Public Health England

Protecting and improving the nation's health

The mental health of children and young people in England

December 2016

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Background and aims

Background

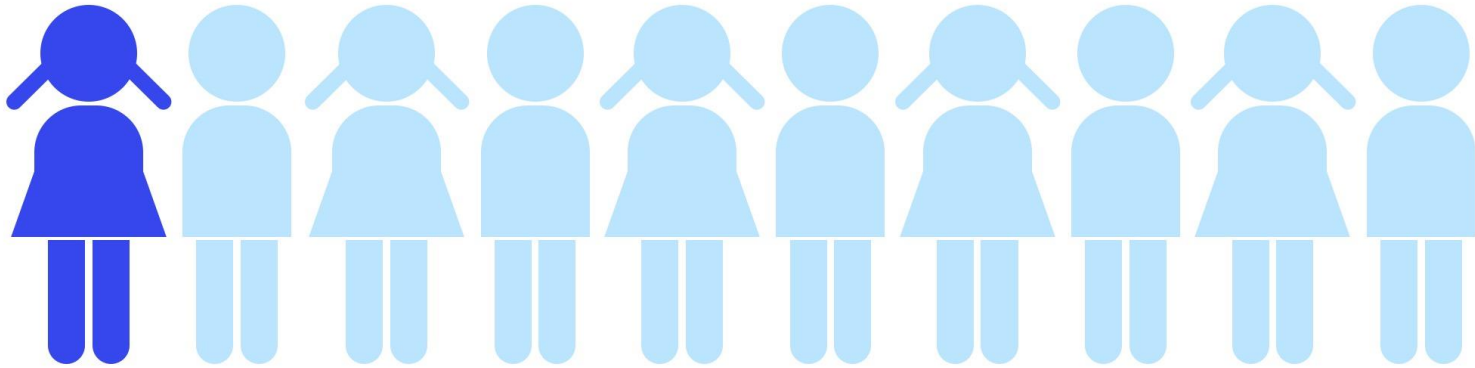
The emotional health and wellbeing of children is just as important as their physical health and wellbeing. Over the past few years there has been a growing recognition of the need to make dramatic improvements to mental health services for children and young people (CYP). This has resulted in:

- significant investment in these services
- the development of local transformation plans outlining how clinical commissioning groups (CCGs) and CCG consortia, working with partner agencies will use the new funding to improve children's health and wellbeing and improve services for CYP with mental health illness across the care pathway, ensuring these service are age appropriate

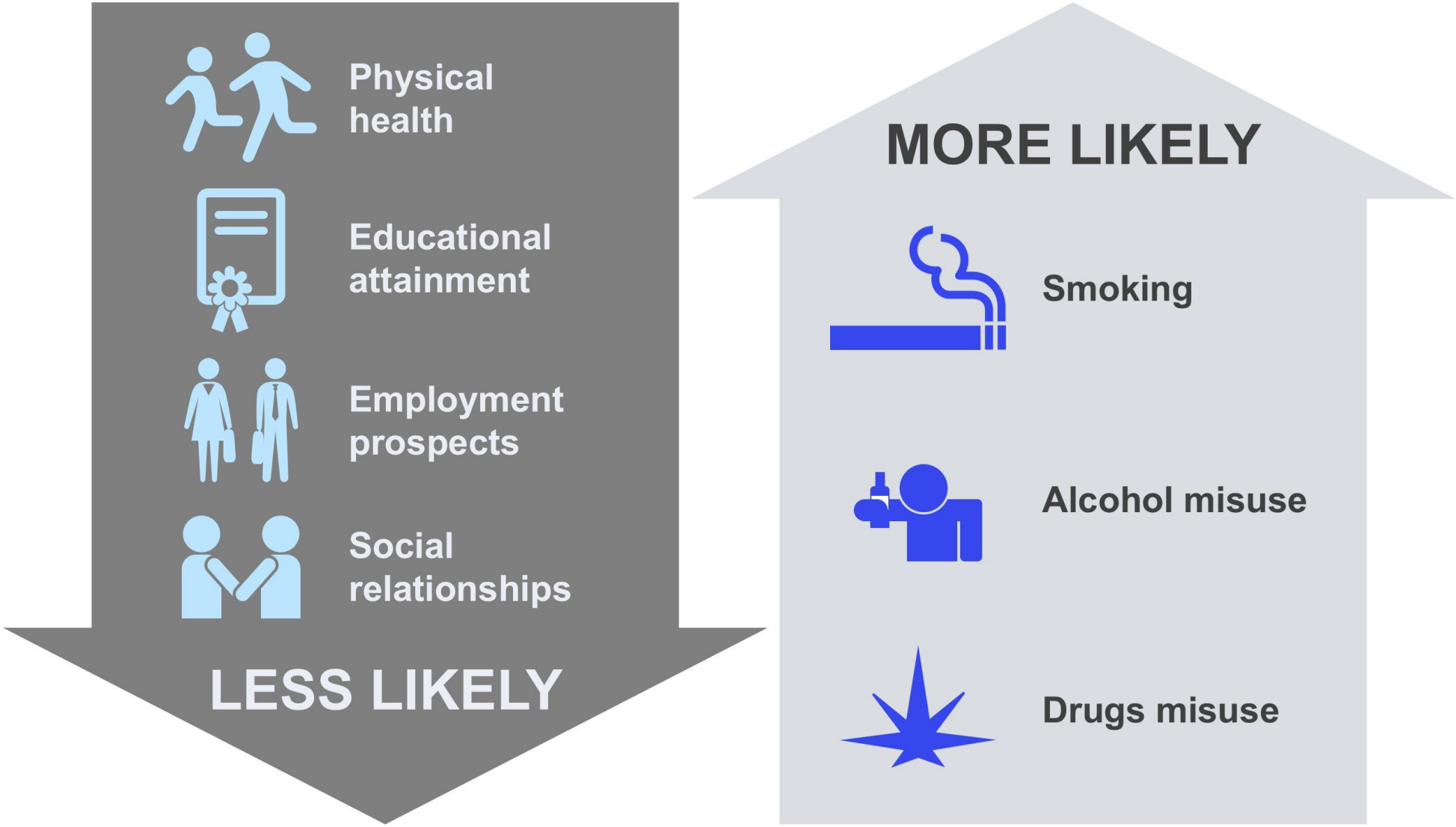
Aims

The purpose of this report is to:

