West Sussex Mental Health Needs Assessment (Children and Young People)
July 2014

Background Evidence - Children and Young People

Engagement with children and young people in West Sussex:

"The services need to be advertised more so that more people know where go for help if they feel embarrassed telling someone that they know."

"I just want somewhere where I can go and be me and not get bullied for it."

"They have all helped a lot with support, and they are always there to help if it's needed."

"I'd trust my mum with everything, but I'd feel awkward to talk to my dad about personal subjects."

"CAMHS used to assume I had all these things wrong with me, but it turned out that it wasn't me; it was my environment. Being in care is the best thing that ever happened to me because now I don't have any of these problems."

"I think we should learn more about love than the biology of having sex … they don't know how to communicate and make relationships work. The before and afters are more important."

"It's important to feel like there's someone there for you, who will never leave."

"YMCA was good because I was talking to a complete stranger so I didn't have to worry about what they thought of me."

"I speak to family; always there to listen. I think that is very important to have people to talk to no matter what age you are."

"I would never talk to my teachers about drinking, or taking drugs, or having sex… because I know that my parents would find out and that would be the worst!"

"A bad social worker is one who rarely comes to see you, or when you ask for something to be done, it isn't done, or they let you down; A good social worker is someone who is there for you and doesn't let you down."

"Since year seven, they've been saying 'If you don't do well in school, you won't do well in life'. If someone had just told me when I was younger that it's not all about doing well at school, or having lots of friends, then it would have helped me a lot."

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EXECUTIVE SUMMARY

1. To inform on the Children's Emotional Wellbeing and Mental Health Needs Assessment, engagements were held with young people across the county in the Autumn of 2013. Eight focus groups were held with young people in the community, young people in residential and foster care and current users of CAMHS. In addition, an online survey was developed to capture a wide range of young people's views and opinions. The findings of these two methods of research are summarised in this section of the wider engagement.

Other sections report on the engagements with a range of professionals and with the parents of service users.

2. The main areas of focus, where young people are concerned or worried, were stress and pressures to succeed; peer support and the effects of not having close friends; bullying and the effects this has on wellbeing.

Children and young people reported the levels to which they felt comfortable confiding in parents. Over one third of surveyed young people said they would not talk to their parents about sensitive or high-risk issues, such as sex and sexuality, self-harm, bullying and eating disorders. An equal number said that there was nothing they would not tell their parents. In discussion groups, the effects of having someone in which to confide, be that parents or friends, was seen as the most central factor in being able to deal with emotional problems.

This was especially prevalent with children in foster or residential care, who spoke about the essential need to build long term emotional connections with new families and friends. It was also a priority for those with long term emotional issues or mental disorders or learning difficulties, as they found it harder to establish and maintain close relationships.

It was widely agreed by the young people from this engagement that understanding of mental health and mental disorders/disabilities was lacking and those with a condition received much prejudice from the wider community and children could be made to feel ashamed of their condition or disability.

3. Many young people believed that information and advice should primarily be provided in person, relying on text only for initial signposting of how and when to access this support. Surveyed young people found that speaking to friends, families and professionals had been most likely to help and books, blogs and forums had been least likely to help. Young people suggested that school assemblies and PSHE lessons could be used to promote mental health awareness and available services.

Many of those who could not access the support they needed felt that they either deteriorated or had to learn to internalise their problems.

There were frequent references to concerns over the training and capabilities of the tier 1 and 2 support workers. Effectiveness here was found to be inconsistent. This was highlighted in multiple contexts.

4.   Those who had low self-esteem or feelings of depression highly valued weekly support groups or social clubs. Youth Services were also greatly valued by those who had used them, with 95% of surveyed users saying that it had helped their wellbeing. The benefit they bring, of being able to make new friends and build relationships, was recognised by many of the discussion groups. Community based drop in clinics were discussed as a way to allow young people to access support at short notice.

When asked what was good about support services they had used, most answers referred to being able to talk to someone; that the staff were understanding and informative or that it gave them motivation or confidence. When asked what could have been better, most referred to waiting times; that they wanted more information and alternative services; that communication was poor or that the service did not meet their expectations.

Many past CAMHS users believed that acceptance criteria assess how the child is now, rather than how they will be in the future if they don't get the help they are seeking. – This created resentment as children felt they had to wait to deteriorate before accessing the service they believed they needed all along.

Some past CAMHS users, especially those with eating disorders, have said that acceptance criteria are set far too high for specialist intervention, to the point where the child's health must be at significant risk in order to access specialist support. Some children in care were referred to CAMHS by their school by default, even if the child insisted that they felt fine. This example of potentially inappropriate referrals is discussed in the professionals' engagement report.

5.   Some young people did not feel comfortable accessing support or advice in schools as they were aware that issues, seen as serious by the school, may have to be reported back to their parents. – As a result there were some schools where young people believed there was no one in which they could confide and high risk issues may be underreported. Where pastoral support was available from those in non-teaching roles, some young people said that they felt more comfortable confiding in them.

Commissioning a CAMHS worker to work in a school, for one day a week, was said by a staff member in one school to allow them to streamline the referrals they made and access CAMHS directly. More generally, mental health provision in schools was inconsistent and depended largely on the priorities and capacities of the individual school.

6.   Further reading has informed the broader understanding of these topics and a summary of relevant materials can be viewed at the back of the main document.

1. INTRODUCTION AND TOTAL CATCHMENT:

Eight discussion groups were held with children and young people across the county in the Autumn of 2013; three with secondary school students, two with children in care, one with children with special educational needs and one each with third and fourth tier users. The ages of the children were between eleven and eighteen; with a few outside this range and groups averaged eight young people in each.

Young people at school: Three state-run secondary schools were visited in order to develop an understanding of the emotional and mental health needs of young people in the county. The pupils who attended these groups usually came from school years 8-10. In one school, the young people selected to join the group were chosen because they had experienced some emotional problems, but this was not generally the case with the other groups. Many of the issues raised concerned first tier community and family support, signposting and advice; though other aspects of the CAMHS pathway and more focused support systems were also discussed.

Young people in foster / residential care: Young people in foster or residential care have long been considered to be at greater risk of needing targeted social services than other children in the community. To explore these needs, discussion groups were held with representatives of older looked after children (OLAC), aged 15 to 21 and younger looked after children (YLAC), aged 11 to 15, at their respective children in care council (CICC) meetings. Views on support services and important issues differed between the groups.

Young people with learning disabilities: Manor Green College, Crawley, is a school for young people with a wide range special educational needs. These students were encouraged to discuss their needs and the wider issues that they face. Also present was the organiser of the student council, a teacher at the school, who was able to elaborate on points raised.

CAMHS Anxiety group: A CAMHS-run community group that brought young people with anxiety disorders together for specialist group and individual therapies; both young people and their parents were invited to separately discuss issues surrounding their needs. The parents' group is discussed in the parents' engagement report.

Service users at Chalkhill, Princess Royal Hospital: Current fourth tier service users at the Chalkhill day and inpatient adolescent unit at Princess Royal hospital.

Due to the personalised nature of their treatment or therapy and the time restrictions for the research, individual third tier users were not accessible for the study on a one to one basis, (outside of the Anxiety group discussed above). However, some service users or siblings of service users were in each of the other discussion groups and their experiences were explored in those settings and collated here.

In parallel with this, an online survey was designed by the Public Health Research Unit to access young people via the Your Space youth services web site, *www.yourspacewestsussex.co.uk.* In all, 67 young people responded to the survey. Though it is not representative of all young people, it provides some broad insight into their views. The survey was designed for young people aged seven to twenty years and age-responses outside of this range were not available.

