A HEALTHY STATE OF MIND

Improving young people's mental fitness

Kulvir Channa

About Localis

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We are an independent, cross-party, leading not-for-profit think tank that was established in 2001. Our work promotes neo-localist ideas through research, events and commentary, covering a range of local and national domestic policy issues.

Neo-localism

Our research and policy programme is guided by the concept of neo-localism. Neo-localism is about giving places and people more control over the effects of globalisation. It is positive about promoting economic prosperity, but also enhancing other aspects of people's lives such as family and culture. It is not anti-globalisation, but wants to bend the mainstream of social and economic policy so that place is put at the centre of political thinking.

In particular our work is focused on four areas:

- **Reshaping our economy.** How places can take control of their economies and drive local growth.
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- **Reforming public services.** Ideas to help save the public services and institutions upon which many in society depend.
- **Improving family li**fe. Fresh thinking to ensure the UK remains one of the most family friendly places in the world.

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We run a broad events programme, including roundtable discussions, panel events and an extensive party conference programme.

We also run a membership network of local authorities and corporate fellows.

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Their contributions, examples and views have been extremely helpful and shaped what follows.

Any errors or omissions remain my own.

Kulvir Channa

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Advisory Panel

This research was supported by an Advisory Panel, whose members are listed below. They may not necessarily agree with every analysis and recommendation made in the report.

- Matthew Reed, Chief Executive of The Children's Society
- Louise Bazalgette, Head of the Strategy Unit at NSPCC
- Helen Riley, Deputy Chief Executive and Director for Family and Communities at Staffordshire County Council
- Graeme Gordon, independent consultant
- Amanda Kelly, Managing Director at iMPOWER

Roundtable Attendees

We held research roundtables in Birmingham and London. A full list of attendees for these events are listed below.

- Heather Bennett, Head of Service for Paediatrics at Sandwell & West Birmingham Hospitals NHS Trust
- Matt Comins, Head of Youth Support Services at Wandsworth Borough Council
- Margaret Courts, Children's Commissioning Manager at NHS Wolverhampton CCG
- Jo Davidson, Director of Children's Wellbeing at Herefordshire Council
- Catherine Evans, Head of Safeguarding at Birmingham & Solihull Mental Health NHS Foundation Trust
- Cllr Alisa Flemming, Cabinet Member for Children, Young People and Learning at London Borough of Croydon
- Catherine Gamble, Head of Mental Health Nursing at South West London & St George's Mental Health NHS Trust
- Ann Graham, Operational Director for Children's Care and Support at London Borough of Barking & Dagenham
- Julie Hackett, Strategic Commissioner for Children and Young People at Solihull Council
- James Kenrick, Head of Policy and Development at Youth Access
- Kevin Pace, HeadStart Head of Service, Wolverhampton City Council
- Carol Rogerson, Head of Universal Children's Services at Birmingham Community Healthcare NHS Trust
- Colette Soan, Senior Specialist Educational and Child Psychologist at Sandwell Metropolitan Borough Council
- Michael Taylor, Head of Corporate Parenting at London Borough of Sutton
- Rod Thomson, Director of Public Health at Herefordshire Council and Shropshire Council
- Sara Williams, Executive Director for Children and Young People at Lewisham Borough Council

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Executive summary

The mental health system is failing young people

In almost all areas of health and care reform the dominant trend is to encourage people to be more independent and resilient. In Child and Adolescent Mental Health Services (CAMHS), however, something has gone badly wrong. Not only are we failing to encourage greater resilience, but we are unable to adequately support young people who truly need specialist support. Shifts in government policy, aiming to reach a parity of esteem between physical and mental health have led towards an extra £1.4 billion of funding to help improve services. Yet, the mental health needs of the young population are so large that, even with significant investment, the vast majority of children and young people with a mental health disorder will need to be helped or treated outside of specialist CAMHS. We need a mental health system for young people that quickly provides help for those in crisis and offers support at an earlier stage to those who feel they need it. To achieve this, however, we need fundamental reform of the mental health system if we are to provide the right support for Britain's young people.

Why is the system failing?

1. For too many young people the first point of contact when trying to access support just isn't working. Many are inappropriately referred onto services which don't accept them or if they are accepted have long waiting lists, are given unhelpful impressions of the severity of their condition or at worse, are left feeling like nobody cares and nothing can, or will, be done.
2. Those who do need specialist CAMHS support often sit on long waiting lists stretching back for months. This is because we have an over-stretched system, that doesn't adequately differentiate between those in crisis and those close to it. This means professionals in the system are too often left trying to identify the needles in an ever increasing haystack.
3. Non-specialist mental health professionals aren't supporting young people at an early enough stage in dealing with mental health issues because they lack confidence and knowledge. Professionals, fearful of the risk attached to 'getting it wrong', instead often widen the pool of professionals around a young person creating greater dependency without actually addressing their concerns.
4. A one size fits all approach to CAMHS means a significant number of young people don't want to access desperately needed support. The stigma associated with mental health is prevalent and services don't do enough to differentiate the ways in which people can access support and guidance.
5. Those statistically more likely to suffer from mental health issues, such as children in the looked after system, are not receiving the same minimum standard of support that government insists they are entitled to.

6. Finally, based on the current configuration of CAMHS, more than half of all areas will miss the government's stated target of 35% of young people with diagnosable conditions being treated by specialist services by 2020/21.

From mental health to mental fitness

In order to support the large number of people in need of help we must encourage greater independence and agency in young people when it comes to their mental wellbeing. But to do this we need to break free of the current approach to mental health which frames too many young people as suffering ailments in need of a specialist cure and instead see mental health as existing on a continuum, one on which we all have the capacity to move up or down. Our mental health system needs to work on two levels, firstly supporting those with severe conditions that require immediate support and secondly, offering a wide variety of support and guidance to those young people who feel they need it. We need to encourage in young people the idea of mental fitness; this means that we intervene earlier for those with severe needs and give them the confidence that the system is working for them and that they can become more resilient. For those with less severe needs but still require support we need to broaden the access points to support and encourage greater agency in the young person.

This must be underpinned by the collective understanding of all professionals that – no matter what service they are formally part of – they are together responsible for the mental wellbeing of the young people who they deliver these services to.

Unfortunately the barriers to progress are significant

Our research however has identified a number of barriers to enabling young people to improve their mental health and services to encourage a shift to the idea of mental fitness;

- The first point of contact for young people is often very poor, setting both negative expectations of the quality of support they will receive and their own understanding of the severity of their condition. **(An estimated 60% of GP referrals to CAMHS are inappropriate[1] and between 21% and 29%[2] of children and young people referred to CAMHS overall are inappropriately referred.)**
- A one size fits all approach means many young people do not wish to access services that still carry a socially unflattering stigma. **(22% of appointments in CAMHS were not completed in 2014/15, either through cancellation or not being attended by the child or young person.[3])**
- Despite school-based interventions being one of the most cost effective and proximate to a young person's everyday life hardly any local transformation plans are set to commission school-based services. **(Whilst 75% of local transformation plans mention school-based approaches to mental health, only 40% refer to school-based counselling and only 3% plan to commission these services.[4])**
- Even vulnerable children in the care system cannot be sure of an appropriate level of service. Despite it being a statutory duty, many local authorities are not ensuring the completion of the important Strengths and Difficulties

1 Pulse (2016) – two-thirds of GP referrals for child mental health lead to no treatment

2 CAMHS Benchmarking Report November 2015; CentreForum (2016) – Children and Young People's Mental Health: State of the Nation; Children's Commissioner – Lightning Review: Access to Child and Adolescent Mental Health Services, May 2016

3 CAMHS Benchmarking Report November 2015

4 NHS England (2016) – Children and young people's mental health Local Transformation Plans – a summary of key themes

Questionnaire designed to assess a young person's risk of poor mental health **(62 councils are currently below the national average completion rate of 75%.[5])**

- 58% of CCG areas are not on course to hit their target of treating 35% of young people who have a clinically diagnosable mental health condition. **(Based on our projections 117 out of 203 CCG areas will not meet the government's target.)**

What we need to do about it

Simply put our approach to young people's mental health is failing too many of them. We're pushing too many young people towards higher tier CAMHS which is placing unneeded pressure on an oversubscribed service. To create a radical shift in mental health services and policy towards mental fitness and greater independence for young people the following things must happen locally.

- A renewed focus on training and supporting non-specialist mental health professionals, in particular GPs. Not only more cost effective, a focus outside of specialist services will create a service that fits with the needs of young people better and creates the necessary capacity to support those with severe mental health issues.
- A dramatic improvement in the quality and sharing of data recorded. The current level of data available is very poor and hampers an area's ability to plan and commission.
- Coordinated efforts to improve the experience a young person receives when first accessing information, advice and guidance on what support is available. The first point of contact is critical.
- Dramatically expand the variety of access points available to young people to access information, support and guidance. For example, we need far more support available on digital platforms that can be accessed anonymously. Too many services are designed in a way that treats young people as 'small adults'.
- Improve the mental health assessment and support of young people in care and become more active in creating a stronger market for specialist foster carers. With the particular goal of ensuring more stable placements for those young people with a diagnosable condition.

Addressing the challenge

An estimated 555,623 young people aged 5-18 with a diagnosable mental illness in 2020/21 will not receive treatment from an NHS-funded community mental health service. A challenge of this scale can't be tackled at the local level alone. It needs a concerted effort from government and policymakers to support all places in order to improve young people's mental fitness.

We call on government to implement the following recommendations:

Recommendation 1: Following on from recommendations from both the Health Select Committee and the Carter Review, the Department for Education should ensure that a mandatory module on mental health is included in initial teacher training.

Recommendation 2: Following from the Prime Minister's announcement that every secondary school in England will be provided with free mental

5 Table LAI4, Children looked after in England including adoption: 2015 to 2016, ONS

health training, government should provide guidance on how it plans to roll this out in order to provide clarity for school leaders.

Recommendation 3: Schools forums in every local area should be provided with the powers to select a lead mental health co-ordinator to encourage a local strategy for school-based mental health services. This co-ordinator should:

- sit on Health and Wellbeing Boards to ensure school-based mental health services are considered in the production of Joint Strategic Needs Assessments
- work with CCGs to ensure that any revised local transformation plans include provision for school-based mental health services

Recommendation 4: Through the passing of the Children and Social Work Act 2017, government should use the requirement for governmental approval on any professional training standards that Social Work England establishes to ensure that mental health is incorporated in social work training.

Recommendation 5: Government should support the provision of school-based support services. This can be achieved by:

5.1 Providing local authorities with the statutory duty to provide school-based support services for all young people between 11 and 18 who attend state maintained schools. Councils should be allowed to centrally retain up to 6.5% of pupil premium allocations to fund such services. These funds would provide a starting point even for areas that would require additional money from local CCGs to provide such services.

5.2 Government should revise current academy funding agreements to make it compulsory for academies to provide school-based support services. Academies may opt into taking advantage of the economies of scale offered by the local authority or may wish to independently commission their own services.

Recommendation 6: NHS England should accelerate their investment into 3,000 practice-based mental health therapists, to provide GPs with support and extra confidence in helping young people with mental health needs directly within the GP clinic.

Introduction

Children and young people are not being adequately supported to look after their mental health. Specialist Child and Adolescent Mental Health Services (CAMHS) are facing a tremendous amount of pressure and, even with significant funding boosts, have only been able to support a fraction of young people experiencing issues with their mental wellbeing. Even government's commitment of an extra £1.4 billion of funding from 2015 to 2020 to see 110,000 more young people cared for by CAMHS will not be enough.[6] An estimated 555,623 young people aged 5-18 with a diagnosable mental illness in 2020/21 will need to be helped or treated outside of community-based NHS services.[7] With such limited capacity, the system needs to work better to help both those with serious conditions that require immediate help and offering a wide variety of support and guidance to those young people who feel they need it.

This report focuses on how we can create a mental health system which supports young people earlier and with far greater flexibility than presently exists. The tendency for many young people to not register on the radar when they try to deal with their problems happens both at their first point of contact with services and after their mental health needs have been acknowledged. For example, one young person described his experience as essentially like being "pushed out of the door" when first raising his mental issues with a professional at his college.[8] Far too many non-specialist mental health professionals lack the confidence and knowledge to support young people at this stage. This leads to young people, instead of receiving sustained support for their mental health, bouncing around different tiers of service without sustained support. Even after being treated for severe mental health difficulties they often again fall off the radar until they reach another crisis.

