

Children and Young People's emotional wellbeing and mental health needs assessment

Public Health Harrow

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EMOTIONAL HEALTH & WELLBEING IN CHILDREN AND YOUNG PEOPLE IN HARROW

This is a rapid Needs Assessment that has utilised available data from various services and organisations in order to develop a picture of the mental health and emotional needs of children and young people in Harrow. The scope of the needs assessments includes the following:

- Demographic data relating to Children and Young People (CYP), 0-25 years where available
- Protective factors for emotional wellbeing and mental health
- General population risk factors for poor emotional health and wellbeing
- High risk groups for mental disorder and low wellbeing
- Prevalence of poor emotional wellbeing and mental health
- Overview of current service provision and demand
- What children and young people say about services

INTRODUCTION

The mental health and emotional wellbeing of children and young people is as important as their physical health. 50% of mental health problems are established by age 14, and 75% by age 24. Of concern, approximately 70% of children and young people who experience mental health problems do not receive appropriate interventions at a sufficiently early age ¹

Mental health illnesses are a leading cause of health-related disabilities and can have adverse and long-lasting effects²; affecting physical health, education and work prospects, chances of committing a crime and length of life. ³

KEY MESSAGES

- Overall, in the last 20 years there has been an increase in prevalence of mental health problems of children and young people
- Approximately 1 in 8 5-19 year olds have at least one mental disorder
- Children and young people with a mental disorder are more likely to self-harm and attempt suicide
- Suicide rates amongst young people have been increasing in recent years; in 2018 there was a 30% increase in suicide rates among men aged 20-24, and the suicide rate for young females is at its highest rate on record
- 20% of 10-19 year olds in Harrow say they need mental health support or know someone who does
- 17% of 10-19 year olds in Harrow say they need help with suicidal thoughts or know someone who does
- 15% of 10-19 year olds in Harrow say they need support need for self-harm or know someone who does

BACKGROUND

¹ Mental Health Foundation. Fundamental factors about mental health (2015). Available here: <https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2015>

² Public Health England. The Mental Health of Children and Young People in London (2016). Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/583866/Mental_health_of_children_in_London.pdf

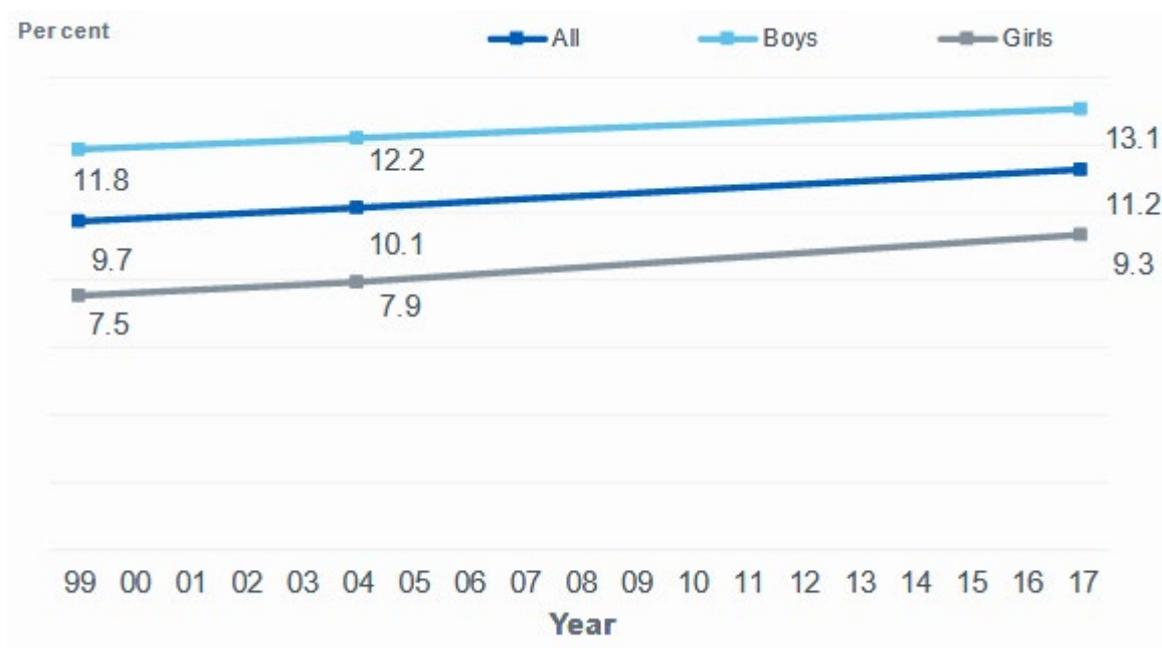
³ National Audit Office. Improving children and young people's mental health services (2018). <https://www.nao.org.uk/wp-content/uploads/2018/10/Improving-children-and-young-peoples-mental-health-services.pdf>.

A national survey of Mental Health of Children and Young People⁴ was conducted in 2017 and aimed to find out about the mental health, development and wellbeing of children and young people aged between 2 and 19 years old in England. Mental disorders were assessed according to International Classification of Disease (ICD-10) diagnostic criteria

The survey found that:

- 1 in 8 (12.8%) 5 to 19-year olds had at least one mental disorder
 - 1 in 20 (5.0%) meet the criteria for two or more mental disorders
- Emotional disorders were the most prevalent type of disorder experienced by 5 to 19 year olds (8.1%)
- Rates of mental disorders increased with age. 5.5% of 2 to 4-year-old children experienced a mental disorder, compared to 16.9% of 17 to 19 year olds.
- Young women are high risk, with nearly 1 in 4 (23.9%) 17 to 19-year-old girls having a mental disorder
- Since 1999 there has been an overall small increase in the prevalence of mental disorders in 5 to 15 year olds
 - There has been an increased prevalence of emotional disorders in 5 to 15 year olds, other types (behavioural, hyperactivity and other less common disorders) have remained similar in prevalence since 1999
- Self-harm, smoking and drug and alcohol use are more common in those with a mental disorder

Fig 1. Trends in any mental health disorder in 5 to 15 year olds by sex, 1999 to 2017.



Source: Mental Health of Children and Young People Survey, 2017

The trend of increasing prevalence of mental health problems, suggests there will be an increased level of mental health need of children and young people in Harrow. This need will be dependent on wider determinants, such as access to services, family income and housing; as well as the impact of the ongoing COVID-19 pandemic.

COVID-19

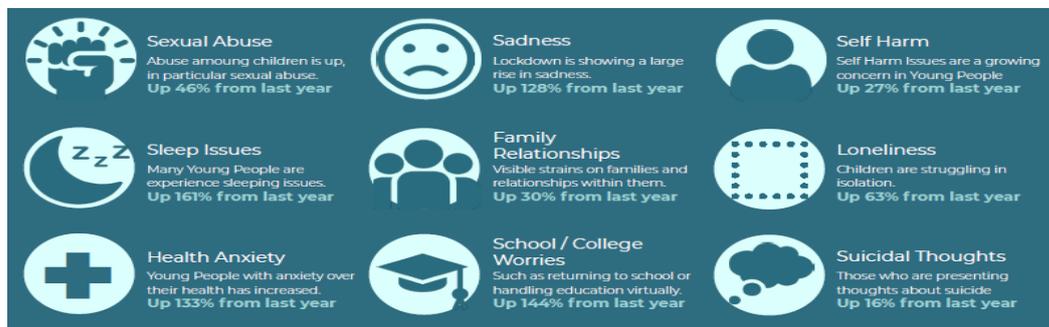
⁴ NHS Digital. Mental Health of Children and Young People in England, 2017 [PAS]. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

The Covid-19 pandemic will affect the child or young person, as well as the adult with caring responsibility. Factors that may have both short- and long-term impacts on children include social isolation, disruption to education, restrictions on movement, bereavement and reduced access to services and support. There is also a significant economic impact of the pandemic; affecting parental employment, household income, debt and housing. Children that may be particularly vulnerable, include those already living in challenging situations, such as poverty and domestic abuse, and children with existing mental health problems and special education needs.^{5 6} An open letter to the Government from over 30 children and young people’s organisations highlighted that the crisis may result in long-term consequences unless funding and support is increased.⁷

A YoungMinds survey of young people (13-25 years) with a history of mental health problems at the beginning of lockdown, March 2020, suggests a significant impact from the pandemic. Over half (51%) reported their mental health as a “bit worse” due to the pandemic, and nearly a third (32%) reported “much worse”. Key factors included concerns about family health, school and university closures, loss of routine and social concern. A quarter (26%) were also no longer able to access mental health support.⁸

Data from Kooth, a digital mental health provider, over the course of the lockdown also show a considerable effect of Covid-19 on the mental health of children and young people using their services. During March-May 2020, Kooth reported a 58% increase in logins compared to the previous year. Suicidal thoughts increased by 16%, and self-harm by 27%; and reported sadness and loneliness have also significantly increased (128% and 63% increase respectively). Further mental health impacts on Kooth service users, including a concerning rise in sexual abuse, are detailed in Fig 2 below.⁹ Data also suggests a disproportionate impact on mental health on BAME children and young people. BAME service users have higher rates of depression, anxiety, self-harm and suicidal thoughts compared to white peers.¹⁰

Fig 2. Impact of Covid-19 on the mental health of CYP using Kooth (March-May 2020)¹¹



⁵ Lee, J. (2020). Mental health effects of schools closures during COVID-19. *The Lancet Child & Adolescent Health*, 4(6), 421. Available here: [https://doi.org/10.1016/S2352-4642\(20\)30109-7](https://doi.org/10.1016/S2352-4642(20)30109-7)

⁶ The Children’s Society. The impact of COVID-19 on children and young people. Available here: <https://childrenssociety.org.uk/site/default/files/cv-19-impact-on-children-report-from-the-childrens-society.pdf>

⁷ YoungMinds. Our open letter to Government on young people’s mental health during lockdown. Available here: <https://youngminds.org.uk/about-us/media-centre/press-releases/our-open-letter-to-government-on-young-peoples-mental-health-during-lockdown/>

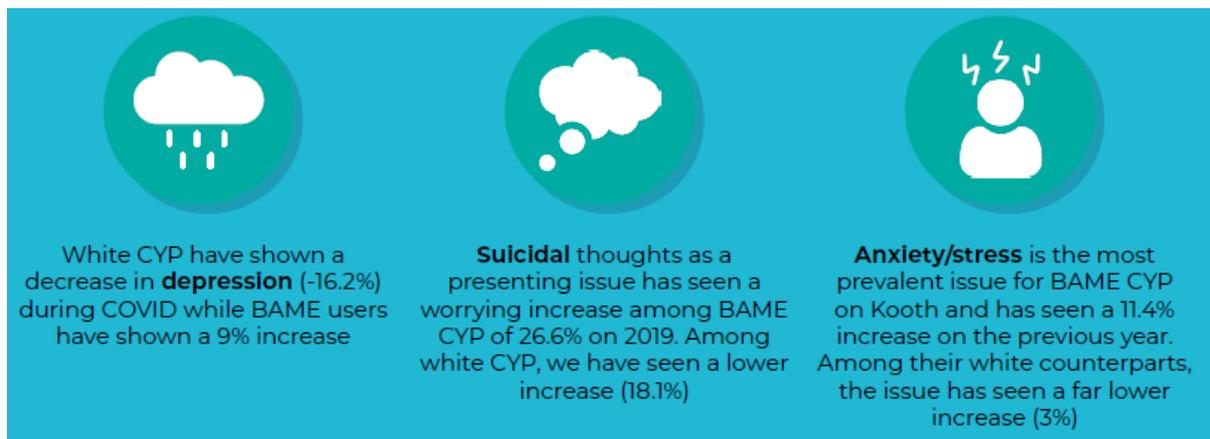
⁸ YoungMinds. Coronavirus: Impact on young people with mental health needs. Available here: https://youngminds.org.uk/media/3708/coronavirus-report_march2020.pdf

⁹ XenZone/Kooth. Week 14: How Covid-19 is Affecting The Mental Health of Children and Young People. Available here: <https://xenzone.com/week14>

¹⁰ XenZone/Kooth. Week 14: How Covid-19 is Affecting The Mental Health of Young People in the BAME Community. Available here: <https://xenzone.com/week14bame>

¹¹ Source: Xenzone/Kooth. NB: Users logging in during the period of 01/03/20-30/05/20 and last year during period 03/03/19-01/06/19

Fig 3. Impact of Covid-19 on the mental health of Kooth service users from BAME backgrounds compared to white service users

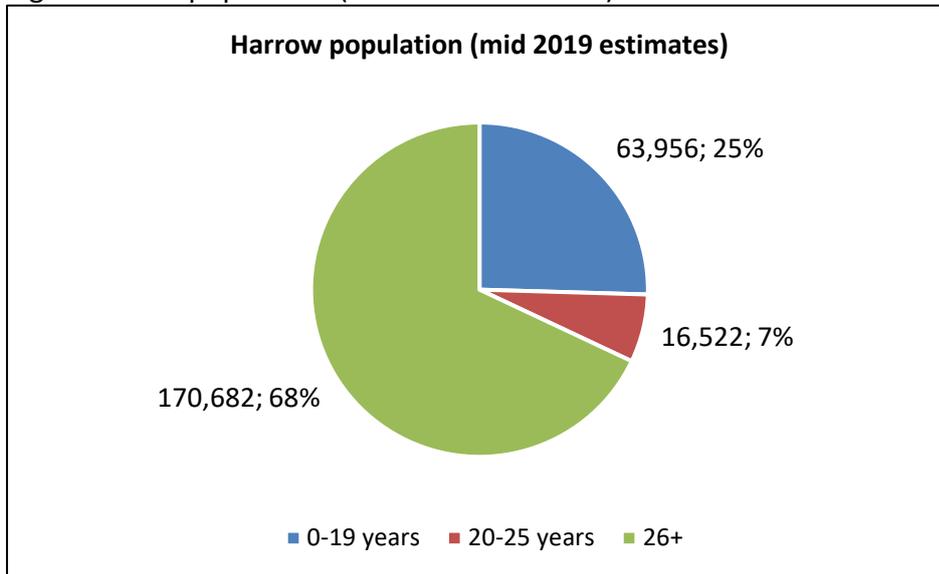


Source: Xenzone/Kooth.

According to the Office of National Statistics mid 2019 estimates¹² there are 63,956 children in Harrow between the ages of 0-19, which equates to a quarter (25%) of Harrow's population. The number increases to 80,478, just under a third (32%) when the numbers of 0-25 year olds are included.

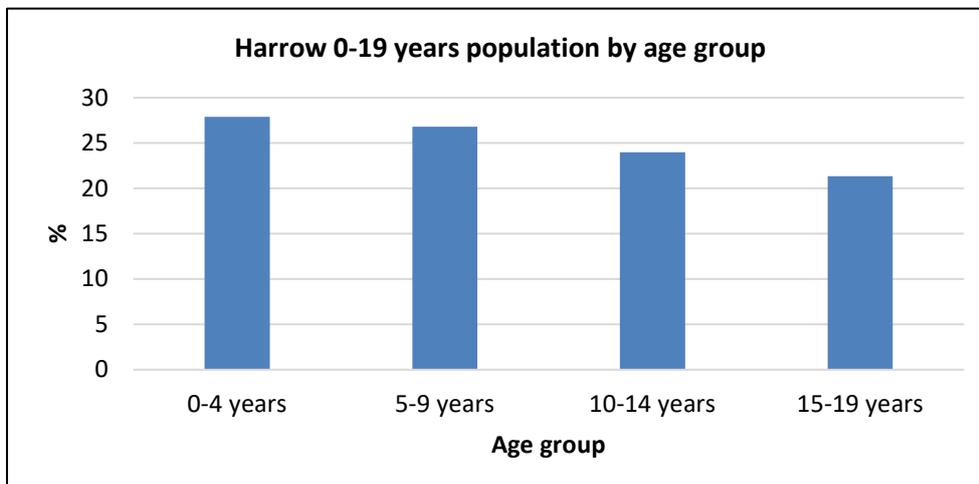
Currently, children between the ages of 0-4 years make up the largest proportion within the 0-19 years, accounting for 17,842 (28%).

Fig 4. Harrow population (mid 2019 estimates)



Source: ONS

Fig 5. Harrow 0-19 years population by five-year age groups (mid 2019 estimates)

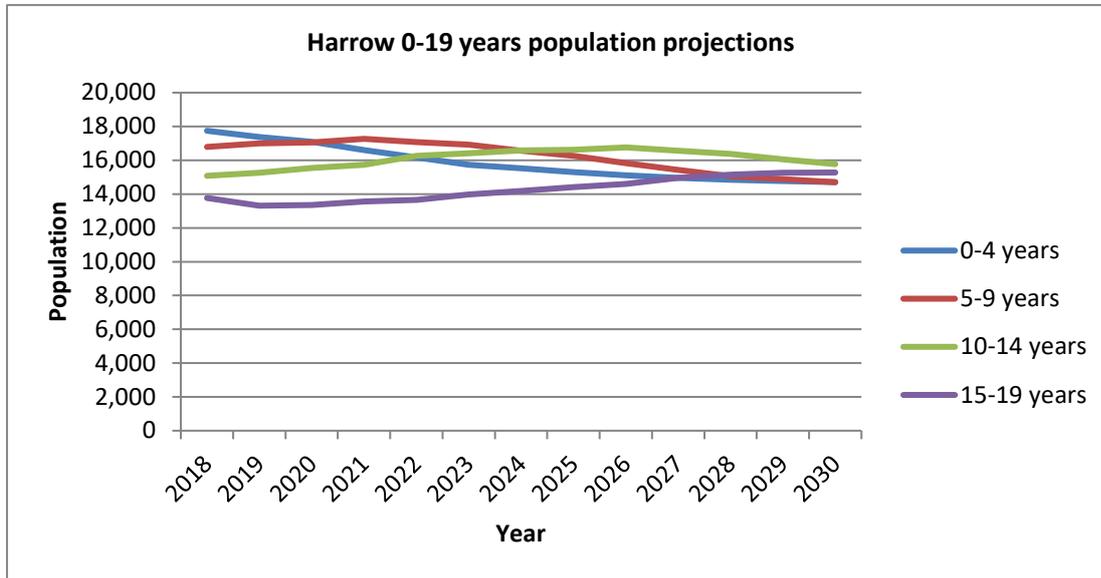


Source: ONS

¹² Office for National Statistics. Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland. Available here: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland>

Based on latest trends (mid 2018), 10-14 year olds are projected to make up the largest proportion of the 0-19 age group within the next 5 years.¹³ This is significant, as 50% of mental health problems are established by the age of 14.

Fig 6. Harrow 0-19 years population projections by 5 year age group (2018-2030)



Source: ONS

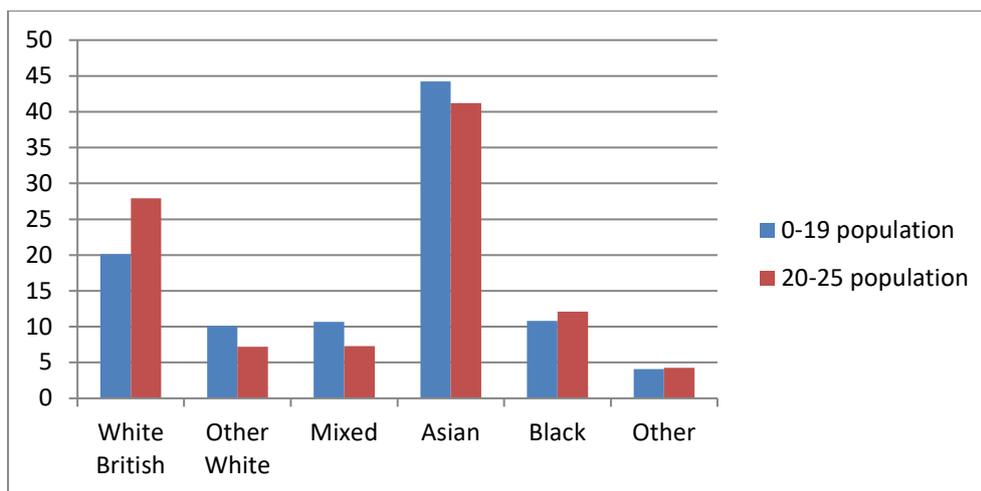
Harrow is home to a range of families from diverse backgrounds, and diversity is increasing over time. Overall 62% of residents in Harrow are from Black and Minority Ethnic (BAME) backgrounds and 50% of the resident population are born abroad.¹⁴ This diversity is reflected in the younger population, where the largest ethnic group (over 40%) for the 0-19 and 20-25 population is Asian.¹⁵

Fig 7. Harrow 0-19 and 20-25 population by broad ethnic group, 2017

¹³ Office for National Statistics. Population projections for local authorities: Table 2 (2018 based). Available here: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2>

¹⁴ Greater London Authority. London Borough Profiles. Available here: <https://data.london.gov.uk/dataset/london-borough-profiles>

¹⁵ Office for National Statistics. Population denominators by broad ethnic group and for White British: local authorities in England and Wales, 2011 to 2017. Available here: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/adhocs/008781populationdenominatorsbybroadethnicgroupandforwhitebritishlocalauthoritiesinenglandandwales2011to2017>



Source: ONS. NB: Chinese is included in Asian group, and Arab is included in Other group.

PREVALENCE

In 2017/18 there were an estimated 4861 children and young people between the ages of 5 to 17 with a mental disorder. Prevalence estimates from national surveys can also estimate the number of children in Harrow with specific mental health conditions. Public Health England's estimates of emotional, conduct and hyperkinetic disorders is based on the prevalence from the ONS survey *Mental health of children and young people in Great Britain (2004)* adjusted for age, sex and socio-economic classification of children resident in the area. Estimates for eating disorders and ADHD are based on the prevalence from the *Adult Psychiatric Morbidity Survey (2007)* applied to the resident population aged 16-24 years.¹⁶

Table 1. Estimated prevalence of common mental health conditions compared to London and England

Condition	Harrow	London region	England
Emotional disorders in 5–16 year olds (2015)	3.4%	3.6%	3.6%
Conduct disorders in 5–16 year olds (2015)	5.3%	5.7%	5.6%
Hyperkinetic disorders in 5-16 year olds (2015)	1.4%	1.5%	1.5%
Potential eating disorders in 16-24 year olds* (2013)	3348	126,462	-
ADHD in 16-24 year olds* (2013)	3592	132,239	-

Source: PHE Fingertips. Children and Young People's Mental Health and Wellbeing. * indicates significant concerns regarding quality of data

Hospital admissions can also be used to understand the burden of mental health problems for children in Harrow. Rates of hospital admission for clinically diagnosable mental health disorders in 0-17 year olds have remained broadly stable in recent years and are also similar to rates in London and England. Hospital admissions as a result of self-harm in 10-24 year olds have also remained stable in recent years; however, rates in Harrow are significantly better than the national average.¹⁷ Local hospital admissions data was unavailable.

¹⁶ Public Health England. Children and Young People's Mental Health and Wellbeing. Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/>

¹⁷ Public Health England. Child and Maternal Health. Available here: <https://fingertips.phe.org.uk/profile/child-health-profiles/>

Table 2. Hospital admissions for mental health conditions and as a result of self-harm, compared to London and England (2018/19)

Condition	Harrow	London region	England
Hospital admissions for mental health conditions in 0-17 year olds (per 100,000)	68.5 (Count – 40)	72.5	88.3
Hospital admission as a result of self-harm in 10-24 year olds (per 100,000)	169.8 (Count – 70)	195.8	444.0

Source: PHE Fingertips. Child and Maternal Health.

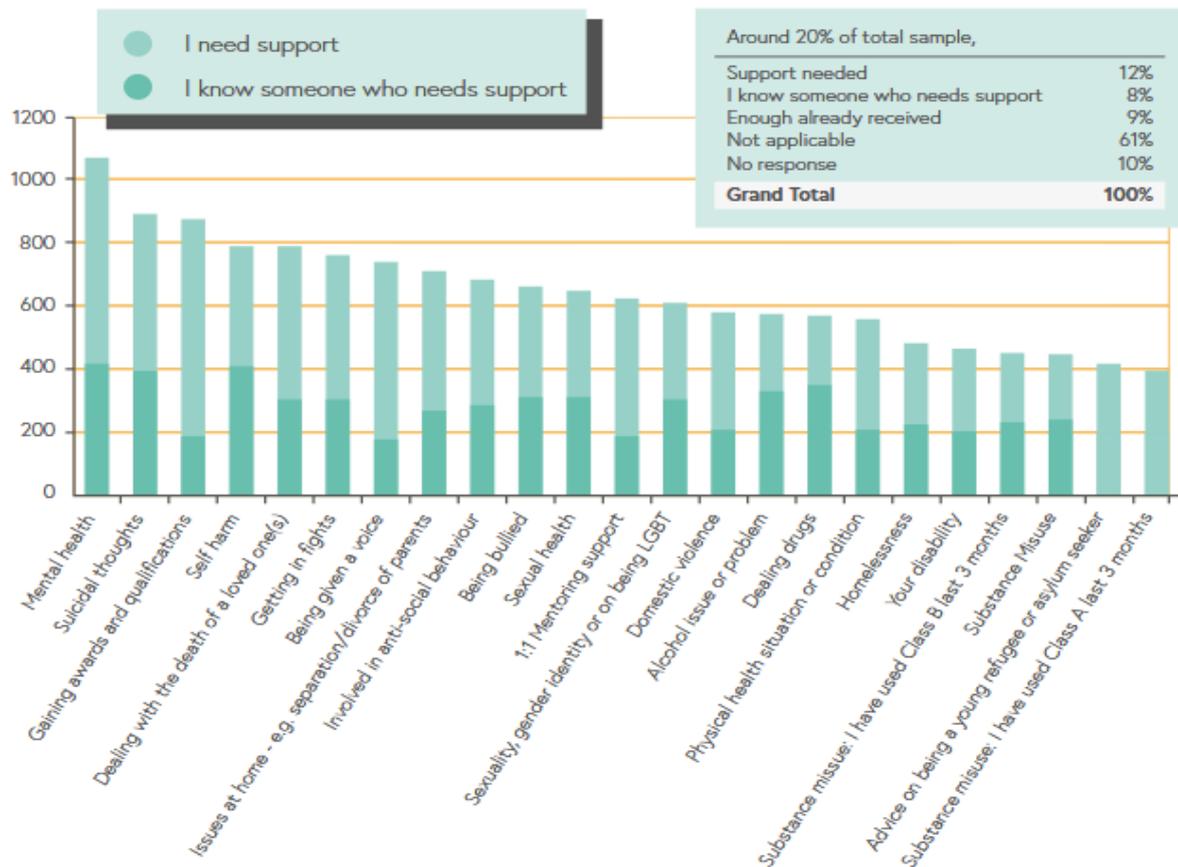
THIS IS HARROW: UNDERSTANDING THE NEEDS OF YOUNG PEOPLE IN HARROW

In 2018 the Young Harrow Foundation, in partnership with Harrow Council, Harrow Youth Parliament and the local voluntary sector, undertook a needs assessment of 10-19 year olds in Harrow.¹⁸ They surveyed 4,358 young people (around 15% of the Harrow 10-19 population). A key theme was mental and emotional well-being, and mental health issues are the largest area where there is unmet need for support (approximately 5,700 young people have an unmet mental health need).