The age and gender of the respondents is summarised below in chart 1, with 22 males and 45 females in total. The responses of the surveyed children and young people tended to differ somewhat to those the discussion groups, regarding needs and issues raised, as they tended to be older and many of the children in the discussion groups were of school age. These differences are discussed where appropriate.

Chart 1, Age and gender of survey respondents
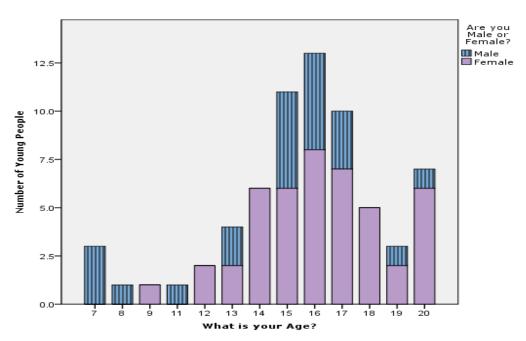

Regarding ethnicity, 85% were white British and 8% were white Irish or White other, with the remainder spread amongst other minorities. Respondents were asked which town they lived in or near and answers are tabled below in table 1. Thirty seven percent of respondents came from Worthing, 9% lived outside the county or did not say and the remaining 54% came from across the county.

Table 1, *"What town do you live in or near?"*	Number & Percentage
Bognor Regis	2 (3%)
Chichester	7 (10%)
Littlehampton/Angmering	4 (6%)
Worthing	25 (37%)
Shoreham/Lancing	5 (8%)
Horsham/Steyning	8 (12%)
Haywards Heath/Burgess Hill	2 (3%)
Crawley	8 (12%)
Outside West Sussex	2 (3%)
Not Stated/Not Clear	4 (6%)
TOTAL	**67 (100%)**

The living situation of the respondents is shown below in table 2, with 10% not providing an answer.

Table 2, *Living situation*	Number & Percentage
I live with my birth mum and dad	24 (36%)
I live with one parent (mum or dad)	17 (25%)
I live with my birth mum/dad & step mum/dad/their partner	11 (16%)
I live with other relatives or carers	<3 (<3%)
I live in foster care	<3 (<3%)
I live in a care home	<3 (<3%)
I live in a children's home	<3 (<3%)
I live somewhere else	3 (4%)
Not Stated/Not Clear	7 (10%)
TOTAL	**67 (100%)**

Key points:

- A Research Unit-designed survey was distributed via the Your Space website, and received 67 responses from young people aged 7-20 years. Of these, 67% were female and 33% were male.

- Eight focus groups were held with young people. Of these, 3 were in secondary schools, 2 with members of the Children in Care Councils, 1 with a CAMHS therapy group, 1 in a special educational needs secondary school and 1 with tier 4 service users.

2. THE WHOLE CHILD AND FAMILY; EMOTIONAL WELLBEING AND MENTAL HEALTH:

2.1 General wellbeing figures:

When asked a series of questions on their general wellbeing, 10% of surveyed young people did not answer and the rest spanned the five point scale as shown in table 3.

Table 3, General wellbeing	Always	Most of the time	Sometime	Not usually	Never	No Answer	TOTAL
I feel happy and content	8 (12%)	17 (25%)	22 (33%)	9 (13%)	4 (6%)	7 (10%)	67 (99%)
I feel confident and able to deal with problems	11 (16%)	12 (18%)	17 (25%)	14 (21%)	6 (9%)	7 (10%)	67 (99%)
I feel that I have good relationships with others	13 (19%)	21 (31%)	14 (21%)	10 (15%)	2 (3%)	7 (10%)	67 (99%)

Of the surveyed young people, 50% said they felt they had good relationships with others most of, or all of the time and 18% said that they never or not usually had good relationships with others. The role of interpersonal relationships and the mutual support received from friendships is discussed in other sections of the report.

In the West Sussex lifestyle survey of fourteen to fifteen year olds (last published in 2010), 3,500 young people responded to similar questions on wellbeing.

Table 4, Lifestyle of 14-15 year olds in West Sussex: 2010	Boys	Girls	Average
I feel I have low self-esteem	10%	25%	18%
I have regular feelings of depression	6%	10%	8%
I have regular feelings of stress	9%	20%	15%
I have been bullied in the last year	19%	18%	19%

The figures in table 4 are notably higher when also considering responses for 'occasional stress or depression'. Additionally, of those who perceived themselves to be 'very overweight', 35% had been bullied in the past year. Wellbeing also correlated with deprivation, with those coming from a Local Neighbourhood Improvement Area (LNIA) scoring worse on all wellbeing indicators shown above.

Though the recent survey had too few respondent numbers to reliably break down by gender, there is a consistent pattern between these survey results and the 'lifestyle survey' figures in table 4, that between roughly ten and twenty percent of young people report considerable wellbeing problems that could elevate to ongoing mental health concerns. Only 34% felt confident and able to deal with problems most of the time or more.

2.2 Factors affecting wellbeing:

Each individual child may have different factors affecting their wellbeing. To ascertain the need young people may have for help, advice and support, they were asked in the survey to identify times when they might have needed help and the degree to which this helped. The most common

responses are included in table 5 below. These included feeling stressed, self-esteem and anxiety, feeling sad (depression), moving schools and bullying. It is possible that the younger children in the discussion groups would have prioritised different responses, e.g. bullying.

Table 5, Important times in your life when you might have needed help, (highest answers)	NEEDED HELP Number & Percentage of all young people replying
If you were feeling stressed (e.g. due to exams)	38 (57%)
If you were feeling anxious or worried	37 (55%)
If you were not feeling good about yourself (self-esteem)	36 (54%)
Moving from primary to secondary school	33 (49%)
If you didn't feel able to cope	32 (48%)
If you were being bullied	31 (46%)
If you were feeling sad a lot of the time	29 (43%)

The wellbeing figures in table 3 were also found to correlate to the number of different issues a young person said they had needed help with. Those with lower wellbeing or less good relationships with others reported more instances where they felt they needed help than those with better wellbeing or more good relationships with others.

2.3 Stress and pressure to succeed:

Highest on the surveyed list of times young people might have needed help was stress, including that felt towards exams. One of the school-based discussion groups said that the education system applies too much pressure to succeed, which can lower the self-worth of those who don't feel like they're going to be as successful as others. For instance, they added, they had sat through an assembly entitled 'Education is the key to opening the door of success.'

"Since year seven, they've been saying 'If you don't do well in school, you won't do well in life'. If someone had just told me when I was younger that it's not all about doing well at school, or having lots of friends, then I think it would have helped me a lot. It seems like they're insisting that success equals happiness and they're not even the same thing!"

Other discussed issues included worries over sexuality and physical appearance (e.g. weight), self-harm, behavioural problems, concerns for family members, troubles with the police and eating disorders were all recognised by the surveyed young people.

2.4 Peer support and moving schools:

Moving schools, from town to town, away from traditional peer groups, was seen by most to be a significant problem for those affected. This may also be a significant problem for those children in care, should they have been moved to a new town and enrolled in a new school.

The lack of an immediately available friend-support network could lower self-esteem and increase psychological isolation. School-based clubs were seen as essential in allowing new students the opportunity to interact with new groups and weave into friendships organically. Towns with large amounts of inward migration of young people should be aware of an increased need at their schools to instigate interaction between young people. In schools, it was suggested that support systems, like the counsellor and school nurse, should personally introduce themselves to the new year-groups or individuals, to ensure that they are familiar to the children if ever needed.