6 House of Commons Briefing Paper (2016) – Children and young people's mental health – policy services, funding and education

7 See Appendix One

8 Sourced at young person's focus group discussion

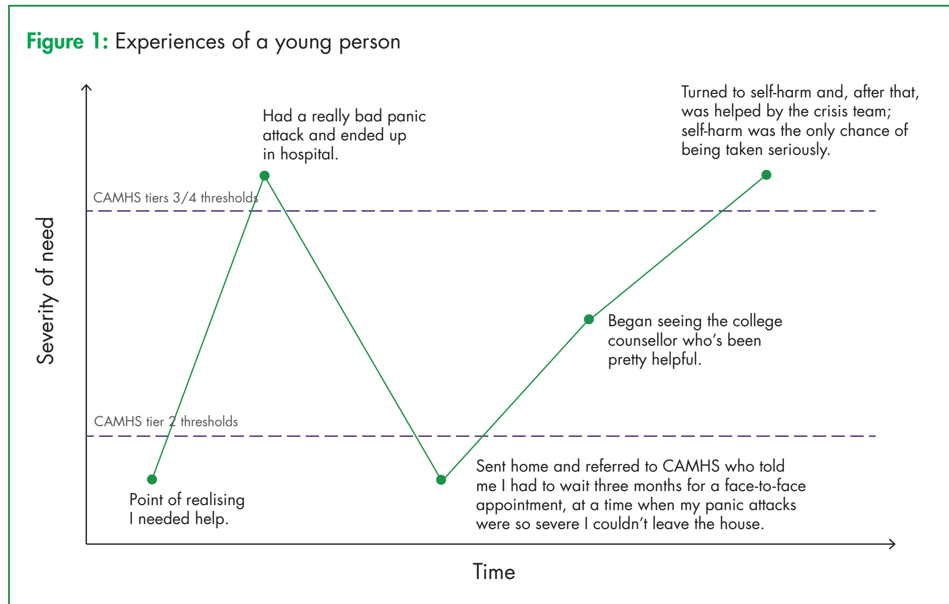


Figure 1: Experiences of a young person

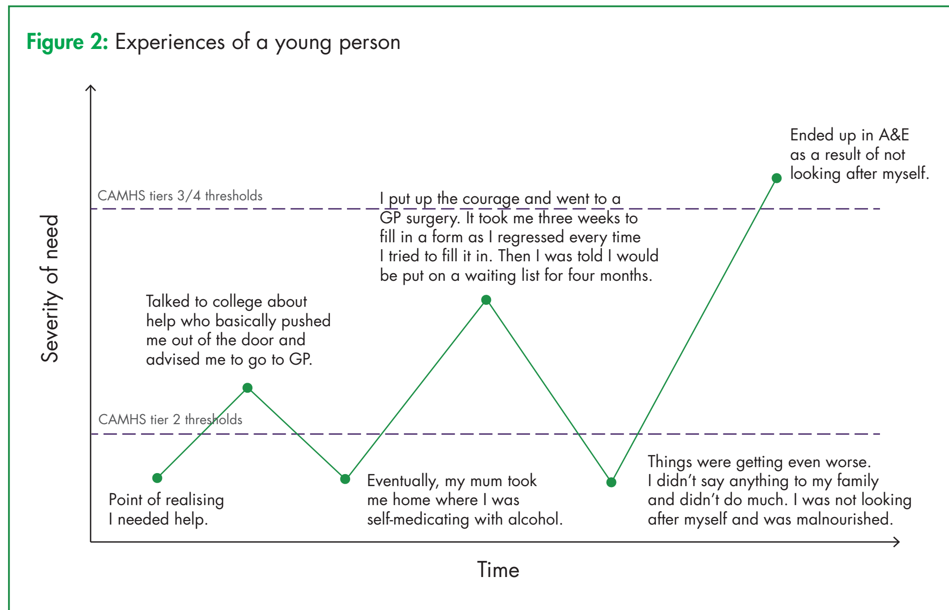


Figure 2: Experiences of a young person

Sourced from young person's focus group discussion

Too often, services that interact with young people perceive mental health in clinical terms. A full assessment of a young person's mental health should not just be confined to checking whether they have specific clinically diagnosable mental health disorders (such as conduct and emotional disorders). They should, rather, address the wider issues associated with a young person's mental wellbeing, or as we prefer, mental fitness.[9] Defined by the World Health Organization as "a state of well-being in which every individual realizes his or her potential, can cope with the stresses of normal life, can work productively and fruitfully, and is able to make a contribution to her or his community,"[10] this term is expansive in acknowledgment that those who do not necessarily have a diagnosable mental disorder still face issues with their mental wellbeing which need addressing. Rather than splitting everyone into two categories; those who need clinical help

9 Paul Kirby has highlighted the problems associated with a current "binary distinction between normal and ill" that has led to a sole focus on people defined as medically ill. Source: Paul Kirby (2016) – On mental health, we've got it so wrong, money alone can't fix it.

10 World Health Organization (2014) – Mental health: a state of well-being

and those who need absolutely none, it acknowledges that mental wellbeing is a continuum where individuals will need differing levels of support at different stages in their life.

It is through defining the issue as one of mental fitness – rather than clinically-defined mental health – that attention can be focused on providing earlier support in mental health services. By not having a clear, clinically diagnosable disorder, many children and young people are not receiving appropriate interventions at a stage where help could prevent a damaging deterioration in their mental state, meaning that they "end up going to crisis, from 0 to 90".[11] This includes the 70% of young people who experience mental health problems that "have not had appropriate interventions at a sufficiently early age".[12]

Local areas are increasingly acknowledging that mental health services should have a much more expansive remit. For example, 44 CCGs are part of the THRIVE model's 'community of practice'.[13] This model acknowledges that even young people without clinical mental disorders may, at some point, need support with their mental fitness. However, policy has not yet caught up with the local. Whilst welcome, there has been a focus on reforming and delivering services at a clinical level.

This report has three focuses: the first point of contact that young people have with professionals, the role of non-mental health professionals in helping young people with their mental fitness and how encouraging young people to have resilience, agency and independence will have a positive effect on how specialist CAMHS are able to deliver their services. In short, a new approach which intervenes earlier, has greater flexibility of access and encourages resilience and independence will ensure young people with severe mental health issues receive the immediate support they deserve, whilst increasing the variety and availability of support for young people overall.

A note on the research's scope

This report has largely concerned itself with settings where non-mental health professionals interact with young people. Specifically, we look at the role of professionals within primary care and the education sector. Whilst we are aware that there are many other public services that young people with mental health difficulties may encounter – such as the police and judicial system – these two services have a key role to play in mental health for the majority of young people. A plurality of referrals into specialist CAMHS come from GPs and there has been an increasing political focus on the role of the education sector.

This report also focuses on the role children's services play in assessing and tackling the mental health difficulties presented by children who are in receipt of social services. We are aware that there are many other cohorts of young people with particularly complex mental health needs that could have been addressed in this report, such as those with disabilities. We chose to concentrate on the needs of children in the looked after system due to the sheer complexity of their needs and the high levels of state interaction with these young people. There is also a political focus on this particularly vulnerable group of young people, with the expert working group on improving mental health support for young people in care. It is our hope this report is a helpful contribution to its ongoing work.

This report is also not about changing the funding system. Whilst we acknowledge the fact that more resources could be allocated towards helping young people improve their mental health, we do not seek to mandate the precise amount that should be directed. That a more appropriate balance of funding between specialist CAMHS and non-specialist services would be desirable however, with a stronger focus on earlier intervention, should be taken

11 Sourced from roundtable.

12 Mental Health Foundation – Fundamental Facts About Mental Health 2015

13 http://www.implementingthrive.org/wp-content/uploads/2016/09/i-THRIVE-Overview.pdf

as read in the context of this report.

Also, this report does not focus on the role of the family in supporting young people with their mental health. Whilst we do acknowledge their role as fundamentally important, it was beyond the available time of this research to fully assess the role of the family.

Note on terminology

Throughout the report, we highlight referrals that have not met thresholds as 'inappropriate'. This is not a value judgement on the ability of or concern noted by professionals referring young people onto CAMHS. We have simply chosen terminology that is already in common usage when highlighting referrals that have not met service thresholds.

We also refer throughout the report to 'young people'. This is used as a collective term to refer to both children and adolescents.

Note on methodology and the availability of data

This report was informed by an extensive literature review and interviews with experts in the field. We also held two roundtables with senior professionals from both the NHS and local government, as well as a focus group discussion with young people, kindly hosted by the Children's Society at Forward Thinking Birmingham's Pause centre.

The general quality and availability of data on young people's mental health is poor. As mental health is an issue that crosses the boundaries of multiple services (including healthcare, education and social services), there is a natural barrier to the building up of cohesive data. Also, difficulties arise from coherently assessing young people's mental wellbeing and mental fitness, compared to diagnosing the appearance of mental disorders. Data on first point of contact, referrals and general prevalence of mental health issues amongst young people were far below what we would expect from an issue with such high political and policy salience. Where there has been scope to include primary data we have done so; and where this has not been possible we have relied on secondary data compiled in other reports. We also sent out a Freedom of Information Request to every CCG and Foundation Trust in England, from which we received 182 replies. The data from these requests have fed into our analysis of how CAMHS operate as a young person reaches 18.

Chapter 1 — Why does the first point of contact matter?

- A young person's experience at the first point of contact sets an expectation about their condition and level of treatment they will receive
- The impact of a negative experience can be very damaging to a young person, leading to further deterioration in their condition and delays in receiving support
- Improving the first point of contact means those who urgently need help receive it, whilst ensuring a greater variety of support and guidance and flexibility of access to young people overall

The current state of mental health in young people

Although government has commissioned a survey on the state of young people's mental health, scheduled to report in 2018, current estimates of mental health amongst young people are reliant on a study from 2004. Despite the lag in time this survey sheds some light on the state of mental health in young people today. There are, however, two caveats. Firstly, being more than a decade old it does not take into account recent technological and social shifts (such as the rise of social media) which have affected young people's mental health. Secondly, the survey narrowly defines the issue in terms of clinically diagnosable mental disorders, rather than taking into account the wider questions of mental wellbeing and mental fitness. However, given the lack of data on the mental state of the young population as a whole, the findings from this survey can be used as a rough guide.

9.6% of all children between 5 and 16 years old have a mental disorder.[14] Assuming that this prevalence can be extrapolated to all young people up to 18, an **estimated 854,804 young people between 5 and 18 years old have a clinically diagnosable mental disorder.**[15] It is very likely that this number would be considerably higher if official statistics took into account young people experiencing difficulties with their wider mental wellbeing.

The prevalence of mental disorders can also be broken down by gender and age. Boys are more likely to have mental disorders than girls – 11.4% compared to 7.8%. Conduct disorders are found in almost twice as many boys (7.5%) than girls (3.9%). This is compared to emotional disorders that are slightly more prevalent in girls – at 4.3% compared to 3.1% in boys.

There is also a significantly higher prevalence of mental health issues in children in the care system, particularly once they reach adolescence. A child only enters the care system when something has gone seriously wrong within their family life: 60% of all children in the looked after system in 2015/16 were in care as a result of either abuse or neglect. The traumatic experiences that lead them into care, including bereavement, disability and serious illness,[16] make them

14 ONS – Mental health of children and young people in Great Britain, 2004

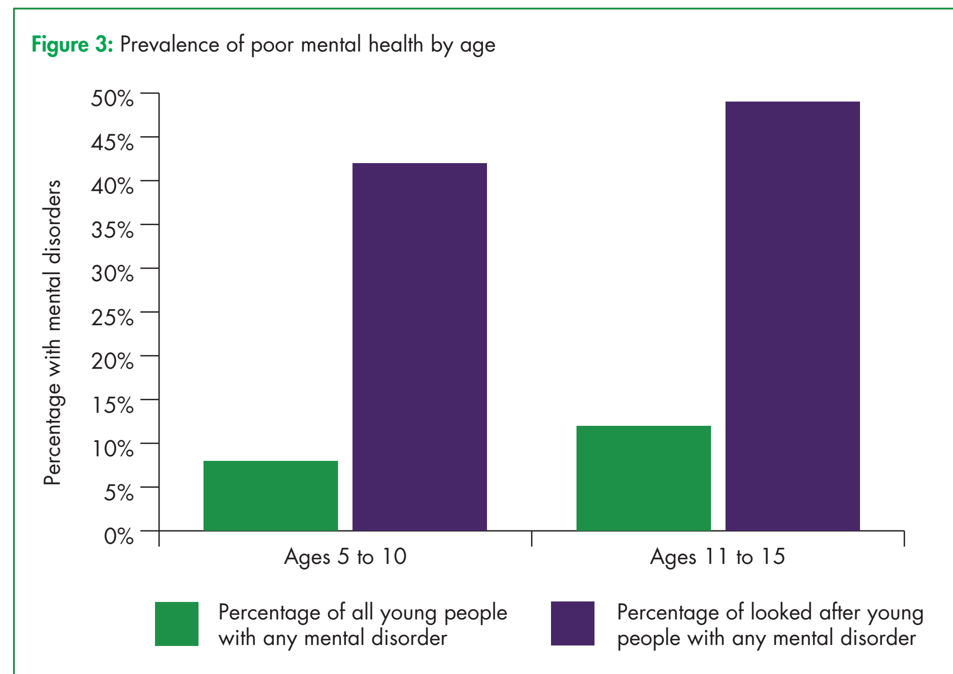
15 See Appendix One.

