

The Emotional and Mental Health of Children and Young People in Nottinghamshire

Health Needs Assessment

Acknowledgements

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Executive Summary: Emotional and Mental Health of Children and Young People in Nottinghamshire

“By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does”. No Health Without Mental Health: A Cross Governmental Strategy (2011).

1. Why is the emotional and mental health of children and young people important?

Good mental and emotional health is essential to enable children and young people to fulfil their potential. Emotional and mental health problems are a common group of disorders affecting about 1 in 10 children and young people living in the UK¹. Mental health problems in childhood and adolescence can have far reaching consequences on health, social and educational outcomes. Mental illness unlike other health problems tends to start early and persist into and throughout adulthood. Mental health has been highlighted as a national priority in the Government’s mental health strategy ‘No Health Without Mental Health’ which highlights the importance of intervening early with children and families. Child and Adolescent Mental Health Services (CAMHS) is a broad term used to refer to all services contributing to the emotional and mental health care of children and young people. A four tier model is used to describe CAMHS with services ranging from those delivered by non-mental health specialists (e.g. midwives and teachers) to highly specialist inpatient services.

The aim of this health needs assessment is to systematically assess the emotional and mental health needs of children and young people aged 0-18 living in Nottinghamshire using epidemiological and corporate methods of assessing need.

2. What are the emotional and mental health needs of children and young people in Nottinghamshire?

There are 171,865 children and young people aged 0-18 years old living in Nottinghamshire, with this population expected to increase by about 3.5% over the next 10 years. About 28,000 (17%) of these children and young people are living in poverty. Mansfield and Ashfield have a greater percentage of children living in poverty than the England average.

Risk factors for emotional and mental health problems are summarised in Box 1. Many of these risk factors tend to cluster together. For example, numbers of lone parents, unemployed parents, parents on disability living allowance, families in social housing and rates of domestic violence were generally highest in Ashfield and Mansfield.

BOX 1: Risk Factors for Emotional and Mental Health Problems in Children and Young People

- | | |
|---|--|
| <ul style="list-style-type: none">• Child abuse• Substance misuse• Being in local authority care• Being in the youth justice system• Homelessness• Physical or learning disability• Physical illness• Special Educational Needs• Gypsy or Traveller• Not in training education or employment• Lesbian, gay, bisexual or transgender | <ul style="list-style-type: none">• Poor parental mental health• Parental substance misuse• Parental unemployment• Parent in prison• Lone parent• Poor parenting skills• Maternal stress during pregnancy• Low household income• Living in deprived areas• Living in social housing |
|---|--|

Looked after children and young offenders are groups of children recognised to have a particularly high risk of emotional and mental health problems, with estimates suggesting about 45% and 40%

respectively have a mental disorder. Numbers of looked after children have increased significantly in Nottinghamshire, from 440 in March 2007 to 800 in March 2012. In 2011 there were 1390 young people in the youth justice system in Nottinghamshire. The rate of new entrants into the youth justice system in Nottinghamshire is significantly higher than the average for England. The districts with the highest numbers of looked after children and young offenders were Ashfield, Mansfield and Bassetlaw.

Based upon data from the Office for National Statistics it is estimated that there are 4015 school aged children with an emotional disorder, 6183 with a conduct disorder, 1597 with a hyperactivity disorder and 1444 with a less common mental disorder in Nottinghamshire. In general the prevalence of mental health disorders is higher among boys and older children.

3. Current service use and views of stakeholders

- **Tier 2 CAMHS** consists of district emotional wellbeing teams. In 2012/13 the most common 'reasons for referral' to Tier 2 were 'behaviour', 'depression/low mood' and 'anxiety'. Numbers of referrals were highest in Ashfield (559), Mansfield (554) and Newark and Sherwood (527).
- **Tier 3 CAMHS** provides specialist multi-disciplinary services for severe and complex child and adolescent mental health problems. Referral rates to Tier 3 CAMHS varied considerably by ward and district. High referral rates were seen within Mansfield, Bassetlaw, Ashfield and specific wards in Newark and Sherwood and Broxtowe.
- **Tier 4 CAMHS** includes highly specialised inpatient care. Over three years (2010-2012) there were 91 admissions to the Thorneywood inpatient unit among 77 Nottinghamshire young people. The districts with the highest crude admission rates were Gedling (32.4 per 100,000), Rushcliffe (20.3 per 100,000) and Mansfield (20.3 per 100,000). The most common diagnoses were 'eating disorders', 'developmental disorders' and 'depression'.

Interviews with those working with children and young people in Nottinghamshire highlighted:

- High numbers of children referred to CAMHS with "behaviour" problems, attention deficit disorder and autistic spectrum disorder.
- The need for early intervention and work with families.
- In some services, a lack of capacity and staff shortages, leading to high waiting times.
- A need for clear pathways and clear understanding of the role of CAMHS among families and referrers.
- A need for services to be more targeted to the areas with the highest levels of need.

4. What are the key gaps and recommendations for child and adolescent emotional and mental health in Nottinghamshire?

Prevention: 'Breaking the cycle and taking a life course approach to preventing emotional and mental health problems'. Within Nottinghamshire, many children and young people are exposed to risk factors for emotional and mental health problems from birth. In some areas there is a clustering of risk factors that are intertwined and interrelated. Issues can be entrenched in families over generations. There is a need to break the cycle, intervene early, collaborate across agencies, 'Think Family' and build emotional and mental resilience. Recommendations include:

- Review parenting course provision and target evidence based programmes to areas with greatest need.
- Investigate current management and screening for perinatal mental health conditions.
- Work with schools to implement evidence based interventions to promote emotional and mental wellbeing, anti-bullying interventions, educational/self-help materials for children and parents, and counselling-type interventions.
- Promote a 'Think Family' approach within services.

- Work with multiagency partners to reduce or mitigate risk factors for child mental health problems (e.g. parental unemployment, child poverty, domestic violence). Raise awareness among these teams and services of their role in improving child emotional and mental health.

Targeting those with the highest needs. Preventative interventions (e.g. parenting courses) and CAMHS services need to be targeted to those with the **highest levels of need**. Eating disorders are a less common condition, but account for a large proportion of inpatient admissions and **very high healthcare costs**. Early recognition of eating disorders and management to prevent the need for admissions appears important. Recommendations include:

- Realignment of investment in Tier 2 CAMHS teams according to the level of need so that Mansfield and Ashfield receive a higher level of funding at Tier 2.
- Carry out targeted preventative work in districts according to need, and according to the types of mental health problems in the district (e.g. eating disorders in Rushcliffe and Gedling).

Services and Pathways: Getting the right care from the right team. There is concern about high numbers of referrals for ‘**behaviour**’ problems. There is a need to further explore these issues with patients, families, schools, and service providers to understand how best to meet the needs of these children and families. **Gaps in current service provision** were highlighted by stakeholders for children on the edge of local authority care, and children seen in Tier 2 CAMHS who need longer term work but do not meet the threshold for Tier 3 services. **Inappropriate referrals and poor referrals** were also highlighted as an issue. Recommendations include:

- Carry out focused work on ‘Behaviour’, including engagement with families, schools and other stakeholders to understand the needs of children with ‘behaviour problems’. Develop a ‘Behaviour pathway’.
- Promote the use of a standard referral form for Tier 2/3 CAMHS, to guide referrers on the information to provide, and support triage of referrals from the Single Point of Access.
- Monitor changes in the Single Point of Access to ensure the new system is working effectively, cases are being assigned to the right team and Tier 2 teams have sufficient capacity to review the referrals.

Supporting and building staff. A well trained and sufficient workforce is essential for the delivery of an effective CAMHS service across the four tiers. In some CAMHS services unfilled posts have increased waiting lists and increased pressures on the team. There is a recognised need to ensure that both the CAMHS workforce and those working in universal services have access to training and development opportunities. Recommendations include:

- Ensure CAMHS across Tiers 2-4 staff have access to training opportunities and continued professional development opportunities.
- Continue delivery of training to universal services. Consider targeted training to meet the needs of particular professional groups within universal services. Develop training for universal staff within Bassetlaw.

Promoting services to children, families and referrers. It is important to ensure universal services, children, young people and families are aware of the services available to support and improve emotional and mental health. It was recognised that referrers to CAMHS need to have sufficient information about the local services that are available to support children (e.g. children’s centres, parenting courses), and the mechanisms and pathways to refer children into CAMHS.

- Promote mental health and wellbeing among children and young people (e.g. online resources or social media) and ensure there is clear information about self-help resources and local services.
- Ensure information about how to refer to CAMHS and pathways is readily available and easily accessible to universal services.
- Ensure key universal services are updated about new evidence based guidelines of relevance to their practise.

Abbreviations

A&E: Accident and Emergency

ADHD: Attention Deficit Disorder

ASD: Autism Spectrum Disorder

BME: Black and Minority Ethnic Groups

CAMHS: Child and Adolescent Mental Health Services

CAF: Common Assessment Framework

CAS: Clinical Assessment Service

CBT: Cognitive Behavioural Therapy

ChiMat: Child and Maternal Health Observatory

DAAT: Drug and Alcohol Action Team

DCSF: Department of Children, Schools and Families

DEHWS: District Emotional Health and Wellbeing Service

DfE: Department for Education

DH: Department of Health

DNA: Did Not Attend

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, version IV.

GP: General Practitioner

HNA: Health Needs Assessment

HoNOSCA: The Health of the Nation Outcome Scales for Children and Adolescents

IAPT: Improving Access to Psychological Therapies

ICD-10: International Classification of Diseases, version 10

IMD: Index of Multiple Deprivation

JSNA: Joint Strategic Needs Assessment

LAC: Looked After Children

LD: Learning Disability

LGBT: Lesbian, Gay, Bisexual, Transgender

LOS: Length of Stay

LSOAs: Lower Super Output Areas

MARACS: Multi-Agency Risk assessment conferences

NEET: Not in Education, Employment or Training (young persons 16-18yrs)

NICE: National Institute of Clinical Excellence

NSF: National Service Framework

NSPCC: National Society for Prevention of Cruelty to Children

OCD: Obsessive Compulsive Disorder

ONS: Office of National Statistics

PTSD: Post Traumatic Stress Disorder

SCIE: Social Care Institute for Excellence

SDQ: Strengths and Difficulties Questionnaire

SEAL: Social and Emotional Aspects of Learning

SEN: Special Educational Needs

SPA: Single Point of Access

TaMHS: Targeted Mental Health in Schools

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1. Introduction

1.1 The importance of child and adolescent mental and emotional health

Good mental and emotional health is essential to enable children and young people to fulfil their potential. Mental and emotional health problems are an important and common group of disorders affecting about 1 in 10 children and young people living in the UK¹. Mental health is best seen as a continuum, ranging from mental wellbeing, to severe and enduring mental disorders that cause considerable distress and interfere with relationships and daily functioning. Mental health problems vary in their nature and severity, and affect individuals differently over time. The factors that affect mental and emotional health are complex, ranging from individual biological factors to complex societal issues. Mental health conditions in childhood and adolescence are particularly important due to the far reaching consequences on health, social and educational outcomes. Mental illness unlike other health problems tends to start early and persist into and throughout adulthood. It is recognised that by the age of 14 about half of all lifetime mental health problems start². This highlights the long term nature of mental illness and the importance of intervening early to prevent mental illness alongside early recognition and treatment.

1.2 Purpose of health needs assessment

A Health Needs Assessment (HNA) is a systematic method undertaken to assess the health issues facing a population³. HNAs provide evidence about a population in order to inform service planning and resource allocation with the aim of improving health and reducing health inequalities.

This HNA is being undertaken to inform and support the commissioning and delivery of a comprehensive Child and Adolescent Mental Health Service (CAMHS) for Nottinghamshire. Reasons for undertaking this HNA include:

- Significant changes in the commissioning structures within the NHS that occurred as a result of the Health and Social Care Act (2012)⁴. Since the 1st April 2013, General Practitioner (GP) led Clinical Commissioning Groups (CCGs) have become responsible for the commissioning of healthcare services for the local population, replacing the previous commissioning bodies, Primary Care Trusts (PCTs). In relation to CAMHS, CCGs are now responsible for the commissioning of specialist CAMHS services. NHS England, which commissions specialised healthcare services, is responsible for commissioning Tier 4 (highly specialised) CAMHS. Preventative emotional wellbeing services are commissioned by the Local Authority Public Health function.
- Recognition nationally and locally of changing patterns of mental health and behavioural disorders among children.
- Recognition nationally of the importance of mental health, and the publication of the government's strategy, 'No Health Without Mental Health'.

1.3 Aim

'To systematically assess the emotional and mental health needs of children and young people aged 0-18 living in Nottinghamshire'.

1.4 Objectives

1. To review the national evidence, policy and guidance on the emotional and mental health needs of children and young people.
2. To estimate the level of emotional and mental health need among children and young people in Nottinghamshire.

3. To map current service provision and assess patterns of service use and uptake.
4. To explore the views of stakeholders about the mental and emotional needs of children and young people.
5. To assess the needs of high risk groups such as young offenders and looked after children.
6. To identify gaps between current service provision and need.
7. To make recommendations to address identified gaps.

1.5 Scope

This HNA will consider the emotional and mental health needs of children and young people aged 0-18 years old living in Nottinghamshire. For the purposes of this HNA 'children and young people' have been defined as those aged up to 18 years old as current CAMHS services are commissioned to provide care for young people up to the age of 18. The focus of this HNA is on understanding population 'need', where 'need' is defined as 'the ability to benefit from intervention'.

In some cases data have been presented within this HNA for age groups other than 0-18 as a result of how data have been recorded. In these situations, the age group used has been highlighted (e.g. 0-19 years old).

1.6 Methods

This HNA uses epidemiological and corporate methods of assessing need. This involves:

- A review of literature on the national context and risk factors for mental health disorders.
- The analysis of epidemiological data to describe the risk factors for, and prevalence of emotional and mental disorders among children and young people within Nottinghamshire.
- A description of current CAMHS services.
- The analysis of service activity data to understand current patterns of service use.
- The views of stakeholders and service users.

1.7 Structure of HNA

The findings of the HNA will be outlined in the following chapters:

Chapter 2: Background. This chapter gives an overview of the background literature on the prevalence and risk factors for mental health problems among children and young people. It also provides key definitions, an overview of the policy context and evidence of effectiveness.

Chapter 3: The Nottinghamshire Child and Adolescent Population. This chapter gives an overview of the demographics and population projections for the population of Nottinghamshire.

Chapter 4: Assessing Emotional and Mental Health Needs of Children and Young People in Nottinghamshire. This chapter estimates numbers of children with mental health disorders. It also outlines available data on parental and household risk factors for mental health disorders.

Chapter 5: High Risk Groups. This chapter presents data on numbers of children and young people in high risk groups and what we know about their mental health needs.

Chapter 6: Current Service Provision. This chapter outlines Tier 2-4 CAMHS services and available service use data.

Chapter 7: Stakeholder Views. This chapter outlines stakeholder views of the emotional and mental health needs of children and young people, and how current services meet these needs.

Chapter 8: Gaps and Priorities for Action. This chapter summarises the key issues identified through the HNA.

Chapter 9: Recommendations. This chapter gives recommendations from this HNA.

2. Background

2.1 What is mental health and wellbeing?

There are many different definitions of mental health and wellbeing. The most commonly used definition is that by the World Health Organisation (WHO), which defines **mental health** as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”⁵. For children, mental health and wellbeing is about having the resilience, self-awareness, and social skills to form relationships and cope constructively with the demands and set backs of day to day life⁶. The term ‘wellbeing’ is a broad concept encompassing emotional, psychological and social wellbeing. The 2012 cross governmental strategy ‘No Health Without Mental Health’ describes **wellbeing** as “a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment”⁷. The importance of mental and emotional wellbeing on children and young people’s physical, social, educational and personal development is increasingly recognised. Good mental and emotional wellbeing helps children and young people to realise their full potential.

2.2 What are mental health problems and disorders?

At some point in their lifetime most individuals will have some mental health needs⁶. This HNA will use two main terms, ‘mental health problem’ and ‘mental disorder’, when discussing children’s mental health. The definitions of these terms are:

‘**Mental Health Problem**’ is a term used to encompass the full range of mental health issues, from common experiences of feeling low in mood, to more severe and enduring problems such as schizophrenia⁸. It is a phrase that encompasses conditions that are short lived or chronic in nature, and vary across the spectrum of severity⁷.

‘**Mental Disorders**’ can be described as a clinically recognisable set of symptoms such as those meeting the requirements of the International Classification of Diseases, version 10 (ICD-10) or The Diagnostic and Statistical Manual of Mental Disorders, version IV (DSM-IV), which are commonly used classification systems for mental disorders. Mental disorders can be described in a number of broad categories as shown in Table 1⁹.

TABLE 1: CLASSIFICATION OF MENTAL DISORDERS

Type of Disorder	Examples
Emotional disorders	Phobias, anxiety states, depression.
Conduct disorders	Aggression, anti-social behaviour
Hyperkinetic disorders	Disturbance of activity and attention
Developmental disorders	Delay in acquiring certain skills such as speech, bladder control and social ability. E.g. Autism
Eating disorders	Anorexia nervosa, bulimia nervosa
Habit disorders	Tics, sleeping problems
Post-traumatic syndromes	Post-traumatic stress disorder
Somatic disorders	Chronic fatigue syndrome
Psychotic disorders	Schizophrenia, bipolar disorder

Source: NHS Advisory Committee. (1995). Together We Stand⁹.

2.3 What is CAMHS?

CAMHS is a broad term used to refer to all services contributing to the emotional and mental health care of children and young people. This ranges from universal services delivered by non-mental health specialists (e.g. GPs and teachers) to highly specialist services as shown by the four-tier conceptual model in Table 2.

TABLE 2: FOUR-TIERED MODEL OF CAMHS

Tier	Description
Tier 1	Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.
Tier 2	Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.
Tier 3	Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.
Tier 4	Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one local authority area.

Source: NHS Advisory Committee. (1995). Together We Stand⁹.

2.4 Prevalence of Mental Health Problems among Children and Young People

A large number of studies have been carried out to assess the epidemiology of mental health problems among children and young people. Different methodologies, definitions of mental health problems, and study populations have led to different estimates of prevalence. Within the UK, the most comprehensive data on the prevalence and risk factors for mental health problems among school aged children and young people comes from large national surveys carried out by the Office for National Statistics (ONS) in 1999 and 2004¹. Less robust evidence is available for younger aged children and for children with 'lower level' mental health problems that do not meet the criteria for clinical diagnosis. Available evidence will be summarised according to the age of the child.

Pre-School Children

Few studies have been carried out to assess the prevalence of mental health problems among pre-school children. Currently there are no large UK studies. There are also a number of recognised challenges in assessing the prevalence of mental health problems among pre-school children. In particular, between the ages of 0 and 5, children undergo rapid developmental changes which makes it difficult to distinguish normal from abnormal emotions or behaviour¹⁰. This leads to a debate about the appropriateness of traditional diagnostic categories for this age group¹⁰. The estimates of prevalence discussed below therefore need to be treated with some caution.

Work carried out in the United States, where parents were interviewed using a structured questionnaire (based on DSM-IV), estimated the prevalence of oppositional defiant disorder and

attention deficit disorder (ADHD) among pre-school children as 7% and 3% respectively¹¹. A review by Gardner and Shaw (2008) found estimated prevalence varied across studies; separation anxiety (0.3-5%), social phobia (2-4%), specific phobia (0-2%) and depression (0-2%)¹⁰. A review by Egger and Angold (2006), which has been used by the Child and Maternal Health Observatory (ChiMat) to provide local UK estimates of mental health problems, found the average prevalence of any mental health problem to be 19.6% across the studies considered¹². This estimated prevalence appears quite high and needs to be treated with caution. Another estimate by the Mental Health Foundation gives a prevalence of mental health problems among 2-5 year olds as 10%¹³.

School-Aged Children

In 1999 ONS carried out a large survey of 10,500 children and young people aged 5-15 years old living in private households. The subsequent survey in 2004 included 7977 children and young people aged 5-16¹. Data were collected from young people, parents and teachers to identify if the child or young person met the ICD-10 criteria of a clinically diagnosable mental disorder. These surveys provide the most robust and comprehensive data on the prevalence of mental disorders among children in the UK. Both surveys found that 1 in 10 children (10%) had a clinically diagnosable mental disorder with variation seen according to age, sex and ethnicity.

The four main groups of disorders considered by the survey were:

- **Emotional disorders**, which includes conditions such as separation anxiety, phobias, generalised anxiety and depression.
- **Conduct disorders**, which includes oppositional defiant disorder and socialised and unsocialised conduct disorders.
- **Hyperkinetic disorders**, such as ADHD.
- **Less common disorders** which includes autistic spectrum disorder, eating disorders and tics.

The key findings were:

- 1 in 10 children had a diagnosable mental disorder associated with distress and interference with personal functions such as social and family relationships.
- 4% of children had an emotional disorder such as anxiety or depression.
- 2% had a hyperkinetic disorder.
- 1% had a less common disorder (e.g. autism, tics, eating disorders).
- 2% had more than one type of disorder.
- More boys than girls had a diagnosable mental disorder.
- Mental disorders were more common among children aged 11-15 than children aged 5-10.
- Boys were more likely to suffer from a conduct or hyperkinetic disorder than girls.
- Girls were slightly more likely to have an emotional disorder than boys.

Young People Aged 16-19

The 2000 Survey of Psychiatric Morbidity Among Adults Living in Private Households, another large ONS survey, included people aged 16-74 living in Great Britain¹⁴. From this survey, the prevalence of mental health disorders for 16-19 year old young people can be identified. The prevalence of certain neurotic disorders is shown in Table 3 for males and females aged 16-19. Overall females had a higher prevalence of any neurotic disorders than males (192 per 1000 compared to 86 per 1000). The most common neurotic disorder was mixed anxiety and depressive disorder for both males and females.

TABLE 3: PREVALENCE OF NEUROTIC DISORDER AMONG 16-19 YEAR OLDS. PREVALENCE PER 1000 REPORTING IN PAST WEEK

Mental health disorder	Prevalence of neurotic disorder among 16-19 year olds. Prevalence per 1000 reporting in past week	
	Females	Males
Mixed anxiety and depressive disorder	124	51
Generalised anxiety disorder	11	16
Depressive episode	27	9
All phobias	21	6
Obsessive compulsive disorder	9	9
Panic disorder	6	5
Any neurotic disorder	192	86

Source: ONS. (2000). Survey of Psychiatric Morbidity Among Adults Living in Private Households.

Compared to neurotic disorders, psychotic and personality disorders were less common. Among females aged 16-19, 5 out of 1000 reported a probable psychotic episode in the last year. The number of males reporting a psychotic episode in the last year was too small to publish.

The prevalence of any personality disorder was presented for people aged 16-34 with males having a higher prevalence (52 per 1000) than females (17 per 1000).

2.5 Trends in mental health problems among children

There is evidence to suggest that there have been substantial rises in the prevalence of mental health problems among children and young people over the last two to three decades. Measuring changes in prevalence over time can be challenging due to changes in diagnostic criteria for conditions, differences in assessment methods and changes in public perception and demand. The most robust evidence comes from a study by Collishaw *et al* (2004) which used data from 3 national surveys, the National Child Development Study, the 1970 Birth Cohort Study and the 1999 British Child and Adolescent Mental Health Survey¹⁵. For each of these surveys, parents completed a questionnaire describing their children's symptoms. The authors found a continuous rise in conduct problems for both boys and girls over the 25 year study period. Reported emotional problems increased among both boys and girls from the mid-1980s to 1999. Over the 3 surveys, there was no clear trend in adolescent hyperactivity for either boys or girls.

While service data are affected by a range of factors, including prevalence of disorders, level of demand from the public, referral patterns and local service provision^{16,17}; service utilisation data from specialist mental health services in England has shown a more than 40% rise in referral rates between 2003 and 2009/10¹⁸.

2.6 Risk factors for mental health problems among children

There are a wide range of individual, family and social factors that can affect the risk of a child or young person developing a mental health problem. Data from a Department of Health (DH) Mental Health Review and from the 2004 ONS survey are outlined in Table 4^{1,2}.

It must be noted that when considering the listed risk factors, Table 4 shows 'associations' between these variables and poor child mental health. These associations do not necessarily mean these factors are direct causes of poor mental health. Many children who grow up in these circumstances will develop without difficulties⁶. What has been recognised is that mental health disorders more

commonly result from the accumulation of multiple factors rather than the occurrence of any one single factor¹⁹.

Table 4: Risk factors for mental illness in children and young people^{1,2}

CHILD RISK FACTORS	
Male	
Increasing age	
Child abuse	15.5 fold increased risk of minor depression as a child 8.9 fold increased risk of suicidal ideation 8.1 fold increased risk of anxiety 7.8 fold increased risk of recurrent depression as adult 9.9 fold increased risk of adult post-traumatic stress disorder (PTSD) 5.5 fold increased risk of substance misuse/ dependence
4 or more adverse childhood experiences (e.g. abuse, neglect, parental divorce, domestic violence)	12.2 fold increased rate in attempted suicide as an adult. 10.3 fold increased risk of injecting drug use 7.4 fold increased risk of alcoholism 4.6 fold increased risk of depression in past year
Low birth weight	4-5 fold increased risk in onset of emotional/conduct disorder in childhood
Adolescent dating violence (ie. physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia
PARENTAL RISK FACTORS	
Poor parental mental health	
Parental unemployment	2-3 fold increased risk of emotional/ conduct disorder in childhood
Lone parent	Prevalence of mental health disorders 16% (lone parent) compared to 8% (2 parent family)
Reconstituted families (a family was defined as 'reconstituted' if stepchildren were present)	Prevalence of mental health disorders: 14% if the child had stepbrothers or stepsisters, compared to 9% if they had no stepbrothers or stepsisters
Receipt of disability living allowance	Prevalence of mental health disorders 24% (member household receiving disability allowance) compared to 8% (no one receiving DLA in household)
Parents with no educational qualifications	4.25 fold increased risk of mental health problem in children
Use of alcohol, tobacco or drugs during pregnancy	Increased risk of long-term neurological and cognitive-emotional development problems
Maternal stress during pregnancy	Increased risk of child behavioural problems. Impaired cognitive and language development
Poor parenting skills	4-5 fold increased risk of conduct disorder in childhood
HOUSEHOLD RISK FACTORS	
Low household income	Prevalence of mental health disorders 16% (gross weekly income <£100) compared to 5% (gross weekly income ≥£600)
Living in deprived areas	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups
Living in social or privately rented accommodation	Prevalence of mental health disorders 17% (social housing) compared to 7% (private ownership)

Sources: Green *et al* (2004). Mental Health of Children and Young People in Great Britain.

DH. (2011). No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages. Annex B- Evidence Base.

It must also be noted that many of the risks or prevalence figures presented in Table 4 do not all take account of the impact of other risk factors. For example, parental educational qualifications are likely to affect household income and parental occupational group. Without adjusting for these other factors, some of the estimates of risk or prevalence may be under- or overestimated as a result.

2.7 High risk groups

There are a number of groups of children and young people who are recognised to be significantly more likely to experience mental health problems than the general population^{2,6}. A number of studies have provided estimates of the increased risk of mental health problems among these groups, as shown in Table 5. More detailed consideration will be given to the needs of these groups in chapter 5 which focuses on estimating the needs of these high risk groups.

TABLE 5: CHILDREN AND YOUNG PEOPLE AT HIGH RISK OF MENTAL HEALTH PROBLEMS

Risk Group	Estimated risk of mental disorder
Children with a learning disability	6.5 fold increased risk of mental health problem
Children with special educational needs	3 fold increase in conduct disorder
Children with physical illness	2 fold increased risk of emotional/conduct disorders over a 3 year period
Homeless Young People	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation
Lesbian, gay, bisexual or transgender Young People	7 fold increased risk of suicide attempts in young lesbians 18 fold increased risk of suicide attempts in young gay men
Young offenders	18 fold increased risk of suicide for men in custody aged 15-17 40 fold increased risk of suicide in women in custody aged <25 3 fold increased risk of mental disorders
Looked after children	5 fold increased risk of any childhood mental disorder 6-7 fold increased risk of conduct disorder 4-5 fold increased risk of suicide attempt as an adult
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes

Source: DH. (2011). No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages. Annex B- Evidence Base.

2.8 Impact of mental and emotional health problems occurring in childhood and adolescence

Poor mental and emotional wellbeing in childhood and adolescence is recognised to have important long term impacts upon educational, social and health outcomes.

Impacts of emotional and mental health problems in childhood

- Lower educational achievement.
- Time off school.
- Exclusion from school. For example, children and young people with a conduct disorder are 17 times more likely to be excluded from school and 4 times more likely to be two or more years behind in intellectual development².
- Risky behaviours (e.g. smoking, alcohol, drug use). For example, 5-16 year olds with a conduct disorder are 6 times more likely to smoke².
- Poorer social skills.
- Poor physical health.
- Self-harm and suicide. Children and young people with emotional disorders are nearly 5 times more likely to self-harm or commit suicide².
- Teenage Pregnancy.

Impacts of childhood mental health problems during adulthood

- Poor adult mental health. Mental illness unlike other health problems tends to start early and persist into and throughout adulthood. It is recognised that by the age of 14 about half of all lifetime mental health problems start². This highlights the long term nature of mental illness and the importance of intervening early to prevent mental illness alongside early recognition and treatment.
- Antisocial behaviour. For example, involvement in crime, domestic violence. It is recognised that nearly half of children with early onset conduct problems go on to have persistent, serious life-course problems including crime, violence, drug misuse and unemployment².
- Lower levels of employment and low earnings.
- Marital Problems.
- Substance Misuse.

2.9 The cost of mental health problems among children and young people

Mental health problems lead to significant costs across health services, social care, the private and voluntary sector, and patients themselves. Supporting documents for the government's 'No Health without Mental Health' strategy have provided evidence on the costs of mental health problems in the UK²⁰. This report stated that:

- The wider economic costs of mental illness in England for both adults and children have been estimated at £105.2 billion each year, which includes direct costs of services, lost productivity at work and reduced quality of life.
- In 2008/9 the NHS spent about £10.4 billion (10.8% of the annual secondary care budget) on mental health services for adults and children.

Few studies have estimated the costs of mental illness among children and adolescents. A review by WHO identified 5 UK studies, all using different methods and different patient populations, leading to large variations in the estimates²¹. For example some of the studies looked at specific populations such as children in foster care, or those with severe behaviour disorders. Across these studies the mean annual cost of mental illnesses was estimated to range between £11,030 and £59,130 per child²¹. These studies attempted to measure all service use costs. The authors note that costs increased with increasing severity of illness and with greater numbers of comorbidities.

When looking at conduct disorders, it has been estimated that the lifetime costs of a one year cohort of children with conduct disorders (6% child population) is about £5.2 billion²⁰.

2.10 Policy Context

2.10.1 National

There is a wealth of national policy related to children and young people with mental health needs. Key documents include:

Every Child Matters. Department for Education. (2003).

Every Child Matters was launched in 2003 and outlined 5 main aims for every child, whatever their background or circumstances. These aims were 'Be healthy', 'Stay safe', 'Enjoy and achieve', 'Make a positive contribution' and 'Achieve economic wellbeing'. Each of these aims requires multiagency partnership and collaboration across social care, health and education.

The National Service Framework (NSF) for Children, Young People and Maternity Services (2004).

