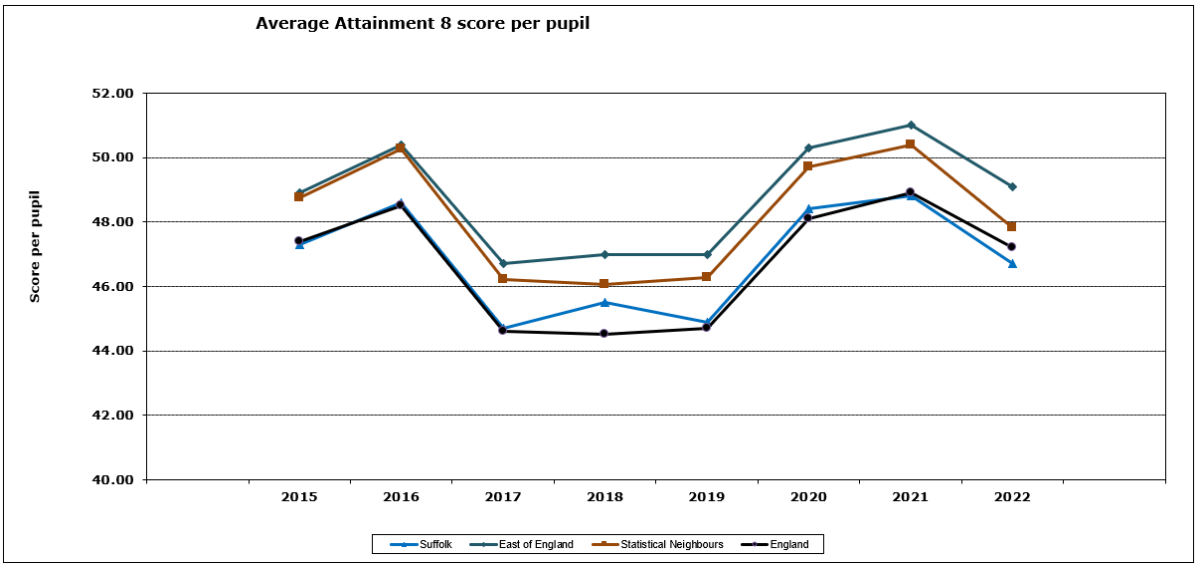
Attainment 8 is a way of measuring how well pupils do in key stage 4, which they usually finish when they are 16 years old. The 8 subjects which make up Attainment 8 include English and maths. Out of the remaining 6 subjects:

- 3 must come from qualifications that count towards the English Baccalaureate (EBacc), like sciences, language, and history
- 3 qualifications can be either GCSE qualifications (including EBacc subjects) or technical awards from a list approved by the Department for Education

Each grade a pupil gets is assigned a point score from 9 (the highest) to 1 (the lowest). Each pupil's Attainment 8 score is calculated by adding up the points for their 8 subjects, with English and maths counted twice. A school's Attainment 8 score is the average of all the scores of its eligible pupils[23].

Comparisons for Attainment 8 are not calculated as summer exams were cancelled in 2020 and 2021, and adaptations were made to exams and their grading for Summer 2022. "Exercise caution when considering comparisons over time, as they may not reflect changes in pupil performance alone."[23]

Figure 12: Suffolk and children's services nearest neighbours, average attainment 8 score, 2015-2022[24]