- 20% say they need mental health support or know someone who does
- 6% specify counselling as a support need
- 36% want support to be able to deal with stressful situations
- 40% want to feel more confident
- 17% say they need help with suicidal thoughts or know someone who does
- 15% register a support need for self-harm or know someone who does

¹⁸ Young Harrow Foundation. This is Harrow: Understanding the Needs of Young People in Harrow. Available here: https://youngharrowfoundation.org/images/downloads/harrow/This-is-Harrow-Report-Final-Low-Res_190613_133641.pdf

Fig 8 Young Harrow Foundation results of needs assessment on the numbers of young people stating that support was needed for self and/or other (figures are weighted)



Source: Young Harrow Foundation. This is Harrow.

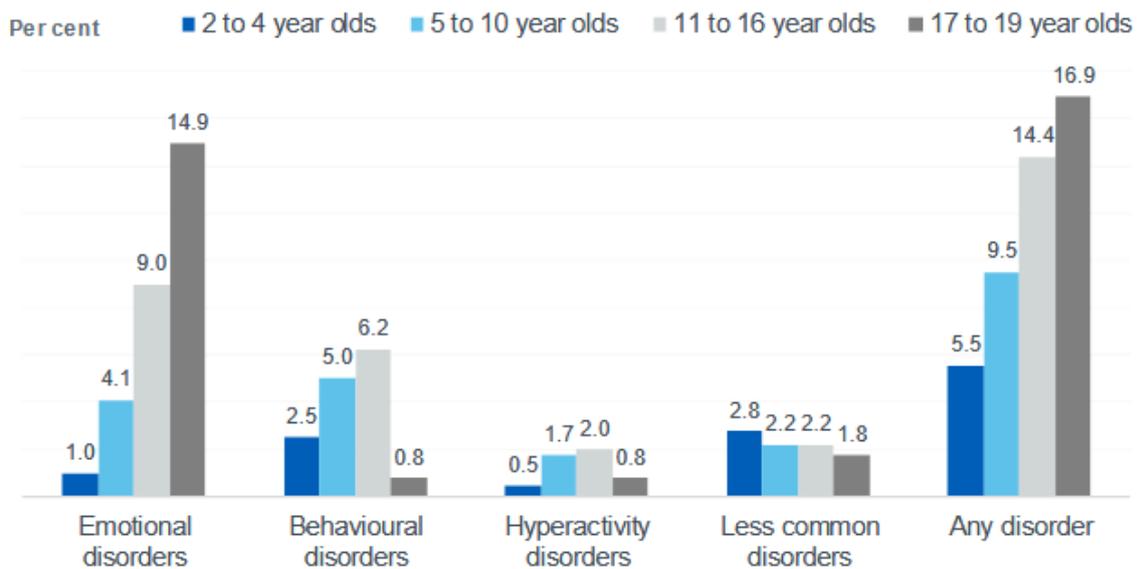
COMMON MENTAL HEALTH PROBLEMS ^{19 20}

There are a variety of mental health problems that can affect children and young people. Mental health disorders can be broadly categorised into emotional, behavioural, hyperactivity and other less common disorders. Behavioural disorders are more common in younger children, and emotional disorders more common in older children

¹⁹ NHS Digital. Mental Health of Children and Young People in England, 2017 [PAS]. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

²⁰ Mental Health Foundation. Children and young people. Available here: <https://www.mentalhealth.org.uk/a-to-z/c/children-and-young-people>

Fig 9. Rates of different types of disorders in 5 to 19 year olds by age.



Source: Mental Health of Children and Young People Survey, 2017

EMOTIONAL DISORDERS

- Includes anxiety disorders, depressive disorders, and mania and bipolar affective disorder
- Emotional disorders are more common in girls
- **Depression** affects more children and young people today than in the last few decades. Teenagers are more likely to experience depression than young children.
- **Generalised Anxiety Disorder (GAD)** can cause young people to become extremely worried. Very young children or children starting or moving school may have separation anxiety.
- **Post-traumatic Stress Disorder (PTSD)** can follow physical or sexual abuse, witnessing something extremely frightening or traumatising, being the victim of violence or severe bullying or surviving a disaster.

BEHAVIOURAL AND HYPERACTIVITY DISORDERS

- Behavioural disorders are characterised by disruptive and violent behaviours
- Behavioural disorders are more common in boys

- Hyperactivity disorders are characterised by inattention, impulsivity and hyperactivity
- Hyperactivity disorders are more common in boys.

OTHER LESS COMMON DISORDERS

- Includes autism spectrum disorders, eating disorders and tic disorders
- **Eating disorders** usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development.

SELF-HARM AND SUICIDE

- Self-harm and suicide are not mental health disorders themselves, but are linked to mental distress
- Self-harm is a very common problem among young people. Some people find it helps them manage intense emotional pain if they harm themselves, through cutting or burning, for example. They may not wish to take their own life.

EVIDENCE BASE AND POLICY CONTEXT

There has been a recent increase in awareness of the extent of mental health problems in children and young people and the importance of tackling these issues early to prevent long-term consequences. This has led to increased investment in improving mental health provision as well as ambitious national proposals. The green paper, *Transforming children and young people's mental health provision 2017*,²¹ outlines what the government is already doing to improve mental health, building on principles from 'Future in Mind, 2015'²² as well as plans to further improve the mental health support offered to children and young people, particularly by schools.

The government is currently focusing on improving the following areas of children and young people mental health provision:

- Waiting times for mental health
- Inpatient care
- Specialised services
- Crisis care
- Journey through mental health services
- Children in need
- Children with special educational needs & disabilities
- Lesbian, gay, bisexual and transgender (LGBT) young people
- Young offenders
- Children and young people in schools and colleges
- Data collection

²¹ Department of Health and Department for Education. Transforming Children and Young People's Mental Health Provision: a Green Paper. Available here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

²² Department of health and NHS England. Future in mind. Available here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Following the consultation on the green paper *Transforming children and young people's mental health provision* three broad themes emerged and three core proposals were agreed for future action.²³

Broad themes

- 1) **Tackling disadvantage.** This recognised the wider determinants of mental health including family breakdown, difficult early years and disability, and included proposals to increase funding for perinatal mental health, increase funding to reduce parental conflict and invest in the 'Troubled Families Programme', 'Healthy Child Programme' and 'Transforming Care Programme'.
- 2) **Improving mental health support.** This included proposals to improve access to specialty services and reduce waiting times.
- 3) **Mentally healthy schools, colleges and communities.** This included proposals to reduce stigma and promote mental health awareness in schools, address concerns about the dangers of social media to mental health and include mental health in the curriculum.

MENTAL HEALTH SERVICES

Thrive Model²⁴

Historically, the child and adolescent mental health services (CAMHS) model for service provision has been divided into four tiers.

- Tier 1: consists of non-specialist primary care workers such as school nurses and health visitors working with, for instance, common problems of childhood such as sleeping difficulties or feeding problems.
- Tier 2: consists of specialised Primary Mental Health Workers (PMHW's) offering support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services.
- Tier 3: consist of specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams based in a local clinic. Problems dealt with here would be problems too complicated to be dealt with at tier 2 e.g. assessment of development problems, autism, hyperactivity, depression, early onset psychosis.
- Tier 4: consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.

The model was considered useful at its time of development for helping differentiate between the forms of support that might be available to children and young people. An alternative model has been proposed by The Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre.

The Thrive Model conceptualises children and young people with mental health issues and their families, within a circular framework, including them as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community. The circular model is still divided into four key groupings, but these groupings are not exclusive but rather inclusive and are not differentiated by severity of need.

²³ Department of Health and Social Care and Department for Education. Government response to the consultation on *Transforming Children and Young People's Mental Health Provision: a Green Paper* and Next Steps. Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf

²⁴ Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust. Thrive. The AFC-Tavistock Model for CAMHS. Available here: https://www.annafreud.org/media/2552/thrive-booklet_march-15.pdf

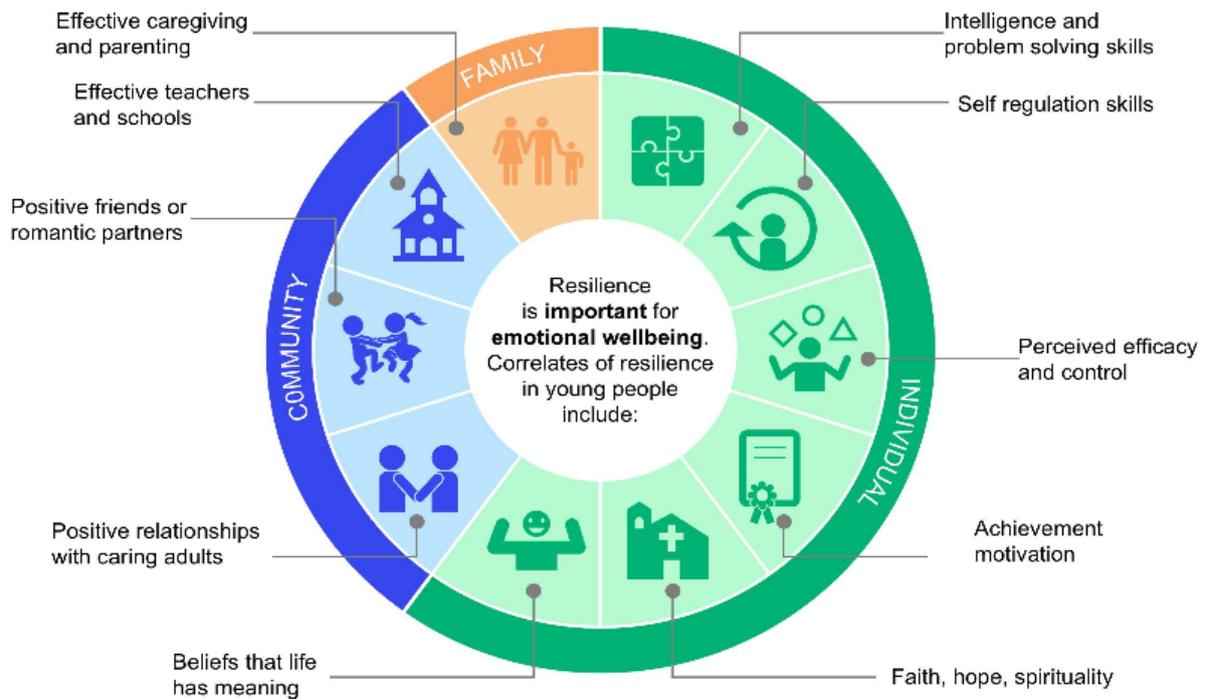
Fig 10. Thrive Model



Source: Thrive. The AFC –Tavistock Model for CAMHS

Public Health England have used this resilience 'thriving model' to highlight what is required to build resilience – the ability to cope with adversity and bounce back/adapt to change.

Fig 11. Resilience Model



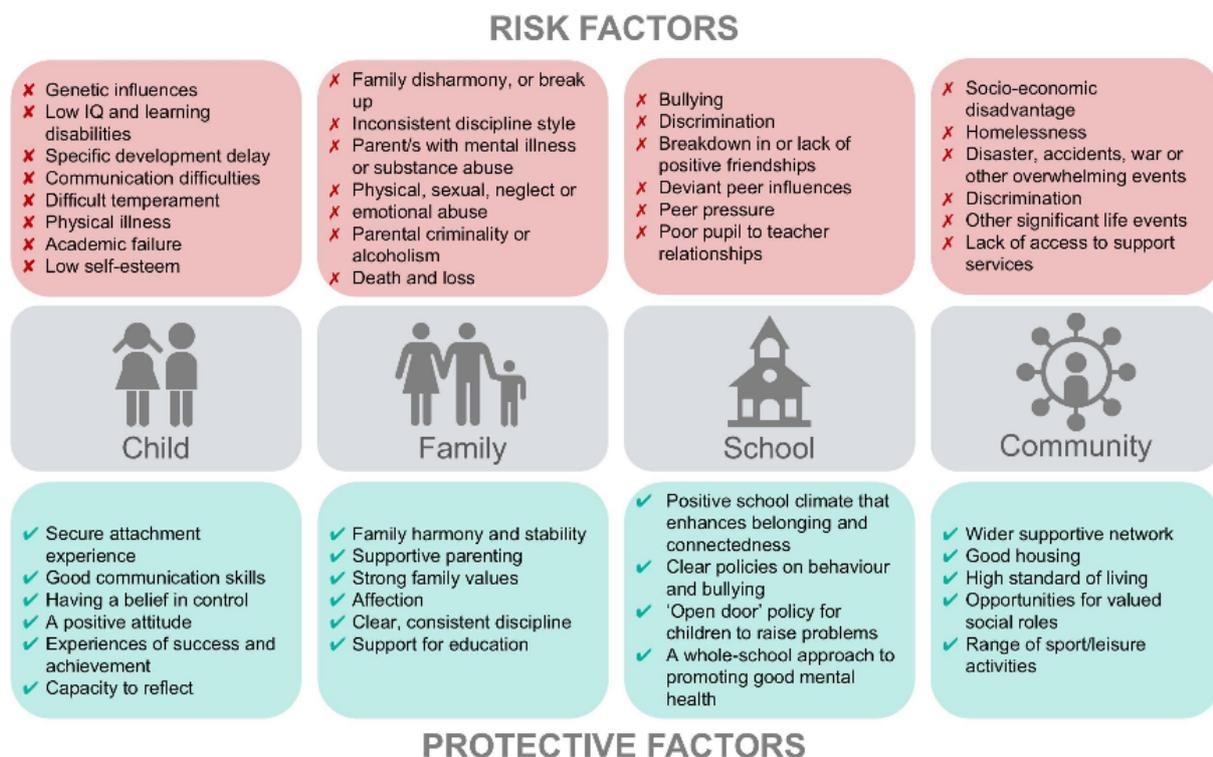
Source: The mental health of children and young people in London, 2016

VULNERABLE GROUPS

The factors that affect mental and emotional health are complex and range from individual biological factors to complex societal issues. Certain groups are at higher risk of developing mental health problems. These include children and young people with special educational needs (SEN), physical health problems, those identifying as lesbian, gay, bisexual, or other sexual identity (LGBT), young offenders, and looked after children.^{25 26}

Fig 12. Risk and protective factors contributing to children and young people’s mental health.

Source: The mental health of children and young people in London, 2016



²⁵ NHS Digital. Mental Health of Children and Young People in England, 2017 [PAS]. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

²⁶ Public Health England. The Mental Health of Children and Young People in London. Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/583866/Mental_health_of_children_in_London.pdf

POVERTY

Growing up in poverty increases the risk for the development of mental health problems. Data from the National Child Development Study has shown that children from the lowest income families are four times more likely (16%) to display psychological problems than children from the richest families (4%).²⁷

The Children and Young People's Mental Health Coalition noted that "being born into poverty puts children at a greater risk of mental health problems and, for many, this will lead to negative consequences through their lives, affecting educational attainment and social relationships, and can be cumulative." The increased risk can be attributed to a wide range of factors associated with poverty, such as low income, debt and poor housing. There is also stigma from those around them, from friends, peers and society as a whole; and children may be victims of bullying. Children are also acutely aware of the situations and may be embarrassed that they are unable to afford the cost of a school trip, or new uniform, for example.²⁸

Harrow performs better than London and England across key indicators related to children and young people and low income, and better than London when comparing homelessness. However, there is a still significant proportion of children in Harrow who are experiencing poverty.

Table 3. Indicators for children living in poverty

	Harrow	London	England
Children in low income families, under 16's (2016)	12.9%	18.8%	17%
Children in low income families, all dependent children under 20 (2016)	13.9%	19.3%	17%
Free school meals uptake among state-funded school age pupils (2018)	8.5%	15.6%	13.5%
Family homelessness, per 1000 (2017/18)	2.6	3.2	1.7
Homeless young people aged 16-24, per 1000 (2017/18)	0.42	0.73	0.52

Source: PHE Fingertips. Child and Maternal Health

The *Harrow Public Health Child poverty and health inequality needs assessment (2016)* reports that child poverty levels in Harrow are 18.54% before housing costs (BHC) and rise to 28.74% after housing costs (AHC). Poverty rises in some of the more deprived areas of the borough, Roxbourne has the highest percentage of child poverty levels with 28.5% BHC, rising to 42% after (AHC). Wealdstone, Marlborough, Greenhill, West Harrow, Queensbury and Roxeth have the next highest child poverty levels in the borough. Harrow's high housing and childcare costs can make it harder for low income families and low skilled workers to survive on their incomes.

²⁹

Wealdstone is Harrow's most deprived ward for income, followed by Roxbourne. These wards have an average rate of 16.7% and 15.8% indicating the proportion of residents in these wards who are likely to be experiencing

²⁷ Centre for Longitudinal studies. Counting the true cost of childhood psychological problems in adult life. Available here: <https://cls.ucl.ac.uk/counting-the-true-cost-of-childhood-psychological-problems-in-adult-life/>

²⁸ The Children's Society. Poor Mental Health. The links between child poverty and mental health problems. Available here: https://www.childrensociety.org.uk/sites/default/files/poor_mental_health_report.pdf

²⁹ Harrow JSNA. Harrow Public Health 2016. Child poverty and health inequality needs assessment. Available here: <https://www.harrow.gov.uk/downloads/file/23300/child-poverty-and-health-inequality-needs-assessment>

income deprivation. The positions are unchanged since 2015, although the rates indicate an improvement over this period.³⁰

CHILDREN IN CARE/LOOKED AFTER CHILDREN

Currently half of all children in care meet the criteria for a possible mental health disorder, compared to 1 in 10 children outside the care system. Furthermore 62% of looked after children are in care due to abuse or neglect, which has a lasting impact on their mental health and emotional wellbeing.³¹

Looked after children are almost four times more likely to have a special educational need (SEN) than all children, and almost nine times more likely to have a education, health and care (EHC) plan than all children. In 2019, 55.9% of looked after children had a special educational need, compared to 14.9% of all children. Of these looked after children the most common primary type of special education need is for social, emotional and mental health. This contrasts to the child population, where this is the primary need for 13.3% of those with EHC plans (40.4% of looked after children) and 18.1% of those with SEN support (compared to 47.5% of looked after children in this group).³²

The number of children in care in Harrow is significantly better than the England benchmark and the London region; however, the percentage whose emotional wellbeing is a concern is higher than both London and England. The number of children between 10 – 18 years old in the youth justice system (those young people being supervised by the youth offending team) is better than London but similar to England.

Table 4. Children in Care and Youth Justice System

	Harrow	London	England
Children in care (under 18 years), per 10,000 (2019)	29	50	65
Looked after children aged <5, per 10,000 (2017/18)	14.1	20.4	34.9
Looked after children aged 10-15, per 10,000 (2016)	34.8	67.7	75.3
Children who started to be looked after by local authorities due to abuse or neglect (0-17 years), per 10,000 (2018)	8.6	13.1	16.4
Percentage of looked after children (5-16 years) whose emotional wellbeing is a cause for concern (2017/18)	46.2%	33.4%	38.6%
Children in the youth justice system (10-18 years), per 1,000 (2017/18)	4.0	5.9	4.5

³⁰ Harrow JSNA 2016. Income deprivation. Available here:

<https://www.harrow.gov.uk/downloads/file/26518/harrow-index-of-multiple-deprivation-summary-2019>

³¹ Department for Education. Improved mental health support for children in care. Available here:

<https://www.gov.uk/government/news/improved-mental-health-support-for-children-in-care>

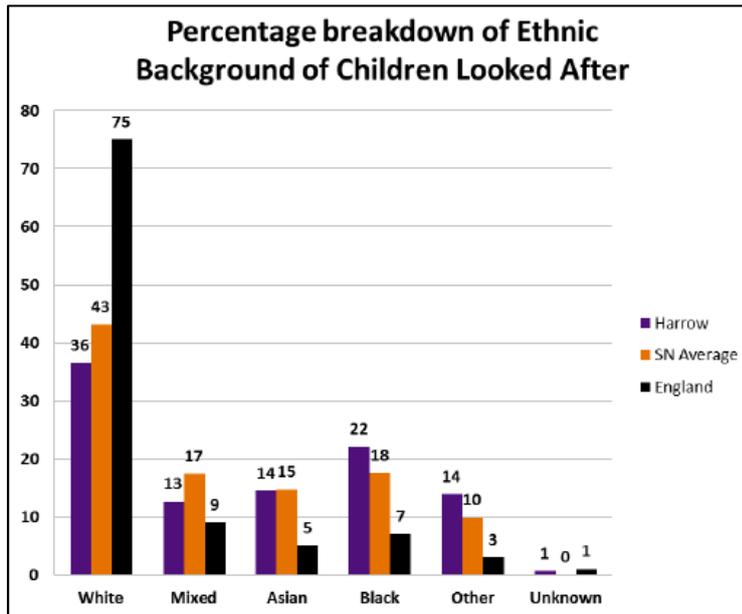
³² Department for Education. Outcomes for children looked after by local authorities in England, 31 March 2019. Available here: <https://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-local-authorities-31-march-2019>

First time entrants to the youth justice system (10-17 years), per 100,000 (2018)	179.0	282.5	238.5
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Source: PHE Fingertips. Child and Maternal Health and Children and Young People's Mental Health and Wellbeing.

Approximately two thirds of Harrow's children looked after population are from BAME groups. Harrow has a higher proportion of children from 'Black' & 'Other' other backgrounds compared to national figures; however, this is not dissimilar to the proportion of children and young people from BAME groups in Harrow overall.³³

Fig 13. Ethnicity of children looked after (2014)



Source: Harrow JSNA

YOUNG CARERS

Children and young people with caring responsibilities are at increased risk of mental health problems and stress. Young carers have adult responsibilities and may miss out on the same opportunities as other children due to their caring role. They may also face additional challenges; for example, young carers experience bullying at school, emotional neglect and live in low-income households at higher rates than their peers. Children with a parent/carer with depression are also at higher risk of homelessness and domestic violence.³⁴ ³⁵ Overall, an estimated 2 in 5 young carers have a mental health problem and almost half report additional stress.³⁶ Local data on young carers was not available.

³³ Harrow JSNA. Children and young people services. Children looked after. Available here:

<https://www.harrow.gov.uk/downloads/file/23302/children-looked-after>

³⁴ The Children's Society. Overwhelming problems damaging children's well-being: Spotlight on children caring for a parent with mental health problems. Available here:

https://childrenssociety.org.uk/sites/default/files/overwhelming-problems-children-caring-for-a-parent-with-mental-health-problems_0.pdf

³⁵ Department for Education. The lives of young carers in England omnibus: January 2017. Available here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582575/Lives_of_young_carers_in_England_Omnibus_research_report.pdf

³⁶ YoungMinds. Beyond Adversity: Addressing the mental health needs of young people who face complexity and adversity in their lives. Available here: https://youngminds.org.uk/media/1241/report_-_beyond_adversity.pdf

MATERNAL MENTAL HEALTH

The social and emotional wellbeing of a baby or toddler can be affected by whether the mother has a mental health problem herself, often due to the effect on the mother-baby relationship:

“... emotional distress and problems during pregnancy, childbirth and the postnatal period warrant particular attention because of the longitudinal impact these difficulties have on the developing fetus and newborn baby, effects which are often mediated through the woman’s disrupted relationship with her infant.”³⁷

PERINATAL MENTAL HEALTH

Perinatal mental health problems are defined as those that occur during pregnancy or in the first year following childbirth. They include mental health problems that arise at this time and those that were present before pregnancy. Women have a substantial risk of developing a mental health condition during pregnancy or postpartum. Up to 20% of women are affected by mental health illness during this period. Perinatal mental health can include a whole range of conditions from mild to severe. Serious perinatal mental health disorders are associated with increased risk of suicide, which is a leading cause of maternal mortality. Over the last two decades mental health disorders have contributed to 15% of all maternal mortality during pregnancy and the first 6 months postpartum.³⁸

Many women experience mild mood changes. Women can also experience common mental health disorders such as depression and anxiety. However, a small but significant number of women develop a severe mental health condition such as postpartum (also called puerperal) psychosis (2 in 1000).³⁹ New onset of severe mental health conditions are more likely to occur postnatally. Furthermore, women with longstanding serious mental health illnesses such as schizophrenia or bipolar are at increased risk of their conditions relapsing or deteriorating during pregnancy and postpartum.⁴⁰

Table 5. Mental health conditions commonly associated with pregnancy or post-partum.

