Task Group Review of Eating Disorders and Self-Harm affecting young people in Merton

FINAL REPORT AND RECOMMENDATIONS

Merton's Children and Young People's Overview and Scrutiny Panel, April 2023

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Acknowledgments:

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Young Peers Educators at their Health information event.

FOREWORD BY THE CHAIR – Cllr Linda Kirby

The impact of Covid on our society was, for many, very difficult. Our young people, in particular, had their education disrupted for almost two years. Many of those that had good support at home and school managed to cope well. Sadly, a lot of young people did not. Additional anxiety about health, Climate Change, the Cost of Living's impact on family budgets and for some the complex influence of social media also took their toll. The level of young people experiencing mental health issues rose dramatically throughout this period.

As a task group, we felt it was important to find out how well young people with Eating Disorders and/or Self Harm have been and are being supported in Merton. We hope our findings and recommendations will offer support to those experiencing these difficult issues and throw a light on what good practice and support there is for preventative action.

In September 2019, a Children & Young People's Scrutiny task group looked at Mental Health of our young people in Merton. It made a number of recommendations. We have included an update on progress made with those recommendations in this report.

TERMS OF REFERENCE

To throw a light on the level of self-harm and eating disorders in young people in Merton with the aim of improving support and preventative action.

Investigate the prevalence of Eating Disorders and Self-Harm in young people in Merton and identify what support there is.

Identify good practice and preventative action.

Report back to C&YP with recommendations

LIST OF RECOMMENDATIONS

Issue of concern relating to Eating Disorders and Self-harm in young people	Recommendation	Responsible Decision Maker
1. Understanding how widespread the problem is in Merton – not just those at the high end of assessment.	Records to be kept and regular monitoring to be done of young people at all stages of the ITHRIVE assessment levels.	Mental Health Forum CAMHS
2. Young people with cannot be left on a waiting list	CAMHS Referral numbers, waiting list times and staffing information should be regularly reported to C&YP Scrutiny panel.	CAMHS C&YP agenda
3. Good parental guidance is essential	Promotion of good practice guidance apps. Information resource pack made available.. Specific point of contact at schools or CAMHS to offer ongoing support or advice.	Schools Community Centre Merton Comms
4. Matching the right counsellor to the young person is vital for a successful outcome.	CAMHS needs flexibility in its approach to counselling	CAMHS
5. Primary school request from Mental Health Forum survey	Primary Schools needs training to identify early signs of eating disorders.	Children Schools and Families Department
6. Secondary School request from Mental Health Forum survey	Secondary schools need ongoing training on how to support self-harming young people	Children Schools and Families Department
7. Secondary School request from Mental Health Forum survey	South West London Eating Disorders, who diagnose conditions, should be invited to speak to Merton Schools' Mental Health Forum.	Children Schools and Families Department
8. The community needs to be informed about these issues and what good practice.	Merton's Social Media should publish information on these issues and support available.	Merton comms
9. The community needs to be informed about these issues and good practice.	My Merton – Double page spread on these issues and information on what support is available	Merton comms
10. Social Media is responsible for the promotion and competitiveness of these issues which is dangerous.	Local & national government and national media need to put pressure on these platforms to address this issue	Merton Leader
11. **Emotionally-based school avoidance** - Merton's School attendance is running nationally at 2% below average.	Information needed on the research behind why this is the case.	Children Schools and Families Department

NHS NATIONAL STATISTICS ON YOUNG PEOPLE NEEDING HELP FOR SERIOUS MENTAL HEALTH PROBLEMS

In recent years, there has been a huge increase in the number of children requiring treatment for serious mental health problems including eating disorders and self-harm, figures show.