The NSF for Children, Young People and Maternity Services outlines in standard 9 a plan for the improvement of mental and psychological wellbeing in children and young people. The vision for child and adolescent mental health included:

- Seeing an improvement in mental health among children and young people.
- Multi-agency services working in partnership, ensuring early intervention.
- Children, young people and families having access to mental health care based upon the best evidence and provided by staff with appropriate skills and competencies.

No Health Without Mental Health: A Cross Government Mental Health Outcomes Strategy For People of All Ages (2011)

In 2011 the government published a national strategy to improve the mental health of adults and children living in the UK setting out six key objectives of:

- More people having good mental health
- More people with mental health problems recovering
- More people with mental health problems having good physical health
- More people having a positive experience of care and support
- Fewer people suffering avoidable harm
- Fewer people experience stigma and discrimination

Central to the strategy is the concept of mental health being 'everyone's business' with roles outlined for healthcare, social care, community groups, education, and employers to work to improve mental health. The strategy outlined that patients, families and carers should be involved in the planning, priority setting and commissioning of services, with the needs of vulnerable groups being considered. In relation to children and young people the strategy outlines that:

- Public services should intervene early with evidence based interventions. This includes work with children and parents from birth and within schools and colleges.
- Age- and developmentally- appropriate information and interventions should be offered.
- Services should work with the whole family, using whole-family assessment and support plans where appropriate.

Linked to this strategy is '**Talking Therapies- A four-year plan of action**' which outlines the Government's commitment to expand access to psychological therapies for all people with depression, anxiety and conduct disorders. This includes a specific programme to meet the needs of children and young people, building on learning from the Improving Access to Psychological Therapies (IAPT) programme and using National Institute for Health and Clinical Excellence (NICE) approved, evidence based therapies.

Public Health Outcomes Framework

The Public Health Outcomes Framework, published in January 2012 outlines the desired outcomes and indicators that will be used to assess how well public health is being improved and protected²². The indicators not only look at measures of mortality but also aim to assess how well people are living. In relation to child and adolescent mental health there is no one specific indicator included in the framework. There are however several related or relevant indicators as listed below²³:

- Emotional wellbeing of looked after children
- Children in poverty
- First time entrants to the youth justice system

- 16-18 year olds not in education not in training
- Self-reported wellbeing (measured for those 16 years and over).
- Suicide rate (all ages, adults and children)

2.10.2 Local Policy and Strategy

Nottinghamshire Children, Young People and Families Plan 2011 to 2014.

Nottinghamshire Children's Trust is a partnership of organisations that provide services to children, young people or families in Nottinghamshire. The Children's Trust enables joint planning and working to make the best use of resources. The Nottinghamshire Children, Young People and Families Plan (2011-14) sets out the direction of the Children's Trust over the three year time period. The overarching ambition is:

'We want Nottinghamshire to be a place where children are safe, healthy and happy, where everyone enjoys a good quality of life and where everyone can achieve their potential'

One of the main priorities outlined in this plan is 'Improving Children and Young People's Emotional Wellbeing'.

Health and Wellbeing Strategy 2012-13.

Health and Wellbeing Boards have been established in each top tier local authority as part of the Health and Social Care Act (2012). They have been operating in shadow form during 2012/13 until taking on their statutory functions from 1st April 2013. These boards bring together elected members, CCG representatives, local authority leads (e.g. adult services, children's services), the director of public health and representation from Healthwatch. These boards have been established to improve the health of the population and reduce health inequalities. These boards have a statutory duty to produce a Health and Wellbeing Strategy outlining their plan for the local area. The emotional health and wellbeing of children and young people is an identified priority in the Nottinghamshire Health and Wellbeing Strategy.

Nottinghamshire County CAMHS strategy 2011-2013.

This document sets the CAMHS strategy for 2011-2013 for the 7 districts making up Nottinghamshire County. It is due to be refreshed in 2013.

A Strategy for the Reduction and Prevention of Suicide in Nottinghamshire and Nottingham City (2009 – 2012)

This joint Nottinghamshire County and Nottingham City Suicide Prevention Action Plan was agreed in response to the 2002 national strategy. This has not been refreshed yet in light of the 2012 national strategy.

2.11 Evidence of Effectiveness: What works to improve the emotional and mental health of children and young people?

2.11.1 Improving and preventing emotional and mental health problems in children and young people

The term 'mental health promotion' is used to describe the process of reducing risk factors for mental health problems, and encouraging healthy behaviours that can help to prevent the onset of mental health problems. Mental health promotion has been shown to be most effective when²⁴:

- It intervenes at a crucial point in peoples' lives²⁴. In particular the importance of intervening early to prevent the development of mental health disorders is highlighted²⁵. This is reflected in the government's 'No Health Without Mental Health' strategy which advocates for a life course approach, recognising the importance of promoting wellbeing in the early years and throughout childhood, adulthood and old age⁷.
- Is integrated within different settings. There are a broad range of factors that influence mental health, many of which relate to the wider determinants of health (e.g. family, communities, environment). To effectively tackle the broad range of factors that influence mental health a multiagency approach is required.
- Uses a combination of methods.
- Involves the social networks of those being targeted (e.g. parents, carers, family).
- It targets those at greater risk²⁵.

There is a growing evidence base of effective interventions for the prevention and management of mental and emotional problems that cover issues such as:

1) Promoting maternal mental health and managing postnatal depression.

The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing in later life²⁶. Mental disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members²⁷.

NICE have produced several guidelines on antenatal and postnatal care²⁷⁻³⁰. Guidance on postnatal care includes recommendations on 'mental health and wellbeing', which recommends that³⁰:

- Women should be asked about their emotional wellbeing, what family and social support they have.
- Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.
- All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth.
- At 10–14 days after birth, women should be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further.
- Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to someone about their feelings and ensuring they can access social support networks.

Detailed guidance from NICE on the management antenatal and postnatal mental health conditions recommends²⁷:

- Early identification of women with mental health problems or those at risk. This involves asking women about past or present severe mental illnesses, a family history of perinatal mental illness and asking screening questions to detect possible depression at booking visits.

- On identification of a possible mental disorder, women should be further assessed by the GP or mental health services.
- The needs of the partner, and family members during pregnancy and the postnatal period should be assessed, which includes considering the welfare of the infant and other dependent children.
- The guideline also provides specific recommendations for conditions such as schizophrenia, obsessive compulsive disorder (OCD) and bipolar disorder and the use of medications during pregnancy and breastfeeding.

2) Supporting parents and carers to parent effectively.

Parenting education is a key intervention in the promotion of all round good health in children³¹. The parent or caregiver/child relationship is vital to a child's development and future psychological wellbeing³¹. Cochrane reviews assessing the effectiveness of parenting programmes on the prevention of emotional and behavioural problems among children less than 3 years old have shown the potential of parenting programmes to improve emotional and behavioural health in the short term³². Less data are available on the long term outcomes of parenting interventions on emotional problems. Greater evidence is available for the use of parenting interventions for those developing conduct disorders³³. NICE recommends the use of parenting programmes as part of their guidance on the management of ADHD, conduct disorders and antisocial behaviour^{34,35}. They recommend that parenting programmes should be:

- be structured and informed by social-learning theory
- include relationship-enhancing strategies
- offer at least 8-12 sessions
- enable parents to identify their own parenting objectives
- incorporate role play during sessions and homework
- be delivered by supervised, appropriately trained and skilled facilitators
- be consistently implemented and follow the developer's manual
- include both parents/all carers where possible
- provide support to allow participation of parents who might find it difficult to access these programmes
- consider giving the child/young person's teacher written information on the areas of behavioural management covered in the sessions, with consent.

3) Promoting social and emotional wellbeing in the early years.

Guidance from NICE on social and emotional wellbeing in the early years recommends the adoption of a life course perspective, recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing³⁶. This guideline highlights that:

- Additional support should be given to the most vulnerable children, across maternity, child health, social care, early education and family welfare services.
- Service providers need to develop trusting relationships with vulnerable families, taking account of the child's needs and factors that pose a risk to the child's emotional wellbeing.
- Antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing. This includes parental mental health concerns, substance misuse and difficult family relationships.
- Health visitors, school nurses and early years practitioners should identify factors that may pose a risk to a child's social and emotional wellbeing, as part of an ongoing assessment of their development.
- Health and early years professionals should ensure procedures are in place to refer to specialist services, ensure continuity of care and integrated team working.
- All vulnerable children should benefit from high quality childcare outside of the home to support them to fulfil their potential.
- Health and early years providers should put systems in place to deliver integrated universal and targeted services that support vulnerable children's social and emotional wellbeing.
- Vulnerable families should be encouraged to use early years services.
- Outreach methods should be used to maintain or improve participation of vulnerable parents and children.

- Health and early years should work with community and voluntary organisations to help vulnerable parents who find it difficult to use health and early years services.

4) Working through schools to promote social and emotional skills.

Schools have an important role in promoting factors that create resilience; helping to develop skills such as emotional management, self-awareness, optimism, a sense of coherence, social skills and empathy³⁷. Targeted approaches are required for children who are showing early signs of emotional and social difficulties.

Existing initiatives such as the Social and Emotional Aspects of Learning (SEAL) programme and the Healthy Schools programme are in place and stress the importance of enabling children to participate fully in the development of such programmes to ensure their views are heard.

NICE have published guidelines on the promotion of children's social and emotional wellbeing in primary and secondary schools^{38,39}. NICE recommends the adoption of a comprehensive 'whole school' approach to children's social and emotional wellbeing. This includes recommendations that:

- Schools should provide an emotionally secure environment that prevents bullying and provides help and support for children (and their families) who may have problems.
- Schools should have a programme to help develop the emotional and social wellbeing of all children. It should be integrated into all aspects of the curriculum and staff should be trained to deliver it effectively.
- Schools should also plan activities to help children develop social and emotional skills and wellbeing, and to help parents develop their parenting skills.
- Schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed.
- Schools and local authorities should work closely with CAMHS including supporting a 'stepped care' approach to preventing and managing mental health problems.

A government led initiative, Targeted Mental Health in Schools (TaMHS) was a three year project established in 2008 that ran in selected schools within each local authority. Learning from the national TaMHS evaluation includes⁴⁰:

- Start early – the TaMHS programme led to a greater impact within primary schools compared to secondary schools, particularly on behaviour.
- Self-help materials had a positive impact within primary schools.
- Mental health provision in schools must be fully integrated and understood by all services within the school and form part of school policy
- The importance of inter-agency working (such as by use of systems such as the Common Assessment Framework) as ways to help address behavioural problems in pupils in secondary schools.
- The need to prioritise the provision of materials to help young people find and access support.
- Educational psychologists appear to be a key group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS.
- Ensuring future roll out of mental health provision in schools uses a common language and is fully integrated with services in schools.

Learning from the Nottinghamshire evaluation of the TaMHS programme highlighted⁴¹:

- TaMHS improved the 'emotional climate' across the participating schools in the four main areas of delivery i.e. emotionally well pupils, emotionally well-managed support systems; emotionally well-managed staff and emotionally well parents.
- Children with complex needs benefit from a structured problem solving tool which drew on multi-agency, multi-disciplinary working. The 'Circle of Adults' is an effective example of this.

- National Research and evaluations have demonstrated the efficacy of 'Zippy's Friends' in increasing resilience and problem-solving skills in keystage 1 pupils.
- That improved training and delivery of training in emotional health and wellbeing leads to improved confidence and competence in teaching staff.

A report by the DH on mental health promotion identified that antibullying programmes in schools had shown mixed results, depending on the design of the intervention and how it was implemented⁴². The consensus of literature is that whole school programmes with a range of components operating at different levels within the school are more effective in reducing the prevalence of bullying than curriculum based programmes. Reported benefits of anti-bullying programmes include improvements in the emotional, physical and social health of victims, school attendance and educational attainment, all of which are associated with better long term employment and earnings outcomes.

NICE guidelines on conduct disorders and antisocial behaviour recommend offering targeted emotional learning and problem-solving programmes to children aged 3-7 years in schools where classroom populations have a high proportion of children at risk of developing behavioural or conduct disorders³⁴. These include groups of children where a high proportion are deprived, have low school achievement, have experience of abuse or parental conflict, have divorced or separated parents, have parents with mental health or substance misuse problems, and children with parents in contact with the criminal justice system.

5) Reducing risky behaviours, such as alcohol misuse.

NICE have published guidelines on 'Interventions to reduce substance misuse among vulnerable young people'⁴³ and 'School based interventions on alcohol'⁴⁴ which include the following recommendations:

Substance misuse⁴³:

- Use screening tools to identify vulnerable and disadvantaged children and young people who are misusing or at risk of misusing substances.
- Offer family based programmes and more intensive support to families where children and young people have been assessed as high risk of substance misuse.
- Offer children aged 10-12 who are persistently aggressive or disruptive (and assessed as high risk for substance misuse), group-based behavioural therapy. Offer parents of these children group-based training in parental skills.
- Offer motivational interviews to vulnerable and disadvantaged children and young people aged under 25 who are problematic substance misusers.

Alcohol in schools⁴⁴

There are no national guidelines on what constitutes safe and sensible alcohol consumption for children and young people, so NICE recommends focusing on encouraging children not to drink, delaying the age at which young people start drinking and reducing the harm it can cause among those who do drink. The guidance recommends:

- Ensuring alcohol education is an integral part of the national science, and Personal Social and Health Education curricula.
- Ensuring alcohol education is tailored for different age groups and takes different learning needs into account.
- Introducing a 'whole school' approach to alcohol.
- Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills.
- Where appropriate offer brief advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Where appropriate refer to external services.

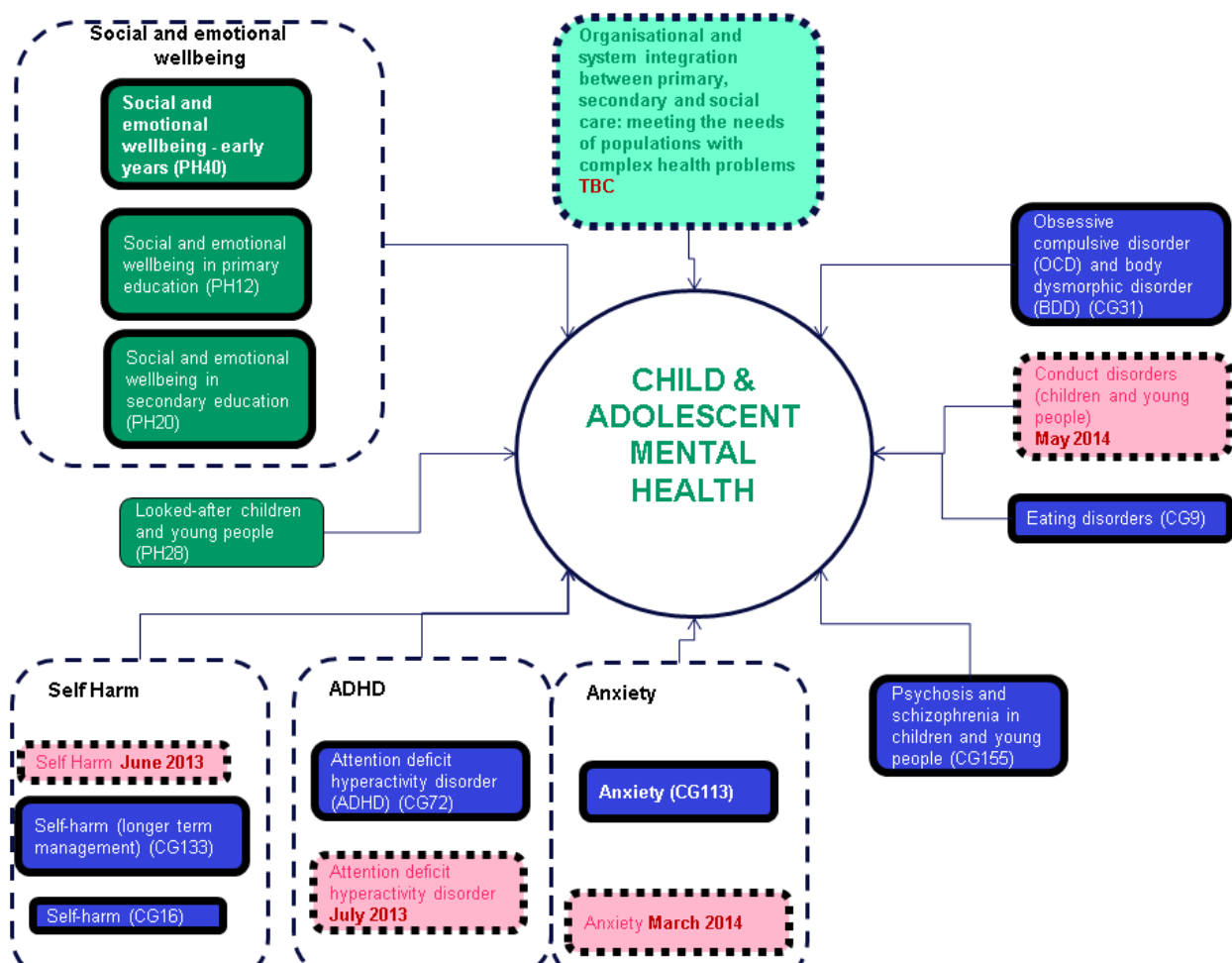
2.11.2 Management of mental health disorders

NICE have published a number of guidelines on the management of mental health disorders among children and young people which include:

- CG9. Eating Disorders. (2004).
- CG26. Post-traumatic stress disorder. (2005).
- CG28 Depression in Children and Young People (2005).
- CG31. Obsessive Compulsive Disorder and Body Dysmorphic Disorder. (2005).
- CG38. Bipolar disorder. (2006).
- CG72 Attention Deficit Disorder (2008)
- CG77. Antisocial personality disorder. (2009).
- CG78. Borderline personality disorder: treatment and management. (2009).
- CG89. When to suspect child maltreatment. (2009).
- CG111. Nocturnal enuresis- the management of bedwetting in children and young people. (2010).
- CG113. Anxiety. (2011).
- CG128 Autism in Children and Young People (2011)
- CG133. Self-harm: Longer term management. (2011)
- CG155 Psychosis and Schizophrenia in Children and Young People (2013)
- CG158 Conduct Disorders in Children and Young People (2013).

Figure 1 provides an overview of NICE guidelines related to child emotional and mental health. Those shown in pink are guidelines currently in development, with their anticipated publication data shown.

FIGURE 1: SUMMARY OF NICE GUIDANCE ON CHILD AND ADOLESCENT EMOTIONAL AND MENTAL HEALTH



A matrix of evidence based interventions according to Tier of CAMHS and the age of child is included in Appendix 1.

2.12 Evidence of Effectiveness: Models of Service Delivery

The four-tiered conceptual model has been used in CAMHS for over a decade to help with the planning and delivery of child mental health services⁶. In reality this model is subject to local variation and differences in understanding. For some, the terms 'universal', 'targeted' and 'specialist' services are more helpful. The provision of effective mental health services for children and young people is difficult to evaluate and assess. Certainly, there is no evidence to support a 'gold standard' model of service delivery. Evidence comes from reviews of CAMHS services which are summarised below:

Right Time, Right Place (Massie, 2008)⁴⁵

A report by Massie (2008) outlines learning from the NSF CAMHS development projects. Recommendations include:

- Taking a holistic and integrated approach to young people, taking account of their social, educational, housing, relationship and health needs.
- Services were more effective if responding to the needs identified by the young people and families themselves. A partnership approach to service delivery.
- Flexibility and responsiveness.
- Intensive support for time limited periods for those with complex disorders including learning disabilities and those with autistic spectrum disorder.
- Training of staff working in universal services.
- A focus on care pathways and a single point of access.
- User participation, in terms of encouraging feedback and involvement in planning of services.

Children and Young People in Mind: the Final Report of the National CAMHS Review (2009)

A summary of some of the key recommendations of this review are outlined below:

- Importance of strategic local and national leadership.
- Importance of promoting understanding of mental health and psychological wellbeing.
- Provision of clear information about available services.
- Children who require more specialised support should have (1) a high quality assessment that informs a clear plan of action, (2) a lead person to be their main point of contact, (3) clearly signposted routes to specialist help and timely access to this, (4) clear information about what to do if things don't go according to plan.

Features of effective services, as defined by children, young people and carers included:

- Greater awareness of mental health and how to deal with it sensitively among universal services.
- The importance of building trust.
- Accessible services, in convenient places. A single point of access.
- Being listened to. Having things explained in a straightforward way.
- Being involved.
- Being supported when it's needed, before it reaches crisis point.
- Holistic approach that sees you as an individual.

The Evidence Base to Guide Development of Tier 4 CAMHS. (2009).

This review summarised that many of the lessons learned from the review related to Maxwell's dimensions of quality. Good quality services should be:

- Equitable
- Accessible
- Acceptable
- Appropriate
- Effective
- Ethical
- Efficient.

The review states that the effectiveness of interventions to meet the complex needs of children and young people depends on young people taking up the services, engaging with the therapeutic activity and staying with it. Effectiveness was therefore suggested to be increased by:

- Intervening at the earliest stages in severe and complex problems.
- Having planned care pathways, rather than intervening in crisis situations.
- Having a full understanding of the needs of the child, and promoting their strengths, self-efficacy and resilience.
- Having staff who are supported, often across agencies, to deal with the complex issues a child can present with.

Transitioning to adult services

Child and adult mental health services are structured in different ways, which can lead to gaps and difficulties transitioning a young person into adult services. DH guidance on the transition of young people to adult services (not specific to mental health) recommends:

- Recognising the importance of the process.
- Being flexible in the timing of transition.
- Including a period of preparation for the young person and family.
- Ensuring good information transfer.
- Monitoring attendance until the young person is established in adult services.

Guidance on the commissioning of mental health services for young people transitioning to adult services highlights the following⁴⁶:

- There should not be strict age boundaries. Rather services should operate in response to need and to provide continuity.
- Formal joint working arrangements should be put in place to address structural and procedural difficulties arising from the interface of CAMHS and adult services.

Summary: Chapter 2 Background

- A national survey by the Office for National Statistics has estimated that 1 in 10 school aged children have a mental health disorder (4% emotional disorders, 6% conduct disorders, 2% hyperkinetic disorders and 1% less common disorder). Less reliable estimates are available for pre-school children suggesting the prevalence of mental health problems could range between 10% and 20% in this age group.
- At a national level, there is evidence to suggest the prevalence of conduct and emotional disorders is increasing over time.
- Risk factors for emotional and mental health problems can be considered at an individual, family and societal level. Many of these risk factors are interrelated and cluster in geographical areas or families (e.g. child poverty, parental unemployment, parental mental health disorders).
- High risk groups of children and young people include looked after children, young offenders, those with learning disabilities, the homeless, those with chronic illnesses and those with special educational needs.
- Emotional and mental health problems have significant long term effects upon educational, social and health outcomes.
- Mental health and wellbeing is a key priority nationally and locally among both adults and children.
- Effective interventions to promote emotional and mental wellbeing in children include; promoting maternal mental health, supporting parents, promoting wellbeing in the early years, working through schools and targeting risky behaviours (e.g. alcohol misuse).
- There is a growing body of evidence based guidelines from the National Institute for Health and Clinical Excellence on the diagnosis and management of mental health problems in children and young people.
- There is no 'gold standard' model of CAMHS services. Services have been organised according to a four tier model of services that cover universal, targeted, specialised and highly specialised needs. Service reviews highlight the importance of creating clear pathways, responding to the needs of children and young people, training universal services and taking a holistic approach to mental health and wellbeing.

3. The Nottinghamshire Child and Adolescent Population

When considering the local need for CAMHS we need to consider the local population figures and projections, to understand the size of the population and any expected population changes.

3.1 Demography

The total number of children aged 0-18 living in Nottinghamshire is 171,865 as shown in Table 6. Ashfield has the largest population of children and young people (27,250), followed by Newark and Sherwood (25,178) and Gedling (24,655).

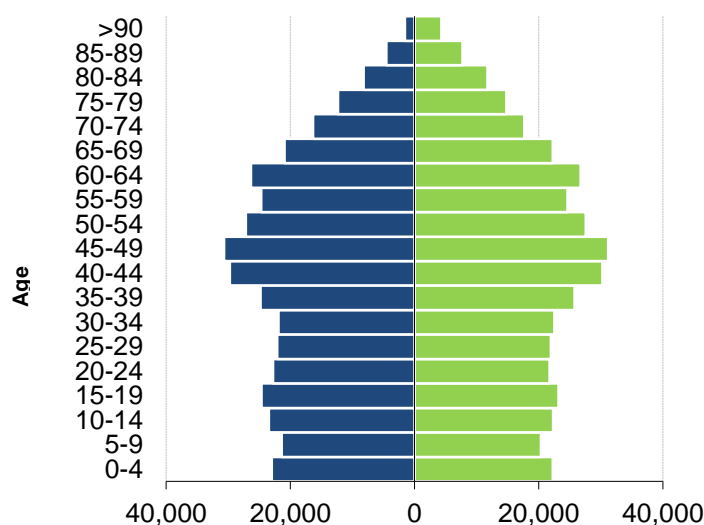
TABLE 6: POPULATION OF NOTTINGHAMSHIRE COUNTY 0-18 YEAR OLDS BY DISTRICT

	Age (years)				Total population 0-18	Population (all ages)
	0-4	5-9	10-14	15-18		
Ashfield	7,413	6,663	7,181	5,993	27,250	119,497
Bassetlaw	6,105	5,826	6,816	5,876	24,623	112,863
Broxtowe	6,163	5,301	5,848	5,220	22,532	109,487
Gedling	6,470	5,986	6,560	5,639	24,655	113,543
Mansfield	6,399	5,471	5,852	5,313	23,035	104,466
Newark and Sherwood	6,317	6,267	6,872	5,722	25,178	114,817
Rushcliffe	6,392	6,233	6,621	5,346	24,592	111,129
Nottinghamshire County	45,259	41,747	45,750	39,109	171,865	785,802

Source: ONS, 2011.

Of the 171,865 children 0-18 years old in Nottinghamshire, 88,084 (51%) are males and 83,781 (49%) are females. Figure 2 shows the population pyramid for the Nottinghamshire population, showing a typical shape for a developed country. As can be seen there are larger numbers of children aged 15-19 than the younger age groups.

FIGURE 2: POPULATION PYRAMID FOR NOTTINGHAMSHIRE COUNTY



Source: ONS, 2011.

3.2 Population Projections

Population projections for Nottinghamshire have been produced for the 0-19 year old population based on the 2011 Census⁴⁷. These population projections are shown in Table 7. Please note, as these projections include 19 year olds, the population numbers are larger than previously presented in Table 6.

The 0-19 population in Nottinghamshire is expected to increase on average by 3.5% over the next ten years, with the highest projected increases in Rushcliffe (6.4%) and Newark & Sherwood (5.0%), and the lowest in Bassetlaw (0.9%) and Broxtowe (1.0%)⁴⁷. The largest increases are in the 5-9 year old population (+17.3% by 2021)⁴⁷. Comparatively, the 15-19 year old population is projected to decrease by 11.7% by 2021⁴⁷.

TABLE 7: POPULATION PROJECTIONS FOR 0-19 YEAR OLDS LIVING IN NOTTINGHAMSHIRE

	2011	2013	2015	2017	2019	2021	% increase 2011-2021
Ashfield	28,526	28,608	28,785	28,886	29,088	29,481	+3.3%
Bassetlaw	25,906	25,669	25,561	25,623	25,747	26,135	+0.9%
Broxtowe	23,774	23,613	23,436	23,463	23,626	24,014	+1.0%
Gedling	25,890	25,716	25,811	26,041	26,310	26,767	+3.4%
Mansfield	24,317	24,366	24,485	24,637	24,883	25,273	+3.9%
Newark and Sherwood	26,526	26,498	26,770	27,048	27,384	27,853	+5.0%
Rushcliffe	25,795	26,048	26,317	26,603	26,927	27,446	+6.4%
Nottinghamshire	180,734	180,517	181,165	182,301	183,965	186,970	+3.5%

Source: ONS, 2011.

3.3 Ethnicity

Table 8 shows the ethnicity of the Nottinghamshire population aged 0-19 years old according to district.

TABLE 8: ETHNICITY OF 0-19 YEAR OLDS IN NOTTINGHAMSHIRE

	Ashfield		Bassetlaw		Broxtowe		Gedling		Mansfield		Newark & Sherwood		Rushcliffe	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	27481	96	24782	96	21060	89	22653	88	23129	95	25476	96	22987	89
Mixed / multiple ethnic groups	644	2	525	2	1100	5	1679	7	662	3	673	3	1259	5
Asian/Asian British	322	1	401	2	1155	5	1043	4	365	2	214	1	1356	5
Black/ African/ Caribbean/ Black British	120	0	86	0	205	1	373	1	75	0	63	0	122	0
Other	35	0	52	0	247	1	73	0	27	0	34	0	132	1

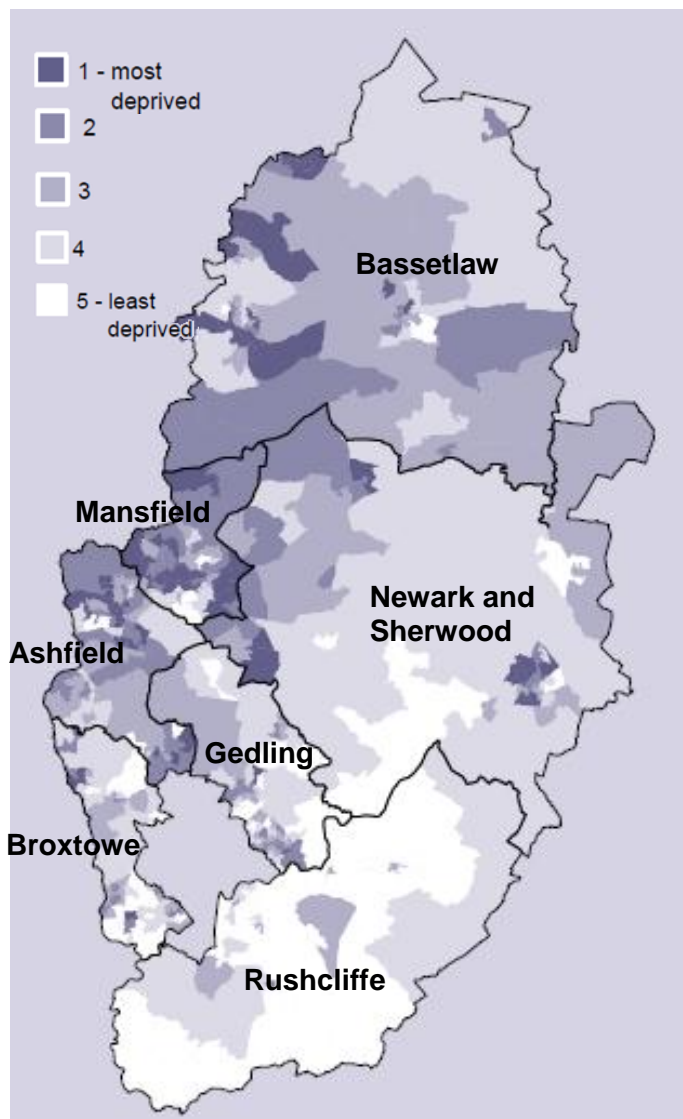
Source: ONS, 2011.

As can be seen from Table 8, the proportion of the 0-19 year old population from black and ethnic minority (BME) groups varied according to district. Ashfield, Bassetlaw and Newark and Sherwood had the smallest BME populations, with 96% of the populations being of 'White' ethnic origin. Comparatively, Gedling, Broxtowe and Rushcliffe were more ethnically diverse. For example, in Gedling 7% of the 0-19 year old population were from 'mixed/multiple' ethnic groups, 4% 'Asian/Asian British' ethnic groups and 1% 'Black' ethnic groups.