When asked if there was a peer mentoring scheme at their school, 33% of the surveyed young people said 'yes', 13% said 'no' and 31% said they 'did not know'; 22% did not answer the question.

Following this, they were asked if it had been helpful to anyone they knew had it been available at their school:

- Helpful to you? – Nine said yes, (13%)
- Helpful for your friends? – Seven said yes, (10%)
- Helpful for other people at school? - Twelve said yes, (18%)

Only one of the three discussion groups based in a standard secondary school mentioned knowing about a formal peer mentoring scheme, but they did not know of anyone who had used the scheme. Though it was not discussed specifically, all three groups talked about the importance of friends and how not having them would make any problems worse.

2.5 Bullying:

Bullying was seen as a common cause of poor emotional wellbeing and being singled out as different, for any reason could incite such behaviour and exacerbate any issues that the victim may be experiencing. The young people who participated in our discussion groups believed that bullying is inevitable in schools. Of the surveyed young people, 46% said that they had needed help with bullying and it was one of the most widely discussed issues affecting young people in the discussion groups, with many varying reflections.

Though there are many reasons for children to bully one another, the groups believed that those who do so lack the understanding that what they are doing is wrong and that they are causing distress and misery for other people. Mainly, the young people believed to be a method for one individual (the bully) to elevate the way they feel about themselves, or their social standing, by displaying that they are above another individual who becomes victimised as a result. *Further insights to this are available in the further reading section of the report.*

The effect of such bullying can have severe consequences for the wellbeing of young people.

"My sister has a mental health issue and it was mainly caused by bullying. She told the year heads but it kept continuing and she developed anorexia because she thought she was fat and with other things, everything just got on top of her"

Verbal bullying was believed by the groups to not be taken seriously enough by the schools, even though it had the same effect on the victim. The West Sussex Lifestyles survey, 2010 reported that 81% of bullying was verbally-based, rather than physical. Though most schools have systems in place to prevent bullying, the children believed that there are many cases that go unreported. This may be due to issues of self-esteem or a fear of the victim's confidentiality. One child said that in their school "there's no one that you can completely trust to be confidential; even the most sensitive things will still go back to other teachers and you know you'll be talked about." This is a widely agreed upon issue, with other children saying that "it's really embarrassing; going up to a teacher and telling them, because they can act the same, but deep down you always know that in every lesson that teacher would know all these things about you". This suggests that some young people do not feel comfortable approaching teachers for pastoral support, due to the cross over into other roles.

In a school where non-teaching pastoral managers were employed, the discussion group reported that they felt able to fully trust the adults, in confidence, with any issue they might have and preferred this to confiding in their peers because they knew that "they would really listen and not try to just tell you their problems too".

Counselling can be offered to victims of bullying if needed, though one child reported that these methods were less effective than intended:

"When I was bullied, I went to counselling and that just made me feel worse, because I was aware of what they were doing and I just felt patronised. I stopped going because it wasn't helping"

On occasion, the children in our discussion groups suggested that punishments for bullies were inappropriate for the severity of their actions:

"Let's say I'm late in the morning; I get a detention. But it's the same detention that I would get if I was bullying someone, so the punishments are equalising the two things in the mind of the bully"

Other children suggested that getting the bully's parents in and explaining what their child had been doing would help, due to the weight a parent can have on getting through to their child. Another believed that "isolation was the best punishment, because bullies tend to be extroverted and isolation would take that social energy away from them".

The children from the anxiety therapy group said that they had troubles managing their anger and frustration. In addition to coping with anxieties, the main problem reported was not with being anxious, but needing an outlet for, or skills in coping with, frustrations, which can be caused by bullying, amongst other things. The children talked about how they felt isolated and alone and wished that they could spend more time with those who had a similar disorder, because this allowed them to feel less stigmatised; bullying played a large part of their lives and had lowered their self-esteem.

"I just want somewhere where I can go and be me and not get bullied for it"

Though there are many views on bullying, what causes it and what can be done, its presence in schools today is something that all young people in our discussion groups had experienced either directly or indirectly and the consequences of this can be damaging.

2.6 Concerning children in care:

When asked about issues that can affect their wellbeing, one of the younger children said that "those in care can usually put up with more than other kids, because they've already been through a lot of problems already"; though they admitted that this is not a truism for all children. Their belief was that "having to deal with change" made them more resilient, after the initial shock had worn off.

What was essential to their wellbeing was their trust in being able to develop meaningful, long-term relationships.

"It's important to feel like there's someone there for you, who will never leave"

The children explained that those who feel anxiety or depression often feel a lack of confidence and this is what prevents them from seeking advice or support.

The older group, in the later stages of adolescence, felt more independent. They explained how they didn't have any needs that were different to 'every day' young people.

2.7 Wider Family Support:

Though the family would always be an ideal place to raise concerns, problems or issues, the children were asked if there were any issues that they might not speak to their parents about. Often they would be more willing to speak to one parent over the other, depending on the issue and the relationship they had with them. Some children did not feel comfortable talking to their parents about any personal issues.

One group discussed how some of them would hide serious issues from their parents, to avoid disrupting the family and upsetting them.

"You don't want your parents to know because they'll think it's their fault; that they've failed you and that guilt just goes back on to you and makes it worse"

The survey respondents were asked if there were any issues that they would not talk to their parents or carers about and six males and twenty three females (43% of respondents) provided an answer.

Most commonly, over a third of those answering said that they would not talk to parents about high-risk or sensitive issues, such as depression, sex and sexuality, eating disorders, suicidal thoughts, self-harm, mental health, bullying and problems with the police.

Next most commonly mentioned were personal issues, such as relationships friends, family issues, and school-stress. A similar number to these, however, said that there was nothing that they would not tell their parents, though some did specify that they would not be so open with their fathers.

Two respondents said that they would not talk to their parents about anything, at all.

There is the potential, therefore, that young people will not necessarily seek out their parents if they have a serious problem and a trusted alternative may need to be available for them to prevent serious problems deteriorating further.

2.8 Children with Special Educational Needs:

Manor Green is a school for young people with a wide range special educational needs. Though it is not the only such school in the county, children are transported to the school each day, from as far away as Worthing (30 miles).

The students at this school have a high need to develop social and emotional skills and much time is spent on encouraging them to talk about themselves and their feelings. The aim is to enable these young people to be less dependent on support, when they move into adulthood and be better able to engage with their community. Older children will spend much of their time at school furthering their independence, including cooking lessons to develop home skills and understand nutrition.

It was mentioned by support staff that placing these children together in higher needs schools raises their self-esteem and confidence as they are able to succeed at their own level, rather than attempting integration with mainstream colleges, where more emphasis is placed on academic achievement and conformity can be difficult. The children in the discussion groups spoke often of how happy they were in the school and one used the term 'like a second family' often.

The school has various schemes in place to allow children to interact with people and services in their community, from bowling, swimming and golf, to theatres and dance clubs. These weekly activities were currently in decline, as funding for transport was unable to meet the need.

The children were able to detect levels of stress in their own homes and acknowledged that their parents might need time away from them to develop relationships with their siblings. Facilities for this do exist, in children's hospice centres, such as Chestnut Tree House, in Arundel. This facility was widely praised by all those who had been involved with it.

Key points:

- Each child may have different factors affecting their wellbeing. The most commonly reported issues were feeling stressed, low self-esteem, anxiety, depression, moving schools and bullying.

- The differences between issues of focus, between the discussion groups and the surveyed groups may be explained by the average ages of those involved. Younger children in the discussion groups would perhaps face bullying more often and older children, who may have likely already left school, faced more problems, such as low self-esteem and high stress and anxiety.