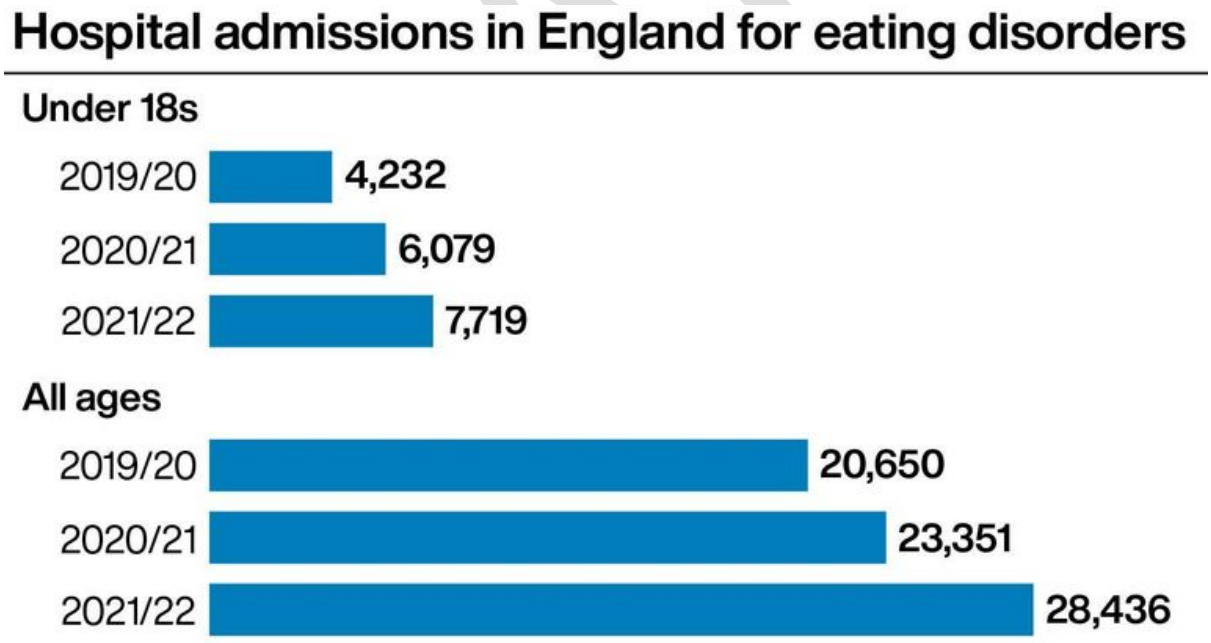
NHS data reveals a 39% rise in a year in referrals for NHS mental health treatment for under-18s to more than a million (1,169,515) in 2021/22.

By comparison, the figure was 839,570 in 2020/21, and in 2019/20 there were 850,741 referrals.

The England-wide data includes children who are suicidal, self-harming, suffering serious depression or anxiety, and have eating disorders.

Separately, NHS Digital data also shows hospital admissions for eating disorders are rising among children and young people.

There were 7,719 admissions in 2021/22 among under-18s, up from 6,079 the previous year and 4,232 in 2019/20 - which is an 82% rise across two years.



The most recent data available, from April to October 2022, reveals there were 3,456 admissions, up 38% from 2,508 for the same period in 2019, before the pandemic.

There were also 3,011 admissions from April to October 2020, as well as 4,600 for the same period in 2021 when the full effects of the pandemic were felt.

And the data suggests 2022/23 could see the highest number of hospital admissions for eating disorders, for people of all ages.

From April to October 2022, there were 15,083 admissions, compared with 28,436 for the whole of the previous year (2021/22).

There were 23,351 admissions a year earlier, and in 2019/20 there were 20,650, marking a 38% rise between 2019/20 and 2021/22.

Anorexia is the most prevalent eating disorder which is leading to hospital admissions among all ages, with 10,808 admissions in 2021/22.

The data also shows that bulimia is the next most common, with 5,563, while other eating disorders accounted for 12,893 admissions.

Dr Elaine Lockhart, chairwoman of the child and adolescent psychiatry faculty at the Royal College of Psychiatrists, said the surge of referrals for children and young people reflects a "whole range" of illnesses.

She said specialist services are needed to respond to the "most urgent and the most unwell", including youngsters who have psychosis, suicidal thoughts and severe anxiety disorder.