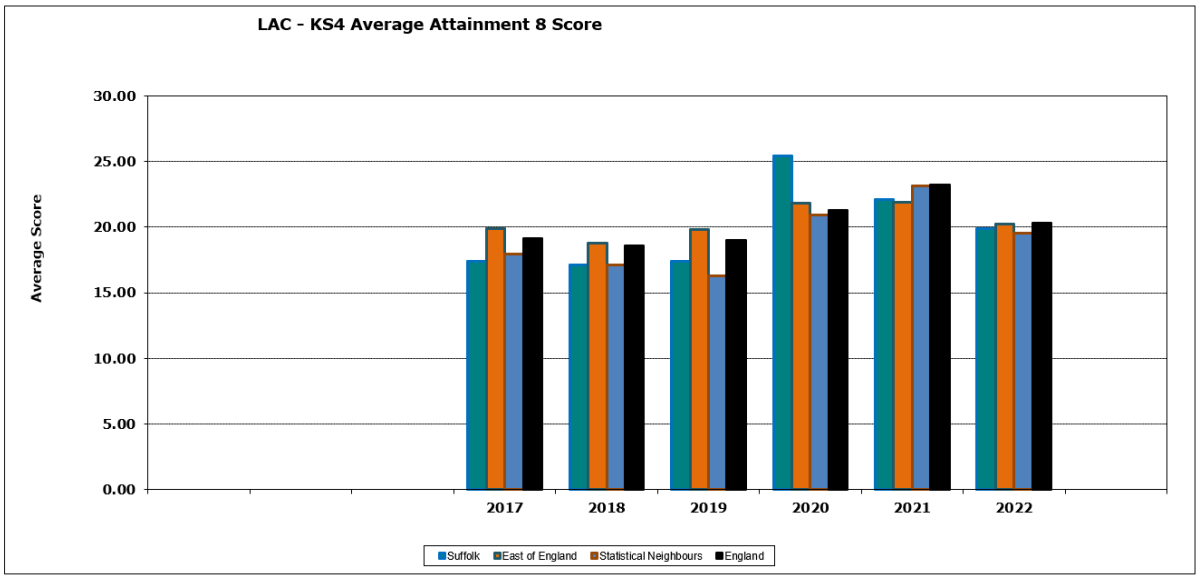


Source: Local authority interactive tool (LAIT)

The definition of a 'looked after child' is a child who has been continuously looked after for at least 12 months up to and including 31st March. This definition has been used because 12 months is considered an appropriate length of time to gauge the possible association of being looked after on educational attainment. However, note that a child may not have been in the care of a local authority for the entirety of a key stage period.

Suffolk's average attainment 8 score for looked after children was 19.9 in 2022, less than half the average pupil attainment score (46.7). Of all English councils providing children's services, Suffolk was ranked 83rd (where 1 is best), in the third (lowest / worst) quartile.

Figure 13: Suffolk and nearest children's services neighbours, average attainment 8 score of children in care, 2022[24]



Source: Local authority interactive tool (LAIT)

Pandemic implications

A systematic review on international studies published between January 1st 2020 and December 19th 2022 uncovered a number of findings for young people (under the age of 19) emergency department visits before and during the pandemic. The systematic review found:

- Strong evidence of an increase in emergency department visits for attempted suicide during the pandemic
- Modest evidence of an increase in emergency department visits for suicidal ideation
- Strong evidence for only a slight change in rates of self-harm
- Self-harm among older children (mean age 16.3 years) showed strong evidence of an increase
- Self-harm among younger children (mean age 9.0 years) showed modest evidence of a decrease[25]

The Government Social Research report into the impact of the pandemic on adolescent mental health found that the pandemic led to an increase in adolescent depressive symptoms and a decrease in life satisfaction[26]. However, a recent systematic review found that symptom change estimates for general mental health, anxiety symptoms and depression symptoms were close to zero and not statistically significant before and during the Covid-19 pandemic[27].

National considerations

The Big Ask survey conducted by the Children's Commissioner between April and May 2021 of over 500,000 children and young people between the ages of 6-17, found that 80% of children and young people were happy, or okay with their mental wellbeing[28]. This suggests most children broadly coped well with the pandemic, but girls and young women, older young people (16-24 years old), disadvantaged children and young people, and those with SEND were more likely to report difficulties with mental health and wellbeing[29].

The Children's Commissioner also found that data on children in inpatient settings is limited, but average waiting times for children and young people to start treatment increased from 32 days in 2020/21 to 40 days in 2021/22.

The cost-of-living crisis is also having an impact on children's health and wellbeing. A report from Barnardo's summarises the impact the crisis is having on children and families in the UK from a YouGov poll of 1,000 parents and 316 children aged 11 to 15. Almost 1 in 3 (30%) parents reported their child's mental health had worsened due to rising costs of living, and additional financial pressures were impacting parent's mental health and capacity to support their children[30].