Condition	Definition	Prevalence
Postpartum psychosis (puerperal psychosis)	Severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions ⁴¹ .	2 in 1000

³⁷ National Collaborating Centre for Mental Health. Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. Available here:

https://www.ncbi.nlm.nih.gov/books/NBK305023/pdf/Bookshelf_NBK305023.pdf

³⁸ Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Available here: <https://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf>

³⁹ Public Health England. JSNA toolkit: Perinatal mental health. Available here:

<https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health>

⁴⁰ Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Available here: <https://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf>

⁴¹ Royal College of Psychiatrists. Postpartum psychosis. Available here: <https://www.rcpsych.ac.uk/mental-health/problems-disorders/postpartum-psychosis>

Chronic severe mental illness (SMI)	SMI includes diagnoses which typically involve psychosis, such as schizophrenia and bipolar disorder. A person with psychosis may have hallucinations, delusions and muddled thinking. ⁴² ⁴³	2 in 1000
Mild-moderate depressive illness and anxiety in perinatal period	Symptoms of depression include feeling tearful, irritable or tired, appetite changes, and problems with sleep, concentration and memory. Typically also have negative thoughts and feelings of guilt and worthlessness; some may self-harm or attempt suicide. In mild depression there are a small number of symptoms that have a limited effect on daily life. In moderate depression there are more symptoms that can make daily life much more difficult than usual. Mild anxiety is experienced as feelings of being overwhelmed by responsibilities and unable to cope. People with depression may have feelings of anxiety as well. ⁴⁴ ⁴⁵	100 in 1000
Post traumatic stress disorder (PTSD) in perinatal period	PTSD is experienced as nightmares, flashbacks, anger, and difficulty concentrating and sleeping. It may be a pre-existing condition or be triggered by a traumatic labour. ⁴⁶	30 in 1000
Adjustment disorders and distress in perinatal period	Adjustment disorders occur in response to a significant life change or stressful live event. It is associated with marked distress not in keeping with what would be expected from the stressor, often affecting social function. Symptoms vary, and can include depression and anxiety. ⁴⁷	150 in 1000

Source (prevalence): PHE Fingertips. Perinatal Mental Health.

PREVALENCE OF PERINATAL MENTAL HEALTH CONDITIONS IN HARROW

BIRTHS IN HARROW

The number of births in the local area gives a good indication of the approximate number of mothers and babies in the local population overall. It should be remembered that this includes multiple births and so does not give the exact number of mothers. In 2018 there were 3,582 live births and 13 still births in Harrow.⁴⁸

⁴² Mental Health Wales. What is serious mental illness? Available here:

<http://www.mentalhealthwales.net/what-is-serious-mental-illness/>

⁴³ Royal College of Psychiatrists. Psychosis – for young people. Available here:

<https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/young-people/psychosis---for-young-people>

⁴⁴ NICE. Depression in adults: recognition and management. Available here:

<https://www.nice.org.uk/guidance/cg90>

⁴⁵ Best beginnings. Antenatal and postnatal mental health. Available here:

<https://www.bestbeginnings.org.uk/helping-parents-with-mental-health-issues>

⁴⁶ Best beginnings. Antenatal and postnatal mental health. Available here:

<https://www.bestbeginnings.org.uk/helping-parents-with-mental-health-issues>

⁴⁷ Clinical Practice and Epidemiology in Mental Health. Adjustment disorder: epidemiology, diagnosis and management. Available here: <https://cpementalhealth.biomedcentral.com/articles/10.1186/1745-0179-5-15>

⁴⁸ Office for National Statistics. Births in England and Wales: summary tables. Available here:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsummarytables>

The general fertility rate is the number of live births for every 1,000 women aged 15 to 44 years and is consistently higher in Harrow compared to London and England. Harrow had a general fertility rate of 74.1 live births per 1,000 women aged 15 to 44 years in 2018; compared to 60.2 in London, and 59.2 in England.⁴⁹

Table 6. General Fertility Rate

	2016	2017	2018
Harrow	72.7	75.9	74.1
London	63.7	62.9	60.2
England	62.5	61.2	59.2

Source: ONS. Live births in England and Wales: birth rates down to local authority areas.

This is unsurprising given that the fertility rate is higher in non-UK born mothers, and Harrow has a considerably higher prevalence of live births born to non-UK mothers than London or England. In 2018 72.8% of live births in Harrow were born to non-UK mothers compared to 57.1% of live births in London and 29.1% of live births in England.⁵⁰

Table 7. Percentage of live births born to non-UK born mothers

	2016	2017	2018
Harrow	70.9	73.6	72.8
London	58.2	57.9	57.1
England	29.0	29.2	29.1

Source: ONS. Parents' country of birth.

PREVALENCE IN HARROW⁵¹

Based on the number of women giving birth in Harrow, the figures below show how many women that can be expected to have certain mental health problems in pregnancy and the postnatal period. These estimates are based on national estimates of these conditions and local delivery figures only and have been rounded up to the nearest five. They do not consider socioeconomic factors or anything else which is likely to cause local variation.

Adding all these estimates together will not give an overall estimate of the number of women with antenatal or postnatal mental health conditions in Harrow, as some women will have more than one of these conditions.

In Harrow, where 3,521 women gave birth in 2017:

- Estimated number of women with postpartum psychosis: 10
- Estimated number of women with chronic SMI: 10
- Estimated number of women with severe depressive illness: 110
- Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate): 355
- Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate): 530

⁴⁹ Office for National Statistics. Live births in England and Wales: birth rates down to local authority areas. Available here:

<https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=207>

⁵⁰ Office for National Statistics. Parents' country of birth. Available here:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/parents-country-of-birth>

⁵¹ Public Health England. Mental health in pregnancy, the postnatal period and babies and toddlers. Report for Harrow local authority. Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health/>

- Estimated number of women with PTSD: 110
- Estimated number of women with adjustment disorders and distress (lower estimate): 530
- Estimated number of women with adjustment disorders and distress (upper estimate): 1,060

RISK FACTORS

Risk factors for some specific perinatal mental health conditions include poverty, poor social support, exposure to violence (domestic, sexual and gender-based), migration, emergency and conflict situations, natural disasters, trauma and history of mental health problems.⁵²

Parents who have suffered a bereavement including miscarriage, still birth or death of an infant are at increased risk of developing a mental health condition. Women who have a personal or family history of bipolar disorder are also at increased risk of developing postpartum psychosis.⁵³

POSTNATAL DEPRESSION

Postnatal depression is particularly important because it occurs at a critical time in the lives of the mother and baby. Depressed mothers have more negative responses (and less positive) in their interaction. Untreated postnatal depression can have a detrimental effect on the child's cognitive, social and behavioural development (short and long term), and on the relationship between mother and baby. Impairment of cognitive development appears limited to children whose mothers find it difficult to maintain sensitive and active engagement.⁵⁴

Risk factors for postnatal depression include previous mental health problems, depression and anxiety during pregnancy, poor support from partner/family and recent stressful events (e.g. bereavement).⁵⁵ Young mothers are also more at risk of developing postnatal depression than average.⁵⁶

Table 8. Percentage of deliveries where the mother is aged under 18 years

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Harrow	0.3	0.2	0.3	0.5	-1.0	0.3
London	0.5	0.5	0.5	0.4	0.4	0.3
England	1.1	1.0	0.9	0.8	0.7	0.6

Source: PHE Fingertips. Child and Maternal Health. '-1' indicates the value has been suppressed.

PERINATAL MENTAL HEALTH SERVICE⁵⁷

Harrow has a joint perinatal mental health service with Brent. The service works in partnership with The London North West Healthcare NHS Trust Maternity Service, primary care community services (including community midwifery, health visitors and GPs), Improving Access to Psychological Therapies (IAPT), children and adult social

⁵² World Health Organization. Maternal Mental Health. Available here:

https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/.

⁵³ Public Health England. JSNA toolkit: Perinatal mental health. Available here:

<https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health>

⁵⁴ SIGN. Management of perinatal mood disorders. Available here:

https://www.sign.ac.uk/assets/sign127_update.pdf

⁵⁵ Royal College of Psychiatrists. Postnatal depression. Available here: <https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-natal-depression>

⁵⁶ Mental Health Foundation. Young Mums Together. Available here:

<https://www.mentalhealth.org.uk/publications/young-mums-together-report>

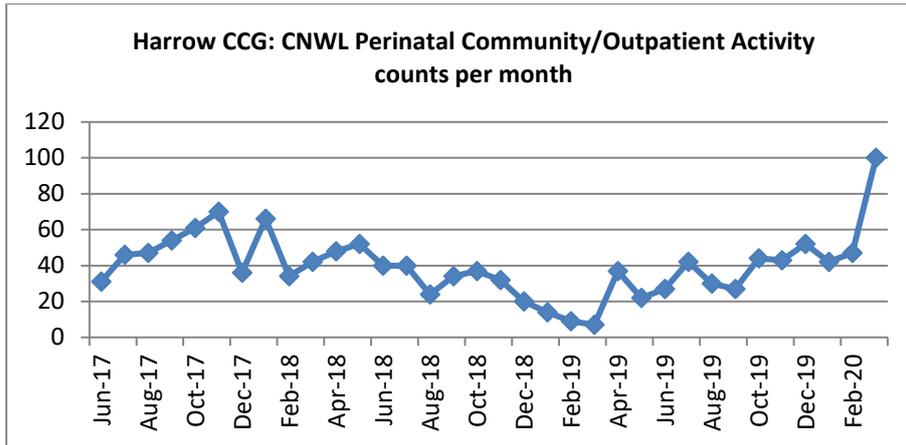
⁵⁷ CNWL. Northwick Park Hospital: Brent and Harrow Perinatal Mental Health Service. Available here: <https://www.cnwl.nhs.uk/mental-health-services/adult-and-older-adult/northwick-park-hospital-brent-harrow-perinatal-mental-health-service/>

care services and voluntary organisations. Midwives, GPs, obstetricians, health visitors, mental health and other health professionals can refer. Any woman who is a Brent or Harrow resident (or registered to a GP in the area) can be referred.

THE PERINATAL MENTAL HEALTH SERVICE PATHWAY

- All pregnant women will receive a formal mental health screen at their booking visit. They will receive informal mental health screens at subsequent antenatal appointments. Those who are considered to be at risk of mental health conditions will be referred to the safeguarding midwife. The safeguarding midwife will assess the referral and if it meets criteria, it will be referred on to the perinatal mental health service. Referrals that do not meet criteria will be discharged back to community midwifery.
- Referrals from safeguarding are triaged by the perinatal mental health service and channelled to the most appropriate team within the perinatal mental health service. Referrals for mild mental health conditions may be forwarded to IAPT. Referrals for moderate to severe mental health conditions that meet criteria for specialist care will be followed up by an initial assessment. Referrals that do not meet criteria will be discharged back to community midwifery.
- The initial assessment should happen within 28 days of referral. Following the initial assessment women will be referred to the most appropriate team(s). They may be added to the perinatal service caseload or referred directly to a particular team, for example, occupational therapy. Women who are added to the caseload may have follow up with nurses, doctors, psychologists or social workers. The support they receive will be tailored to their individual needs. Patients with complex conditions or medication issues are likely to be seen by the perinatal mental health consultant. Following the initial assessment if it is felt that the woman's mental health condition is mild, they may be referred to IAPT. The number of follow-up appointments for any patient will be decided on an individual basis.
- Women who are severely mentally unwell can either be admitted to the mother and baby inpatient unit at Coombe Wood or seen by the adult mental health services crisis team. The crisis team is not specifically a perinatal mental health service.
- The perinatal mental health service will liaise with adult mental health services regarding the care of patients already under adult services. For example, the perinatal mental health service may offer support to the home treatment team for patients already under this service.

Fig 14. CNWL Perinatal Community/Outpatient Activity counts per month



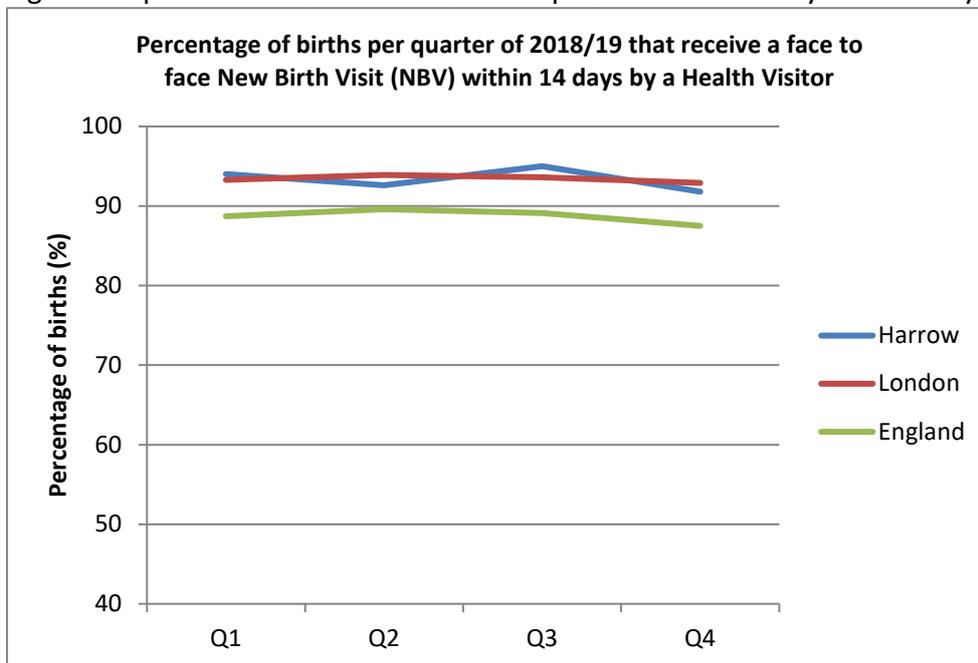
In 2019 -2020, approximately 115 Harrow CCG patients aged 16 or over in the perinatal period were in contact with specialist community based perinatal mental health services. During this period, there were also approximately 205 pregnancies for Harrow CCG patients aged 16 or over with a “Mental Health Referral” open in the perinatal period.

HEALTH VISITING^{58 59}

NEW BIRTH VISITS

All infants and their families should receive a New Birth Visit by a health visitor within 14 days of birth. This visit forms part of the Healthy Child Programme and is important for the early identification of mental health conditions postnatally. In 2018/19 the proportion of New Birth Visits (NBVs) in Harrow was around 93%, similar to the London average and slightly higher than the national average.

Fig 15. Proportion of New Birth Visits completed within 14 days of delivery



Source: PHE. Health Visitor survey delivery metrics: 2018 to 2019

⁵⁸ SIGN. Management of perinatal mood disorders. <https://www.sign.ac.uk/sign-127-management-of-perinatal-mood-disorders.html>

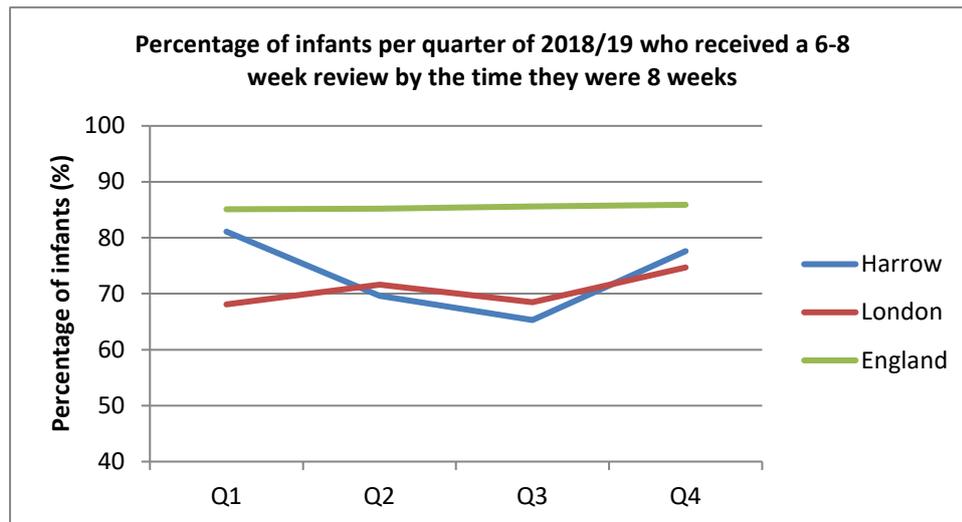
⁵⁹ Public Health England. Health visitor service delivery metrics: 2018 to 2019 Available here: <https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019>.

6-8 WEEK REVIEW

New mothers should also receive a 6-8 week review as part of the 'Healthy Child Programme'. This is another opportunity to assess the mother's mental health and if the mother is eligible for benefits this can be an opportunity to offer guidance and support in this area. In 2018/19 the proportion of infants receiving a 6 to 8 review in Harrow varied throughout the year, (81.1% in quarter 1 compared to only 65.3% in quarter 3) but was consistently lower than the national average.

(Please note that performance for the 6-8 week check has significantly improved over 2019-20. In Q3 19-20 97% of infants received their 6-8 week check by 8 weeks.)

Fig 16. Proportion of infants receiving a 6 to 8 week review



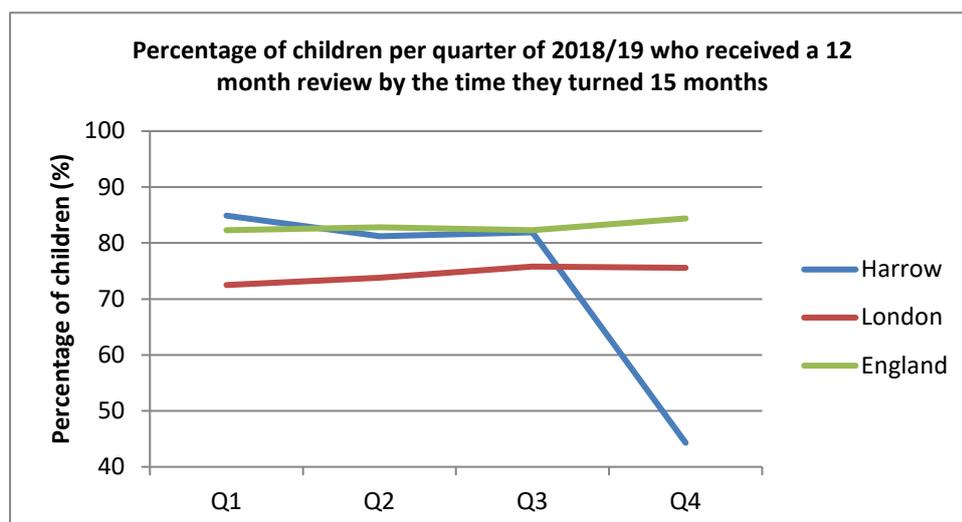
Source: PHE. Health Visitor survey delivery metrics: 2018 to 2019

ONE YEAR REVIEW

All children should receive a review by a health visitor shortly before they turn one. This is to assess the physical, emotional and social wellbeing of the infant in the context of their family. It is also an opportunity to assess preconception health if the woman is considering another pregnancy. In 2018/19 the proportion of children in Harrow receiving their 12 month review before they turned 15 months was initially around 83%, which was above the London average and similar to the national average. However, the proportion dropped substantially in the last quarter to 44%.

(Please note that performance for the 12 month review by 15 months has significantly improved over 2019-20. In Q3 19-20 89% of infants received their 12 month review by 15 months.)

Fig 17. Proportion of children receiving 12 month review by the time they turned 15 months.



Source: PHE. Health Visitor survey delivery metrics: 2018 to 2019

At any health visit, if the health visitor is concerned about the mental health of the mother, they can refer her to the GP, IAPT or the perinatal mental health service, depending on which service is most appropriate. Health visitors can also see women for up to six additional visits called 'listening visits' where they are able offer

additional emotional support. In Harrow in 2019 46 patients received listening visits between January and September; of these 29 were first time mothers.

SUICIDE AND SELF-HARM

SUICIDE

Suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent⁶⁰. Suicide is the biggest killer of young people in England and Wales, accounting for 15% of deaths in 5-19 year olds, and 22.6% of 20-34 year olds.⁶¹

PREVALENCE

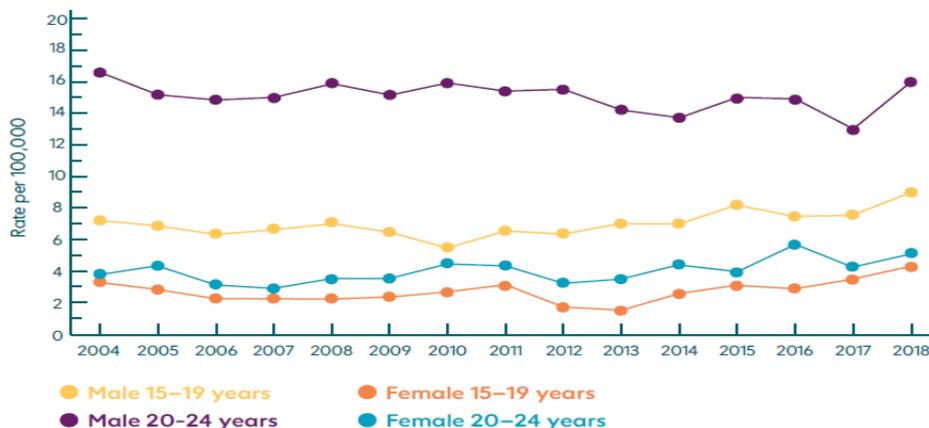
In 2018, 6,507 suicides were registered in the UK. The suicide rate is highest among men aged 45-49, however suicide rates amongst young people have been increasing in recent years. Three quarters of suicides amongst young people are male, with rates highest in those aged 20-24. In the UK suicide rates increased for all groups of young people in 2018; there was a 30% increase in suicide rates among men aged 20-24, and the suicide rate for young females is at its highest rate on record.⁶²

Table 9. Suicide rate per 100,000, for young people in the UK in 2018

	Male	Female
15-19 years	9.0	4.4
20-24 years	16.9	5.1

Source: Samaritans. Suicide statistics report 2019

Fig 18. Suicide rate per 100,000 for young people in the UK 2004-2018.



Source: Samaritans, Suicide statistics report 2019

⁶⁰ Office for National Statistics. Suicide occurrences, England and Wales. Available here: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicideinenglandandwales>

⁶¹ Office for National Statistics. Deaths registered in England and Wales. Available here: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredinenglandandwalesseriesdrreferencetables>

⁶² Samaritans. Suicide Statistics Report 2019. Available here: <https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/>

The suicide rate for Harrow is either statistically better or similar when compared to London and England.⁶³

Table 10. Suicide rates compared with London and England

	Harrow	London	England
All persons per 100,000(2016-2018)	6.4	8.1	9.6
Suicide rate male per 100,000(2016-2018)	9.0	12.5	14.9
Suicide rate female per 100,000(2016-2018)	3.6	4.0	4.7
Suicide crude rate for 10-34 year males per 100,000 (2013-2017)	10.0	8.3	10.5

Source: PHE Fingertips. Suicide prevention profile.

RISK FACTORS⁶⁴

A national study has shown that in their findings there were 10 common themes in suicide by children and young people.

- Family factors, such as mental illness
- Abuse and neglect
- Bereavement and experience of suicide
- Bullying
- Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas

The prevalence of these risk factors varies with age, reflecting the stressors experienced at different ages. For example, academic pressures and bullying were more common in under 20's, and workplace, housing and financial problems were more often reported in young people aged 20-24. These experiences may also combine over time, until suicide occurs in a crisis.

Over half of young people who die by suicide have a history of self-harm, therefore services that respond to self-harm are key to suicide prevention in children and young people.

⁶³ Public Health England. Suicide prevention profile. Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/>

⁶⁴ University of Manchester and Health Care Quality Improvement Partnership. Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Available here: <http://documents.manchester.ac.uk/display.aspx?DocID=37566>

SELF-HARM

Self-harm is a term used when someone injures or harms themselves on purpose rather than by accident and is always a sign of something being seriously wrong. Self-harm is more common in children and young people; the greatest incidence in females is 15-19 year olds, and in males is 20-24 year olds.