3.4 Deprivation in Nottinghamshire

The level of deprivation varies considerably within the county, both between districts and within districts (Figure 3). The Index of Multiple Deprivation (IMD) is a composite measure of deprivation taking account of income, employment, health, education, crime, barriers to housing and services and living environment. The higher the IMD score the more deprived the area. Table 9 shows the IMD scores for each district and how the scores are ranked compared to the rest of districts in England. Of the districts in Nottinghamshire, Mansfield is the most deprived and falls among the 10% most deprived districts in England⁴⁷. Comparatively, Rushcliffe is among the 10% least deprived areas in the country⁴⁷.

FIGURE 3: DEPRIVATION WITHIN NOTTINGHAMSHIRE COUNTY, INDEX OF MULTIPLE DEPRIVATION



Source: Department for Communities and Local Government, Indices of Deprivation, 2010

TABLE 9: DEPRIVATION LEVELS IN NOTTINGHAMSHIRE

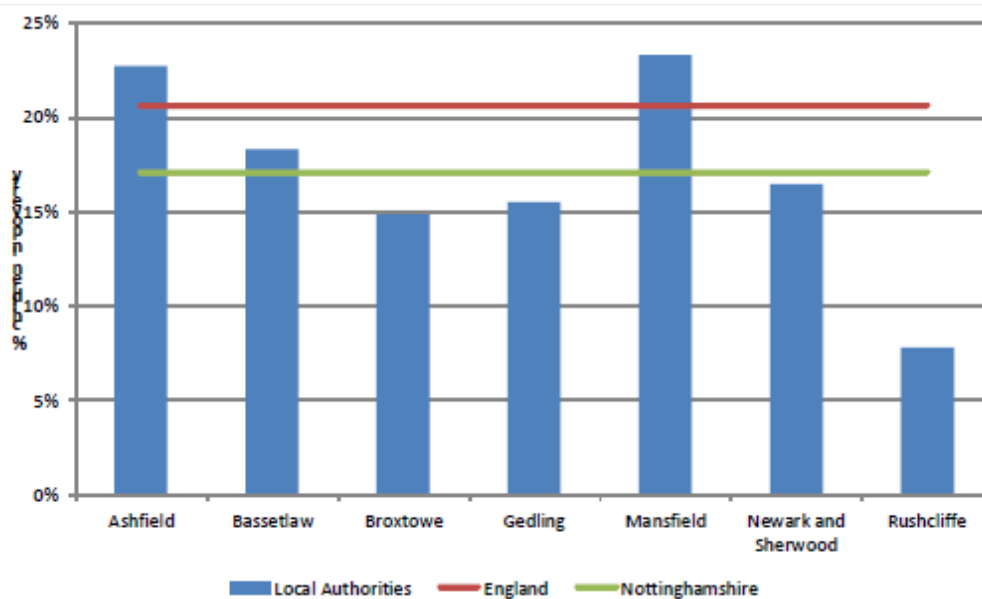
Index of Multiple Deprivation		
	Score (low=less deprived)	Rank out of 326 areas nationally (1=most deprived. 326=least deprived)
Ashfield	26.18	63
Bassetlaw	24.96	82
Broxtowe	13.86	216
Gedling	15.29	199
Mansfield	30.29	38
Newark and Sherwood	19.26	147
Rushcliffe	7.61	318
Nottinghamshire	19.52	N/A
County average		

Source: Department for Communities and Local Government, 2010

Deprivation affecting children

The Income Deprivation Affecting Children Index is a subset of the income deprivation domain and shows the percentage of children living in income deprived families. In 2010 there were 27,950 children and young people aged 0-19 living in poverty in Nottinghamshire, which equates to 17.1% of the 0-19 population. As shown in Figure 4 Mansfield and Ashfield have higher percentages of children living in poverty compared to the England average.

FIGURE 4: PERCENTAGE OF CHILDREN LIVING IN INCOME DEPRIVED HOUSEHOLDS



Source: Department for Work and Pensions, 2013

3.5 An Overview of the Health and Wellbeing of Children and Young People in Nottinghamshire

Figure 5 is a spine diagram produced by ChiMat as part of their Child Health Profiles to give an overview of the health and wellbeing of children and young people in Nottinghamshire compared to the average for England⁴⁸. Red dots show indicators where Nottinghamshire is significantly worse than the England average. Green dots show indicators that are significantly better than the England average. Overall, as can be seen in Figure 5, health indicators for children in Nottinghamshire are generally similar to the England average or significantly better than the England average. The indicators where Nottinghamshire was 'significantly worse' than the England average were, the rate of new entrants to the youth justice system, smoking in pregnancy, breast feeding initiation and breast feeding at 6-8 weeks.

There are however considerable differences between the districts within the county which this diagram does not highlight. These differences will be discussed in subsequent chapters.

FIGURE 5: CHILD HEALTH PROFILE, NOTTINGHAMSHIRE (2013)

The chart below shows how children's health and well-being in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
 - Not significantly different
 - Significantly better than England average
 - ◆ Regional average
- 25th percentile England average 75th percentile
range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst		Eng. best
Preventable mortality	1 Infant mortality rate	35	3.9	4.4	8.0		2.2
	2 Child mortality rate (age 1-17 years)	18	11.8	13.7	23.7		7.5
Health protection	3 MMR immunisation (by age 2 years)	7,988	91.7	91.2	78.7		97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	8,465	97.2	96.1	85.7		98.8
	5 Children in care immunisations	390	81.3	83.1	0.0		100.0
	6 Acute sexually transmitted infections (including Chlamydia)	2,873	31.1	35.6	75.2		19.9
Wider determinants of ill health	7 Children achieving a good level of development at age 5	5,621	64.3	63.5	51.5		76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	5,279	60.6	59.4	40.9		79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	-	14.6	0.0		40.0
	10 Not in education, employment or training (age 16-18 years)	1,210	4.5	6.1	11.8		1.6
	11 First time entrants to the Youth Justice System	874	1,189.0	876.4	2,436.3	●	342.9
	12 Children living in poverty (aged under 16 years)	24,480	17.8	21.1	45.9	●	7.4
	13 Family homelessness	313	0.9	1.7	7.4	●	0.1
	14 Children in care	800	49.0	59.0	150.0	●	19.0
Health improvement	15 Children killed or seriously injured in road traffic accidents	36	25.7	22.1	47.9	●	4.4
	16 Low birthweight	689	7.6	7.4	11.0	●	5.0
	17 Obese children (age 4-5 years)	656	8.4	9.5	14.5	●	5.8
	18 Obese children (age 10-11 years)	1,205	17.7	19.2	27.8	●	12.3
	19 Participation in at least 3 hours of sport/PE	56,206	55.2	55.1	40.9	◆	79.5
	20 Children's tooth decay (at age 12)	-	0.7	0.7	1.5	●	0.2
	21 Teenage conception rate (age under 18 years)	461	32.9	35.4	64.7	●	6.2
	22 Teenage mothers (age under 18 years)	136	1.5	1.3	2.8	●	0.3
Prevention of ill health	23 Hospital admissions due to alcohol specific conditions	71	44.4	55.8	138.3	●	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	64	69.1	69.4	186.3	●	25.7
	25 Smoking in pregnancy	1,560	18.2	13.2	29.7	●	2.9
	26 Breastfeeding initiation	5,945	69.4	74.0	41.8	●	94.3
	27 Breastfeeding at 6-8 weeks	3,474	38.6	47.2	19.7	●	82.8
	28 A&E attendances (age 0-4 years)	18,988	431.6	483.9	1,187.4	●	136.3
	29 Hospital admissions due to injury (age under 18 years)	1,721	106.0	122.6	211.1	●	72.4
	30 Hospital admissions for asthma (age under 19 years)	189	110.0	193.9	484.4	●	73.4
Prevention of ill health	31 Hospital admissions for mental health conditions	102	62.8	91.3	479.7	●	22.6
	32 Hospital admissions as a result of self-harm	175	107.8	115.5	311.9	●	26.0

Source: Child Health Profiles, ChiMat (2013).

Summary: Chapter 3 The Nottinghamshire Child and Adolescent Population

- The local need for CAMHS is affected by the local demography of the population.
- There are 171,865 children and young people aged 0-18 living in Nottinghamshire, with Ashfield having the highest number of children and young people (27,250).
- The population of 0-19 year olds is expected to increase on average by 3.5% over the next ten years, with the largest increases in Rushcliffe (+6.4%) and Newark and Sherwood (+5%). The largest increase is expected to be in the 0-5 year old age group.
- The percentage of the population from BME groups varied by district with Gedling, Broxtowe and Rushcliffe being more ethnically diverse.
- Deprivation level varied considerably by district. Mansfield was the most deprived and falls within the 10% most deprived areas in the country. Comparatively Rushcliffe is the least deprived.
- The percentage of children living in poverty in Nottinghamshire is 17.1%, lower than the England average. Mansfield and Ashfield however have higher levels of poverty and are above the England average.
- A number of indicators of health are used by the Child and Maternal Health Observatory to give an overview of the health of children and young people in Nottinghamshire. Generally, these health indicators are similar to the England average or significantly better. Indicators where Nottinghamshire is 'significantly worse' than the England average relate to breastfeeding and the rate of new entrants to the Youth Justice System.

4. Assessing Emotional and Mental Health Needs of Children and Young People in Nottinghamshire

4.1 Prevalence of Mental Health Problems among Children and Young People in Nottinghamshire

National prevalence data have been applied to the Nottinghamshire population to estimate the number of children with mental health problems. The data sources used have been outlined in section 2.4. It is important to note that there are several limitations with the data presented:

- By applying national prevalence data to the local population, variations in risk factors between geographical areas are not taken account of. These estimates therefore need to be treated with some caution, particularly at district level, where numbers of children may be over- or underestimated depending upon the prevalence of risk factors for mental health problems compared to the England average. For example, estimated numbers of children with mental health problems are likely to be underestimated in Mansfield and Ashfield, and overestimated in Rushcliffe based upon the prevalence of risk factors such as deprivation.
- Data on pre-school children are for mental health problems, conditions of all severities. It must be noted that not all these children will require use of mental health services.
- Data for school aged children and those aged 16-19 years old focus on certain mental disorders, those meeting ICD-10 diagnostic criteria. These estimates are likely to give a better indication of children and young people requiring services. Less severe mental health problems not meeting these criteria are excluded from the estimates presented.

4.1.1 Pre-school children

Estimates of the prevalence of mental health problems among preschool children vary considerably from 10%¹³ to 19.6%¹¹. Applying these two estimated prevalence figures to the Nottinghamshire population suggests that between 3586 and 7028 children aged 2-5 could have a mental health problem (Table 10).

TABLE 10: ESTIMATED NUMBERS OF 2-5 YEAR OLD CHILDREN WITH ANY MENTAL HEALTH DISORDER

District	Estimated number of children aged 2-5 with a mental health problem (Prevalence 10%)	Estimated number of children aged 2-5 with a mental health problem (Prevalence 19.6%)
Ashfield	578	1133
Bassetlaw	489	945
Broxtowe	473	937
Gedling	510	1000
Mansfield	497	968
Newark and Sherwood	513	988
Rushcliffe	526	996
Nottinghamshire	3586	7028

Sources: Chimat, 2011. The Mental Health Foundation.

4.1.2 School-aged children

Using prevalence data from the 2004 ONS survey 'Mental health of children and young people in Great Britain', Table 11 shows estimated numbers of school aged children with mental health disorders in Nottinghamshire¹. The term 'any mental health disorder' includes emotional, conduct, hyperkinetic and less common disorders.

TABLE 11: ESTIMATED NUMBER OF CHILDREN AGED 5-16 IN NOTTINGHAMSHIRE WITH 'ANY MENTAL HEALTH DISORDER' ACCORDING TO DISTRICT AND GENDER

District	Children aged 5-10			Children aged 11-16		
	Male	Female	All	Male	Female	All
Ashfield	422	204	627	564	433	998
Bassetlaw	377	182	551	539	412	952
Broxtowe	337	162	499	474	367	842
Gedling	386	181	564	519	400	920
Mansfield	347	162	514	469	371	842
Newark and Sherwood	398	192	591	534	412	957
Rushcliffe	406	186	579	514	396	911

Source: Chimat, 2011. Note: 'Any mental health disorder' includes emotional, conduct, hyperkinetic and less common disorders.

Table 12 shows the estimated numbers of children with emotional, conduct, hyperkinetic and 'less common' disorders for Nottinghamshire. Appendix 3 provides estimated numbers of children with each disorder according to district.

TABLE 12: ESTIMATED NUMBER OF CHILDREN IN NOTTINGHAMSHIRE WITH A MENTAL HEALTH DISORDER, ACCORDING TO DISORDER TYPE

Type of Disorder	Children aged 5-10	Children aged 11-16	Total (5-16 year olds)
Emotional disorders	1223	2792	4015
Conduct disorders	2498	3685	6183
Hyperkinetic disorders	816	781	1597
Less common disorders	663	781	1444

Source: Chimat, 2011

4.1.3 Young people aged 16-19

Using data from the 2000 Adult Psychiatric Morbidity Survey, Chimat have estimated numbers of young people aged 16-19 living in Nottinghamshire who would be expected to have a neurotic disorder (Table 13)⁴⁹. The data have been presented according to district and type of condition.

TABLE 13: ESTIMATED NUMBERS OF YOUNG PEOPLE AGED 16-19 WITH A NEUROTIC DISORDER, ACCORDING TO DISTRICT

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
Ashfield	502	80	103	77	52	32	799
Bassetlaw	488	77	100	75	51	31	777
Broxtowe	447	71	91	68	46	19	710
Gedling	470	74	96	72	49	30	748
Mansfield	452	70	93	70	47	28	719
Newark & Sherwood	484	76	99	74	50	30	770
Rushcliffe	456	72	93	70	47	29	726

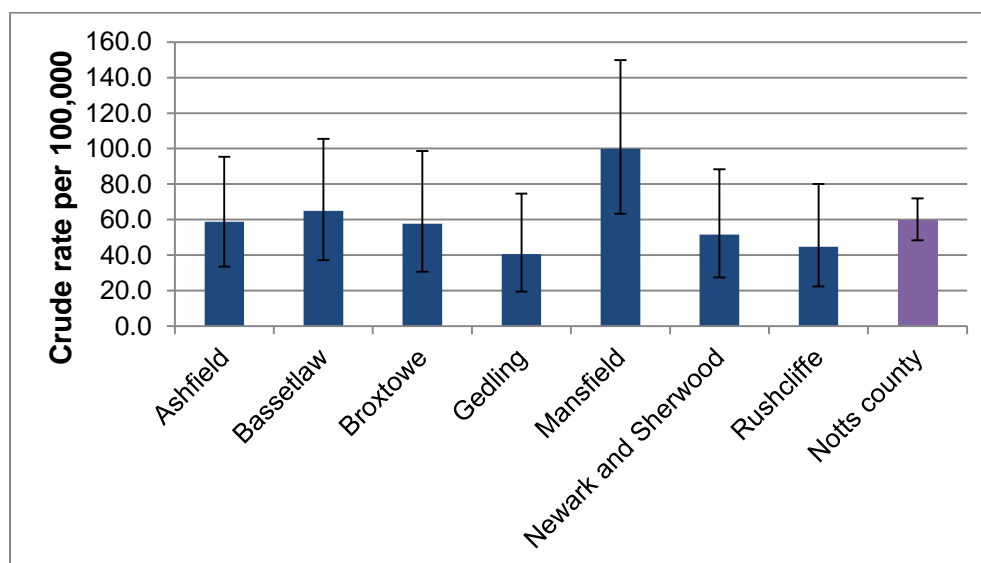
Source: Chimat, 2011.

4.2 Self Harm and Suicide

4.2.1 Self-Harm

Self-harm occurs in people of all ages. Children as young as eight have been found to have hurt themselves⁵⁰. Self-harm is more common in adolescent females than males. Risk factors for self-harm in childhood are varied but can include physical or sexual abuse, alcohol problems in childhood, existence of coexisting mental health disorders (e.g. depression), and difficult relationships with friends or family. Those who repeatedly self-harm are at increased risk of suicide. Figure 6 shows crude rates of hospital admissions for self-harm among children and young people. The crude rate is highest in Mansfield followed by Bassetlaw, although none of these differences are statistically significant due to the small numbers. It must be noted that these rates are likely to underestimate the true burden of self-harm among children and young people, as these data exclude those seen in primary care or within CAMHS. Self-harm is often carried out in secret and so will often not come to medical attention.

FIGURE 6: CRUDE RATE OF HOSPITAL ADMISSIONS FOR SELF-HARM AMONG CHILDREN AND YOUNG PEOPLE AGED 0-18 BY LOCAL AUTHORITY (2012)

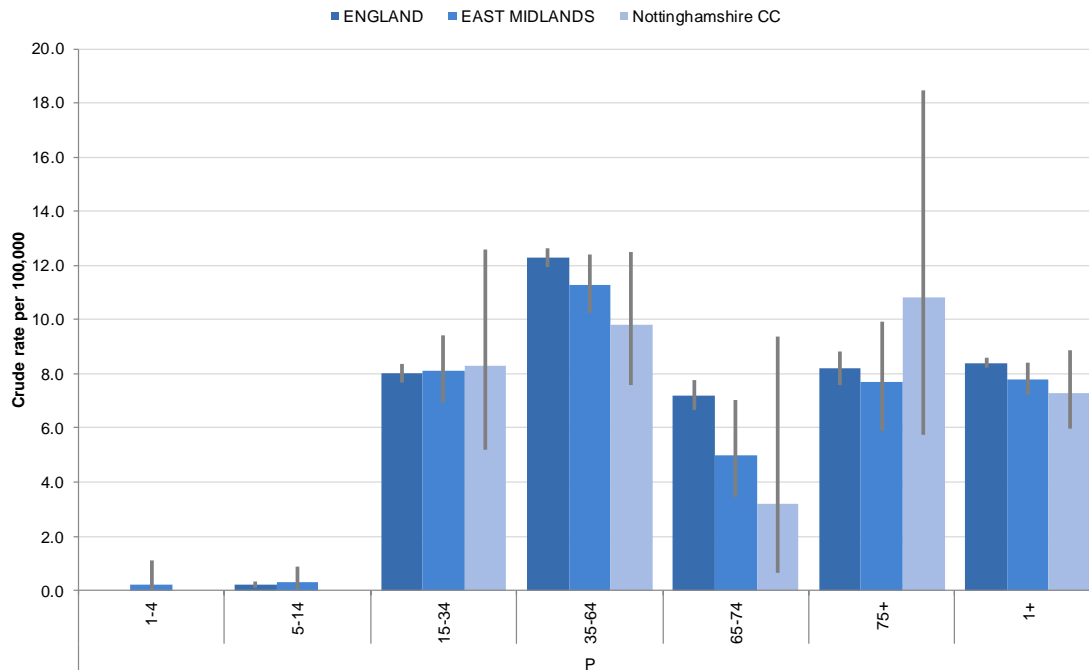


Source: Hospital Episode Statistics, 2012

4.2.2 Suicide

Numbers of suicides are small among children and young people. Figure 7 shows the rates of suicide for Nottinghamshire, the East Midlands and England according to age for 2008-10. As can be seen the crude rate of suicide is low in under 15 year olds, but rise steeply in the 15-34 year old age group.

FIGURE 7: SUICIDES IN NOTTINGHAMSHIRE, COMPARED TO THE EAST MIDLANDS AND ENGLAND, ALL AGES, 2008-10



Source: Health and Social Care Information Centre, 2008-10

Local analysis of data from the Child Death Overview Panel on cases of suicide among children 2009-12 has been carried out⁵¹. Due to the small numbers of cases, the specific findings will not be outlined. Broad findings include:

- Recognition of two main groups of young people committing suicide. (1) Those with recognised needs and service involvement from CAMHS/other services and (2) A group of young people often invisible to services carrying out impulsive acts.
- The vast majority die by asphyxiation (from hanging/ligatures around neck). Overdoses were the cause of death in a minority.
- The presence of parental mental health disorders was highlighted in a large number of cases. Domestic violence was seen in a smaller group of cases.

Recommendations from this work include:

- A need for further research into the prevention of suicides by impulsive young people.
- A proposal for further work examining cases of suicide among young people across the East Midlands.

4.3 Prevalence of risk factors for emotional and mental health disorders among children and young people

4.3.1 Risk factor data from the 2011 Census

Data are available from the 2011 Census that helps to build a picture of the distribution of risk factors for emotional and mental health problems among children and young people. An overview of these data compared to the East Midlands and England are displayed in Table 18. The table has been colour coded to rank the local authority areas within Nottinghamshire according to the prevalence of each risk factor.

Lone parent families

The prevalence of lone parent households with dependent children was 6.5% for Nottinghamshire in the 2011 census, lower than the average for the East Midlands (6.7%) and England (7.1%). Ashfield (7.9%), Mansfield (7.4%) and Gedling (6.9%) have a higher prevalence of lone parents with dependent children than the England average. Table 14 shows the numbers of lone parents according to district.

TABLE 14: NUMBERS OF LONE PARENTS IN NOTTINGHAMSHIRE ACCORDING TO DISTRICT AND ECONOMIC ACTIVITY

	Lone parent in part-time employment	Lone parent in full-time employment	Lone parent not in employment	Total number of lone parents
Ashfield	1,228	1,020	1,733	3,981
Bassetlaw	1,101	827	1,082	3,010
Broxtowe	945	753	869	2,567
Gedling	1,233	1,018	1,147	3,398
Mansfield	1,045	897	1,378	3,320
Newark and Sherwood	1,129	838	1,070	3,037
Rushcliffe	865	907	547	2,319
Nottinghamshire	7,546	6,260	7,826	21,632

Source: ONS, 2011.

Tenure

Mansfield has the highest proportion of households in socially rented accommodation (18.2%), higher than the East Midlands and England averages. Please note that these data are for all households and not just those where there are children and young people. All other districts have a lower percentage of households in socially rented housing compared to the England average. Private rented housing was most common in Broxtowe (14.1%), Mansfield (13.6%) and Rushcliffe (13.3%).

TABLE 15: HOUSEHOLDS IN SOCIALLY RENTED HOUSING ACCORDING TO DISTRICT

District	Number of households in district	Number of households in socially rented housing	Percentage of households in socially rented housing (%)
Ashfield	50,931	8,258	16.2
Bassetlaw	47,667	7,579	15.9
Broxtowe	46,820	5,218	11.1
Gedling	49,349	4,926	10.0
Mansfield	44,928	8,199	18.2
Newark and Sherwood	48,773	7,050	14.5
Rushcliffe	45,835	3,854	8.4

Source: ONS, 2011.

Parental Unemployment

The percentage of households with no parent working in Nottinghamshire is 3.5%, lower than the average for the East Midlands (3.8%) and England (4%). Table 18 and Table 16 show the variation across the county, with Ashfield (5%) and Mansfield (4.9%) having the highest percentage of families where no adult works.

TABLE 16: NUMBERS OF HOUSEHOLDS WITH NO ADULTS IN EMPLOYMENT WITH DEPENDENT CHILDREN

District	Number of households with no adults in employment with dependent children	Percentage of households with no adults in employment with dependent children (%)
Ashfield	2,530	5.0
Bassetlaw	1,708	3.6
Broxtowe	1,375	2.9
Gedling	1,568	3.2
Mansfield	2,187	4.9
Newark and Sherwood	1,594	3.3
Rushcliffe	786	1.7
Nottinghamshire	11,748	3.5

Source: ONS, 2011.

Residents over 16 with no qualifications

Nottinghamshire has a higher percentage of residents over the age of 16 with no qualifications (25.5%) than the England average (22.5%). Ashfield (31.4%), Mansfield (30.4%) and Bassetlaw (28.5%) have the highest prevalence of residents over 16 with no qualifications.

Long term health problems or disability

Data are presented for households where there are dependent children where one of the household members has a long term health condition or a disability. Mansfield (5.5%), Ashfield (5.3%) and Bassetlaw (4.8%) have a higher prevalence of this risk factor than the average for England.

TABLE 17: NUMBERS OF HOUSEHOLDS WITH DEPENDENT CHILDREN WHERE ONE PERSON IN HOUSEHOLD HAS A LONG TERM ILLNESS OF DISABILITY

District	Number of households with dependent children where one person in household has a long-term health problem or disability
Ashfield	2,681
Bassetlaw	2,279
Broxtowe	1,839
Gedling	2,170
Mansfield	2,484
Newark and Sherwood	2,180
Rushcliffe	1,677
Nottinghamshire	15,310

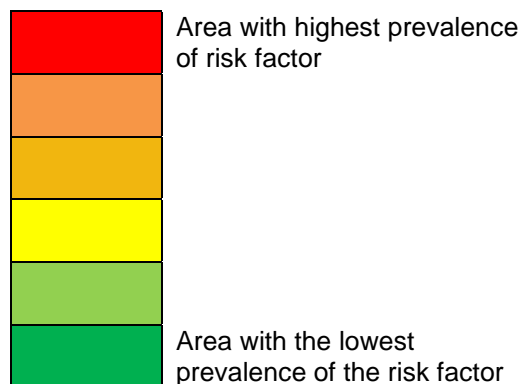
Source: ONS, 2011.

TABLE 18: PREVALENCE OF RISK FACTORS FOR CHILD AND ADOLESCENT EMOTIONAL AND MENTAL HEALTH DISORDERS (2011)

	Prevalence of risk factor (%)									
	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark & Sherwood	Rushcliffe	Notts	East Midlands	England
Lone parent household with dependent child(ren)	7.9	6.3	5.5	6.9	7.4	6.2	5.1	6.5	6.7	7.1
%of all households in social rented housing	16.2	15.9	11.2	10.0	18.2	14.4	8.4	13.5	15.8	17.7
% of all households in private rented housing	12.8	12.5	14.1	13.2	13.6	12.9	13.3	13.1	14.9	16.8
Reference person in household from Routine Occupational group	19.1	15.6	11.6	11.1	18.5	14.1	6.8	13.8	13.6	11.0
Households with no adults in employment with dependent children	5.0	3.6	2.9	3.2	4.9	3.3	1.7	3.5	3.8	4.2
Percentage of usual residents over the age of 16 with no qualifications	31.4	28.5	23.1	23.6	30.4	25.1	16.4	25.5	24.7	22.5
One person in household with a long term health problem or disability, with dependent children	5.3	4.8	3.9	4.4	5.5	4.5	3.7	4.6	4.6	4.6

Source: ONS, 2011.

KEY



Notes on table:

-all data originated from the 2011 Census.

-local authority data in this table are ranked according to prevalence, and colour coded to assist rapid interpretation. Please note colours do not indicate statistical significance from the national, regional or local average.

4.3.2 Domestic Violence

Domestic violence is defined as “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional”⁵². This definition includes so called 'honour' based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Witnessing domestic violence during childhood is not uncommon. A survey of 6196 children and young people found that 12% of under 11 year olds, 17.5% of 11-17 year olds, and 23.7% of 18-24 year olds had been exposed to domestic violence between adults in their homes during childhood⁵³. This study also found that 3.2% of under 11s, 2.5% of 11-17 year olds reported exposure to domestic violence in the past year⁵³. If applied to the Nottinghamshire population this would mean that about 4726 children and young people (3056 children aged under 11, and 1670 aged 11-17) have witnessed domestic violence in the last year.

Domestic violence is important in terms of child mental health as:

- It is recognised as a key indicator for child abuse and neglect, with young people experiencing family violence being between 2.9 to 4.4 times more likely to have experienced physical violence and neglect from a caregiver⁵³.
- Estimates suggest that children who have witnessed domestic violence are 2.5 times more likely to develop serious social and behavioural problems than other children⁵⁴.
- It compromises attachment between parent and child by undermining the developmental need for security and stability.
- It can lead to an internalizing of emotions by the exposed child, which is associated with higher levels of mental health problems.

Data from the Nottinghamshire Police Crime Recording System on numbers of domestic violence incidents and crimes reported to the police in 2012 are shown in Table 19. The rate of domestic violence crimes reported to the police was highest in 2012 in Mansfield and Ashfield, and lowest in Rushcliffe.

TABLE 19: NUMBER OF DOMESTIC INCIDENTS AND DOMESTIC VIOLENCE CRIMES IN NOTTINGHAMSHIRE, 2012

	Incidents	Crimes	Crime rate per 1,000 females
Ashfield	1,866	822	13.5
Bassetlaw	1,605	665	11.7
Broxtowe	1,204	458	8.3
Gedling	1,424	577	9.9
Mansfield	1,855	820	15.4
Newark and Sherwood	1,278	510	8.7
Rushcliffe	759	258	4.6
Nottinghamshire	9,991	4,110	10.3

Source: Nottinghamshire Police, 2013.

Within Nottinghamshire, Multi-Agency Risk assessment conferences (MARACs) are held to discuss high risk victims of domestic violence. In Nottinghamshire these case conferences are held weekly alternating between the north and the south of the county. They are designed to identify the necessary support and agree effective interventions in order to reduce the risk. In 2012/13 545 cases were discussed at the MARACs of which 103 cases were repeated incidents among the same women. Many of the women discussed at the MARCS have children. For 2012/13 the average number of children per woman was calculated as being 1.4⁵⁵. Table 20 shows the numbers of cases discussed at the MARACs according to district. It must be noted that these data will only be the tip of the iceberg as low and medium risk domestic violence cases are not included.

TABLE 20: HIGH RISK CASES OF DOMESTIC VIOLENCE SEEN AT THE NOTTINGHAMSHIRE MULTI-AGENCY RISK ASSESSMENT CONFERENCE, 2012/13

	Number of MARAC cases 2012/13	Number of repeat cases 2012/13	Number of women discussed at MARAC 2012/13
Ashfield	87	11	76
Bassetlaw	103	16	87
Broxtowe	80	16	64
Gedling	67	20	47
Mansfield	99	24	75
Newark and Sherwood	77	14	63
Rushcliffe	32	2	30
Nottinghamshire	545	103	442

Source: Nottinghamshire Multi-Agency Risk assessment conference, 2012/13

Data from the 2012 MARACs showed that there were 685 children in households where high risk and potentially life threatening domestic violence was taking place in their home.

Further local data on domestic violence are available from the 2013 Nottinghamshire Joint Strategic Needs Assessment (JSNA)⁴⁷. Key findings from the JSNA were:

- Concerns about the risk of domestic violence to the child or young person were identified in 24% of safeguarding referrals to Nottinghamshire Children's Social Care.
- There were concerns about domestic violence in 61.8% of children who were the subject of a Child Protection Plan between July and September 2012. This was a total of 496 children in this time period.

4.3.3 Parental Mental Health Disorders

Research has shown that parental mental health impacts upon the wellbeing of children. For example, in the early years, maternal depression can affect parenting (too intrusive or withdrawn) and the development of secure attachments. The importance of good perinatal mental health is increasingly recognised. NICE estimates that about 10-15% of new mothers suffer some perinatal mental health difficulties⁵⁶. Applying these estimates to the numbers of new mothers in Nottinghamshire in 2011 suggests that of the 9027 new mothers, between 903 and 1354 may have had a perinatal mental health problem.

