Leeds
CITY COUNCIL

Leeds in Mind

Young People 16 - 24 years

Leeds in Mind Young People (16- 24 years)

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Public Health/Leeds City Council

February 2018

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Executive Summary: Key Findings and Areas for Action

1.	**Increasing Levels of Need** Partners in Leeds are delivering significant programmes of work to prevent mental ill health in this age group and support young people to develop resilience. This includes the work of individual organisations along with initiatives delivered under: Child Friendly Leeds, Best Start and Future in Mind. However national research suggests that: • Rates of many mental health problems may be higher in young people than in other age groups; • The mental health of young people appears to be worsening and, • This is driven by the deteriorating mental health of young women. Local practitioners report that national trends appear to be reflected in Leeds.
Areas for action	• What can be done to further to prioritise this age group and address their mental health needs? • What additional targeted work can be developed for young women that increase protective factors and reduces risk factors for poor mental health?
2.	**Current service configuration means that young people's needs are not being met or they are 'falling through the gaps'** The current configuration of adult mental health services has resulted in their being **a gap in provision for people exhibiting varying levels and signs of distress** or 'not coping'. This is perceived clearly in the young adult population. Practitioner's report that young people are experiencing increasing levels of distress. There is broad agreement that the way in which to support young people with these types of mental health problems is related to approaches that make explicit the links between external stressors/life events and coping strategies/behaviours. In practice this may be found in 'Community Psychology' approaches, case-loading and flexible models of person-centred care. A significant programme of work is in place to address transitions – however, this is a particular issue for students when moving between child and adult services as well as sometimes, new cities. The recent Institute of Public Policy Research report suggests key areas for improving the mental health of the student population include: • New place based coalitions through integration across local services. • Pilots of 0 – 25 year mental health services in places with high student populations
Areas for action	• What can be done in the city to build on the work of youth-focussed mental health services that take flexible approaches to supporting young people? • Is there value in explicitly adopting trauma informed/community psychology approaches for this age group? • How can we improve communication between local HE institutions and NHS services and develop agreements about shared care? How might this feed into new models of care/provider arrangements.

	• How possible is it to move towards 0 -25 year mental health services in the city?
3.	**Specific Mental Health Problems**
	Eating Disorders Broad estimates for eating disorder symptoms in the 16 – 24 year population, applied to Leeds, yield significant numbers (ie. 15,000 people). Thresholds for access to treatment for serious eating disorders are strict (although the FREED project is addressing this). Anecdotally, much eating disorder morbidity is contained within Primary Care. GP systems show that there are currently around 530 people aged 16 – 24 with a code for ED, although as there are many codes for Eating Disorders, this may be incomplete. The majority of people in primary care with a record for ED are women. Eating disorders may not be visible in mental health data systems as they are often comorbid with other conditions and contained within broader clustering processes/systems. However, there were around 30 people supported by IAPT in 2016/17 and another 30 people on the LYPFT caseload with eating disorders coded.
Areas for action	• Do we have a true sense of morbidity related to eating disorder in Leeds and where would we want to 'draw the line' with morbidity. • Can we use SCOFF for cross sectional survey of pop? • How can we link FREED into local commissioning cycles systems – and can we learn from their early intervention type approach? • Is there further work to be done through the Women's HNA on this issues?
	Self-Harm Anecdotally, levels of self-harm are high and increasing, particularly in young women. Self-harm is the single largest reason for referral to CAMHS. Population level responses include work in schools targeting young women and new pathways in acute medical settings.
Areas for action	• Is there a specific action? • How are we addressing low level self-harming behaviour?
	Personality Disorder Personality disorders are psychiatric diagnoses that are based on the identification of certain behaviours or difficulties forming healthy relationships. The categorisation of PD is open to debate – so closely aligned are such difficulties with adverse experiences such as trauma and abuse. Local practitioners suggest that community psychology approaches (which make explicit the links between disadvantage, discrimination and abuse – and coping strategies) have much to offer this group of people. The personality disorders network have seen a lowering of the median age over the last 5 years to 26 years and around 70% of service users are women.

Areas for action	• What role might Community psychology/PTM framework have with this group of people? • Can we increase capacity within the Journey programme • Can we support young people's services (CAMHS and HE providers) to be more trauma informed? Or are they already?
4	**Key Groups** The Future in Mind work programme targets key groups of young people, including those CYP who are transitioning from CAMHS to adult services and care leavers/children looked after. Whilst CLA are at increased risk of mental health problems - referrals to the specialist team within the Therapeutic Social work service are low – around 4% of CLA population. There are also other groups of young people that, in line with wider literature are thought to be at increased risk or poor mental health/illness. These include young people who identify as LGBTQ, young people from deprived backgrounds who experience multiple disadvantage and young people from BME groups. The adult mental health needs assessment: Leeds in Mind, 2017, details inequalities across the mental healthcare system that are experienced by BME groups. More work is needed to understand the experience of young BME people – although first analysis included here shows that BME people are perhaps over represented in EIP services and appear to have lower access and recovery rates through IAPT. Within Leeds, HE students make up between 30% - 50% of the 16 – 24 year old age group. The widening participation agenda has resulted in the student population more closely resembling the general population and mental health/counselling services in the city report increasing levels of distress, higher levels of acuity and overall increased demand.
Areas for action	• Is there specific mental health support/provision for young BME groups • Is there specific mental health support/provisions for LGBT+ groups? • What proactive mental health support is in place for CLA other than TSW team? Can/do IAPT and other services report who is CLA? • What role can/could Mindmate/Mindwell play in meeting needs of these particular groups?

Young People in Mind

Summary Paper: The Mental Health Needs of Young People in Leeds aged 16 – 24 years.

'…The brain embarks on an epic phase of development around puberty that is incomplete until the late 20s. ….This is accompanied by profound cognitive, psychological and social changes for the individual ….' [1]

Background and Policy Context

It is estimated that 75% of mental health problems in adult life (excluding dementia) start by the age of 18 (Future in Mind, DH, 2015). The period between 16 and 24 years is, in particular, a significant part of the life course.

There has been, to date, a focus upon supporting young people in their transition to adult mental health services. More recently however, an interest in young people specific mental health services has emerged, though service re-orientation is at an early stage. Future in Mind (2015) highlights the development in some areas of the country of mental health services for young people up to the age of 25. The Five Year Forward View for Mental Health (2016) goes further and recommends that partners working with Vanguard sites should trial a new model of acute inpatient care for young adults aged 16–25

There is also a significant policy focus upon mental health disorders that are more prevalent during this life stage: The Mental Health Five Year Forward View sets targets around providing e**vidence-based Early Intervention Services** to people experiencing First Episode Psyschosis, and in January 2016, the then prime minister promised a focus on 'faster care and expanded services' for teenagers with **eating disorders'** (UK Government, 2016). This recognises mortality associated with eating disorders, and includes an introduction of waiting time target.

Along with well-known risk factors for poor mental health in the general population – including those associated with deprivation and adverse experiences/trauma, there are particular groups of young people who are at increased risk of poor mental health. These include: **Children and young people under the care of the local authorit**y (*Promoting the health and well-being of looked-after children* (2015, DH and DoE) recognises that almost half of children in care have a diagnosable mental health disorder) and **Students living away from home** - an NUS survey (2015) found that 78% of students surveyed said they had experienced mental health problems, with 33% having had suicidal thoughts.