- Stress (e.g. due to exams), was the highest ranked issues for which young people sought help. The pressure to succeed was generally discussed in a negative, rather than a positive context.

- Most young people were aware of bullying in schools and 46% of surveyed young people said that they needed help with it at some point; 80% of bullying was verbally based and young people believed that schools do not take it seriously enough. Bullying is linked to serious wellbeing issues.

- Reliance on peers for maintaining wellbeing and avoiding psychological isolation is important and those moving schools may lose their usual peer support. – Areas of a high inward migration of young people may require more school and community-based support programmes.

- Children in care described the need to have faith in building long term emotional connections with new families and friends and wish to be treated in the same way as other young people.

- The needs of those in care changes with age, with older children seeking independence from usual targeted support systems.

- Some young people did not feel comfortable raising concerns with parents or carers, especially high risk issues such as sexual relationships, mental health, bullying or self-harm. Some did not wish to talk to their parents about any personal issues at all.

- Those with learning disabilities spend a greater proportion of their time in school developing social and emotional skills, than other young people, which allow them to improve and develop interpersonal relationships.

- It was widely agreed that understanding of mental health and mental disorders/disabilities is lacking and young people can receive prejudice from the wider public and can be made to feel ashamed of their condition or disability.

3. AWARENESS/ACCESS TO ADVICE/TRAINING:

3.1 Access to information, education and signposting:

Education on homosexuality was believed to be poorly delivered by one of the groups. The students explained that they receive formal lessons on sexual education and sexual health, but, - at a later age, - they receive separate lessons on homosexuality, the distinction of which differentiated the two. Students believed that the message they were supposed to take from this was that 'heterosexual relationships were normal behaviour and homosexuality was something apart from normal behaviour'. The group suggested that all sexual activity should be discussed at the same time in the same context.

"When you think of sexual education, you should think of all of it; not just as normal sex and gay sex"

Other related concerns were the focus on the sexual act/health, without knowing about the surrounding contexts of sexual and emotional relationships. They said that young people are new to sexual relationships and guidance through these early formative years would save them from a lot of emotional pressures and apprehensions.

"I think we should learn more about love than the biology of having sex. Anyone can be told how to penetrate someone, but they don't know how to communicate and make relationships work. The before and afters are more important"

The OLAC group discussed how printed information, such as leaflets and booklets can be good methods of wide coverage, but they insisted that, with everyone's individualised problems, printed text should be viewed as an initiating resource to further advice, rather than as adequate information in their own right.

School assemblies were considered by one of the school groups to be the best place to promote support services and signpost entire year groups to services that they may need in the future; providing them with the knowledge of where to go before they felt distressed and in need. This coupled with the consensus that "raising awareness should be done by people."

"I don't agree with everything being in writing. If you see some poster on the wall, you don't care about that do you? - Especially if it's in a corridor. Assemblies are the best place to get information out to children. That's more real than if it's just in writing on a leaflet"

"In the six years I've been here I can only think of two assemblies that have covered who I can go and talk to; what the procedures are and that sort of stuff."

There is a language barrier for some immigrants and foreign young people seeking advice or support in the health care system. Two of those at the older CICC discussion group spoke English as a second language and spoke of how they had felt isolated from support systems. Without a clear understanding of English, they were less able to navigate the systems in place as well as a fluent English speaker.

In schools where the students chose to access a pastoral manager, they could access personal support and further signposting, with follow-up conversations common-place to support the child after the initial discussions.

All young people believed there was a lack of awareness in schools and in the wider public sphere, regarding mental health disorders and emotional wellbeing. As well as assemblies, PSHE lessons were considered to be the best place to focus on these issues and educate the entire school, as a lack of understanding can lead to harassment, ridicule and discrimination.

The surveyed young people were asked a question on different methods of accessing information or advice, shown below in Table 6. The table shows that, of those who answered (roughly half did not answer), the most commonly used methods were speaking to a professional, searching on the internet, or speaking to friends or family members. Speaking to friends produced the highest responses for 'Helped a lot' and searching the internet was most likely to 'help a little'. One in three of those who supplied an answer (18% of all respondents) said that speaking to family members did not help them. When given the opportunity to leave a comment at the back of the survey, two of the ten comments made spoke of frustration in not knowing how or where to access information or services.

Table 6, If you were worried about something or needed help, how useful were the following methods in getting more information?				
How did you get information: [...number who used this method]	**How useful was it:**			
	Helped a LOT	Helped a LITTLE	Did NOT help	**Not Answered**
Spoke to friends [36/67]	19 (28%)	12 (18%)	5 (8%)	**31 (46%)**
Searched on the internet [39/67]	13 (19%)	20 (30%)	6 (9%)	**28 (42%)**
Spoke to a professional [39/67] (E.g. GP, nurse, social worker, school staff)	15 (22%)	13 (19%)	11 (16%)	**28 (42%)**
Spoke to family [37/67]	14 (21%)	11 (16%)	12 (18%)	**30 (45%)**
Read a blog [30/67]	5 (8%)	13 (19%)	12 (18%)	**37 (55%)**
Read books [28/67]	4 (6%)	9 (13%)	15 (22%)	**39 (58%)**
Used a forum [29/67]	3 (4%)	9 (13%)	17 (25%)	**38 (57%)**
Other, please say how: Jellyfish and Arts Award – helped a lot Talked to Youth Worker at Arts Award Youth Worker at (Name of Centre given) School CAMHS - didn't help I couldn't access anything				

The respondents were then asked if there was room for improvement to make it easier to obtain information, with varying results (Table 7)

Table 7, Could there have been an easier way to find out information?	Number & Percentage replying
Yes	13 (19%)
No	14 (21%)
Not sure	25 (37%)
Not answered	15 (22%)
TOTAL	67 (99%)

The following suggestions were made by respondents:

- *Making it a common knowledge subject so that I would have known the information I needed before it became an issue.*

- *Was never told during school where to go to get help. Mental health and wellbeing was never spoken about at school.*

- *More information on help.*

- *More information on websites about mental health and being a young carer.*

- *Social media professionals on topic.*

- *Counsellor so I can talk about my problems*

- *Having spoken to (name given) who had been through the same thing*

- *Leaflets*

- *Not being in fear of reprimand*

- *Talking to GP or doctor with parents there or knowing about you being there on your own*

As a follow-up question, the young people were asked what they did, if they had needed help, but were unable to access it; 29 young people gave an answer, though two were unsure or unclear.

Roughly a third answered that they had to "*Learn to/try to ignore it*", or "*deal with it*" themselves. One of these commented on how they "*thought that there was nothing that could have been done about it, due to the lack of promotion of mental health in secondary school*".

Another third said that that they felt they deteriorated, including responses that "*I felt really worried and upset, also felt heartbroken*"; "*I kept people from getting close to me*"; "*I let it get worse without telling anyone*"; "*Self-harmed*" and "*Lost control*".

The remainder said that they sought out other help, including speaking to a family member, or the youth organisation and two specifically mentioned the need for arts or activities.

3.2 Young people's views on training:

The OLAC group suggested that resources be put into the foster and residential care facilities and training for carers. They felt that their carers would be able to guide them through any problems that they had, so long as they could access information for signposting. There was a general feeling that facilities were often low in funding and this led to the group believing that health and social care workers were being commissioned with resources that could be more effectively used to support them.

School counsellors were believed by both CICC groups to be inconsistent in their skill base and there was a concern that no one monitors or looks into their performance, as in nearly all instances their work was behind closed doors and confidential.