- describe the importance of mental health in CYP
- describe the case for investing in mental health
- provide a descriptive analysis of mental health in CYP in England
- summarise the evidence of what works to improve mental health in CYP in order to inform local transformation of services



Mental health illnesses are a **leading** cause of health-related disabilities in CYP and can have **adverse** and **long-lasting** effects



Risk and protective factors for CYP's mental health

RISK FACTORS

Child

- ✘ Genetic influences
- ✘ Low IQ and learning disabilities
- ✘ Specific development delay
- ✘ Communication difficulties
- ✘ Difficult temperament
- ✘ Physical illness
- ✘ Academic failure
- ✘ Low self-esteem

Family

- ✘ Family disharmony, or break up
- ✘ Inconsistent discipline style
- ✘ Parent/s with mental illness or substance abuse
- ✘ Physical, sexual, neglect or
- ✘ emotional abuse
- ✘ Parental criminality or alcoholism
- ✘ Death and loss

School

- ✘ Bullying
- ✘ Discrimination
- ✘ Breakdown in or lack of positive friendships
- ✘ Deviant peer influences
- ✘ Peer pressure
- ✘ Poor pupil to teacher relationships

Community

- ✘ Socio-economic disadvantage
- ✘ Homelessness
- ✘ Disaster, accidents, war or other overwhelming events
- ✘ Discrimination
- ✘ Other significant life events
- ✘ Lack of access to support services

PROTECTIVE FACTORS

Child

- ✔ Secure attachment experience
- ✔ Good communication skills
- ✔ Having a belief in control
- ✔ A positive attitude
- ✔ Experiences of success and achievement
- ✔ Capacity to reflect

Family

- ✔ Family harmony and stability
- ✔ Supportive parenting
- ✔ Strong family values
- ✔ Affection
- ✔ Clear, consistent discipline
- ✔ Support for education

School

- ✔ Positive school climate that enhances belonging and connectedness
- ✔ Clear policies on behaviour and bullying
- ✔ 'Open door' policy for children to raise problems
- ✔ A whole-school approach to promoting good mental health

Community

- ✔ Wider supportive network
- ✔ Good housing
- ✔ High standard of living
- ✔ Opportunities for valued social roles
- ✔ Range of sport/leisure activities

Facts about mental health illness in CYP

10%

children aged 5-16 years suffer from a clinically significant mental health illness

25%

of children who need treatment receive it

50%

of those with lifetime mental illness (excluding dementia) will experience symptoms by the age of 14

75%

of those with lifetime mental illness (excluding dementia) will experience symptoms by the age of 24

5x

maternal depression is associated with a 5 fold increased risk of mental health illness for the child

1.3x

boys aged 11-15 years are 1.3x more likely to have a mental illness compared to girls aged 11-15 years

60%

of looked after children have some form of emotional or mental health illness

18x

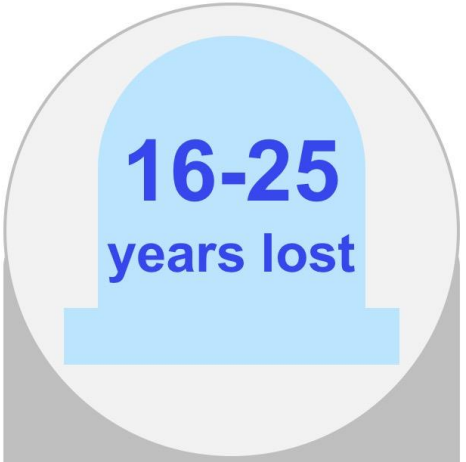
young people in prison are 18x more likely to take their own lives than others of the same age

The relationship between mental and physical health

12%

of young people live with a long term condition

People with a chronic condition have a **2-6x higher risk** of mental health illness