16 Mental Health Foundation (2002) – The mental health of looked-after children

particularly vulnerable to experiencing problems with their mental wellbeing. Furthermore, once a young person begins to receive support from children's services they can experience additional issues that affect their mental health including a greater likelihood of teenage pregnancy and risk of self-harm.[17] There are varied estimates of how widespread mental health issues are amongst this cohort: 51% of Strengths and Difficulties Questionnaires from this cohort had either a 'concerning' or 'borderline' result (indicating high likelihood of mental health problems) and the Children's Society calculate that 72% of children in residential care experience some form of emotional and mental health problem.[18] Although there is not a consensus over the precise level of need, the prevalence of mental health issues is clearly high.

These issues are exacerbated at the onset of adolescence, a "time of considerable change"; with a young person's physical development, greater inclination to take risks and growing need to exercise independence leading to increased exposure to sources of risk and harm.[19] Analysis by the ONS found that, amongst the general population, mental disorders were much more pronounced amongst children in the 11-16 age bracket, with an overall prevalence rate of 11.5%, compared to only 7.7% between ages 5 and 10. These rates are significantly higher for children in the looked after system, at 42% for 5 to 10 year olds and 49% for 11 to 15 year olds.

Figure 3: Prevalence of poor mental health by age



Source: ONS – Mental health of children and young people in Great Britain, 2004 and ONS (2003) – The mental health of young people looked after by local authorities in England

Even when looking at mental disorder, rather than the wider problem of mental wellbeing, the prevalence amongst young people is very high. Despite commitments for an extra £1.4 billion of funding from 2015 to 2020, this will only see 110,000 more young people cared for by CAMHS and by 2020/21, it is expected that local areas will hit a target of only 35% of young people with a diagnosable mental health condition receiving treatment from an NHS-funded community mental health service.[20] As a result, an estimated 555,623 young people aged 5-18 with a diagnosable mental illness in 2020/21 will need to be

17 22% of female care leavers became teenager parents in 2014 and children in the looked after system were reported to be between four and five times more likely to self-harm in adulthood. Source: National Audit Office (2015) – Care leavers' transition to adulthood

18 The Children's Society (2015) – Access Denied: A teenager's pathway through the mental health system

19 Action for Children (2015) – Supporting Adolescents on the Edge of Care. The role of short term stays in residential care

20 NHS England – Five Year Forward View for Mental Health: one year on

helped or treated outside of NHS services.[21]

Even reaching the target of 35% seems to be a tall order. The below graphs show the estimated progress each CCG has made in 2016/17 to increase the number of young people receiving community-based NHS treatment, as well as the predicted increase in such access between 2016/17 and 2020/21. Although these graphs only show the number of additional young people accessing such services rather than the total number, it can be assumed that, given the large difference between predicted increase and the 35% target, a large number of CCG areas (approximately 58%) will fail to meet this target. With just three years before these targets must be met, and no significant resources being put into specialist CAMHS (aside from the £1.4 billion), there needs to be an alternative method to better target existing resources towards young people facing crises in their mental health.

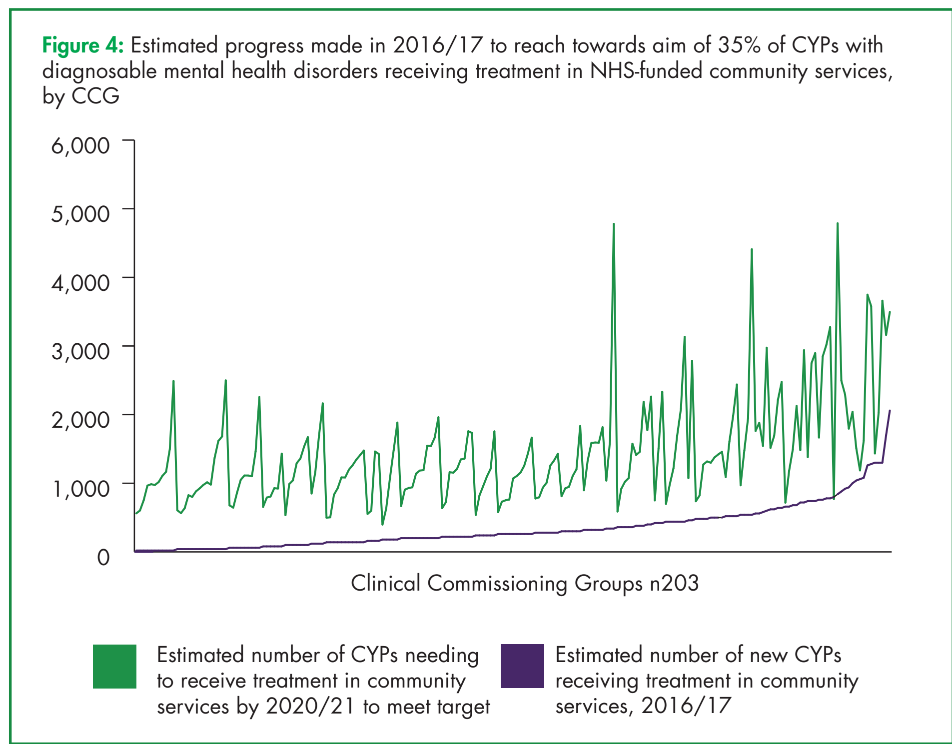


Figure 4: Estimated progress made in 2016/17 to reach towards aim of 35% of CYPs with diagnosable mental health disorders receiving treatment in NHS-funded community services, by CCG

Sources: Five Year Forward View for Mental Health Dashboard, NHS Digital; Mid-2015 Population Estimates for Clinical Commissioning Groups in England, by single year of age, ONS. See Appendix Two for full calculations

21 See Appendix One

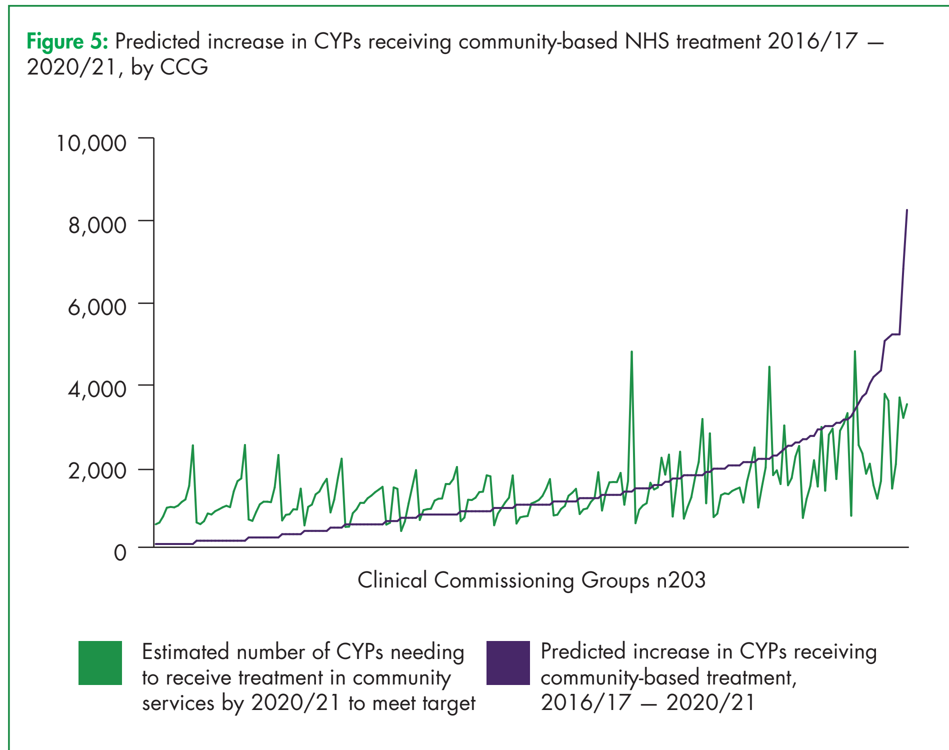


Figure 5: Predicted increase in CYPs receiving community-based NHS treatment 2016/17 — 2020/21, by CCG

Sources: Five Year Forward View for Mental Health Dashboard, NHS Digital; Mid-2015 Population Estimates for Clinical Commissioning Groups in England, by single year of age, ONS. See Appendix Two for full calculations

This is why it is crucial the first point of contact is delivered in an effective and efficient way, to refer those who desperately need specialist intervention onto CAMHS and utilise the wider network of services and social capital around a young person for the majority of people whose needs could be better served elsewhere. The first contact that a young person has with specialist CAMH services is not the first point that they realise they are experiencing problems with their mental health. Before the stage of seeking specialist intervention, young people tend to reach out towards other trusted adults in their life to discuss their issues. The trusted adult that they turn to varies. It could be someone from a young person's family, or a friend. A young person may also seek to rely on more formal networks of professionals within schools or, for particularly vulnerable children, professionals within social care settings. In any case, the ways in which a young person's mental health needs are addressed at this first point sets the stage for their mental health journey.

The first point of contact in the online world

Young people do not necessarily make their first point of contact with traditional services or people who they know. There are many platforms that young people could go to online to either talk to other people facing similar problems or even to receive treatment from an anonymous mental health professional. The use of online services are beneficial in allowing young people to access information and support when they may be uncomfortable in talking to someone face to face.

There are many innovative technological platforms that are tailored towards young people unable or unwilling to access mental health services in traditional settings. For example, XenZone are commissioned by local authorities and CCGs to deliver online counselling services. This service, named Kooth, "helps to reduce the stigma attached to young people accessing support, by providing a safe, confidential and anonymous service available through any connected device".[22] Similar digital initiatives should be encouraged, and local areas should look at how they could adopt such services that are potentially transformative for young people's mental health.

The first point of contact with:

1. The family

Young people, experiencing difficulties with their mental wellbeing, may initially turn to their family to discuss their problems. These networks comprise of the most important people in a young person's life. Their reaction to a young person reaching out towards them, a pivotal and vulnerable moment for someone wishing to receive help, has a large effect in the latter progression of their mental state.

The composition of a young person's family can affect their mental health. For example, the prevalence of mental disorders is twice as high in lone parent families as in two-parent families, at 16% and 8% respectively.[23] Parental education and employment also have significant effects, with only 4.4% of young people experiencing mental health issues in families where a parent is educated to degree level; compared to 17% where parents have no qualifications.[24] Also, 20% of young people with no working parent have mental health difficulties compared to 8% where both parents work. Family type, employment and education are not the only indicators of a young person's mental wellbeing. However, they clearly have an effect on their mental state.

As with all networks, decisions made by a family once a young person has reached out to them can have both a positive and negative experience on their mental wellbeing. In our discussions, both were highlighted with, for example, one young person describing how their parent brought him back into the family home to better help with his problems. This was in contrast to another young person not receiving a formal assessment of his mental health until a very late stage. This was a result of his parents not wishing for their child to be treated differently on account of the stigma associated with having a mental disorder. Some young people may simply wish to talk out issues within the family. Others may wish for support in receiving intervention from elsewhere. In whatever way a young person wishes to progress after seeking help, it is clear that this point of contact is crucial in determining how a young person will seek to improve their mental fitness.

22 https://xenzone.com/kooth

23 ONS – Mental health of children and young people in Great Britain, 2004

24 Ibid.

2. Professionals within educational settings

Some young people do not reach out to their family. Alternatively, they may, having reached out to their family, wish additional support from a more formal setting. This may come from someone within an education setting; in a school or college, from a teacher, nurse or another member of staff. Professionals in these settings have the potential to be very involved in providing support for the mental wellbeing of the majority of children that attend formal schooling. Of course, not all young people will seek out someone within their school or college. This would include children who dropped out of education at 16 and those who have been excluded. However, it is a connection for many young people who wish to use the guidance of trusted school and college staff to discuss issues or seek referral onto other sources of help.