Some higher level service users raised issues surrounding concerns over support staff training, as where professionals were seen as highly skilled, supporting staff were seen to not fully understand the subtleties required to handle sensitive conditions. An advocacy service for these service users had been commissioned at the time of the engagement. However, when asked if they felt there was anyone available to them with whom they felt they could raise concerns, the group in question said "*no*". This has also highlighted a need for clearer advocacy channels for all service users to feedback any concerns they may have.

Key points:

- One group expressed serious concerns over the distinction between hetero and homosexual relationships in school-based sexual education. They said that by teaching homosexuality separately at later ages, it can create an impression of being something other than normal behaviour in the minds of the children.

- Generally the groups agreed that information and advice is best conveyed by a person, rather than in printed form (e.g. a poster in a corridor), to make information relevant to the individual and make sure that it is heard.

- School assemblies and PSHE lessons could be utilised to introduce mental health and wellbeing support issues and raise awareness. It is believed by all groups that public awareness is lacking, which leads to discrimination.

- There is a language barrier for non-English speaking young people. This can inhibit access to information and support services.

- When the surveyed group were asked about times they sought out information, speaking to friends was most likely to help a lot. – Reading books, blogs or forums were least likely to help.

- Most of those who were unable to access help or support either had to learn to ignore their problems or noticed that they ended up getting worse.

- The Older Children in Care group suggested that more resource be put into training and access to information for residential and foster carers, as they preferred to speak with their carers for advice and support when they felt they needed it.

- There was a concern by some that counselling support through schools is inconsistent and unmonitored, as students can leave sessions feeling no benefit what so ever.

- Some service users raised concerns over the training of support staff as where professionals were seen as highly skilled, supporting staff were seen to not fully understand the subtleties required to handle sensitive conditions. - When asked if they felt there was anyone available to them with whom they felt they could raise concerns, the group said "no".

4. CAMHS / INTERAGENCY WORKING / APPROACHES TO WORKING:

4.1 Non-CAMH services in the community:

For out-of-school support, one group said that the Samaritans were very useful and other volunteer-based counselling was very appealing due to the anonymity it provided. Only one of the children had used the service directly, but the group did agree that anonymity was an important factor.

The Anxiety group discussed how the therapy sessions allowed them to interact with peers of a similar condition which built their confidence and resolve. They may also make friends with other children in the group. Some of the children wanted depression groups to be available to them as well, in order to cope with their feelings.

Weekly activities allowed them a regular event in the future on which to focus their optimism and were highlighted as essential to their wellbeing, they said. One child gave an example of a local group funded by the Lottery Trust, but funding had since been cut and this left him with little to engage with in his life outside of the house.

"Now that they've stopped, I haven't got anything to look forward to anymore"

The group mentioned the need for family therapies and respite for both the child and the family. Everyday frustrations could develop into serious stresses in a family's life without emotional outlets and professional guidance to resolve issues. Weekly activities and social clubs were a good opportunity for this, although these services have now reduced.

The group discussed the need for community-based services which allowed them to 'drop-in' and talk about their feelings. They felt that sometimes they feel increased depression and at a moment's notice would want to speak to someone about this in their local area, without having to travel to other towns.

The surveyed young people were shown a list of services known to be available to them in West Sussex, though not necessarily locally. Table 8 shows the numbers who had used each service (n=67)

Table 8, Services which can aid emotional wellbeing. If you used these services, did they help you?	Used Service	If you used the service, what difference did it make:		
		Helped a LOT	Helped a LITTLE	Did NOT help
Youth Services	22	10 (45%)	11 (50%)	1 (5%)
Child and Adolescent Mental Health Service (CAMHS)	17	4 (24%)	8 (47%)	5 (29%)
School Counselling Service	14	4 (29%)	5 (36%)	5 (36%)
Counselling arranged through your GP	10	4 (40%)	2 (20%)	4 (40%)
School Nurse	12	3 (25%)	3 (25%)	6 (50%)
General Social Work Services for Children and Young People	9	6 (67%)	2 (22%)	1 (11%)
Voluntary Sector Counselling (eg. YMCA, MIND)	9	5 (55%)	2 (22%)	2 (22%)
Social Work Mental Health Team	7	2 (29%)	2 (29%)	3 (42%)
WORTH Emotional Support Service (Counselling where there is domestic abuse)	4	2 (50%)	-	2 (50%)
Intensive Specialist Care (eg. Chalkhill, Eating Disorders Team)	5	1 (20%)	2 (40%)	2 (40%)
Youth Offending Team	3	2 (67%)	1 (33%)	-
Horsham Learning Assessment and Neurocare Centre	3	-	1 (33%)	2 (67%)

The largest group of young people had used Youth Services with over 95% saying that it had helped them. The next most common service accessed was CAMHS, where 29% said that it did not help, 47% said it helped a little and 24% said it had helped a lot.

Nearly a quarter of respondents had accessed school counselling, though opinions on the use of this service were equally divided, with one in three saying it did not help them at all. A similar pattern was seen in counselling arranged by their GP.

When asked in a follow-up question what they thought was good about the services they had accessed, 25 young people gave an answer.

The most common response, with over a third, was to say that they appreciated being able to talk with someone, saying that *"YMCA was good because I was talking to a complete stranger so I didn't have to worry about what they thought of me"* and *"I could tell someone how I was feeling and not keep it all bottled up".*

Another third said that they found the staff to be supportive, understanding, informative or helpful; "They helped a lot with support, and they are always there to help if it's needed". Further to this

were some comments describing how the service motivated them, or gave them confidence; that it was fun and exciting, or just made them "feel okay".

Other comments referenced specifically that they were given information about other services, or therapeutic strategies to help themselves and the rest were split between those who thought that 'everything' was good and those who thought that 'nothing' was good.

When asked what could have been better about the services they had accessed, 19 young people gave an answer, with multiple themes mentioned.

The comments made covered the following areas:

- Waiting times and accessibility to the service were poor.
- One answered simply with *"CAMHS"*
- More information could be offered on mental health and on available / alternative services.
- Poor communication, between the different services and between the provider and themselves.
- Inadequate services, desiring more sessions, or in one case that "*they could have actually dealt with my problems, not just ignoring me until I got worse*"

Some said, however, that it couldn't have been any better, with one of these explaining that "it's not that it could be better it just didn't work for me."

Two gave fuller explanations of why they were unhappy, inserted below:

"I was messed around with meetings and times and not given a meeting with people for ages and then saw a different person to the original. Organisation of meetings and communication could have been better."

"GP service very patronising and said I had "typical teenage problems" even though was a young carer and later diagnosed with depression followed by eating disorder and bipolar. Never got referred to CAMHS. - Better links in schools and peer mentoring."

4.2 Social workers and LAC support services:

The role of the social worker was a strong topic of discussion for both CICC groups and both groups agreed that there were inconsistencies in the effectiveness of the individual social worker.

"I've had more bad social workers than I've had good social workers; Out of the ten that I've had, I've only had maybe two good ones."

"Some are good and some are a waste of time and resources"

When asked what makes a good or bad social worker in their eyes, the groups were consistent in their responses, not giving anecdotal stories, but speaking generally.

"A bad social worker is one who rarely comes to see you, or when you ask for something to be done, it isn't done, or they let you down; A good social worker is someone who is there for you and doesn't let you down"

The groups did admit that the needs of a child changed over time and that this should be reflected in the efforts of the social worker. A younger child was seen to need less direct intervention, as their needs could be met by their carers, whereas older children would need more guidance in finding employment and moving out into independence.