Process and Methodology

This report takes the form of a Rapid Mental Health Needs Assessment. **It provides a 'first cut' analysis of the mental health needs of this age group which can be used to inform future decisions about service provision and improving outcomes for this age group.**

An early draft was presented to children/young people's mental health commissioners and service leads and to a convened meeting of practitioners who work primarily with students. Feedback at his stage led to a focussing of the report on particular areas – namely '**transitions', crisis services, self-harm, eating disorders and emerging personality disorder or increasing levels of psychological distress.**

The HNA combines desk-based research (epidemiological modelling, analysis of service use data and qualitative reports/surveys), with primary research (1:1 interviews with key stakeholders). This triangulation enables identification of priority areas and key gaps.

1. Stephen Stansfeld1,2, Sally McManus3, Kamaldeep Bhui4, Peter Jones5,6https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

Scope and Interfaces

- Leeds GP registered young people aged 16 – 24 years.
- It is recognised that many mental health problems begin early in life. There are therefore clear interfaces between this work, the Leeds Best Start programme and the Children and Young Peoples' Mental and Emotional Wellbeing Health Needs Assessment published in 2017.The mental health needs of young adults aged 18+ are also covered In Leeds in Mind, 2017 – Leeds adult mental health needs assessment.

Format

1. Epidemiology: Local Modelling of disease prevalence/incidence
2. Service use – Third Sector and NHS
3. Key developments in the city and target groups
4. Students - Overview and Service Use data (HE and FE)
5. Summary of Qualitative Reports and Surveys
6. Themes from 1:1 Interviews
7. Summary of Key Findings and Areas for Action

1. Epidemiology: What is the estimated level and nature of mental health need

The Adult Psychiatric Morbidity Survey (APMS), 2014 has been used in this section to estimate the prevalence and incidence of mental health problems in the 16 – 24 year old population in Leeds. In summary, this national study found that rates of Common Mental Health Disorders (CMHD) were higher in this age group than other age groups, along with rates of possible Post Traumatic Stress Disorder (PTSD), Self-Harm and Bipolar Disorder.

Rates of First Episode Psychosis used here use the estimates published as part of the psymaptic.org.uk tool (www.psymaptic.org.uk) along with local analysis.

Common Mental Health Disorders (CMHD)

Figure 1 APMS Rates of CMHD (16 – 24 years) applied to Leeds Population

APMS Estimates CMHD (16 – 24 years)	Estimated rates	GP Reg Figs 2016 Jan	Leeds Prevalence (95% Confidence Intervals)
All	17.3%	120,352	20,821 (20,580 – 21,062)
Women	26%	63,878	16,608 (16,417 – 16,800)
Men:	9.1%	56,473	5,139 (5,026 – 5,252)

Figure 1 uses the APMS to estimate numbers of young people in Leeds with a CMHD. It shows that there are an estimated 20,821 young people experiencing CMHD. The rate of CMHD for women in the APMS was three times greater than that of young men. This equates to 16,608 women in Leeds experiencing CMD and 5,139 young men.

Post-Traumatic Stress Disorder (PTSD)

PTSD was notable in the national APMS study ([2]) as likelihood for screening positive was particularly high among 16–24 year old women (12.6%) and then declined sharply with age. This was different for men, where the rate remained stable between the ages of 16 and 64 (between 3.6% and 5.0%), only declining in later life.

Figure 2 APMS Rates of PTSD (16 – 24 years) applied to Leeds Population

APMS Estimates PTSD (16 – 24 years)	Estimated rates	GP Reg Figs 2016 Jan	Leeds Prevalence (95% Confidence Intervals)
All	8%	120,352	9,628 (9,387 – 9,869)
Women	12.6	63,878	8,049 (7,857 – 8,240)
Men	3.6	56,473	2,033 (1,920 – 2,146)

Figure 2 estimates that there may be 8,000 young women in Leeds with symptoms that are suggestive of PTSD and another 2,033 young men

2 A positive screen for PTSD does not mean that someone necessarily has the disorder; instead it indicates that someone has sufficient symptoms to warrant a clinical assessment.

Bipolar Disorder

Figure 3 applies the APMS (2014) estimated rates for Bipolar Disorder to the Leeds population. It shows that there are an estimated 4,092 young people in Leeds who are likely to screen positive for bipolar disorder. In the APMS study, positive screening for bipolar disorder was highest in young people and broadly declined with age.

Figure 3 APMS estimated rates of Bipolar Disorder applied to Leeds population

APMS Estimates Bipolar Disorder (16 – 24 years)	Estimated rates	GP Reg Figs 2016 Jan	Leeds Population (95% Confidence Intervals)
All	3.4%	120,352	4,092 (3,972 – 4,212)

First Episode Psychosis

First Episode Psychosis (FEP) is defined as the first time someone experiences disturbances in thinking which may include delusions or distort reality. National incidence modelling of FEP via www.psymaptic.org consistently underestimates local service need in the North of England – for reasons that are not entirely clear. NHS England has therefore advised local commissioners to review local service use/pathways and to use judgement about current service use to predict likely future incidence.

Providers, NHS Leeds Commissioners and Public Health have worked together to agree an incidence in Leeds of 31.7/100,000 for the full age range of 14+ in the city. However, the Aspire service (the locally commissioned FEP service) has an annual caseload which is suggestive of a much higher incidence - nearer to 50/100,000.

Self-Harm

The APMS asked people who took part in the survey if they had 'ever self-harmed'. The rates used below are therefore not true annual prevalence, but lifetime reporting. They suggest that women are more than twice as likely as men to report having self-harmed There may be up to 16,419 young women and 5,478 young men who have 'ever self-harmed' in Leeds.

Figure 4 APMS rates of self-harm applied to Leeds population

APMS Estimates self-harm (16 – 24 years)	Estimated rates	GP Reg Figs 2016 Jan	Leeds Population
			95% Confidence Interval
Women	25.7	63,878	16,417 (16,225 – 16,608)
Men	9.7	56,473	5,478 (5,365 – 5,591)

(NB: Rates in the general population have increased from 2.4% in the APMS 2000 survey to 6.4% in 2014. It is suggested that this may be due, in part to greater awareness about self-harm)

Personality Disorder

There are clear associations between having experienced trauma/abuse and what can be termed 'personality disorders'. There is therefore, significant debate regarding diagnosis and whether clustering of certain behaviours can or should be classed as a psychiatric condition. However, to provide a sense of population level need and of scale, detail from the APMS on personality disorders is included below:

The APMS included a **general personality disorder screen** (the SAPAS) in the 2014 survey, to screen adults of all ages for 'any personality disorder' (PD). This found that: 13.7% of people aged 16 and over screened positive for any PD, with similar rates in men and women. This is a significant proportion - and goes some way to signalling the large number of people who, regardless of 'diagnosis' may experience challenges in developing healthy relationship and by implication, engaging with services.

Rates amongst young people appeared significantly higher than for other groups: **There was a strong, linear association between age and screening positive for any PD: 22.4% of 16–24 year olds screened positive compared with 8.0% of adults aged 75 and over.**

Eating Disorders

Public Health England s (www.fingertips.phe.org.uk) estimates that there were 15,604 people between the ages of 16-24 years with eating disorders in Leeds in 2013[1]. The tool used as part of this analysis is very broad and likely to be an over –estimate of clinical eating disorder prevalence.

A note on gender

The APMS (2014) notes that the mental health of young women in particular is of significant concern, and nationally that across many of the mental health disorders/illnesses that were measured, it appears to be worsening. A recent review of student mental health reports similar findings. In 2009/10 first-year male and female students were equally likely to report a mental health condition, whereas in 2015/16 this rose to 2.5% of women but only 1.4% of men (IIPPR, 2017)

The APMS (2014) found that rates of self-harm in young women were almost double that of young men. However, a smaller survey found that rates in young men, were similar to women. The YouGov poll, commissioned by three charities, the Mix, Self-Harm UK and Young Minds, found that of the 500 men aged 16 to 24 who took part in the survey, 24% said they had intentionally hurt themselves and 22% said they had considered self-harming (Ref).