TABLE 21: ESTIMATED NUMBERS OF NEW MOTHERS WITH A PERINATAL MENTAL HEALTH PROBLEM (2011)

	Number of live births (ONS 2011)	Estimated numbers of new mothers with a perinatal mental health problem	
		Estimate if prevalence 10%	Estimate if prevalence 15%
Ashfield	1517	152	228
Bassetlaw	1292	129	194
Broxtowe	1255	126	188
Gedling	1225	123	184
Mansfield	1381	138	207
Newark and Sherwood	1213	121	182
Rushcliffe	1144	114	172
Nottinghamshire	9027	903	1354

Sources: ONS Birth Summary table, 2011. Estimates of prevalence from NICE⁵⁶.

Other parental mental health problems have been shown to impact upon child emotional and mental wellbeing. For example, research has shown that children who have a parent with schizophrenia are more likely to experience psychiatric disturbance themselves, more likely to be socially isolated and

can experience stress about their parents symptoms⁵⁷. Many of the risk factors outlined in this chapter overlap. Parents at increased risk of mental health problems include lone parents, those living in poverty, those who have chronic health problems and those who are unemployed⁵⁸. Local data on numbers of children living in households with a parent who has a mental health problem are not available. From the 2000 Psychiatric Morbidity Survey, it is known that about 23% of adults have a mental health problem⁴⁹. Estimated numbers of adults with common mental health disorders, according to lower tier local authority, are shown Table 22. Mansfield (155.1 per 1000 adults) and Ashfield (150.9 per 1000 adults) have the highest estimated rates of common mental health disorders among adults in Nottinghamshire.

TABLE 22: ESTIMATED PREVALENCE OF COMMON MENTAL HEALTH DISORDERS AMONG ADULTS BY LOWER TIER LOCAL AUTHORITY

Local authority	Prevalence of any common mental disorder (rate/1000 population)	Estimated number of cases
Ashfield	150.9	14,290
Bassetlaw	121.3	11,250
Broxtowe	143.2	13,460
Gedling	147.3	13,620
Mansfield	155.1	12,710
Newark and Sherwood	117.6	10,850
Rushcliffe	115.6	10,360
Nottinghamshire	135.8	86,550

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment.

4.3.5 Parental Substance Misuse

Data from the 2013 Nottinghamshire JSNA highlights a number of risks to children as a result of parental substance misuse⁴⁷:

- Abuse or neglect.
- The development of behavioural and long-term developmental problems.
- Separation from parents, including removal to local authority care, which is estimated to occur in around 60% of cases.
- An increased risk of eviction or housing in temporary or unsuitable accommodation.
- Responsibility for caring for a parent with substance misuse problems, which has been shown to lead to a higher incidence of educational difficulties.
- A greater risk of experiencing domestic violence or foetal alcohol syndrome where a parent is a problematic drinker.
- Inter-generational transmission of harms where the children of substance misusers will also go on to misuse substances.

Using the formula from the Hidden Harm Report 2003, Nottinghamshire Drug and Alcohol Action Team (DAAT) estimates that up to 4,266 children and young people are affected by parental illicit drug use across the county, and between 13,271 and 21,565 are affected by parental problematic alcohol use⁴⁷.

4.3.5 Children with Parents in Prison

There is no reliable, routinely recorded information on the parental status of prisoners or systematic identification of their children, where they live or which services they are accessing. It is estimated that 7% of youngsters will see their father imprisoned during their school years and approximately 200,000 children in England and Wales experience the imprisonment of a parent every year⁴⁷. Research has shown that having a parent in prison can impact upon the child in a number of ways, including⁵⁹:

- Defiant or aggressive behaviour by the child or young person.
- Reduced levels of obedience, and reduction in school performance.
- Changes in contact and relationships with the parent. This can lead to a grief reaction and a sense of loss on the imprisonment of the parent.
- Fear, anxiety, nightmares and fear of strangers.

Applying the 7% estimate to Nottinghamshire would mean that around 8,000 of the county's school aged children and young people will see their father imprisoned during their school years⁴⁷.

Summary: Chapter 4 Assessing Emotional and Mental Health Needs of Children and Young People in Nottinghamshire

- Using national data from ONS, estimated numbers of school aged children (5-16 years old) in Nottinghamshire with a mental disorder are: 4015 with an emotional disorder, 6183 with a conduct disorder, 1597 with a hyperactivity disorder and 1444 with a less common disorder. These estimates need to be treated with some caution as they are based on national data and do not take account of local variation in risk factors for emotional and mental health problems.
- Numbers of suicides are small among children and young people. The crude rate of hospital admissions for self-harm is highest in Mansfield. This is however not significantly different to the Nottinghamshire average.
- Risk factor data from the 2011 census has been used to examine risk factors for emotional and mental health problems among children and young people. Risk factors tend to cluster in Ashfield and Mansfield. For example:
 - There are 21,632 lone parent families in Nottinghamshire, with the highest numbers in Ashfield (3,981), Gedling (3,398) and Mansfield (3,320).
 - There are 11,748 households where dependent children live where there is no adult in employment. Numbers were highest in Ashfield (2,530), Mansfield (2,187) and Bassetlaw (1,708).
 - There are 15,310 households with dependent children where there is someone with a long-term health condition or disability in Nottinghamshire. Highest numbers of households are in Ashfield (2,681), Mansfield (2,484) and Bassetlaw (2,279).
 - Domestic violence crime rates are highest in Mansfield (15.4 per 1000 women) and Ashfield (13.5 per 1000 women).
 - In 2011 there were 9027 live births in Nottinghamshire. From these births, it is estimated that between 903 and 1354 new mothers have a perinatal mental health problem.
 - Data are not available on parents with mental health problems. Estimated rates of common mental health disorders among adults are highest in Mansfield (155.1/1000) and Ashfield (150.9/1000).
- Estimates by the Nottinghamshire Drug and Alcohol Action Team suggest that up to 4,266 children and young people are affected by parental illicit drug use across the county, and between 13,271 and 21,565 are affected by parental problematic alcohol use.
- It is estimated that about 8,000 of Nottinghamshire's school aged children and young people will see their father imprisoned during their school years.

5. High Risk Groups

There are a number of groups of children who are recognised to have disproportionately high levels of mental and emotional health disorders. Each of these will be considered in turn.

5.1 Looked after children

Numbers of looked after children (LAC) in Nottinghamshire

At the end of February 2013 there were 891 LAC in Nottinghamshire, an increase from 792 at the same time in 2012⁴⁷. The majority of the LAC are placed into foster care (76%, Feb 2013). Table 23 shows the number of LAC according to district, showing Ashfield (22%), Mansfield (21%) and Bassetlaw (18%) to have the highest numbers of LAC.

TABLE 23: LOOKED AFTER CHILDREN BY DISTRICT OFFICE, FEBRUARY 2013

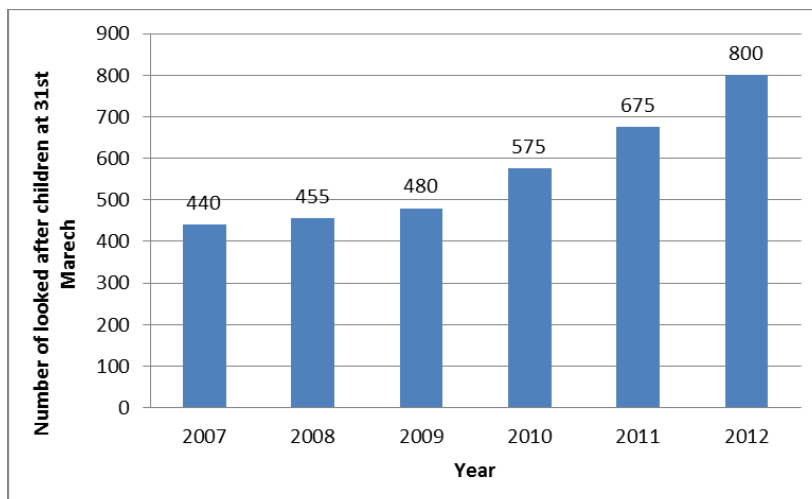
District Office	Number of LAC
Ashfield	198
Bassetlaw	162
Broxtowe	75
Gedling	65
Mansfield	187
Newark and Sherwood	124
Rushcliffe	*
Aftercare	*
Disabled	53

Source: Nottinghamshire County Council, 2013⁴⁷

*Low numbers have been suppressed.

Numbers of LAC have increased considerably over time as shown in Figure 8.

FIGURE 8: NUMBER OF CHILDREN LOOKED AFTER BY NOTTINGHAMSHIRE COUNTY COUNCIL (2007-2012)

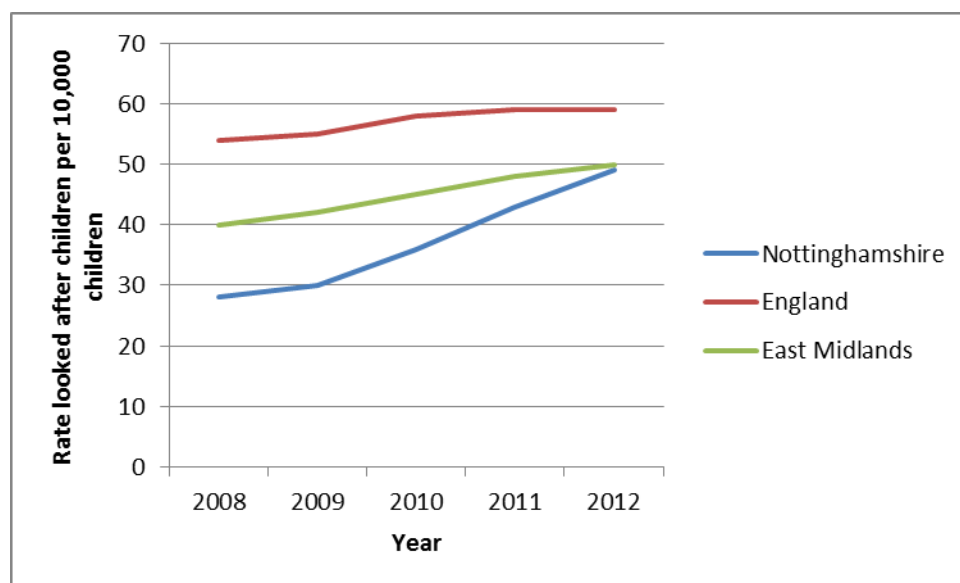


Source: Department for Education (DfE). The figures are based on data from the SSDA903 return collected from all local authorities, in March of each year.

Compared to the England average, Nottinghamshire has a lower rate of LAC (Figure 9). It must however be noted that Nottinghamshire has seen a progressive increase in the rate of LAC,

particularly rising steeply between 2009 and 2012. Comparatively, the England rate has flattened since 2010.

FIGURE 9: RATE OF LOOKED AFTER CHILDREN PER 10,000 CHILDREN



Source: DfE, 2008-2012

Unaccompanied asylum seekers are a group of looked after children with additional and complex needs. They may have experienced or witnessed extreme violence or abuse, and been dislocated from their home, family and community. Numbers of unaccompanied asylum seekers in Nottinghamshire are shown in Table 24.

TABLE 24: NUMBER OF UNACCOMPANIED ASYLUM SEEKER CHILDREN LOOKED AFTER BY NOTTINGHAMSHIRE COUNTY COUNCIL, 2007-2011

	2007	2008	2009	2010	2011
Nottinghamshire	15	20	30	35	20

Source: DfE, 2007-2011⁶⁰.

Emotional and mental health needs of LAC

The emotional and mental health of LAC is affected by both the factors that led them to enter care, and their experiences as a looked after child. A large proportion of LAC enter care because of abuse, neglect or severe family dysfunction⁶¹. For example, the child’s parents may have been struggling with issues such as domestic violence, substance abuse, alcohol abuse, mental health problems or a combination of these factors.

Estimates suggest that about 45% of children in local authority care have a clinically recognisable mental health disorder compared to 10% of the general population⁶². The prevalence of mental health disorders rises to 70% for children living in residential care⁶². Table 25 summarises data from the 2002 ONS survey of the mental health needs of children looked after by local authorities according to the type of disorder and age compared to the general population.

TABLE 25: PREVALENCE OF MENTAL HEALTH DISORDERS AMONG LOOKED AFTER CHILDREN

	Prevalence of mental health disorders among children aged 5-10 (%)		Prevalence of mental health disorders among children aged 11-15 (%)	
	Looked after children	General population	Looked after children	General population
Emotional disorder	11	3	12	6
Conduct disorder	36	5	40	6
Hyperactivity disorder	11	2	7	1
Any mental health disorder	42	8	49	11

Source: ONS, 2002.

Through using national prevalence data from the 2002 ONS survey of the mental health needs of children looked after by local authorities, it can be estimated that **from a population of 891 LAC, approximately 401 will have a mental health disorder**. It can be estimated there would be about 330 children with a conduct disorder, 107 with an emotional disorder, and 62 with a hyperactivity disorder. It must be noted that some children are likely to have more than one disorder.

From April 2008 all local authorities in England have been required to provide information on the emotional and behavioural health of the children they look after⁶³. Data are collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a summary figure for each child is submitted through the SSDA903 data return. Data for 2010-12 is shown in Table 26. In 2012, the average score on the SDQ was 14.6, slightly worse than the national figure of 13.8. About half of LAC in Nottinghamshire had a normal SDQ, but over a third (38%) had a score of concern.

TABLE 26: EMOTIONAL AND BEHAVIOURAL HEALTH OF LOOKED AFTER CHILDREN ASSESSED BY THE SDQ, 2012

	Nottinghamshire		East Midlands		England	
	Average SDQ score	% children with an SDQ score of 'concern'	Average SDQ score	% children with an SDQ score of 'concern'	Average SDQ score	% children with an SDQ score of 'concern'
2010	16.1	50	16.4	49	14.2	38
2011	15.0	42	15.5	46	13.9	37
2012	14.6	38	14.9	41	13.8	36

Source: DfE, 2012

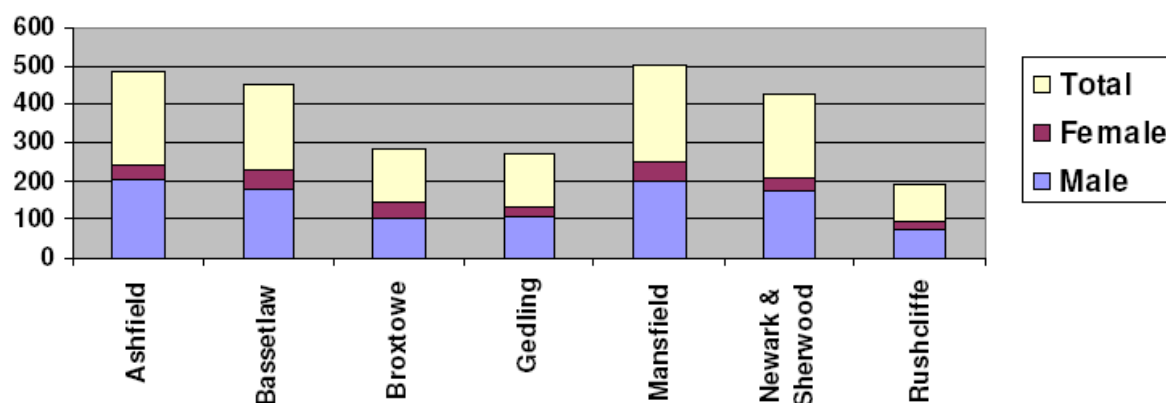
Note: SDQ score, 0-13 = normal; 14-16 = borderline cause for concern; 17+ = cause for concern

5.2 Young Offenders

Numbers of young offenders in Nottinghamshire

Between January and December 2011, there were 1,390 young people in the youth justice system, of which 79.6% were boys and 20.4% girls⁴⁷. The majority of offences committed by children and young people within Nottinghamshire were violence (28.3%) and theft (22.5%). Figure 10 shows the number of young people in the youth justice system according to district, with Mansfield, Ashfield and Bassetlaw having the highest numbers.

FIGURE 10: NUMBER OF YOUNG PEOPLE IN THE YOUTH JUSTICE SYSTEM BY DISTRICT



Source: Nottinghamshire County Council, 2013

Compared to the East Midlands and England, Nottinghamshire has a high rate of young people entering the youth justice system for the first time (929 per 100,000). This rate has however been reducing since 2009/10.

TABLE 27: RATE OF FIRST TIME ENTRANTS (PER 100,000) TO THE YOUTH JUSTICE SYSTEM, YOUNG PEOPLE AGED 10-17

	2008/9	2009/10	2010/11	2011/12
Nottinghamshire	1240	1320	1189	929
East Midlands	1320	1100	999	834
England	1472	1160	876	712

Source: DfE. Accessed via ChiMat.

Further data on numbers of young offenders and their general health needs can be found in the 2013 Nottinghamshire JSNA and the Nottinghamshire Health and Well-being Needs Assessment for young offenders⁶⁴.

Emotional and mental health needs of Young Offenders

There are a number of factors that contribute to young offenders having a higher risk of mental health problems than the general population. Firstly, the risk factors for offending behaviour (e.g. deprivation, poor parenting, problematic behaviour) overlap with risk factors for poor mental health⁶⁵. Secondly, contact with the youth justice system may lead to stress, anxiety, depression and exacerbation of existing mental health problems⁶⁵. Thirdly, offending behaviour may be an expression of developing mental health disorders (e.g. emerging personality disorders). The prevalence of mental health problems among young offenders has been estimated as about 40%, rising to about 90% among those in custody^{6,66}. Vermeiren *et al* (2000) have estimated the prevalence of certain mental health disorders among young offenders⁶⁷, as shown in Table 28. Estimates of the number of young offenders with these conditions have been made based upon the 1390 young people in the youth justice system in Nottinghamshire in 2011.

TABLE 28: PREVALENCE OF MENTAL HEALTH DISORDERS AMONG YOUNG OFFENDERS

	Estimated prevalence of a mental disorder amongst Youth Offenders ⁶⁷	Estimated number of young offenders with mental disorder in Nottinghamshire (of 1390 in 2011)
Conduct Disorders	53%	737
ADHD	19%	264
Substance Abuse	24%	334
Depression	14%	195
Psychotic Symptoms	4%	56

Source: Vermeiren *et al* (2000). A descriptive survey of Flemish delinquent adolescents⁶⁷.

5.3 Children in traveller families

Estimating numbers of Gypsy and Traveller Children in Nottinghamshire

Estimating numbers of children in Traveller families and their likely risk of mental illness is difficult for several reasons. Firstly the population tends to be mobile and so numbers of traveller children could vary considerably with time. Secondly, routine data sources often do not allow identification of travellers, and in some cases, individuals will not identify themselves as travellers. Two main surveys provide some local evidence.

School Census

In the 2012 School Census, data on ethnicity was collected for primary and secondary school children, with 0.16% of primary and secondary school children in Nottinghamshire identifying themselves as from a Gypsy/Roma ethnic group⁶⁸. This compares to 0.19% for the East Midlands and 0.22% for England. Table 29 shows the absolute numbers from this 2012 survey.

TABLE 29: NUMBERS OF PRIMARY AND SECONDARY SCHOOL GYPSY OR TRAVELLER CHILDREN, SCHOOL CENSUS 2012

	Traveller, Irish Heritage	Gypsy Roma
Primary school	17	125
Secondary school	6	25

Source: School Census, 2012

Caravan Count

A caravan count is carried out twice a year in January and June to provide a snapshot of numbers of caravans in each local authority, whether on local authority, private or unauthorised sites. While this does not give numbers of people, it does give an indication of where within the county travellers predominantly reside. Data from the July 2012 Caravan count is shown in Table 30⁶⁹, and shows that the majority of caravans within Nottinghamshire are within Newark and Sherwood.

TABLE 30: NUMBER OF CARAVANS IN NOTTINGHAMSHIRE, JULY 2012

	Number of caravans (July 2012)
Ashfield	5
Bassetlaw	62
Broxtowe	0
Gedling	0
Mansfield	0
Newark and Sherwood	211
Rushcliffe	7
Nottinghamshire County	285

Source: Caravan Count, 2012⁶⁹

Emotional and mental health needs of Travellers

There is a paucity of data on the mental health needs of Gypsies and Travellers, particularly in relation to the needs of children. National evidence has shown that Travellers have significantly poorer health status and significantly higher self-reported symptoms of ill health than other UK ethnic minority or economically disadvantaged UK residents⁷⁰. The study found that significantly more Gypsies and Travellers reported long term illnesses which limited their daily activities or work (42% versus 31% comparators), and overall health status, as measured using EQ-5D, was significantly worse among Gypsies and Travellers. A qualitative study focusing on the mental health needs of Travellers found that economic and social factors affected their mental wellbeing⁷¹. While it is not possible to easily quantify the mental health of Traveller children, poor physical health and economic and social stresses faced by families could all impact upon child mental health.

5.4 Homelessness

Estimating numbers of homeless children and young people in Nottinghamshire

The rate of homelessness among children and families accepted as being in priority need in 2011/12 was 0.9 per 1000 households in Nottinghamshire. Comparatively, rates of homelessness in this group were higher in the East Midlands (1.6 per 1000) and nationally (1.7 per 1000)⁷². These rates will only include children and families who are known to the local authorities and categorised as being in priority need for housing.

Local data are available from an annual survey carried out in Nottingham City and Nottinghamshire County, 'Homeless Watch'⁷³. This survey provides a snapshot of people presenting to agencies as being homeless, over the same two week period each year. Findings from the 2012 survey include⁷³:

- Families made up 19% of those presenting as homeless, of which 58 were single parent families and 12 were couples with children.
- There had been an increase in the proportion of single parent mothers presenting as homeless.
- In 2012 there were 0.30 children per adult being reported as being part of a homeless household compared to 0.33 in 2011. Of these children 58% were reported as being aged 0-4 years old.

Emotional and mental health needs of homeless children and young people

Children and young people who are homeless are significantly more likely to have delayed development, learning difficulties, and mental health problems, such as sleep disturbance, overactivity, anxiety, depression and self harm⁷⁴. Evidence suggests that compared to the general population, mental health problems are eight times higher for people living in hostels and bed and breakfast accommodation, and 11 times higher for people who are sleeping rough⁷⁵. Homelessness is also associated with risk taking behaviours such as substance or alcohol misuse⁷⁵. The causes of

homelessness are diverse, but can include factors such as domestic violence, family breakdown, going through the asylum process, or being in the criminal justice system. A study by Vostanis *et al* (1998) showed that even after rehousing, two fifths of children and a quarter of mothers had persistent mental health problems⁷⁴.

5.5 Young Carers

Young carers are defined as *'children and young people under 18 who provide, or intend to provide, care, assistance or support to another family member who is disabled, physically or mentally ill, or has a substance misuse problem. They carry out, on a regular basis, significant or substantial tasks, taking on a level of responsibility that is inappropriate to their age or development'*⁷⁶.

According to the 2011 census, there were 177,918 young carers aged 5-17 years old living in England and Wales⁷⁷. Of these, 54% were girls and 46% were boys. The majority of young carers contributed between 1 and 19 hours of unpaid care per week. Between 2001 and 2011 there has been an increase in young carers by about 19% across England and Wales.

Estimating numbers of young carers in Nottinghamshire

The actual number of young carers in Nottinghamshire is unknown. Those presenting to support agencies are likely to underestimate the true number of children and young people with caring responsibilities. Data from the 2011 census can be used to estimate the number of young carers in Nottinghamshire. Within the East Midlands, 2.1% of children and young people aged 5-17 were identified as young carers. Applying this to the Nottinghamshire population, this would equate to 2659 children and young people aged 5-18 acting as carers.

There is some evidence to suggest that the percentage of young people acting as carers may be even higher. In 2010 the BBC surveyed more than 4000 school pupils finding that 8% of those surveyed carried out caring roles such as helping someone to dress, bathe or shower⁷⁸. Based upon this estimate of 8%, this would mean that there could be up to about 10,000 young carers aged 5-18 in Nottinghamshire.

This compares to about 400 children and young people known to the Nottinghamshire Young Carers Service.

Emotional and mental health needs of young carers

The impact of being a young carer varies according to age and the extent of caring responsibility. The 2011 census showed that the percentage of people reporting 'Not Good' general health was higher among carers compared to those not providing care, and increased as the number of hours of care provided increased⁷⁷. A research briefing by the Social Care Institute for Excellence on the health of young carers identified that:

- Children and young people often take on a caring role when supporting parents with mental health problems (about 30% of cases).
- Caring can adversely affect school attendance and employment opportunities.
- Surveys of young carers have shown carers experience stress, anxiety, low self-esteem and depression. Young carers can particularly experience anxiety about a parent's welfare when they are not there to look after them.

5.6 Children and Young People Using Drugs and Alcohol

Estimating numbers of children and young people using drugs and alcohol in Nottinghamshire

Prevalence of drug and alcohol use

There are no concrete data on the prevalence of drug and alcohol use among children and young people. Evidence from a national survey carried out in 2011 of 11-15 year olds on the use of alcohol and drugs in England found that⁷⁹:

- 12% of pupils reported having taken drugs in the last year
- 3% of pupils reported taking drugs at least once a month
- Cannabis was the most common drug pupils had tried (7.6%)
- Factors associated with drug use in the last year included being male, older, from a Black ethnic group, smoking, drinking alcohol, truancy, exclusion from school and low levels of reported wellbeing.
- 12% of pupils had drunk alcohol in the last week.
- 7% of pupils reported drinking at least once a week.
- Drinking alcohol was more common in older aged children.

Another national survey that provides data on alcohol and drug use among children and young people is the Tellus Survey, a national survey initiated by Ofsted last carried out in 2009. The survey reports the views of children and young people in school years 6, 8 and 10 (Table 31).

TABLE 31: CHILDREN AND YOUNG PEOPLE USING DRUGS AND ALCOHOL, TELLUS SURVEY FINDINGS (2009)

	Percentage of children in years 8 and 10 who reported taking drugs in the past 4 week. (%)	Percentage of children in years 6, 8 and 10 who reported being drunk in the past 4 weeks. (%)
Nottinghamshire	3	17
East Midlands	4.5	15.9
England	4	15

Source: Tellus Survey, 2009.

Service use related to drugs and alcohol

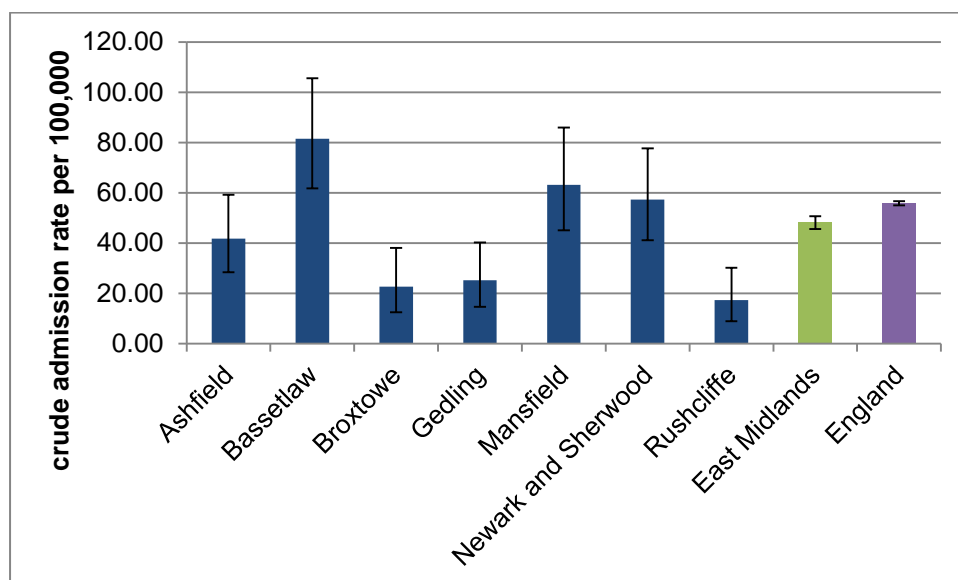
Over the 3 year time period of 2008/9 to 2010/11 there were 212 hospital admissions among under 18 year olds for 'alcohol specific conditions' (Table 32). 'Alcohol specific conditions' are those that wholly relate to alcohol, such as alcohol overdose. Figure 11 shows the crude hospital admission rates for each district, showing Bassetlaw, Mansfield and Newark and Sherwood to have the highest admission rates.

TABLE 32: NUMBERS OF ADMISSIONS TO HOSPITAL FOR ALCOHOL SPECIFIC CAUSES IN UNDER 18S, 2008/9-2010/11

	Number of under 18s admitted for alcohol specific causes (2008/09-2010/11)
Ashfield	31
Bassetlaw	57
Broxtowe	14
Gedling	17
Mansfield	40
Newark and Sherwood	41
Rushcliffe	12
Nottinghamshire	212

Source: Public Health England, Local Alcohol Profiles for England, 2008/9-2010/11.

FIGURE 11: CRUDE HOSPITAL ADMISSION RATE FOR ALCOHOL SPECIFIC CAUSES AMONG UNDER 18 YEAR OLDS 2008/9 – 2010/11



Source: Public Health England, Local Alcohol Profiles for England, 2008/9-2010/11.

In 2008/9 there were a total of 500 young people in specialist substance misuse treatment across Nottinghamshire⁴⁷. The main substances young people received treatment for were alcohol and cannabis. Referrals for alcohol increased significantly between 2007/8 and 2008/9, whereas referrals for cannabis use have reduced slightly⁴⁷.

Emotional and mental health needs of children and young people using drugs and alcohol

Alcohol and drug use are associated with poorer mental health among children and young people. Recreational drugs are associated with increased risk of suicide, depression and behavioural disorders. Regular use of cannabis has been associated with psychotic symptoms (e.g. hallucinations, anxiety, and paranoia) in about 1 in 10 cannabis users⁸⁰. Associations between substance misuse and mental health disorders are complex. The substances themselves affect mental health, but it is also argued that those with developing symptoms of, for example, schizophrenia or depression, may use drugs or alcohol as a form of 'self-medication'. Drinking during childhood, particularly heavy drinking, is associated with a range of problems including physical and mental health problems, alcohol-related accidents, violence, and anti-social behaviour. Young people recognised to have a greater risk of substance misuse include looked after children, children affected by parental substance misuse, young offenders, those excluded from school and homeless young people⁸¹.

5.7 Young People Not in Education, Employment or Training

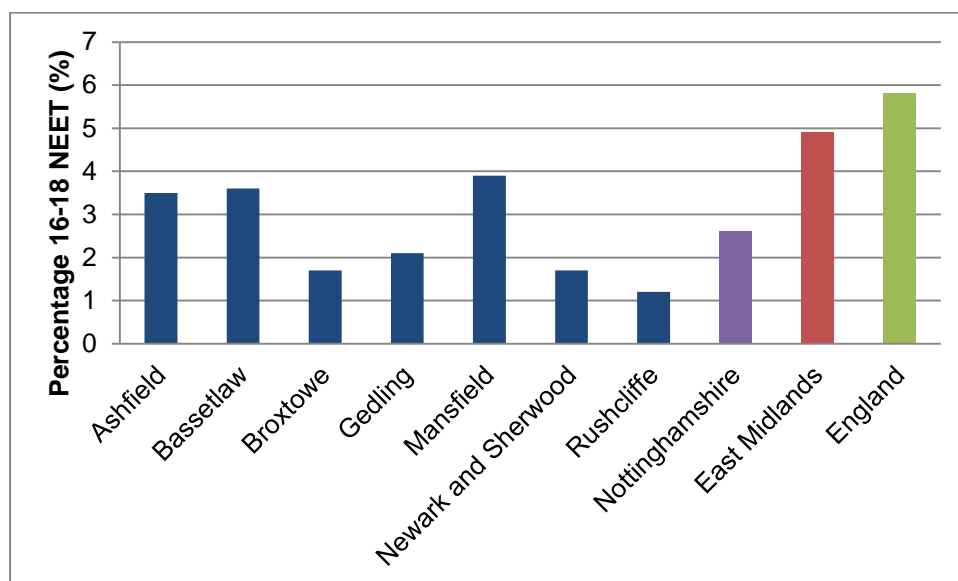
Estimating numbers of young people Not in Education, Employment or Training (NEET) in Nottinghamshire

The percentage of young people NEET in Nottinghamshire (2.6%) is significantly lower than the average for the East Midlands (4.9%) and England (5.8%). This percentage is lower than previous years, but it must be noted that there has been an increase in the recording of 'not known' which could account for some of this reduction in young people recorded NEET.