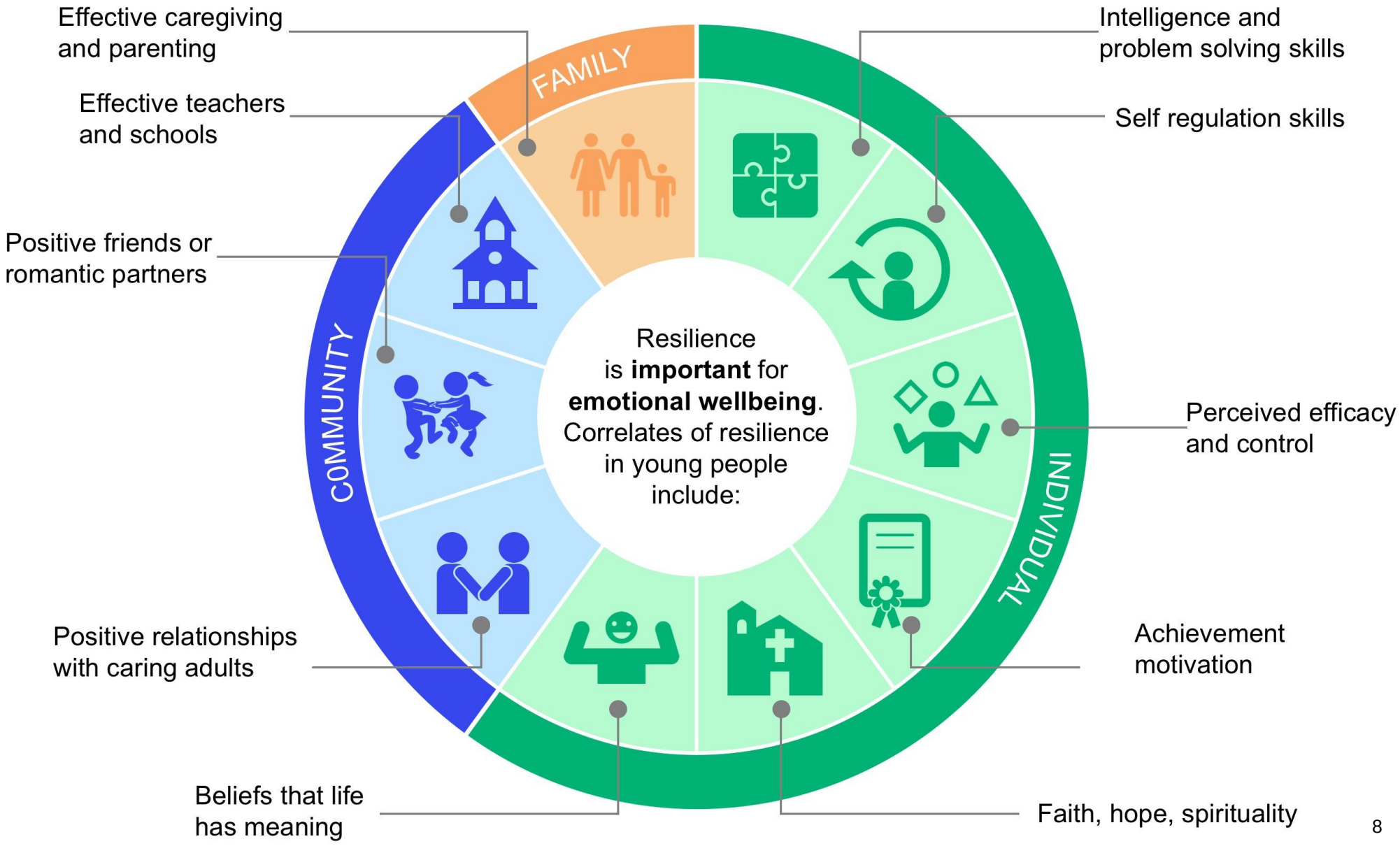


People with mental health illness e.g. schizophrenia or bipolar disorder die on average **16-25 years** sooner than the general population