It does therefore appear that the mental health of young women is worsening and should be a key policy concern – however, it is also the case that men have higher rates of suicide and may not report their own mental ill health (The State of Men's Health 2017). Analysis and understanding of mental ill health and how it is experienced and patterned is therefore very complex.

However, **rates of mental health disorders do appear to vary by gender. This suggests that service design, provision and approaches may need to be 'gendered' in order to meet need and improve outcomes.**

[1] This estimate uses the 2007 Adult Psychiatric Morbidity Survey (APMS) data applied to 2013 mid-year ONS population estimates. The APMS used the 'SCOFF' screen, a survey tool that aims to illicit 'attitudes and behaviours associated with possible eating disorders' (Thompson *et al*, 2007, p137) [excluding Binge Eating Disorder]. APMS report the prevalence derived from this tool is likely an overestimation.

2. Service Use - Third Sector and NHS Services

Young people in Leeds have access to support for emotional and mental health issues from services commissioned under the remit of Children Commissioning (CCGs) and Leeds City Council – including Child and Adolescent Mental Health Service's (CAMHS), Cluster Mental Health Support, The Market Place, The Therapeutic Social Work team and Leeds Mind. When young people reach 18 years old they transfer from children and young people's services into services commissioned within the adult portfolio.

There is currently no NHS commissioned mental health service that spans the particular age range of 16 – 24 years. However, IAPT (Community Links) has a particular focus upon young people aged 17 to 21 years and Aspire has historically targeted Early Intervention in Psychosis support toward 14 to 35 years olds (although this is set to expand to an older age bracket in line with national policy). For other mental health support, young people aged 18+ years are able to access a range of adult services, as set out in this needs assessment

The data for this section has therefore been collected for the relevant age cohort from both child and adult services. This includes data about:

- 16 - 18 year olds attending CAMHS
- 17 - 21 year olds attending IAPT
- 16 – 24 year olds on the Aspire caseload
- 18 – 24 year olds using LYPFT acute mental health services

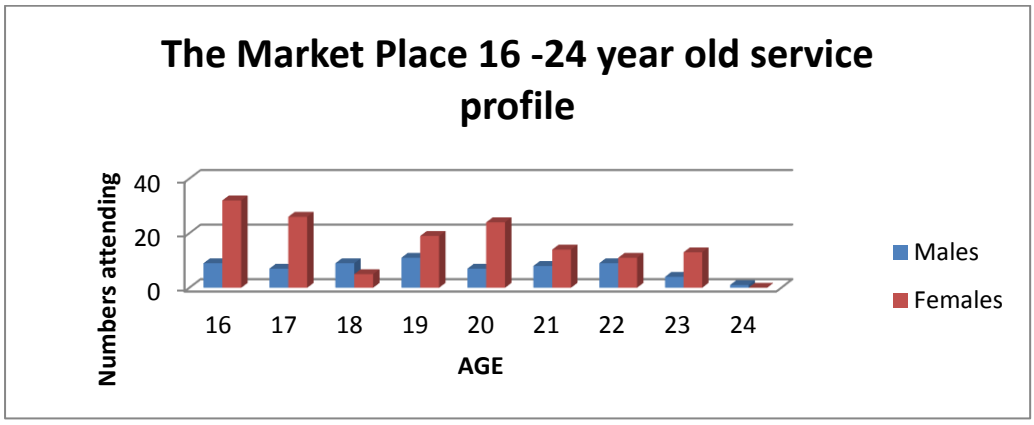
There are however, two Third Sector organisations/projects that do specifically target the 16 – 24 year old age group: The Marketplace and THRU (Leeds Mind). Service use data about these projects is included below.

Students are a group who also constitute a high proportion of the 16 – 24 age bracket in the city. Students are able to access the citywide services detailed below, however, FE and HE institutions also provide 'in-house' mental health/emotional wellbeing services. Data from these services is included in the next section.

The Marketplace

The Market Place is a city-centre based third sector organisation commissioned by NHS Leeds CCGs and Leeds City Council to provide 1:1 support, counselling, open access through a drop-in facility and self-harm support groups, for young people aged 13 to 25 years old.

Figure 5 The Market Place Service User profile for age range 16 – 24 years old (April 2015 - March 2016)



Total numbers 65 (men) and 144 (women) = 209

Leeds Mind: The THRU (**T**alk, **H**elp, **R**elate, **U**nderstand) is a partnership between Leeds Mind and The Market Place). It operates as a peer support group and offers group work for young people aged between 16 and 25 addressing issues such as managing stress, confidence building and self-esteem. **Around 30 young people attend the group regularly.**

Cluster Mental Health Support: Cluster Mental Health Support (previously known as TaMHS) is a citywide service that provides early intervention and short term specialist mental health support to children and young people via school clusters. The service works with school age children so will support some young people aged 16 and 17 years in sixth forms that are attached to secondary schools, however this is likely to be a small proportion of their service user profile. The commissioners do not have access to service use data broken down by age.

Therapeutic Social Work Service (TSWS): The Therapeutic Social Work Team is funded and delivered by Leeds City Council. It provides therapeutic support to children and young people who are looked after and to care leavers. In addition, NHS Leeds CCG funds an additional element that aims to deliver a level of therapeutic support to those young people who are Looked After and Placed outside of Leeds but within an 80-mile radius of the Leeds boundary.

In 2015/16 the service received 8 referrals for young people aged 18-25 who were care leavers out of a total of 234; just 3.4% of the total. There is no data regarding referrals of young people within the 16-18 age range but anecdotally the feedback is that this is also small numbers.

Child and Adolescent Mental Health Services (CAMHS): Leeds CAMHS is a specialist Tier 3 and 4 service provided by Leeds Community Healthcare NHS Trust. CAMHS provides assessment and therapeutic treatments to children and young people with mental health problems and neurodevelopmental conditions. They offer a citywide service from a number of locality based multi-disciplinary teams. Clinics are held in over 30 different locations across the city. There is also an inpatient unit (Little Woodhouse Hall) which is a regional unit (Ref: CYP HNA, 2016)

Figure 6 Total Referrals: CAMHS 16 and 17 year olds (2015/16)

All	590
Women	339
Men	151

Figure 6 shows that more young women were using the service than young men.

The top three referral reasons (internal and external data combined) are:

- Self-harm (36% of cases) [28.5% of total referrals for males and 40.1% of referrals for females (16 and 17 year olds) were for self-harm.]
- Depression/low mood (20.8%)
- Anxiety (10%).

Improving Access to Psychological Therapies (IAPT): IAPT is designed to meet the needs of 16% of the estimated population of Leeds with CMHD. IAPT for young people is a service provided by Community Links that specifically targets people aged 17 – 21 years.

The wider IAPT service (consortium led by Leeds Community Healthcare) also works with this age range. Data from the IAPT service (including the young people focussed Community Links service) covering the 17 - 25 year age range is shown below:

Figure 7 IAPT 2015/16 Ages 17 – 25 years

CCG (of GP)	N	SE	W	Grand Total
Referrals	696	1174	2175	4045
Referral rate/100,000	3,141	3,939	2,887	3,178
Entered	464	755	1493	2712
% of referrals who entered treatment	66.7%	64.3%	68.6%	67%
% who entered treatment who recovery	34.86	34.79	37.06	35.57

Figure 7 shows crude referral numbers and rates for IAPT treatment in the 17-25 year old population group, along with recovery rates. It indicates that Leeds West CCG area has the highest percentage of referrals entering treatment and the highest recovery rate – possibly associated with the student population.