The percentage of young people NEET varies according to district, with Mansfield (3.9%), Bassetlaw (3.6%) and Ashfield (3.5%) having the highest percentages of young people NEET (Figure 12). The

percentage of young people NEET is higher among teenage mothers, young offenders, and looked after children.

FIGURE 12: PERCENTAGE OF 16-18 YEAR OLDS NOT IN EDUCATION, EMPLOYMENT OR TRAINING (DEC 2012)



Source: NCCIS Health Check Data, November 2012.

Emotional and mental health needs of young people NEET

Being in education, employment and training between the ages of 16-18 increases a young person's resilience and is essential to their future employability and wellbeing⁸². Being NEET between the ages of 16-18 is a major predictor of later unemployment, low income, teenage motherhood, depression, and poor physical health.

5.8 Children and Young People With a Physical Illness, Physical and Learning Disabilities

Nottinghamshire County Council and its partners have adopted the Disability Discrimination Act (DDA) 2005 definition of disability:

"A child or young person is disabled if they have a physical or mental impairment which has substantial and long term adverse effect on his / her ability to carry out normal day to day activities"

This can include children and young people with long-term conditions such as diabetes mellitus and cystic fibrosis, in addition to those children and young people with learning and physical disabilities.

Estimating numbers of children and young people with disability

It is estimated that there are between 7,000 and 12,000 children and young people with some form of disability living in Nottinghamshire⁸³. There are numerous challenges with collecting accurate and timely data on disability among children and young people which is why estimates vary considerably. Further detail is given in the Nottinghamshire HNA on disability and special educational need among children and young⁸³.

In 2011 there were 7,210 claimants for Disability Living Allowance among 0 to 24 year olds. Highest numbers of children and young people receiving disability living allowance in 2011 were in Ashfield (1,380), Mansfield (1,170) and Newark and Sherwood (1,170), and lowest in Rushcliffe (640).

Estimated numbers of children and young people with chronic conditions have been calculated by applying prevalence data to the local population. In Nottinghamshire it is estimated that there are⁸³:

- 70 children/young people with Cystic Fibrosis.
- 70 children/young people with Sickle Cell Disease.
- 240 children/young people with Crohn's Disease.
- 360 children/young people with Diabetes Mellitus.
- 280 children/young people with a neoplasm such as Leukaemia.
- 10,690 with asthma characterised by persistent episodes of wheezing.

In addition it is estimated that in Nottinghamshire⁸³:

- Approximately 1 in every 33,000 0-17 year olds are hard of hearing.
- Approximately 1 in every 17,000 0-17 year olds are deaf.
- Approximately 1 in every 4,500 0-17 year olds are registered blind.
- Approximately 1 in every 1,900 0-17 year olds are registered partially sighted.

The prevalence of severe disability is recognised to be increasing because more children and infants with complex needs are surviving for longer. Numbers of claimants for disability living allowance have increased by about 60% over the last decade.

Emotional and mental health needs of children and young people with disability

A secondary analysis of the 1999 and 2004 Office for National Statistics surveys of the mental health of British children and adolescents assessed the prevalence of psychiatric disorders among those with and without learning difficulties⁸⁴. The study found the prevalence of psychiatric disorders was 36% among children with a learning disability compared to 8% among children without, indicating that children with a learning disability had a 6.5 times greater odds of a psychiatric disorder than those without a learning difficulty.

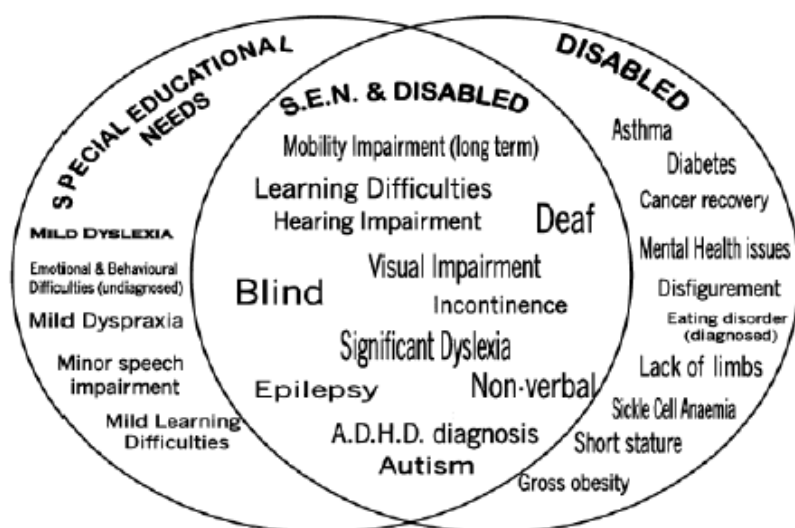
The same study also assessed risk factors for the development of emotional or mental health problems over time. Those with a physical illness were almost twice as likely to have developed an emotional disorder in the three years between the two surveys, than those with no physical illness⁸⁵.

5.9 Children and Young People with Special Educational Needs

Children with a 'Special Educational Need' (SEN) "*have learning difficulties or disabilities that make it more difficult for them to learn or access education than most children of the same age. These children may need extra or different help from that given to other children of the same age... They may have difficulties in thinking and understanding, physical or sensory difficulties, emotional and behavioural difficulties, difficulties with speech and language or how they relate to and behave with other people*"⁸⁶.

Figure 13 illustrates the differences between SEN and disabilities and the overlap between the two.

FIGURE 13: UNDERSTANDING SEN AND DISABILITY AND WHERE THEY OVERLAP



Source: The Learning Trust, 2009. Copyright C O'Mahony and R.Rieser Nov 2001.

Estimating numbers of children and young people with SEN

Data on numbers of children with SEN come from the annual school census. Currently there are three levels of intervention for pupils with SEN:

- **School Action:** The teacher or the school Special Educational Needs Coordinator decides to provide something for the child additional to or different from the school's usual differentiated approach to help children learn.
- **School Action Plus:** Where the school consults specialists and requests help from external services.
- **Statement:** Where the child requires support beyond that which the school can provide and the local authority arranges appropriate provision. A statement is given following a formal assessment.

Within Nottinghamshire about 1 in 5 children (19.8%) have some kind of SEN which is similar to the estimated national prevalence⁸³. Table 33 shows the numbers of children and young people recorded with a SEN in the 2011 School Census according to the level of intervention they required. The districts with the highest percentages of children and young people with SEN were Mansfield (24.1%), Ashfield (21.4%) and Bassetlaw (21.3%). Rushcliffe had the lowest percentage of children with SEN (14.3%)⁸³. The percentage of children with a SEN Statement across Nottinghamshire was 1.1%.

TABLE 33: NUMBERS OF CHILDREN WITH SPECIAL EDUCATIONAL NEEDS (2011)

District	Number on roll	SEN Status							
		No Provision		School Action		School Action Plus		Statemented	
		Number	%	Number	%	Number	%	Number	%
Ashfield	18,269	14,364	78.6	2,935	16.1	750	4.1	220	1.2
Bassetlaw	16,375	12,887	78.7	2,471	15.1	835	5.1	182	1.1
Broxtowe	14,358	11,817	82.3	1,907	13.3	500	3.5	134	0.9
Gedling	16,655	13,547	81.3	2,156	13.0	800	4.8	152	0.9
Mansfield	16,921	12,849	75.9	3,046	18.0	764	4.5	262	1.6
Newark & Sherwood	15,323	12,249	80.0	2,240	14.6	689	4.5	145	1.0
Rushcliffe	16,706	14,321	85.7	1,723	10.3	534	3.2	128	0.8
Notts	114,607	92,034	80.3	16,478	14.4	4,872	4.3	1,223	1.1

Source: School Census, 2011. Nottinghamshire HNA on disability and special educational need among children and young⁸³.

Table 34 shows the 'primary need' of children and young people with a SEN. In some cases children may have more than one need. The three commonest SEN in 2011 were 'behaviour, emotional and social difficulties', 'moderate learning difficulties' and 'autistic spectrum disorder' across both primary and secondary schools.

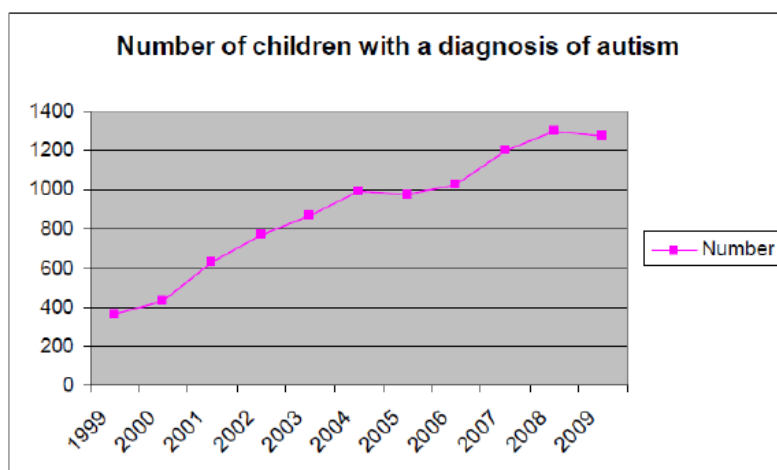
TABLE 34: CHILDREN WITH SEN ACCORDING TO PRIMARY NEED (2011)

	Nursery	Primary	Secondary	Special	Total
Specific Learning Difficulty	-	151	230	12	393
Moderate Learning Difficulty	-	507	373	158	1,038
Severe Learning Difficulty	-	89	55	199	343
Profound & Multiple Learning Difficulty	-	35	*	75	110+*
Behaviour, emotional and social difficulties	-	563	927	65	1,555
Speech, language and communication needs	9	460	137	13	619
Autistic Spectrum Disorder	*	428	344	246	1,018+*
Visual Impairment	-	43	46	*	89+*
Hearing Impairment	-	62	42	*	104+*
Multi-Sensory Impairment	-	9	5	*	14+*
Physical Difficulty	-	189	118	61	368
Other Difficulty / Disability	-	117	115	10	242

Source: School Census, 2011. Nottinghamshire HNA on disability and special educational need among children and young⁸³.

Figure 14 shows a consistent increase in the numbers of children and young people with ASD recorded by the Nottinghamshire County Council Inclusion Support Team.

FIGURE 14: NUMBERS OF PUPILS IN NOTTINGHAMSHIRE WITH A DIAGNOSIS OF AUTISM, 1999-2009



Source: Inclusion Support Service, Nottinghamshire County Council, 2010. Nottinghamshire HNA on disability and special educational need among children and young⁸³.

Emotional and mental health needs of children and young people with SEN

As discussed above ONS has demonstrated that children with a learning disability have a higher prevalence of psychiatric disorders than children without⁸⁴. Other studies have suggested that the relationship between SEN and mental health problems is complex. In some cases, distinguishing symptoms of a mental health problem from the underlying SEN (e.g. ASD, ADHD) can be difficult⁸⁷. Symptoms may be wrongly attributed to the underlying disorder leading mental health problems to be

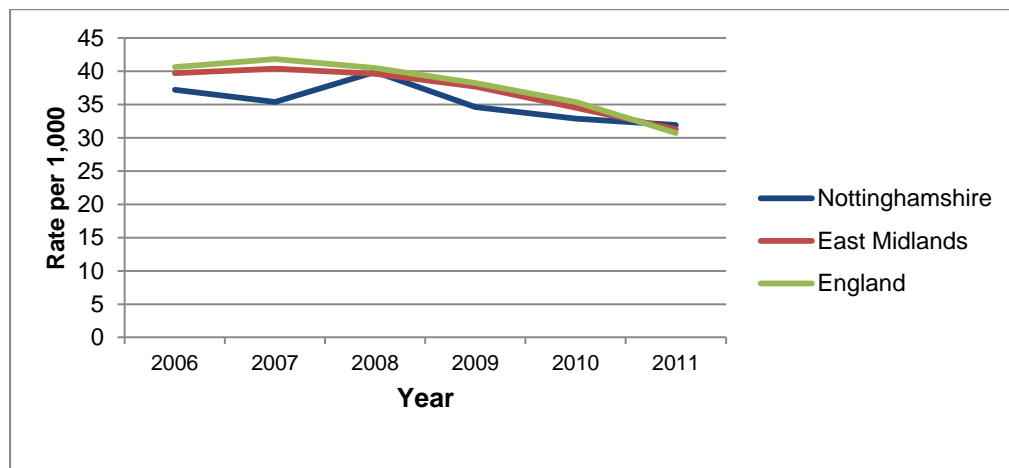
underdiagnosed. Other studies have suggested that those with ADHD, ASD and Asperger Syndrome have high levels of anxiety and depression⁸⁷.

5.10 Teenage Mothers

Estimating numbers of teenage mothers

In Nottinghamshire 31.9 young women aged under 18 years conceived per 1,000 population in 2011 compared to the national average of 30.7 per 1,000⁸⁸. Of the conceptions in Nottinghamshire 42.6% led to termination of pregnancy, compared with the national average of 49.3%. 83 were aged under 16 years, which equates to a rate of 6 per 1,000 population; the national average is 6.1. Of these, 62.7% led to termination of pregnancy, compared with the national average of 60.5%.

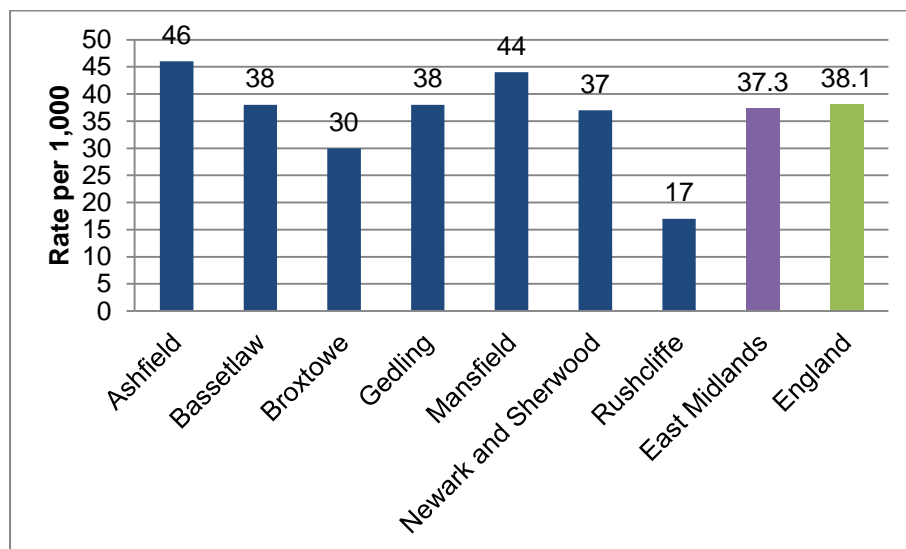
FIGURE 15: TEENAGE CONCEPTION RATE AMONG UNDER 18 YEAR OLDS, 2006-2011



Source: Chimat, Teenage Pregnancy Report⁸⁸.

At district level there are marked variations in rates, with Mansfield and Ashfield having the highest teenage conception rates with rates of 44 per 1,000 and 46 per 1,000 respectively (Figure 16).

FIGURE 16: TEENAGE CONCEPTION RATES AMONG UNDER 18S BY DISTRICT, 2008-10



Source: Chimat, Teenage Pregnancy Report⁸⁸.

Emotional and mental health needs of teenage mothers

National data have shown that teenage mothers are more likely to suffer from post natal depression and suffer from poorer mental health in the three years after the birth compared with other mothers—they have 30% higher levels of mental illness 2 years after the birth, after which they start to converge to the population average⁸⁹. Being a teenage mother has also been associated with higher risk of partnership breakdown, isolation, living in poor quality housing and lower education achievement⁸⁹.

Children of teenage mothers are more likely to have behavioural problems, lower educational achievement, greater risk of economic inactivity and increased risk of becoming a teenage mother in turn⁸⁹.

5.11 Children and Young People Subject to abuse / with a Child Protection Plan

Numbers of children and young people who experience abuse and/or neglect in Nottinghamshire

Abuse and neglect are underreported and under detected. A large survey conducted by the National Society for Prevention of Cruelty to Children (NSPCC) identified that about 23% of children aged 11-17 who were physically hurt by a parent or guardian did not tell anyone⁵³. Sexual abuse by a parent or guardian was even less commonly reported, with a third of children not telling anyone else. When sexually abused by a peer, 82.7% reported having never told anyone else about it. The most comprehensive estimates of the prevalence of abuse for children and young people aged 11-17 come from this survey⁵³, and have been applied to the Nottinghamshire population in Table 35. Clearly these estimates only focus on 11-17 year olds, and so actual numbers are likely to be higher once under 11s are included.

TABLE 35: PREVALENCE OF ABUSE AMONG 11-17 YEAR OLDS

Abuse	Estimated prevalence 11-17 year olds (NSPCC) (%)	Estimated number of 11-17 in Nottinghamshire
Sexual abuse	16.5	11,024
Physical abuse at the hand of parent/guardian	6.9	4,610
Experienced severe neglect	9.8	6,548
Emotional abuse	6.8	4,543

Source: NSPCC⁵³ and ONS, 2011.

Numbers of children and young people subject to a child protection plan in Nottinghamshire

During 2011/12, there were 901 children who were the subject of a child protection plan in Nottinghamshire, which represented a slight drop in the rate per 10,000 on the previous year. Overall however there has been an upward trend both locally and nationally since in 2001/02. Those subject to a child protection plan were most commonly aged 1-4 years old and about 8% of children were from BME groups.

As shown in Table 36 the most common single reason children were the subject of a child protection plan was neglect (30.4% of cases). However, multiple categories of abuse made up over a third of cases (38.5%).

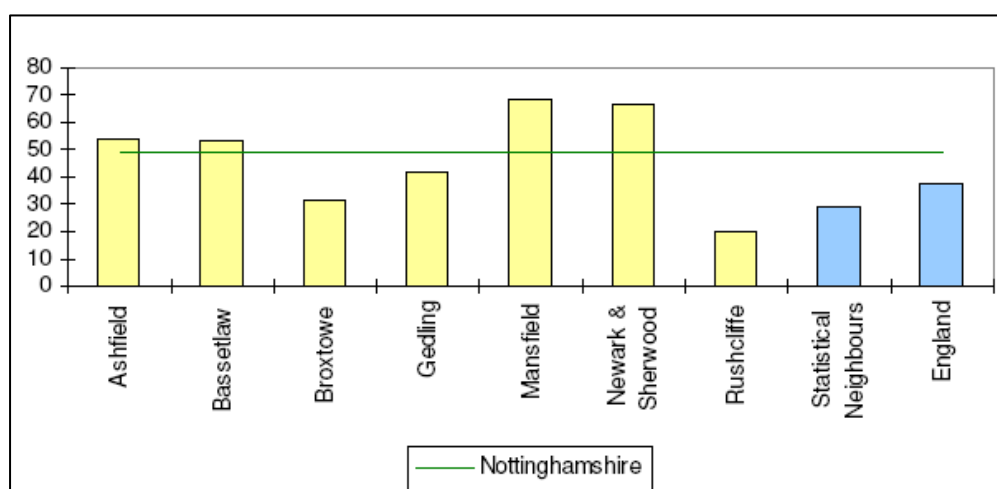
TABLE 36: CHILD PROTECTION CATEGORY FOR CHILDREN WITH A CHILD PROTECTION PLAN (31ST MARCH 2012)

Child Protection Category	Number of children	Percentage (%)
Emotional	124	17.2
Neglect	219	30.4
Physical	47	6.5
Sexual	53	7.4
Multiple categories of abuse	277	38.5

Source: DfE, 2012. Accessed via Nottinghamshire JSNA 2013.

Figure 17 shows Mansfield, Newark and Sherwood and Ashfield had the highest rates of children requiring statutory child protection interventions in quarter 2 of 2012/13.

FIGURE 17: NUMBER OF CHILDREN REQUIRING STATUTORY CHILD PROTECTION INTERVENTIONS (PER 10,000) (Q2 2012/13)



Source: Nottinghamshire County Council, 2013. Accessed via Nottinghamshire JSNA 2013.

Emotional and mental health needs of Children and Young People who have experienced abuse

Child abuse is an important risk factor for child and adult psychiatric morbidity. Studies have demonstrated that those who have experienced abuse have a higher risk of depression (15.5 fold increased risk), suicidal ideation (8.9 fold increased risk) and anxiety (8.1 fold increased risk) during childhood². Abuse during childhood can also increase the risk of recurrent depression in adulthood and substance misuse. Witnessing violence in the home or experiencing abuse is recognised to have a long term impact. In a survey of offenders, 41% reported witnessing violence in their home as a child and 29% reported emotional, sexual or physical abuse as a child⁹⁰.

Research has however shown that not all maltreated children experience mental health problems as adults. Collishaw *et al* (2007) identified parental care, adolescent peer relationships, the quality of adult love relationships, and personality style as resilience factors to the effects of abuse⁹¹.

5.12 Lesbian, gay, bisexual or transgender Young People

Estimating numbers of lesbian, gay, bisexual or transgender young people

There is no local data available on sexual orientation. There are wide variations in prevalence estimates of homosexuality amongst adults, with between 1.5% to 6% of the adult population estimated to be lesbian, gay or bi-sexual⁹².

Emotional and mental health needs of lesbian, gay, bisexual or transgender young people

A poll of secondary school teachers identified that homophobic bullying was the most frequent form of bullying after bullying because of weight, and three times more common than bullying related to religion or ethnicity⁹³. Homophobic bullying can lead young people to skip school, lowers their self-esteem and lowers their educational attainment.

Summary: Chapter 5 High Risk Groups

There are a number of groups of children and young people who are recognised to have an increased risk of emotional and mental health needs. For some of these groups there are limited data sources to estimate numbers within Nottinghamshire.

- **Looked after children (LAC).** At the end of February 2013 there were 891 LAC in Nottinghamshire. It is estimated that 45% of LAC have a clinically recognisable mental disorder, which would equate to 401 of the LAC in Nottinghamshire have a mental disorder. Numbers of LAC have increased substantially each year from 440 in March 2007 to 800 in March 2012.
- **Young Offenders.** Between January and December 2011 there were 1390 young offenders in the youth justice system in Nottinghamshire. Estimates suggest that about 740 of these young offenders have a conduct disorder, 264 ADHD and 334 a problem with substance misuse. Nottinghamshire has a significantly higher rate of new entrants to the youth justice system (929 per 100,000) than the average rate for England of (712 per 100,000).
- **Travellers.** In the 2012 School Census, 173 Roma and Irish Travellers were recorded. The 2012 Caravan count recorded 285 caravans within Nottinghamshire, most of which were recorded within Newark and Sherwood (211) and Bassetlaw (62). Little data are available on the emotional and mental health needs of Traveller children and young people.
- **Homeless children and young people.** The rate of homeless children and families is lower in Nottinghamshire (0.9 per 1000) than the rate for the East Midlands and England.
- **Young carers.** Numbers of young carers are unknown. Estimates suggest there could be between 2600 and 10,000 young carers aged 5-18 years old, most of which are unknown to support services.
- **Drugs and Alcohol Use.** A national survey found that 12% of 11-15 year olds reported drinking alcohol at least once in the last week and 12% of young people reported having taken drugs in the last year. Alcohol-specific hospital admission rates were highest in Bassetlaw and Mansfield. In 2008/9 there were about 500 young people in specialist substance misuse services across Nottinghamshire.
- **NEET.** Nottinghamshire has a lower percentage of young people NEET (2.6%) compared to the England average. Percentages of young people NEET are highest in Mansfield (3.9%), Bassetlaw (3.6%) and Ashfield (3.5%).
- **Physical illnesses and disability.** Estimates suggest there could be between 7000 and 12,000 children and young people with some form of disability. Claims for disability living allowance among children and young people were highest in Ashfield, Mansfield and Newark and Sherwood. Those with a learning disability are estimated to have about a 6 fold increased odds of a mental disorder. Those with a physical disability are about 2 times more likely to develop a mental disorder than those without a physical disability.
- **Special Educational Needs.** About 1 in 5 children and young people in Nottinghamshire have a SEN. The percentage of children with a SEN was highest in Mansfield (24.1%), Ashfield (21.4%) and Bassetlaw (21.3%). The most common SEN were behavioural, emotional and social difficulties. Numbers of children diagnosed with autistic spectrum disorder have persistently increased since 1999 in Nottinghamshire.

- **Teenage Mothers.** The rate of teenage pregnancies among under 18 year olds was 31.9 per 1000 in Nottinghamshire compared to 30.7 per 1000 in England. Rates were highest in Mansfield and Ashfield.
- **Children and Young People Subject to Abuse.** Abuse is not uncommon. The NSPCC estimates that about 16% of 11-17 year olds have been sexually abused and about 7% emotionally abused. Abuse is commonly unreported. In 2011/12 901 children were subject to a child protection plan in Nottinghamshire. Reasons for a child protection plan were predominantly for 'multiple categories of abuse (38.5%) and neglect (30.4%). Mansfield and Newark and Sherwood had the highest numbers of children with child protection plans in Quarter 2 of 2012/13.
- **Lesbian, Gay, bisexual or transgender young people.** Few local data are available on numbers of young people who are LGBT. Homophobic bullying is recognised to be common in many schools. It is estimated that between 1.5% and 6% of the population are LGBT.

6. Current Service Provision

6.1 Overview of Nottinghamshire CAMHS

Figure 18 shows the overall organisation of emotional and mental health services across Nottinghamshire, according to the 4-tier model outlined in section 2.3. This model is a helpful concept but it must be noted that children do not always fall neatly into the tiers of this model.

FIGURE 18: OVERVIEW OF CAMHS SERVICES IN NOTTINGHAMSHIRE



6.2 Tier 1 Services

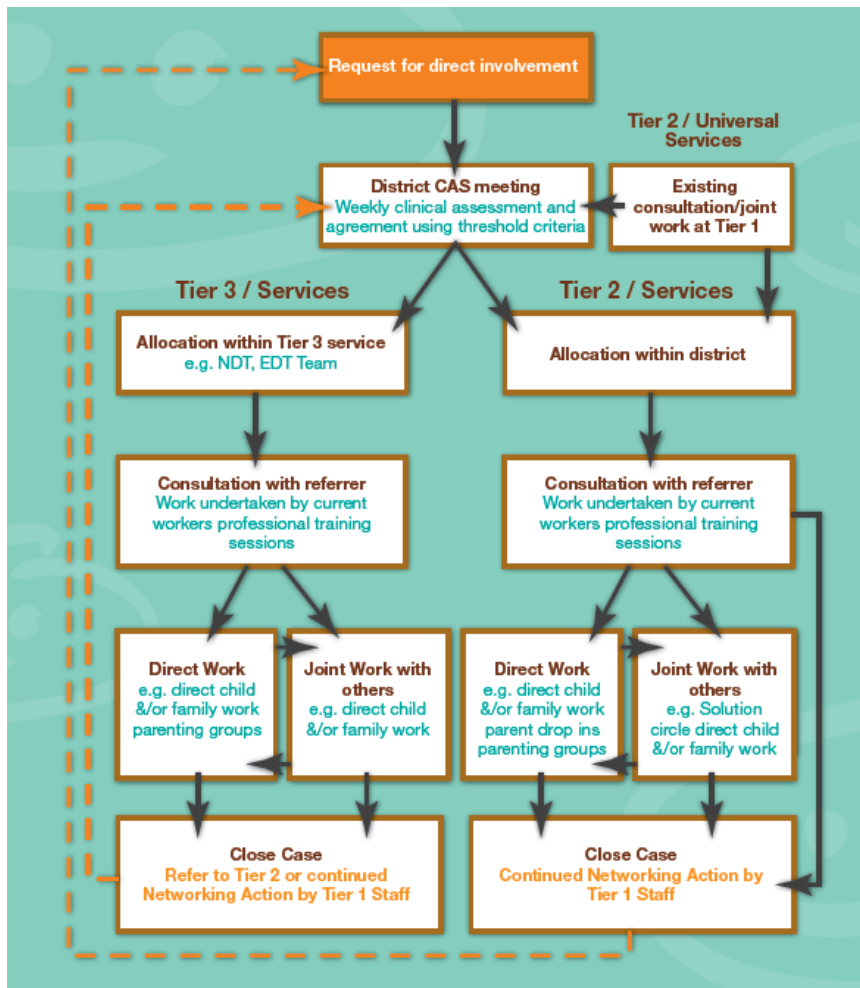
Tier 1 (universal) services consist of a broad range of services available to the local population, which help to promote emotional and mental wellbeing, alongside recognising those with more severe mental health needs who need further support. They include GPs, school nurses, health visitors, midwives, schools, early year services and youth services. There are no readily accessible routine data sources that can be used to capture the uptake and use of these services for emotional and mental health needs. Mapping tier 1 services was beyond the scope of this HNA.

6.3 Single Point of Access (SPA)

6.3.1 Description of SPA

All referrals received by CAMHS (tiers 2-3) are screened at a single point of entry at a 'Clinical Assessment Service' (CAS) meeting. The CAS consists of a once weekly meeting of representatives from tier 2 and 3 services. Cases are discussed and allocated to the appropriate team. Where referrals are not appropriate for targeted/specialist CAMHS, advice is given to the referrer of alternative services that might be more appropriate. The SPA flowchart is shown below in Figure 19.

FIGURE 19: CAMHS SINGLE POINT OF ACCESS FLOWCHART

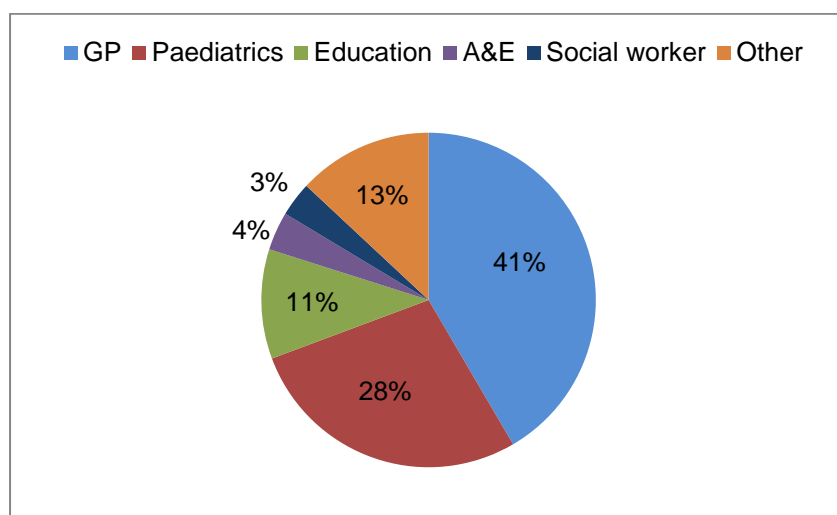


It must be noted that there is a plan to move the SPA to sit within Tier 2, so that each of the seven districts will review their local referrals and escalate them to tier 3 as required.