More information on the impact of the pandemic on children and young people's mental health can be seen in The State of Children in Suffolk 2022 Mental Health section.

Planning quality mental health and care services

Child and adolescent mental health services (CAMHS) encapsulates all services who work with children and young people who experience difficulties with their emotional, or behavioural wellbeing. These can be from statutory, voluntary, or school-based sectors such as NHS trusts, local authorities and schools or charitable organisations.

Specialist CAMHS are NHS mental health services that focus on the needs of children and young people. They are multidisciplinary teams that often consist of:

- psychiatrists
- psychologists
- social workers
- nurses
- support workers
- occupational therapists
- psychological therapists – this may include child psychotherapists, family psychotherapists, play therapists and creative art therapists
- primary mental health link workers
- specialist substance misuse workers

Evaluation of service delivery is important to understand if care and interventions children and young people are receiving, are having the intended positive effect. This is in addition to looking at how available interventions fit with the preferences of children and young people and their parents/carers, to have the greatest impact[15].

To plan user friendly services, children and young people's current use of mental services needs to be understood. Based on the data within Mental Health of Children and Young People in England, 2017:[31]

- 66% of 5 to 19 year olds with a mental disorder have had contact with a professional service in the past year because of worries about mental health; teachers are the most common source of support (48.5%), followed by primary care professionals (33%), mental health specialists (25%) and educational support services (23%)
- over 1 in 5 children with a disorder reported waiting more than 6 months for contact with a mental or physical health specialist (21%) or with educational support services (22%)
- 2.5% of 5 to 19 year olds take medication with the aim of improving their mental state, this equates to 16% of children with a disorder

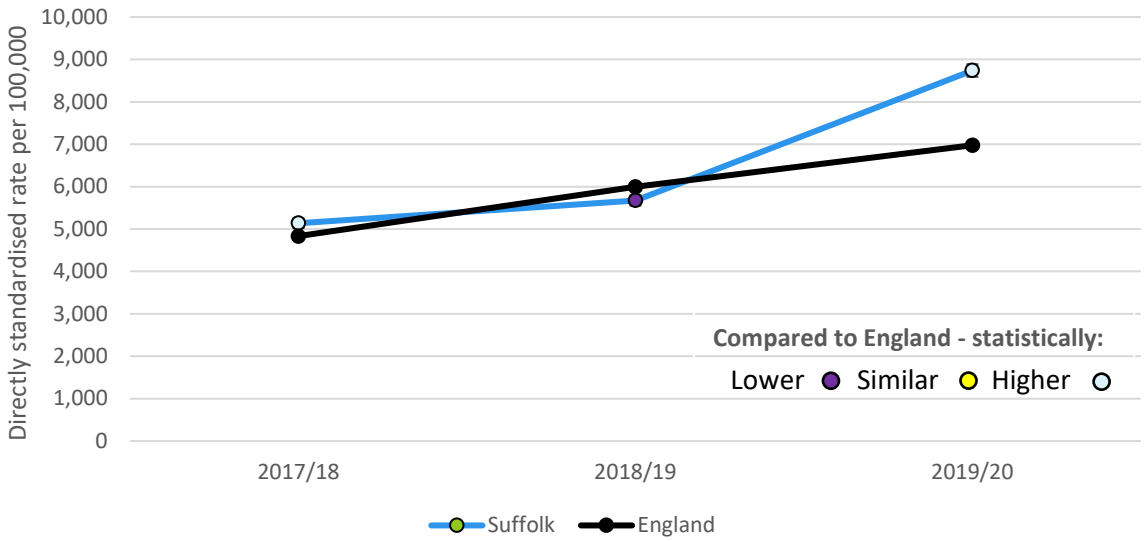
Understanding local population: data sources

There is a strong and clear need for improved local data (including inequalities breakdown) on access to mental health care and outcomes from mental health treatment. The rate of new referrals provides local health and care systems with an important measure of demand. It will help to assess how the demand reflects the mental health needs of the local population and if the demand can be met by current service provisions. It is a measure of the number of referrals made to mental health services in the time period which will reflect factors such as the prevalence of mental ill health in the community, the capacity of primary care services to manage this need, local secondary mental health services and the expectation that the secondary services are able to accept referrals. Secondary mental health services usually require a referral from a GP – these includes hospitals, some psychological wellbeing services, community mental health teams (CMHTs), crisis resolution and home treatment teams (CRHTs)[32].