Dr Lockhart said more staff were needed and that targets for seeing children urgently with eating disorders were sliding "completely".

"I think what's frustrating for us is if we could see them more quickly and intervene, then the difficulties might not become as severe as they do because they've had to wait," she added.

An NSPCC spokesperson said: "These alarming figures are sadly reflected in the conversations we are having through Childline. The service delivers tens of thousands of counselling sessions every year to children and young people who are self-harming, suffering depression or anxiety, experiencing suicidal thoughts and have eating disorders."

CASE STUDY 1 – WHAT I LEARNED FROM THE TIME I HAD AN EATING DISORDER.

I first started dieting when I was 12/13 - at the time many girls at school were talking about their diets and exercise, and I decided that I wanted to start watching what I ate and exercising more (hitting puberty and body changes due to that were possibly also a factor).

At some point it switched from wanting to be a bit healthier to wanting to be extremely thin - I'm not sure exactly what triggered this change (at around the time this happened two close friends moved away, this was likely a factor). I began an extremely restrictive diet. It involved skipping breakfast and lunch whenever I could do so without it being noticed, and just eating dinner. However, I found that I wasn't able to stick to the diet, and would have bingeing episodes, where I ate vast amounts of food in short periods of time. At first my response to the bingeing episodes was to just continue restricting the next day, but soon I began purging after I had binged. At this point the bingeing episodes became much more frequent. Sometimes they were happening because I was incredibly hungry, other times as an emotional release. I continued this for some time, and maintained a healthy weight (although slightly lower than I was before I started dieting I believe).

After some time (between 6 months and a year after I had started purging) my parents became aware of the issue because they realised I was purging. They took me to my GP to get help, and I was put on the wait list to be seen at CAMHS. I believe that after this initial referral it was about 18 months before I received other treatment (other than one appointment with my GP where he tried to help by talking about the issues with me). During this time my eating disorder got significantly worse - the fact that my family knew about it and it had been given a name by my doctor meant that I was no longer trying so hard to hide it from my family (or convince myself that it wasn't serious) and this allowed the disordered behaviours to become much more severe. I was bingeing and purging almost every day, still severely restricting food, and beginning to lose significant amounts of weight.

After this period I received treatment both at CAMHS and the Priory, I don't remember exactly the order in which different things happened, but the types of treatments were:
- Cognitive behavioural therapy at the Priory for around 6 months. I think this therapy could have been useful - it was very focused around sticking to a regular meal plan to reduce the hunger induced binge-purge episodes, and also on identifying emotional triggers for episodes.

However, I was still obsessed with losing weight, and though I was able to stick to regular eating times, I wasn't willing to eat sufficient amounts in those meal times so there was no significant improvement in my behaviours. Without someone forcing me to eat more this therapy wasn't going to work.

Family therapy at CAMHS. We only had one session of this with my whole family present - it was frankly bizarre and unhelpful. It felt more like an episode of Jeremy Kyle than anything else, with the practitioners seeming to want to cause conflict. At no

point had I ever said that family issues were the primary (or any) cause of my eating disorder, so it wasn't clear to me why family therapy was considered a good way to treat them anyway, and the sort of family therapy which seemed designed to pit people against each other definitely wasn't helpful.

Sessions at CAMHS with just me and my parents. This was with the same practitioners as the family therapy had been. I still didn't find this particularly helpful. As far as I remember there was no concrete advice on steps to take (such as meal plans, or keeping a food diary like I was encouraged to do while receiving CBT). Instead my main memory of the sessions is the practitioners asking my "why won't you just eat". I was receiving weekly weigh ins during this, but I found it very easy to lose weight while hiding it from the practitioners by `water loading' or carrying weights in my pockets.

Eventually my parents realised that during my sessions with CAMHS I had lost significant amounts of weight while hiding it from them and the practitioners. I was made to do a proper weigh in at CAMHS without artificially increasing my weight at all and at that point I was diagnosed with anorexia and started seeing a doctor at CAMHS. I was also told that unless I started gaining weight I would be treated as an inpatient. This was something I was terrified of, so at that point I did gain weight and get back up to a healthy weight.

