My Health, Our Future (Summary)

Understanding Children and Young People’s Mental Health - The State of Suffolk

November 2017
Prepared by Thomas Delaney
ACKNOWLEDGEMENTS

Healthwatch Suffolk would like to thank the pastoral staff, senior management and teachers who made My Health, Our Future possible. Without working in collaboration across Suffolk, this project would not have received such a positive response.

Above all, we thank the pupils at the following schools:

- Felixstowe Academy
- Farlingaye High School
- Northgate High School
- Ipswich Academy
- Stowupland High School
- Samuel Ward Academy
- Newmarket Academy
- Mildenhall College Academy

Important note:

Much of the data highlighted within this report is presented according to the differences that are evident between male and female respondents. Please note the below icons (and colours) that have been used to represent gender within many of the graphs and graphics that you will find throughout this document.

Female  Male
FOREWORD

“My Health, Our Future” is one of a growing number of influential reports by Healthwatch Suffolk, many of which have been designed, researched and completed with the help of partner agencies.

A combination of in-house expertise, knowledge, key resources and our extensive Suffolk wide network of partners, has led to this report being the most keenly awaited since Healthwatch Suffolk was launched in 2013.

In my opinion, “My Health, Our Future” is impactive, significant, co-produced and visually powerful. Let me explain why.

The report is impactive because it is distinct, challenging and offers achievable recommendations that will positively influence strategy and implementation, both at a county level and within individual schools. This State of Suffolk report is supported by 8 individual reports. The individual reports are to be shared directly with the 8 participating schools.

The report is significant because it is based on a particularly large sample size. In fact, we have been unable to identify any other equivalent research at county level, with over 6,800 respondents having taken part. The potential for eventually reaching 70-75% of secondary school pupils across all of Suffolk, numbering tens of thousands, is now plausible, thereby creating a unique county database of intelligence for commissioners, schools and providers.

The study, PHSE learning activity and our sign-posting posters/cards, have also already created opportunities for passing on critically important information to the pupils and their teachers. The report is wide reaching because the core essentials of the project were added to by the schools involved, allowing them to add factors that were relevant to them.

The report has been co-produced, with pupils, teachers and other school staff. Co-production is a priority for Healthwatch Suffolk and now also Suffolk’s Health and Wellbeing Board. The value and strength of co-production cannot be underestimated when considering how much of an impact a researcher and commissioner, as in this case, aims to achieve.

Andy Yacoub
Chief Executive of Healthwatch Suffolk
The success of the project may also potentially lead to larger and broader ‘mental & physical health’ State of Suffolk initiative. Our activities with 9 secondary schools in Suffolk (inclusive of our innovative pilot with Thomas Gainsborough school, Sudbury, in 2016), is now also opening doors to other secondary schools. The basis upon which the data and intelligence has been gathered and analysed also lends this study to be compared nationally, because of the adoption of the Short Warwick Edinburgh Emotional Wellbeing Scale (SWEMWBS).

The report is visually powerful because of the stunning pupil artwork from our participating schools. A selection of the artwork has been appropriately interspersed throughout the text of the report. The art accentuates what pupils told us through the survey and we have also created a range of infographics in order to clearly and creatively carry our key messages.

We all have school in common from an early age. Actions taken in school can have a big impact on a student’s wellbeing, not just in the short term but also throughout their lives. Secondary school spans a crucial juncture and often challenging transition into physical and social maturity. Our report therefore sets out why recognising the emotional health needs of young people and taking steps to meet those needs at this stage is of the utmost importance.

I sincerely hope you find the report interesting and helpful. You will, I believe, be surprised at some facts, shocked by others, and left feeling positive by some aspects, such as the recommendations. The fact these recommendations have been agreed with the commissioners involved leaves me to believe that they will be acted on, and that change of a positive nature will come about. My thanks to everyone involved, particularly our researcher Tom Delaney, other team members at Healthwatch Suffolk, the pupils, teachers and other school staff, our commissioners, and those who supported the project through other means.