Self-harm significantly increases suicide risk (50-00 times the rate of the general population), and approximately 1 in 6 that attend A&E for self-harm will self-harm again within a year. Complications from self-harm can also be detrimental to an individual's long-term physical health; paracetamol poisoning is a major cause of acute liver failure and self-cutting can result in permanent scarring of skin and damage to tendons and nerves.^{65 66}

Common examples:

- Taking too many tablets - 'overdosing'
- Hitting oneself
- Cutting oneself
- Burning oneself
- Pulling hair or picking skin
- Self-strangulation

Common reasons why young people self-harm:

- To feel more in control – may feel trapped and helpless
- To relieve tension – feelings of anger or tension bottled up
- To punish oneself – feelings of guilt or shame
- To feel more connected and alive – may feel 'numb' or 'dead' from coping with difficult experiences
- To commit suicide

Risk factors for self-harm:

- Being depressed, having an eating disorder or any other serious mental health problem
- Substance misuse or drinking too much alcohol
- Abuse, neglect or rejection

⁶⁵ Royal College of Psychiatrists. Self-harm in young people: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/self-harm-in-young-people-for-parents-and-carers>

⁶⁶ NICE CKS (clinical knowledge summaries). Self-harm. Available here: <https://cks.nice.org.uk/self-harm>

THE GOOD CHILDHOOD REPORT

The Good Childhood Report (2018)⁶⁷ produced by the Children's Society in partnership with the University of York, is the annual report on subjective wellbeing and mental ill health. The report used the findings from the sixth wave of the Millennium Cohort Study (MCS) carried out in 2015. Providing data of approximately 19,000 14 year olds born in the UK (in 2000-01).

The report found that:

- Over 15% of children who responded self-harmed in the past year
- Girls (22%) were more than twice as likely as boys (9%) to self-harm
- Children in the Indian, Pakistani/Bangladeshi and Black/Black British ethnic groups were much less likely to self-harm than children from White, Mixed and Other groups
- Almost half of children who were attracted to children of the same gender or both genders had self-harmed in the past year
- There was a weaker link with household income – although children in the highest two income groups were less likely to have self-harmed than children in the lowest two income groups.

BOYS AND SELF-HARM⁶⁸

Research in 2017 on boys and self-harm found that 24% of boys age 16 - 24 in the UK self-harm. This suggests that self-harm may be more hidden in males and self-harm in young men and teenage boys may exhibit differently to females. In females the highest recorded form of self-harm is cutting; in males it is self-poisoning. Punching walls, getting into fights and over-exercising combined with under-eating, are examples of self-harm that may be missed in boys.

LGBTQ AND SELF-HARM⁶⁹

The statistics for young people in the LBGTQI community who have considered suicide is 59%, while 48% have self-harmed. These numbers sadly reflect the feeling of being alone and the emotional turmoil that many journey through.

EATING DISORDERS AND SELF-HARM⁷⁰

There are links between self-harm and different types of eating disorders. Nationally, the prevalence of self-harm in people with eating disorders is thought to be about 25% and is particularly high among people who engage in the binge-purge cycle of Bulimia Nervosa. For many, self-harm and an eating disorder co-exist, but for others self-harm can develop to replace an eating disorder or vice versa.

SPECIAL EDUCATIONAL NEEDS (SEN) AND SELF-HARM⁷¹

⁶⁷ The Good Childhood Report 2018. Available here:

https://www.childrenssociety.org.uk/sites/default/files/the_good_childhood_report_full_2018.pdf

⁶⁸ Self Harm UK. Boys and self-harm. Available here: <https://selfharm.co.uk/get-information/the-facts/boys-and-self-harm>

⁶⁹ Stonewall, LGBT Facts and Figures. Available here: <http://www.stonewall.org.uk/media/lgbt-facts-and-figures>

⁷⁰ Self Harm UK. Available here: <https://selfharm.co.uk/get-information/the-facts/who-self-harms>

⁷¹ Self Harm UK. SEN and Self Harm Available here: <https://www.selfharm.co.uk/get-information/the-facts/sen-and-self-harm>

There are many contributing factors as to why young people with Special Educational Needs (SEN) begin to self-harm. Complex Emotional, Social, Behavioural and Communication difficulties will often cause young people to harm for different reasons to others.

SELF-HARM AND AUTISM

Self-harm is very common in people with Autism Spectrum Disorders. It is thought that between 20-30% of people with autism will self-harm in some way. This is often seen as something different to someone cutting or burning as a coping mechanism. There is a distinction between both and can be referred to as “self-injurious behaviour”. It can be treated as a challenging, unwanted behaviour and is part of a condition.⁷²

Based on national proportions of 20% - 30% and the count of children with autism known to school, we can estimate the number likely to self-harm. The rates of children with autism in Harrow, are lower than London and England.⁷³

Table 11 Number of children with autism in Harrow and estimated number likely to self-harm

Period	Count and rate in Harrow	London rate	England rate	Estimated number likely to self-harm (20% - 30%)
2015	381 (9.9)	11.5	10.8	76 – 114
2016	414 (10.6)	12.5	11.7	83 – 124
2017	432 (10.8)	13.6	12.5	86 - 130
2018	423 (10.5)	15.0	13.7	85 - 127

Source: PHE Fingertips. Learning Disability Profiles. NB: rate of children with autism known to schools is per 1,000 pupils

PREVALENCE

Self-harm is not uncommon; 10-13% of 15-16 year olds have self-harmed and only a fraction are seen in hospital.⁷⁴ Overall hospital admissions for self-harm in children and young people have also increased in recent years, with admissions higher in young women than young men.⁷⁵ Hospital admissions are also higher in the 15-19 year age group. In Harrow, admissions across all age groups of young people are consistently lower than national figures, and lower or similar to London.

Table 12. Hospital admissions as a result of self-harm

	Harrow	London	England
Hospital admissions as a result of self-harm in 10-24 year olds, per 100,000 (2018/19)	169.8	195.8	444.0

⁷² Self Harm UK. Autism and Self-harm. Available here: <https://selfharm.co.uk/get-information/the-facts/autism-and-self-harm>

⁷³ Public Health England. Learning Disability Profiles. Available here: <https://fingertips.phe.org.uk/profile/learning-disabilities>

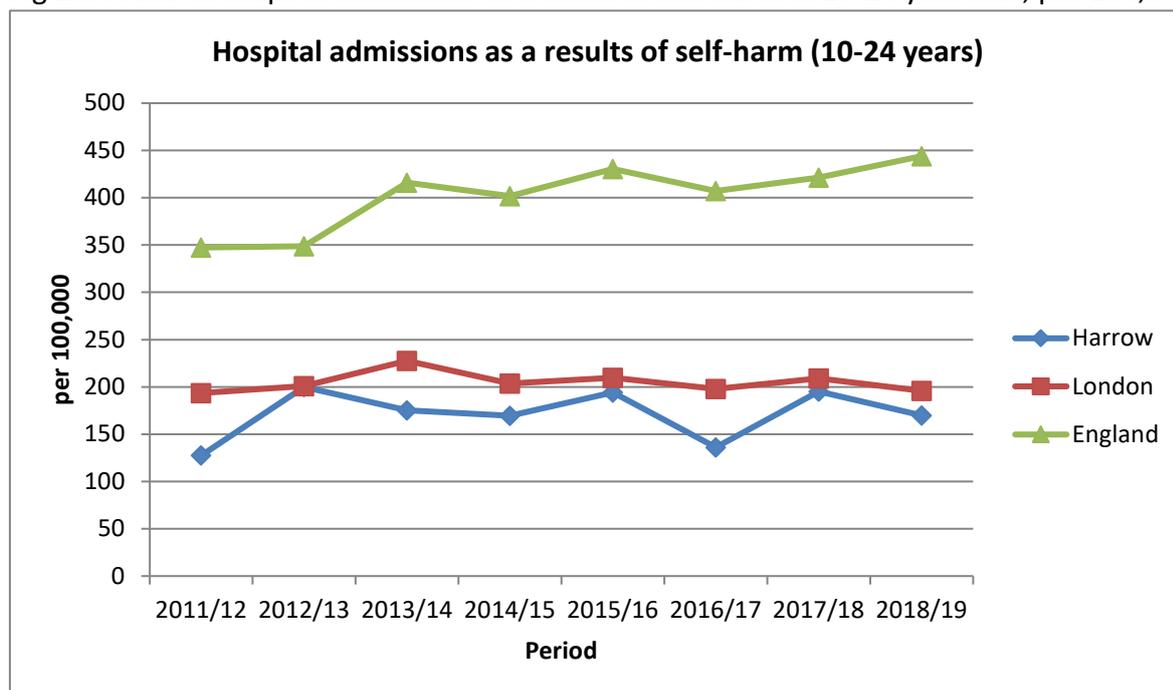
⁷⁴ HMG/DH. No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf

⁷⁵ Public Health England. Children and Young People’s Mental Health and Wellbeing, Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>

Hospital admissions as a result of self-harm in 10-14 year olds, per 100,000 (2017/18)	81.7	100.3	210.4
Hospital admissions as a result of self-harm in 15-19 year olds, per 100,000 (2017/18)	309.4	341.0	648.6
Hospital admissions as a result of self-harm in 20-24 year olds, per 100,000 (2017/18)	194.5	188.0	406.0

Source: PHE Fingertips. Children and Young People's Mental Health and Wellbeing.

Fig 19. Trend of hospital admissions as a result of self-harm in 10-24 year olds, per 100,000

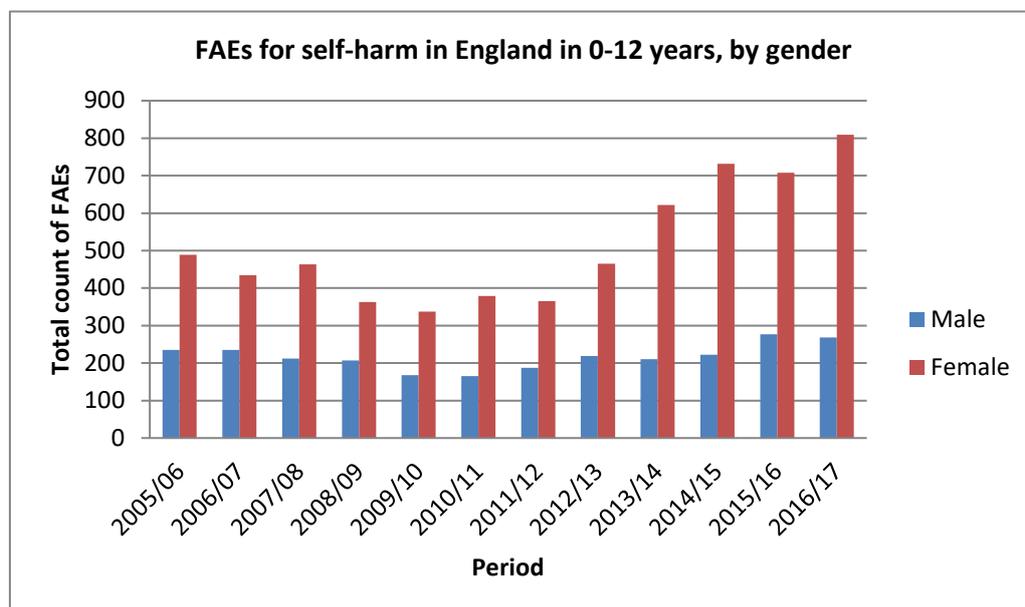


Source: PHE Fingertips. Children and Young People's Mental Health and Wellbeing.

There have been several attempts to estimate prevalence of self-harm among very young people in recent years (0-12 year olds).⁷⁶ For children under the age of 12, girls are more likely to attend hospital for self-harming. The graph below shows hospital activity on the total counts 0-12 year olds attending hospital at least once under one consultant within one healthcare provider (finished admission episode). However, this should not be interpreted as the same person as a child may have been admitted on one or more occasion.

⁷⁶NHS Digital. Hospital admissions for self harm by gender and 0-12 age group 2005-2017. Available here: <https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/hospital-admissions-for-self-harm-by-gender-and-0--12-age-group-2005--2017>

Fig 20. Trend of Finished Admission Episodes (FAEs) in England for males and females between the age of 0-12 years



Source: NHS Digital. Hospital admissions for self harm by gender and 0-12 age group 2005-2017.

LOCAL PREVALENCE

In the financial year 2018/9, Harrow CCG had a total of 205 Finished Admission Episodes (FAEs) for self-harm.⁷⁷ The highest amount was in the age group 20-24 (35 FAEs), jointly followed by the age bands 15-19 year olds and 35-39 year olds each with 25 finished hospital episodes.

Table 12. Self- Harm FAEs in Harrow CCG in financial year 2018/19

Age Band	0-4	5-9	10-14	15-19	20-24	25-29
Harrow	0	0	1-7	25	35	20

Source: NHS Digital. Hospital admissions for self-harm. Note: count reported as between 1 and 7 for confidentiality purposes, otherwise counts are rounded to the nearest 5

YOUNG HARROW FOUNDATION NEEDS ASSESSMENT

In 2018, Young Harrow Foundation undertook a needs assessment of approximately 15% of 10-19 year olds in Harrow.⁷⁸ Findings showed that there were high numbers of young people self-harming and experiencing suicidal thoughts. Whilst the report recognised that this does not necessarily equate to a high prevalence of suicide locally, it does show that many young people are living with high levels of distress. 15% registered a

⁷⁷NHS Digital. Hospital admissions for self harm. Available here: <https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/hospital-admissions-for-self-harm>

⁷⁸ Young Harrow Foundation. This is Harrow: Understanding the Needs of Young People in Harrow. Available here: https://youngharrowfoundation.org/images/downloads/harrow/This-is-Harrow-Report-Final-Low-Res_190613_133641.pdf

support need for self-harm or know someone who does, and 17% say they need help for suicidal thoughts or know someone who does.

THE WISH CENTRE

The Wish Centre was founded in Harrow to support young people who self-harm. In 2018, the Centre for Mental Health (CMH) was commissioned to evaluate the service. The CMH analysed two years of data and interviewed former and current users of the service.⁷⁹

The report analysed data from 154 service users in Harrow. Of this number, 27 were male and the vast majority (126) were female. The average age was 15.8 years and over three-quarter (77.9%) of service users lived at home with a parent(s). In terms of ethnicity, 44.8% of service users were White; 25.3% were Asian; 13% were Black; 7.8% were Mixed-heritage and 4.5% Other.

Referrals come from a variety of services including social care and school.

Table 13. Referral Source to WISH centre

Referrer	Harrow
Social Care	45 (29.2%)
School	60 (39%)
Parent/self	31 (20.1%)
Health service	11 (7.1%)
Other statutory services	12 (7.8%)

The WISH Centre enables service users to use multiple services or just one service. A majority of service users only use a single service (71.4%). Table 14 shows of the 110 single service users, Safe2Speak, the one to one counselling service was used the most.

Table 14 WISH Centre multiple service use

Service	Harrow
Safe2Speak	84
Self-Harm Xpress	11
Outreach	7

⁷⁹ Centre for Mental Health. A space to talk, an evaluation of the WISH Centre's services with young people who self-harm. Available here: https://www.centreformentalhealth.org.uk/sites/default/files/2018-11/CentreforMentalHealth_A%20space%20to%20talk_fullreport.pdf

ANXIETY DISORDERS

It is natural for children and young people to feel fearful or worried from time to time; however, a small group will have severe anxiety that causing severe distress and affects their everyday lives. Children with anxiety disorders are overwhelmed by feelings of intense fear or worry that are out of proportion to the situation or thing that triggers them. The Royal College of Psychiatrists describes different groups of anxiety affecting children and young people:^{80 81}

Fears and phobias – examples of fears include animals or the dark. A phobia is an extreme fear that causes a lot of distress and affects day to day life (e.g. refusing to ever go to the park because of a fear of dogs)

General anxiety – feeling anxious most of time for no apparent reason. If it becomes severe the child may not want to attend school or cannot concentrate or learn.

Separation anxiety – worry about not being with a child’s regular care-giver. It normally develops at six months and in the pre-school years. If it becomes severe it can affect the child’s development, education and family life.

Social anxiety – this is akin to an extreme, often disabling, type of shyness. Children and young people will often avoid social situations due to a fear of humiliation or embarrassment, which for example can make it difficult to make new friends or cope at school.

Other specific types – these include post-traumatic stress disorder, obsessive-compulsive disorder and panic disorder.

Separation anxiety is common in younger children, whereas older children and teenagers tend to worry more about school or have social anxiety.⁸²

SYMPTOMS OF ANXIETY⁸³

- Feeling nervous, on edge, or panicky all the time
- Feeling overwhelmed or full of dread
- Feeling out of control
- Having trouble sleeping
- Low appetite
- Finding it difficult to concentrate
- Feeling tired and grumpy
- Heart beating really fast or thinking you’re having a heart attack
- Having a dry mouth
- Trembling, feeling faint or wobbly legs
- Stomach cramps and/or diarrhoea/needing to pee more than usual
- Sweating more than usual, getting very hot

⁸⁰ Child Mind Institute. Anxiety disorders. Available here: <https://childmind.org/topics/disorders/anxiety-disorders/>

⁸¹ Royal College of Psychiatrists. Worries and anxieties – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/worries-and-anxieties---helping-children-to-cope-for-parents-and-carers>

⁸² NHS. Anxiety disorders in children. Available here: <https://www.nhs.uk/conditions/anxiety-disorders-in-children/>

⁸³ YoungMinds. Anxiety. Available here: <https://youngminds.org.uk/find-help/conditions/anxiety/>

CAUSES OF ANXIETY⁸⁴

- Family history – anxiety tends to run in families (genes and “learned” anxious behaviour)
- Bullying
- Lack of friends
- Difficulties in school
- Experience of frightening/traumatic event – e.g. burglary, car accident
- Having to cope with a stressful situation – e.g. bereavement, parental separation
- Poor parenting, anxious or harsh family

TREATMENT OF ANXIETY DISORDERS⁸⁵

The type of treatment will depend on the child's age and the cause of their anxiety. Types of treatment include:

- **Counselling** – help a child understand what is making them anxious and help them to work through the situation
- **Cognitive behavioural therapy (CBT)** – is a talking therapy that can help a child manage their anxiety by changing the way they think and behave
- **Medication** – may be offered to a child if their anxiety is severe or does not improve with talking therapies. Children are usually only prescribed by doctors who specialise in child and adolescent mental health.

PREVALENCE

Anxiety is a common mental health problem and nearly 300,000 young people in the UK have an anxiety disorder.⁸⁶ In the most recent survey of the *Mental Health of Children and Young People in England (2017)*⁸⁷, 7.2% of 5-19 year olds met the criteria for an anxiety disorder. Anxiety disorders were also the most common type of emotional disorder present in children and young people.

The most common type of anxiety disorder overall was generalised anxiety disorder and other anxiety disorder. Anxiety disorders were slightly more common in boys aged 5-10 compared to girls; however overall and in older age groups the prevalence was higher in girls. 9.1% of 5-19 year old girls had an anxiety disorder, compared to 5.4% of 5-19 year old boys. In both boys and girls, the prevalence of anxiety disorders increased with age; with 20% of girls aged 17-19 meeting the criteria for an anxiety disorder.

The survey was previously conducted in 1999 and 2004, and data from this shows an increase in anxiety disorders since 2004 in 5-15 year olds.

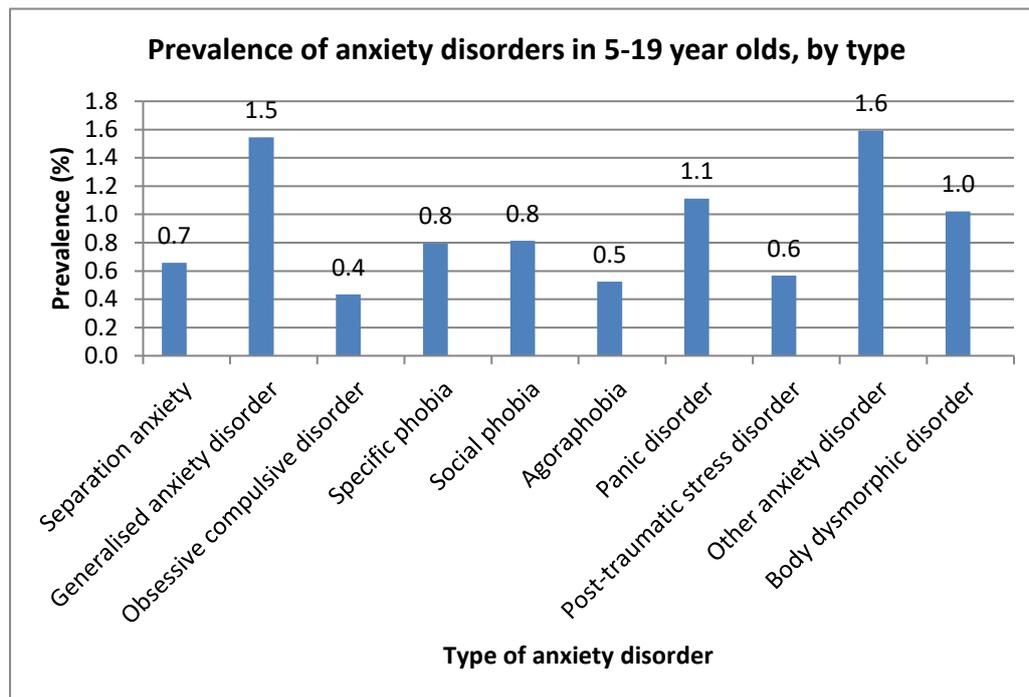
⁸⁴ Royal College of Psychiatrists. Worries and anxieties – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/worries-and-anxieties---helping-children-to-cope-for-parents-and-carers>

⁸⁵ NHS. Anxiety disorders in children. Available here: <https://www.nhs.uk/conditions/anxiety-disorders-in-children/>

⁸⁶ Royal College of Psychiatrists. Worries and anxieties – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/worries-and-anxieties---helping-children-to-cope-for-parents-and-carers>

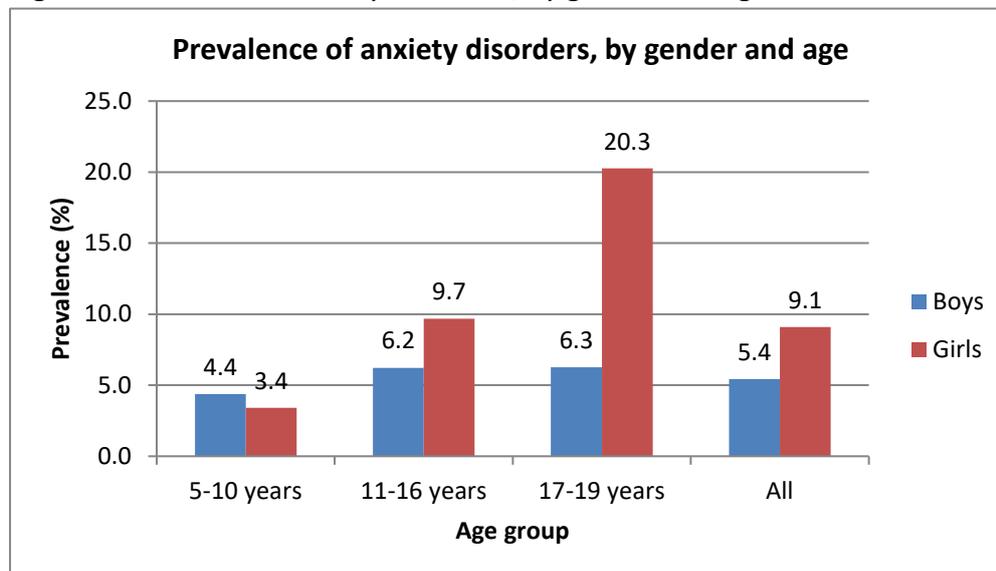
⁸⁷ NHS Digital. Mental Health of Children and Young People in England, 2017 [PAS]. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

Fig 21. Prevalence of different types of anxiety disorders in 5-19 year olds



Source: Mental Health of Children and Young People in England, 2017

Fig 22. Prevalence of anxiety disorders, by gender and age



Source: Mental Health of Children and Young People in England, 2017

Table 15. Trends in prevalence of anxiety disorders in 5-15 year olds

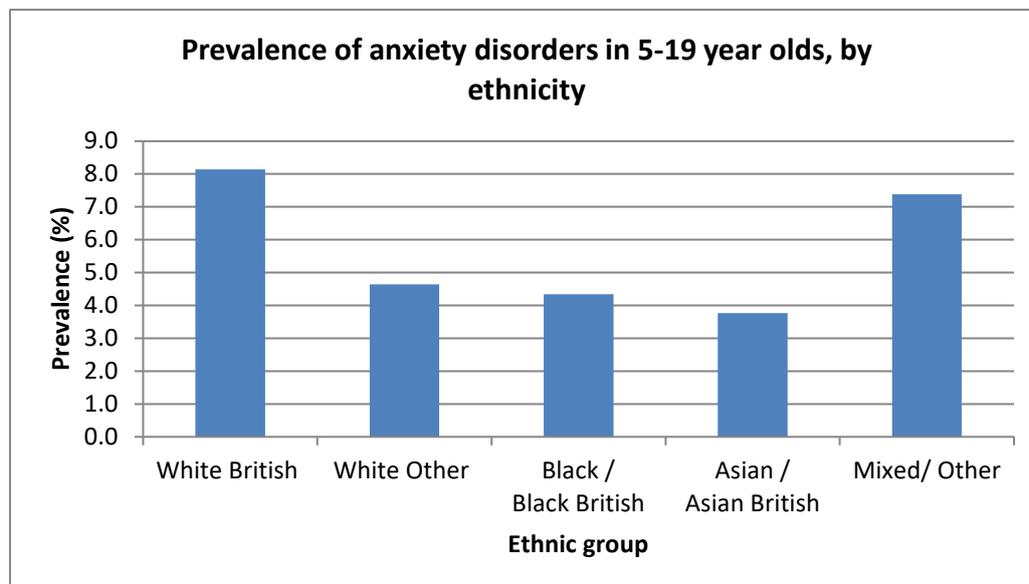
5-15 year olds	Prevalence of anxiety disorder (%)		
	1999	2004	2017
All	3.7	3.5	5.3
Boys	3.6	3.0	5.1
Girls	3.8	4.1	5.5

Source: Mental Health of Children and Young People in England, 2017 (trends and characteristics)

HEALTH INEQUALITIES

The *Mental Health of Children and Young People in England (2017)* survey found that anxiety disorders in 5-19 year olds were most common in those from a White British, followed by those from a Mixed/Other background. They were also more common in children and young people with special educational needs, those whose parents have mental health problems and those from lower income families.