However by that point by binge-purge behaviours had become so ingrained that even though I was no longer restricting food, I used them as an emotional release, and I still suffered from bulimia for two more years after recovering from anorexia. At some point in those two years I stopped being seen at CAMHs, and my binge and purge behaviours fluctuated in frequency.

When I turned 18 I took a year out between school and university and focused on fully recovering. As part of this I was diagnosed anti depressants by my GP (high doses of anti depressants for short periods of time are a treatment that is sometimes used for bulimia). And I also saw the adult mental health services. I'm not sure exactly what worked that year, but I was able to recover from the bulimia (except for one relapse while I was at university). They key step in recovery was accepting that even if I binged, I had to stop myself purging. Eventually after forcing myself to do so I naturally stopped binging too.

I did gain significant amounts of weight that year (I was already at a healthy weight at the beginning of the year, by the end of the year I was still a healthy weight but a higher healthy weight). This was difficult, but I think gaining weight in bulimia recovery is fairly normal (even when starting at a healthy weight), and something that mental health services and families need to help patients come to terms with.

Eating disorder awareness at school: I didn't receive any treatment at school, and the only time my school was made aware of my eating disorder was when I started going home for lunch so that my parents could check I was eating it. The only time I recall eating disorders being raised at school was in a PSHE lesson (I don't remember what year I was in when it happened - I was experiencing disordered eating at the time, but I don't think the school were aware of it). We watched a video in class about a teenage girl with anorexia. The video was designed to raise awareness of body dysmorphia

and the dangers of anorexia, but for me it functioned more like a `how to guide' of ways to hide disordered eating from family & friends. The video showed a number of techniques the protagonist used to make it seem like she was eating at family meals and around friends. Some of these I was already using at the time, but others were new and I used many of them later.

Showing a film like this to parents may be useful to guide them on behaviours to look out for, but I think that showing it to students was very harmful, and care should be taken to make sure that no resources are shown to students which could give them ideas on how to hide disordered eating. (Admittedly advice on these kinds of behaviours can be found on the internet, but I think that policing internet use is a separate issue.)

Another issue I'd like to raise about the video is that it was very focused on the idea that people with eating disorders have extremely low body weight, and even showed images of the protagonist in her underwear a a dangerously low weight. While this image was designed to horrify students and make them realise how terrible anorexia is, at the time to me the image was motivational. It is common for people with eating disorders to be obsessed with comparing themselves to other people with eating disorders / people who are very underweight, and I don't think that schools should be encouraging this by showing those sorts of images. Anyone with an eating disorder is very likely to already be obsessed with body weight, and feeding this obsession is dangerous. While many people with anorexia do have very low body weight, those at the early stages of anorexia or with bulimia or binge eating disorder may be a normal weight (or overweight). Schools should be careful not to spread the myth that people need to wait until they are dangerously underweight before they are `deserving' of treatment. Overall thoughts Early intervention is really important for eating disorder recovery, but often by the time parents / teachers notice a young person has issues they have already been ill for some time. So swift treatment after the initial diagnosis is crucial. This is true even when the patient doesn't present as being significantly underweight. Bulimic patients may never be severely underweight, but they still deserve treatment. And anorexic patients / some bulimic patients who don't initially present as very underweight can deteriorate very fast while waiting for treatment, so long waiting times just lead to more treatment being needed in the long run. I think the time between family first becoming aware of the issue and receiving treatment is a particularly difficult time - both because the eating disorder is likely to be causing significant family conflict which can make the patient feel isolated, and because the problem being out in the open can lead to a loss of inhibition over the disordered behaviours which allows them to become worse. In order to make this time easier I think support for the parents is crucial. Both practical support about what kind of things they should be looking out for (i.e. ways patients might try and `fake' their weigh ins, or make it look like they've eaten when they haven't) and what they should be doing to help (i.e. should they be forcing the patients to eat, if so how much, what should they do if the patient tries to purge). These kinds of supports for the parents could still be useful after the patient has started treatment. Support groups for the patients can also be helpful, but it's crucial to remember that when people are in the grip of their eating disorder they may not want to get better yet (for me I wanted to try and recover