Eugene Staunton
Associate Director of Transformation for Ipswich and East Suffolk Clinical Commissioning Group and NHS West Suffolk Clinical Commissioning Group (CCG)

In October 2015 CCG areas were required to develop a Local Transformation Plan (LTP) in response to the recommendations set out in the Future In Mind Report - promoting, protecting
and improving our children and young people’s mental health and wellbeing, the report of the Government’s Children and Young People’s Mental Health Taskforce.

Suffolk’s plan sets out how over the next five years, it will improve children and young people’s emotional wellbeing and mental health by transforming services.

The work is overseen by the Children’s Emotional Wellbeing Group with representation from across our Health and Care system - NHS Ipswich & East Suffolk CCG, West Suffolk CCG, Suffolk County Council, health and care organisations, young people, Suffolk Parent Carer Network, charities and schools.

In our annual review of our Transformation Plan (October 2017), we celebrate progress made and consider areas for further focus over the next 12 months which include:

1. Working in partnership to develop a behaviour pathway for East and West Suffolk that will provide a clear, consistent pathway for all families and young people in Suffolk and will align with the requirements within the SEND Action Plan Priority 3 to review and develop pathways for ADHD and Autism.

2. The Emotional Wellbeing Hub (a new health and care single point of contact) will become operational in April 2018 and is key to our strategy and focus on prevention and early intervention.

3. Recruiting to a new pilot crisis service and monitoring the outcomes for Suffolk’s young people and families.

We commissioned Healthwatch Suffolk to produce this report to support us in better understanding the specific needs of our young people in schools, we are both encouraged and challenged by the comprehensive findings of the My Health, Our Future report. In working together on the recommendations, we have been able to reflect on how these are woven into the Transformation Plan and can see where there is significant progress, and where we will continue to work in co-production to deliver health and care, system-wide improvements that will benefit the children, young people and families of Suffolk.
Getting creative about mental health and wellbeing

Healthwatch Suffolk encouraged young people to get creative about their understanding of mental health and wellbeing.

Students attending the schools that took part in “My Health, Our Future” were tasked with submitting something that is personal, powerful and that represents what mental health and wellbeing means to them. We have included a few of the submissions within this report.
EXECUTIVE SUMMARY

Background

My Health, Our Future has been an iterative process building on a pilot study in 2015/16.

The project was informed by the vision of Future in Mind, a report produced by Norman Lamb MP in 2015. It highlighted the need to move towards a children and adolescent mental health system focused on prevention and early intervention, as half of all diagnosable disorders establish by the age of 14.

My Health, Our Future sought to establish clear patterns of need among children and young people across Suffolk. The findings are discussed in relation to the school’s Tier One functions: mental health and wellbeing promotion and prevention.

Objectives

Our objective is simple: to engage children and young people via a whole-school approach, including their curriculum, local services and their understanding of mental health and wellbeing issues. The objectives are threefold:

1. The project forms part of Suffolk’s Emotional Wellbeing Plan (CAMHS Transformation Plan);
2. The responses have been used to create bespoke reports for each school involved. This allows schools to truly understand the needs of their students, leading to new forms of engagement and changes to the curriculum; and
3. The students completing the online survey have been up-skilled on issues surrounding mental health and wellbeing.

My Health, Our Future is a part of the Children and Young People’s Emotional Wellbeing Plan (EBW2020).
This drawing to me represents anxiety. To me, mental health is something I feel strong about because I have mental health anxiety and tend to be a young person in my family who has bipolar disorder.

This is something hard for me to understand sometimes. When my adult friends, family, or someone I know adult is upset over anything or someone, I have usually found because it's too emotional it to me but this have because can get be very hard. And I don't know I've been really understand it all.
Data was collected between February and July 2017.

Over 6,800 responses were recorded from a total of eight schools across the county. The response rate is 79%, which means our results can be generalised to the wider population of children and young people in Suffolk.

After checking for safeguarding issues (see page 40), low wellbeing scores, incomplete surveys and duplication, a total of 6,238 responses were analysed.

The Short Warwick-Edinburgh Mental Wellbeing Scale:
The survey used a measure of wellbeing called the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Scores can range between 7 (lowest possible wellbeing) and 40 (highest possible wellbeing).

5,397 responded to the SWEMWBS. The average score was 22.6. This is at the lower end of ‘average’ when compared to the Population Norms in Health Survey for England (23.6). The graph below shows average ratings for each SWEMWBS item.