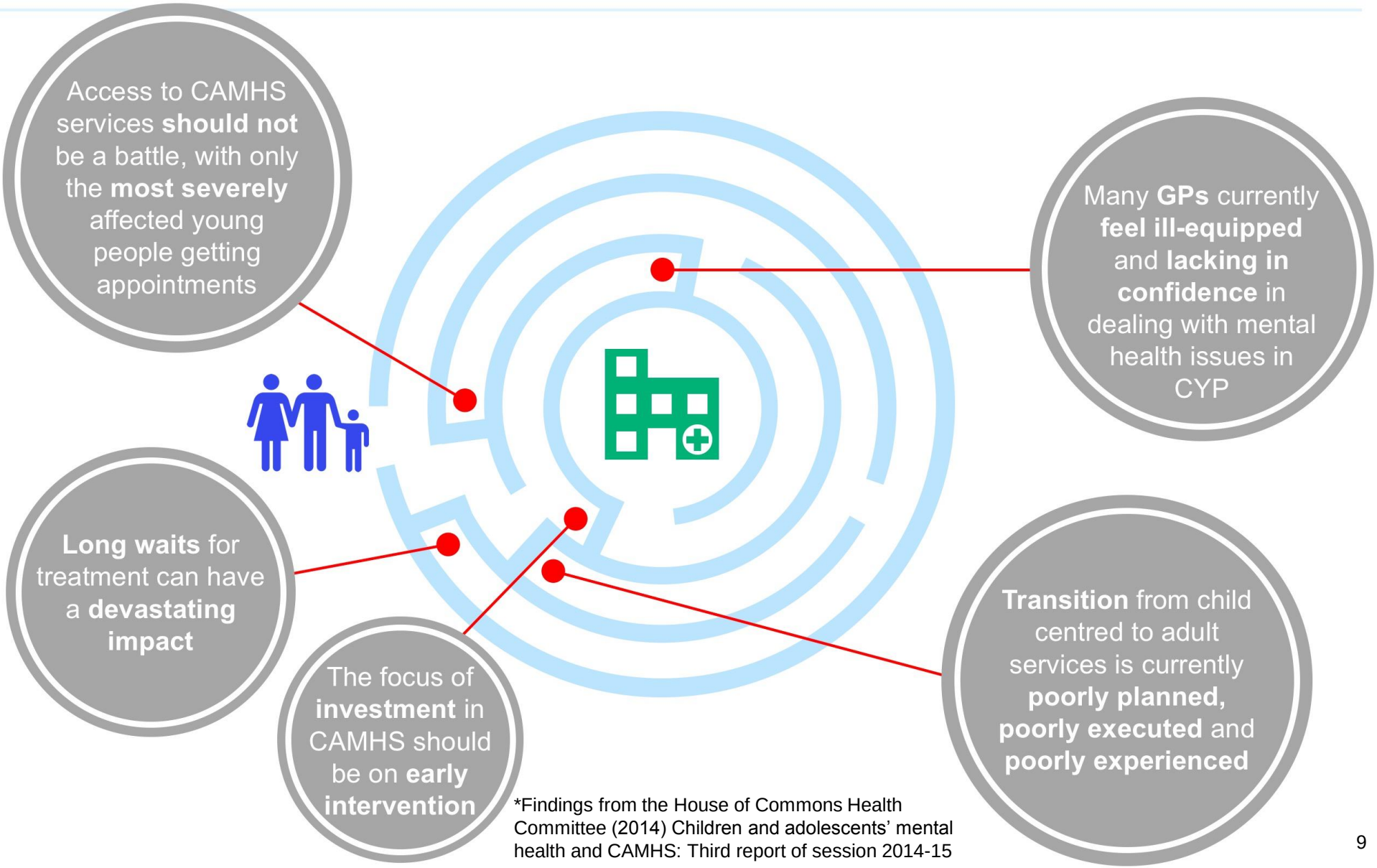
50%

increased risk of mortality in people who are depressed

Building resilience (the ability to cope with adversity and adapt to change)



There are **serious problems** with the **commissioning** and **provision** of children's and adolescents' mental health services*



*Findings from the House of Commons Health Committee (2014) Children and adolescents' mental health and CAMHS: Third report of session 2014-15

Why invest in CYP mental health?

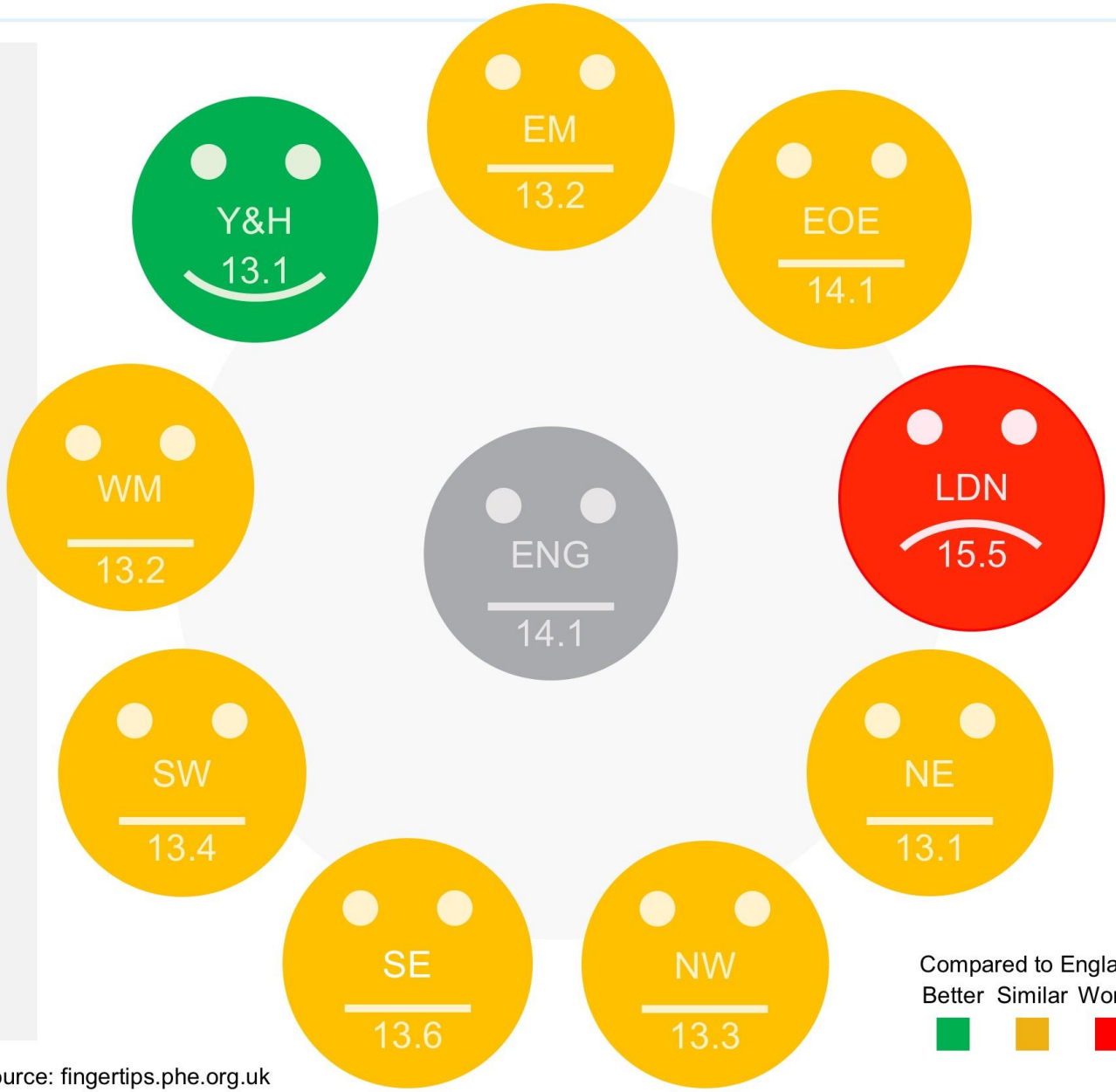
- Mental health problems in CYP are associated with **excess costs** estimated as being between **£11,030** and **£59,130** annually per child
- In 2012/13, **NHS** expenditure on child and adolescent mental health illness was estimated to be **£700 million** or **6%** of the total spend on mental health
- **Early intervention avoids** young people falling into crisis and **avoids** expensive and longer term interventions in adulthood
- Measured **benefits** include **reductions** in the use of public services because of better mental health and **increases** in earnings associated with the **impact of improved mental health** on **educational attainment**