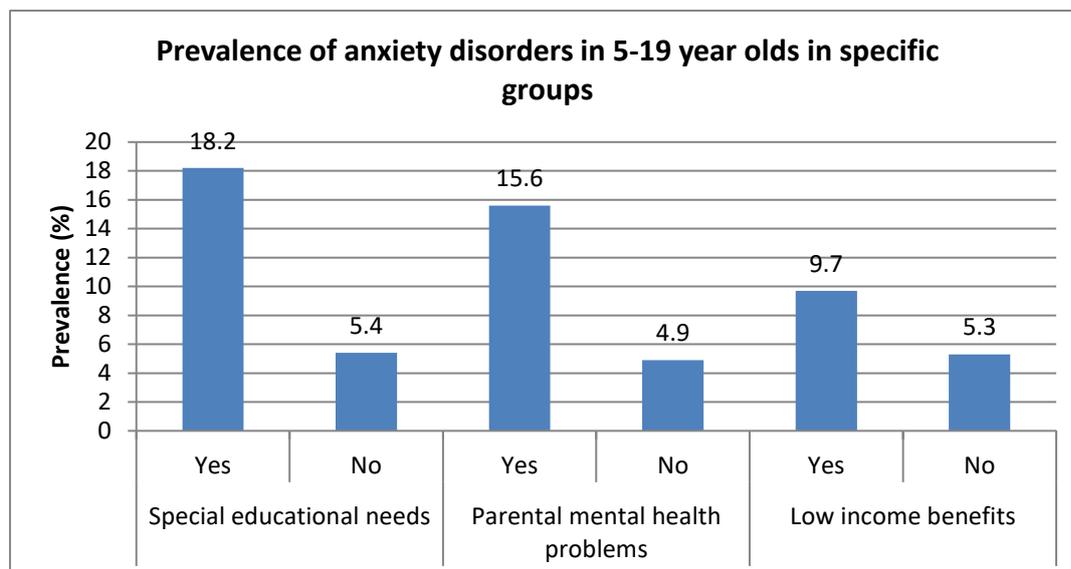
Fig 23. Prevalence of anxiety disorders in 5-19 years, by ethnicity



Source: Mental

Health of Children and Young People in England, 2017

Fig 24. Prevalence of anxiety disorders in 5-19 year olds, by special education needs, parental mental health problems and low income benefits



Source: Mental Health of Children and Young People in England, 2017

LOCAL PREVALENCE

Public Health England has published data on the prevalence of emotional disorders (anxiety disorders and depression) in Harrow. 3.4% of 5-16 year olds in Harrow are estimated to have an emotional disorder, this is similar to rates in London and England. These figures are estimates and based on national prevalence data from 2004, which has been adjusted for age, sex and socio-economic classification of children resident in the area. ⁸⁸

Table 16. Estimated Prevalence of Emotional disorders in 5-16 year olds.

	Estimated prevalence of emotional disorders in 5-16 year olds		
	Harrow	London	England
2014	3.4%	3.6%	3.6%
2015	3.4%	3.6%	3.6%

Source: PHE Fingertips. Children and Young People's Mental Health and Wellbeing.

⁸⁸ PHE. Children and Young People's Mental Health and Wellbeing. Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>

DEPRESSION

Feeling sad or fed up is a normal reaction to difficulty or stressful experiences; however, in some people these feelings can go on for a long time and affect everyday life. Depression is a mood disorder where you feel down all the time, and often develops alongside anxiety. This can cause difficulties at home, school as well as relationships with family and friends.^{89 90}

SYMPTOMS OF DEPRESSION⁹¹

- Loss of interest in activities previously enjoyed
- Appetite loss, or over-eating
- Problems with concentration, in remembering things or in making decisions
- Thoughts of suicide or self harm
- Disturbed sleep, or sleep far too much
- Feel tired all the time, exhausted
- Complain of aches and pains like headaches, tummy pains
- Have little self-confidence
- Express feelings of guilt for no reason

In severe cases, some children and young people may also experience very unusual and unpleasant thoughts and experiences (psychotic depression). Some will also have periods of high mood along with periods of low mood (bipolar mood disorder or manic depression).

CAUSES OF DEPRESSION^{92 93}

There are no specific causes of depression, and can be a reaction to a mixture of things:

- Abuse
- Bullying
- Family breakdown e.g. parental separation
- Bereavement
- Conflicts with family or friends
- Family history

TREATMENT OF DEPRESSION⁹⁴

⁸⁹ Royal College of Psychiatrists. Depression in young people – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/depression-in-young-people---helping-children-to-cope-for-parents-and-carers>

⁹⁰ YoungMinds. Depression. Available here: <https://youngminds.org.uk/find-help/conditions/depression/>

⁹¹ Royal College of Psychiatrists. Depression in young people – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/depression-in-young-people---helping-children-to-cope-for-parents-and-carers>

⁹² Royal College of Psychiatrists. Depression in young people – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/depression-in-young-people---helping-children-to-cope-for-parents-and-carers>

⁹³ YoungMinds. Depression. Available here: <https://youngminds.org.uk/find-help/conditions/depression/>

⁹⁴ NICE. Depression in children and young people: identification and management. Available here: <https://www.nice.org.uk/guidance/ng134>

All children and young people and their families should have good information and support; and most should be treated on an outpatient or community basis. NICE (National Institute for Health and Care Excellence) recommends a stepped-care model approach to treatment.

- **Mild depression** – watchful waiting, psychological therapy (e.g. CBT, family therapy)
- **Moderate to severe depression** – psychological therapy (e.g. CBT, family therapy, psychodynamic psychotherapy) and/or medication. Children and young people with moderate to severe depression should be reviewed by a CAMHS team.
- **Depression unresponsive to treatment/recurrent depression/psychotic depression** – intensive psychological therapy and/or medication (and/or an antipsychotic as well)

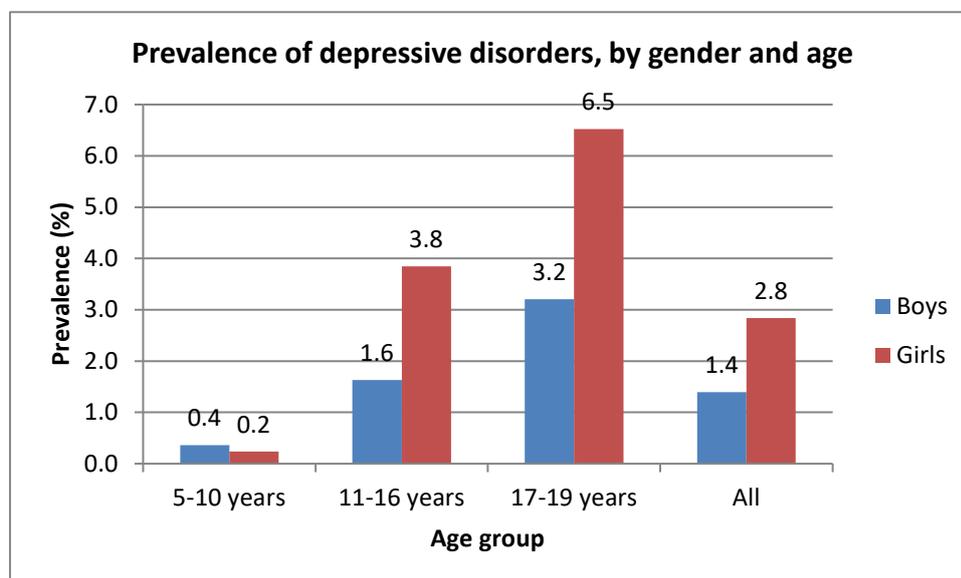
PREVALENCE

Depression is thought to occur in 1-3% of children and young people. It happens in people of all ages, races, income and education levels. Teenage girls are twice as likely as teenage boys to be depressed.⁹⁵ In the most recent survey of the *Mental Health of Children and Young People in England (2017)*, 2.1% of 5-19 year olds met the criteria for a depressive disorder.⁹⁶

Depressive disorders were slightly more common in boys aged 5-10 compared to girls; however overall and in older age groups the prevalence was higher in girls. 2.8% of 5-19 year old girls had a depressive disorder, compared to 1.4% of 5-19 year old boys. In both boys and girls, the prevalence of depressive disorders increased with age.

The survey was previously conducted in 1999 and 2004, and data from this shows an increase in depressive disorders since 2004 in 5-15 year olds.

Fig 25. Prevalence of depressive disorders, by gender and age



Source: Mental Health of Children and Young People in England, 2017

⁹⁵ Royal College of Psychiatrists. Depression in young people – helping children to cope: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/depression-in-young-people---helping-children-to-cope-for-parents-and-carers>

⁹⁶ NHS Digital. Mental Health of Children and Young People in England, 2017 [PAS]. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

Table 17. Trends in prevalence of depressive disorders in 5-15 year olds

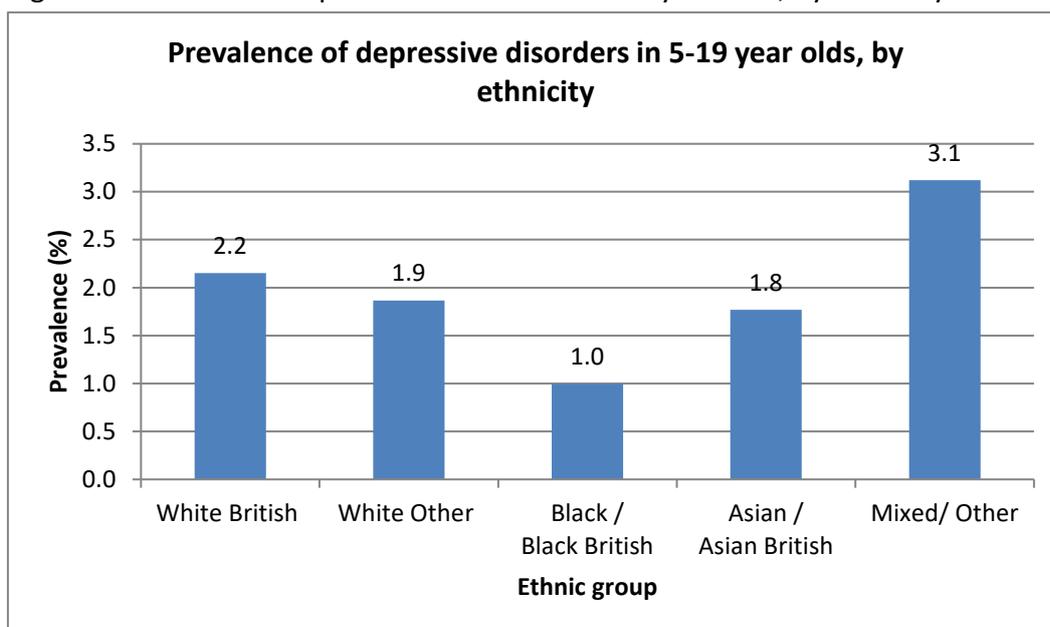
5-15 year olds	Prevalence of depressive disorder (%)		
	1999	2004	2017
All	0.9	0.8	1.2
Boys	0.9	0.6	0.8
Girls	1.0	1.0	1.7

Source: Mental Health of Children and Young People in England, 2017 (trends and characteristics)

HEALTH INEQUALITIES

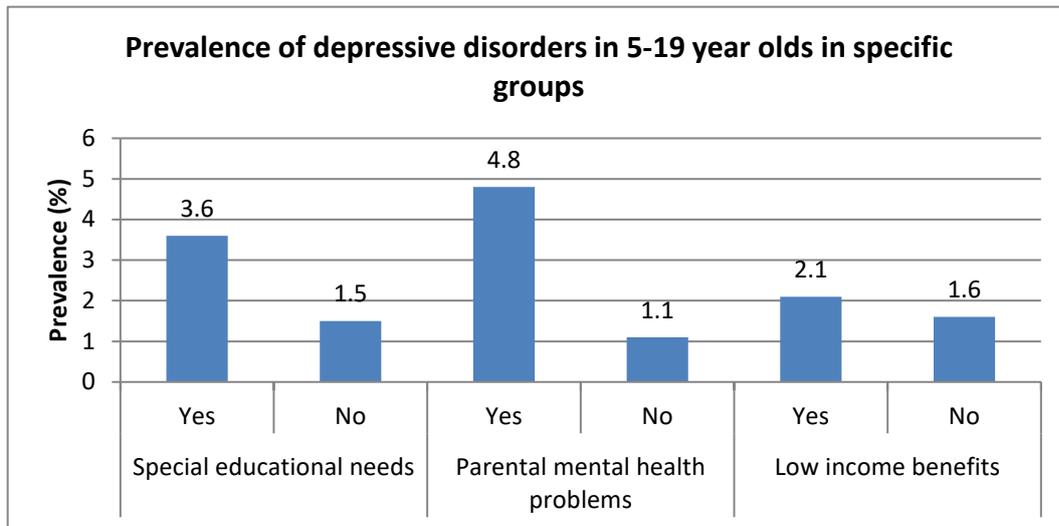
The *Mental Health of Children and Young People in England (2017)* survey found that depressive disorders in 5-19 years olds were most common in those from a Mixed/Other background, followed by those from a White British background. Depressive disorders were also more common in children and young people with special education needs and those whose parents have mental health problems; they were also slightly more common in those from low income families.

Fig 26. Prevalence of depressive disorders in 5-19 year olds, by ethnicity



Source: Mental Health of Children and Young People in England, 2017

Fig 27. Prevalence of depressive disorders in 5-19 year olds, by special education needs, parental mental health problems and low income benefits



Source: Mental Health of Children and Young People in England, 2017

LOCAL PREVALENCE

As previously discussed, data from Public Health England estimates that 3.4% of 5-16 year olds in Harrow have an emotional disorder (anxiety disorders and depression). This is similar to rates in London and England.⁹⁷

⁹⁷ Public Health England. Children and Young People's Mental Health and Wellbeing. Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>

EATING DISORDERS

Worries about weight, shape and eating are common; but for some worries become an obsession and can turn into an eating disorder. The most common eating disorders are anorexia nervosa and bulimia nervosa. Other types of eating disorder include binge eating disorder and other specified feeding and eating disorders (OSFED). Eating disorders can develop at any age, but the risk is highest for young men and women between 13 and 17 years of age. Eating disorders can become life-threatening if left untreated; the emotional and physical consequences result in a high mortality rate from malnutrition, suicide and physical issues.^{98 99} Anorexia has the highest mortality rate of any psychiatric disorder.¹⁰⁰

ANOREXIA NERVOSA^{101 102}

Anorexia nervosa is an eating disorder where you worry about your weight, want to lose weight and eat less and less food. People are low weight due to limiting energy intake. As well as restricting the amount of food eaten, they may excessively exercise, and some may experience cycles of bingeing and purging. Sufferers often have a distorted body image, and a have a deep fear of gaining weight.

Symptoms:

Behavioural and psychological	Physical	Long term effects
Eating less and less	Losing lots of weight quickly	Loss of bone density (osteoporosis)
Exercising too much	Periods stopping, or being unable to have an erection	Erosion of tooth enamel
Thinking a lot about calories	Feeling cold all the time	Difficulty conceiving, infertility
Feeling panicked about eating food in front of others or having a big meal	Growing new downy hair on body	Heart problems
Feeling fat even though others tell you you're too thin	Poor sleep and concentration	Damage to kidneys, bowels and liver
Obsession with body image and comparing to others	Constipation	Weakened immune system
Losing interest in things		Delayed onset of puberty, or stunted growth
Low mood and irritability		

⁹⁸ Royal College of Psychiatrists. Eating disorders in young people: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/eating-disorders-in-young-people-for-parents-and-carers>

⁹⁹ NICE Guidance (NG69). Eating disorders: recognition and treatment. Available here: <https://www.nice.org.uk/guidance/ng69>

¹⁰⁰ Association for Young People's Health. Key Data on Young People. Available here: <http://www.youngpeopleshealth.org.uk/key-data-on-young-people>

¹⁰¹ YoungMinds. Anorexia. Available here: <https://youngminds.org.uk/find-help/conditions/anorexia/>

¹⁰² Beat eating disorders. Anorexia Nervosa. Available here: <https://www.beateatingdisorders.org.uk/types/anorexia>

BULIMIA NERVOSA^{103 104}

Bulimia is an eating disorder where you have cycles of bingeing (eating large quantities of food), and then trying to compensate by purging (vomiting, taking laxatives or diuretics, fasting or exercising excessively). People with bulimia may have previously suffered from anorexia. Some people feel that purging gives them a sense of control, when other parts of their lives feel out of control. Sufferers often maintain a normal weight.

Symptoms:

Behavioural and psychological	Physical	Long term effects
Thinking obsessively about weight	Sore throat, bad teeth (from vomiting), swollen glands	Permanent damage to teeth
Binge eating	Dehydration	Damage to vocal cords and throat
Exercising too much	Stomach cramps	Damage to intestines and stomach
Isolating	Muscle spasms	Heart problems
Feeling helpless	Feeling weak and tired	Kidney damage
Poor sleep	Some weight loss, or weight swings	
Low mood	Change in periods	
Losing interest in things or people	Constipation	

OTHER EATING DISORDERS

Binge eating disorder¹⁰⁵ – eating large quantities of food, over a short period of time. Binge eating episodes are associated with eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not physically hungry, eating alone through embarrassment at the amount being eaten, and feelings of disgust, shame or guilt during or after the binge. Episodes may be triggered by uncomfortable or negative emotions. People with binge eating disorder do not regularly use purging methods after a binge.

Other Specified Feeding or Eating Disorder (OSFED)¹⁰⁶ – people whose symptoms don't fit the exact diagnostic criteria of anorexia, bulimia or binge eating disorder. OSFED accounts for a large percentage of eating disorders. Examples include atypical anorexia (symptoms of anorexia, but weight in "normal" range), purging disorder

¹⁰³ YoungMinds. Bulimia. Available here: <https://youngminds.org.uk/find-help/conditions/bulimia/>

¹⁰⁴ Beat eating disorders. Bulimia Nervosa. Available here: <https://www.beateatingdisorders.org.uk/types/bulimia>

¹⁰⁵ Beat eating disorders. Binge Eating Disorder. Available here: <https://www.beateatingdisorders.org.uk/types/binge-eating-disorder>

¹⁰⁶ Beat eating disorders. Other Specified Feeding or Eating Disorders (OSFED). Available here: <https://www.beateatingdisorders.org.uk/types/osfed>

(purging to affect weight, but not part of binge/purge cycles) and night eating syndrome (repeatedly eating at night after evening meal).

CAUSES OF EATING DISORDERS¹⁰⁷

- Worry or stress may lead to comfort eating, this may cause worries about getting fat.
- Dieting and missing meals lead to craving for food, loss of control and over-eating.
- Complication of more extreme dieting
- Triggered by an upsetting event, such as family break-down, death or separation in the family, bullying at school or abuse
- May be a way of trying to feel in control if life feels stressful
- More ordinary events, such as the loss of a friend, a teasing remark or school exams, may also be the trigger in a vulnerable person

Being female, previously overweight, having low self-esteem, or being perfectionistic, sensitive or anxious also increase the likelihood of an eating disorder. Eating disorders can also run in families.

TREATMENT OF EATING DISORDERS¹⁰⁸

Treatment varies depending on type of eating disorder:

- **Anorexia nervosa** – psychoeducation of disorder, monitoring of weight, mental and physical health, psychological treatment (family therapy, FT-AN, or cognitive behavioural therapy, CBT-ED)
- **Bulimia nervosa** – psychological treatment (family therapy, FT-BN, or CBT-ED)
- **Binge eating disorder** – self-help programmes, psychological treatment (CBT-ED)
- **OSFED** – use the treatment for the eating disorder it most closely resembles

Children and young people with an eating disorder may need specialist paediatric or endocrinology input for delayed physical development, faltering growth or low bone mineral density. Physical health should also be monitored and assessed for all eating disorders.

PREVALENCE

Eating disorders are relatively uncommon compared to other mental disorders in children and young people. In Western countries the estimated prevalence for eating disorders in adolescents and young adults, is 3% for females and 0.1% for males.¹⁰⁹ In the most recent survey of the *Mental Health of Children and Young People in England (2017)*, 0.4% of 5-19 year olds met the criteria for an eating disorder.¹¹⁰

Eating disorders were more common in girls in both the 11-16, and 17-19 year old age group. Overall, 0.7% of 5-19 year old girls had an eating disorder, compared to 0.1% of 5-19 year old boys. In girls the prevalence of

¹⁰⁷ Royal College of Psychiatrists. Eating disorders in young people: for parents and carers. Available here: <https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/eating-disorders-in-young-people-for-parents-and-carers>

¹⁰⁸ NICE Guidance (NG69). Eating disorders: recognition and treatment. Available here: <https://www.nice.org.uk/guidance/ng69>

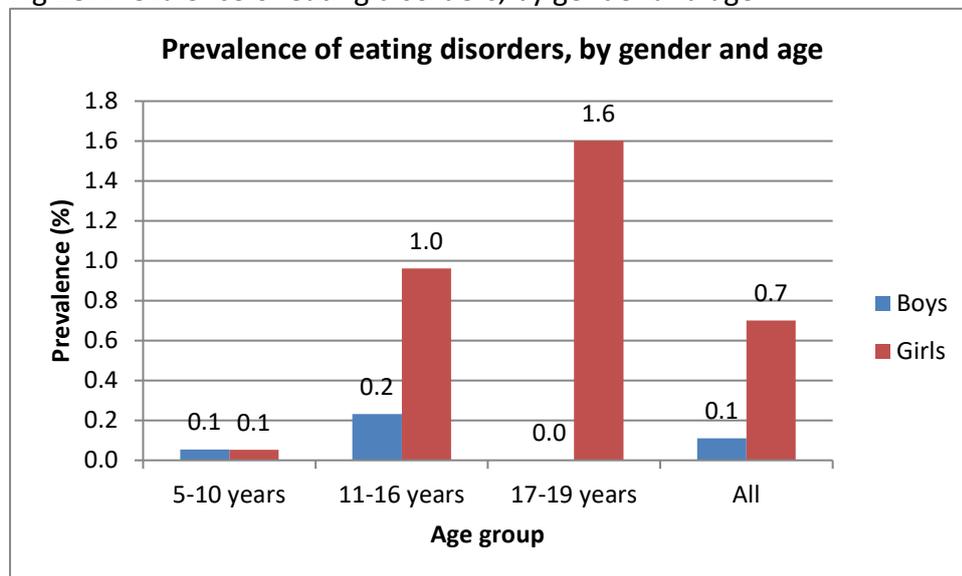
¹⁰⁹ Association for Young People's Health. Key Data on Young People. Available here: <http://www.youngpeopleshealth.org.uk/key-data-on-young-people>

¹¹⁰ NHS Digital. Mental Health of Children and Young People in England, 2017 [PAS]. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

eating disorders increased with age, with 1.6% of 17-19 year old girls meeting the criteria for an eating disorder. Eating disorders were not associated with age for boys.

Prevalence of eating disorders in 5-15 year olds have remained similar when compared to findings from survey in 2004 (no data from 1999).

Fig 28. Prevalence of eating disorders, by gender and age



Source: Mental Health of Children and Young People in England, 2017

Table 17. Trends in prevalence of eating disorders in 5-15 year olds

5-15 year olds	Prevalence of eating disorder (%)	
	2004	2017
All	0.1	0.2
Boys	0.1	0.1
Girls	0.1	0.3

Source: Mental Health of Children and Young People in England, 2017 (trends and characteristics)

HOSPITAL ADMISSIONS

Hospital admissions as a result of eating disorder can also be used to understand prevalence of eating disorders. In 2017/18 there were 2,196 hospital admissions in England for children and young people aged 10 to 24 years and at all ages more girls were admitted than boys. Girls accounted for 91% of hospital admissions. In girls, the incidence peaked in mid-adolescence, with the largest admission from 15 year old girls. In boys, the incidence also peaked in mid-adolescence, with the largest admission from 14 year old boys.¹¹¹ Although bulimia is more common, anorexia accounts for a larger proportion of hospital admissions.¹¹² No local data available for hospital admissions.