School-based staff, however, are currently ill-prepared to deal with a young person's mental health at the initial point of contact. Evidence on school-based referral processes to specialist CAMHS highlights this. A survey of primary school headteachers revealed that, in primary schools without a school-based counsellor, nearly four in five headteachers would equally advise a child experiencing mental health difficulties to both visit their GP and refer to specialist CAMHS.[25] Referring a young person onto GPs rather than directly towards specialist CAMHS creates a more burdensome route for young people with mental health needs which warrant specialist CAMHS intervention. Similarly, for young people whose problems could be helped outside of clinical intervention, referral onto GPs and specialist CAMHS leaves them sitting on waiting lists for many months. This period is very damaging to a young person's mental health as many experience little positive action in the interim, making a young person less resilient.

Encouraging whole-school approaches to mental health

The need for educational settings to adopt 'whole-school approaches' to mental health has been well-established and largely welcomed by schools themselves.[26] Such a focus would enable a better first point of contact for young people who wish to seek out professionals in these settings. The exact nature of a whole-school approach must be determined by individual schools, but policy should be directed to better facilitate such approaches. This should come via two methods: increasing knowledge of mental health in educational settings and providing links for specialist CAMHS to support schools.

School-based professionals need additional formal training to ensure the majority who will not receive specialist mental health treatment get some form of appropriate intervention at a lower level. This includes providing them with increased awareness of mental health both during initial teaching training and once they have qualified teacher status. The Carter Review of initial teacher training made explicit the need to provide new teachers with an understanding of mental health, including knowledge of how to identify concerning issues and refer appropriately to specialist support.[27] This strongly echoed the conclusions of the Health Committee in 2014 that sought to ensure teaching staff were provided with a mandatory module on mental health.[28] Government should endorse these recommendations and update its initial teacher training criteria for providers to include a mandatory module on mental health.

25 77% of headteachers would advise parents to visit their GP if they identified a child was having difficulties and 87% would refer to specialist CAMHS. Source: Place2Be and National Association of Head Teachers – Children's Mental Health Matters: Provision of Primary School Counselling

26 For example, in the recent joint report by the Education and Health Committees (2017) – Children and young people's mental health – the role of education

27 Sir Andrew Carter OBE (2015) – Carter review of initial teacher training (ITT)

28 Health Committee – Children's and adolescents' mental health and CAMHS

Recommendation 1:

Following on from recommendations from both the Health Select Committee and the Carter Review, the Department for Education should ensure that a mandatory module on mental health is included in initial teacher training.

The Prime Minister's January 2017 announcement that every secondary school in England will be given free mental health training over the next three years is a welcome start in better equipping professionals with the tools to combat mental health issues directly within schools.[29] Government should provide guidance on how it plans to roll out this training to provide clarity for school leaders.

Recommendation 2:

Following from the Prime Minister's announcement that every secondary school in England will be provided with free mental health training, government should provide guidance on how it plans to roll this out in order to provide clarity for school leaders.

Mental health is a problem that crosses the lines of formal services. In order to enable better whole-school approaches to mental health, specialist CAMHS must be more involved with schools in their local area. A policy focus has been established on such links through the Mental Health Services and School Links Pilot. This project, which focused on creating dedicated lead contacts within specialist CAMHS and schools, showed "considerable success in strengthening communication and joint working arrangements between schools and NHS CYPMHS" even where relationships were seen to be weak at the start of the programme.[30] The evaluation of the pilot also found that the project increased the frequency of contact between schools and CAMHS; established a better knowledge of the referral routes amongst school lead contacts; and better working relationships between the two services. In some pilot areas, school-based contact leads were also able to refer directly to specialist CAMHS, simplifying the referral process for children and young people.

Whilst this pilot was effective, concerns were raised over the high costs of such a programme. An alternative method of making such links more widespread would be through utilising schools forums. Providing these forums with the power to designate a lead mental health co-ordinator would create a single point of contact with specialist CAMHS to encourage the better use of specialist resources directly within schools and strengthen communications between mental health services and the education sector. This co-ordinator would encourage provision for school-based mental health services by sitting on Health and Wellbeing Boards and working with CCGs to revise local transformation plans. Through encouraging resources towards education-based settings and ensuring that specialist CAMHS are more involved with the education sector, a whole-school approach to mental health can be encouraged.

29 Schools Week (2017) – PM pledges free mental health training for secondary school teachers

30 Department for Education (2017) – Mental health services and schools link pilot: evaluation

Recommendation 3:

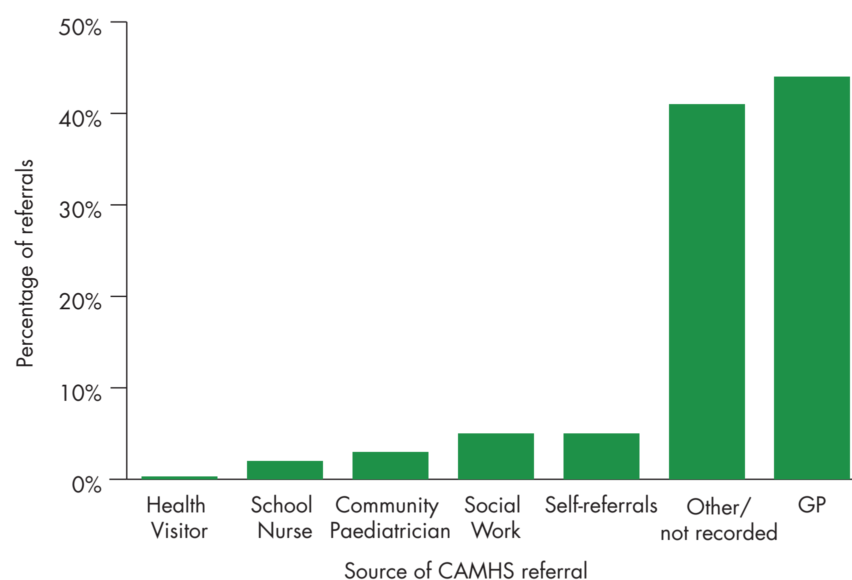
Schools forums in every local area should be provided with the powers to select a lead mental health co-ordinator to encourage a local strategy for school-based mental health services.
This co-ordinator should:

- sit on Health and Wellbeing Boards to ensure school-based mental health services are considered in the production of Joint Strategic Needs Assessments
- work with CCGs to ensure that any revised local transformation plans include provision for school-based mental health services

3. Primary care

For the plurality of children and young people who experience difficulties with their mental health, their first point of contact will be with their GP: 38% of young people with mental health problems are identified as such by their GP[31] and 30% of all GP appointments are related to mental health.[32] The reasons for this heavy GP involvement in providing support for mental health is twofold. Firstly, it is partly a result of other non-mental health professionals (including school-based professionals) referring young people with mental health difficulties onto GPs. Secondly, it is a result of the familiarity and ease in which a young person and/or their parents can talk about their mental and physical health to the same GP over a lifetime, offering "a continuity that no other health professional can".[33] Given GPs are the main 'connectors' to specialist CAMHS, they need to be provided with the tools to increase their confidence levels in appropriately tackling mental health needs of the young people they see.

Figure 6: Sources of referral to CAMHS



Source: Children's Commissioner – Lightning Review: Access to Child and Adolescent Mental Health Services, May 2016

An estimated 60% of GP referrals to specialist CAMHS lead to no treatment[34] and when one local authority audited the quality of GP referrals they had a

31 Dr Maryanne Freer – A Toolkit for GPs

32 Mental Health Foundation – How to talk to your GP about your mental health

33 Dr Maryanne Freer – A Toolkit for GPs

34 Pulse (2016) – two-thirds of GP referrals for child mental health lead to no treatment

100% failure rate.[35] Once a child fails to meet these thresholds, there is also a tendency to constantly re-refer them onto these services.[36] GPs are medical, not mental health, professionals. Only 46% of trainee GPs have taken a training placement in a mental health setting and "the only mental health-related option offered to trainee GPs was in psychiatry, which is based in hospitals and secondary care-focused".[37] This means that GPs can lack an understanding of the best methods to deal with the mental health difficulties of young people. This results in a tendency to refer too many onto specialist CAMHS even when they do not meet the criteria for these services, building inappropriate demand into the system and putting unnecessary further pressure on CAMHS.

4. Children's services

There are a specific cohort of vulnerable young people who may reach out to someone looking after them within children's services. A child in the looked after system may seek initial support from a number of people working with them, including their social workers, family support workers, residential carers and foster carers. Given the drastically higher prevalence of mental health problems amongst children in the looked after system, there is an emphasis on actively identifying young people who are presenting with problems rather than waiting for the young person to initiate the first point of contact. The two main statutory methods of ensuring their mental health needs are adequately processed are through the use of a Strengths and Difficulties Questionnaire to estimate their level of need and a health assessment (physical and mental) to create a plan to tackle any issues they may be facing. Yet, many social services are currently unable to or not providing adequate support for a significant proportion of young people in the care system who are facing problems with their mental wellbeing.

Use of health assessments

Firstly, there is evidence to suggest that health assessments are not being properly conducted.[38] Health assessments are meant to clearly identify any problems with a child's physical and mental health in order to create a series of actions that can be met to improve the child's condition; initially assessing the child right at the start of their placement and then at least once every year. Yet, they tend to be singularly focused on physical health, meaning that they are not being used to take into account a young person's mental health. The NSPCC, whilst conducting research on four local areas, found that not a single area gave "a routine assessment of their mental health".[39] The lack of focus on mental wellbeing in these assessments is something that needs rectifying.

Use of Strengths and Difficulties Questionnaires (SDQs)

Another method of identifying young people who may need help with their mental wellbeing is through a Strengths and Difficulties Questionnaire (SDQ). A SDQ can be given to a child or young person, or an adult with a good understanding of the child's behaviour (e.g. a parent, teacher or social worker) to produce a scoring that will provide an initial assessment of whether a child is exhibiting 'normal' or 'concerning' behaviour that may need further assessment. However, many social workers are failing to use SDQs for early identification of

35 Sourced from roundtable.

36 A according to the Children's Commissioner, 44% of referrals and 43% of re-referrals to 44 CAMHS that provided data came from GPs. Source: Children's Commissioner – Lightning Review: Access to Child and Adolescent Mental Health Services, May 2016

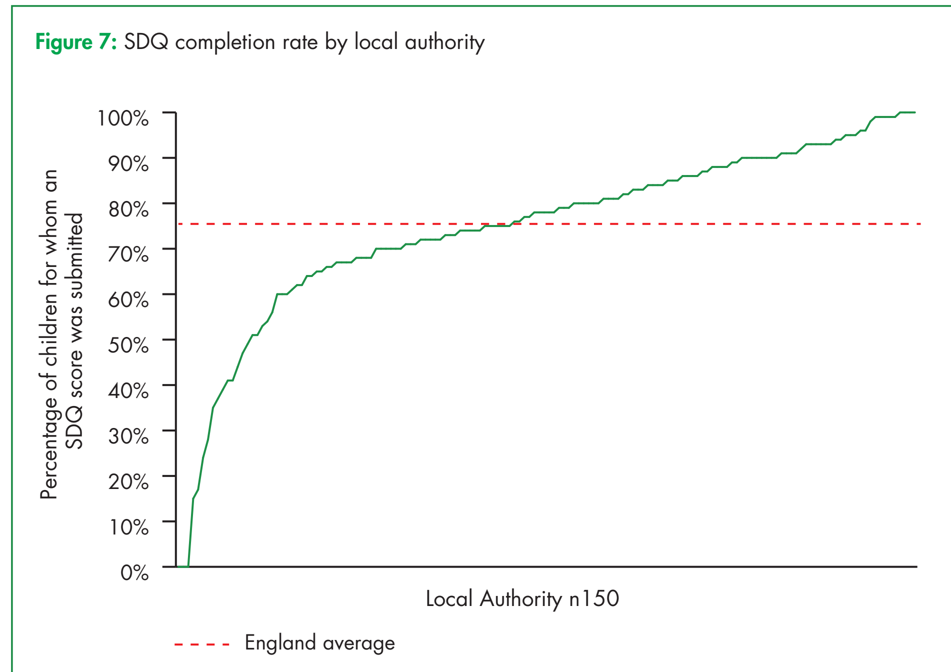
37 Mind (2016) – GPs and practice nurses aren't getting enough mental health training

38 NSPCC (2015) - Achieving emotional wellbeing for looked after children: a whole system approach

39 Ibid.

mental health needs despite their statutory requirement to do so.[40] Between 2014 and 2016, the completion rate for England was 75%; leaving a large proportion of children with their mental health needs potentially unchecked.[41] The completion rate is highly variable: 15 local authorities have a completion rate of 50% or under whilst 36 local authorities complete SDQs for 90% (or more) of children in the looked after system.