Figure 1: All participants average score for each SWEMWBS item (out of a possible score of five). n = 5,397
When we look at the differences between male and female SWEMWBS scores, we see that the overall average is 'low' due to female respondents. The average male score was 23.6 (slightly above average), while the average female score was 21.6 (almost in the lowest 25% of the population).

Figure 2: Average SWEMWBS score by age and gender. n = 5,397

Figure 3: Gender and age comparison of SWEMWBS score. Female participants experience poorer wellbeing with increasing age, falling below the 25th percentile when compared to the national average. n = 5,397
Prevalence of mental health and wellbeing education in Schools

45% of respondents said they are not taught about mental health and wellbeing in schools.

Respondents aged 15 onwards have lower levels of mental health and wellbeing provision in schools (this is due to exams etc). Older students (14+) are discontent with current PSHE curriculum as it does not reflect their life experiences.

The desire for mental health and wellbeing to be taught in school increases among female respondents from age 12 (73%) to age 17 (89%).

On average, 52% of male respondents wanted to be taught about mental health and wellbeing in schools (this percentage remained stable across all ages).
**Figure 6:** Respondent’s preference for what topics should be taught in school. \( n = 1,707 \)
Topics students would like to see taught in school:

Female Top Three:
- Anxiety (77%);
- Body image (74%); and
- Understanding and managing stress in school (73%).

Male Top Three:
- General overview of mental health and wellbeing (74%).
- How to manage my mental health and wellbeing (67%); and
- Understanding and managing stress in schools (66%).

Figure 7: Respondent’s preference for what topics should be taught in school by age and gender. 
\( n = 1,707 \)
When visiting an NHS service, what’s the most important thing?

Top three:

1. To be taken seriously (92%);
2. To be listened to and understood (91%), and
3. Confidentiality (83%).

This was the same across all age groups.

When visiting an NHS service, how far can you travel?

Although ‘close to where you live’ was the least important factor when visiting an NHS mental health Service, 68% of respondents can’t travel more than 20 miles to visit an NHS Service.

This was the same across all age groups.

This is due to public transport and issues around expressing mental health or low wellbeing to their parents.
What makes you feel stressed?

Revision, exams and managing a work-life balance were listed as the top three stressors for respondents. This increased from age eleven to seventeen.

Fears of being bullied and peer pressure decreased with age.

The young people’s comments expressed that the reason adolescents like school less as they get older is because of the increasing pressures generated by exams and pressures on academic performance. They thought that girls were particularly affected by this partly because they care more than boys about doing well at school, and partly because girls were seen (by both genders) as internalising emotions more easily.

Boys were described as more laid back and caring less about what others thought of them.

Figure 9: Gender differences between responses to options about what makes respondents feel stressed (see page 72 for a detailed breakdown). n = 2,266
The prevalence of school work as a stressor among female respondents is particularly worrying.

- Exams (54% at age eleven to 90% at age seventeen)
- Revision (41% at age eleven to 82% at age seventeen)
- Managing work-life balance (34% at age eleven to 81% at age seventeen)

Coping: The young people felt that parents and family are an important source of support for adolescents but that it would become more difficult to discuss things with parents as they became older. This was partly because some things were felt to be more personal as young people age but respondents also spoke about wanting to feel independent and therefore discussing problems with parents less to feel autonomous.

Across both male and female students, reliance on the family unit falls with increasing age. At age 11, 2 out of 3 students said family are important in helping them to cope. This drops to less than 1 in 3 by age 17.
Body image and self-esteem

3 out of 5 females and 1 in 4 males worry about their appearance and/or body image most or all of the time (based on 4,609 responses).

Figure 12: Levels of worry (most or all of the time) generally increase with age for both genders but is particularly noticeable amongst female respondents (based on 2,305 responses).

Female respondents had lower levels of self-esteem compared to their male counterparts. As with body image, age is positively correlated to lower levels of self-esteem.

1 in 3 female and just over 1 in 10 male respondents would rate their day-to-day self-esteem as either poor or very poor.