The rates per 100,000 are directly standardised – from 2017/18 to 2019/20 (latest figures), services in Suffolk experienced statistically significant higher rates of referrals into secondary mental health services for those under the age of 18. In 2019/20, 13,195 (8,738 per 100,000) new referrals for children and young people were made, statistically significantly higher than the national average of 6,977 per 100,000. The Suffolk rate was also significantly higher than four of its top five children's services statistical nearest neighbours:

- Norfolk 10,734 per 100,000, statistically significantly higher than England and Suffolk
- Cornwall 5,194 per 100,000, statistically significantly lower than England and Suffolk
- Somerset County 4,269 per 100,000, statistically significantly lower than England and Suffolk
- Devon 4,234 per 100,000, statistically significantly lower than England and Suffolk
- Dorset 4,180 per 100,000, statistically significantly lower than England and Suffolk

Figure 14: New referrals to secondary mental health services per 100,000 between 2017/18 to 2019/20 (under 18 years of age)[21]



Source: Fingertips, Mental Health and Wellbeing

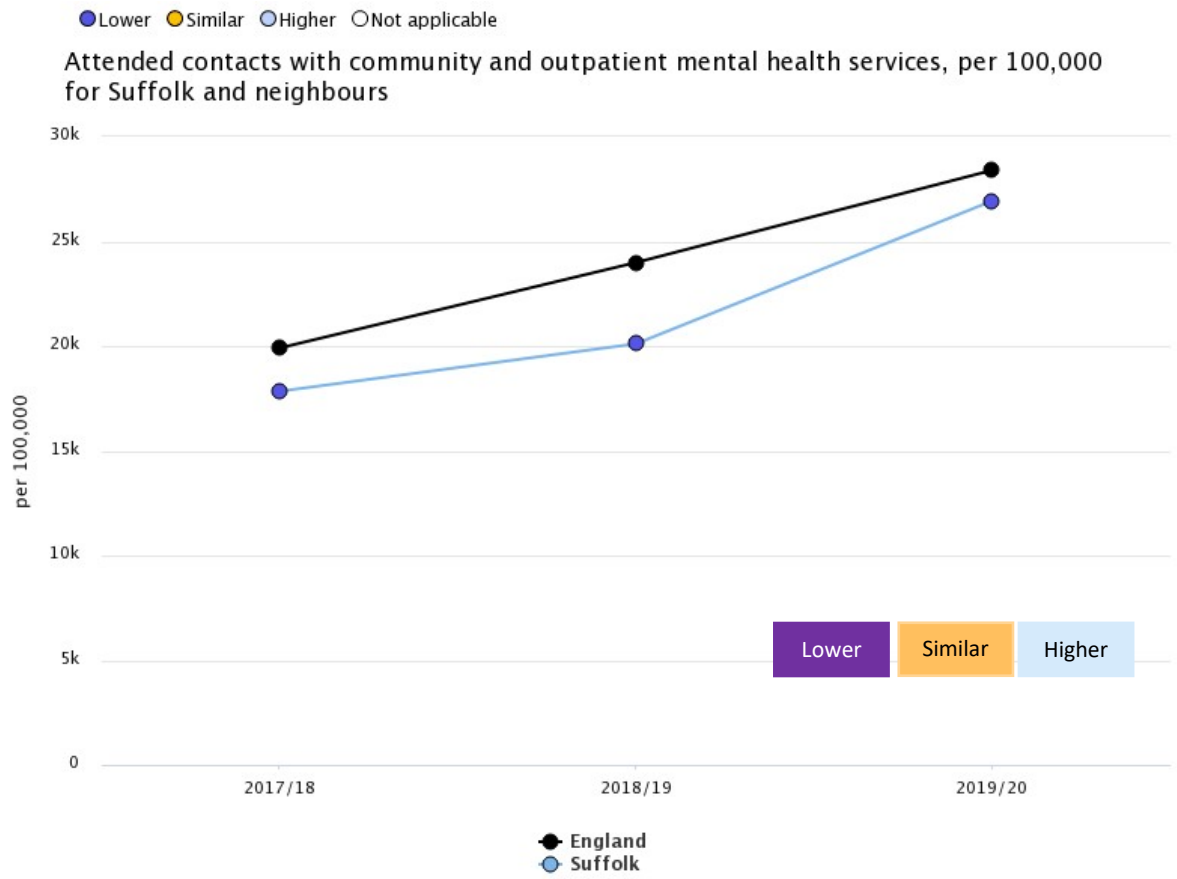
The rate of attended contacts provides local health and care systems with an important measure of demand. It will help to assess how the demand reflects the mental health needs of the local population and if the demand can be met by current service provisions. It is a measure of the number of attended contacts with mental health services that are happening in the community in the time period. This will be influenced by the prevalence of mental ill health in the community, the capacity of primary care services to manage this need, and how much activity local secondary mental health services are delivering.