Percentage of 15-year-olds reporting low life satisfaction (2014/15)

About **1 in 7** young people (YP) aged 15 years in England reports low life satisfaction

There is some variation in the proportion of children reporting low satisfaction

London (15.5%) has the **highest proportion** of YP reporting low life satisfaction and the **North East and Yorkshire and the Humber** (13.1%) have the **lowest** proportion



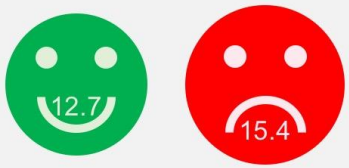
Source: fingertips.phe.org.uk

Inequalities in reporting low life satisfaction (2014/15)

About **1 in 7** young people (YP) aged 15 years in **England** reports low life satisfaction

YP from the **most deprived** group are **1.2x more likely** to report low life satisfaction than the **least deprived** group

Percentage reporting low life satisfaction



YP who are black are **1.3x more likely** to report low life satisfaction compared to YP who are white

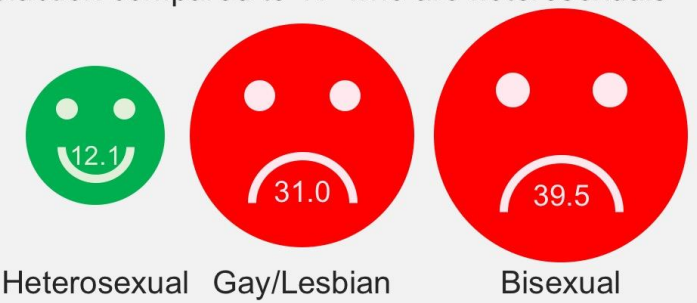
Percentage reporting low life satisfaction

Girls are **2.2x more likely** to report low life satisfaction compared to boys

Percentage reporting low life satisfaction

YP who are bisexual are are **3.3x more likely** to report low life satisfaction compared to YP who are heterosexuals

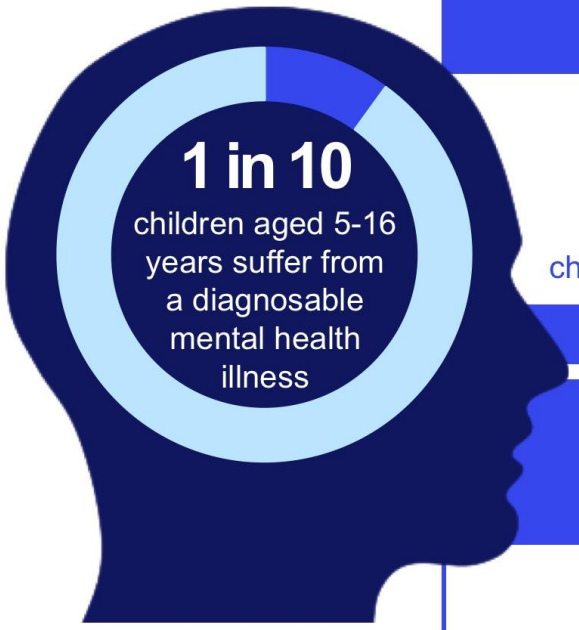
Percentage reporting low life satisfaction



Compared to England: Better | Similar | Worse

Source: fingertips.phe.org.uk

About **695,000** children aged 5 to 16 years in England have a clinically significant mental health illness