Figure 7: SDQ completion rate by local authority



Source: Table LAI4, Children looked after in England including adoption: 2015 to 2016, ONS

The reasons for SDQs not being completed vary. For example, the Care Quality Commission highlighted that there is currently no provision in Southampton to provide SDQs for those working with children in care.[42] The 15 local authorities that have failed to complete Strengths and Difficulties Questionnaires for over half of the children they look after, however, must dramatically improve these rates. The need for improvement is especially pressing for the three areas that have not reported a single use of a SDQ. If even this relatively simple method of mental health assessment is not being used then it is likely that such local authorities also find it difficult to conduct much more labour intensive screening processes, such as health assessments.

SDQs are not the only way of identifying children that have mental health issues. Nor can they be the sole means of assessment. But, professionals across local government and the NHS have stated the advantages of using them.[43] They are a means to roughly assess the mental wellbeing of young people – especially for professionals who have no grounding in mental health – and ensure that young people who may not be explicitly showing problems with their mental health (and are, perhaps, quieter than others) are picked up by the system. The usage of these SDQs should be encouraged to ensure that multiple professionals working with children in the looked after system are able to use it to establish a "single assessment tool that's recognised across professions", creating a common ground for assessing mental health needs of these children.[44]

40 Completion of SDQs for looked after children has been a statutory requirement since 2009. (Source: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108592.pdf)

41 Table LAI4, Children looked after in England including adoption: 2015 to 2016, ONS

42 Care Quality Commission (2016) – Review of health services for Children Looked After and Safeguarding in Southampton

43 Sourced from roundtable.

44 Sourced from roundtable.

Making mental health a priority for social workers

From the little emphasis given to mental health on health assessments and gaps in use of SDQs, it can be ascertained that mental health is fighting with other concerns to be a priority for social services. One method of making it a priority is giving social workers a grounding in mental health and wellbeing during their initial training, and updating them with best practice once they enter. This is not currently happening in a systematic way, leaving the existing cohort of social workers as "a group of under-trained, under-knowledgeable and under-skilled workers" with regards to young people's mental health.[45] There is, however, a chance for government to improve this through directly regulating social workers via the passing of the Children and Social Work Act 2017 and the replacement of the Health and Care Professions Council by a government-controlled body (Social Work England) for social workers.[46] The requirement for governmental approval of any professional training standards that Social Work England establishes gives government the ability to ensure that mental health issues are included in any new social work training courses.

Recommendation 4:

Through the passing of the Children and Social Work Act 2017, government should use the requirement for governmental approval on any professional training standards that Social Work England establishes to ensure that mental health is incorporated in social work training.

45 Interviewee.

46 Community Care (2016) – Government to regulate social workers from 2018

Chapter 2 – How to support mental fitness

- Professionals working with young people must understand that – no matter what service they are formally part of – they are together responsible for the mental wellbeing of the young people who they deliver these services to
- Services must be offered to young people before their issues become so serious that they need specialist treatment
- These support services must be based in settings that enable young people to access support for their mental health at an earlier stage and accessible in a variety of ways which reflect changing modes of communication and social stigmas

This chapter outlines the practical changes that can happen outside of specialist CAMHS that would improve the capacity of non-specialist mental health professionals to help young people. There are a number of specific barriers preventing this earlier intervention. These include, although are not limited to, the difficulty faced by schools in providing services to support mental health, the lack of consistent mental health support within primary care and, for children in the looked after system, the instability of placements arising from a weak market in specialist foster carers and in some cases poor placement planning. Given the scale of these challenges, this report will not be able to offer comprehensive suggestions for every issue. In particular, children in the looked after system have been experiencing unstable placements for many decades as there is no simple solution. However, the impact of these issues on young people's mental health is significant. The recommendations highlighted in this chapter offer a starting point for government to promote shared accountability for mental health from all services that interact with young people.

Providing school-based support services

Professionals within the education sector have the potential to be more involved in providing support for the mental wellbeing of the majority of children that attend formal schooling. Yet, schools are not sufficiently included in wider strategic thinking about CAMHS provision. In the drafting phase for local transformation plans, only one in four schools were aware of the plans being formed and, of those aware, only 39% had any input into it.[47] Also, whilst 75% mention school-based approaches, only 40% refer to school-based counselling and a tiny minority of local areas, 3%, actually plan to commission it.[48] Mental health commissioners are acknowledging the need for school-based services yet are unable to deliver, in all likelihood resulting from a combination of low

47 IPPR (2016) – Education, Education, Mental Health

48 NHS England (2016) – Children and young people's mental health Local Transformation Plans – a summary of key themes

resource and low prioritisation relative to specialist CAMHS.

There are advantages to increased activity in an educational setting. It can provide children with support through familiar and trusted adults, in a more comfortable setting, widening access to mental health support to children unable to access specialist CAMHS. Such support should include school-based counselling for young people that want to talk about their issues. But it should not be limited to traditional forms of counselling, there should also be greater innovation in providing and promoting new digitally based support services which protect anonymity.[49] These services, that are intended for children and young people with non-acute needs that can be supported outside of specialist CAMHS, also tend to cheaper. For example, the average cost per session of school counselling in Wales, when taking inflation into account, is £166.14.[50] This is compared to contact with mental health specialist teams within CAMHS, which costs an estimated £217 per contact.[51] These services have been effective. Evaluation showed that the levels of initial distress at school-based counselling services were similar to those recorded at CAMHS, yet were still "associated with large and significant reductions in psychological distress".[52] Using the Young Person's CORE measure, the psychological distress reduced, on average, from 18.70 to 10.56 from the beginning to end of counselling (lower scores indicate less distress).[53]

Given that local transformation plans acknowledge that school-based mental health services are needed, and such services have proven to be effective, local authorities and CCGs should be commissioning them on a more consistent basis. The PSSRU estimate that 90% of mental health-related costs (this cost pertains to the more general impact of poor mental health and does not relate to the funding of mental health services) fall on the education sector,[54] and heavier involvement of mental health commissioners within this sector would relieve a lot of this heavy financial pressure.

Take the example of Wales where there has been a focus on providing school-based counselling services for young people. Under the Welsh model, local authorities are given a statutory duty to provide independent counselling services for young people between 11 and 18. In 2015/16, an estimated 4.09% of young people between these ages used these services.[55]

Local authorities in England should be given a statutory duty to commission school-based mental health support for young people between 11 and 18, funded through centrally retaining 6.5% of pupil premium allocations. (We do not envisage these counselling services to necessarily be face-to-face. Local authorities should look at innovative methods of providing young people with support, such as online counselling services to help those who wish to receive support whilst maintaining their anonymity.) Local authorities would not be expected to deliver services but provide a co-ordinating role to commission school-based support alongside local schools. Although not all local authorities will be able to fully finance such services through centrally retaining an element of pupil premium allocations, it would provide a starting point to fund such services and encourage local CCGs to also contribute to build these services. 84 out of 150 local authorities would be able to fully finance school-based support through centrally retaining 6.5% of pupil premium allocations and, of those unable, 37 would be able to finance at least 75% of these costs.[56]

49 Sourced from roundtable.

50 Welsh Government (2011) – Evaluation of the Welsh School-based Counselling Strategy: Final Report; Consumer Price Inflation time series dataset, ONS.

51 PSSRU – Unit costs of Health & Social Care 2016

52 Welsh Government (2011) – Evaluation of the Welsh School-based Counselling Strategy: Final Report

53 Ibid.

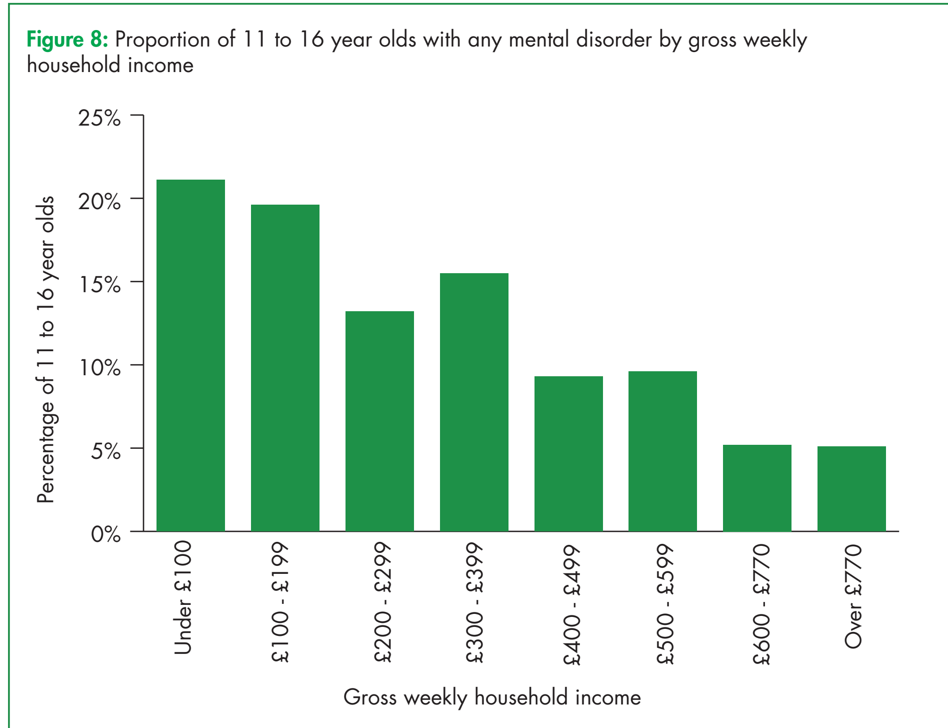
54 PSSRU (2016) – Young Mental Health: New Economic Evidence

55 See Appendix Two.

56 See Appendix Three.

The use of the pupil premium would help the disadvantaged young people to whom this money is directed towards. There is a clear link between the prevalence of mental health issues and household income. 21% of young people aged between 11 and 16 and with a gross weekly household income of under £100 had a mental disorder. This is compared to 5.1% of young people with a weekly household income over £770.

Figure 8: Proportion of 11 to 16 year olds with any mental disorder by gross weekly household income



Source: ONS – Mental health of children and young people in Great Britain, 2004

The majority of schools in England are now academies without any links to local authorities. Government should revise the contractual funding agreements with academies to make it compulsory for academies to provide school-based support services. Academies may choose to opt into the local authority scheme, and benefit from the economies of scale achieved by this. Alternatively, they should be provided with the freedom to commission their own services should they feel it necessary to do so.

Establishing a local authority and academy duty to provide school-based support would allow schools to be increasingly involved with their pupils' mental health whilst alleviating the burden on specialist CAMHS. This recommendation would allow an English model of school-based support to encourage better mental fitness of 209,822 young people (the equivalent proportion helped by similar services in Wales) at a cost of £150,243,524 per year.[57]

57 See Appendix Three for full calculations of costs.

Recommendation 5:

Government should support the provision of school-based support services. This can be achieved by:

5.1 **Providing local authorities with the statutory duty to provide school-based support services for all young people between 11 and 18.** Councils should be allowed to centrally retain up to 6.5% of pupil premium allocations to fund such services. These funds would provide a starting point even for areas that would require additional money from local CCGs to provide such services.

5.2 **Government should revise current academy funding agreements to make it compulsory for academies to provide school-based support services.** Academies may opt into taking advantage of the economies of scale offered by the local authority or may wish to independently commission their own services.