In 2021, Suffolk has a statistically significantly lower number of attended contacts per 100,000 with community and outpatient mental health services for under 18s, at 26,932 per 100,000 compared to the national average of 28,395 per 100,000. This rate has statistically significantly increased each year since 2017/18 (17,842 per 100,000), similar to the number of new referrals. Suffolk's children's services statistical neighbours:

- Norfolk 28,188 per 100,000, statistically significantly similar to England and higher than Suffolk
- Cornwall 26,678 per 100,000, statistically significantly lower than England and Suffolk
- Dorset 25,853 per 100,000, statistically significantly lower than England and Suffolk
- Somerset County 20,471 per 100,000, statistically significantly lower than England and Suffolk
- Devon 18,960 per 100,000, statistically significantly lower than England and Suffolk

This means that Suffolk's community and outpatient mental health services are being used more, however number of contacts does not equate to unique visitors. Therefore, further analysis could identify the number of contacts per individual to understand if more people are attending, more frequently – or the same number of individuals are accessing services more often.

Figure 15: Suffolk attended contacts with community and outpatient mental health services per 100,000 (under 18 years of age), 2017/18 – 2020/2021[21]

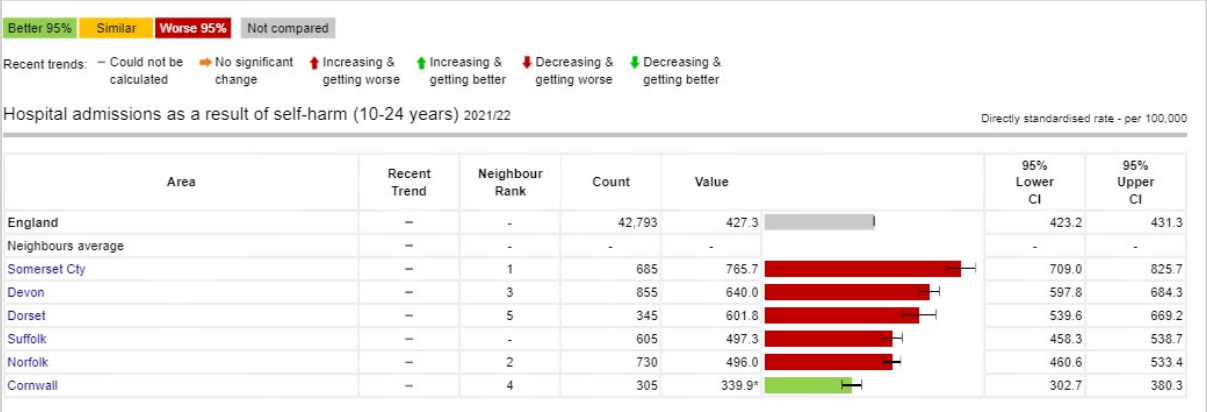


Source: Fingertips, Mental Health and Wellbeing

Hospital admissions for self-harm in children have increased in recent years, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.