Some of the children had more than one current social worker, who shared their duties and the children believed that it was much better to have just one focused worker. Though some of the children would talk to their social workers about their problems, they would usually prefer to confide in their foster carers.

In addition to this, was a consensus from the OLAC that employing additional workers, such as LAC nurses and social workers went against the principles they were striving towards; that they were no different to those living with traditional parents and that they were as strong or capable as other young people. They felt this was a fundamental contradiction and suggested that resources should go into the residential facilities or foster carers themselves. The OLAC felt that the resource was wasted and if they had a medical concern they would access their GP, via the normal route. The YLAC found this support to be beneficial, however and they appreciated the opportunity to discuss health-related issues.

4.3 The collected views of third tier CAMHS services:

Young peoples' experiences of tier three CAMHS are mainly similar to those of the parents' discussion groups. Those whom it had helped spoke very positively of the resource, especially those from the Anxiety therapy group, discussed earlier.

There is a view from young people that CAMHS had a referral criteria set to register the child's current needs and are not mindful enough of how they may develop. Often, the service users in discussion groups described seeking support, only to be told that their illness or need was not serious enough. If they then deteriorated over time, they were then able to access the support; contrary to focusing on prevention and early intervention.

Standard treatments were said to revolve around talking therapies, which were seen as low impact and slow to develop. Little range of support was offered and most young people's experience of their tier three service was of scheduled talking therapies. These therapies could sometimes go on for months or years without marked signs of improvement. If the child deteriorated, they would then be given intensive intervention from a fourth tier service.

Some young people gave examples of how their (or a relative's) efforts to receive the help they needed resulted in inadequate responses from third tier services.

"I was first taken to the doctors by my mum, because I was self-harming due to depression. My doctor, at the first appointment was really lovely and got me appointments to CAMHS, but I was put

in hospital two days before my appointment and they said, 'sorry, we're a tier 3 service and your needs aren't serious enough for us to deal with...' They did offer therapy, but we knew I needed more than that, so my grandparents ended up having to pay for private psychiatrists at the Priory in Southampton, who've been amazing."

One young person explained how her sister was offered support, but too little and too late, which allowed her to deteriorate and was eventually referred to Chalkhill as an inpatient to recover from the effects of her eating disorder.

"When my sister told my mum that she might be anorexic, my mum tried to get help – this was in February and my sister had been in and out of hospital – and they didn't actually get back in touch to help her until April. If she'd had therapy sooner, I don't think she would have ended up in the place she was, in Chalkhill."

Some young people were critical of the use of GPs as gatekeepers as this only makes the process more confusing and takes up the time of all parties. They commented on how there are really two referrals to get through to see the professional you wanted to see: "A doctor assesses you and refers you to CAMHS, who then assess you and refer you to a specialist!" Direct access to a specialist, who could either accept you or signpost you onwards, was preferable to these young people.

4.4 Regarding children in care:

Young people from the CICC discussion groups commented on how they are referred to CAMHS, almost by default, just because they are in care. One child was referred by their Social Worker, though they did not understand why, because the Social Worker never told them. Another was (in their eyes) referred by the school, just because they were a child in care. The child had insisted that they felt fine, but the school referred them anyway; just in case they had any unidentified problems. – The child said they went for one month and stopped going, because it was a waste of time.

A third child alluded to the difference between genuine mental health illnesses and those symptoms that are caused by environmental strains. They said that their repeated referrals to CAMHS were inappropriate because it was their home environment that was causing them the distress. They were offered medication which, after talking with parents, they decided not to accept.

"CAMHS used to assume I had all these things wrong with me, but it turned out that it wasn't me; it was my environment. Being in care is the best thing that ever happened to me because now I don't have any of these problems – I don't think that after two hours you can really know a person and offer them drugs."

4.5 Referrals from tier three to four; process and accessibility:

Many of the young people at the Chalkhill inpatient unit (Tier 4) were past or present CAMHS users, who had deteriorated to the level of needing inpatient care.

- It should be noted that much of what was discussed was from the viewpoints of young people who felt that CAMHS had let them down and failed to help or support them and that, in their eyes, their very being at Chalkhill was enough to confirm these views. -

Children were often referred directly to Chalkhill from their local hospital or community service at short notice, due to the identified high risk to their wellbeing. They often had little to no knowledge of the facility beforehand.

Those admitted with an eating disorder may have been involved with the Family Eating Disorders team (FEDs) beforehand. The group had appreciated these attempts to help them, but believed that the diet and physical activity programmes given to them could be easily ignored which just delays hospitalisation. The group felt that their hopes of getting better had been unfairly raised by the FEDs programme.

"They made us think it was really going to help; like we weren't going into hospital because of it"

"They said, 'you can either go to hospital or you can do FEDs' and I thought, well I'm not going to hospital. So I just took the long route here"

A comment was also left at the end of one of the completed surveys, talking about the frustration felt with support for eating disorders:

"If you have an eating disorder you get no support unless you're on your death bed, even if you have been extremely underweight in the past. They tell you you're not thin enough or ill enough and just ignore you."

The group believed that the support they received at tier 3 had been inadequate, with their needs unrecognised and untreated; that if they had received the help that they wanted all along, they might not have ended up an inpatient. They felt that little alternative to talking therapies were offered and, due to the CAMHS system of prioritising high-risk cases, they had built up feelings of resentment for the months or years of talking therapies, only to be followed by heavily focused and reactive care once they had been hospitalised; the help was available all along, but they weren't yet ill enough to access it.

"With CAMHS, it feels like you have to be dying before someone actually does something"

The group felt that their tier 3 therapies were aimless and described their confusion regarding outcomes and what they were meant to achieve. They all felt that actually knowing what they were working towards and when this might happen would have given them something clear on which to focus their efforts.

"It's good to know what we're working towards [now], but the first person I saw, you're just sat there… I think it's a waste of a year, because I didn't know what I was meant to be doing"

4.6 Inpatient Experiences at Chalkhill:

The group thought that the mental health specialists were very effective and they spoke very highly of the professional support provided. The group felt, however, that they were not adequately involved in the planning of their ongoing treatments. The review process was said to usually be conducted without the child's involvement and the child is brought in afterwards to be informed of what the staff had decided for them.

"I find my review is completely useless. They sat in there for an hour talking about me and I came in for five minutes. They told me I was having double snacks; I started crying and they said "we'll end it here because it's too distressing for her". I didn't get to say anything…"

The inpatients received schooling during regular term time, of which the group members were very fond. They had good relationships with their teachers and spoke highly of them. During holiday weeks, however, the school did not operate and this left the inpatients with little to occupy their time. They ended up bored and restless, describing weeks of "just sitting around" in the summer holidays. Activities were planned, but were frequently cancelled.

"In Summer we did nothing. We had a timetable of arranged activities but we didn't do any of them. It was horrible; they never bothered to do anything with us, we just sat there like all day"

The group discussed how they were always encouraged to seek out assistance if they were unhappy or had a complaint, but they felt unable to do so, as their relationships with the support staff were often not good enough to give them the confidence to raise issues. Because of this, the young people in the discussion group felt that many of their concerns went unmentioned and, as a result, unaddressed.

4.7 Placement issues and discharge practices:

West Sussex children were not always initially placed at Chalkhill but were sometimes sent to other NHS England facilities, around the country. A high demand for beds can mean that young people were left waiting whilst beds are sought out by local healthcare professionals.

The children, feeling safe at Chalkhill, sometimes believed that the facility was under pressure to move them on as soon as possible. They were not sure for how long they would be there, which created feelings of anxiety and uncertainty.