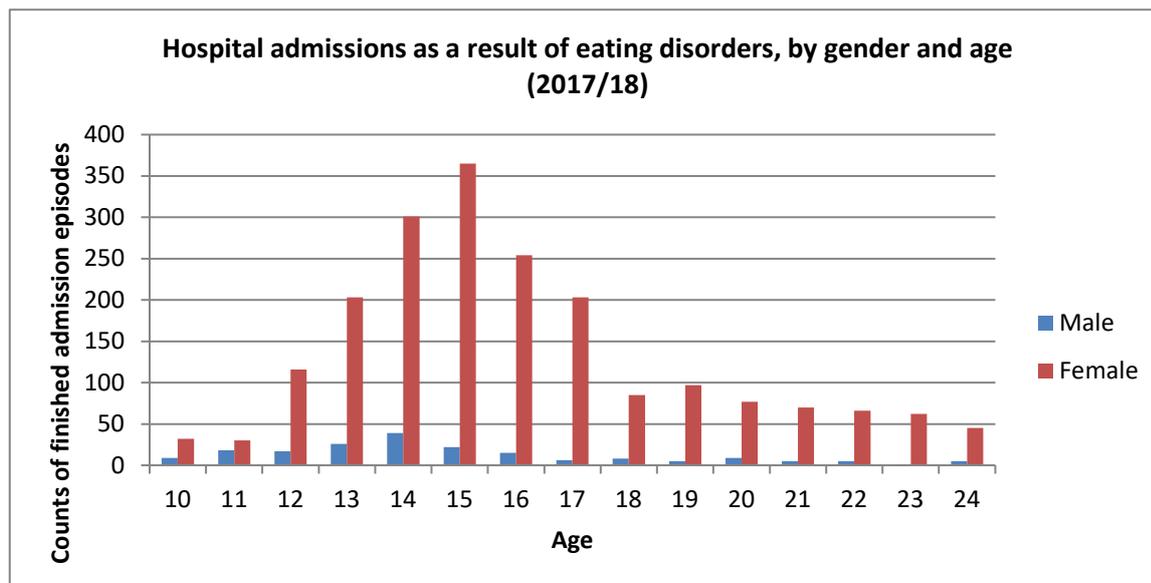
¹¹¹ Public Health England. Eating disorders in young people. Available here:

<https://www.gov.uk/government/publications/eating-disorders-in-young-people>

¹¹² Association for Young People's Health. Key Data on Young People. Available here:

<http://www.youngpeopleshealth.org.uk/key-data-on-young-people>

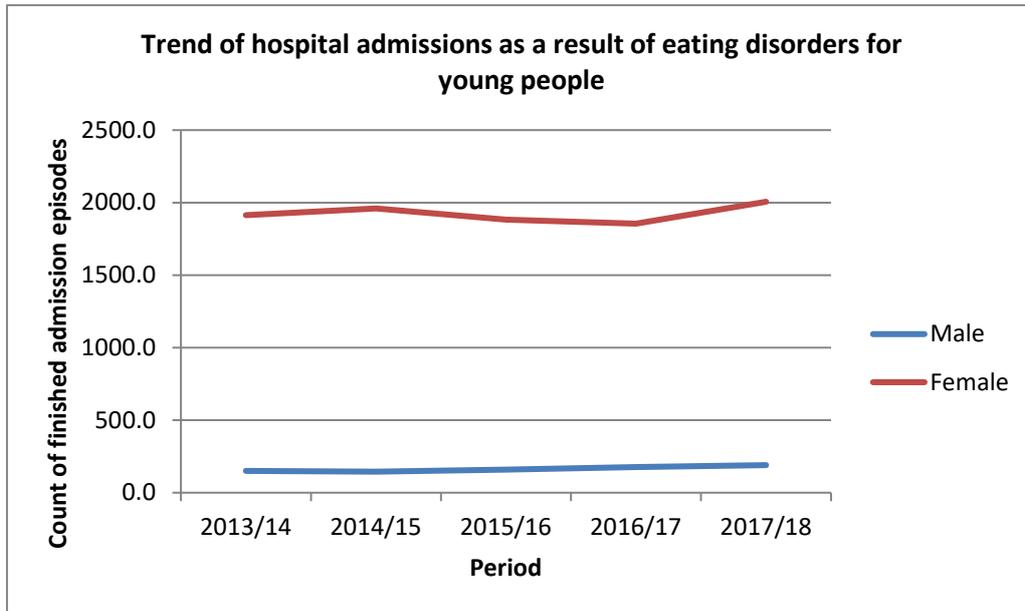
Fig 29. Hospital admissions in England as a result of eating disorders, by gender and age (2017/18)



Source: PHE. Hospital admissions as a result of eating disorders for young people, 2013/14 to 2017/18.

Trends also show that in 2017/18 there were more admissions for young people (10-24 years) than in any of the preceding four years where numbers were relatively stable.

Fig 30. Hospital admissions in England as a result of eating disorders for young people (10-24 years) between 2013/14 and 2017/18

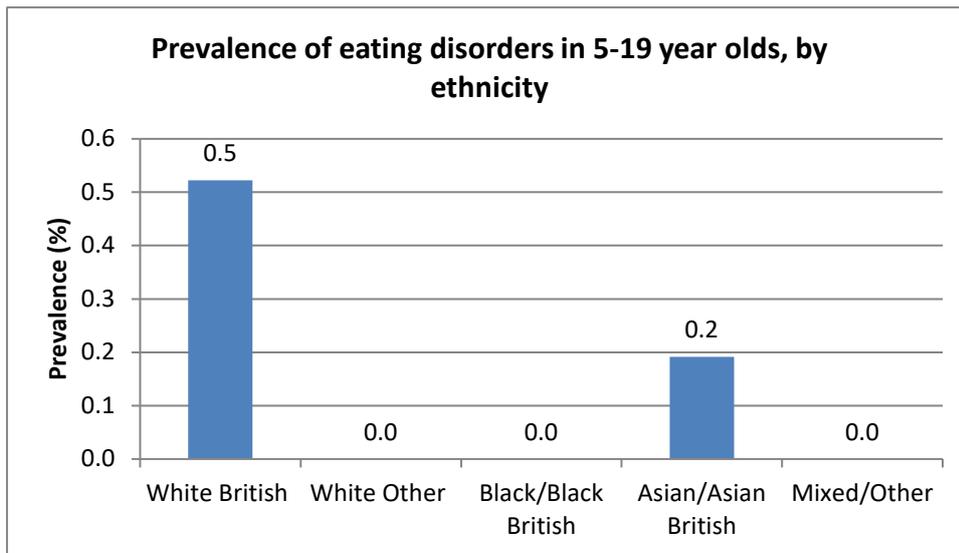


Source: PHE. Hospital admissions as a result of eating disorders for young people, 2013/14 to 2017/18.

HEALTH INEQUALITIES

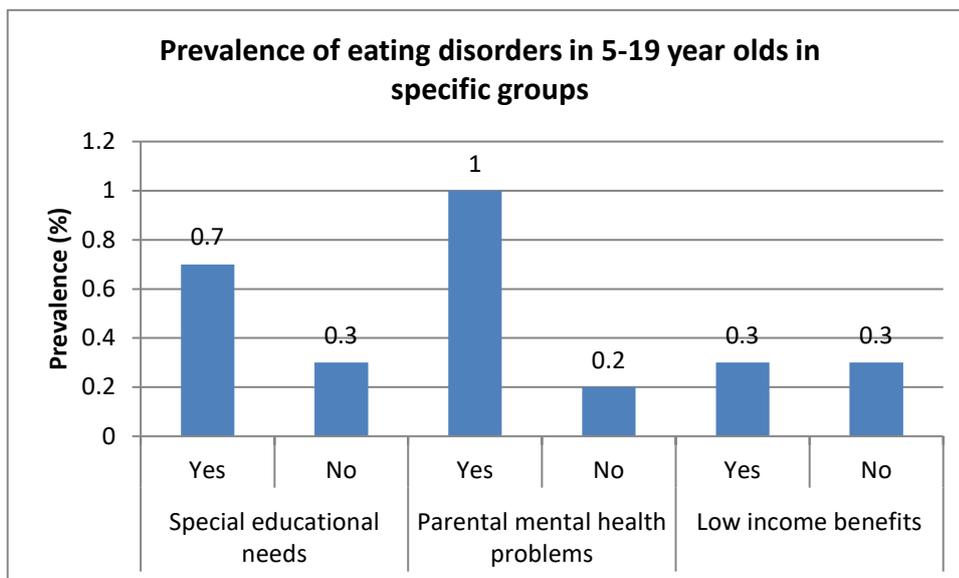
The *Mental Health of Children and Young People in England (2017)* survey found that eating disorders were most common in White British 5-19 year olds, followed by children and young people from an Asian/Asian British background. Rates were also higher in children and young people with special educational needs, and those with parental mental health problems. Rates were the same when comparing if children were from families in receipt of low income benefits or not.

Fig 31. Prevalence of eating disorders in 5-19 year olds, by ethnicity



Source: Mental Health of Children and Young People in England, 2017

Fig 32. Prevalence of eating disorders in 5-19 year olds, by special education needs, parental mental health problems and low income benefits



Source: Mental Health of Children and Young People in England, 2017

SERVICES

Approximately two-thirds of children and young people with a disorder contact a professional service; this includes health care professionals, teachers and educational support services. The most common source of professional services is teachers. ¹¹³

Table 18. Table shows types of service and support contacted for mental health in the past year by disorder in 5 to 19 year olds, 2017

Type of service	Percentage of 5 to 19 year olds
Any professional service	66.4
Primary health care professional (e.g. GP or health visitor)	33.4
Physical health specialist (e.g. paediatrician)	15.4
Mental health specialist (e.g. psychologist)	25.2
Teacher	48.5
Educational support services (e.g. educational psychologist)	22.6
Social care services (e.g. social worker)	8.0
Youth justice services (e.g. probation officer)	1.3

Source: Mental Health of Children and Young People in England, 2017

During 2018-19, 1,325 children and young people under 18 accessed NHS funded community mental health services in Harrow CCG. ¹¹⁴

The main mental health service accessed was Central and North West London NHS Foundation Trust (CNWL). This includes services such as Harrow CAMHS (children and adolescent mental health services) and the Community eating disorder service for children and young people. ¹¹⁵ Some CYP are referred to mental health services provided by other NHS Trusts and organisations such as Tavistock and Portman NHS Foundation Trust or Great Ormond Street Hospital for Children NHS Foundation Trust.

¹¹³ NHS Digital. Mental Health of Children and Young People in England, 2017. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

¹¹⁴ NHS Digital. Number of children and young people accessing NHS funded community mental health services in England, April 2018 to March 2019, Experimental Statistics. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/number-of-children-and-young-people-accessing-nhs-funded-community-mental-health-services-in-england-april-2018-to-march-2019-experimental-statistics>

¹¹⁵ CNWL. CNWL Mental health services. Available here: <https://www.cnwl.nhs.uk/services/mental-health-services>

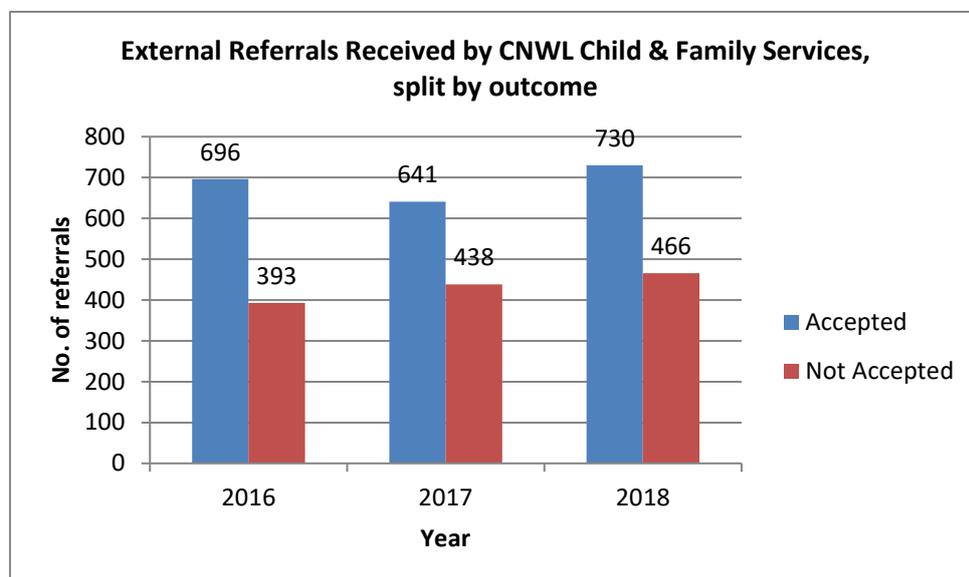
Table 19. Number of individual children and young people aged under 18 accessing treatment by NHS funded community mental health services in 2018-19 in Harrow CCG, by provider

Provider	Number of children and young people accessing treatment
Barnardos Harrow Horizons	530
Barnet, Enfield and Haringey Mental Health Trust	10
Cambridgeshire and Peterborough NHS Foundation Trust	<5
Central and North West London NHS Foundation Trust	725
Dorset Healthcare University NHS Foundation Trust	<5
Elysium Healthcare	<5
Great Ormond Street Hospital for Children NHS Foundation Trust	15
Hertfordshire Partnership University NHS Foundation Trust	<5
Priory Group Limited	<5
Tavistock and Portman NHS Foundation Trust	10
West London NHS Trust	10
Xenzone Limited	15

Source: NHS Digital. Number of children and young people accessing NHS funded community mental health services in England, April 2018 to March 2019, Experimental Statistics. NB: These figures count the number of children and young people who received least 2 contacts with a mental health provider during the financial year, with the second contact falling in 2018-19, and where their first contact occurs before their 18th birthday. Figures are rounded to the nearest 5.

Harrow CAMHS provides community mental health services to children and young people up to the age of 18 with complex mental health difficulties, and their families.¹¹⁶ CAMHS receives over 1000 referrals per year, primarily from GP's, A&E's and education services. The majority of referrals are "routine", and over a third of all referrals are not accepted.

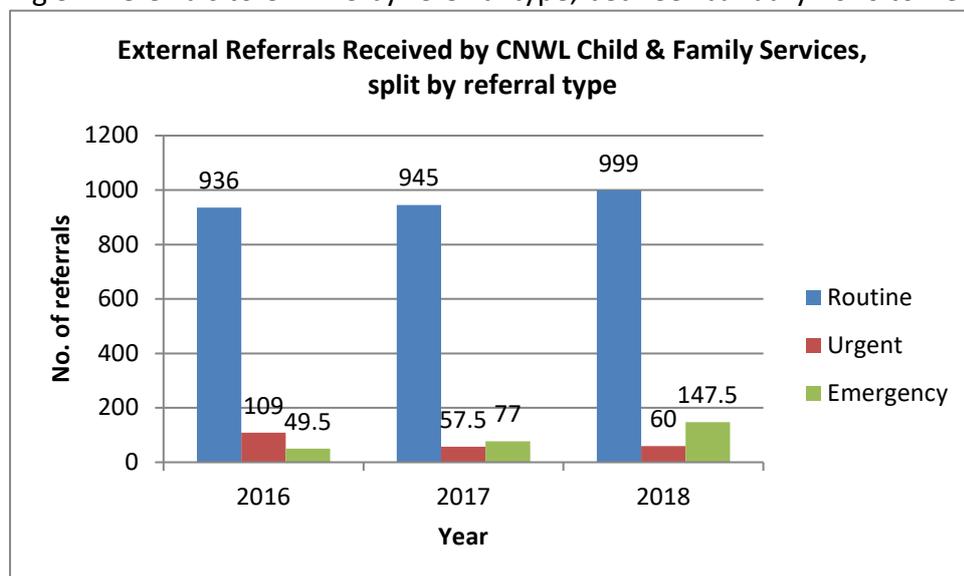
Fig 33. Number of referrals to CAMHS by outcome, between January 2016 to December 2018.



Source: CNWL referrals

data set

Fig 34. Referrals to CAMHS by referral type, between January 2016 to December 2018



Source: CNWL referrals data set. NB: months with <5 referrals recorded were counted as having 2.5 referrals for the purposes of the graph.

The table below shows the source of referrals received by CNWL CAMHS from January 2016 to December 2018

¹¹⁶ CNWL. Harrow CAMHS. Available here: <https://www.cnwl.nhs.uk/services/mental-health-services/child-and-adolescent-mental-health-services/harrow-camhs>

Table 20. Source of referrals received by CNWL CAMHS

Referral Source	Number of Referrals
General Medical Practitioner	2187
Accident And Emergency Department	540
Education Service	159
Other service or agency	129
Hospital-based Paediatrics	95
Community-based Paediatrics	84
Social Services	59
School Nurse	45
Other secondary care specialty	29
Other Independent Sector Mental Health Services	9
Other Primary Health Care	8
Court Liaison and Diversion Service	8
Carer	6
Self	<5
Out of Area Agency	<5
NHS Direct	<5
Permanent transfer from another Mental Health NHS Trust	<5
Health Visitor	<5
Drug Action Team / Drug Misuse Agency	<5
Temporary transfer from another Mental Health NHS Trust	<5
Probation Service	<5
Grand Total	3377

Source: CNWL referrals data set

REASONS FOR REFERRAL

The table below shows the number of referrals for different reasons received by CNWL Child & Family Services from January 2016 to December 2018.

Table 21. Number of referrals for different reasons by CNWL CAMHS

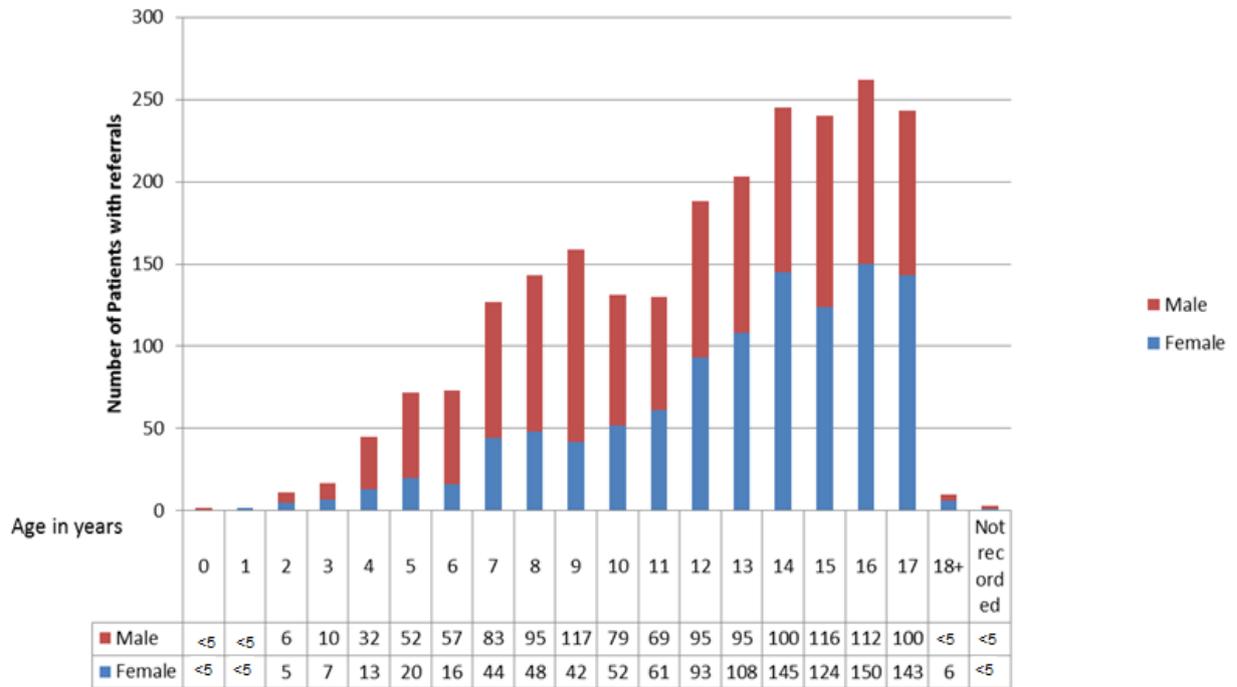
Referral Reason	Number of Referrals
In crisis	684
Depression	510
Anxiety	495
Conduct disorders	431
Suspected ADHD	400
Suspected Autism Spectrum Disorder	136
Relationship difficulties	131
Self-harm	128
Suspected ASD	109
Neurodevelopmental conditions	82
Unexplained physical symptoms	73
Eating disorders	69
Post-traumatic stress disorder	42
Obsessive compulsive disorder	39
Capacity (advice/assessment)	19
Adjustment to Physical Health Condition	14
Drug and alcohol difficulties	5
Perinatal mental health issues	<5
Phobias	<5
Ongoing or Recurrent Psychosis	<5
Bi polar disorder	<5
Personality disorders	<5
Medication Review	<5
Grand Total	3377

Source: CNWL referrals data set

DEMOGRAPHICS OF PATIENTS

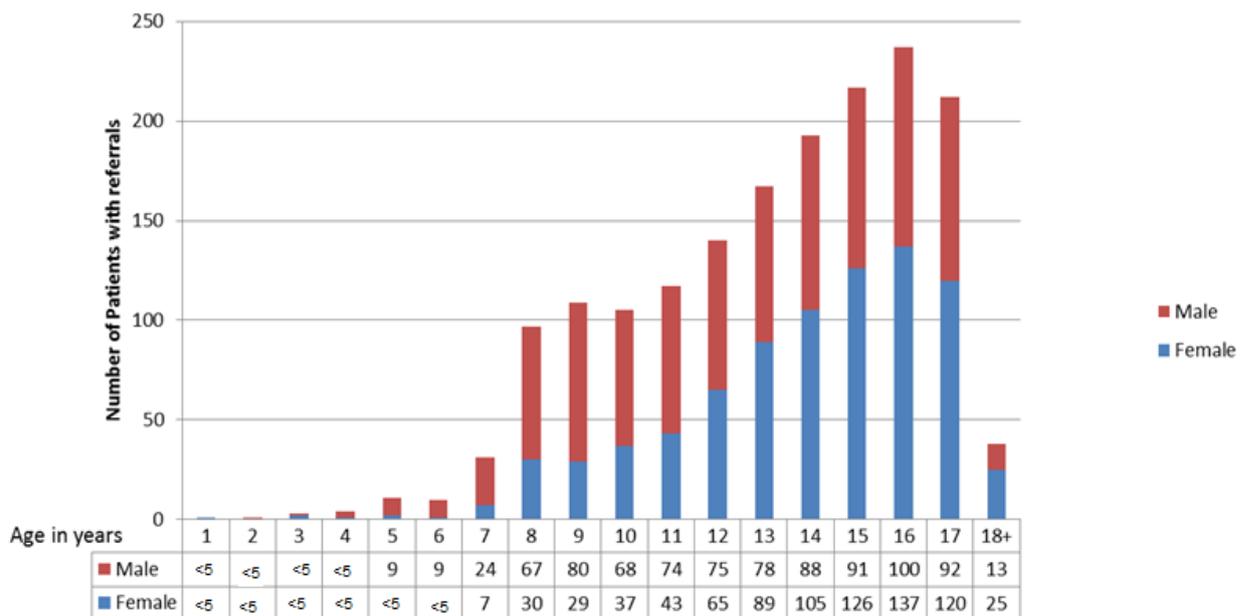
There is an overall trend of increasing referrals with increasing age. In children <13 years, there are more males referred and seen than females. However, in older children, there are more females referred and seen by CAMHS.

Fig 35. Patients from Harrow CCG referred to CNWL CAMHS Services between 01/01/2016 and 31/12/2018, by age and gender



Source: CNWL referrals data set. NB: only external referrals are included, and patients are only counted once even if they have multiple referrals during the time period

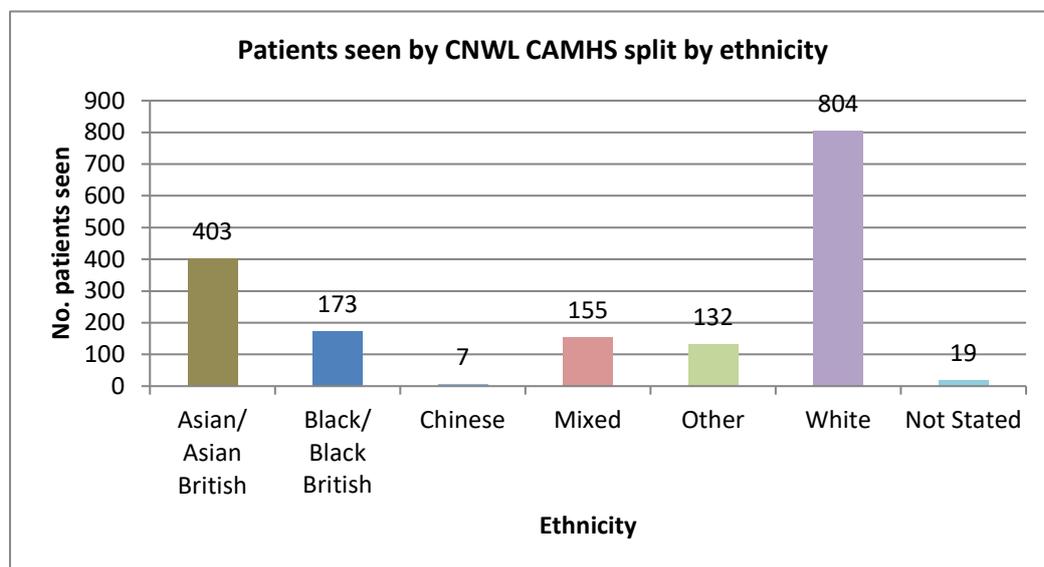
Fig 36. Patients from Harrow CCG with at least one contact in CNWL CAMHS Services between 01/01/2016 and 31/12/2018, by age and gender



Source: CNWL referrals data set. NB: patients are only counted once even if they have multiple contacts during the time period.

Most children and young people seen by CAMHS are from a White background, and the next significant population is CYP from an Asian background.