Since 2018/19 the Suffolk rate of hospital admissions as a result of self-harm in children and young people aged 10 to 24 has been statistically significantly higher than England. In 2021/22, it was 497.3 hospital admissions per 100,000 (n=602). Rates among Suffolk's top five children's services statistical neighbours range from 339.9 per 100,000 in Cornwall (statistically significantly lower, better than Suffolk and England) to 765.7 per 100,000 in Somerset (statistically significantly higher, or worse, than England and Suffolk). Suffolk's rate of self-harm in 202/22 is 16.4% higher than the national average.

Figure 16: Hospital admissions as a result of self-harm (10-24 years), England, Suffolk and Suffolk's top five children's services statistical neighbours, directly standardised rates 2011/12 to 2021/22[21]



Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	42,793	427.3	423.2	431.3
Neighbours average	–	-	-	-	-	-
Somerset Cty	–	1	685	765.7	709.0	825.7
Devon	–	3	855	640.0	597.8	684.3
Dorset	–	5	345	601.8	539.6	669.2
Suffolk	–	-	605	497.3	458.3	538.7
Norfolk	–	2	730	496.0	460.6	533.4
Cornwall	–	4	305	339.9*	302.7	380.3

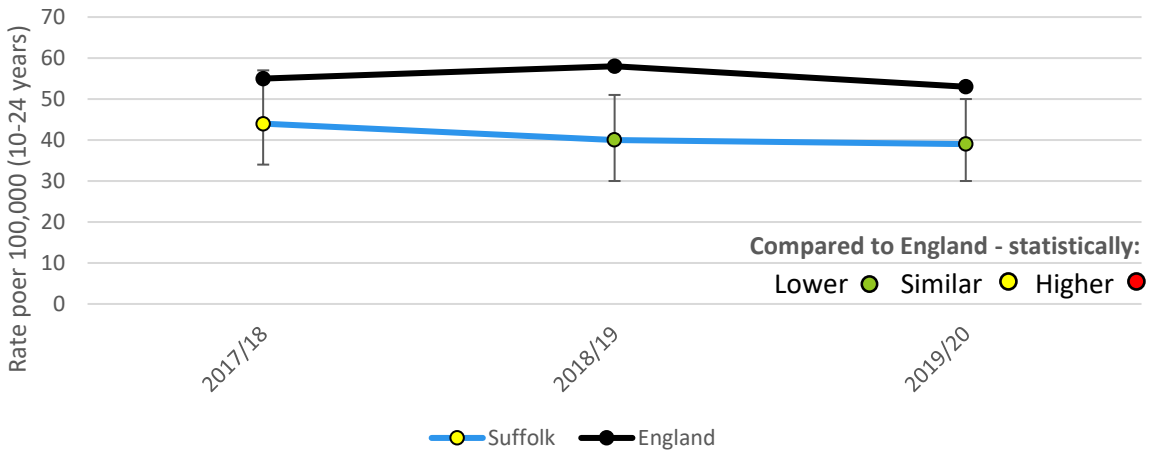
Source: Fingertips, Mental Health and Wellbeing

The number of inpatient stays in secondary mental health services per 100,000 for those under the age of 18, is a measure of the all-inpatient stays where the patient was in hospital for all or part of the time period. This measure reflects factors such as the prevalence, and possibly severity, of mental ill health in the community, the capacity of primary care and community mental health services to manage this need, local secondary mental health service structures and how inpatient capacity is used within Suffolk.