"They say if you self-harm in here they'll discharge you because you're not cooperating with your treatment, but then if you don't self-harm in here they'll discharge you because they say you're better. So you can't really win."

Going home on temporary leave or being discharged from inpatient care could be distressing for some young people and when leaving the 24/7 support of inpatient facilities they described feeling unsafe and not confident enough to contact specialists for support, though they are always invited to do so. Children reported not wanting to be a "burden", or not feeling that they are "important enough" to trouble the staff with their problems.

Children could also be discharged at short notice, which didn't allow them the time to prepare themselves for the coming change in support.

"A girl only found out a couple of hours before she was getting moved into a new house and that was horrible; another girl was told that she was going home to a foster family on Monday that she'd never met before. You need time to take it in."

Coupled with the need for support whilst on leave, ongoing care was said to be lacking, once a child has been discharged from inpatient care. A young girl from one of the other discussion groups had a sister, who was admitted to Chalkhill for her eating disorder after she had collapsed and she spoke of how the family had been left without any meaningful support after her sister was discharged.

"She's still got a tube in, but they've just left us to our own devices, because they thought my mum was capable. My mum's had to cope with her for a few months on her own; not knowing what to do and she was the one who had to get in touch with other people. No one was getting in touch with her to try and give support for my sister. No one's been around to check up on her, at all."

Key points:

- Helplines like the Samaritans were valued as methods of obtaining confidential and anonymous support.

- Those who had low self-esteem, anxiety or feelings of depression highly value weekly support groups or social clubs as without these some may not have anything to look forward to in their daily lives.

- Community based drop in clinics were discussed as a way to allow young people to access support at short notice.

- Youth Services were greatly valued by those who had used them, with 95% saying that it had helped their wellbeing.

- Of the surveyed group, 71% of those whom had accessed CAMHS said that it had helped, either a little or a lot.

- When asked what was good about support services they had used, most answers referred to being able to talk to someone, that the staff were understanding and informative or that it gave them motivation or confidence.

- When asked what could have been better, most answered referring to waiting times, that they wanted more information and alternative services, that communication was poor or that the service did not meet their expectations.

- Support offered by social workers was viewed as inconsistent, with some children in care reporting that they'd had more bad social workers than good. One child summarised that *"A good social worker is someone who is there for you and doesn't let you down".*

- Older children in care do not value extra targeted support services as they are more independent and feel that additional support counters their drives to have a normal life. Younger children in care did value this support, when asked.

- Some children in care were referred to CAMHS by their school by default, even if the child insisted that they feel fine.

- Many past CAMHS users believed that acceptance criteria assessed how the child is now, rather than how they will be in the future if they don't get the help they are seeking. – This created resentment as children felt they had to wait to deteriorate before accessing the service they believed they needed all along.

- Often, young people perceived there to be at least *two referrals* to get to CAMHS; one from the GP and the next from the CAMHS workers, before getting an appointment for support.

- Those with eating disorders had said that acceptance criteria are set far too high for specialist intervention, to the point where the child's health must be at serious risk to access support; *"With CAMHS it feels like you have to be dying before someone actually does something"*

- Inpatients at Chalkhill had said that they were often bored and restless and lack activities to occupy themselves with, when there is no school during holiday weeks.

- Going home on leave could be distressing for inpatients who go from 24/7 support and safety to home environments. Patients often lacked the confidence to seek support when they needed it, even though they were invited to do so.

5. RESOURCE / CAPACITY ISSUES:

5.1 School support services and facilities:

Manor Green College, for those with special educational needs, employed speech therapists, counsellors, nurses, teaching assistants and other support staff on site. Staff there said that the counsellors were heavily oversubscribed and work straight through, each day, even seeing children during lunch breaks, to accommodate demand.

The teachers said that the children of the school were missing facilities that could benefit the children's wellbeing and this was considered to be due to inadequate resources. The children of the student council had previously petitioned the school to purchase specialist playground equipment for physically disabled children, so they could expel energy at break times, which the school was currently unable to afford. Additionally, when children became disruptive and needed to be restrained by the staff, they were currently dealt with in the corridors, sometimes in view of other children, because they lacked the resources necessary for small, individual, 'Time out' rooms to be available at all times. Some children in the discussion group reported feeling nervous being around unpredictable class mates.

The school referenced cases where children with higher level needs, for which they cannot cater, were placed in residential care in other counties for high sums of money each year. They suggested that access to these funds would allow them to develop their own facilities and keep the child closer to their families and home.

5.2 CAMHS therapy groups:

Though the children involved in the Anxiety group had nothing but praise for the sessions, it became apparent that the environment was not appropriate for the intended therapy. One child, who was wheelchair-bound, felt let down because the only wheelchair access was via a service elevator on the other side of the hospital. Car parking capacities at the hospital were also overstretched during the evening sessions.

The CAMHS facilities themselves where not believed to be conducive to a relaxing environment for children and were thought to be too clinical. The walls were plain beige; the florescent lights were very bright and children were required to lie down on the old office carpet for their therapies. These conditions were believed to need updating in order to be suitable for therapeutic anxiety treatments.

The group's organisers said that it was only a short-term project and they had no indication of whether or not the Anxiety therapy group would still be running into 2014.

Key points:

- Professionals said that the special school lacks funding for facilities that could be beneficial to the young people's wellbeing, such as time out rooms and play equipment for physically disabled children.

- Service users of the CAMHS therapy group had high praise for the sessions, but believed that disabled access was poor and that parking was a problem for those travelling many miles.

- Additionally the offices used were considered by children and staff to not be suitable for effective treatment of anxiety disorders, with harsh lighting and sterile environments.

6. MODELS / STRUCTURES / GAPS:

6.1 How much the current support systems really helped:

Table 9 shows the times that the surveyed young people tried to access help or support and how effective they believed that this help was. Though the question specifically noted that the help could come from anywhere; from friends and families to religious leaders and psychiatrists, the table highlights some of the current gaps in support systems for young people.

Table 9, Important times in your life where you might have needed help and what difference this made. (n=67) (- The help may have come from family members, friends, teachers, doctors, nurses, psychiatrists, psychologists, social workers, youth workers, counsellors, religious leaders, peer mentoring in school, helplines, internet chat rooms, etc.)	If you received Support, what difference did it make:				
	TOTAL saying they received help	Though that it Helped a LOT	Thought that it Helped a LITTLE	Thought that it Did NOT help	Percentage of those who did **NOT** think it helped*
Moving from primary to secondary school	**28**	7	12	9	**32%**
Moving from one school to another at a different time	**17**	1	9	7	**41%**
If you didn't feel able to cope	**27**	9	12	6	**22%**
If you were feeling anxious or worried	**28**	11	12	5	**18%**
If you were being bullied	**22**	8	4	10	**45%**
If you were not feeling good about yourself (self-esteem)	**28**	7	9	12	**43%**
If you questioned your sexuality	**15**	4	-	11	**73%**
If you were finding it hard to behave	**19**	7	5	7	**37%**
If you were feeling stressed (e.g. due to exams)	**29**	8	18	3	**10%**
If you were feeling sad a lot of the time	**24**	5	9	10	**42%**
If you wanted to harm yourself	**14**	1	5	8	**57%**
If you had eating problems (not able to eat, eating too much)	**20**	3	5	12	**60%**
If you were in trouble with the police	**9**	1	3	5	**56%**
If you were feeling suicidal	**17**	1	7	9	**53%**
If someone in your family was being hurt or abused	**10**	1	2	7	**70%**
If someone in your family was very unwell	**17**	7	3	7	**41%**
If someone in your family died	**17**	4	4	9	**53%**
If your parents separated or divorced	**15**	3	4	8	**53%**
If someone in your family was in prison	**9**	2	1	6	**67%**

* Issues with 40%-50% thinking support did not help are highlighted in light blue and issues with 50% or more thinking support did not help are highlighted in dark blue.