from the bulimia, but I didn't see any problem with being anorexic so I was not willing to stop restricting food). As such they may need the people around them to be actively involved in their recovery, and parents and families will need help with this. I don't think it necessarily makes sense for this help to be given in front of the patient (if they know what behaviours their parents are looking out for they'll try and find other ones), so I'm not talking about family therapy as much as support groups and information solely for parents. When treatment starts I think in an ideal world the patient & their family should have a say over what treatments are helping. Eating disorders aren't all the same, and what works for one person is not going to be the same as what works for another. It's a waste of NHS time and money to say that people have to sit through sessions which everyone knows aren't helping because the patient & their family know there is no other help available and they don't want to be discharged. I realise this may not be an easy thing to achieve on the NHS with limited resources, but even if there is no choice of practitioner, the practitioner could work with the patient and their family to find what sort of style works for them. Moreover, making sure that patients are getting a mix of emotional & practical support - I found that at some points in my treatment the support was all practical, and other times it was all emotional, but really what was probably needed was a mixture of both.

CASE STUDY 2 – PARENT'S OBSERVATION OF THEIR CHILD'S EATING DISORDER AND SELF HARM.

I have two children.. The younger one has generally breezed along through life but my oldest child has always been more complicated.

At the age of 13, I noticed that she was getting very picky about meals. I put this down to her being a grumpy teenager because she disguised what was really going on so well. However, over time it became clear from her moods and physique that something wasn't right. It wasn't easy to have conversations with her because she had distanced herself from members of the family and was generally quite stroppy. In her company, we were walking on eggshells. Luckily, the cry for help came when her periods stopped and she felt panicked and knew things were out of control.

Both my husband and I were fully supportive and keen to get her the help she needed. We read up on everything there was to read, looked at all the available apps for support and organised for her to get medical attention. She took time out from school for these visits. The person we worked with insisted on an eating diary and expected weight to be gained by each of our weekly appointments. There was a level of dominance from this person that installed some fear in my daughter who stuck with the diary and the regular appointments.

However, overseeing how someone eats every day is both intrusive and scary. Too much intervention and the compliance stops; not enough and panic ensued in me. Trying to control another's behaviour is challenging. Trying to control a teenager, dealing with hormone issues, social media and other teenage angst is a 24/7 nightmare that you wonder you'll ever wake from. The problem is you're dealing with a person who's in the grip of something awful; who's mind is locked in negativity; and who has mastered techniques to prevent you helping even though you know she wants your help.

When her periods returned, it felt like we were getting somewhere. She had put on weight too and seemed to be eating better. Her mood fluctuated but was, generally, less grumpy. We had some good times together again when she chose to be included. However, your antenna tells you not to switch off. You've become a detective snooping around looking for clues and when you find razor blades in her room and marks on her arms, your heart breaks. It's impossible to maintain a sense of calm when you're dealing with this. You thought it was an eating disorder but now it's something else as well – self harm.

I spent time looking at myself and how I have behaved with the children to see whether I needed to change and whether I was the cause of some of this. I took up meditation which helped. I softened my line on things; spent time, when she allowed it, to talk things through with her and share ideas I'd read about. Lisa Feldman Barrett's book – *How emotions are made*, particularly kept me sane during this awful period. It is an empowering read that really helped me think about emotions in a completely different and life-changing way.

My husband and I sought counselling sessions for her. However, it had to be the right kind of person. One that she felt comfortable talking about things that concerned her. It can take time to find that person and when you do you are so grateful because it really helps. A stranger telling you what your parents have told you over and over again actually registers. The emotion isn't there. That umbilical chord is never an issue.

I started to notice pleasant changes in my daughter's behaviour and was really impressed when a friend of hers was struggling with her own mental health and she stepped in to assist. It felt good to know she was able to empower another. That she had learned things that she could pass on.