Suffolk had a statistically significant lower number of inpatient stays in secondary mental health services in 2019/20: 39.0 per 100,000 compared to England, 53.0 per 100,000. Three of the five children's services statistical neighbours to Suffolk have statistically significantly lower rates than England:

- Cornwall 64 per 100,000, statistically significantly similar to England and higher than Suffolk
- Dorset 57 per 100,000, statistically significantly similar to England and Suffolk
- Norfolk 42 per 100,000, statistically significantly lower than England and similar to Suffolk
- Somerset County 21 per 100,000, statistically significantly lower than England and similar to Suffolk
- Devon 14 per 100,000, statistically significantly lower than England and Suffolk

Figure 17: Inpatient stays in secondary mental health services, per 100,000 (<18 years), 2017/18 - 2019/20 directly standardised rate per 100,000[21]



Source: Fingertips, Mental Health and Wellbeing

Evidence and further information (general)

Further indicators within the Fingertips Children and Young People's Mental Health and Wellbeing Profile includes further metrics which can be used to identify additional risk factors and preventative factors between children aged 0 to 18. The Department for Education also publishes statistics on the number of pupils with special educational needs and school exclusions.

The Child and Maternal Health Intelligence Network provides statistics on children and young people generally, in addition to information within Fingertips profiles.

The Local Health tool contains several indicators around poverty and education reported at geographies lower than local authority – such as MSOA and Ward areas.

Commissioning cost-effective services for promotion of mental health and Wellbeing and prevention of mental ill health provides return on investment resources to support the design and implementation of mental health and wellbeing support services.

The toolkit produced between the Evidence Based Practice Unit at University College London and the Anna Freud National Centre for Children and Families provides resources on measuring and monitoring children and young people's wellbeing in schools and colleges.

The Office for Health Improvement and Disparities (OHID/formerly Public Health England) in 2015 published a Rapid review to update evidence for the healthy child programme 0 to 5. This review brought together evidence on 'what works' in:

- parental mental health
- smoking
- alcohol/drug misuse
- intimate partner violence
- preparation and support for childbirth and the transition to parenthood
- attachment
- parenting support
- unintentional injury in the home
- safety from abuse and neglect

- nutrition and obesity prevention
- speech, language, and communication

PHE: Supporting public health: children, young people, and families (last updated May 2021) is a series of resources designed to support local authorities and providers responsible for commissioning, and delivery public health services for ages 0-19. The documents include health and wellbeing, resilience, maximising learning, and achievement, supporting complex and additional health needs and transition to adulthood.

Evidence and further information (system planning)

The Evidence Based Practice Unit: Anna Freud National Centre for Children and Families is a collection of resources on academic research and mental health practice, for children and young people in additional to mental health practitioners.

Choice and Partnership Approach (CAPA) is a clinical service transformation model involving young people and their families – addressing demand and capacity, skills, and job planning.

A whole system approach utilising children and their families as active decision makers in the service approach is used in THRIVE Elaborated. This resource also has a clear distinction between treatment, and support.

Evidence and further information (planning for specific conditions)

Often, services will need to be planned with a specific condition considered. In that instance, these resources may be useful:

The 2016 Mental Health of Children and Young People in England report details different mental ill health experienced, as well as the body of evidence of what works to improve children and young people's mental health.

National Institute for Health and Care Excellence provides clinical guidelines and standards for recognising, diagnosing, and managing various mental health conditions for children and young people, including ADHD, depression, eating disorders, self-harm and social anxiety among others.

References

1. NICE. Glossary (H). *Nice* 1–3 (2018).
2. NHS. Patients Registered at a GP Practice April 2021 - NDRS. https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/april-2021.
3. Kessler, R. C. *et al.* Age of onset of mental disorders: A review of recent literature. *Curr. Opin. Psychiatry* **20**, 359–364 (2007).
4. Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey - NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey.
5. Relationships and sex education (RSE) and health education - GOV.UK. https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education.
6. Supporting public health: children, young people and families - GOV.UK. https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-

children.

7. Transforming children and young people's mental health provision: a green paper - GOV.UK. https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper.

8. The Mental Health Taskforce. The Five Year Forward View for Mental Health. 81 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (2016).