Improving the mental health of young people in the looked after system

The vast majority of young people in the care system are placed there with the intention of remaining there for the medium-to-long term: only 2,280 out of 100,810 placements in 2016 were explicitly designed as short term respite services.[58] Yet, there are a large subsection of young people who move between placements and who move in and out of care. Of all children in the looked after system at 31 March 2016, 21% had been in two placements and 10% had been in three or more placements.[59]

This problem is most significant amongst adolescents. 35% of young people leaving care in 2013/14 aged 16 or above had five or more placements.[60] Young people between 12 and 14 years old are the most likely to 'rebound' back into care.[61] Placement changes for older children also tend to be more volatile and "as a result of placement breakdown, whereas those for younger children tend to be planned".[62]

58 Table LAB1, Children looked after in England including adoption: 2015 to 2016, ONS

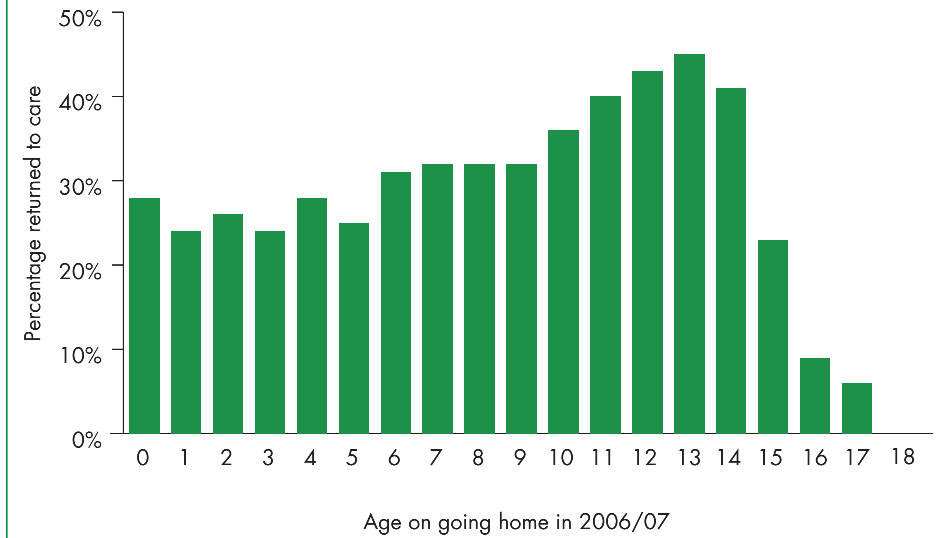
59 ONS – Children looked after in England (including adoption) year ending 31 March 2016

60 National Audit Office (2015) – Care leavers' transition to adulthood

61 45% of 13 year olds who went home in 2006/7 had returned to care by 2012. This is almost twice as much as the 24% of 3 year olds who did so. Source: Department for Education (2013) – Data Pack: Improving permanence for looked after children

62 Loughborough University – Placement stability: a review of the literature

Figure 9: Children who went home in 2006/07 — the percentage who had returned to care by 31 March 2012



Source: Department for Education (2013) – Data Pack: Improving permanence for looked after children

Placement instability is damaging to a young person's mental wellbeing. Data compiled by the ONS in 2003 on mental disorders amongst children in the looked after system shows that the prevalence of disorders is 18% less amongst children who had been in their current placements for over five years compared to those who had been there for less than a year. Young people with complex mental health issues may find it more difficult to thrive in placements, making the stability of these placements difficult to achieve. Yet, the formation of longer lasting placements and the better relationships that these create for young people should certainly be encouraged to improve stability.

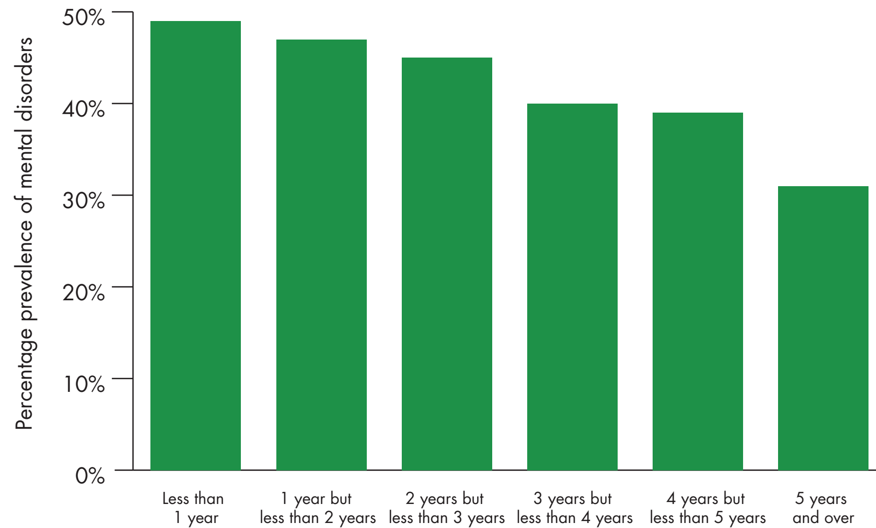
The constant churn of placements also has a large financial impact. For example, it costs an estimated £3,435 per week for a local authority to provide a care home for a single child[63] and these costs rise six fold for children with emotional and behavioural difficulties.[64] Improving the stability of placements can minimise the costs and administrative burden of re-allocating children to different locations. It takes a child considered difficult to place, on average, 18-24 working hours (more than double the typical time) to find a new placement.[65]

63 PSSRU – Unit costs of Health & Social Care 2016

64 NICE (2014) – Looked-after children and young people

65 Ibid.

Figure 10: Prevalence of mental disorders by length of time in current placement



Source: Prevalence of any mental disorder by time in current placement, in ONS (2003) – The mental health of young people looked after by local authorities in England

The instability of placements for children in the looked after system has been a recurring problem for many decades.[66] This report does not offer a solution to this long-standing problem, the complexity of which demands multiple reports in its own right. However, there are methods to improve stability through a better planning process that takes into account a young person's mental fitness and by encouraging a stronger market for specialist foster carers.

Placement breakdown tends to occur at a very early stage, with 12% occurring within 7 days; 57% within 6 months; and 77% within a year.[67]

66 Loughborough University – Placement stability: a review of the literature

67 Table B3: Duration of placements ceasing during the year ending 31 March 2016, Children looked after in England (including adoption) year ending 31 March 2016, ONS

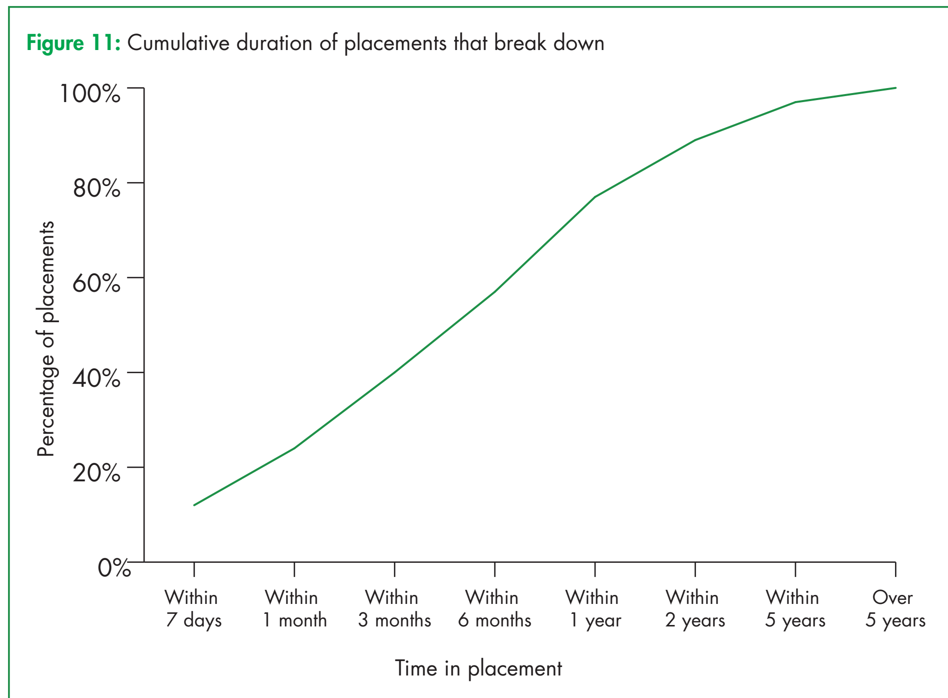


Figure 11: Cumulative duration of placements that break down

Source: Table B3: Duration of placements ceasing during the year ending 31 March 2016, Children looked after in England (including adoption) year ending 31 March 2016, ONS

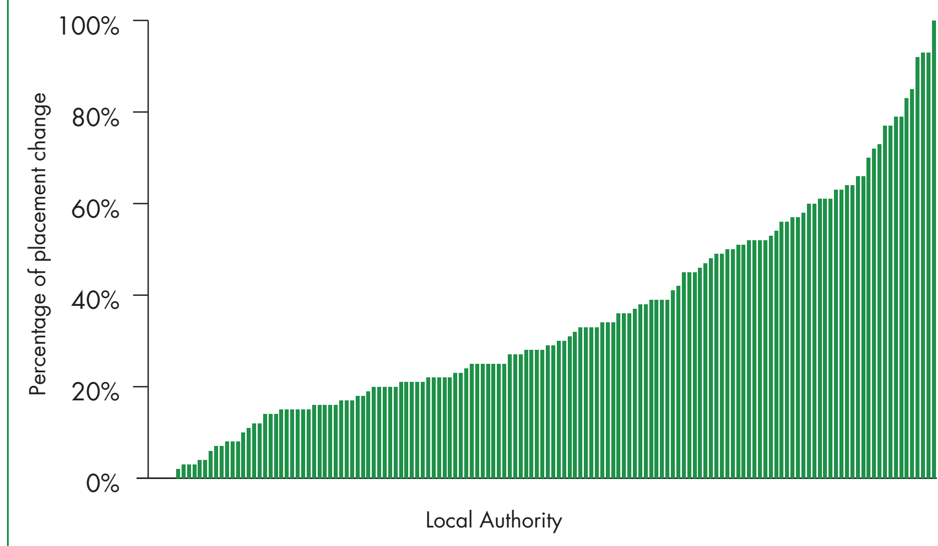
There are many reasons for this quick movement. A large proportion of placement changes in England, 33%, occur due to a "change to/implementation of the child's care plan".[68] There is also large local variation within this. 18 local authorities reported that 10% or less of their placements broke down as a result of care plan changes and 4 local authorities had this as the determining factor in 90% or more of their placement changes. These changes within care plans are likely to be a result of three overlapping factors. Firstly, a lack of time to plan effectively can result in young people being quickly rushed into unsuitable placements at a time of crisis. Secondly, there can be a lack of support after the placement process to encourage the formation of strong relationships between a young person and their foster carer. Thirdly, there are not enough specialist foster carers who are equipped with the ability to support young people with severe mental health needs at home.

The NSPCC have suggested that young people's mental health needs tend to be ignored as a factor in deciding placements.[69] Owing to a lack of specialist foster carers, there may not be a lot that can be done to help a young person if such needs were routinely acknowledged. In order to reduce the likelihood of placements breaking down, local authorities should encourage a stronger market for specialist foster carers and ensure that mental health is taken more into consideration when making placement decisions. Whilst this would not completely eradicate the complexity surrounding placements, it would be a step towards providing children who are looked after with a stable home and improving their mental wellbeing.

68 Table LAB3: Reason for placement change for children whose placements ended in the year, Children looked after in England (including adoption) year ending 31 March 2016, ONS

69 NSPCC (2015) – Achieving emotional wellbeing for looked after children: A whole system approach

Figure 12: Percentage of placement change due to 'change to/implementation of care plan' by local authority



Source: Table LAB3: Reason for placement change for children whose placements ended in the year, Children looked after in England, 2016, ONS. Note that this is experimental data and a "small number of local authorities" reported problems in recording the data in 2016.

Improving services in primary care

More people presenting issues with anxiety and depression (from all age groups) were treated through medication such as anti-depressants or sleeping pills than referred to a counsellor or therapist.[70] Qualitative research for this report suggests that GPs lack the confidence to directly help young people with the 'problems' in their mental wellbeing. With this, they feel as they only have a choice between sending a young person onto specialist CAMHS (where it is likely they will either not be successfully referred or sit on long waiting lists) or "prescribing the same set of medications that they believe work".[71] One young person highlighted the damaging nature of solely using medication to address their mental health: "if I go [to a medical professional] saying I'm suicidal, I'm given medication but never feel any better".

There are other forms of interventions, besides the use of medication, which can be used within primary care to help young people who do not require specialist intervention with their mental health. These forms of intervention do not necessarily require a professional to have formal training in mental health. Dr Maryanne Freer's *Toolkit for GPs* describes the ideal role for GPs in mental health, which is ultimately based on a recognition that young people can come to them with "problems" rather than "symptoms" that are clinically diagnosable; meaning that GPs can create plans with the young person to encourage better mental health and reduce risk factors.[72] Allowing GPs without mental health expertise to offer such support, however, will require them to receive some form of support from those who have such expertise.[73] NHS England's *General Practice Forward View* has acknowledged this by investing in 3,000 practice-based mental health therapists by 2021[74]; the equivalent, according to Mind, of a full-time therapist for every two to three typically-sized GP practices.[75] Such extra support would be a step towards improving their confidence levels to effectively support young people with low level needs directly within the GP

70 The Aviva Health Check UK Report Autumn 2015
71 Sourced at young person's focus group discussion
72 Dr Maryanne Freer – A Toolkit for GPs
73 Mind (2016) – Mental health in primary care: a briefing for Clinical Commissioning Groups
74 NHS England (2016) – General Practice Forward View
75 Mind (2016) – Mental health in primary care: a briefing for Clinical Commissioning Groups

clinic rather than through inappropriate referrals to CAMHS or a reliance on medication. To further facilitate this support, NHS England should consider the acceleration of their investment in 3,000 full-time practice-based mental health therapists.

Recommendation 6:

NHS England should accelerate their investment into 3,000 practice-based mental health therapists, to provide GPs with support and extra confidence in helping young people with mental health needs directly within the GP clinic.