5 years on and my daughter is taking her A levels and will be off to university soon. Am I worried still? She seems in control. She's healthy and seems to be eating well. I've not noticed any more cuts to her body. We can cuddle again. She talks to me a lot now and we've had a couple of holidays together just the two of us to build our relationship. But is it over? Will she be able to cope at University without our support. Time will tell. Fingers crossed.

Love, patience and family support and the earliest intervention that was possible have helped us deal with this. Plus all the amazing advice that support groups have taken time to produce through their apps for both young people, parents and peers. These are serious problems that need to be got on top of quickly. Luckily for us, my daughter recognised she was out of control and asked for help, that meant we were included in finding a solution. Also, we had the money to be able to buy the help we needed.

Knowing what we've been through and how challenging it is, time is of the essence. We have to ensure that no young person experiencing eating disorder or self-harm issues are left on a waiting list. The consequences for that are too awful to think about.

FINDINGS ON PREVALENCE OF EATING DISORDERS AND SELF HARM IN YOUNG PEOPLE IN MERTON

In Merton Self Harm is more common that Eating Disorders and more prevalent with teenagers.

Eating Disorders

Eating disorders can wreck lives, not just of the people experiencing them, but those of their family and friends too. Many of the issues are caused by society's praise of weight loss, celebrity culture, social media, objectification of bodies (both women's and men's but mostly women's and girl's).

Eating disorders are often symptomatic of other mental health issues which could include post-traumatic stress disorder, anxiety, depression, poor self-image, self-harm and OCD. Poor mental health can be the cause of poor attendance and concentration in lessons and can also affect other students as well as the young person's capacity for benefitting from their education at a crucial stage in their lives.

The numbers of children and young people presenting with eating disorders are relatively low in Merton.

By the end of December 2023 (the third quarter as the year runs April to April), the total number of children referred to Merton Single point of access with this as a presenting problem was 15, so unlikely to be much higher than that at the end of the year. It was eleventh in the list of reasons for referrals accounting for 0.8% of all referrals received in this time. However, there has been an increased focus on support for this aspect of children and young people's health.

70% of children with an eating disorder are from high achieving families. Pressure is often the key – they may put pressure on themselves or have pressure put on them to succeed. Not eating gives them a sense of control to prevent failure. An example of that pressure has been evidenced by a significant number of Merton children in Sutton Grammar Schools or independent schools experiencing this problem.

Some children may experience eating disorders that are trauma related or through abuse, severe neglect or triggered by lack of money, a sensory need or anxiety.

Self-Harm

The number of referrals for young people with self harm as the reason for referral was 160. It was six in the list of reasons for referrals, accounting for 8.7% of all referrals received in this timeframe.

Advice on working with the extreme end of self-harm adolescents before hospitalisation. "Young people might take themselves to the medical room with a self-harm wound. It's better for staff not to focus on the wound because that is likely to escalate the problem but to treat the wound and focus on the fact that the person is

going through a difficult time. Offering an hour a week of pastoral support when there is no self-harm is a better way of supporting the young person.

Sadly, self-harm is often a group thing of a competitive nature with social media involvement. "*My wound is worse that yours."*

WAITING TIMES

Once a referral is made to the Single Point of Access the referrals are triaged and assessed as to what the best way forward is for each case. It is worth noting that sometimes during this process the reason for referral may prove not to be the whole picture but a symptom of a different mental health need.

Access Metric	Target	% Achieved	Average Wait
Referral to Triage	24hrs	99.4%	99.6 Hours
Triage to Assessment	14 days	92%	7 days

It is worth noting that treatment times are likely to be quite individual as this will depend on the severity of the issue.

Emotionally-based school avoidance - Merton's School attendance is running nationally at 2% below average. Researching the reasons behind this is ongoing.

Findings from the two case studies.

The importance of early intervention. The situation can quickly deteriorate and other issues like self-harm can arise if left untreated, especially if the initial intervention is unsuccessful.