HELLO
my name is
Anxiety
39,500
children aged 5-16 years affected

HELLO
my name is
Depression
10,800
children aged 5-16 years affected

HELLO
my name is
ADHD
18,900
children aged 5-16 years affected

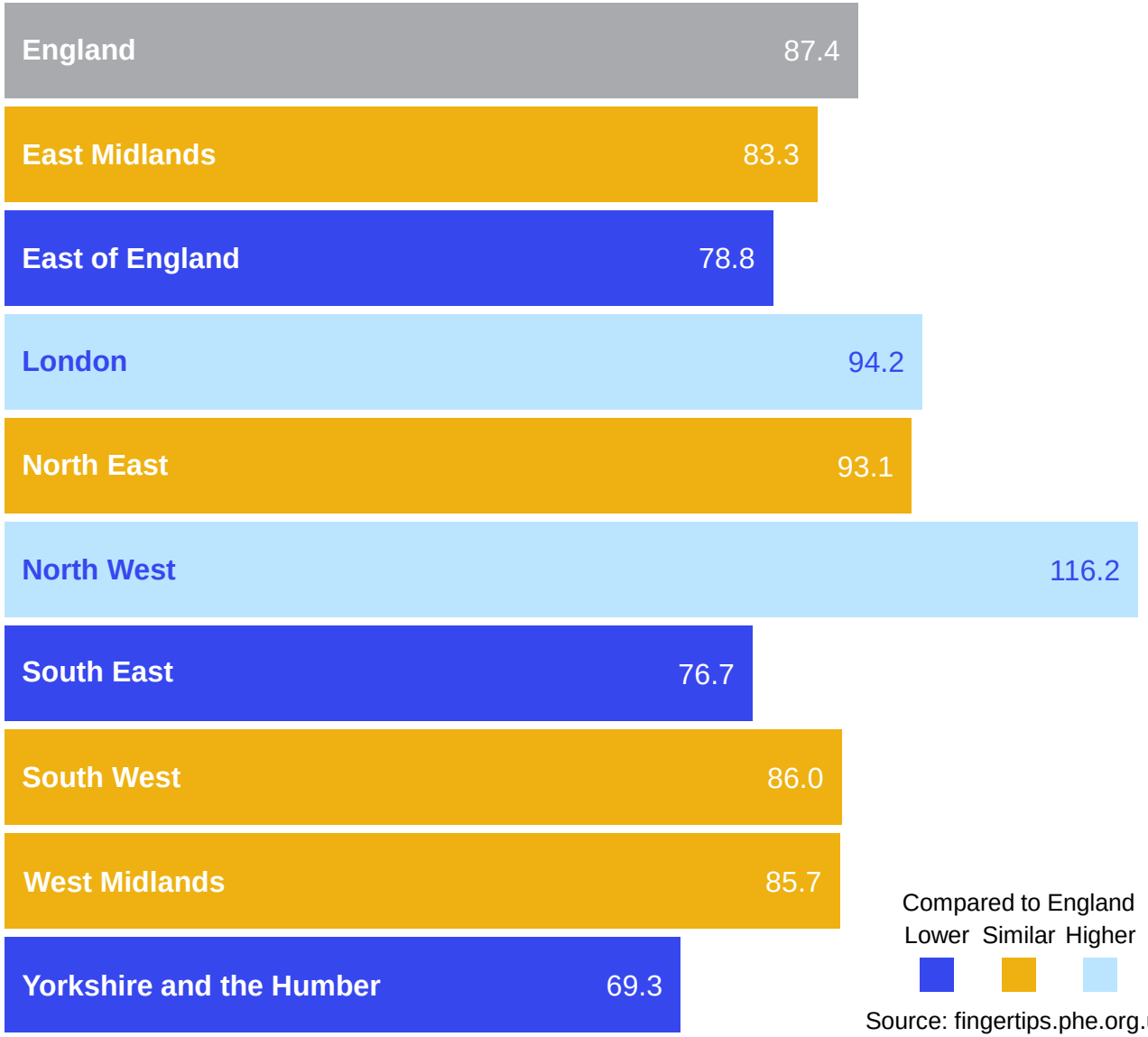
HELLO
my name is
Conduct disorder
68,100
children aged 5-16 years affected

Numbers do not add up as individuals may meet the criteria for more than one category

Hospital admission rate for mental health illnesses for children per 100,000 population aged 0-17 years (2014/15)

There is a **wide variation** in the rate of children aged 0-17 years admitted to hospital for mental health illnesses

Hospital admissions were **1.7x higher** in the **North West** (116.2 children per 100,000 population) compared to **Yorkshire and the Humber** (69.3 children per 100,000 population)



Source: fingertips.phe.org.uk

Anxiety disorders

Anxiety disorders are amongst the **most common** causes of childhood psychiatric conditions

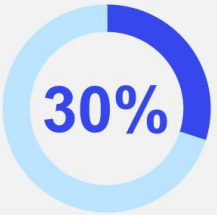
They include:

- Generalised anxiety disorder
- Panic disorder
- Obsessive-compulsive disorder
- Specific phobias
- Social phobia
- Agorophobia

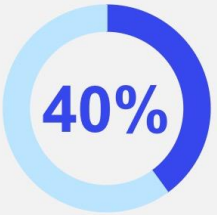
They occur in:

- **2.2%** of 5-10 year olds
- **4.4%** of 11-16 year olds

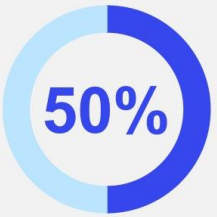
Anxiety disorders are associated with **other mental health** illnesses. Of those with a diagnosis of social anxiety disorder:



have a **mood disorder**



have a **substance misuse disorder**



have another **anxiety disorder**

Anxiety disorders are associated with:

Depression later in life
Suicidal behaviours

Poor educational attainment
Truanting

Lower earnings due to dropping out of school early

Every £1 spent on cognitive behavioural therapy for children returns:

Group therapy

Therapy via parents

Actions to manage anxiety include:

Early intervention

Targeted work with small groups of children to develop problem solving approaches and other skills

Specific approaches

These are dependent on the anxiety disorder and include:

- ✔ Group based cognitive interventions
- ✔ Behaviour focused interventions
- ✔ Education support
- ✔ Play based approaches to develop more positive child/parent relationships
- ✔ Considering medication if therapy alone is not working

Attention deficit hyperactivity disorder (ADHD)

ADHD affects **1.5%** of children aged 5-16 years

Factors that **increase** the **risk** of ADHD include:

Increased risk

Boys — 6.5x

Children with special educational needs — 4x

Living in a home where no parent works — 2x

Living with a lone parent — 2x

ADHD is associated with **poorer outcomes** in later life:

- **Lower educational attainment**
- **Teenage pregnancy**
- **Criminality**
- **Poorer employment** and **lower earnings**
- **Interpersonal difficulties**

ADHD places very **substantial costs** on society

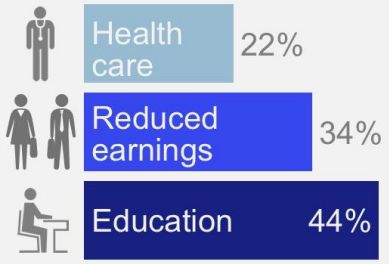
The estimated **annual healthcare costs** associated with the treatment of ADHD in adolescents are

£670 million

Long term costs for every child with ADHD are estimated to be

£102,135

consisting of



The high costs of ADHD support an economic case for **early intervention**

Actions to manage ADHD include:

- ✔ Parenting programmes to give parents the skills and strategies to help their child
- ✔ Behaviour therapy with children to replace behaviours that don't work or cause problems
- ✔ Advice for teachers about how to teach children with ADHD
- ✔ Medication for severe cases