Chapter 3 – Relieving the pressure on specialist CAMHS

- The act of referring a young person that does not meet thresholds sets a level of expectation about their severity of need which can prove damaging
- Specialist services must be delivered in ways that fit the unique needs of each young person
- The point that a young person reaches adulthood is not necessarily the point at which they reach maturity, services must reform to reflect this

Currently, fearful of the risk attached to 'getting it wrong', non-mental health professionals have a tendency to refer almost all young people worried about their mental health onto specialist CAMHS. This has put a tremendous and unsustainable pressure upon these services that are unable to effectively sort between those in crisis and those close to it. This means specialist CAMHS professionals are often left looking for needles in an ever increasing haystack.

Estimates on the precise rates of these inappropriate referrals vary, but between 21% and 29% of children and young people referred to CAMHS (from all sources) fail to meet service thresholds[76] and 14% of referrals received in 2014/15 were re-referrals.[77] The process of constantly referring a young person onto specialist CAMHS will not improve their mental health, especially when their needs could be better dealt with outside of specialist services. Furthermore, the act of referring someone who does not meet thresholds sets inappropriate levels of expectations about their severity of need, undermining the use of non-specialist, community-based intervention that would be better placed to deal with their issues.

Once a young person passes through the referral process and gets into specialist CAMHS they are faced with long waiting times before they can actually receive treatment: young people with life threatening conditions can wait over 100 days before receiving any form of treatment.[78] (These include those at a high risk of suicide, severe self-harm and suffering from severe depressive episodes.[79]) The damaging nature of this waiting period was repeatedly raised during our focus group discussion with young people, leading to further deteriorations in their mental fitness. Those with less serious conditions can also face extremely lengthy waiting times, and through some providers can face a median wait of 128 days to receive first contact with CAMHS after referral.

76 CAMHS Benchmarking Report November 2015; CentreForum (2016) – Children and Young People's Mental Health: State of the Nation; Children's Commissioner – Lightning Review: Access to Child and Adolescent Mental Health Services, May 2016

77 CAMHS Benchmarking Report November 2015

78 Ibid.

79 Ibid.

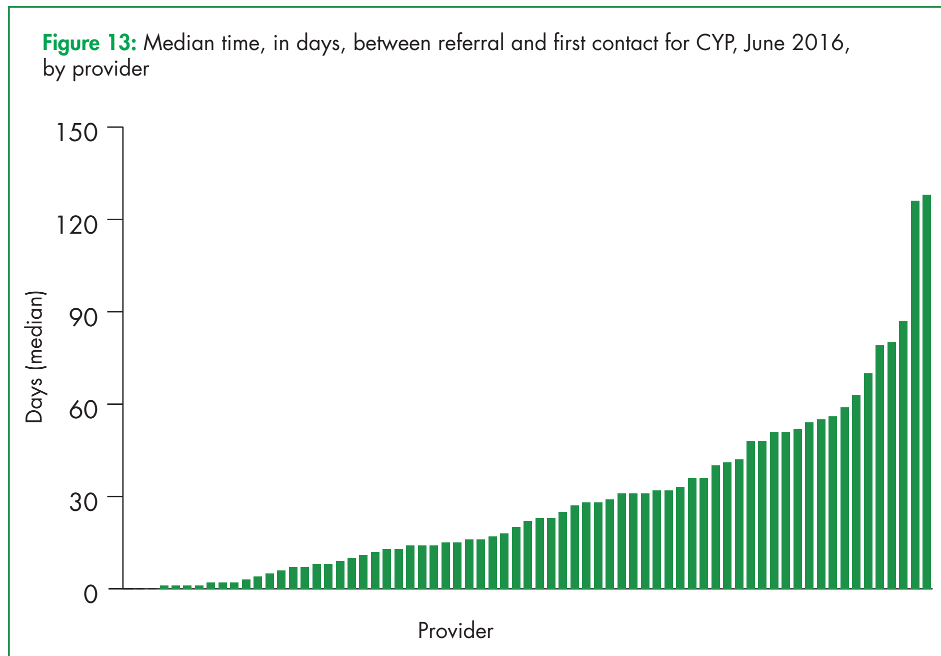


Figure 13: Median time, in days, between referral and first contact for CYP, June 2016, by provider

Source: Time from referral to first contact for children and young people aged 0-18, 2016, NHS Digital

By providing non-mental health professionals with the requisite training, knowledge of referrals and, crucially, improving the quality of non-clinical sources of intervention that can be conducted by either themselves or another professional within the wider community, these inappropriate referral rates can be minimised. This would allow specialist CAMHS to better target their services to those in crisis and in need of receiving urgent support.

CAMHS currently suffer from a one size fits all approach which struggles to differentiate between the access needs of young people. There is a tendency to place all young people into a set of neat clinical pathways without taking into account these needs.[80] This has led to a high number of appointments that are either cancelled or not attended. The CAMHS Benchmarking Report for 2015 revealed that 7% of appointments were cancelled by patients, 4% were cancelled by the service provider and Did Not Attend (DNA) rates were at 11% in 2014/15;[81] meaning that a total of 22% of appointments were not completed as planned. The movement towards a THRIVE model of service is a welcome step towards acknowledging the multitude of problems that young people face with their mental health. Whilst it would be inappropriate for this report to set out precisely how this is achieved, specialist CAMHS will need to move towards more person-centred services, such as those being delivered through the THRIVE model, which would help young people address their specific mental health issues and improve their mental fitness.

Mental health provision as a young person transitions into adulthood

The changes that occur in a young person's life as they approach adulthood have the ability to negatively affect their mental wellbeing. This can include transitioning from living as a dependent and being in education, towards living independently and entering the workplace. On top of this, transitions towards adult services can fail to provide such young people with adequate support. For example, there tends to be a lack of transitional arrangements for those receiving services from CAMHS, as well as specific transitional problems that children in the looked after system experience once they become care leavers.

80 Sourced from roundtable

81 Ibid.

Receiving mental health support as a young adult

Currently, there is an "expectation that [young people] move seamlessly into adulthood" once they reach 18.[82] This has led to an under-provision of mental health support for the 18-25 age cohort as they approach and reach adulthood. This age group sits at the boundary between CAMHS and Adult Mental Health Services (AMHS). Whilst AMHS are meant to provide support for them they tend to focus on provision for over 25s and are therefore ill-equipped to tackle the specific mental health needs of young people. For example, *Future in Mind* showed that they "are not universally equipped to meet the needs of young people with conditions such as ADHD, or mild to moderate learning difficulties, or autistic spectrum disorder". On the CAMHS-side of provision, there tends to be a focus on supporting the mental health needs of under 18s, meaning there is a significant gap in services for young people that fail to meet the much higher thresholds required for AMH services.

Whilst *Future in Mind* did not want to be "prescriptive about the age of transition", it recognised that automatically seeking some form of transitional arrangement the moment a young person turns 18 "will often not be appropriate". To this aim, it recommended that transition should be "based on individual circumstances rather than absolute age". A strict cut off point for CAMHS at 18 does not necessarily mean that mental health services are failing to provide for young people providing that there is good communication to ensure that services are simply switched to AMHS rather than completely removed. But, the success of this largely depends on the nature of local relationships. In response to Freedom of Information requests sent to every CCG and NHS Foundation Trust in England, eight areas responded with the information that their local CAMHS stop providing services at 16, of which only two stated plans to extend their provision to 18.

Freedom of Information responses that indicated CAMHS are cut off at 16

FOI Respondent	CAMHS age threshold
Blackburn with Darwen CCG	16 (to be extended to 18)
Bolton CCG	16
Bury CCG	16
Lancashire North CCG	16
East Lancashire CCG	16 (to be extended to 18)
Tameside and Glossop CCG	16
Stockport CCG	16
Chorley and South Ribble CCG	16
Greater Preston CCG	16

A relatively new response to the need for young people between 18 and 25 to have access to mental health services has been to extend the age limit on young people's mental health services to 25 years. Forward Thinking Birmingham is one example of this new type of provision. These services are based on the rationale that a young person at 25 years is more mentally resilient than at 18 and, therefore, extending provision up to this age makes it more likely that a young person becomes a "functioning adult".[83] These services are relatively new and, as such, it is too soon to see just how effective and sustainable it is to extend provision to 25 years.

However, it is clear that all local areas should have some form of provision

82 Sourced from roundtable.

83 Sourced from roundtable.

that addresses the mental health needs of 18-25 year olds who do not meet the thresholds for AMHS. Approaching this as an issue of mental fitness means that such services would not necessarily have to be provided by traditional clinical services. Whilst they could be delivered through CAMHS or AMHS (with reduced thresholds), they could just as effectively be delivered through alternative methods such as by the voluntary sector. Whichever way their needs are met, all professionals who work with young people within that area must be able to clearly articulate what the offer is and how they can be signposted onto these services.

Transitions for children in the looked after system as they leave care

Local transformation plans have placed particular attention on mental health provision for children in the looked after system: 85% of plans explicitly identified both this cohort and care leavers as a priority group.[84] As shown in responses to our Freedom of Information requests, many local areas have sought to service the mental health needs of care leavers by slightly extending the age criteria for this vulnerable group. This age extension ranges significantly by local area with some, such as in Aylesbury Valley CCG and Chiltern CCG, only allowing access up to 18 and a half years whilst others, such as in Lincolnshire, have extended provision to 25 years.[85]

Such specific flexibility for this particularly vulnerable group of young children is welcome, yet the risk of a deterioration in the mental health of care leavers is not just affected by the provision of CAMHS but with the cut off from the wider support of social services as they approach 18. A large portion of teens continue to stay in care until they reach their 18th birthday – 25% of all children ceasing care in 2016 did so. By at least the age of 14, a transition plan must be in place for such children. These are designed to allow such children to easily move into adult social services without any abrupt changes in provision or help.

However, these transition plans are narrowly concerned on how to effectively shift teenagers to the correct adult social service(s). They miss the wider issues which affect the mental wellbeing of those in care, ranging from homelessness, to teenage pregnancy and self-harm.[86] A simple transfer to another social service cannot prepare a teenager for the wider social expectations of transitioning into adulthood. The scope of these transitions need to be widened to include these issues, which have "significant cost implications on the public purse".[87] Providing that the tools already available for social workers are used effectively (such as SDQs and health assessments) it would be a relatively simple to ensure that mental wellbeing is addressed within transition plans.

84 NHS England (2016) – Children and young people's mental health Local Transformation Plans – a summary of key themes

85 Freedom of Information responses.

86 National Audit Office (2015) – Care leavers' transition to adulthood

87 Barnardo's (2014) – The cost of not caring: supporting English care leavers into independence

Conclusion

In this report we highlight the need to better help young people with their mental health. Addressing severe mental health issues earlier and supporting greater mental fitness gives agency and independence to young people as they cope with difficult and often distressing circumstances. Crucially, reforms to the mental health system must allow young people who are in crisis to access the specialist services they desperately need far more quickly.

The wide body of non-mental health professionals working with young people – as part of the community around them – can be better equipped and prepared to provide the right support under such an approach. Encouraging greater provision of school-based mental health support and providing statutory school-based support is one method of securing this within the education sector. Also, further training in mental health can support teachers, social workers and GPs alike. Whilst we have chosen to focus on specific professional settings in this report (e.g. schools, care settings, etc) the principle that underpins the thinking is universal; where possible support young people in a way that encourages resilience in their mental wellbeing and focus specialist resources on supporting those presenting with severe mental health issues. The system at present is failing too many young people and without immediate and urgent reform it will continue to do so.

Appendices

Appendix One: estimated number of children and young people with a clinically diagnosable mental health disorder

- The estimated number of young people aged 5-18 with a clinically diagnosable mental health disorder was calculated through multiplying the total number of young people in this age cohort in England with 9.6% (the estimated prevalence given by the ONS). Sources: Population estimates – local authority based by single year of age, 2015, ONS (accessed via Nomis) and ONS – Mental health of children and young people in Great Britain, 2004
- The estimated number of young people who will need to be helped or treated outside of NHS services was calculated through using the above calculation, multiplied by 65% - using NHS England's target that 35% will receive treatment from an NHS-funded community mental health service by 2020/21. Source: NHS England – Five Year Forward View for Mental Health: one year on

Appendix Two: full calculations for figures 3 and 4

- The method explained in Appendix One was used to calculate the estimated number of young people needing to receive treatment in community services by 2020/21 to meet the 35% target. Source: Mid-2015 Population Estimates for Clinical Commissioning Groups in England, by single year of age, ONS
- The estimated number of new CYPs receiving treatment in community services in 2016/17 was calculated through extrapolating data from Q2 2016/17 from the Five Year Forward View for Mental Health Dashboard, assuming that the rise in this quarter can be taken as an average for the year.
- The predicted increase in CYPs receiving treatment in community services between 2016/17 and 2020/21 was also calculated through extrapolating data from Q2 2016/17, assuming that the rise in this quarter can be taken as an average for the entire period.
- 6 CCGs were excluded from these calculations due to a lack of data: Wirral, Luton, West Cheshire, Eastern Cheshire, Isle of Wight and Vale Royal. Source: Five Year Forward View for Mental Health Dashboard, NHS Digital

Appendix Three: pupil premium costs

- Number of users in England estimated at 201,537. This is from assuming that the proportion of young people using such a service would be equivalent to the proportion using equivalent services in Wales. 11,337 young people used these counselling services in 2015/16, equating to 4.09% of the population between 11 and 18. Sources: Number of children and young

people attending counselling by Area and Year, Counselling for children and young people, StatsWales; Population estimates – local authority based by single year of age, 2015, ONS (accessed via Nomis).