As the IAPT data recording system is so rigorous it is possible to compare referral rates and recovery rates of this age group with the population overall. Figure 8 shows that the percentage of young people entering treatment after referral is lower than the population overall, and recovery rates are 5% lower than for Leeds overall.

Figure 8 IAPT service use (17 -25 years) compared to general population

CCG (of GP)	Young People (17 – 25 years)	Total Population
Referrals	4,045	16,620
Referral rate/100,000	3,178	2,403
Entered	2712	11,709
% of referrals who entered treatment	67%	70%
% who entered treatment who recovery	35.57	41.5

Data is also available from IAPT regarding access and outcomes by ethnic group and by sexuality. The numbers ins some categories are too small to be able to draw firm conclusions about the effectiveness of IAPT for different groups of young people. However, what is notable from Fig 9a is that referrals to the service with a 'known ethnicity' constitute around 15% of all referrals. This is slightly below the proportion of the BME population in Leeds (around 19%), and given that rates of CMHD are higher in certain BME groups – most notably Black women, this may represent an under-representation. More work may be needed to understand young people's experience of IAPT, particularly related to ethnicity.

Figure 9

a) IAPT Access and Recovery rates by ethnic category 16 – 24 years

Ethnicity	No. Referrals	*Recovery rate
A-White-British	3290	39.7%
B-White-Irish	25	33.3%
C-White-Any other White background	100	46.9%
D-Mixed-White and Black Caribbean	96	31.4%
E-Mixed-White and Black African	14	100.0%
F-Mixed-White and Asian	43	54.5%
G-Mixed-Any other mixed background	63	18.2%
H-Asian or Asian British-Indian	43	38.5%
J-Asian or Asian British-Pakistani	54	18.5%
K-Asian or Asian British-Bangladeshi	10	50.0%
L-Asian or Asian British-Any other Asian background	22	45.5%
M-Black or Black British-Caribbean	27	22.2%
N-Black or Black British-African	48	22.2%
P-Black or Black British-Any other Black background	9	22.2%
R-Other Ethnic Groups-Chinese	18	40.0%
S-Other Ethnic Groups-Any other ethnic group	48	16.7%
Z-Not stated	118	36.0%
Not Known	83	50.0%
Grand Total	**4111**	38.6%

b) IAPT Access and Recovery rates by recorded sexuality

Sexuality	Referrals	Recovery rates
1-Heterosexual	3144	39.3%
2-Gay / Lesbian	153	39.0%
3-Bisexual	281	35.2%
4-Not Known(person asked and not known or not sure	120	44.4%
NA-Not Stated(person asked but declined to provide a response)	243	32.2%
UNKNOWN	152	36.0%
Missing	18	N/A
Grand Total	4111	38.6%

*Recovery rate is calculated Recovered /Completed - not at casenesss)

Figure 9 b indicates that Lesbian/Gay and Bisexual people constitute 10% of known referrals to the IAPT service. This may be suggestive of higher levels of need in this group of young people (estimates tend to give 10% as the upper limit of LGB people in any given population). Again, whilst numbers are small (and over 500 referrals do not have a record of sexuality) notable are the lower recovery rates in people who identify as Bisexual. There is currently no field in the data system to record whether someone accessing IAPT identifies as Trans.

Leeds and York Partnership Trust: LYPFT provides both inpatient and community based services for people with moderate/severe mental health problems. 12 months data – detailed below - shows that out of 8,381 total referrals there were 2,632 individual young people who were taken onto caseload

Figure 10 LYPFT Service Use 18 – 24 year olds 01/04/2015 to 31/03/2016.

Team Category	Team Category Desc	Count of Referrals	Count of Service Users
A06	Community Mental Health Team - Functional	2020	1578
A08	Assertive Outreach Team	27	22
A09	Rehabilitation & Recovery Service	41	19
A10	General Psychiatric Service	207	118
A13	Psychological Therapy Service (non IAPT)	253	229
A18	Single Point of Access Service	5191	2180
C03	Eating Disorders/Dietetics Service	35	31
Z01	Other Mental Health Service - in scope of National Tariff Payment System	482	311
Z02	Other Mental Health Service - out of scope of National Tariff Payment System	125	87
Overall - Summary		**8381**	**2632**

Source: LYPFT PARIS system

Eating Disorders

Eating Disorders range in severity and are treated across the primary care and mental healthcare system. They are also often co-morbid with other mental health problems. Available service data is detailed below.

Yorkshire Centre for Eating Disorders: The Centre for Eating Disorders accepts referrals for people with significant eating disorder morbidity. People are accepted into caseload if they:

• Are 8 years of age or above,
• Have moderate to severe Anorexia Nervosa, i.e. core psychopathology and BMI<17kg/m²
• Have severe Bulimia Nervosa, i.e. core psychopathology and daily bingeing AND daily purging
• Have 'Eating Disorder Not Otherwise Specified' (EDNOS) if they are pregnant or have type 1 Diabetes Mellitus

The FREED (First Episode and Rapid Early Intervention Service) eating disorders project (based within the YCED) specifically targets young people and has been developed to provide early intervention and support in eating disorders (similar to Early Intervention in Psychosis Services). Key goals are to decrease the duration of time someone has untreated eating disorders and to provide flexible person centred care that promotes early recovery. Criteria include:

- Diagnosed ED <3 years
- BMI less than 18.5
- 18 – 25 years old
- Weekly bingeing in the case of bulimia nervosa
- Leeds postcode

Early findings from this work (reported by South London and Maudesley Hospital) are positive – in terms of reducing the duration of untreated eating disorders, clinical outcomes, and engagement. Findings from the national roll out (including Leeds) will be available at the end of 2018. The intervention currently has 27 people enrolled.

LYPFT: Eating disorders may be recorded as part of diagnosis/clustering within the acute mental health system and are often be co-morbid with other mental health problems. Eating disorders may therefore appear across the fields in Figure 10 above. However, where it is recorded as a primary diagnosis, Figure 10 shows that 31 people received specific support for eating disorders from acute mental health services.

Eating Disorders and Hospital Episodes Statistics: People may be admitted to hospital because of complications associated with eating disorders. Data from February 2015 to January 2016 indicates:

- There were a total of 2,703 finished admission episodes (FAEs) for an eating disorder (All age)
- 2,454 (91%) of the FAEs were female and 247 (9%) were male.
- **The most common age for a patient being admitted to hospital for an eating disorder was 15 years old for both females (308 FAEs) and males (29 FAEs).**

IAPT: IAPT services support people with mild/moderate eating disorder symptoms as part of either Step 2 or Step 3 provision.

Figure 11 IAPT: 2016/2017 (Primary or Secondary Diagnosis F50 Eating Disorder)

16 – 24 years	38 (37 Female/1 male)
17+ years	97 (91 female/6 male)
Total Number	17,438

Finally, Figure 12 provides a snapshot of eating disorders recorded in primary care (although as many codes exist for eating disorders on GP systems, it is likely that the audit is incomplete). It shows that in October 2017 there were approximately 530 young people recorded s having and eating disorder in primary care.