6.3.2 Single point of access data

Between 1st April 2012 and 31st March 2013, 4035 referrals were received by the CAMHS SPA. Figure 20 shows that the three commonest sources of referrals were from GPs (41%), paediatrics (28%) and education (11%) in 2012/13.

FIGURE 20: SOURCE OF REFERRAL TO THE CAMHS SINGLE POINT OF ACCESS, 2012/13



Sources: County Health Partnership, Nottinghamshire Healthcare Trust, 2012/13.

At the CAS meeting, referrals are allocated to the most appropriate service. Table 37 shows that of those referrals allocated in 2012/13, 2758 (71%) were allocated to Tier 2 targeted services, 440 (11%) to specialist tier 3 services and 170 (4%) were managed jointly between tiers 2 and 3. Numbers of referrals coming through the SPA that were allocated to Tier 2, varied according to district. The Broxtowe team received 190 referrals via the SPA compared to 538 in Ashfield. These differences could have important implications on capacity and staff workload if Tier 2 teams take over reviewing the referrals from the SPA.

TABLE 37: ALLOCATIONS TO TARGETED, SPECIALIST AND JOINT SERVICES FROM THE SPA, 2012/13

Service referral allocated to		Number of referrals
Targeted (Tier 2)	Ashfield DEWHS	538
	Bassetlaw Emotional Wellbeing Team	456
	Broxtowe DEWHS	190
	Gedling DEWHS	251
	Mansfield DEWHS	495
	Newark and Sherwood DEWHS	535
	Rushcliffe DEWHS	293
	Total allocations to Tier 2 (all districts)	2758
Specialist (Tier 3)	440	
Joint (Tier 2 & 3)	170	
Other (e.g. redirection)	503	

Sources: County Health Partnership, Nottinghamshire Healthcare Trust, 2012/13.

6.4 Tier 2 Services

6.4.1 Description of Tier 2 Services

Service	Need being met	Spectrum of disorders addressed	Services Provided	Professionals involved in service	Location of services
District Emotional Health and Wellbeing Service (DEHWS) Community Health Partnerships	-Provide targeted support and intervention for those who are vulnerable or at risk of mental health disorders. -Provide local and more accessible access to mental health services. -Recognition and response to local needs. Building of local relationships with referrers (e.g. schools).	Social, emotional and behavioural difficulties.	-Support and consultation for universal services (e.g. for school nurses). -Individual, group and family work. -Parenting courses, e.g. '1-2-3 Behaviour'.	-District lead -2 x Specialist Practitioners -CAMHS Social Worker -Family Support Worker -Administrator -Community/ Voluntary Sector specific projects (e.g. CASY and Mustard Seed) -District teams were supported by six county-wide practitioners (ADHD, learning disability, chronic disease, diabetes). The roles of these county-wide practitioners are under review due to high demand on some practitioners and the difficulties of working across teams. It is proposed instead that each district team will have an 'additional needs practitioner'. -1x Training Lead, providing countywide training programme.	Six teams across Nottinghamshire: -Ashfield -Broxtowe -Gedling -Mansfield -Newark & Sherwood -Rushcliffe Teams are generally located in schools and primary care centres.
Bassetlaw Emotional Wellbeing Team	-Provides targeted support and intervention for those who are vulnerable or at risk of mental health disorders.	Social, emotional and behavioural difficulties.	-Support and consultation for universal services. -Individual, group and family work.	-Specialist Practitioners -CAMHS Social Worker - Community/ Voluntary Sector specific projects	Bassetlaw
Future Minds	Commissioned to work with those who are victims of sexual abuse.			Multidisciplinary psychological service	Nottinghamshire

6.4.2 Healthy Young Minds, CAMHS Training Programme

Nottinghamshire has a CAMHS training programme covering a number of emotional and mental health topics. These include depression and anxiety, psychosis, eating disorders, self-harm, ADHD, ASD, conduct disorders, bereavement and loss and sleep disorders. This training programme is designed to respond to the needs of all universal staff working with children and young people, to enable them to have sufficient knowledge, training and support to promote emotional wellbeing and identify early indicators of more difficult cases. This training programme is designed to build capacity within tier 1 universal services. The training is commissioned as part of DEHWS (tier 2). Training is provided across a number of locations in Nottinghamshire and throughout the year. Please note the training programme does not cover Bassetlaw as the Bassetlaw Tier 2 team is commissioned separately.

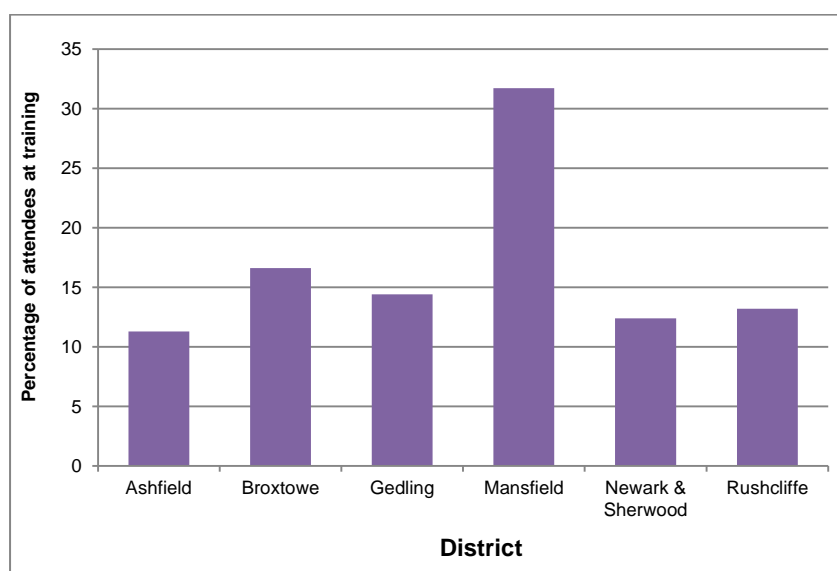
In 2012/13, 42 training courses were carried out (Table 38). A total of 705 people attended the courses, although it must be noted that some individuals may have attended more than one course.

TABLE 38: CAMHS TRAINING PROGRAMME COURSES, 2012/13

Topics and Numbers of Training Courses, 2012					
Bereavement and loss	3	Eating disorders	4	Continence	2
Conduct and behaviour	3	Self harm	4	Introduction to CAMHS	8
ASD	5	Psychosis	1	ADHD	3
Depression and anxiety	4	Sleep	3	Attachment	2

The main groups of attendees were those employed by Nottinghamshire County Council (56%), the NHS (31%) and Education (10%). Figure 21 shows that about a third (32%) of those who attended the CAMHS training courses in 2012 were from Mansfield. It is again important to note that the same individuals may have attended more than one course.

FIGURE 21: DISTRICT OF THOSE ATTENDING CAMHS TRAINING



Source: Healthy Young Minds Training Programme, 2012/13.

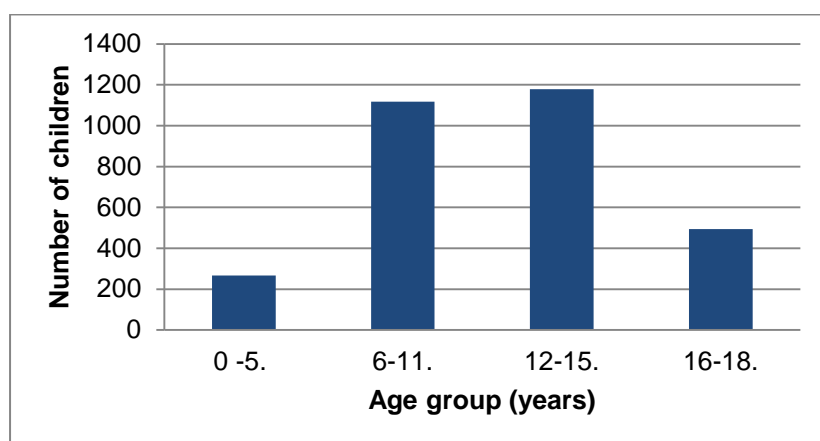
6.4.3 Tier 2 CAMHS Service Data

Data are presented for Tier 2 services for the time period 1st April 2012 to 31st March 2013. Tier 2 services are provided by County Health Partnership and Bassetlaw Health Partnership. Data have been provided from both of these organisations and are displayed together.

Age and sex of referrals

In 2012/13 there were 3004 referrals to Tier 2 CAMHS, of which 1619 were among males (54%) and 1385 among females (46%). Children referred to tier 2 CAMHS were more commonly aged 12-15 years old followed by those aged 6-11 years old (Figure 22).

FIGURE 22: AGE OF CHILDREN AND YOUNG PEOPLE REFERRED TO TIER 2 CAMHS, 2012/13



Sources: County Health Partnership and Bassetlaw Health Partnership, 2012/13.

Referrals by district

Table 39 shows the number of referrals to Tier 2 CAMHS according to district. Numbers of referrals varied according to district from 230 in Broxtowe to 559 in Ashfield. In addition to these referrals, 14 referrals were made to the Future Minds service for victims of sexual abuse in 2012/13.

Table 39 also presents the percentage of the district population referred to Tier 2 CAMHS. For example, in 2012/13, 2.4% of the Mansfield population aged 0-18 were referred to Tier 2 CAMHS, compared to 1.0% of the Broxtowe population.

Table 39: Numbers of referrals to Tier 2 CAMHS teams, 2012/13

DEHWS Team	Number of referrals 2012/13	Population of district aged 0-18 (Census 2011)	Percentage of population 0-18 referred to Tier 2 (%) in 2012/13
Ashfield	559	27250	2.1
Bassetlaw	488	24623	2.0
Broxtowe	230	22532	1.0
Gedling	269	24655	1.1
Mansfield	554	23035	2.4
Newark and Sherwood	527	25178	2.1
Rushcliffe	340	24592	1.4

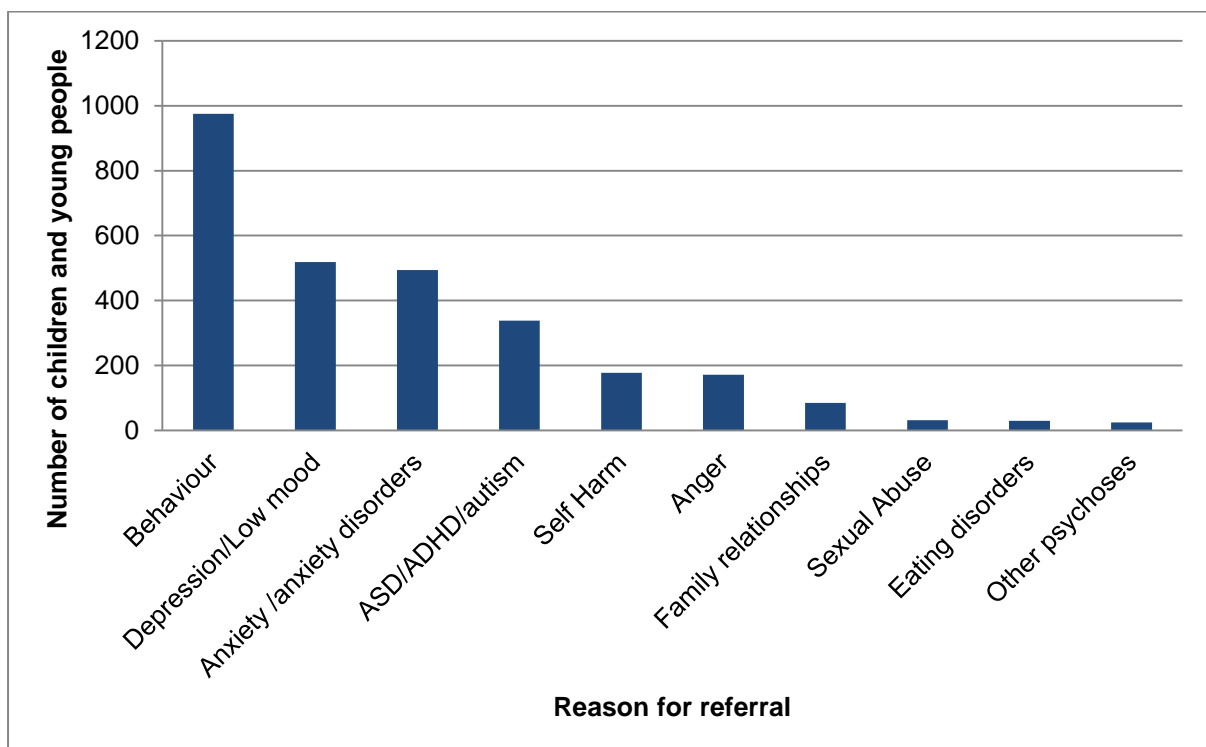
Sources: County Health Partnership and Bassetlaw Health Partnership, 2012/13.

Please note, these referrals overlap with the SPA data shown in section 6.3.2, as Tier 2 teams receive a large proportion of their referrals via the SPA.

Reason for referral

Figure 23 shows the ten commonest reasons for referral to Tier 2 CAMHS in 2012/13. A complete list of reasons for referral can be found in Appendix 4. It must be noted that these are the conditions or symptoms children and young people are referred with, not a diagnosis given once the child is reviewed by CAMHS services. There may be discrepancies between what the child is referred with and the diagnosis or issues that are revealed when the child is seen in CAMHS. As can be seen, the most common reasons for referral to Tier 2 CAMHS were ‘Behaviour’, ‘Depression/low mood’ and ‘Anxiety/anxiety disorders’.

FIGURE 23: REASON FOR REFERRAL TO TIER 2 CAMHS, 2012/13

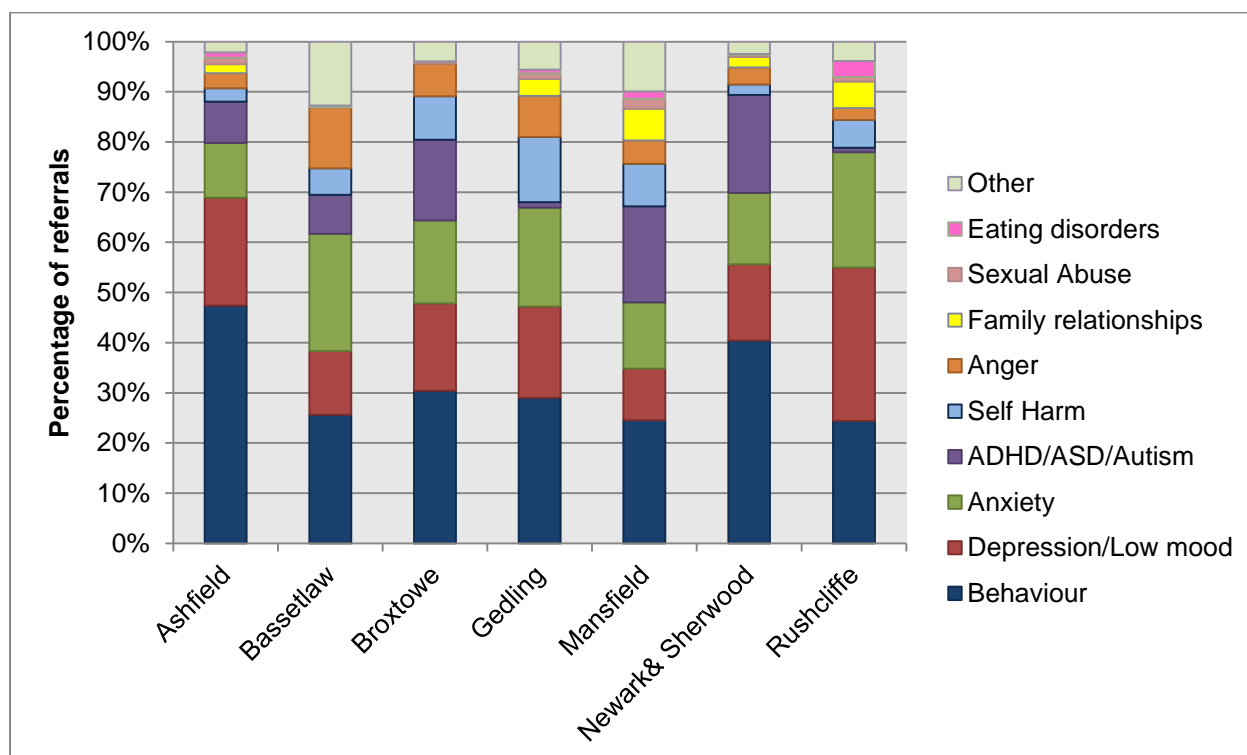


Sources: County Health Partnership and Bassetlaw Health Partnership, 2012/13.

Figure 24 and Figure 25 show the reason for referral to Tier 2 CAMHS according to district. Figure 24 shows the percentage of referrals according to district that were due to each of the main ‘reasons for referral’. For example, in Ashfield 47% of referrals were for ‘Behaviour’, 22% for depression/low mood and 11% for anxiety. Different patterns are seen in other districts. For example, in Rushcliffe, 24% of referrals are for behaviour, 31% for depression/low mood and 23% for anxiety.

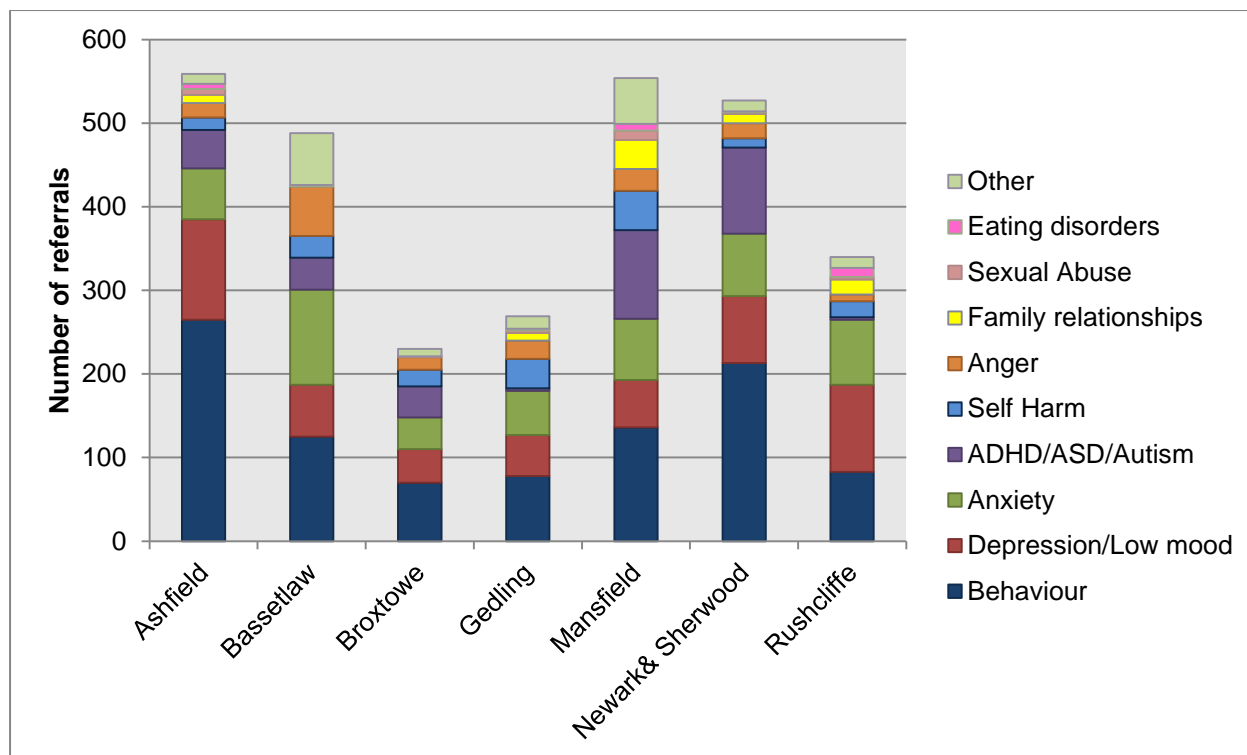
Comparatively, Figure 25 shows the referrals to each district team in absolute numbers. It is important to take account of absolute numbers as this highlights the burden of different mental health problems across the county. For example, in Rushcliffe 3.2% of referrals are for eating disorders. In 2012/13 there were 30 referrals across the county for eating disorders, of which 11 were in Rushcliffe (37%).

FIGURE 24: REASON FOR REFERRAL TO TIER 2 CAMHS ACCORDING TO DISTRICT (PERCENTAGES), 2012/13



Sources: County Health Partnership and Bassetlaw Health Partnership, 2012/13.

FIGURE 25: REASON FOR REFERRAL TO TIER 2 CAMHS ACCORDING TO DISTRICT (NUMBERS), 2012/13

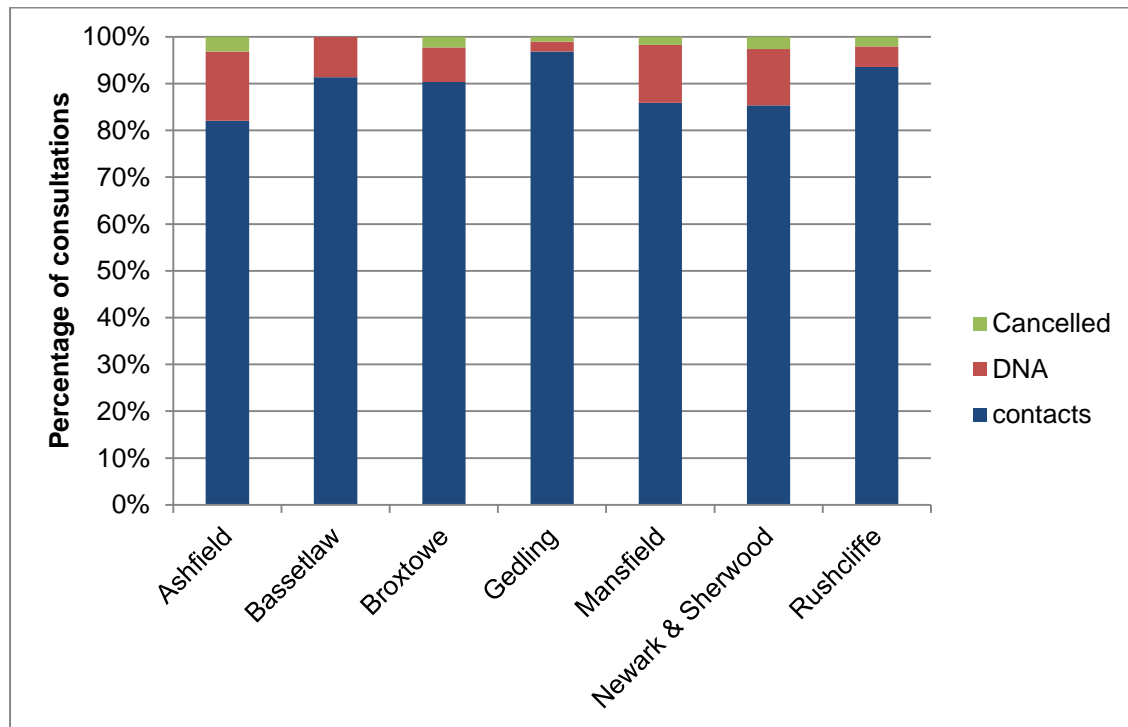


Sources: County Health Partnership and Bassetlaw Health Partnership, 2012/13.

Consultations, DNAs and Cancellations

Data are also available on numbers of consultations carried out, numbers of cancellations and numbers of appointments where the patient didn't attend (DNAs). Figure 26 shows the proportions of consultations that were attended, cancelled or were DNAs in 2012/13 for Tier 2 CAMHS. Higher percentages of DNAs are seen in Ashfield (14.7%), Mansfield (12.4%) and Newark and Sherwood (12.0%).

FIGURE 26: CONSULTATIONS, DNAs AND CANCELLATIONS IN TIER 2 CAMHS



Sources: County Health Partnership and Bassetlaw Health Partnership, 2012/13.

6.5 Tier 3 Services

Tier 3 services provide a specialised multi-disciplinary service for severe and complex child and adolescent mental health problems and neurodevelopmental disorders. The teams provide assessment and treatment to patients and advice to tiers 1 and 2.

6.5.1 Description of Tier 3 Services

Service	Need being met	Spectrum of disorders addressed	Services Provided	Professionals involved in service	Location of services
Specialist Community CAMHS	Children and young people 0-18 experiencing a range of complex mental health disorders.	Significant mental health problems, including: -Depression (moderate to severe) -OCD -PTSD -Self-harm -Eating disorders -Severe attachment, emotional or behavioural disorders.	Specialist assessment and intervention. Behavioural, psychological, medical and psychiatric assessment.	Psychiatrists Mental health nurses Psychologists Specialist mental health workers	2 teams (1) Nottingham City and Nottinghamshire South (2) Nottinghamshire North and Bassetlaw Clinics run at Thorneywood (Nottingham), Mansfield, Newark and Worksop.
Neuro-developmental Disorders Team	Children and young people with neurodevelopmental disorders who present with mental health disorders.	-ADHD -ASD -Tics and Tourette's -Acquired organic brain disorders (e.g. head injury, post meningitis) -Psychiatric conditions in children with learning disabilities.	Specialist assessment and management. Work alongside community and hospital paedcs.		Based within QMC
Self-Harm Team	Provides comprehensive risk assessment to young people under 16 admitted to a paediatric ward at Queen's Medical Centre Hospital following an episode of self-harm.	Self-harm	Assessment on ward at QMC and short term follow up in community (up to 4 sessions).	Nurse consultant. Clinical nurse specialists.	QMC Thorneywood Covers Nottingham City and

	In the North, Specialist Community CAMHS band 6 staff provide cover to Bassetlaw and King's Mill Hospital, assessing and providing follow up to those presenting with self-harm.		Therapy skills include: systemic family/psychotherapy, CBT, group work, and dialectic behaviour therapy.		Nottinghamshire South
Paediatric Liaison	Provides assessment, management and joint management of children and young people experiencing behavioural, emotional or psychiatric disorders in the context of acute, chronic and terminal illness.	Emotional, behavioural and psychiatric disorders in the presence of an acute, chronic or terminal condition. Unexplained illness.	Assessment and management.		QMC
Head2Head	Head2Head provide a number of services. They work with: (1) Young Offenders who present with a mental health issue. (2) Dual Diagnosis. Children and young people who have a mental health disorder and are also using drugs or alcohol. (3) Young people who have significant mental health problems or learning disabilities and have sexually harmed others.	Emotional and mental health disorders that cover tiers 2 and 3. Complex emotional and behavioural problems- trauma, disrupted attachment, substance misuse by parents. Specific mental health disorders. Comorbidities of mental health disorders and substance misuse. Significant mental health disorders that are interrelated / interdependent with substance misuse. Covers Tier 3 and 4.	Assessment and treatment (including prescribing, CBT, counselling, brief therapies, family work). Provide services for as long as the young person needs. If they stop offending but had persistent needs then would be transferred to community team.	13 clinical staff: Child and Adolescent Psychiatrist 11 registered mental health nurses 1 Learning disabilities nurse 0.1 probation / social work	Cover Nottinghamshire County, Bassetlaw and Nottingham City. Flexible about where young people receive service- at home, public places, youth centres, GP surgeries. Head to Head aim to provide the service where it will suit the young person.
Head2Head: Early	People aged between 14 and 35 who present with symptoms that	Psychosis or suspected episode of psychosis. Early onset	Assessment and management.	See above Head2Head staff	Thorneywood Mansfield

Intervention in Psychosis Team	are indicative of a first episode of psychosis.	schizophrenia, bipolar disorder and affective psychoses. Psychoses related to substance misuse or secondary to organic brain conditions.	Psychoeducation/ family work. Psychological therapies (e.g. CBT). Psychopharmacology.		
Looked After Children's Team	Young people who are looked after or who have been adopted, and their families / networks.	Children entering care have a physical and mental health assessment. SDQ carried out. Those with high score seen by Looked After Children's CAMHS. Hold Tier 2-4 cases. Broad range of conditions seen.	Consultation, support, assessment, therapeutic intervention. Tailor interventions to meet the needs of the child / young person. Jointly work with Head to Head and Specialist Community CAMHS	Multidisciplinary and multiagency team: -Team manager -Specialist social workers -Specialist social worker/play therapist -Consultant Clinical Psychologist -Systemic Psychotherapist -Consultant Psychiatrist -Art Psychotherapist -Specialist Nurse Practitioner -Consultant Psychotherapist	Countywide provision for looked after children.
Intensive Interventions Team	New service that is continuing to run after a pilot that ended in July 2012. It aims to provide intensive interventions to support community teams or prevent admissions (supports Tiers 3 and 4)	Mental health disorders. The team provides intensive support to prevent inpatient admission or to support early discharge.	Group work Individual work Attend CAMHS school Parenting support		Thorneywood, Nottingham
Specialist Learning Disability		Children and young people who are experiencing severe and debilitating learning disability			

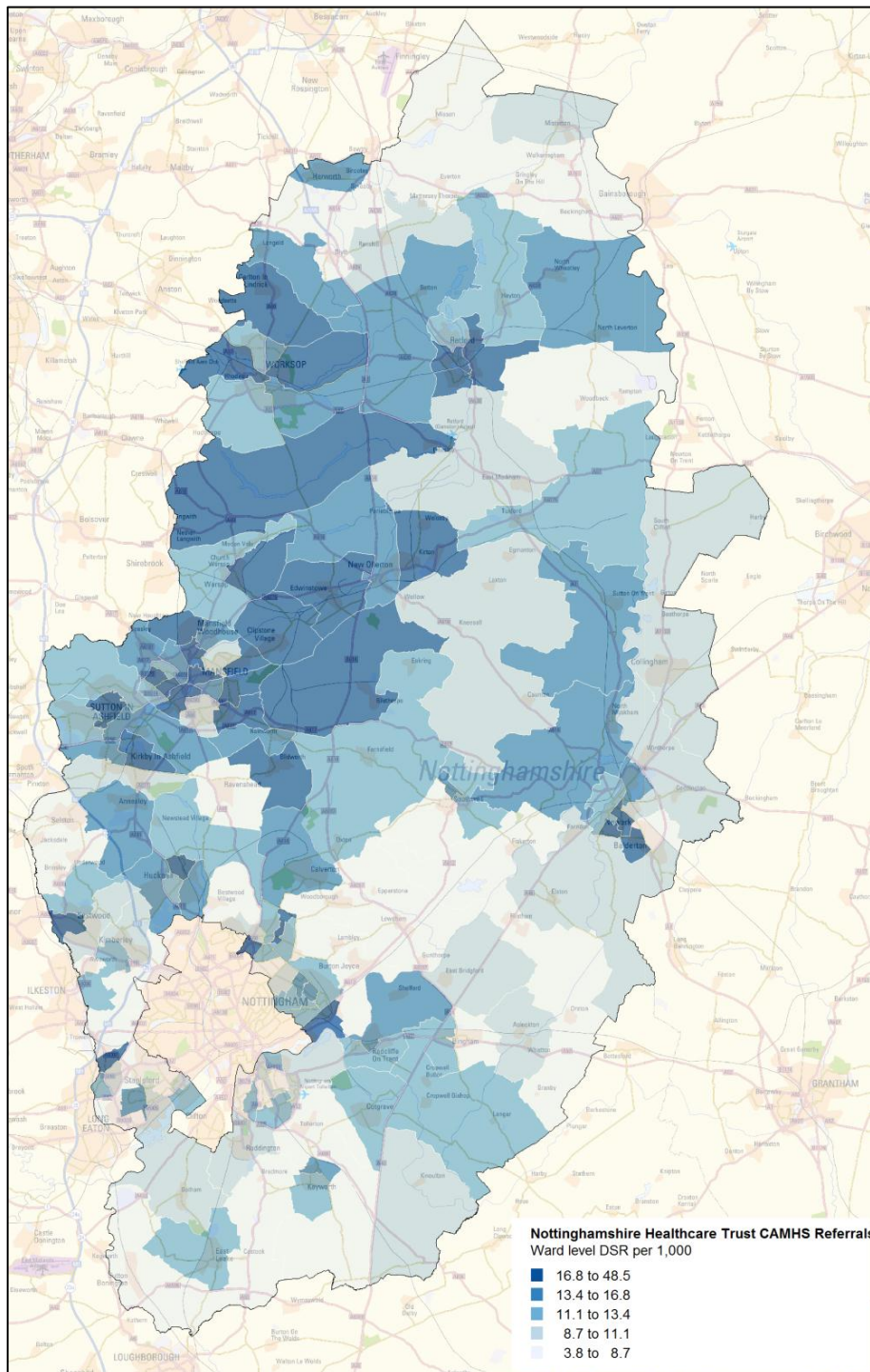
Service		presentations/impact.			
Eating Disorder Virtual Service (Pilot)	An outpatient service to work with young people with an eating disorder. Being piloted currently.	Eating disorders.			