- The median cost per episode has been estimated at £745.59 per pupil. This has been based on the Welsh Government's evaluation of the Welsh School-based Counselling Strategy in 2011 and inflated to 2017 prices. Based on the estimated number of users in England, this would cost £150,243,524. Source: Welsh Government (2011) – Evaluation of the Welsh School-based Counselling Strategy: Final Report
- Total pupil premium allocations in 2016/17 were £2,406,456,479. 6.5% of these allocations would provide £156,419,671.15 for school-based support across England. Source: Department for Education and Education Funding Agency – Pupil premium: allocations and conditions of grant 2016 to 2017.
- The above method was also used to calculate the total funds that could be obtained through the pupil premium and the total cost of running school-based services by local authority. Sources: Population estimates – local authority based by single year of age, 2015, ONS (accessed via Nomis); Department for Education and Education Funding Agency – Pupil premium: allocations and conditions of grant 2016 to 2017.

Ranking: Predicted increase in young people receiving community-based NHS treatment between 2016/17 – 2020/21 against NHS England's target by CCG

Rank	CCG	Predicted increase in CYPs receiving community-based treatment, 2016/17 - 2020/21	Estimated number of CYPs needing to receive treatment in community services by 2020/21 to meet 35% target	Difference between predicted increase of CYPs receiving treatment and estimated numbers needing to receive treatment to reach target
1	Birmingham CrossCity	1,360	4,779	-3,419
2	Bedfordshire	80	2,490	-2,410
3	Cumbria	160	2,499	-2,339
4	Northern, Eastern and Western Devon	2,160	4,409	-2,249
5	Bristol	240	2,255	-2,015
6	East Lancashire	480	2,164	-1,684
7	Doncaster	160	1,681	-1,521
8	Shropshire	160	1,615	-1,455
9	Cambridgeshire and Peterborough	3,360	4,787	-1,427
10	South Gloucestershire	80	1,499	-1,419
11	Sandwell and West Birmingham	1,760	3,134	-1,374
12	Milton Keynes	400	1,672	-1,272
13	Basildon and Brentwood	240	1,463	-1,223
14	Surrey Downs	480	1,698	-1,218
15	North Derbyshire	160	1,368	-1,208
16	North West Surrey	720	1,884	-1,164
17	Ealing	800	1,962	-1,162
18	Leeds West	400	1,535	-1,135
19	Leeds South and East	320	1,432	-1,112
20	Lincolnshire West	80	1,168	-1,088
21	North Somerset	80	1,107	-1,027
22	South Devon and Torbay	400	1,360	-960
23	Kernow	1,840	2,783	-943
24	Thurrock	80	1,017	-937
25	City and Hackney	560	1,477	-917
26	Blackburn with Darwen	80	986	-906
27	Islington	80	975	-895
28	South Norfolk	400	1,292	-892
29	South Cheshire	80	966	-886
30	Dudley	880	1,758	-878
31	Greater Preston	240	1,113	-873
32	Lincolnshire East	240	1,113	-873

33	Walsall	800	1,665	-865
34	Leeds North	240	1,102	-862
35	Telford and Wrekin	160	1,014	-854
36	Hillingdon	880	1,733	-853
37	Trafford	560	1,409	-849
38	Rotherham	640	1,463	-823
39	Slough	160	980	-820
40	Wokingham	160	976	-816
41	North Tyneside	240	1,049	-809
42	Wigan Borough	960	1,756	-796
43	Harrow	640	1,427	-787
44	Greater Huddersfield	560	1,345	-785
45	Chorley and South Ribble	160	926	-766
46	Hounslow	720	1,482	-762
47	South Worcestershire	800	1,546	-746
48	Tower Hamlets	800	1,543	-743
49	North East Lincolnshire	160	881	-721
50	Birmingham South and Central	560	1,263	-703
51	Guildford and Waverley	480	1,164	-684
52	South Lincolnshire	80	753	-673
53	Ipswich and East Suffolk	1,520	2,187	-667
54	Fylde & Wyre	160	826	-666
55	Bradford Districts	1,600	2,263	-663
56	Croydon	1,680	2,334	-654
57	East Surrey	400	1,042	-642
58	Lancashire North	160	801	-641
59	North Kirklees	560	1,198	-638
60	Bromley	1,200	1,834	-634
61	Nottingham City	1,040	1,665	-625
62	Bracknell and Ascot	240	859	-619
63	North Lincolnshire	320	928	-608
64	Norwich	320	923	-603
65	Redditch and Bromsgrove	400	987	-587
66	West Hampshire	2,400	2,976	-576
67	Brent	1,280	1,817	-537
68	Richmond	560	1,085	-525
69	Merton	560	1,084	-524
70	West Lancashire	80	603	-523
71	Windsor, Ascot and Maidenhead	320	807	-487
72	Hardwick	80	561	-481
73	Wandsworth	880	1,358	-478
74	Newbury and District	160	638	-478
75	North Norfolk	320	792	-472

Rank	CCG	Predicted increase in CYPs receiving community-based treatment, 2016/17 - 2020/21	Estimated number of CYPs needing to receive treatment in community services by 2020/21 to meet 35% target	Difference between predicted increase of CYPs receiving treatment and estimated numbers needing to receive treatment to reach target
76	Horsham and Mid Sussex	880	1,347	-467
77	North and West Reading	160	606	-446
78	South West Lincolnshire	240	678	-438
79	Crawley	240	645	-405
80	South Reading	160	565	-405
81	Bexley	1,040	1,436	-396
82	West Suffolk	800	1,191	-391
83	Calderdale	800	1,185	-385
84	West Norfolk	480	851	-371
85	Kingston	560	928	-368
86	Coastal West Sussex	2,080	2,439	-359
87	Fareham and Gosport	720	1,071	-351
88	Camden	800	1,140	-340
89	Bradford City	320	655	-335
90	Southampton	880	1,211	-331
91	Enfield	1,760	2,084	-324
92	Northumberland	1,280	1,594	-314
93	Stockport	1,280	1,591	-311
94	Stoke on Trent	1,120	1,428	-308
95	East Riding of Yorkshire	1,280	1,587	-307
96	South Eastern Hampshire	880	1,161	-281
97	Warrington	880	1,154	-274
98	Knowsley	560	833	-273
99	Medway	1,360	1,620	-260
100	North East Hampshire and Farnham	960	1,212	-252
101	North Hampshire	1,040	1,255	-215
102	Brighton and Hove	1,120	1,332	-212
103	Wakefield	1,600	1,774	-174
104	Gloucestershire	3,120	3,276	-156
105	St Helens	800	941	-141
106	North Staffordshire	960	1,099	-139
107	Swindon	1,120	1,258	-138
108	Greenwich	1,440	1,576	-136
109	Surrey Heath	400	535	-135
110	Bath and North East Somerset	800	930	-130
111	Sutton	1,040	1,155	-115
112	Airedale, Wharfedale and Craven	800	907	-107

113	Portsmouth	1,040	1,106	-66
114	Southern Derbyshire	2,880	2,939	-59
115	South Warwickshire	1,280	1,328	-48
116	Canterbury and Coastal	1,040	1,069	-29
117	Solihull	1,200	1,204	-4
118	High Weald Lewes Havens	960	959	1
119	Bassetlaw	640	600	40
120	Erewash	560	504	56
121	Barking and Dagenham	1,520	1,460	60
122	Wyre Forest	560	498	62
123	Somerset	2,960	2,897	63
124	Bolton	1,760	1,696	64
125	Coventry and Rugby	2,560	2,475	85
126	Nottingham West	640	553	87
127	Newark & Sherwood	720	631	89
128	Great Yarmouth and Waveney	1,200	1,107	93
129	Newham	2,080	1,982	98
130	Sheffield	3,120	3,018	102
131	Sunderland	1,520	1,412	108
132	West London	1,120	1,008	112
133	Swale	800	667	133
134	South Sefton	960	822	138
135	Central London (Westminster)	880	725	155
136	Haringey	1,680	1,505	175
137	Hastings and Rother	1,120	937	183
138	West Kent	3,040	2,846	194
139	Chiltern	2,160	1,951	209
140	Wiltshire	2,960	2,749	211
141	Rushcliffe	880	637	243
142	Herefordshire	1,200	949	251
143	Eastbourne, Hailsham and Seaford	1,200	926	274
144	South Tyneside	1,040	763	277
145	Ashford	1,040	752	288
146	Halton	1,040	731	309
147	Mansfield and Ashfield	1,360	1,039	321
148	Corby	720	398	322
149	Nottingham North and East	1,120	795	325
150	Thanet	1,120	778	342
151	Barnet	2,560	2,214	346
152	Redbridge	2,240	1,880	360

Rank	CCG	Predicted increase in CYPs receiving community-based treatment, 2016/17 - 2020/21	Estimated number of CYPs needing to receive treatment in community services by 2020/21 to meet 35% target	Difference between predicted increase of CYPs receiving treatment and estimated numbers needing to receive treatment to reach target
153	South Kent Coast	1,440	1,076	364
154	Harrogate and Rural District	1,280	897	383
155	Hammersmith and Fulham	1,200	811	389
156	Warwickshire North	1,440	1,022	418
157	Scarborough and Ryedale	960	538	422
158	Southport and Formby	1,040	579	461
159	Lewisham	2,080	1,610	470
160	Vale of York	2,240	1,762	478
161	Castle Point and Rochford	1,440	917	523
162	Wolverhampton	2,000	1,458	542
163	Aylesbury Vale	1,760	1,217	543
164	Tameside and Glossop	2,000	1,420	580
165	Mid Essex	2,720	2,126	594
166	Salford	1,920	1,318	602
167	Hull	2,000	1,376	624
168	Barnsley	1,920	1,273	647
169	Dartford, Gravesham and Swanley	2,160	1,479	681
170	Heywood, Middleton and Rochdale	2,000	1,299	701
171	Central Manchester	1,840	1,075	765
172	Waltham Forest	2,320	1,544	776
173	Southend	1,760	980	780
174	West Essex	2,480	1,691	789
175	Darlington	1,440	588	852
176	Hambleton, Richmondshire and Whitby	1,680	750	930
177	Lambeth	2,480	1,515	965
178	Bury	2,080	1,091	989
179	Newcastle Gateshead	3,520	2,495	1,025
180	East Staffordshire	1,760	699	1,061
181	South Manchester	1,920	822	1,098
182	Blackpool	1,920	737	1,183
183	North Manchester	2,160	970	1,190
184	Oldham	2,720	1,496	1,224
185	Dorset	5,040	3,748	1,292

186	North East Essex	3,040	1,666	1,374
187	Liverpool	3,680	2,293	1,387
188	Southwark	2,880	1,483	1,397
189	South East Staffordshire and Seisdon Peninsula	2,640	1,180	1,460
190	Nene	5,200	3,660	1,540
191	Oxfordshire	5,120	3,580	1,540
192	Havering	2,960	1,381	1,579
193	Cannock Chase	2,640	717	1,923
194	Leicester City	4,000	2,041	1,959
195	East Leicestershire and Rutland	3,760	1,796	1,964
196	Stafford and Surrounds	3,200	770	2,430
197	South Tees	4,160	1,512	2,648
198	Hartlepool and Stockton-on-Tees	4,320	1,620	2,700
199	North Durham	4,240	1,187	3,053
200	West Leicestershire	5,200	2,029	3,171
201	East and North Hertfordshire	6,800	3,161	3,639
202	Durham Dales, Easington and Sedgefield	5,200	1,434	3,766
203	Herts Valleys	8,240	3,496	4,744

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Localis
8a Lower Grosvenor Place
Westminster
London, SW1W 0EN

0870 448 1530
info@localis.org.uk

localis.org.uk

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