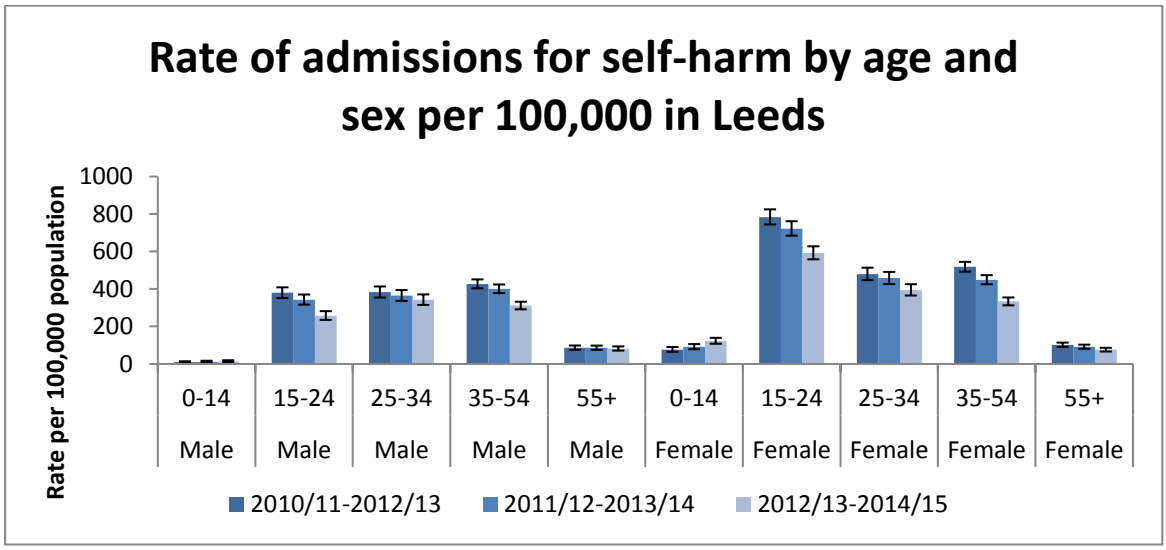
Figure 12 Eating Disorders in Primary Care October 2017

auditdate		201710
age		16-24
Registration Status		Current
Row Labels		Count
E271	Anorexia Nervosa	96
E275	Other unspecified non-organic eating disorder	11
E2750	Unspecified non-organic eating disorder	6
E2755	Non-organic infant feeding disturbance	2
E2756	Non-organic loss of appetite	2
E275y	Other specified non-organic eating disorder	1
E275z	Non-organic eating disorder NOS	1
Eu50	Eating disorders	133
Eu500	Anorexia Nervosa	8
Eu501	Atypical Anorexia Nervosa	3
Eu502	Bulimia Nervosa	28
Eu505	Vomiting associated with other psychological disturbances	2
Eu50y	Other eating disorders	1
Eu50z	Eating disorder, unspecified	86
X00Sx	Eating disorder	110
X00Sy	Weight fixation	2
X00Sz	Atypical Anorexia Nervosa	2
XE1bQ	Eating disorder named VARS or Pick A or Infant Feeding problem	3
XE1Yk	Bulimia Nervosa	35
XE1Zq	Other eating disorder	7
		TOTAL 539
not searched:		
1FF	Binge eating	
R030	Anorexia	
R0300	Appetite loss	
R030z	Anorexia NOS	
ZV4K3	Inappropriate diet and eating habits	

Self-harm Admissions

Self-harm is symptomatic of mental distress – locally and nationally there is a growing concern regarding self-harm in young women. Admissions data only records the most serious cases that need medical attention and there is a focus in the city on not admitting people for self-harm wherever possible. The data that is available however, shows that women in Leeds in the 15 – 24 year age group have twice the rate of admission as young men.

Figure 13 Rate of admissions for self-harm by age and sex per 100,000 in Leeds



Primary care data – Common Mental Health and Serious Mental Illness Qof Registers

Common Mental Health Disorders: CMHD are recorded in Primary care on the QoF payment system. They include: Depression, Anxiety, OCD, Panic, Phobia, PTSD, and Postnatal Depression. The Public Health Intelligence Team audit GP registers on a quarterly basis. Once someone has been recorded on a register it is likely that they will remain on that register – even if, for example, their depressive spell has ended. This data therefore represents 'lifetime primary care prevalence' and not the number of people in a given year that might be experiencing CMHD. Anecdotally, there is wide variation in the recording/coding practices of GPs. Mental illness may in itself also not be recorded at all, so the data presented must be treated with caution.

Figure 14: Number of people on Primary Care CMHD QoF Register (by Age) Snapshot October 2016

All Age	Number of People	Percentage	Dsr/100,000
LNCCG	30483	14.4	15,022
LSECCG	41564	15.2	16,061
LWCCG	57563	15.5	16,780
Total	**129,610**		
16 – 24	10,701	8.7	
60+	35,789	21.6	

Figure 14 shows that nearly 11,000 young people are recorded as having a CMHD in primary care. This equates to 8.7% of the total population of GP registered young people. This compares to 21% of people aged 60+ and 15% of the general population. Section 1 summarised findings from national research which found

that 17% of young people reported CMHD symptoms. This suggests that, locally, young people are under-represented in Primary Care registers for Common Mental Health Disorders.

Figure 15 Serious Mental Illness (Q4 2016/17 Leeds registered)

All Age	Number of People	Leeds population	Percentage of Leeds population
Total	8,069	677,501	1.2
16 – 24	297	120,352	0.25

Figure 15 provides a snapshot of the SMI register in Primary Care. It shows that overall, 1.2% of the Leeds population are recorded as having an SMI. For the population aged 16 – 24 years, this is 0.25%. This is set against higher than average rates of First Episode Psychosis in Leeds, and the fact that rates of likely bipolar disorder are higher in young people.

Young people appear under-represented in primary care registers for both CMHD and SMI. This may signal that young people are seeking help directly from other, bespoke mental health support services (such as Aspire or IAPT); or that that the apparent 'need' in the population is not being diagnosed. This is potentially positive - as young people's mental health needs may not be 'medicalised'. However it may equally signal that young people are not receiving early support for mental ill health.

Early Intervention in Psychosis Services

Early Intervention in Psychosis Services are recommended by NICE as key to improving outcomes for people with psychosis. Figure 16 indicates, in line with the national picture that the highest service use of EIP services in Leeds is by the 18 – 24 year old age group.

Notable is the high proportion of people using the service from a BME background. Over 30% of service users are from a BME background – this compares to around 20% of the Leeds population.

Figure 16 Early Interventions in Psychosis Service Use (Age and Ethnicity) 2015/16

Age Groups	Number	% service use
Under 18	12	3.7
18- 24	141	43
25-29	83	25
30-34	66	20
35-39	25	7.6
	327	

Broad Ethnic Group	Number	% service use
Asian	46	14
Chinese	1	0.3
Black	36	11
Mixed	26	8
White	180	55
Client declined to answer	2	0.6
Not known/to obtain	27	8.3
Other	7	2.1

Personality Disorder Network

The personality disorder network report: Personality Disorder Networks care co-ordination caseload: the median age of service users have decreased from 30 years old in 2012/13 to 21 years old in 2016/17.

At present 70% of service users are aged between 18-25 years - the majority of these being women.

3. Key development and Target Groups

1. Young People making the transition from CAMHS to Adult Mental Health Services

The Future in Mind Leeds Strategy has the following priority: 'Work with children and young people who have mental health needs as they grow up and to support their transition into adult support and services'

This programme of work has, to date, delivered:

- Young Adults page for MindMate website developed with MindMate 16 plus panel and linked to adult MindWell portal
- Engagement with young people on "what great looks like" for services 17+
- Each adult Community Mental Health Team has identified a young person's champion (role co-designed with CYP)

Future deliverables (2018/19 to 2019/20) include

- Extend the number of young people's champions in adult services to include specialist services in LYPFT and third sector providers (2018/19)
- Scope the possibility of creating a single offer for young adults from the age 16 – 25 with the commissioners of adult mental health services (2019/20)

2. Young People in Crisis

Future in Mind also has a key focus on improving access to crisis care for young people**. Provision for young people aged 16 and 17 years is however already in place through Leeds Survivor-Led Crisis Service** (via Dial House) which provides face-to-face service, 1-1 support and a safe place to socialise and The Well-Bean Café, run in partnership with **Touchstone**. 16-17 year olds from Black and Minority Ethnic (BME) backgrounds can also access Dial House @ Touchstone service which is run entirely by BME staff and volunteers. The Connect Helpline is also open every night of the year.