6.5.2 Tier 3 Service Use Data

Tier 3 Referral Rates

Directly standardised referral rates are presented in Figure 27 for Tier 3 CAMHS for the time period 2009-2011. These are referrals of children and young people to be seen within Tier 3 CAMHS services. Up-to-date data are unavailable due to national changes in Information Governance regulations that have limited commissioner access to patient identifiable information.

FIGURE 27: DIRECTLY STANDARDISED REFERRAL RATES TO TIER 3 CAMHS 2009-2011



Source: Nottinghamshire Healthcare Trust, NHS Nottingham City CCG. 2009-2011.

As can be seen in Figure 27, rates of referral to Tier 3 CAMHS were generally highest in the North Nottinghamshire. Rates of referrals ranged from 3.8 per 1000 in Lamley (95% CI 0.4-7.2) to 48.4 per 1000 in Stapleford North (95% CI 41.3-55.5). As can be seen, confidence intervals were generally wide due to the relatively small numbers of referrals. Table 40 shows the 15 wards with the highest directly standardised rates of referrals to Tier 3 CAMHS. Stapleford North appears to have a particularly high rate of referral, which may warrant further investigation into the underlying data and whether the numbers of children from this ward being seen in Tier 3 CAMHS is truly this high. For example, this referral rate could be inflated if children DNA appointments and are repeatedly referred into the service. Appendix 5 shows the directly standardised referral rates for each ward ranked according to ward deprivation level.

TABLE 40: DIRECTLY STANDARDISED REFERRAL RATES TO TIER 3 CAMHS 2009-2011, (WARDS WITH THE HIGHEST RATES)

District	Ward	Directly standardised rate of referral (per 1000)	Upper confidence interval	Lower confidence interval	Number of events
Broxtowe	Stapleford North	48.4	55.5	41.3	186
Newark & Sherwood	Blidworth	28.1	33.3	22.9	112
Bassetlaw	Welbeck	26.6	35.0	18.2	40
Mansfield	Lindhurst	25.2	30.6	19.8	84
Mansfield	Cumberlands	24.7	29.8	19.6	92
Ashfield	Kirkby in Ashfield East	24.4	28.4	20.5	146
Mansfield	Portland	22.9	28.1	17.8	80
Mansfield	Forest Town East	22.9	27.4	18.3	98
Mansfield	Ravensdale	22.1	26.7	17.5	89
Newark & Sherwood	Boughton	21.2	25.4	17.1	102
Newark & Sherwood	Magnus	21.1	25.9	16.4	78
Mansfield	Oak Tree	21.1	24.7	17.5	134
Mansfield	Robin Hood	21.1	25.0	17.2	115
Bassetlaw	Carlton	21.0	25.3	16.7	93
Newark & Sherwood	Bilsthorpe	20.8	25.0	16.5	93

Source: Nottinghamshire Healthcare Trust, NHS Nottingham City CCG. 2009-2011.

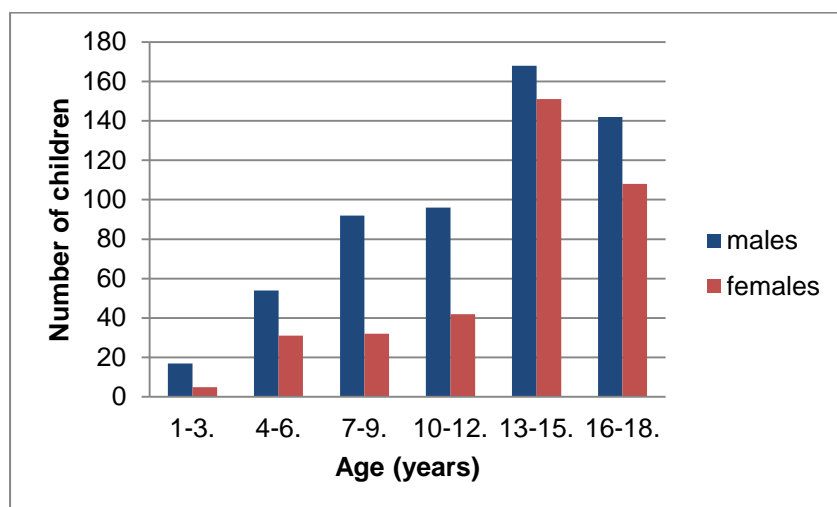
Children seen within Tier 3 CAMHS 2012

Anonymised Tier 3 data were supplied by Nottinghamshire Healthcare Trust for children living in Nottinghamshire who were seen in Tier 3 between 1st Jan 2012 and 31st Dec 2012. It is advised that these data are treated with some caution as it does not include all Tier 3 services. Services that are coded within the dataset supplied include Looked after children's team, Head 2 Head, Specialist Community CAMHS (North), Neurodevelopmental disorder team, Paediatric liaison and Psychotherapy. Data from the Specialist Learning Disability service are not included as this team is employed by County Health Partnership.

Age and gender

In 2012, 938 children and young people were seen in Tier 3 CAMHS, of which, 569 (61%) were males and 369 (39%) were females. These children had a total of 6055 consultations across the year. Figure 28 shows the age distribution of those seen in Tier 3 CAMHS in 2012 according to gender. The most common age group was 13-15 years for both males and females. At all ages there were greater numbers of males seen within Tier 3 CAMHS.

FIGURE 28: AGE AND GENDER OF CHILDREN AND YOUNG PEOPLE SEEN IN TIER 3 CAMHS, 2012



Source: Nottinghamshire Healthcare Trust, 2012.

Ethnicity

Table 41 shows the ethnicity of children and young people seen in Tier 3 CAMHS compared to the ethnicity of the Nottinghamshire population. Percentages of children from White (British), Mixed and Asian ethnic groups were lower in Tier 3 CAMHS compared to the Nottinghamshire population. Comparatively children from Black, White (Other) and 'Other ethnic group' categories appeared overrepresented within Tier 3 CAMHS.

TABLE 41: ETHNICITY OF CHILDREN SEEN IN TIER 3 CAMHS COMPARED TO THE POPULATION OF NOTTINGHAMSHIRE

	Tier 3 CAMHS		Notts County (2011 Census)
	N	%	%
White: British	820	87.4	90.5
White: Irish	4	0.4	0.2
White: Other White	39	4.2	2.0
Mixed/multiple ethnic groups	27	2.9	3.6
Asian/Asian British	5	0.5	2.7
Black/African/Caribbean/Black British	10	1.1	0.6
Other ethnic group	28	3.0	0.3
Not recorded	5	0.5	-

Source: Nottinghamshire Healthcare Trust, 2012. ONS, 2011.

Deprivation

Data on deprivation has been presented using National Index of Multiple Deprivation (IMD) quintiles. National quintiles take into account all lower super output areas (LSOAs) in England, with each quintile containing an equal number of national LSOAs. Using national quintiles helps to place the level of deprivation in Nottinghamshire in the context of the rest of England.

Table 42 shows both the numbers of patients seen in Tier 3 according to national deprivation quintile, and the numbers of 0-18 year olds living in Nottinghamshire according to deprivation quintile. Those

in National IMD 1 are the most deprived, and as can be seen 27% of patients seen in Tier 3 CAMHS came from the most deprived group. Comparatively, only 17% of the Nottinghamshire population aged 0-18 fall within the National IMD 1 quintile.

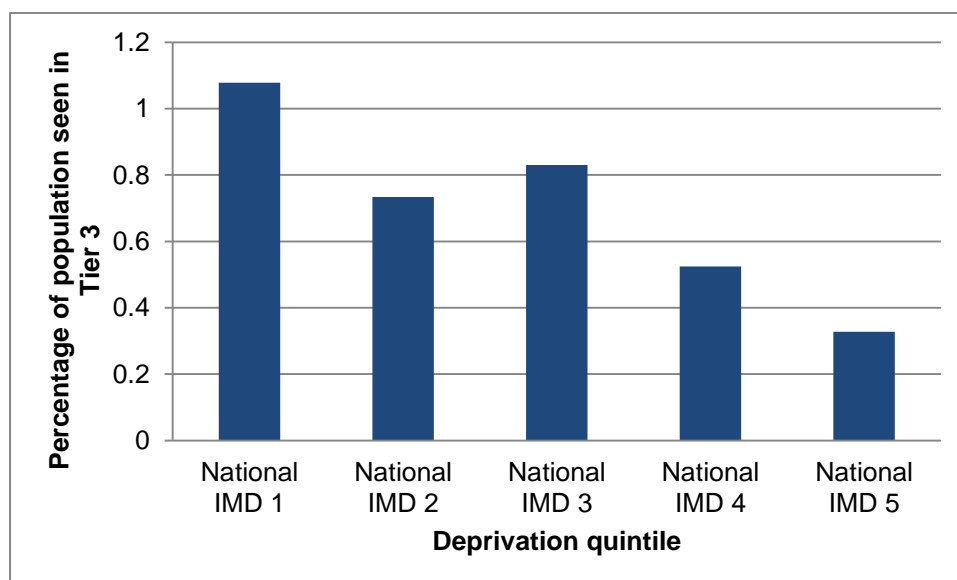
TABLE 42: PATIENTS SEEN IN TIER 3 CAMHS ACCORDING TO DEPRIVATION LEVEL (NATIONAL IMD QUINTILES)

	Number of Tier 3 CAMHS patients	Percentage Tier 3 CAMHS patients (%)	Nottinghamshire population 0-18 years	Percentage of Nottinghamshire population 0-18 (%)
National IMD 1 Most deprived	256	27	23754	17
National IMD 2	208	22	28350	20
National IMD 3 Average	216	23	26030	19
National IMD 4	147	16	28006	20
National IMD 5 Least deprived	111	12	33837	24

Source: Nottinghamshire Healthcare Trust, 2012. ONS, 2011.

Figure 29 shows the percentage of the Nottinghamshire population categorised in each of the deprivation groups that has been seen in Tier 3 CAMHS. As can be seen, there appears to be a trend, with increasing percentages of the population being seen in Tier 3 CAMHS with increasing deprivation.

FIGURE 29: PERCENTAGE OF POPULATION SEEN IN TIER 3 CAMHS ACCORDING TO DEPRIVATION QUINTILE



Source: Nottinghamshire Healthcare Trust, 2012.

District

Table 43 presents data on children and young people seen in Tier 3 CAMHS in 2012 according to district. Children seen in Tier 3 CAMHS in 2012 most commonly came from Ashfield (20%), Mansfield (19%) and Newark and Sherwood (17%). The percentage of the population seen within Tier 3 CAMHS varied according to district, from 0.31% of Rushcliffe's population to 0.77% of Mansfield's population.

TABLE 43: CHILDREN AND YOUNG PEOPLE SEEN WITHIN TIER 3 CAMHS ACCORDING TO DISTRICT

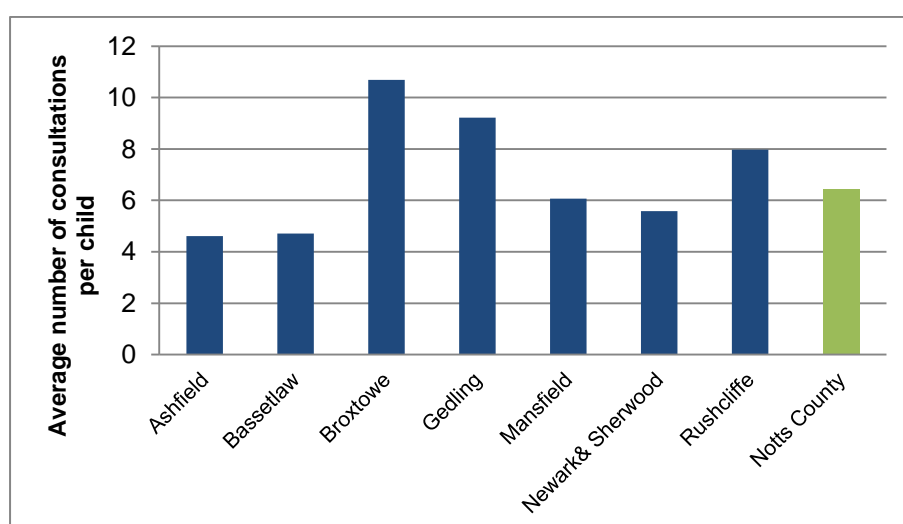
District	Number of children seen in Tier 3 CAMHS	Percentage of children in Tier 3 CAMHS (%)	Population aged 0-18	Percentage of district population 0-18 seen in Tier 3 CAMHS (%)
Ashfield	186	20	27250	0.68
Bassetlaw	142	15	24623	0.58
Broxtowe	104	11	22532	0.46
Gedling	89	9	24655	0.36
Mansfield	178	19	23035	0.77
Newark & Sherwood	162	17	25178	0.64
Rushcliffe	77	8	24592	0.31

Sources: Nottinghamshire Healthcare Trust, 2012. ONS, 2011.

Numbers of consultations by child

The 996 children seen within Tier 3 CAMHS had a total of 6299 consultations, an average of 6.3 consultations per child. Figure 30 shows the average number of consultations per child according to district. This varied according to district with Broxtowe (10.7), Gedling (9.2) and Rushcliffe (8.0) having the highest numbers of consultations per child. Comparatively Ashfield (4.6) and Bassetlaw (4.7) had the lowest average number of consultations.

FIGURE 30: AVERAGE NUMBER OF CONSULTATIONS PER CHILD WITH TIER 3 CAMHS ACCORDING TO DISTRICT

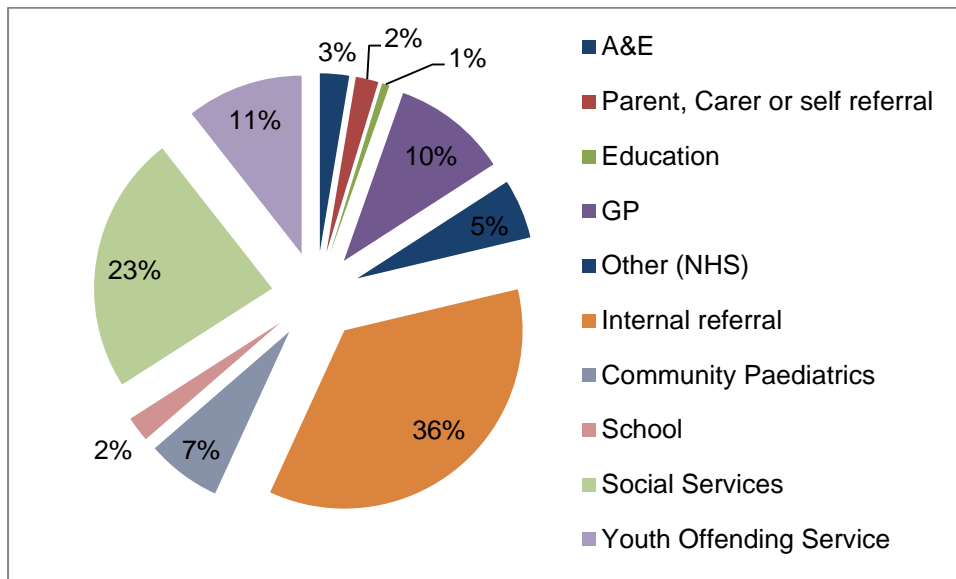


Source: Nottinghamshire Healthcare Trust, 2012.

Source of referrals

The three commonest sources of referral to Tier 3 CAMHS were internal referrals within CAMHS, (e.g. from Tier 2) (36%), social services (23%) and the youth offending service (11%).

FIGURE 31: SOURCE OF REFERRAL FOR CHILDREN AND YOUNG PEOPLE SEEN IN TIER 3 CAMHS, 2012

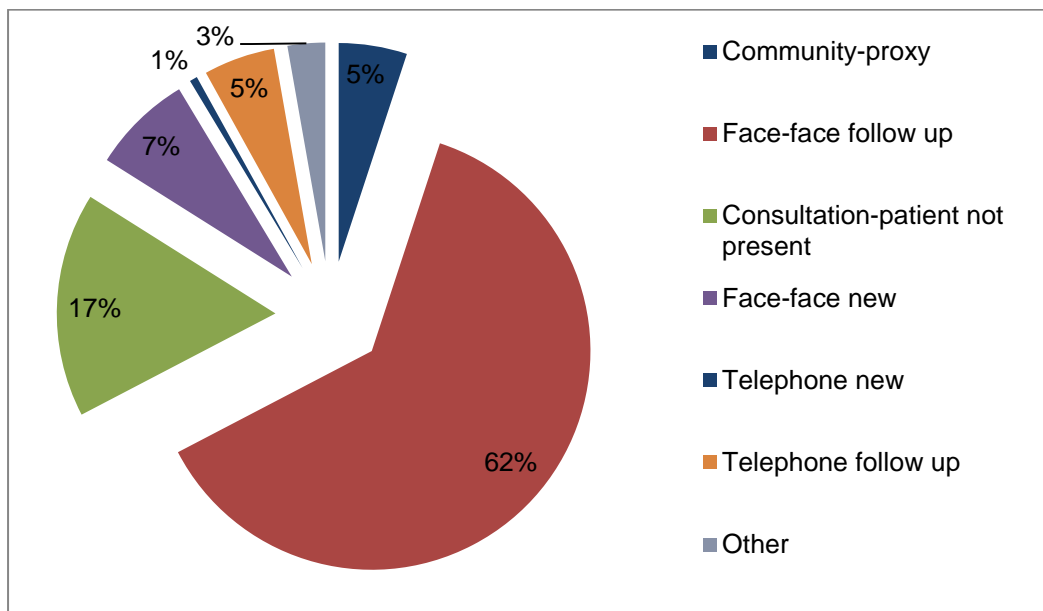


Source: Nottinghamshire Healthcare Trust, 2012.

Appointment types

Figure 32 shows the types of consultations delivered in 2012. Of the 6299 consultations carried out in 2012, 62% were face-face follow up appointments, 17% were consultations where the patient wasn't present and 7% were new patient face-face appointments.

FIGURE 32: APPOINTMENT TYPE DELIVERED, TIER 3 CAMHS 2012

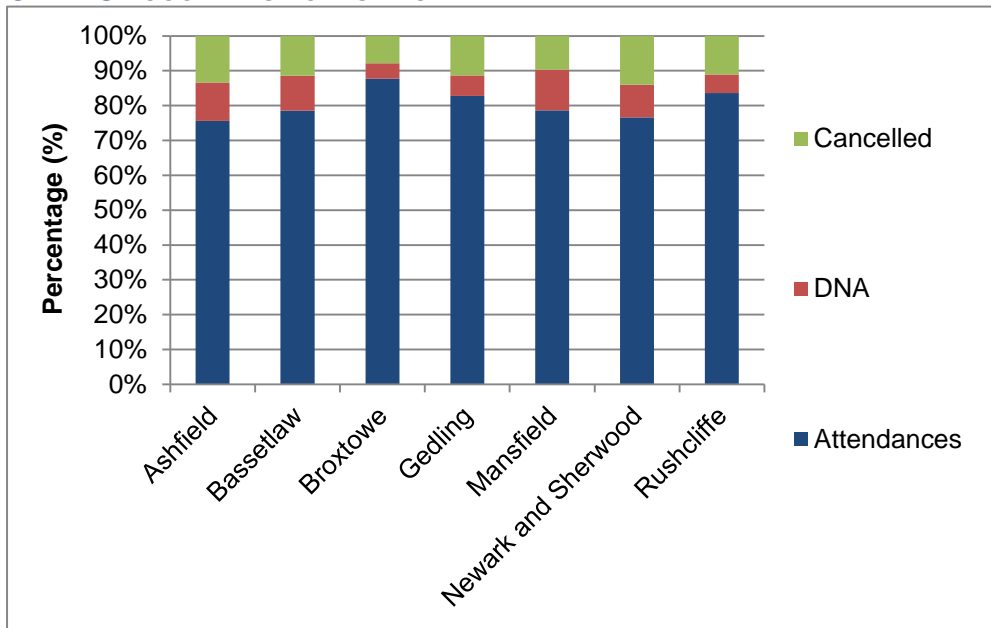


Source: Nottinghamshire Healthcare Trust, 2012.

Consultations, DNAs and Cancellations

Figure 33 shows the percentage of consultations that were cancelled or where the patient didn't attend. Higher percentages of DNAs were seen in Mansfield (12%), Ashfield (11%), Bassetlaw (10%), and Newark and Sherwood (9%).

FIGURE 33: PERCENTAGES OF ATTENDANCES, DNAs AND CANCELLATIONS WITHIN TIER 3 CAMHS ACCORDING TO DISTRICT



Source: Nottinghamshire Healthcare Trust, 2012.

6.6 Tier 4 Services

6.6.1 Description of Tier 4 Services

Service	Catchment Area	Need Being Met	Spectrum of Disorders Addressed	Services Provided	Professionals Involved in Service Delivery	Where services are located
Highly Specialised Adolescent In-patient Unit	<ul style="list-style-type: none"> • Nottingham City • Nottinghamshire County • Derby City • Derbyshire County 	In-patient treatment for young people with complex or severe mental health problems requiring specialist assessment, with continuous and prolonged observation for life threatening illnesses. The unit provides a service for young people between the ages of 12 and 18 from within Nottinghamshire and Derbyshire.	<ul style="list-style-type: none"> • Psychiatric disorders with clear psychiatric symptoms (elated mood, depressed mood, hallucinations and delusions) • Eating disorders. • Thoughts or behaviours that are so severely disturbed that outpatient treatment is impossible • Severe self-harming behaviour • Socially unacceptable behaviour that requires psychiatric assessment • Behaviour whereby it is not known whether it is in relation to a psychiatric illness or to a school or family problem. 	Multidisciplinary team provides: <ul style="list-style-type: none"> • Comprehensive Assessment • Diagnosis • 24 hour intense nursing care • High levels of observation • Risk assessment • Individual therapy • Group therapy • Family therapy • Education 	<ul style="list-style-type: none"> • Consultant Paediatric Psychiatrists • Nursing staff • Dietetics • Occupational therapist • Family Therapists • Educational staff 	Thorneywood Adolescent Unit 12 bedded inpatient unit.

Neuropsychiatry Team		Specialist tertiary, district and regional service, offering assessment, consultation and treatment of neuropsychiatric disorders in childhood and adolescence up to 18 years of age.	<ul style="list-style-type: none"> • Complex ADHD • Autistic Spectrum Disorders • Tourettes Syndrome and tic disorders • Behavioural aspects of epilepsy and other brain disorders • Childhood onset psychoses Paediatric psychopharmacology 	<ul style="list-style-type: none"> • Specialist expertise <ul style="list-style-type: none"> • Assessment • Consultation • Treatment • Second opinions in highly complex cases 	<ul style="list-style-type: none"> • Professor Hollis 	Nottingham Universities NHS Trust - QMC Campus
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6.6.2 Tier 4 Inpatient Data

Inpatient Tier 4 data for young people living in Nottinghamshire County were analysed for the three year time period of 2010-2012. It was necessary to consider multiple years of data due to the small numbers of young people who require inpatient services.

Between 1st Jan 2010 and 31st Dec 2012, there were a total of 91 admissions to Tier 4 CAMHS among 77 young people living in Nottinghamshire County. This gives an average of 1.18 admissions per young person over the 3 years. The maximum number of admissions in the 3 year time period was 4. Most young people had 1 admission (84%). Table 44 shows the number of admissions each year for 2010 to 2012.

TABLE 44: NUMBER OF ADMISSIONS TO TIER 4 CAMHS AMONG NOTTINGHAMSHIRE COUNTY RESIDENTS, 2010-12

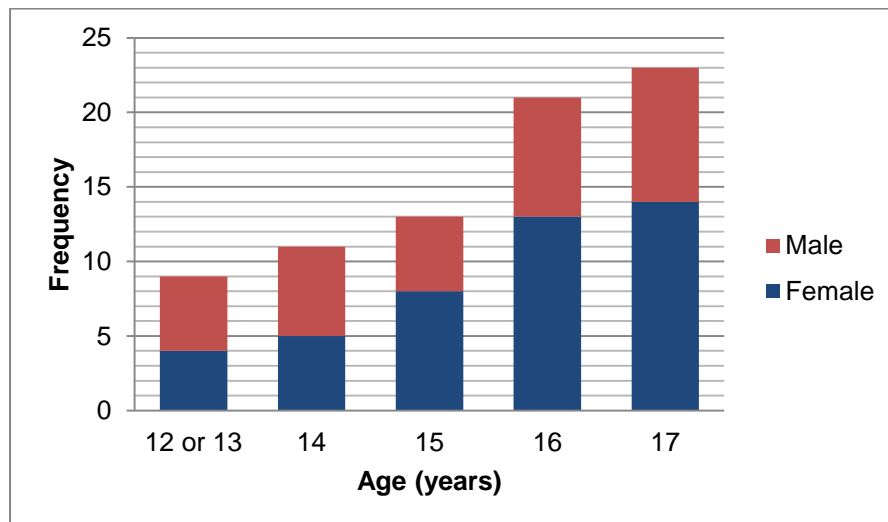
Year	Number of inpatient admissions to Tier 4 CAMHS
2010	30
2011	34
2012	27

Source: Nottinghamshire Healthcare Trust, 2010-2012.

Characteristics of young people admitted to Tier 4 CAMHS

Of the 77 children admitted to Tier 4 inpatient care, 44 were female (57%), and 33 were male (43%). Figure 34 shows the numbers of children admitted according to age and sex, showing admissions were more common among females, and with increasing age.

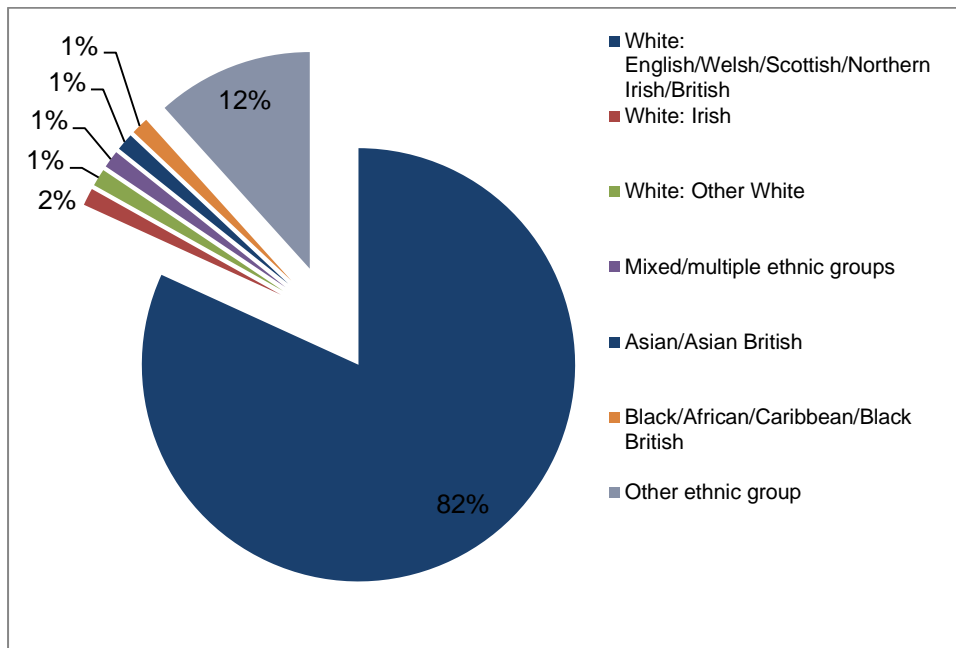
FIGURE 34: AGE AND GENDER OF YOUNG PEOPLE ADMITTED TO INPATIENT CAMHS 2010-12



Source: Nottinghamshire Healthcare Trust, 2010-2012.

Ethnicity data had been recorded for all young people admitted to Tier 4 CAMHS between 2010 and 2012. Most young people were recorded as being White British (82%). The second largest group was 'Other ethnic group'. It is unclear whether this reflects how ethnicity data have been captured or whether this group is truly overrepresented in inpatient CAMHS. The relatively small numbers of admissions also need to be taken into account when interpreting these data.

FIGURE 35: ETHNICITY OF CHILDREN AND YOUNG PEOPLE ADMITTED TO TIER 4 CAMHS

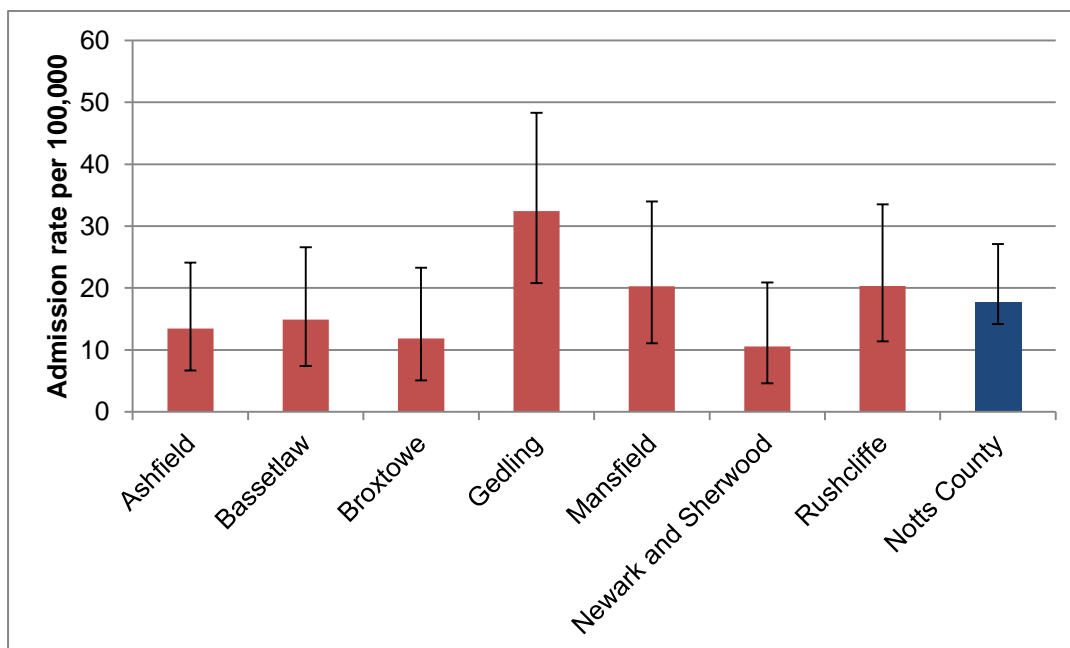


Source: Nottinghamshire Healthcare Trust, 2010-2012.