Fig 37. Patients from Harrow CCG with at least one contact in CNWL CAMHS Services between 01/01/2016 and 31/12/2018, by broad ethnic group



Source: CNWL referrals data set. NB: patients are only counted once even if they have multiple contacts during the time period. Asian British, Black British, Mixed, Other and White categories have been grouped together respectively.

Table 22. Patients from Harrow CCG with at least one contact in CNWL CAMHS Services between 01/01/2016 and 31/12/2018, by ethnicity

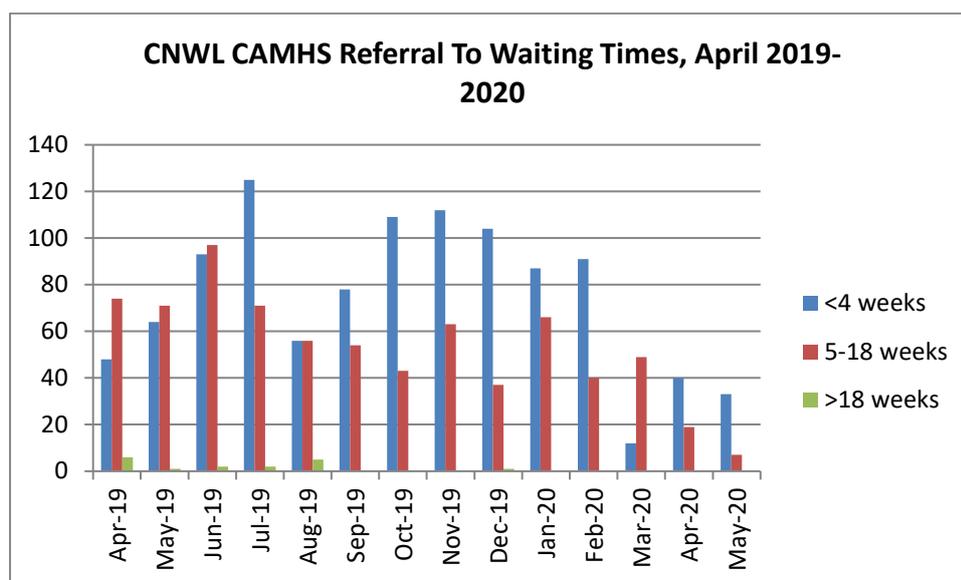
Ethnic Group	Female	Male	Grand Total
Asian/Asian British Bangladeshi	6	6	12
Asian/Asian British Indian	84	91	175
Asian/Asian British Other	79	69	148
Asian/Asian British Pakistani	32	36	68
Black/Black British African	32	42	74
Black/Black British Caribbean	32	40	72
Black/Black British Other	16	11	27
Chinese	<5	<5	7
Mixed Other	37	29	66
Mixed White and Asian	10	14	24
Mixed White and Black African	9	17	26
Mixed White and Black Caribbean	13	26	39
Not Stated	11	8	19
Other	39	26	65
Other - Arab	26	41	67
White British	272	294	566
White Irish	11	16	27
White Other	108	103	211
Grand Total	820	873	1693

Source: CNWL referrals data set. NB: patients are only counted once even if they have multiple contacts during the time period.

WAITING TIMES

Waiting times for CAMHS assessment have increased between 2016 and 2018; most children and young people now wait over 11 weeks for assessment. After assessment, most children and young people wait less than 4 weeks for treatment. Nationally among children with a disorder, approximately 60% report waiting less than 10 weeks to see a mental health specialist.¹¹⁷

Fig 38. Counts of patients in specified referral to assessment waiting time bands, between 01/01/2016 and 31/12/2018



Source: CNWL Monthly Information Returns. NB when no. of patients per month were recorded as '<5' they were counted as 2.5 for the purposes of the graph. No data available for April 2016.

OTHER SERVICES

URGENT CARE SERVICE

The urgent care service, delivered by CAMHS, aims to meet the needs of CYP up to the age of 18 experiencing an acute mental health or emotional crisis. There are 4 functions; A&E liaison, 7 day follow up, supported discharge and home treatment (to prevent admissions). The Urgent Care service is divided into 4 hub teams: Kensington, Chelsea and Westminster (KCW) (covering St Mary's and Chelsea and Westminster Hospitals), Brent and Harrow (covering Northwick Park Hospital), Hillingdon (covering Hillingdon Hospital) and the Out of Hours (OOH) (covering all 4 sites). According to the 2018/2019 annual review, Brent and Harrow were unable to offer supported discharge and home treatment due to reduced staffing and highest demand.¹¹⁸

ADOLESCENT COMMUNITY TREATMENT SERVICE

The adolescent community treatment service, delivered by CAMHS, is for CYP between 13th and 18th birthday presenting in crisis. There are 2 aims; admission prevention and supported discharge. The service offers evidence-based interventions, and can include CBT, DBT, family interventions and psychosocial interventions.

¹¹⁹

¹¹⁷ NHS Digital. Mental Health of Children and Young People in England, 2017. Available here: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

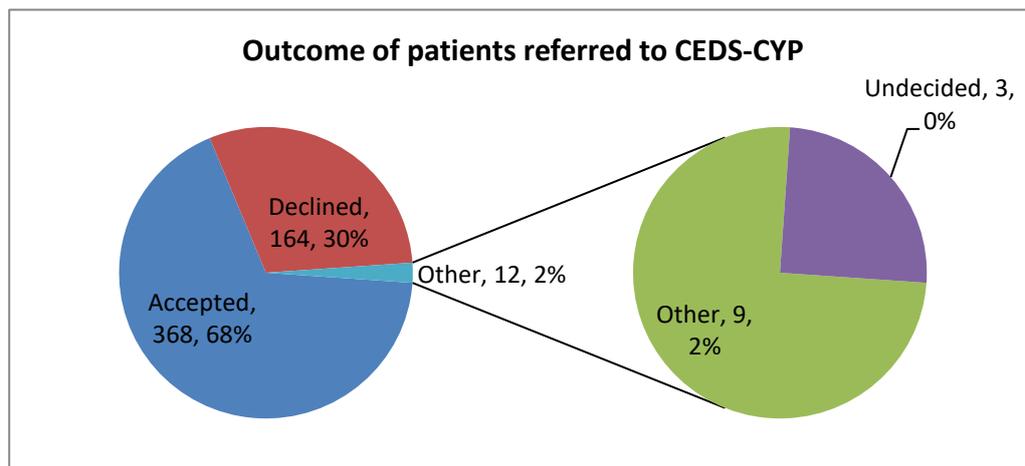
¹¹⁸ CNWL. CNWL CAMHS Urgent Care Team – Annual Review 2018/2019

¹¹⁹ CNWL. Adolescent Community Treatment Service presentation 2019

COMMUNITY EATING DISORDER SERVICE

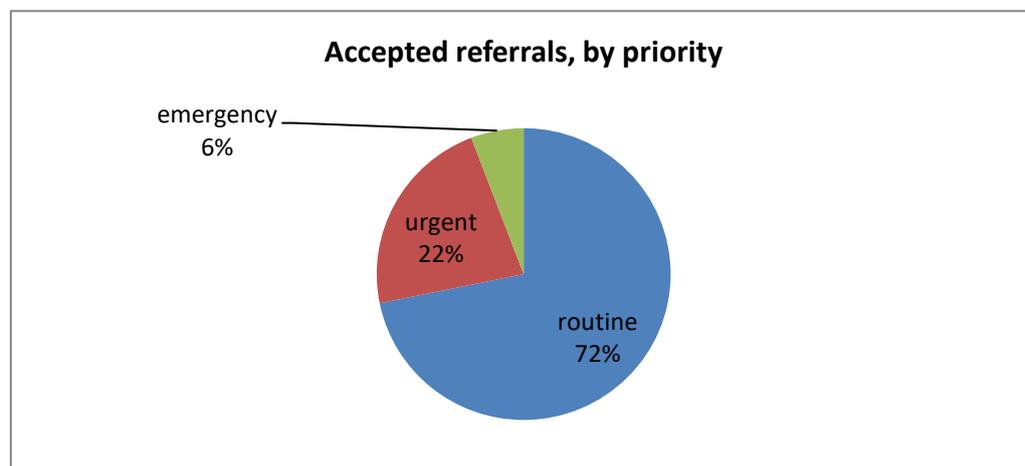
The community eating disorder service for children and young people (CEDS-CYP) is provided by CNWL. They aim to see emergency presentations within 24 hours, urgent referrals within 5 working days, and routine referrals within 28 days. Interventions offered include family based treatment, adolescent focused therapy, CBT-ED, early intervention parent group, supportive clinical management and medication where appropriate. Approximately 30% of all referrals are declined, mainly because the referrals are not appropriate for eating disorder assessment and treatment.¹²⁰

Fig 39. Number of referrals to CEDS-CYP by outcome, between April 2017 and September 2019.



Source: Community Eating Disorder Service for Children and Young People (CEDS-CYP) presentation 2019

Fig 40. Accepted referrals to CEDS-CYP by priority, between April 2017 and September 2019.



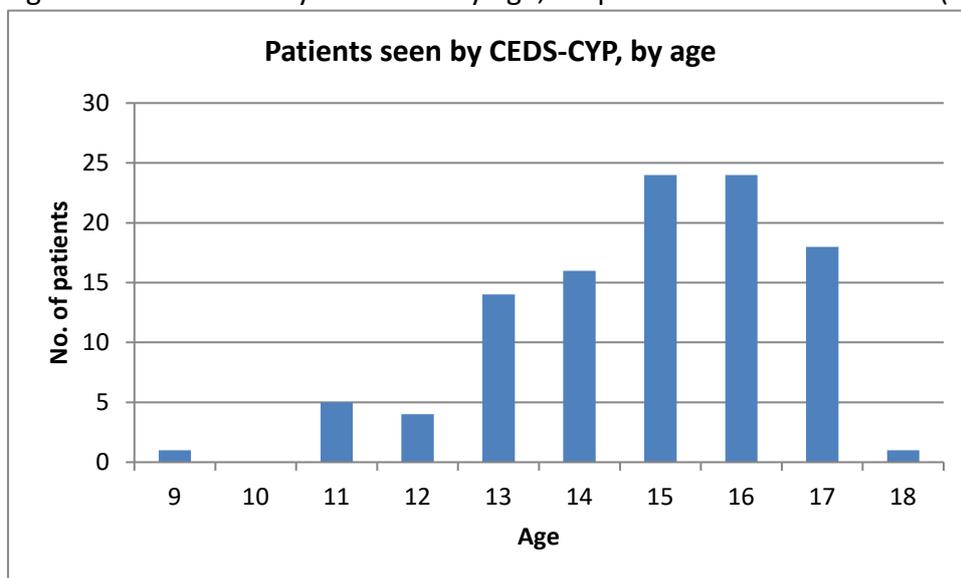
Source: Community Eating Disorder Service for Children and Young People (CEDS-CYP) presentation 2019

¹²⁰ CNWL. Community Eating Disorder Service for Children and Young People (CEDS-CYP) presentation 2019

DEMOGRAPHICS OF PATIENTS SEEN BY CEDS-CYP

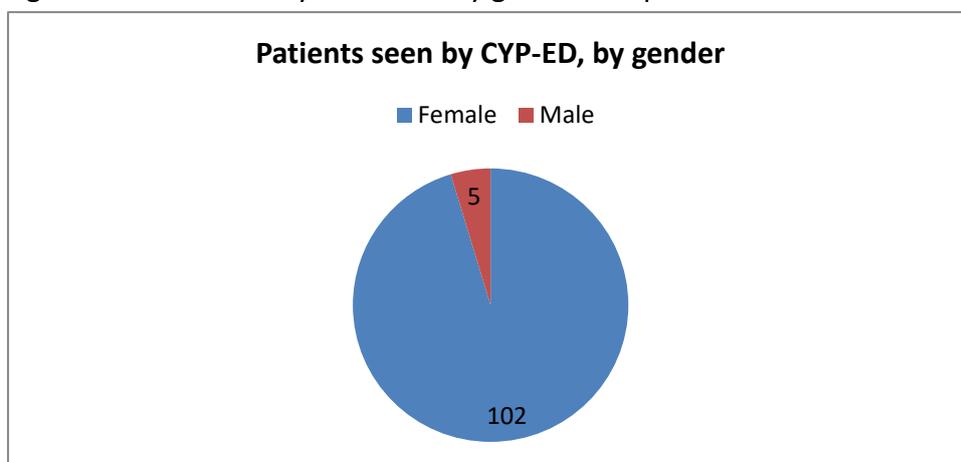
Children and young people seen by CEDS-CYP are likely of adolescent age, with the highest numbers of children aged 15 and 16. The overwhelming majority are also female.

Fig 41. Patients seen by CEDS-CYP by age, snapshot of current caseload (2019)



Source: Community Eating Disorder Service for Children and Young People (CEDS-CYP) presentation 2019

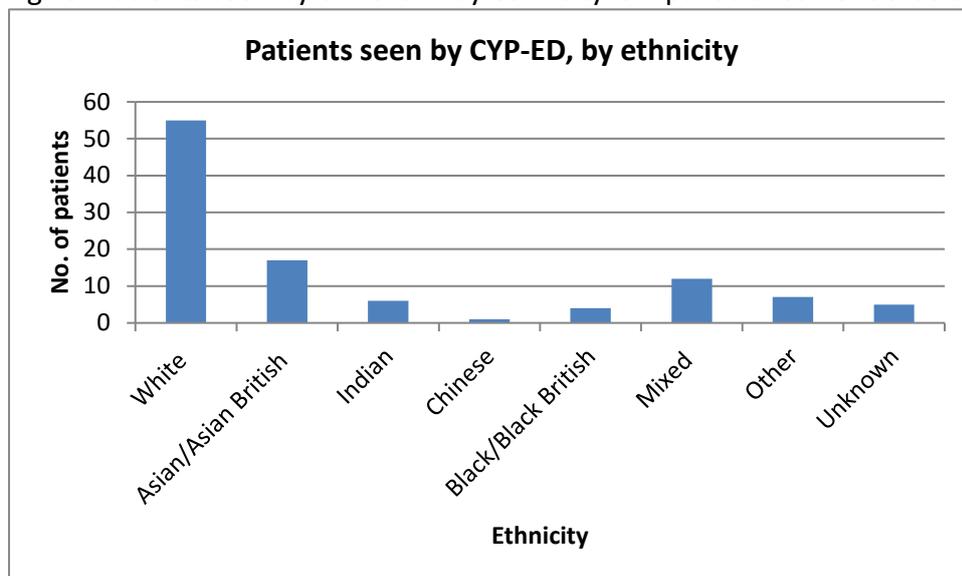
Fig 42. Patients seen by CEDS-CYP by gender. snapshot of current caseload (2019)



Source: Community Eating Disorder Service for Children and Young People (CEDS-CYP) presentation 2019

Most children and young people seen by CEDS-CYP are from a White background. This is similar to the demographics of CYP seen by CAMHS.

Fig 43. Patients seen by CEDS-CYP by ethnicity. snapshot of current caseload (2019)



Source: Community Eating Disorder Service for Children and Young People (CEDS-CYP) presentation 2019

WAITING TIMES

Harrow CCG performs better than local and national average in waiting times for treatment for eating disorder for urgent cases; however performs worse than local and national average with regards to routine cases.¹²¹

Table 23. Table comparing the percentage of cases starting treatment for eating disorder, between Q3 2018-19 – Q2 2019-20

	Harrow	CNWL	London	England
Urgent cases – started treatment within 1 week	100%	98%	93.5%	83.2%
Routine cases – started treatment within 4 weeks	81.8%	84.2%	91.9%	85.2%

Source: NHS England. Children and Young People with an Eating Disorder Waiting Times Q2 19-20. NB: London percentage is an average of all London STPs, and England percentage is an average of all England STPs. Data from Cornwall and the Isles of Scilly and Somerset has been suppressed.

¹²¹ NHS England. Children and Young People with an Eating Disorder Waiting Times Q2 19-20. Available here: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/11/CYPED-Publication-Q2-2019-20-Provider-CCG-new-codes.xls>

SCHOOLS

Schools have an important role in the emotional and mental wellbeing of children and young people. There are 41,251 children and young people attending 75 schools in Harrow.¹²² 1.84% of school pupils in Harrow are reported to have social, emotional and mental health needs, which is better than overall rates in London.¹²³ Teachers are the most commonly cited source of contact with a professional service for children with a mental disorder. Children with a disorder are more likely to play truant or be excluded from school; and over a third are recognised as having special educational needs.¹²⁴

Table 24. Percentage of school pupils with social, emotional and mental health needs (2018)

	Harrow	London	England
School pupils with social, emotional and mental health needs	1.84%	2.41%	2.39%
Primary school age school pupils with social, emotional and mental health needs	1.45%	2.19%	2.19%
Secondary school age school pupils with social, emotional and mental health needs	2.47%	2.53%	2.31%

Source: PHE Fingertips. Children and Young People's Mental Health and Wellbeing.

SCHOOL SURVEY

A survey of how state-funded schools in Harrow respond to the emotional and mental wellbeing of its students was conducted in 2019/20 by Public Health Harrow. A total of 16 schools responded, mostly primary schools (up to the age of 11 years). This accounts for approximately a quarter of schools in Harrow; where there are a total of 59 state-funded schools (42 primary, 13 secondary and 4 special).¹²⁵

Overall schools report a good approach towards mental health and feel supported in dealing with challenging behaviour and emotional issues with children. All report an environment that promotes good mental health and wellbeing. Examples of how it is promoted and supported varied across the schools, and included mentors, counsellors and mental health first aid training. Mental health and wellbeing is included in the curriculum of the majority of schools, most commonly through PSHE (personal, social, health and economic education) lessons or assemblies. Most schools have a designated mental health lead; and in most schools, teachers and school staff also receive mental health training.

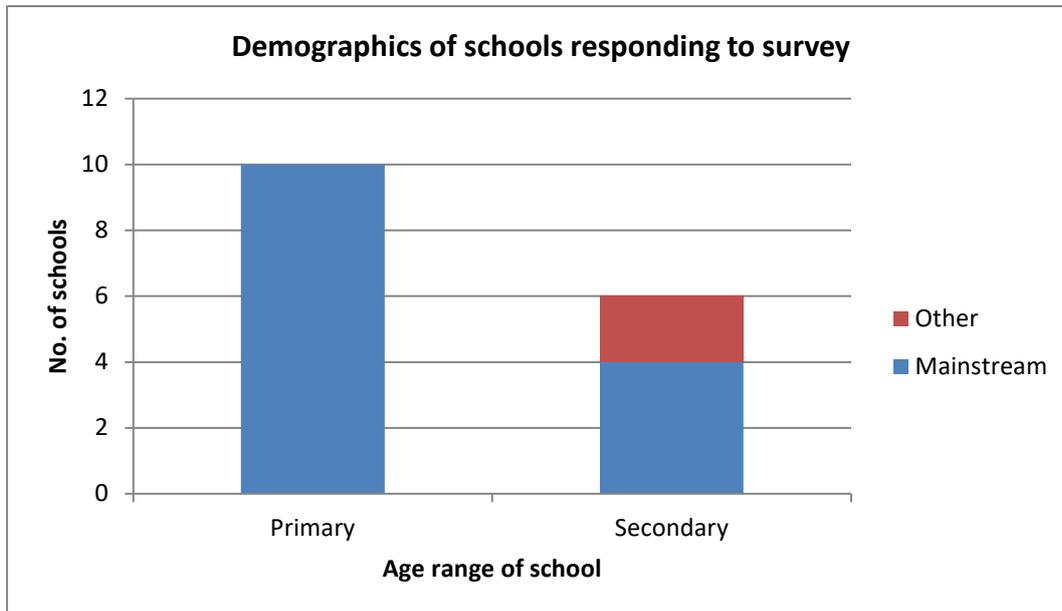
¹²² National Statistics. Schools, pupils and their characteristics: January 2019. Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/826252/Schools_Pupils_and_their_Characteristics_2019_Accompanying_Tables.xlsx

¹²³ Public Health England. Children and Young People's Mental Health and Wellbeing. Available here: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/>

¹²⁴ NHS Digital. Mental Health of Children and Young People in England, 2017. Available here: <https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf>

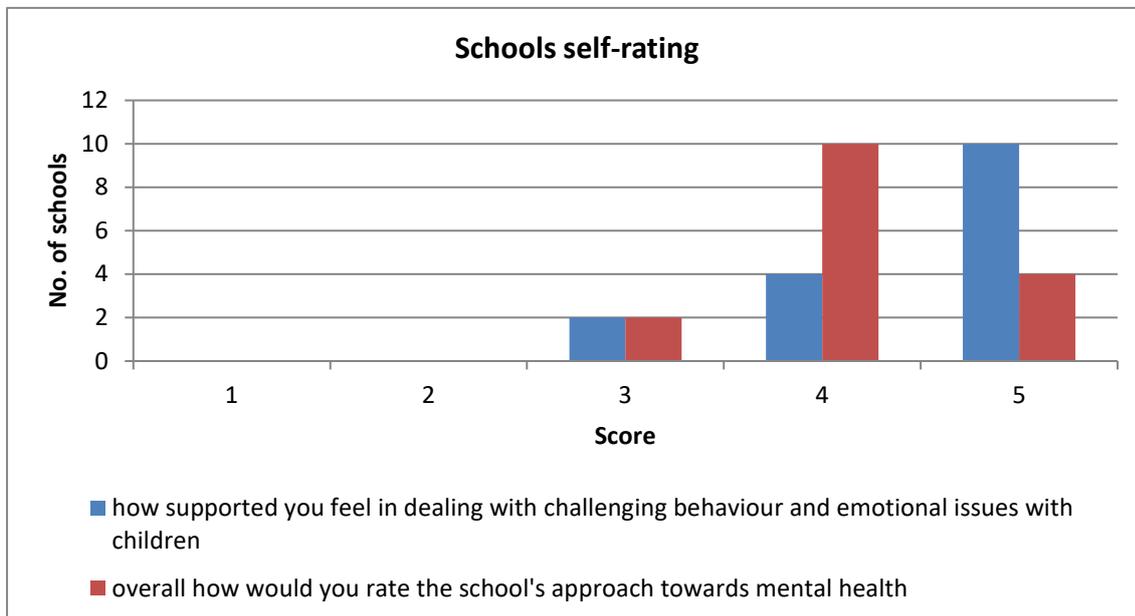
¹²⁵ National Statistics. Schools, pupils and their characteristics: January 2019. Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/826252/Schools_Pupils_and_their_Characteristics_2019_Accompanying_Tables.xlsx

Fig 44. Demographics of schools surveyed by Public Health Harrow.



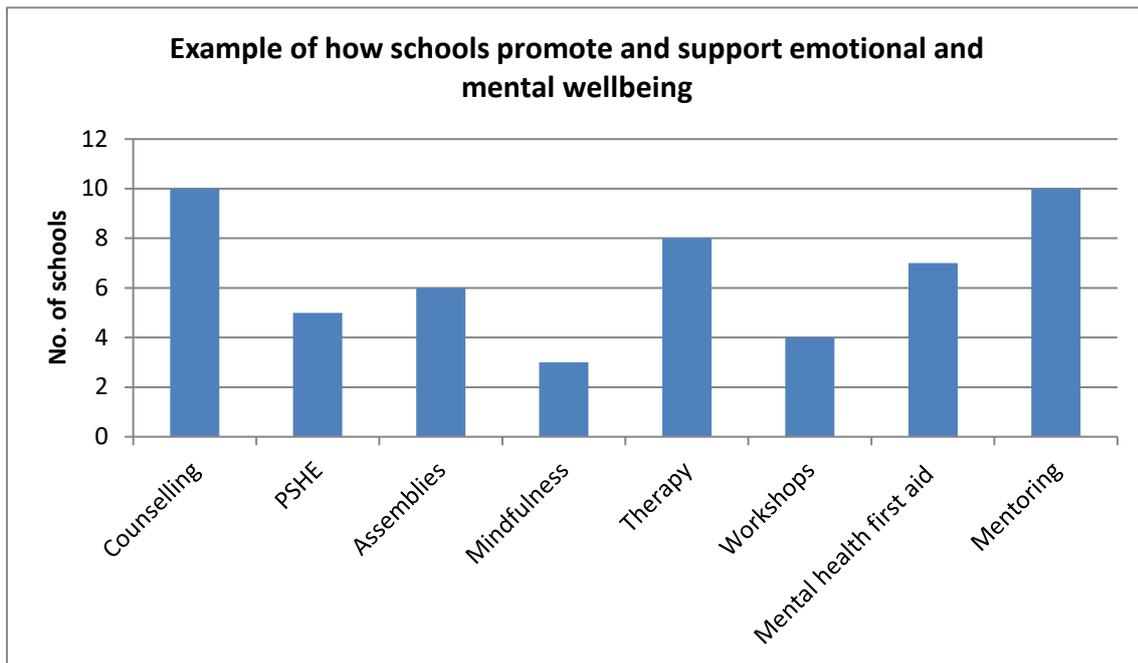
NB: Primary indicates schools up to 11 years of age, and secondary indicates 11 years of age and over. Other indicates special or alternative provision school.

Fig 45. Schools self-rating of their overall approach towards mental health and how supported they feel in dealing with challenging behaviour and emotional issues with children.