3. Children who are Looked After (CLA)

CLA are at particular risk of poor mental health often due to levels of trauma and difficult early attachment relationships. Key interventions in the city targeting this group of young people include:

1. A fast track process in place for CLA or with a CP plan (via CAMHS psychologists embedded into the Therapeutic Social Work Service).

2. Films describing some of the challenges of being a CLA and a foster carer are available on the professional tab of the MindMate website. These are used as a workforce training tool for staff across health, education and social care.

3. The Market Place has been commissioned to offer faster access to longer-term counselling for young people who are Looked After or are Care Leavers up to the age of 21 years.

4. LGBT Young People:

Stonewalls' : ***School Report: the Experience of Lesbian, Gay Bi and Trans young people in Britain's schools in 2017*** found that: from a survey of 3700 LBGT school pupils,

- Almost half of all LGBT pupils still face bullying at school for being LGBT (including 64% of trans pupils)
- More than two in five trans young people have tried to take their own life.

There is a developing programme of work in the city which seeks to address mental health inequalities experienced by LGBT young people. This is being led supported by Public Health England and the national LGBT consortia.

4.Student Mental Health Overview and Service Use

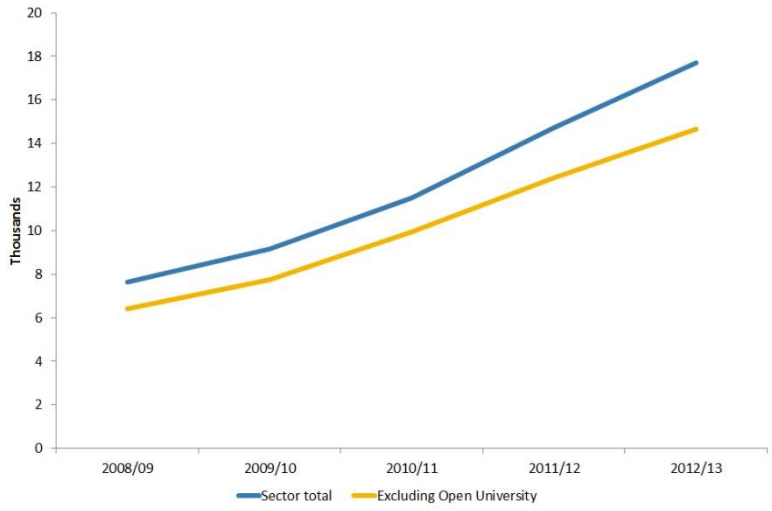
There are over 60,000 students living 'away from home' and attending higher education in Leeds. The largest Higher Education (H.E.) providers in the city are: University of Leeds, Leeds Beckett University, Trinity and all Saints College – however Leeds City College and Leeds College of Music and Leeds College of Art all have significant numbers of FE and HE students enrolled. There are approximately 120,000 young people aged 16 – 24 years registered with a GP in Leeds; students living away from home therefore constitute around 50% of the population group considered in this report, with many other young people studying and living in the city.

Overview

In 2014 the Higher Education Funding Council for England (HEFCE) commissioned a report to update the Council's understanding of institutional support provision for students with mental health problems and other impairments with high cost or intensive support needs. In July 2015, The Institute for Employment Studies published their report, based on a literature review and case studies completed at 12 Higher Education Institutions and Further Education Colleges across England

Headlines from survey:

a) Increase in reported mental ill health



b) shift in the nature of mental health problems

'Whereas traditionally the university counselling services would have been around transition, homesickness, relationships, developing a sense of identity outside your primary caregivers. Now it's severe and enduring mental health problems that we are seeing as our most common presenting concern.'

Possible reasons for the increase in mental health problems include:

- Institutions have grown in size, with increasing numbers of students.
- A more open culture concerning mental health makes it easier to ask for help.
- Diagnostic procedures have improved, producing more reliable diagnoses at an early stage in a student's life.
- Better quality of care and treatment may mean that individuals who would not previously have attended HEI are now studying at HEI.
- Shortcomings in external statutory mental health provision, including barriers to referral and long NHS waiting lists, may mean HEIs are bearing the load as this provision recedes.
- Support in school is better in terms of improved awareness of mental health and access to counselling. This was thought to have enhanced students' knowledge that there is access to support.
- Intensified individual pressures exerted on students which were exacerbating mental health problems:
- Recent student cohorts were less prepared in terms of their resilience to make the transition into HEI.
- Increased body and image awareness coupled with decreased social interaction was felt to stem from the advent of social media
- The dangers of very accessible and unpredictable legal highs, as well as the impact of incidences following overconsumption of alcohol.

The Institute for Public Policy Research (IPPR) published a further report in 2017: *Not by Degrees: Improving Student mental Health in the UK's Universities* (September 2017). It details findings from:

- In depth literature review and analysis of secondary datasets provided by HE Statistics Agency
- Findings from a survey of 58 HE and FE institutions
- Qualitative Stakeholder Analysis (via telephone and face to face interviews – including the University of Leeds

Findings:

- **The worsening mental health of this age group overall – driven by worsening mental health of women.**
- **The increasing number of people reporting a mental health problem to universities**
- **The dramatic increase in pressure on HE services.**

Recommendations include:

- **HE sector to collectively adopt student mental health and wellbeing as a priority**
- **HEIs to increase funding for student mental health**
- **Government to facilitate:**
- **New place based coalitions ….through integration across local services and a new Student Health Fund.**
- **Pilots of 0 – 25 year mental health services in places with high student populations**
- **A new student premium to top up the funding of GP practices in places with high student numbers**
- **Pilot new student heath passport to improve continuity of health care and treatment**

Service use data Universities and Colleges are an important source of emotional and mental health support for young people. The HE and FE providers in the city deliver a range of mental health provision and support. Detail from services is included below. Almost all providers have a wellbeing/emotional support function and provide 'in house' counselling. A notable difference is between the role of 'Mental Health Advisors' at UoI - who provide, in essence case co-ordination and mental health advisors at Leeds Beckett who provide mental health case loading

Leeds City College is both an FE and HE provider in the city.

Figure 17 Leeds City College Counselling Service Use Data September 2016 – March 2017 (7 months)

Total number of students	
Total number of service users (All age)	314
Age 16 - 18	183
Age 19 - 21	53
Female	209
Male	95
Transgender	6

Figure 18 Leeds College of Music Mental Health Service Provision (Academic year 2016/17)

		% of total pop 16 – 25 years
Total number of students (16 – 25 years)	1,248 (72% Male/28% Female)	
Total presenting to mental health/wellbeing services	280 (60% Male/40% Female)	22%
Counselling	93	7.5%
Wellbeing	125	10%
Mental health advisor	59	4.7%

Figure 19 University of Leeds Mental Health Service provision, 1st September to 4th November 2017

	2016/17	2017/18	% Increase
Student contacts through Duty System	0	39	n/a
Student Counselling first appointments	368	425	15%
Wellbeing Triage first appointments	0	167	n/a
Mental Health Advisor first appointments	82	113	38%
Ongoing counselling appointments	579	639	10%
Total first appointments	450	744[1] (excl Duty)	57% (excl Duty)
Total appointments	1029	1344	29%

Figure 20 Leeds Beckett University Mental Health Service Provision 2016/17

		% total university pop 16 – 25 yrs
Total number of students (16 – 25 years)	20,896	
Total presenting to services	1,214 (68% Female/32% Male)	5.8%
Counselling	444	2%
Wellbeing	431	2%
Mental health advisor (including caseloading)	231	1.1%

[1] We estimate around 100 students are double counted here, as they will have attended an initial Wellbeing Triage appointment, followed by a first counselling or mental health appointment.