Nearly all parents of children with ADHD seek some form of help because of concerns about their child's mental health, but only a **minority** of children receive **evidence-based** treatment

Conduct disorders

Conduct disorders such as defiance, aggression and anti-social behaviour, affect **5.8%** of children aged 5-16 years. Factors that **increase** the **risk** of conduct disorder include:

Children with conduct disorders are **more likely** to have **poorer** outcomes:

- **2x more likely** to leave school with no qualifications
- **4x more likely** to be drug dependent
- **6x more likely** to die before the age of 30 years
- **20x more likely** to end up in prison

The case for **prevention** of conduct disorders is clear

£5.2 billion
Estimated lifetime costs of a one-year cohort of children with conduct disorder

£60 billion
Estimated costs in England and Wales of crime attributed to adults who had conduct disorders in childhood

Potential savings from each case prevented through early intervention:

Severe: **£150,000**
Moderate: **£75,000**

The **cost** of managing conduct disorders is **very low** relative to the potential benefits

Every **£1** invested in the **early years saves**

Family nurse partnership	£2
Parenting programmes	£2
School based interventions	£27
Whole school anti-bullying interventions	£14

Every **£1** invested in **adolescence saves**

Aggression replacement therapy	£22
Functional family therapy	£14
Multi-systemic therapy	£2

Actions to manage conduct disorder include:

- **Classroom-based** emotional learning and problem-solving programmes
- Group **parent training** programmes
- **Multisystemic therapy** to young people aged 11-17 years
- Do **not** offer pharmacological interventions for the **routine** management
- Develop local **care pathways** between education and healthcare that **promote access** to services

Depression

About **67,600** CYP in England are seriously depressed

7x

Depression is 7x **more** common in **older** children:

5-10 years	**11-16 years**
0.2%	1.4%

Prevalence (%)

Depression is **more common** in girls aged 5-16 years

Prognosis

10% recover by 3 months

40% recover by 1 year

20% recover by 2 years

30% do not recover by 2 years

Depression is caused by a **combination** of **risk factors** including:

Biological
Family history of depression

Family
Lone parent
More than 1 child
Unemployment

Factors intrinsic to the child
Chronic ill health
Disability

Interpersonal
Poor friendships
Being bullied
History of abuse

Psychological
Emotional distress e.g. bereavement
Emotional temperament
High levels of critical self thought

Behavioural therapy to manage depression is **cost effective**, with benefits including:

Higher earnings

Lower costs in the **NHS**

Lower costs in the **education system**

Every £1 spent on cognitive behavioural therapy for children returns:

Group therapy

Individual

Most parents of children with depression seek advice, but **only** about **25%** have contact with a children's mental health service

Actions to manage depression include:

Mild depression

- ✔ Watchful waiting
- ✔ Psychological therapy, if there are no co-morbid conditions or suicidal ideation
- ✔ Referral to tier 2 or 3 CAMHS team if no response after 2-3 months

Moderate or severe depression

- ✔ Review by tier 2 or 3 CAMHS team
- ✔ Individual psychological therapy
- ✔ Consider medication
- ✔ Multidisciplinary review if unresponsive to psychological therapy
- ✔ Consider inpatient treatment if high risk of suicide or self-harm

Eating disorders

Eating disorders, such as anorexia nervosa, bulimia nervosa and eating disorder unspecified, are a group of illnesses that cause a person to have **issues** with their **body weight** and **shape**, which disturbs their everyday **diet** and **attitude to food**

Over **725,000** people in the UK have an eating disorder*

Anorexia nervosa
associated with under-eating

8x more common in girls

16-17 years average age of onset

Bulimia nervosa
associated with binge eating

90 percent affected are female

18-19 years average age of onset

1 in 5 of the most seriously affected will die prematurely

Eating disorders are caused by a **combination** of **risk factors** including:

Biological
Genetic makeup can make some people more vulnerable to eating disorders

Social
Media /cultural pressures

Psychological
Emotional distress e.g. bereavement
Low self esteem
Depression/anxiety

Interpersonal
Troubled relationships
Being bullied
History of abuse

The **physical impacts** of eating disorders include:

- Anxiety, depression, obsessive behaviours
- Changes in hair and skin
- Tooth erosion, dry mouth, tooth decay
- Increase risk of heart failure
- Brittle bones
- Kidney stones, renal failure
- Constipation, diarrhoea, bloating
- Irregular or absent periods, infertility

£16.8 billion
Estimated total annual costs of eating disorders* (comprising treatment costs (NHS and private), costs to sufferers and carers and costs to the economy)

Actions to manage eating disorders include:

Prevention through **school-based peer support** groups

Family therapy

Cognitive-behavioural therapy

Hospital care
Inpatient or outpatient

There is a clear pattern of **delay** in **seeking help** for eating disorders, which in turn **delays diagnosis** and **treatment** creating more **severe** and **long term impacts**

*Estimated total for CYP and adults

Schizophrenia

Schizophrenia represents a **major psychiatric disorder** characterised by **psychotic symptoms** that **alter** the child's **perception, thoughts** and **mood** and **behaviour**

Schizophrenia is **rare** in CYP, the prevalence **increasing** from **age 14** onwards

Childhood schizophrenia affects about

1.6-1.9 children

per 100,000 child population

Symptoms of schizophrenia include:

Positive symptoms
- Hallucinations
- Delusions

Negative symptoms
- Emotional apathy
- Poverty of speech
- Social withdrawal

Schizophrenia is caused by a **combination** of **risk factors**, including:

- **Genetic makeup**
- **Family history** of schizophrenia
- **Birth complications**
- **Emotional distress**
- **History of abuse**
- **Cannabis use** in adolescence