9. Health Scotland. *Establishing a core set of national, sustainable mental health indicators for children and young people in Scotland: Final Report*. (Health Scotland, 2012).

10. Office for Health Improvement and Disparities. Child and Maternal Health Profile. *Fingertips Public Health Profiles* https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/6/par/E12000006/ati/302/are/E10000029/yrr/1/cid/4/tbm/1/page-options/car-do-0.

11. Early years foundation stage profile results: 2021 to 2022 - GOV.UK. https://www.gov.uk/government/statistics/early-years-foundation-stage-profile-results-2021-to-2022.

12. Promoting children and young people's mental health and wellbeing - GOV.UK. https://www.gov.uk/government/publications/promoting-children-and-young-peoples-emotional-health-and-wellbeing.

13. Chanfreau, J. *et al. Predicting wellbeing*. (2014). doi:10.13140/2.1.3267.4564.

14. Mesman, E., Vreeker, A. & Hillegers, M. Resilience and mental health in children and adolescents: An update of the recent literature and future directions. *Curr. Opin. Psychiatry* **34**, 586–592 (2021).

15. Department of Health & NHS England. *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf (2015).

16. Cyberbullying: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England, 2014. (2017).

17. Tullett-Prado, D., Stavropoulos, V., Gomez, R. & Doley, J. Social media use and abuse: Different profiles of users and their associations with addictive behaviours. *Addict. Behav. Reports* **17**, 100479 (2023).

18. RSPH. #StatusofMind. https://www.rsph.org.uk/our-work/campaigns/status-of-mind.html (2017).

19. Children's mental health services 2021-2022 | Children's Commissioner for England. https://www.childrenscommissioner.gov.uk/resource/29751/.

20. Twivy, E., Kirkham, M. & Cooper, M. The Lived Experience of Adolescent Depression: A Systematic Review and Meta-Aggregation. *Clin. Psychol. Psychother.* (2023) doi:10.1002/CPP.2834.

21. OHID. Mental Health and Wellbeing JSNA. *Office for Health Improvement and Disparities* https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna (2021).

22. British Psychological Society. Practice Guidelines - BPS.

https://explore.bps.org.uk/content/report-guideline/bpsrep.2017.inf115 (2017) doi:10.53841/BPSREP.2017.INF115.

23. GOV.UK. GCSE results (Attainment 8) (Ethnicity facts and figures). https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/11-to-16-years-old/gcse-results-attainment-8-for-children-aged-14-to-16-key-stage-4/latest/.

24. Department for Education. Local authority interactive tool (LAIT). https://www.gov.uk/government/publications/local-authority-interactive-tool-lait.

25. Madigan, S. *et al.* Comparison of paediatric emergency department visits for attempted suicide, self-harm, and suicidal ideation before and during the COVID-19 pandemic: a systematic review and meta-analysis. *The Lancet Psychiatry* **0**, (2023).

26. Mansfield, R., Hayes, D. & Boehnke, J. R. The impact of the COVID-19 pandemic on adolescent mental health Research report March 2022.

27. Sun, Y. *et al.* Comparison of mental health symptoms before and during the covid-19 pandemic: evidence from a systematic review and meta-analysis of 134 cohorts. *BMJ* **380**, e074224 (2023).

28. Children's Commissioner for England. The Big Ask: Big Answers. https://www.childrenscommissioner.gov.uk/resource/the-big-ask-big-answers/ (2021).

29. The Good Childhood Report 2021 | The Children's Society. https://www.childrenssociety.org.uk/information/professionals/resources/good-childhood-report-2021.

30. Cooper, A. *A crisis on our doorstep The deepening impact of the cost-of-living crisis on children and young people in the UK*. https://cms.barnardos.org.uk/sites/default/files/2023-03/crisis-on-our-doorstep-barnardos-report-march2023.pdf (2023).

31. NHS Digital. Mental Health of Children and Young People in England, 2017. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 (2018).

32. About healthcare - Mind. https://www.mind.org.uk/information-support/legal-rights/health-and-social-care-rights/about-healthcare/.