Figure 21 Leeds Student Medical Practice/Primary care and service use data Snapshot: November 2017

Parent count registered patients 16+	44229	
Name	Count	%
Anxiety/Depression/Anxiety and Depression	**1559**	**4%**
Male	**473**	**30.3%**
Female	**1086**	**69.7%**
Eating Disorders	**173**	**0.3%**
Male	**13**	**7.5%**
Female	**160**	**92.5%**
Self Harm	**417**	**0.9%**
Male	**95**	**22.8%**
Female	**322**	**77.2%**
SMI register	**63**	**0.1%**
Male	**25**	**39.7%**
Female	**38**	**60.3%**

Leeds Student Medical Practice has a list size of 44,000 patients. It provides primary care services primarily for the student population and therefore is an excellent way in which to understand the health needs of a large proportion of the young people living in the city. Primary Care populations in general, provide a good basis for estimating prevalence/incidence although GP QoF registers may not always represent need as GPs do not always code diagnoses/problems on the system. Within this student population group in particular there may also be concerns that if health problems are recorded this will have an impact upon careers.

GPs at this practice estimate that around 30% of consultations are 'mental health related'.

The data does show that women appear to have greater levels of mental health need/are using services for mental ill health to a greater extent than men.

5.Summary of qualitative reports and survey

1. ***Future in Mind: Leeds An Insight into views and experiences of young people, parents and professionals***

This report was produced by Healthwatch Leeds (supported by Common Room) who gathered the views of young people, parents and professionals via surveys and workshops. It was published in March 2017.

Key findings include:

- An overall improvement in waiting times for CAMHS
- A lack of awareness of the MindMate website and Mindmate Single Point of Access
- Family and Friends are a vital source of support for children and young people who were waiting to access/use services.

*Specific findings regarding **IAPT for Young People** included:*

- "The service was helpful as it gave me a better way to cope with everything going on and helped me get through it"
- "In the initial phonecall the lady that I spoke to was incredibly condescending and made me feel as if I was deliberately making my problems worse".

*Feedback on **The Market Place** included:*

- 'It is easily accessible and welcoming'
- 'It's really helped me and I'm very grateful for it, I would recommend it
- 'Spread the word, so more people know about it"

In analysis of **Aspire** the report recommends:

- Further service user engagement work to develop a greater understanding of how young people experience the service,
- Improved gender sensitive approaches
- That young people can get in touch a variety of ways – not just by phone.

2. At an event regarding the **mental health needs of the LGBT population**, which employed an approach called Roads Bridges and Tunnels. The following key areas were noted in relation to young people:

Roads: Service regularly accessed include: CAMHS/Leeds City Council Youth Service/Mind Mate/Mind Well/School counselling/Barnardos (8-24) - 1-1 support for Leeds schools

Road blocks include: Age restriction/Waiting lists/Students populations/ Not asking right questions - so no referrals were made/Mind mate's screening process

6.Summary of 1:1 interviews with stakeholders

Short, 20 minute telephone interviews were held with key stakeholders in the city. Where this was not possible, the interview schedule was emailed to participants to fill in and return electronically (further details are available in Appendix 1). 6 people responded/took part in the interviews – with none returned from the Third Sector. Responses have been grouped thematically below and quotes included where appropriate.

What do you think are the main issues that affect the mental health of young people in Leeds?

Risk factors for the poor mental health of young people in Leeds were reported as being:

- **Those issues or clustering of experiences that are well – known to increase the risk of mental health problems in the general population. These are often associated with:**

- Deprivation/Poverty
- Adverse Childhood experiences including trauma and abuse
- Maternal mental ill health and the impact of this on stable attachment relationships

- **Specific issues or circumstances that are more likely to affect this age group include**:

- Family breakdown
- Social media and peer pressure
- Debts
- Alcohol/recreational drugs: "not just soft drugs and possibly on 2 nights a week – with no understanding this is bad for mental health"

- **16 – 24 years is a time during which a new** identify is being formed and young people are becoming autonomous adults. This bring challenges.

- **The HE student** population is undergoing this psychological transition, often away from support networks of family and old friends, this is compounded by stress of exams/academic pressures, course fees and transitions in learning styles to a more independent style of learning

- **There is an increase in the number of young people studying in Leeds who arrive in the city with mental health problems:**

- *" they have had previous CAMHS or student counselling experience – this suggests that there are a number of people who are struggling earlier in life – and this is being brought to university"*
- *"Widening participation means that many more young people are coming to University many of whom are unprepared for the challenges it entails"*

What types of mental health need/illness do the young people that you see present with?

Anxiety is a significant issue for young people

- *"Anxiety – particularly social anxiety and perfectionism"*
- *"10 years ago student counselling was around depression/low mood….now it is anxiety and panic attack"*

There is an increase in 'emergent personality disorder', **self-harming behaviour** and **eating disorders**

Increasing numbers of people are 'expressing psychological distress' within the student population:

- *"We are noticing an increase, especially this year, of a rise in people seeking help. Many of these needs may not have a psychiatric diagnosis, but there is a greater expression of distress*
- *"Levels of distress measured by CORE10 are increasing year on year"*

And in the population overall,

"*The young people we (*Personality Network*) see usually already have a long history with services. However, we have also started to work with young women who have only recently come to the attention of services but have a history of trauma, emotional difficulties and self-harming behaviour".*

Do you have a sense of how/if problems are changing (over-time)?

Primary care and IAPT practitioners who responded perceive there to be an increase in

- Social anxiety, and anxiety/depression
- Eating disorders – particularly in females
  People disclosing previous trauma and abuse

Student counselling services report:

- A **30% increase on last year in people accessing mental health support.** Part of this is an increase in severe/enduring mental health problems coming to Leeds but some is an over medicalisation of stress as a mental health problem
- **Rise in demand, complex, severe and enduring**

What/where are the gaps in service provision

Respondents identified very clear gaps in service provision:

- There are **no inpatient eating disorders beds** in Leeds
- There is **no out of hours safe space/crisis support for young people** in the city until they reach 18 years old (However, the children and young people's mental health commissioners report that DIAL house/Touchstone does offer a service for 16 and 17 year olds).
- **Step 3 IAPT – the wait is too long** (and for students this is complicated by the fact that waiting times don't align with the academic cycle)
- **There needs to be better support for families/Children and Young People** with SEND but who are below the threshold for support
- **Transitions need to be improved. There are particular concerns regarding** support for 17 year olds who are too old for CAMHS but too young for adult mental health services.
- **There is a gap in provision between primary and secondary care services -** There are some people who 'bounce around' and that 'fall through the cracks'. They may not meet criteria for IAPT, CMHT, the Eating Disorders Service or Journey:

  "They may self-harm, get worse, attend A and E, see ALPS and then their GP. This constitutes huge pressure on the system, and in the meantime, the person is not getting better".

- Who meets the need around distress – between IAPT and CMHTs? Young people need someone to talk to, so they can **work through problems, to help them manage distress and give coping strategies.** There are a lack of **appointments in the city for counselling and psychotherapy**

  "The increasing presentation of young women/people in distress to services across the city….has to be considered in a much wider social and political context and not just focused on locating 'the problem' and the 'solution' in the individual. There is a growing movement to make more explicit the links between how changes within society have an impact upon people… leaving them to become increasingly oppressed, marginalised and distressed. And that we should resist the urge to medicalise this distress"

Are there particular groups of young people that you are concerned about?
Are there groups whose needs are not currently well met in Leeds?