Figure 13: Female and male respondents level of worry about their appearance (most or all of the time) n = 4,609
“Why do you feel like you have low self-esteem?”

“Because I hold lots of problems in and I just explode on people.” - Female (Age 12)

“Because I have few trusted friends.” - Female (Age 11)

“I feel as if I am not cared about, useless and a pain to the people around me.” - Male (Age 14)

“Society values people who are skinny or toned and fit - not natural.” - Female (Age 17)

“Because of school pressure and little attempts to try and mitigate this.” - Male (Age 17)

“Because my ‘friends’ pretend there my friends but there not and they have groups about me on Snapchat.” - Female (Age 13)
“Always feeling like whatever question I ask will be a stupid one, that every question I answer I will be told its wrong. When I sit alone I can feel people looking and judging me.” - Female (Age 16)

“I always think that I’m useless to my family and I feel lifeless when I think about that and life in the school that I can’t find the way to be my true self at school.” - Female (Age 16)

“Don’t really think I have any potential.” - Male (Age 17)

“All my life I have had people insult me because of my body image and that’s what I think of myself now, I’ve heard it so much that its what I believe.” - Female (Age 13)

“I never think good about myself because I don’t like to and feel bad about it also. I don’t think I am a good person. I care about what others think about me.” - Female (Age 11)

“Because I’ve been put down quite a lot in the past and don’t have very much confidence in myself and need people to help me believe that I do.” - Male (Age 14)

“I’m worse than most people at most things.” - Female (Age 12)

“...all I am able to think about are the bad things.” - Female (Age 13)
Self-harm was classified under the following themes:

1. self-injury or self-poisoning intentionally to cause harm

2. an act with non-fatal outcome, in which an individual deliberately initiates a behaviour that, without intervention from others, will cause self-harm

Just over a fifth of 15-year old respondents reported that they had self-harmed, in line with other recent research.

15% of respondents reported previously self-harming. Of those who had self-harmed, three quarters were female.

40% of respondents indicated that they do not know where to go for support with self-harming.
Cyberbullying

The prevalence of cyberbullying increases with age – from 7% at age eleven to 16% at age sixteen.

Cyberbullying was more prevalent among female respondents. The comments provided attributed this to the judgements young people make of each other on looks and how social media was a catalyst to do this publicly.

Figure 16: Almost one in ten respondents stated that they had been a victim of cyberbullying in the last two months (8 per cent). n = 1,432

Children who told someone about being cyberbullied report making a disclosure to a number of individuals, with 1 in 3 telling their friends.

n = 115

Friends - 37%
Parents - 29%
Teacher - 9%
Other school staff - 3%
I didn't tell anybody - 22%

Sleep duration on a school night

The number of respondents that get less than six hours of sleep on a school night increases with age from one in ten at age 11 to six in ten at age 16.

The findings indicated that those respondents getting less than six hours sleep on a school night experience higher levels of worry about their body image, poorer self-esteem and score lower on wellbeing than those who get more than six hours sleep (see page 93).
Figure 18: Correlations between different factors related to the wellbeing of respondents.
Why didn’t you tell anyone that you were being cyberbullied?

“Don’t want any other drama to happen, and make it worse.” - Female (Age 12)

“Because I’m not a tell-tale.” - Male (Age 12)

“I was scared.” - Female (Age 16)

“I didn’t want the people to bully me anymore then they did.” - Female (Age 12)

“I didn’t want to get that person told off and didn’t want to start more drama.” - Female (Age 12)

“Because I didn’t want anyone else to get involved.” - Male (Age 12)

“It would make it worse.” - Female (Age 14)

“Didn’t want to snitch.” - Male (Age 14)

“I don’t like to discuss my problems I often feel like I’m bothering people and I don’t want to bring people down and make them feel like me.” - Male (Age 15)

“I couldn’t let people know I was hurting.” - Female (Age 15)

“Because I thought if I didn’t say anything it would go away.” - Female (Age 14)

“I couldn’t let people know I was hurting.” - Female (Age 15)

“Because I thought if I didn’t say anything it would go away.” - Female (Age 14)
'Words hurt more than you think. Taste your word before you spit them out.'