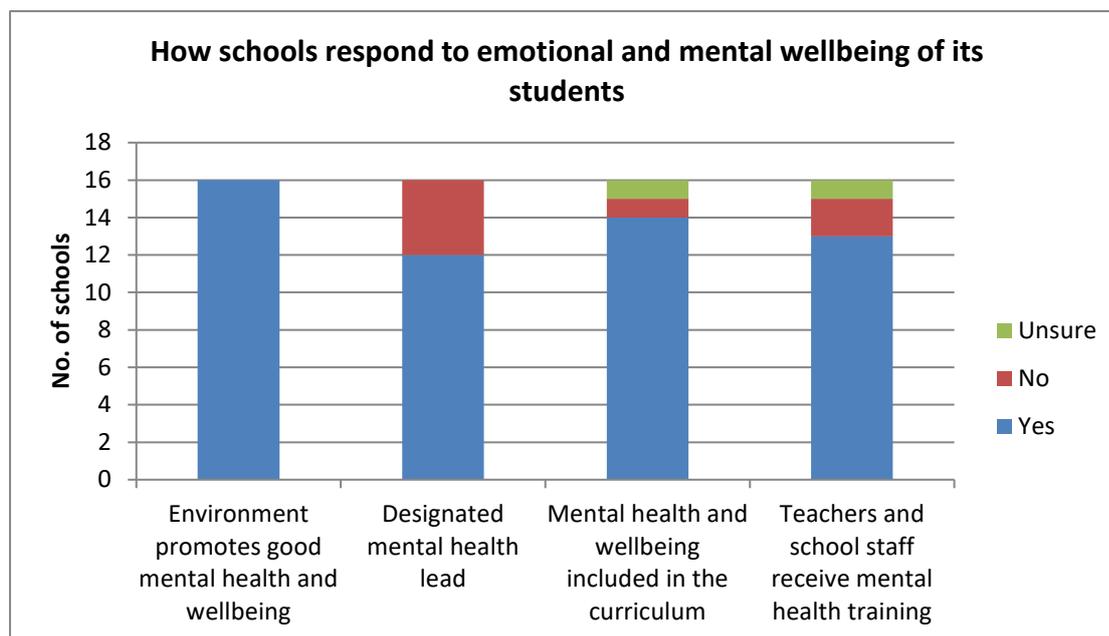
NB: 1 indicates “needs improvement” and 5 indicates “very good”. Where score was recorded as 3.5/4, counted as 4 for the purposes of the graph; and where score was recorded as 4/5, counted as 5 for the purposes of the graph.

Fig 46. Common examples of how schools promote and support emotional and mental wellbeing.



NB: common indicates it is included by at least 3 schools. Types of therapy have been grouped together (e.g. play, drama) and types of mentors have been grouped together (e.g. peer, learning).

Fig 47. Shows how schools respond to emotional and mental wellbeing of its students



Schools surveyed identified various areas for improving emotional and mental health. Common themes included further training for staff, development of mental health and wellbeing policies and raising awareness. Other ideas involved development of specific programmes and workshops; for example, resilience programmes and parent workshops.

PUBLIC HEALTH SUPPORT FOR SCHOOLS

HEALTHY SCHOOLS LONDON

Harrow public health have supported the Healthy Schools London programme since 2015. There are some key elements to the Healthy schools' programme that align with supporting mental health in schools. HSL links to emotional wellbeing. There are 4 health and wellbeing topics:

1. PSHE
2. Healthy Eating
3. Physical activity
4. Mental Health

In order to meet the requirements of the award, an emotional wellbeing and mental health policy is required and if they do not have one public health support with this. In addition, the criteria include:

- School behaviour and anti-bullying – a statutory requirement that schools need to have and we check that is in place
- Relationships and sex education policy
- Physical activity is not a straightforward link, but we know that PA can improve mental health
- There is also a whole section that focuses on the curriculum and links to ethos and environment and ways how schools ensure children build their confidence and self-esteem and how their achievements are celebrated, how they assess risk and stay safe. It also looks at the health and wellbeing on staff. We can almost find in every section of bronze there is a link to emotional wellbeing and mental health if we use the whole school approach
- The silver and gold awards mean that schools can focus on one area for example emotional wellbeing and mental health and narrow it down further to anti-bullying or peer to peer relationships in the playground.

HEALTHY EARLY YEARS

The Healthy Early years programme also requires settings to look at the social and emotional wellbeing of staff, parents and children at the settings. There is a section on physical activity and links to mental health and wellbeing, and breastfeeding and emotional support for parents and mothers. There are also questions about adult health and wellbeing experiences of Domestic Violence and substance misuse and support for teenage parents and fathers all having a link to mental health. There is also a section on leadership and management, and this looks at the wellbeing of staff.

IMPACT OF COVID-19

The support has had an impact on schools completing the work and requirements needed for the HSL and HEYL. Since March 2020 the schools have been focussing on giving support to students online and to the children of key workers. Support is still available and free to access however this has not been a priority for many schools.

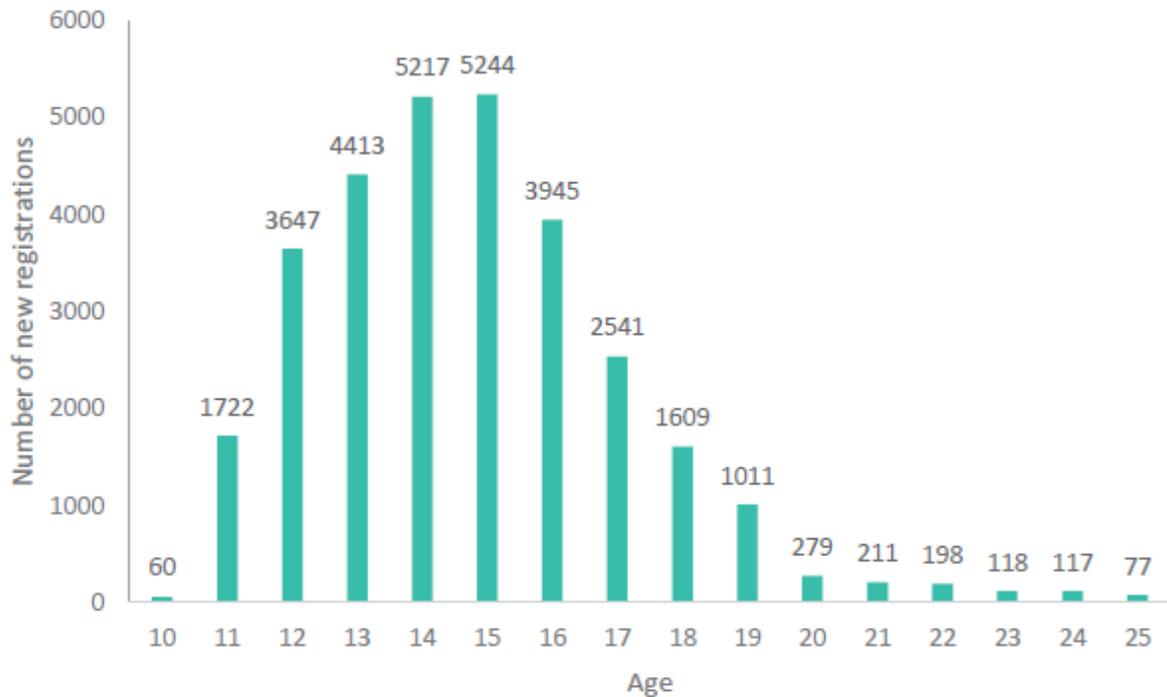
KOOTH

Kooth, from XenZone, provides online mental health services for children and young people. Kooth is available for all 11-25 years olds in Harrow and is a free online counselling and emotional well-being platform commissioned by Harrow CCG. It is accredited by the British Association for Counselling and Psychotherapy (BACP). Kooth is accessible through mobile, tablet and desktop and is anonymous and free at point of use. Access for users is anonymous and not associated with the barriers of waiting lists, thresholds and costs. Kooth is a lower cost intervention due to its digital based access.¹²⁶

¹²⁶Xenzone. Kooth. Available here: <https://xenzone.com/kooth/#>

According to national data from Kooth, the median age for service users is 15 and the majority are female.¹²⁷ There is also a higher proportion of service users from a BAME (Black, Asian and minority ethnic) background compared to the local population; and higher proportion identifying as gender non-conforming (agender or gender fluid) compared to CAMHS population.¹²⁸

Fig 48. Age profile of young people using Kooth online mental health support, between April 2016 and March 2017.



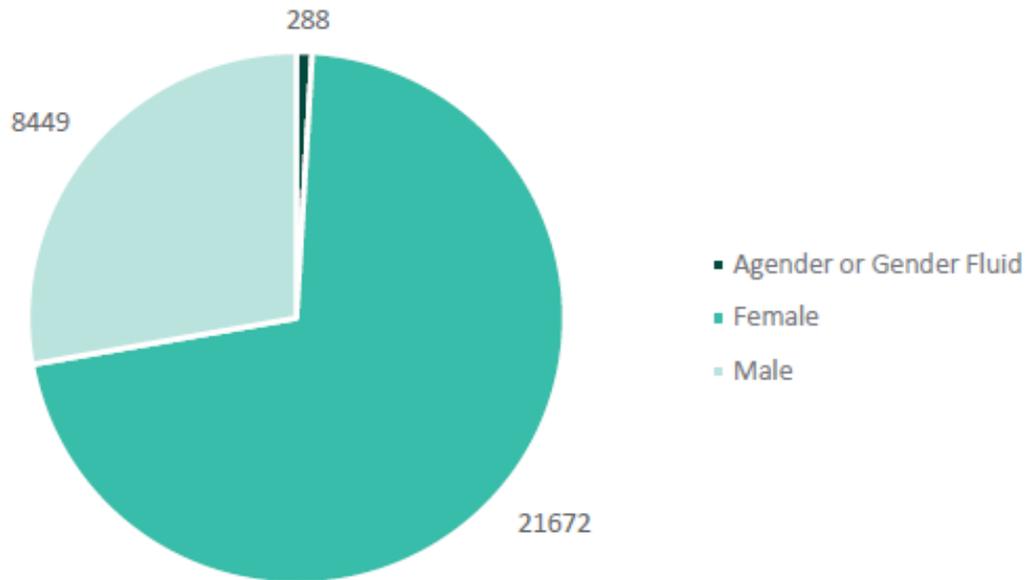
Note: Not all 27 local authorities commission Kooth to support those aged 10 or 20 and above

Source. Education Policy Institute. Online mental health support for young people.

¹²⁷ Education Policy Institute. Online mental health support for young people. 2017. Available here: https://xenzone.com/wp-content/uploads/2018/11/Online_Mental_Health.pdf

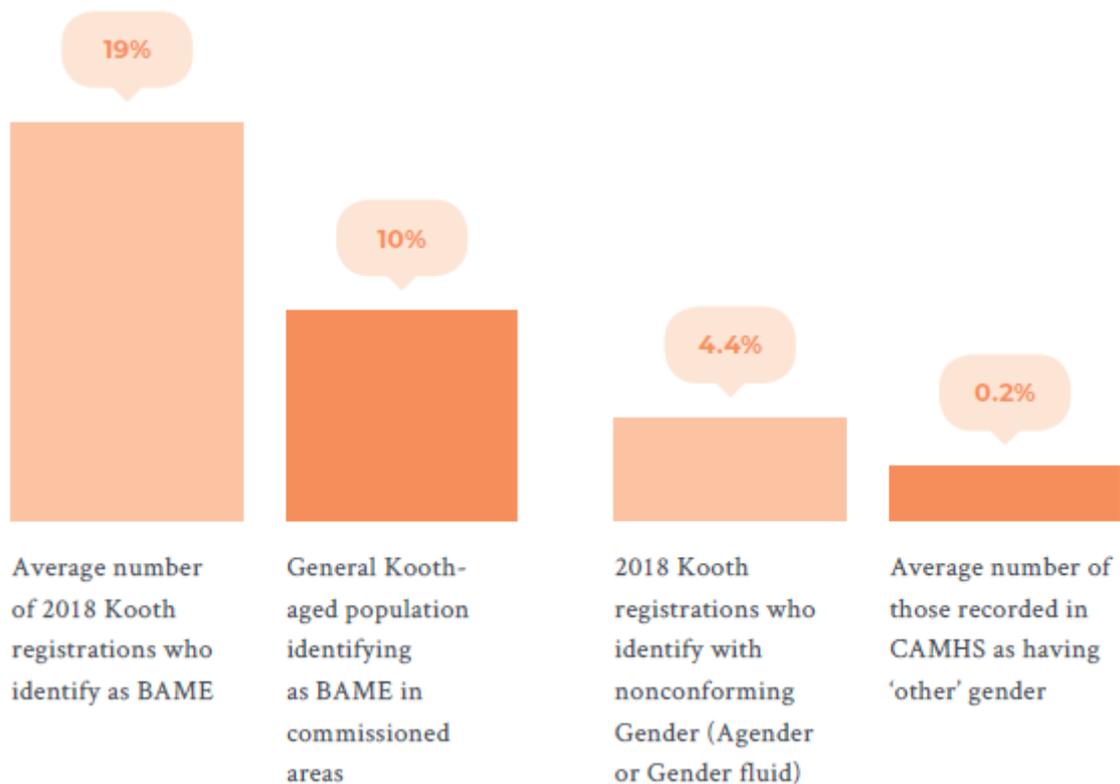
¹²⁸ Kooth. A year in review 2018/2019. Available here: <https://xenzone.com/wp-content/uploads/2019/04/Kooth-A-Year-In-Review.pdf>

Fig 49. Gender profile of young people using Kooth online mental health support, between April 2016 and March 2017.



Source. Education Policy Institute. Online mental health support for young people.

Fig 50. Registration of harder to reach groups on Kooth, 2018



Source: Kooth. A year in review 2018/2019.

HARROW HORIZONS

Harrow Horizons is an emotional health and wellbeing service for children and young people in Harrow. This service is jointly funded by Harrow CCG and Harrow Council, and available for CYP up to the age of 18, and up to 25 with a special educational need or disability. Schools can also request tailored interventions.¹²⁹ Harrow Horizons provides early intervention services, counselling, advice and guidance/support.¹³⁰ There has been no evaluation of the service so far. The service needs to be reviewed to inform future commissioning decisions.

MIND

Mind in Harrow is a mental health charity that provides a range of services in the area. There are approximately 500 service users under the age of 25.¹³¹ The HeadsUp project is a specialist young people's mental health service provided in partnership with four other voluntary organisations (Mosaic LGBT Youth Centre, Paiwand, Centre for ADHD and Autism Support, and the Wish Centre).¹³² This service is available for children and young people aged 13-25 and can provide mental wellbeing workshops, and one-to-one and group sessions. The peer-led workshops work well with 87% of young people self-reporting improved mental health coping strategies and 70% increased ability to care for their own mental health.¹³³

YJLD

The Youth Justice Liaison and Diversion Service (YJLD) is part of an all age police and court liaison and diversion service. The YJLD worker can offer screening, assessment and support for mental health problems.

¹²⁹ Barnardo's. Harrow Horizons. Available here: <https://www.barnardos.org.uk/what-we-do/services/harrow-horizons>

¹³⁰ Harrow Council. Harrow horizons. Available here: <https://www.harrow.gov.uk/adult-social-care/harrow-horizons/1>

¹³¹ Mind in Harrow. Service users and volunteer demographic data

¹³² Mind in Harrow. HeadsUp Project. Available here: <https://www.mindinharrow.org.uk/heads-up.asp>

¹³³ Mind in Harrow. Trustees' Annual Report & Financial Statements 2019. Available here: <https://www.mindinharrow.org.uk/DocumentLibrary/Mind%20in%20Harrow%20-%202019%20Trustees%20Annual%20Report%20and%20Financial%20Statements%20002.pdf>

COVID-19

Support and research for the impact of Covid-19 on the emotional health and wellbeing children and young people has been rapidly growing throughout the pandemic. Listed below are some of the resources that are available.

RESEARCH

RCPCH: research studies on children and young people's views

- RCPCH (Royal College of Paediatrics and Child Health) compilation of studies across the UK that are collecting children and young people's experiences and insights.
- <https://www.rcpch.ac.uk/resources/covid-19-research-studies-children-young-peoples-views>

Emerging evidence: Coronavirus and young people's mental health

- Review of research about the potential impact of the pandemic on children's mental health by the Evidence Based Practice Unit (partnership of UCL and the Anna Freud Centre). Key findings are that the pandemic will cause a significant psychological impact which may have long term consequences for mental health. Certain groups will also be more vulnerable.
- <https://www.annafreud.org/media/11643/coronavirus-emerging-evidence-1-final.pdf>

Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19

- A review into the long-term mental health impacts of isolation on young people's mental health. Analysis suggests an increase in depression and anxiety in the years to come, and services should be prepared for a spike in demand.
- <https://www.bath.ac.uk/announcements/impact-of-childrens-loneliness-today-could-manifest-in-depression-for-years-to-come/>

Checking in: Voices of young people during lockdown

- Bi-weekly listening project with young people aged 14-24 in and around London and their experience of Covid-19. This is a collaboration by Healthy London Partnership, Partnership for Young London and Tik Tok. Key points are that young people have been disproportionately impacted by the wider impacts of the pandemic, and are feeling overwhelmed and need support.

- https://www.healthylondon.org/wp-content/uploads/2020/05/Youth_Listening_Report_Final.pdf

Sibs: Life in Lockdown

- Survey on life in lockdown for siblings of disabled children by Sibs charity. Lockdown and the Covid-19 pandemic has created further isolation and challenges for this group of vulnerable children.
- <https://www.sibs.org.uk/supporting-young-siblings/parents/how-has-lockdown-affected-your-sibling-child-children/>

GUIDANCE FOR SCHOOLS AND ORGANISATIONS

Teaching about mental wellbeing

- Practical materials for primary and secondary schools to use to train staff about teaching mental wellbeing.
- <https://www.gov.uk/guidance/teaching-about-mental-wellbeing>

Healthy London Partnership: School mental health toolkit

- Toolkit to promote emotional wellbeing and mental health within schools which has been updated with resources relating to Covid-19.
- <https://www.healthylondon.org/resource/schools-mental-health-toolkit/>

Bi-Borough Educational Psychology Consultation Services: Transition, recovery and learning in the aftermath of a pandemic

- Resources for nursery and primary and secondary schools created post Grenfell that have been shared to be used post Covid-19 return to schools.



2020 Transition
Recovery and Learni



2020 Transition,
Recovery and Learni

Back to School with SCARF

- SCARF (Safety, Caring, Achievement, Resilience and Friendship) is an online teacher resource to support primary schools in promoting positive behaviour, mental health, wellbeing, resilience and achievement.
- <https://www.coramlifeeducation.org.uk/back-to-school-with-scarf>

Yorkshire & the Humber Children & Young People's Mental Health Clinical Network: Guide for education settings

- A guide for education settings supporting children and young people's mental health and emotional wellbeing needs which have arisen from Covid-19.
- <http://www.yhscn.nhs.uk/media/PDFs/children/Docs%20and%20Links/Guide%20for%20Education%20Settings%20Supporting%20CYP%20MH%20EWB%20-%20COVID-19%20FINAL%20v1.0.pdf>

Winstons Wish: Online bereavement training for schools

- Free online training courses to help teachers and school staff understand how to support grieving children and young people in their school.
- <https://www.winstonswish.org/bereavement-training-courses-schools/>

LGA: Tackling domestic abuse during the COVID-19 pandemic

- Resource for councils on how they can provide help and support to domestic abuse victims during the Covid-19 pandemic, and tackle perpetrators' abusive behaviour.
- <https://www.local.gov.uk/tackling-domestic-abuse-during-covid-19-pandemic>

ADVICE AND SUPPORT

Family Links: The Centre for Emotional Health

- Articles, videos and resources to support families during the pandemic.
- <https://www.familylinks.org.uk/news-hub/categories/c-19-support>

Families Under Pressure

- Series of films offering parenting tips for families struggling under the pandemic. Produced by The Institute of Psychiatry, Psychology & Neuroscience (IoPPN), South London and Maudsley (SLAM) NHS Foundation Trust and Maudsley Charity.
- <https://maudsleycharity.org/familiesunderpressure/>

Young Minds: Coronavirus and mental health

- Tips, advice and guidance on where you can get support for your mental health during the pandemic.
- <https://youngminds.org.uk/find-help/looking-after-yourself/coronavirus-and-mental-health/>

WHO: Helping children cope with stress during the 2019-nCoV outbreak

- Leaflet produced by the World Health Organisation to help support children's stress from the pandemic.
- https://www.who.int/docs/default-source/coronaviruse/helping-children-cope-with-stress-print.pdf?sfvrsn=f3a063ff_2

ONLINE COURSES

COVID-19: Helping Young People Manage Low Mood and Depression

- Free FutureLearn course exploring practical ways to help young people manage their mood and maintain healthy habits during the coronavirus pandemic. Aimed at young people with low mood or depression, their parents and carers, or anyone who has contact with young people during Covid-19.
- <https://www.futurelearn.com/courses/low-mood-during-covid-19>

Anxiety in Children and Young People during COVID-19

- Free FutureLearn course on anxiety and helpful strategies to support young people struggling with anxiety during the Covid-19 pandemic. Aimed at teachers, supporters, guardians, and parents of children affected by the current Covid-19 situation.
- <https://www.futurelearn.com/courses/youth-mental-health-during-covid-19>

PODCASTS/WEBINARS

Thrive LDN: Education and Covid-19

- A special podcast recorded in the context of the Covid-19 outbreak and the impact on education.
- <https://thrivedn.co.uk/season-2-episode-4-act-on-education-and-covid-19/>

Children and young people's mental health: the impact of the pandemic

- Webinar by Kadra Abdinasir, Head of Children and Young People's Mental Health at the Centre for Mental Health (21 May 2020).
- <https://www.local.gov.uk/supporting-mental-health-and-wellbeing-our-communities-during-covid-19-webinar-21-may-2020>

Back to school after lockdown: school reintegration and youth mental health

- Joint webinar by The Emerging Minds Network and The Mental Elf on the implications for children, young people and their families as schools reopen after the COVID-19 lockdown (22 May 2020).
- <https://emergingminds.org.uk/podcast-back-to-school-after-lockdown-school-reintegration-and-youth-mental-health/>

RECOMMENDATIONS

1. Focus and enhance support for CYP BAME residents (improve access rates to mental health services)
Majority of the under 19 population in Harrow are of BAME origin (7 out of 10)ⁱ. BAME are considered higher risk for poor mental wellbeingⁱⁱ. BAME children are more likely to be exposed to other risk factors for poor mental wellbeing such as povertyⁱⁱⁱ and acting as a young carer^{iv}. Majority of service users in Harrow (CAMHS & Community Eating Disorders) are from a White Background, which differs from the local Harrow population. Stigma around mental wellbeing and a lack of understanding of mental health services are significant barriers to young BAME children seeking support^v. Analyses of an online offer of mental health support (Kooth) suggests a disproportionate impact on mental health on BAME CYP and BAME service users had higher rates of depression, anxiety and self-harm and suicidal thoughts compared to white peers. This may suggest that their mental wellbeing needs are not being addressed by mainstream services.
2. Promote mentally healthy schools & colleges
Children spend about a third of their time in school. Schools therefore present a critical opportunity in addressing the mental health needs of CYP. Schools in Harrow (School Survey) have self-identified areas for improvement e.g. further training, development of specific policies and raising awareness.
3. Understand reasons for referrals being declined by specialist services and ensure solutions in place for appropriate referrals
30% referrals declined for CAMHS and Community Eating Disorder Service. Reasons for referrals being declined were not reported in the needs assessment. This needs to be explored further to inform action.
4. Reduce waiting times for Specialist Child and Adolescent Mental Health Services (CAMHS).
The needs assessment reported that waiting times for CAMHS have increased (>11 weeks for assessment).
5. Develop a digital response to promote emotional wellbeing and mental health & provide support. Ensure digital responses relate to the way CYP use digital technology and involves CYP in the design and promotion of new IT solutions.
Kooth reported a 58% increase in logins compared to previous year during lockdown. Explore online mental health support services to reach CYP populations under-represented in traditional services or those unwilling to engage with mainstream support. Harrow Kooth service demonstrated high engagement figures with BAME young people representing 68.39% of service users (April 2019-March 2020).
6. Increase information on local prevalence of eating disorders.
This could include reporting from existing services, engagement with groups at higher risk (such as transgender).

7. Understand locally the size of the hidden and known population of young carers and the impact of caring on young people.
There is an adverse impact of caring on mental health outcomes, social activity, educational engagement, and employment opportunities for young carers. There was no local available data in relation to young carers in Harrow. Further understanding of this group will ensure appropriate support is directed to them.

8. Understand the impact of the COVID-19 pandemic on CYP in Harrow. COVID-19 pandemic will have short and long-term impacts of on children and young people in Harrow. Further information at a local level to understand the impact will inform adaptation of existing services and commissioning of new services to meet demand.

ⁱ From 0-19: A Children's Needs Assessment. Online via: <https://www.harrow.gov.uk/downloads/file/23299/0-19-children-s-needs-assessment>

ⁱⁱ McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital

ⁱⁱⁱ Independent Mental Health Taskforce (2016) The Five Year Forward View for Mental Health

^{iv} The Children's Society (2013) Hidden from View: The experiences of young carers in England

^v Street C, Stapelkamp C, Taylor E, Malek M and Kurtz Z (2005). Minority Voices: Research into the access and acceptability of services for the mental health of young people from Black and minority ethnic groups. YoungMinds Research

^{vi} Clarke R, Annon S, Douglas G, Allen M, Kaur P, Brown K, et al. (2008). Report of the community led research project focusing on the mental health needs of BME young people. University of Central Lancashire