The highest percentages for issues where the support system sought out did not help them were for when questioning sexuality (73% said support did not help) and if someone in their family was being hurt or abused (70% said support did not help).

Survey responses indicated that the most effective support accessed was for issues relating to feeling stressed (i.e. due to exams) with only 10% saying the support did not help and if they were feeling anxious or worried about something, where 18% said the support did not help.

Though the severity and inherent risk to wellbeing of the listed issues varies, many of those issues with the least successful support in place were the more serious, with self-harm, eating problems, troubles with police, suicide, concern of abuse and bereavement scoring high in this manner.

6.2 Mental health services in schools (Tiers 1 and 2):

As discussed in section 2.7, some young people felt unable to confide in their parents when needing advice or support. Many schools have developed systems of care, including counsellors, pastoral workers and school nurses, amongst others. These systems of support are different for each school, however and depend on the individual services each school commissions. The young people's differing understanding and views of the support services available to them in their respective schools highlighted a concern over the equity of mental health and wellbeing service provision.

The young people in our school-based discussion groups were aware that teachers and support workers were often mandated to report back to the parents in cases of risk or harm. This clearly drawn responsibility could often prevent them from seeking advice or support from workers in the community.

"I would never talk to my teachers about drinking, or taking drugs, or having sex… because I know that my parents would find out and that would be the worst, - and anything that counts as 'hurting myself', because everyone would find out."

When asked if there was someone available in the school that they could go to in confidence, if they had a problem, the children of one group responded "No, No, definitely not". However, in the school which employed non-teaching pastoral managers, the children said confidently that if they needed support or just someone to speak to they would usually go to the pastoral managers in the first instance, ahead of other support on offer, such as peer mediators, school/community nurses, teachers or even their own parents in some cases.

The role of the non-teaching pastoral manager was seen by the children in schools which used them as being the first point of contact for any issue or concern and they would then signpost the children where necessary. This was also discussed by a child from the YLAC group, who attended a different school with a similar system. The feelings were that they were "really nice and always put the student first, whereas other professionals might put their job or their targets first instead." The pastoral manager's only responsibility was to maintain the wellbeing of the students within their cohort.

Regarding counselling support in schools, the children had different attitudes depending on the school they attended. Each school commissions their own mental health and emotional well-being support systems and sometimes they come together in consortia to group-buy services shared between them. In one school the children said "counselling doesn't work; it's the worst thing I've ever done" and another suggested that "therapy is a lot better than counselling because there's an actual method behind it. Counselling is just talking". Some did not know where the counsellor's office was in their school.

Other children's experiences were very positive, saying that they thought the support was valuable and that it was a shame that there were sometimes one or two years of waiting lists to see the school counsellor. In this school, six months blocks of counselling were offered to a student, although they were "allowed a certain amount of time and then can't go back". Students believed more resources could provide more access to this support.

The third school had a counsellor employed for four days a week, which the staff said mainly covered their needs. A child would see the pastoral manager if they had concerns or issues and, if necessary, the child would be referred on to the counsellor in confidence. The school also employed a CAMHS worker to come in for one day a week and see children directly at school. Though the children in the discussion group had not used this resource, the pastoral manager said that it was needed to give them direct access to CAMHS services, rather than taking the long way around by using the GPs referral pathway; it was intended as a "short-cut" through the system. This CAMHS worker could assess the children in their school setting and make a decision to refer them to other services if necessary. One of their main uses was to identify ADHD and similar cases that had been missed in primary school. They also dealt with self-harm and other high risk behaviours. This one day a week was believed to be roughly appropriate for their ongoing needs, though more research is needed to understand the views of the children on the effectiveness of this service.

 - A case was described by staff where, prior to the CAMHS worker being at the school, a child had waited for twelve months to go through the CAF process to receive medication and support for ADHD, by which point they had already been excluded from school for disruption.

The schools may also have support workers who run separate self-esteem, anxiety, confidence and support groups and students are directed to these by the pastoral workers.

Sometimes a school will have a youth centre on site that runs afterschool and weekend groups for physical, artistic, social and homework clubs. Some students with emotional or mental problems enjoyed these clubs because they take their mind off of the daily problems they face, providing respite from low self-worth.

The surveyed young people, when asked if they had anything on which they would like to comment, spoke highly of the Youth Services. Of the ten comments made, four were directly related to youth centres:

- *"Glynn Owen youth workers, always helpful, helped deal with personal issues very helpful and provide great and useful services, youth clubs and music activities (jellyfish)."*
- *"James the jellyfish group which involves playing music in a band at the Glynn Owen centre and did the nos."*
- *"The Arts Award has helped me the most."*
- *"That most Youth Services help a lot and most are getting shut down :("*

Key points:

- Some young people did not feel comfortable accessing support or advice in schools as they are aware that serious issues may have to be reported back to their parents. – As a result some schools exist where young people believe there no one in which they can confide and high risk issues may be underreported.

- Where pastoral support is available, but not from those in teaching roles, young people said that they felt more comfortable confiding in them.

- Counselling support is inconsistent and young people range in opinions of this support, from 'very helpful' to 'completely useless'.

- Commissioning a CAMHS worker to work in a school, for one day a week, was said by a staff member to allow them to streamline the referrals they made and access CAMHS directly. Mental health provision in schools is inconsistent and depends largely on the priorities and capacities of the individual school.

- Youth clubs and support groups were viewed very positively by those who attended them.

FURTHER READING:

In addition to the broad scale engagement, there were numerous reports and examples of previous research which have advised on the interpretations of the data collected.

Lifestyles of 14 to 15 year olds in West Sussex, 2010:

A West Sussex Public Health commissioned survey aimed at 3,500 year ten students of West Sussex secondary schools. The survey asked questions on multiple facets of physical, mental and emotional health and wellbeing and broader questions on lifestyle. The report, published in 2010, summarises findings by gender, locality, deprivation and other individual factors. (The next edition of the survey is due in 2014.)

Available at: http://jsna.westsussex.gov.uk/JSNA-Reports

UNICEF international child wellbeing index, 2013:

"Part one presents a league table of child well-being in 29 of the world's advanced economies. Part two looks at what children say about their own well-being (including a league table of children's life satisfaction). Part three examines changes in child well-being in advanced economies over the first decade of the 2000s, looking at each country's progress in educational achievement, teenage birth rates, childhood obesity levels, the prevalence of bullying, and the use of tobacco, alcohol and drugs."

Available at: http://www.unicef-irc.org/publications/

From indirect aggression to invisible aggression: A conceptual view on bullying and peer group manipulation:

A recent literature review exploring the psychosocial motivations of children to bully others, who is more likely to be targeted by the bullies and what damage this can do. The authors suggest that educating young people about these underlying motivations to bully will bring them into the open where they can be recognised.

"This paper suggests that in most cases [bullying] results from the encounter between a skilful bully and a group that lacks true cohesiveness, through a process of normative social influence. Groups with low quality of friendships may be more likely than others to become instruments of aggression as victimization provides them with a common goal and an appearance of cohesion… We also suggest that in such a situation the aggressive act is not just indirect, but invisible and the influence exerted on the group might be *informational* and not *normative*." - (Garandeau and Cillessen, 2006)

Available at: http://www.sciencedirect.com/