—Unknown
Discussion

It should be clear from the range of issues discussed that there is considerable potential for improving children’s subjective well-being. This over-arching goal will not be achieved through focusing on a single issue, nor can it be achieved by the actions of only one key stakeholder.

Some of the findings appear to be amenable to national and local policy initiatives, while others are more relevant to services and practitioners, to parents and to children themselves. In this section we provide a few selected examples of the relevance of the findings for different stakeholder groups.

Leadership and Management:

To ensure actions are integrated, sustained and monitored for impact it is important that a commitment to addressing social and emotional wellbeing is referenced within improvement plans and policies. This includes safeguarding; confidentiality; PSHE education; SMSC (Social, Moral, Spiritual and Cultural) education; behaviour and rewards and practice.

It is also important to involve pupils, staff and parents in developing these policies via coproduction so that they remain ‘live’ documents that are reviewed and responsive to the evolving needs of the school community.

Making children and young people’s voices heard across health and education sectors:

Involving students in decisions that impact on them can benefit their emotional health and wellbeing by helping them to feel part of the school and wider community and to have some control over their lives. At an individual level, benefits include helping students to gain belief in their own capabilities, including building their knowledge and skills to make healthy choices and developing their independence. Collectively, students benefit through having opportunities to influence decisions, to express their views and to develop strong social networks.

Upskilling Suffolk’s Workforce:

It is important for staff to access training to increase their knowledge of emotional wellbeing and to equip them to be able to identify mental health difficulties in their students. This includes being able to refer them to relevant support either within the school or from external services.

Promoting staff health and wellbeing is also an integral principle of the whole school approach to emotional health and wellbeing. Teaching and learning establishments can demonstrate a commitment to staff health and wellbeing in many ways. For example, by providing opportunities for assessing the emotional health and wellbeing needs of staff, by providing support to enable staff to reflect on and to take actions to enhance their own wellbeing and by promoting a work-life balance for staff.
Implementing a whole-school approach to mental health and wellbeing:

The findings from My Health, Our Future indicate that a shift towards a whole-school approach is warranted. Building resilience among Suffolk’s children and young people should not be left to certain aspects of the curriculum, such as PSHE or RSE, as schools are a universal service, accessed five days a week by most children.

With such a huge amount of time spent in the classroom, schools provide an ideal environment for promoting good emotional wellbeing and identifying early behaviour changes and signs of mental distress. For children experiencing adversity at home, school can also provide a consistent, protective and therapeutic environment, which can help them to cope.

Digital literacy:

Schools and other educational settings should take proactive measures to help prevent cyberbullying from occurring, and to reduce the impact of any incidents that do happen.

All schools are required to follow anti-discrimination and equality laws. Staff must act to prevent discrimination, harassment and victimisation within the school. Cyberbullying prevention should build on these requirements, promoting and maintaining a safe and welcoming environment.

Recommendations:

1. The Emotional Wellbeing 2020’s Workforce Development programme should proactively offer all secondary schools training and development.

2. Stakeholders should work collaboratively to provide a systematic approach to upskilling children and young people on issues regarding mental health and wellbeing across secondary schools in Suffolk.

3. Personal, Social, Health and Economic Education (PSHE) and Relationship and Sex Education (RSE) should include digital literacy and online safety.

4. EWB2020 stakeholders should work collectively to promote children and young people’s voices throughout health and education systems, such as the Health and Wellbeing Board.

5. The EWB2020 should increase funding for Tier One support.

6. Schools should be engaged on the forthcoming Emotional Wellbeing Hub and, where possible, should receive increased signposting material.

7. Healthwatch Suffolk will help My Health, Our Future schools to implement a Mental Health and Wellbeing Roadmap.
This report has been produced to support the ongoing development and implementation of the Suffolk Children and Young People’s Emotional and Wellbeing Transformation Plan (EWB2020).

It will be publicly available on the Healthwatch Suffolk website. It will also be made available to Healthwatch England and bodies responsible for the commissioning, scrutiny or delivery of children and young people’s services in Suffolk.

This may include Suffolk Clinical Commissioning Groups, the Suffolk Health and Overview Scrutiny Committee, the Suffolk Health and Wellbeing Board and Suffolk County Council.

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