The importance of help for the family, in particular the parents. The parents are on the front line – dealing with the issue every day and often with very little support themselves. They also don't have the professional expertise to know how best to intervene. Questions like: Should they force eating? Oversee mealtimes? Do weigh-ins? need careful thought. Family therapy can be, at best unhelpful and at worst cause further issues. So good accessible guidance and information is essential.

Getting the right treatment and therapist.

This is so important and is raised in both case studies.

Concern that a *one size fits all* approach still pervades in the NHS. Whilst it is understandable, given cost implications, it ican lead to serious failure.

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WHAT SUPPORT IS AVAILABLE IN MERTON FOR CHILDREN AND YOUNG PEOPLE.

MENTAL HEALTH LEADS

Each of Merton's Schools has a Mental Health Lead (a bit like a Designated Safeguarding Lead but without payment.) The Mental Health Forum meets with these Leads every term.

There is money available to pay for services and training and Merton has a higher than national average coverage of a trained workforce.

TRAILBLAZER Ged Curran, SLAM (Croydon) and St George's worked together to set this up

This aims to give advice on how pupil/students and their families can access the latest support for emotional wellbeing.

Each School has a Mental Health Plan

100% of Merton's schools have a link to a team of:

- 2 Senior workers and 5 trainers.
- Extra Senior Therapist working at a low level of entry to Self-harm and Eating Disorders.

SCHOOL CLUSTERS

Merton operates in clusters:

- Holy Trinity (includes Catholic Schools)
- Cricket Green - Merton & Sutton Special Schools
- The ex CCG funded a cluster for Mitcham and Morden
- Further Education Cluster
- Bishop Gilpin group
- Band A seniors have a separate group to improve delivery.

ITHRIVE – is a model for all mental health services that looks at different ways of configuring support:

- THRIVING
- COPING - GETTING ADVICE AND SUPPORT
- GETTING HELP
- GETTING MORE HELP
- GETTING RISK SUPPORT.

There has been 4 years of working on this.

The Integrated Care Board is setting this up across SW London. Currently the language is there but service is not.

MELBURY COLLEGE AT THEIR LAVENDER CAMPUS

Offers high quality, bespoke education provision for highly vulnerable students who live in Merton and who are unable to attend mainstream school because of medical and/ or mental health needs.

Merton's NHS Education Wellbeing Services

This service is linked to and embedded within Merton CAMHS with a role of supporting young people, their parents and schools to think about mental health and wellbeing, and also specifically around self-harm.

In July 2022 a multi-agency group of professionals substantively updated Merton's protocol for supporting young people who self-harm or experience suicidal ideation: this included creating and updating practical guidance for those supporting young people, including decision making flowcharts, available resources locally and nationally for young people, parents and professionals. Attached pdf

Much of the support currently available in Merton for young people who are self-harming is overviewed in this document, page 4 has a decision making flowchart, pages 17-20 resources and key services for young people, parents and professionals. Some of the stated organisations have also been doing lots of work in the area

This service has delivered multi-agency workshops as part of the launch of the policy and has a number of resources on their Youtube channel including around self-harm and workshops for parents (as well as direct work in schools with young people):
https://www.youtube.com/channel/UCrRKV84Ib8Jr69Z7ZhjSjCg

OFF THE RECORD
For young people aged 11-25 that live in the London borough of Merton (or have a GP in the Merton borough) they can access emotional support ranging from one-off support through the walk-in counselling sessions and outreach work through to ongoing individual support online counselling and face-to-face counselling. Those under 13 will need the consent of parent/carers.

Young people can self-refer by calling 020 3984 4004 or emailing merton@talkofftherecord.org. 11-17 can also be referred through Merton CAMHS SPA (Child & Adolescent Mental Health Services, Single Point of Access).

Off the Record is an established charity which has been providing free, professional support to young people in Croydon, Sutton, and most recently Merton over the last 25 years. Staff share a vision of "Bringing an end to mental health misery for children and young people in South London".

Off the Record offers young people individual, face-to-face and online counselling across all three boroughs, and last year received over 1,200 referrals and offered young people over 7,000 counselling sessions. Their

work has been recognized through a national award programme with the charity receiving the prestigious 2019 GSK IMPACT award for work to improve young people's health and wellbeing.