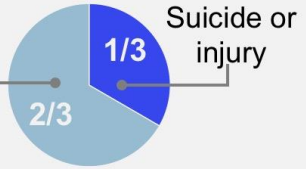
Schizophrenia places very **substantial costs** on society

Every £1 spent on **early intervention psychosis teams** saves **£18**

CYP with schizophrenia have **poorer physical health** than the general population when they get older

Life expectancy is **reduced** by **16-25 years**

Causes of **premature** deaths



Early onset schizophrenia in CYP is associated with **poor long-term outcomes**

Actions to manage schizophrenia include:

- **Exclude** organic causes
- **Antipsychotic medication**
- **Psychoeducational group intervention** for young people with psychosis and their carers
- Help the child or young person to **continue their education**
- Provide a **supported employment programme** for those above school age
- **Discuss** and **plan transition** to adult services

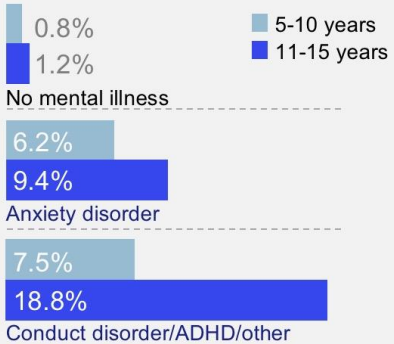
Self-harm and suicide

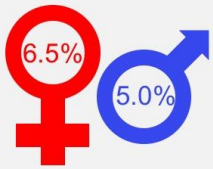
Each year **self-harm** leads to

150,000

attendances at A&E

About **1 in 10** young people will self-harm. The **prevalence** of self-harm varies by **age** and is **more common** in children with mental illness





Girls are **more likely** to report self-harm than boys

The **annual cost** of hospital self-harm **admissions** in England and Wales in 2014-15 was **£40 million**

Risk factors for self-harm include:

Mental health illness
Depression

Family issues
Poverty
Parental criminality
Parental separation or divorce

Being abused

Supporting CYP who self-harm includes:

- ✔ Appropriate medical and surgical care
- ✔ Prevention e.g. building resilience
- ✔ Individual support and/or group counselling

100x

Those who have self-harmed are **100x more likely** than the general population to die by suicide in the following year

149 children aged 10-19 years in England committed **suicide** in 2014, almost **three** children every week

Risk factors include:

Biological
- Family factors e.g. mental health illness or history of suicide
- Long-term conditions

Psychological
- Alcohol or drug abuse
- Bereavement and experience of suicide
- Mental health illness, self-harm and suicidal ideas
- Social isolation

Environmental
- Abuse and neglect Bullying
- Academic pressures

Actions to **reduce suicide** include:

Tailor approaches to **improvements** in mental health

Reduce access to the means of suicide

Support the media in delivering **sensitive approaches** to suicide

Support **research, data collection** and **monitoring**

Provide **better information** and support to those bereaved or affected by suicide

Useful resources

Websites

- www.adhdfoundation.org.uk/main-v1.php
- www.b-eat.co.uk
- www.centreformentalhealth.org.uk
- www.chimat.org.uk/camhs
- www.chimat.org.uk/PIMH_Needs_Assessment
- http://fingertips.phe.orh.uk/profile-group/mental-health/profile/cypmh
- www.chimat.org.uk/camhstool
- www.headmeds.org.uk
- www.local.gov.uk/camhs
- www.mind.org.uk
- www.minded.org.uk
- www.papyrus-uk.org
- www.place2be.org.uk
- www.rcpsych.ac.uk
- www.themix.org.uk
- www.youngminds.org.uk

Useful resources

Reports

- Department of Health, Department of Education (2013) Supporting the health and wellbeing of young carers
- Department of Health (2014) Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence
- Department of Health, Public Health England (2015) Promoting emotional wellbeing and positive mental health of children and young people
- Department of Health and NHS England (2015) Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing
- Local Government Association (2016) Best start in life: Promoting emotional wellbeing and mental health for children and young people
- PHE and Children and Young People's Mental Health Coalition (2015) Promoting children and young people's emotional health and wellbeing: A whole school and college approach
- PHE and UCL Institute of Health Equity (2014) Local action on health inequalities: Building children and young people's resilience in schools
- PHE (2015) Measuring mental wellbeing in children and young people
- PHE and Evidence Based Practice Unit (2016) Measuring and monitoring mental wellbeing – a toolkit for schools and colleges

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- NHS England (2015) Local transformation plans for children and young people's mental health and wellbeing
- NHS England (2016) The five year forward view for mental health
- NHS England (2016) Implementing the five year forward view for mental health

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- Department of Health (2011) No health without mental health

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- Commonwealth of Australia (2012-13) Kids matter: Australian primary school mental health initiative
- Department for Education (2016) Mental health and behaviour in schools: Departmental advice for school staff

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- *10% of children aged 5-16 years suffer from a clinically significant mental health illness*
  Department of Health (2013) Our children deserve better: Prevention pays
- *Percentage of people with lifetime mental illness who experience symptoms in childhood*
  Kessler R, Berglund P, Demler O et al Arch Gen Psychiatry. 2005;62(6):593-602 Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey
- *25% of children who need treatment receive it*
- *60% of looked after children have some form of emotional or mental health illness*
- *Young people in prison are 18x more likely to take their own lives than other of the same age*
  Children and young people's health outcome forum (2012) Report of the children and young people's health outcomes forum – mental health subgroup
- *Boys aged 11-15 years are 1.3x more likely to have a mental illness compared to girls aged 11-15 years*
  Department of Health (2013) Our children deserve better: Prevention pays

References

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