Responses to this question were less definitive and may signal that more work needs to be done to understand inequalities within this population/age group. Answers that were given included:

- Men and some BME groups are under-represented in student counselling services.
- Asian females appear to particularly vulnerable group in terms of CMHD - high levels of perfectionism and cultural/family expectations
- Children or Young People who are withdrawn from education – what support do they receive?
- How well do we support young people with emerging Personality Disorder?
- How much support is there for LGBT and Transgender young people?

If you could make one service change what would it be?

- **Focus on prevention:**

- Parenting and family support
- Better early intervention and education in schools - It is concerning that in the future schools that are academies - there is no requirement to buy into emotional/mental health support
- TAMHS has moved to cluster model – there are now educational packages for schools that can be used

- **Getting Transitions right and improving Crisis Care services for young people:**

- **Address the increase in expressions of psychological distress, but do not medicalise these issues.**
  - *"There are a number of services in the city that are beneficial and that young people report, work well for them. It's about increasing what's working"*
  - *"Build on the MarketPlace – expand this to provide a multi-agency matrix of services that takes a less medical model and can be less rigid"*
  - *"Look at what CAMHS and the marketplace provide – why does that need to change at 18…. It works?"*
  - *"Don't need to use clinical outcomes"*

  - *"Mental health services have a role to play in 'distress'….there is a clear evidence base for psychological interventions, however, the 'offer' to these young people should be more inclusive, drawing upon the assets and resilience within the communities, whilst also 'calling out' those policies and practices which undermine mental well-being. We need a more whole systems and systematic approach to the work"*

- **Service communication and thresholds**

- Increase resources of services to provide a primary care mental health service.
- We need to align triage and allocation processes more closely between university and NHS Services
- Students are often committed to lectures so they need something in the evenings/weekends
- **"***Ensure that something is available for everyone who needs it. Services (should) talk to each other and criteria either overlap or have clear cuts offs to the next services to pick up - so people get the appropriate person they need*".

Students

- Effective and brief interventions can be life changing – the majority don't need long term therapy
- The student section in Mindwell is currently blank.

7.Summary of Key Findings and Areas for Action

1.	**Increasing Levels of Need** Partners in Leeds are delivering significant programmes of work to prevent mental ill health in this age group and support young people to develop resilience. This includes the work of individual organisations along with initiatives delivered under: Child Friendly Leeds, Best Start and Future in Mind. However national research suggests that: • Rates of many mental health problems may be higher in young people than in other age groups; • The mental health of young people appears to be worsening and, • This is driven by the deteriorating mental health of young women. Local practitioners report that national trends appear to be reflected in Leeds.
Areas for action	• What can be done to further to prioritise this age group and address their mental health needs? • What additional targeted work can be developed for young women that increase protective factors and reduces risk factors for poor mental health?
2.	**Current service configuration means that young people's needs are not being met or they are 'falling through the gaps'** The current configuration of adult mental health services has resulted in their being **a gap in provision for people exhibiting varying levels and signs of distress** or 'not coping'. This is perceived clearly in the young adult population. Practitioner's report that young people are experiencing increasing levels of distress. There is broad agreement that the way in which to support young people with these types of mental health problems is related to approaches that make explicit the links between external stressors/life events and coping strategies/behaviours. In practice this may be found in 'Community Psychology' approaches, case-loading and flexible models of person-centred care. A significant programme of work is in place to address transitions – however, this is a particular issue for students when moving between child and adult services as well as sometimes, new cities. The recent Institute of Public Policy Research report suggests key areas for improving the mental health of the student population include: • New place based coalitions through integration across local services. • Pilots of 0 – 25 year mental health services in places with high student populations
Areas for action	• What can be done in the city to build on the work of youth-focussed mental health services that take flexible approaches to supporting young people? • Is there value in explicitly adopting trauma informed/community psychology PTM approaches for this age group?

	• How can we improve communication between local HE institutions and NHS services and develop agreements about shared care? How might this feed into new models of care/provider arrangements. • How possible is it to move towards 0 -25 year mental health services in the city?
3.	**Specific Mental Health Problems**
	Eating Disorders Broad estimates for eating disorder symptoms in the 16 – 24 year population, applied to Leeds, yield significant numbers (ie. 15,000 people). Thresholds for access to treatment for serious eating disorders are strict (although the FREED project is addressing this). Anecdotally, much eating disorder morbidity is contained within Primary Care. GP systems show that there are currently around 530 people aged 16 – 24 with a code for ED, although as there are many codes for Eating Disorders, this may be incomplete. Eating disorders may not be visible in mental health data systems as they are often comorbid with other conditions and contained within broader clustering processes/systems. However, there were around 30 people supported by IAPT in 2016/17 and another 30 people on the LYPFT caseload with eating disorders coded.
Areas for action	• Do we have a true sense of morbidity related to eating disorder in Leeds and where would we want to 'draw the line' with morbidity. • Can we use SCOFF for cross sectional survey of pop? • How can we link FREED into local commissioning cycles systems – and can we learn from their early intervention type approach? • Is there further work to be done through the Women's HNA on this issues?
	Self-Harm Anecdotally, levels of self-harm are high and increasing, particularly in young women. Self-harm is the single largest reason for referral to CAMHS. Population level responses include work in schools targeting young women and new pathways in acute medical settings.
Areas for action	• Is there a specific action? • How are we addressing low level self-harming behaviour?
	Personality Disorder Personality disorders are psychiatric diagnoses that are based on the identification of certain behaviours or difficulties forming healthy relationships. The categorisation of PD is open to debate – so closely aligned are such difficulties with adverse experiences such as trauma and abuse. Local practitioners suggest that community psychology approaches (which make explicit the links between disadvantage, discrimination and abuse – and coping strategies) have much to offer this group of people. The personality disorders network have seen a lowering of the median age over the last 5 years to 26 years and around 70% of service users are women.

Areas for action	• What role might Community psychology/PTM framework have with this group of people? • Can we increase capacity within the Journey programme • Can we support young people's services (CAMHS and HE providers) to be more trauma informed? Or are they already?
4	**Key Groups** The Future in Mind work programme targets key groups of young people, including those CYP who are transitioning from CAMHS to adult services and care leavers/children looked after. Whilst CLA are at increased risk of mental health problems - referrals to the specialist team within the Therapeutic Social work service are low – around 4% of CLA population. There are also other groups of young people that, in line with wider literature are thought to be at increased risk or poor mental health/illness. These include young people who identify as LGBTQ, young people from deprived backgrounds who experience multiple disadvantage and young people from BME groups. The adult mental health needs assessment: Leeds in Mind, 2017, details inequalities across the mental healthcare system that are experienced by BME groups. More work is needed to understand the experience of young BME people – although first analysis included here shows that BME people are perhaps over represented in EIP services and appear to have lower access and recovery rates through IAPT. Within Leeds, HE students make up between 30% - 50% of the 16 – 24 year old age group. The widening participation agenda has resulted in the student population more closely resembling the general population and mental health/counselling services in the city report increasing levels of distress, higher levels of acuity and overall increased demand.
Areas for action	• Is there specific mental health support/provision for young BME groups • Is there specific mental health support/provisions for LGBT+ groups? • What proactive mental health support is in place for CLA other than TSW team? Can/do IAPT and other services report who is CLA? • What role can/could Mindmate/Mindwell play in meeting needs of these particular groups?

Appendices

Gap Analysis: CMHD (low/moderate mental health need):

Estimated prev	20,000 (10,000 with moderate/severe)	
HE/FE Counselling:		
City College	314	
Music	93	
UoL	639	
L Beckett	444	1,490 (supported by HE/FE provision) = 30%
Marketplace	209	
Entered IAPT treatment	2712	
Activity within schools, Third Sector and Primary Care	?	
	4,411	