STEM 4 - SUPPORTING TEENAGE MENTAL HEALTH

stem4 is a charity that promotes positive mental health in teenagers and those who support them including their families and carers, education professionals, as well as school nurses and GPs through the provision of mental health education, resilience strategies and early intervention.

This is primarily provided digitally through innovative education programme, pioneering mental health apps, clinically-informed website and mental health conferences that contribute to helping young people and those around them flourish.

Their supportive apps are available on their website https://stem4.org.uk/

BEAT **Contact:** info@b-eat.co.uk https://www.beateatingdisorders.org.uk/

BEAT has a dedicated helpline for England (0808 801 0677) and a range of services available for people who need support for their eating disorder.

Their national Helpline exists to encourage and empower people to get help quickly, because they know the sooner someone starts treatment, the greater their chance of recovery. People can contact BEAT online or by phone 365 days a year. They listen, help to understand the illness, and support taking positive steps towards recovery.

They also support family and friends, equipping them with essential skills and advice, so they can help their loved ones recover whilst also looking after their own mental health.

BEAT campaigns to increase knowledge among healthcare and other relevant professionals, and for better funding for high-quality treatment, so that when people are brave enough to take vital steps towards recovery, the right help is available to them.

The work they do means that every year lives are saved, families are kept together, and people are able to live free of eating disorders.

Input from Merton's Young Inspectors has been valuable – checking out sites to see how they work and pointing out problems.

TASK GROUP'S CONCLUSION

Adolescence is a crucial time for young people to start defining who they are, and role models can lead them into self-destructive behaviours, such as disordered eating and self-harm.

Schools can play a key role in monitoring the mental health of their students.

It is reassuring to know that all Merton Schools have a Mental Health lead and that they are linked in clusters to the Merton Schools' Mental Health Forum which meets termly and has good access to professional support. Also pleased that regular training takes place.

Referrals to CAMHS in Merton are lower than the national average for both these issues at the top end of the ITHRIVE assessment system - *getting risk support level*. However, we are unaware of how many young people in Merton who are not thriving, are at the *coping, getting help, getting more help* levels.

It is not always easy to assess whether people with disordered eating or who are self-harming are deteriorating. (Eg.Young people with Bulimia don't necessarily lose weight but can cause significant physical/mental harm to themselves). Hence why record keeping and close monitoring at the "lower levels" of the IThrive assessment system are important.

It is also important to evaluate whether the help being offered at these levels is sufficient. This information would be valuable because, as we have seen from our case studies, early intervention is vital if these serious issues are to be dealt with successfully.

Another concern from both our case studies is ensuring that the person offering counselling has a good rapport with the young person. There needs to be flexibility in who is available to offer support and a range of treatments available. Eg Cognitive Behaviour Therapy might work well for some but not others.

If support at this crucial stage is not working for the young person, it needs to be known. A satisfaction survey or assessment to evaluate what is working after a certain amount of time is needed. Other options available should be on offer. Time is of the essence. Also, we should investigate who is out there in the community that could offer support.

The satisfactory waiting times reported to us from CAMHS are 92%. However, that means 8% of young people with serious problems are not included in that target. It is vital that CAMHS is fully resourced as staff shortages at this crucial stage could be fatal.

We feel Children and Young People's Scrutiny Panel should be requesting regular feedback on staffing levels, satisfaction of support and waiting times from CAMHS.

Lots is being done in our schools. However, we feel a lot could be done in our communities to promote information and good practice and would suggest the following: Targeted poster campaigns; a double page spread in My Merton focused on these issues and support available; E-Merton promoting these campaigns.

One of the biggest worries we encountered was the impact of social media, particularly with the competitiveness of Self-Harm "*My wound is worse that yours."* We feel that national media, local authorities and government need to be putting pressure on these platforms to promote positive messages and remove negative material.

We have produced some recommendations in this report that we hope will help to address these important issues.