Admission rates according to district

Figure 36 shows the crude admission rates to tier 4 inpatient services according to district. Admission rates were highest in Gedling (32.4 per 100,000), Rushcliffe (20.3 per 100,000) and Mansfield (20.3 per 100,000). It must however be noted that with small numbers of admissions, the observed differences in admission rates between districts are not statistically significant (overlapping 95% confidence intervals).

FIGURE 36: CRUDE ADMISSION RATE INTO TIER 4 INPATIENT SERVICES ACCORDING TO DISTRICT, 2010-2012

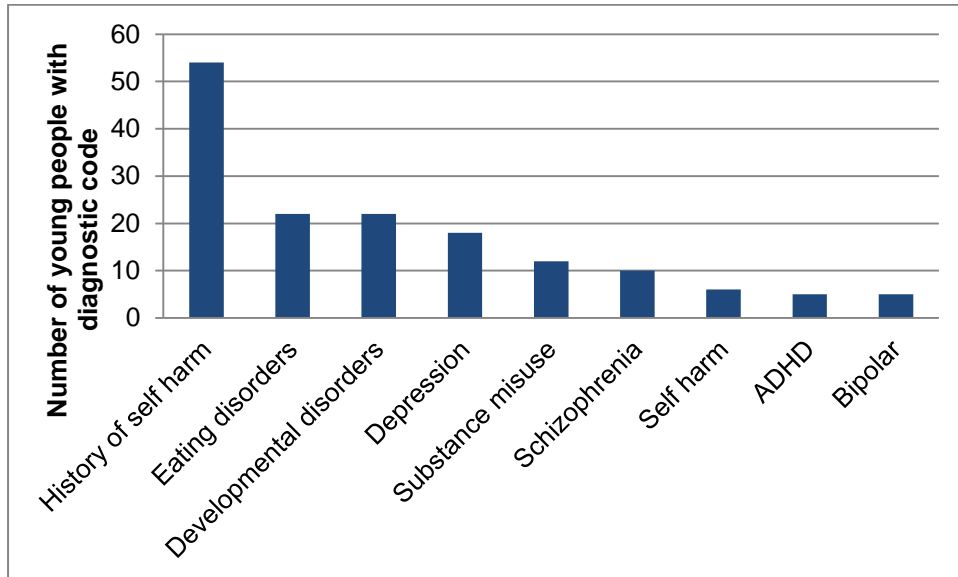


Sources: Nottinghamshire Healthcare Trust, 2010-2012. ONS, 2011.

Admissions according to diagnosis

Diagnoses were recorded using the ICD-10. Young people commonly had more than one ICD-10 code on their record, often indicating multiple diagnoses, comorbidities or their past medical history (e.g. asthma, self-harm). The commonest code recorded was 'history of self-harm'. The three other most common diagnoses were eating disorders, developmental disorders and depression. Diagnosis data according to district has not been presented due to the small numbers involved.

FIGURE 37: DIAGNOSES OF YOUNG PEOPLE ADMITTED TO TIER 4 CAMHS

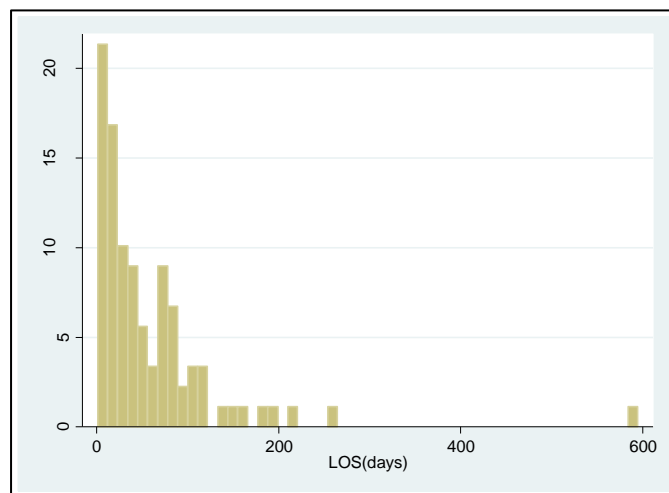


Source: Nottinghamshire Healthcare Trust, 2010-2012.

Length of stay

Figure 38 shows length of stay for children and young people in Tier 4 services. As to be expected, length of stay is positively skewed, with most young people having shorter lengths of stay, and the minority having prolonged admissions. The median length of stay was 49 days for females and 28.5 days for males.

FIGURE 38: LENGTH OF STAY OF CHILDREN AND YOUNG PEOPLE IN TIER 4 INPATIENT CARE



Source: Nottinghamshire Healthcare Trust, 2010-2012.

6.7 Estimating Current Service Use Compared to Need

Work by Kurtz (1996) provides an estimate of the percentage of children and young people within a population who may experience mental health problems that require a response from CAMHS Tier 1, 2, 3 and 4 services (Table 45)⁹⁴. From local service data, the percentage of children and young people seen within each Tier of CAMHS has been estimated. For each Tier, the percentage of children and young people seen in Nottinghamshire CAMHS is lower than the estimates by Kurtz.

Table 45: Estimated numbers of Nottinghamshire children and young people requiring access to Tiers 1-4 CAMHS

	Percentage of population requiring service (Kurtz 1996)	Estimated number of Nottinghamshire Children and Young People requiring service (based on Kurtz)	Percentage of Nottinghamshire population seen in each Tier (Local data)
Tier 1	15.0	23,899	Unknown
Tier 2	7.0	11,153	1.73% (2012/13)
Tier 3	1.85	2948	0.55% (2012)
Tier 4	0.075	119	0.016% (2012)

Source: Kurtz, 1996⁹⁴. ONS, 2011.

Summary: Chapter 6 Current Service Provision

- **Tier 1** encompasses a broad range of services available to the local population, which help to promote emotional and mental wellbeing. They include GPs, school nurses, health visitors, midwives, schools, early year services and youth services. Mapping Tier 1 services was outside of the scope of this HNA.
- **Single Point of Access (SPA)**. In 2012/13 the SPA received 4035 referrals for Tier 2 or 3 CAMHS. Of the referrals 71% were assigned to Tier 2, 11% to Tier 3 and 4% were jointly managed between Tiers 2 and 3.
- **Tier 2 CAMHS** consists of district emotional wellbeing teams provided by County Health Partnership and Bassetlaw Health Partnership. In 2012/13 the most common 'reasons for referral' to Tier 2 were 'behaviour', 'depression/low mood' and 'anxiety'. Numbers of referrals were highest in Ashfield (559), Mansfield (554) and Newark and Sherwood (527).
- **Tier 3 CAMHS** provides specialised multi-disciplinary services for severe and complex child and adolescent mental health problems and neurodevelopmental disorders. Referral rates to Tier 3 CAMHS varied considerably by ward and district. High referral rates between 2009 and 2011 were seen within Mansfield, Bassetlaw, Ashfield and specific wards in Newark and Sherwood and Broxtowe. Data from 2012 showed that those seen in Tier 3 were most commonly male and aged 13-15 years. 27% of those seen in Tier 3 CAMHS were from the most deprived quintile.
- **Tier 4 CAMHS** provides highly specialised mental health services, including an inpatient adolescent unit at Thorneywood, Nottingham. Over three years (2010-2012) there were 91 admissions to the inpatient unit among 77 Nottinghamshire young people. The districts with the highest crude admission rates were Gedling (32.4 per 100,000), Rushcliffe (20.3 per 100,000) and Mansfield (20.3 per 100,000). The most common diagnostic codes were 'history of self-harm', 'eating disorders', 'developmental disorders' and 'depression'.

7. Stakeholder Views

7.1 Views of commissioners and providers

Semi-structured interviews were carried out with stakeholders about their perceptions of the emotional and mental health needs of children and young people, alongside their experiences of current service provision (see appendix 6 for details of those interviewed). The key issues identified from these interviews are summarised below, and have been grouped according to themes:

7.1.1 Needs of children and young people

Stakeholders identified a number of areas where there were perceived unmet needs or a growing demand upon services.

Behavioural issues

- It was reported that a large number of referrals to CAMHS are related to 'behaviour'. Some felt there was a 'blur' around what the role of CAMHS was in behaviour management; what the boundary was between the need for parenting support, and whether the child had a diagnosable disorder.
- It was felt that schools had to deal with challenging behaviour on a day to day basis, but often without support or training.
- There was a perceived need for more parenting programmes and training.
- It was felt that school nurses, teachers, and GPs were meant to be gatekeepers to CAMHS. Yet, often they have received little training on behaviour management and distinguishing cases that need to be seen by CAMHS. It was felt there was a need to support the gatekeepers and see them as part of pathways.
- Some felt that there was nowhere to send children and families where the child had significant behaviour problems but did not have a mental health problem.

ASD/ADHD

- It was perceived that there have been huge increases in referrals and diagnoses of ASD and ADHD, leading services to be swamped.
- It was reported that children and young people were often referred for post-diagnostic support of ASD in the absence of other mental health problems. It was felt CAMHS was not the appropriate place to provide this support, where in some cases more long term holistic support was required.
- In some situations, it was felt ASD/ADHD was being over diagnosed. There was a perception of over medicalization. It was felt that children who have had early trauma or attachment problems were wrongly being labelled as having ASD/ADHD.
- Stakeholders expressed care should be multidisciplinary and focused on the child's needs rather than the medical diagnosis.

Self-Harm

- The number of children and young people harming themselves was reported to be increasing, alongside an increase in the complexity of cases.
- The Self Harm Team that covers Nottingham City and Nottinghamshire South reported an increase in numbers of children admitted to the Queen's Medical Centre for self-harm from 108 in 2008 to 168 in 2012 leading to increased demand on their service.

Early intervention

- Stakeholders felt there needed to be greater emphasis on early intervention, identifying emotional and mental health problems early in order to “break the cycle”. Often emotional and mental health issues seen by CAMHS were perceived to be rooted in societal and generational problems which could not easily be fixed by CAMHS services alone. Some felt that children could be referred to CAMHS for social problems; “*What can CAMHS do?*”
- Early identification and action on safeguarding concerns was identified as being part of preventing child emotional and mental problems.
- Some felt emotional and mental health disorders weren’t identified and acted upon early enough. An example was given of a young person presenting with a body mass index of 14, significantly underweight and at considerable risk.
- There was a perceived gap around teaching young people to work through and manage issues themselves (e.g. coping strategies). Some proposed the need for greater work with schools focusing on these skills.

Working with families

- It was felt that in some children presenting to CAMHS, parental mental health disorders or substance misuse were related to the child’s presentation. Identifying these wider issues and working with families (e.g. more family therapy) was highlighted as a need.
- The need to work with families was also highlighted in terms of behaviours and social issues that are entrenched in families.

7.1.2 Issues related to provision of CAMHS Services

Understanding of CAMHS

- It was felt that those working within universal services do not always understand what CAMHS does. It can appear a complex system. There was a perception among stakeholders that referrers do not always understand the boundaries between primary care, paediatrics and CAMHS.
 - “*CAMHS can often feel shrouded in mystery*”
 - “*People don’t feel part of it……. How to get people into it?……. How to get people out of it?*”
 - “*Who is CAMHS really aimed at?*”

Training and support for universal services

- It was felt that there was a gap between what schools could cope with and the threshold for CAMHS. Some felt schools needed more support, including how to recognise emotional and mental health problems and how to manage them.
- Some stakeholders felt that universal services were not always aware of the support available for families from, for example, Children’s Centres or the third sector.
- The existing training programme was recognised to be under high demand. It was felt that training needed to be widened out, with more publicity and capacity. Some stakeholders reported time constraints that affected their ability to attend training.

Referral and movement across the Tiers

- Some working within CAMHS felt that there was a “*refer them to CAMHS*” mentality within universal services leading to inappropriate referrals. In some situations, children with difficult backgrounds or social situations were being referred to CAMHS yet did not have a mental illness.

- “not anything medical.....no one else knows what to do with them.....[CAMHS is a] catch it all service”
- It was felt there needed to be clearer referral criteria for those working in universal services. Some cited that referrals could be poor quality, giving little information about the child’s history or symptoms to allow assessment of risk. It could take up time of CAMHS staff to contact referrers for further information.
- The boundary between Tier 2 and 3 services was felt to be artificial, and that in some cases the split between services was unclear or led to a waste of time moving children between services.
- Tier 2 services are employed by a different organisation to Tier 3 services. Different computer systems (System 1 versus Rio), different assessment and risk assessment forms were reported to be used by Tier 2 and Tier 3. Some felt that these differences could lead to duplication of effort with a child or young person being assessed multiple times, therefore potentially delaying treatment.

Impact of changes in universal services and CAMHS

- Several stakeholders reported cuts to universal services, such as counselling services. Concern was expressed that as a result, children who had been managed within tier 1 were being escalated to tier 2 as there were no alternative services for them.
- Conversely, there was the feeling within universal services that they were required to “soak up demand” from CAMHS without adequate training or support.

Tier 2 Services

- Tier 2 teams were felt to have filled a large need, making services more accessible and allowing relationships to develop with local services and referrers.
- Some felt that Tier 2 services were sometimes dealing with Tier 3 or risky cases. Reasons given included tier 2 holding cases while they waited for tier 3 services, and children disclosing different issues than they were initially referred with.
- A reported gap in CAMHS provision is where children require longer term work in Tier 2 but do not meet the threshold for Tier 3 services.

Lack of capacity

- A lack of capacity across CAMHS was identified by a number of stakeholders.
- Some felt that the role of Tier 2 had expanded; absorbing more patients when universal and Tier 3 services were squeezed.
- The large geographical area of Nottinghamshire was cited as a challenge, covering the area with some relatively small teams within Tier 3.

Waiting times

- Waiting times were highlighted both for Tier 2 and 3 services. For tier 2, waiting lists varied by district, being particularly long where staffing was low. For tier 3, long waiting times were highlighted for tier 3 interventions.

Targeting those most in need

- Several stakeholders reported that they felt CAMHS needed to be more targeted at those with the greatest need. It was felt there was a need to understand which children or conditions really needed targeting.
 - “We need to use CAMHS smarter”

- There was a perception among several stakeholders that those with the greatest needs were more likely to be those who would not attend appointments.

Looked After Children

- Positive feedback was given about the Looked After Children's Team. It was reported to be a good service and tailored to the needs of the children. The Consultation model and multidisciplinary team working were reported as positive attributes of the team.
- Stakeholders reported numbers of looked after children have increased considerably since 2007- increased demand on services.
- Children at the edge of care were identified as an at risk group. Those on the edge of care, going into and out of care, don't fit the criteria of the LAC team. It was felt they didn't clearly fit into the system.

Transition to adult services

- Stakeholders expressed mixed views about transitioning from child to adult mental health services. Many reported that in general, transitioning appeared to work ok. Where it did not work well, cases were complex or had been out of area. It was felt in these cases, transitions weren't always planned far enough in advance, particularly where there were complex needs.
- Transitions were reported to work well when young people have significant mental health disorders that clearly map onto adult services. For example, it was felt there was a good match between child and adult psychosis services.
- Several stakeholders however reported that adult and child services are configured differently with some young people not necessarily meeting criteria to be seen in adult services, particularly for emotional or behavioural conditions.
- Linked to the above, it was felt that transition was a vulnerable time for the young person, potentially having left school, losing other support networks and potentially losing support from CAMHS.

CAMHS Workforce

A number of stakeholders raised concerns about the CAMHS workforce. Issues identified included:

- **Difficulties in recruiting and retaining staff.** In some teams there were unfilled posts or posts being filled on a temporary basis by third sector organisations. It was felt that it was difficult to get good applicants for jobs that had the right skills. It was difficult to get new people into CAMHS. It was perceived that there is a shrinking pool of people with CAMHS experience.
- **Staff roles.** Within Tier 2, some stakeholders discussed issues around clarity of staff roles. For example, the tier 2 social workers commonly carried out very similar roles to the NHS staff. Some also discussed that in some roles, career progression was unclear. It was felt that it was important to identify the right skills and competencies needed in the workforce to meet the needs of the children and young people in CAMHS.
- **Staff morale.**
- **Lack of structured Continuing Professional Development.** *"We could be better at training and growing our own. There aren't enough courses to send people on, and there isn't a structured CPD programme, journal club or grand rounds".*

7.1.3 Commissioning of CAMHS

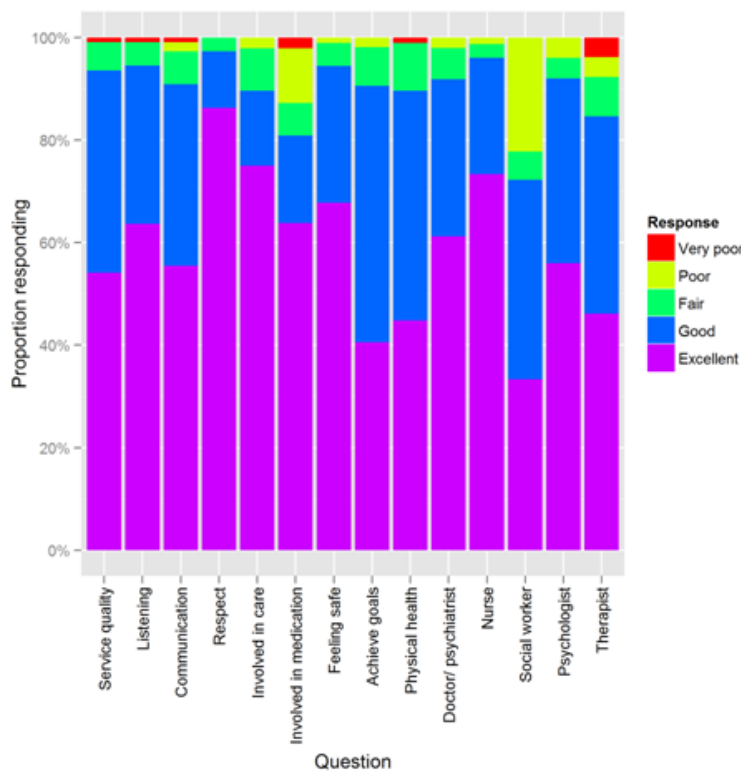
- Due to changes in the commissioning of NHS services (introduction of CCGs and move of public health to the local authority), a new lead commissioner for CAMHS is being identified. Stakeholders reported a need for clear proactive leadership and commitment from commissioners, and a clear strategy and plan for the future.
- Those working in CAMHS reported the complexity of commissioning arrangements for the Healthcare Trust across the City and County across Tiers 2, 3 and 4. With Tier 4 commissioned separately, multiple CCGs in the County, Nottingham City CCG, and Tier 2 provision provided separately for the county, city and Bassetlaw; it was felt there were lots of organisational splits.
- It was felt that data currently fed back to the Integrated CAMHS Commissioning Group was limited (e.g. lack of tier 3 data). Data was reported to be process data about who had been seen rather than outcome data. It was felt that there was a need for suitable outcome measures.

7.2 Views of service users

7.2.1 User feedback from CAMHS Services

Service user and carer feedback from April-June 2012 for Tier 3 and 4 CAMHS was supplied by Nottinghamshire Healthcare Trust. In this time period 110 responses were received. It must be noted that response rates to service user surveys tend to be very low, in this case about 8%, and so findings may not be representative of all those using CAMHS services. Figure 35 shows overall responses to a series of questions about patient/carer experiences. Most questions about care received high proportions of ‘excellent’ or ‘good’ ratings (about 90% between these 2 categories). Areas with high ratings of ‘excellent’ were “Respect”, and views of care delivered by nursing staff.

FIGURE 39: SERVICE USER FEEDBACK, NOTTINGHAMSHIRE HEALTH CARE TRUST (Q1 2012)



Source: Nottinghamshire Healthcare Trust, 2012

Figure 40 and Figure 41 show service user feedback to the questions “If you could improve one thing about the care you received what would it be?” and “What was the best thing about the care you received?”. Responses are summarised and grouped into themes. Suggested improvements commonly related to waiting times and faster access to services. Positive aspects of care related to staff, the care they received, communication and the outcomes they felt from treatment.

FIGURE 40: INDIVIDUAL COMMENTS FROM SERVICE USERS/CARERS ON IMPROVEMENTS TO SERVICES (SERVICE USER FEEDBACK Q1 2012)

If you could improve one thing about the care received what would it be?

INVOLVEMENT

"Staff should keep everything individual and not generalise care plans."

COMMUNICATION

"Too many forms!"

"I would like the service to be ?? up and the staff to communicate with one another or at least read the notes so that they are up to date - and for the notes to be in one place or to be managed electronically."

FOOD / ENVIRONMENT

"A coffee machine for parents whilst waiting."

"The offer of refreshments."

STAFF

"Having someone to talk to who understood about my medication."

"Nurses should regularly ask / check that patients are OK as some don't feel comfortable with approaching staff."

"Feeling like I can approach the nurses easy."

"More one to ones."

"Some weeks to have more 1 to 1's with key and co worker."

"More staff so other young people can be seen."

"Not enough staff. More staff to go out and do activities. Budget for holiday could have been spent better."

ACCESS TO SERVICES AND WAITING TIMES

"Accessible out of Mon-Fri - 9-5 hours".

"That they had more resources to see young people before it got to crisis stage".

"At my worst, I think I would have benefitted more at home".

"Not such a long waiting list! Currently waiting for play therapy".

"To get an initial appointment more quickly".

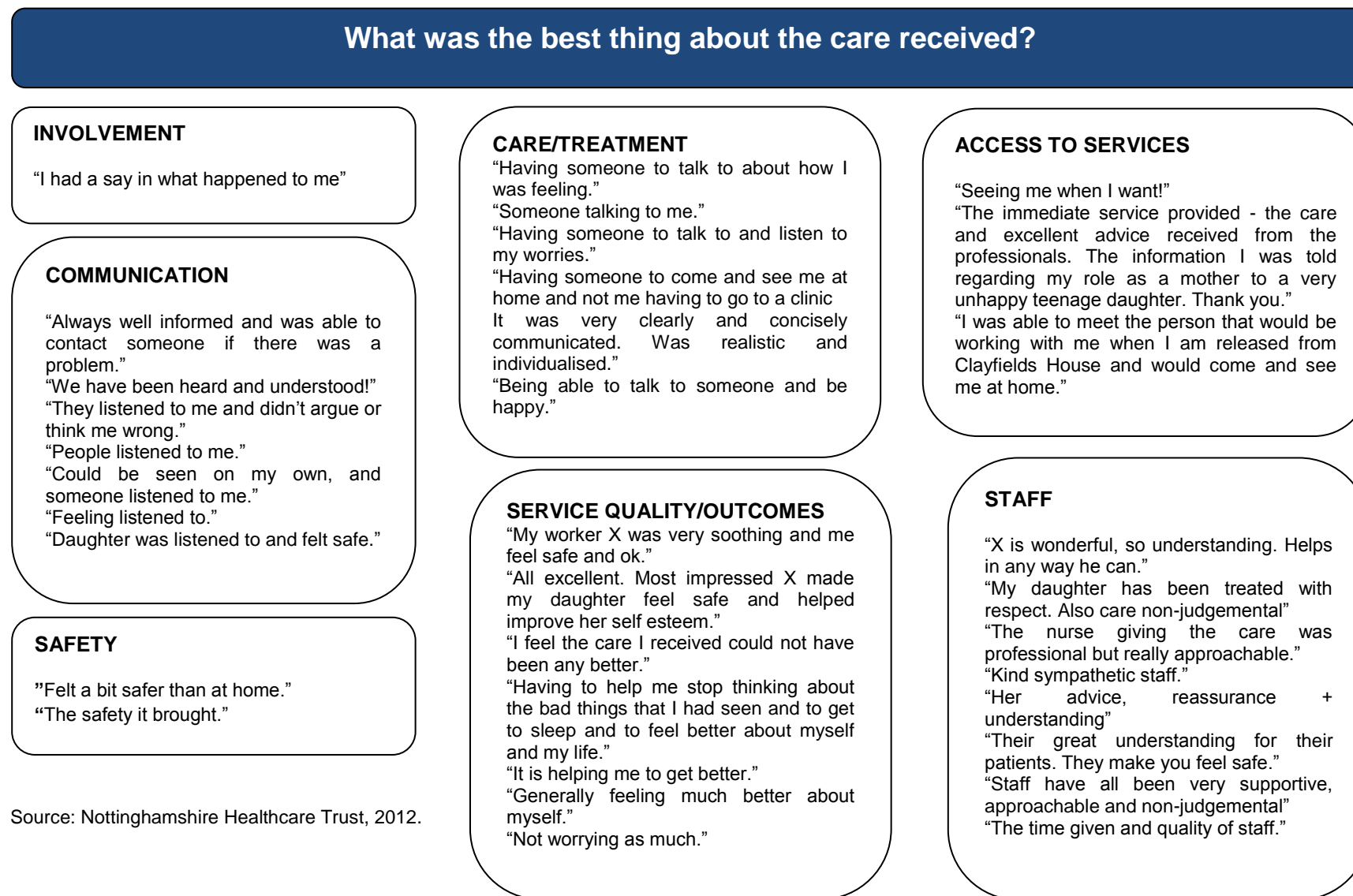
"Faster service, involved in your own care more, more staff to support patients, more therapy available, more confidentiality about care plans".

"The service should receive more funds so help is received quicker".

"The waiting list time to get into the system".

Source: Nottinghamshire Healthcare Trust, 2012.

FIGURE 41: INDIVIDUAL COMMENTS FROM SERVICE USERS / CARERS ON THE BEST BIT ABOUT CARE (SERVICE USER FEEDBACK Q1 2012)



Source: Nottinghamshire Healthcare Trust, 2012.

7.2.1 Views of young people, Youth Council (2013)

A workshop was held in May 2013 with 12 young people from across Nottinghamshire who are part of Youth Councils. They were asked questions in relation to mental health and how to make young people more aware of services. Case studies were used to identify where they would go for help if they or a friend were experiencing symptoms of certain mental health problems (appendix 7). Sources of help listed commonly included teachers, parents, school nurses, doctors, counsellors and youth workers.

Q: How to make young people aware that CAMHS services are available?

- posters
- CAMHS should come into assemblies at school/ or into lessons to tell us what they do and so we can meet staff
- family centres
- young people dedicated website
- link website to school websites etc
- bill boards
- Youtube/ twitter / facebook for CAHMS- counsellors with own pages, can communicate directly.
- Notice boards e.g. in the toilets/ back of doors
- Buses – inside and outside – advertising
- Professionals should carry bags with information on it – numbers to call, logo etc
- “phone” deck chairs with info/ numbers on them (gimmick tools to promote a telephone number and website that young people will like)
- School nurses, youth workers and others need to tell us about these services
- Services could be located near schools

Q: How do we get health services to be ‘young people friendly’?

- need to employ people who have had problems e.g. drug users
- waiting rooms need to be redesigned
- staff shouldn't be too nose
- more publicity
- young people need after school appointments with GP's
- young people clinic in GP's after school times
- more adverts
- Staffs needs to come to PSHE lessons to tell CYP another service and explain confidentiality.
- Should let friends go with you for appointments
- more friendly and approachable
- Need to understand what services can offer
- Need to promote via talks to young people
- Need to use more social media to advertise to young people
- Adverts should not use jargon and acronyms.

It must be noted that these young people may not necessary be representative of all young people, as by being involved in Youth Councils, they may be those more aware of services and events within the County.

7.2.2 Evidence from focus groups, Mansfield and Newark & Sherwood (2008 & 2009)

Focus groups were carried out with young people, parents/carers and professionals in Newark and Sherwood in 2008 (Meldrum, J. Let Us Grab Your Attention) and Mansfield in 2009 (Meldrum, J. Let Us Grab Your Attention 2) in order to inform the development of targeted tier 2 CAMHS.

Seventy-four people participated in Newark and Sherwood (39 young people, 7 parents/carers and 28 professionals), and 104 people participated in Mansfield (73 young people, 31 parents/carers). Some of the main findings included:

- 3 factors were highlighted as affecting young peoples' willingness to use services:
 - What the service looks and feels like.
 - Accessibility.
 - Staff.
- Attributes of those providing support to young people that were listed as desired included:
 - Confidentiality
 - Honesty and openness.
 - Non-judgemental.
 - Trusted relationship.
- Parents and carers commented on current service provision highlighting:
 - The need for common language and avoidance of using acronyms like CAMHS.
 - A need for tailored information about what services are available locally.
 - Difficulties accessing appointments, e.g. hospital not on a bus route.
 - They didn't want to be passed from professional to professional.
 - Services need to be tailored to family, flexible approach.

Summary: Chapter 7 Stakeholder Views

- **Interviews with stakeholders.** Interviews were carried out with commissioners and those working in universal services and CAMHS. Identified needs included high numbers of children referred to CAMHS with "behaviour" problems. Numbers of children diagnosed with ADHD and ASD were reported to have increased. Stakeholders reported the need for early intervention and work with families. Feedback about current service provision highlighted a lack of capacity and staff shortages in some CAMHS teams, leading to high waiting times. The need for clear pathways and clear understanding of the role of CAMHS was also highlighted. Some stakeholders felt services needed to be more targeted to areas with the highest levels of need.
- **Service feedback (Tier 3 CAMHS).** Service user feedback was supplied by Nottinghamshire Healthcare Trust. Positive feedback was given about the care received, staff and communication. Recommended improvements included comments about waiting times for appointments and interventions, alongside a perception of staff shortages.
- **Focus groups** were carried out in Mansfield and Newark and Sherwood in 2008 and 2009 primarily focused on Tier 2 provision. Factors reported to affect young peoples' uptake of services were 'what the service looked and felt like', 'accessibility' and 'staff' factors. Young people wanted staff who they felt were honest, open, trustworthy and would be non-judgemental.

8. Gaps and Priorities for Action

Bringing together data on risk factors, service use and stakeholder views, the following key issues have been identified.

8.1 Prevention: Breaking the cycle and taking a life course approach to preventing emotional and mental health problems

Within Nottinghamshire, many children and young people are exposed to risk factors for emotional and mental health problems from birth. In some areas there is a clustering of risk factors that are intertwined and interrelated; for example, high levels of deprivation, teenage mothers, lone parents, abuse, unemployment, and parental substance misuse. Issues can be entrenched in families and over generations. Identified priorities from this HNA include:

- **Intervening early.** Children are shaped by early life experiences. Evidence has shown that intervening early, e.g. from birth, during the early years and primary school can reduce emotional and behavioural problems. Early recognition and management of perinatal depression or maternal mental health problems can help bonding and attachment between mother and child.
- **Working collaboratively** across agencies and services to prevent some of the drivers of child emotional and mental health problems. It is only collaboratively that issues such as parental unemployment, poverty and substance misuse can be reduced. As discussed in the Government's mental health strategy, 'No Health Without Mental Health', mental health is 'everyone's business'.
- **"Think Family"**. Child and adolescent emotional and mental health problems do not happen in isolation from the wider family and community children live in. Parents and families often need *support and advice* to help their child with the problems they are facing. For example, parenting courses help to prevent the development of emotional and behavioural problems and support parents with children who have conditions such as ADHD. In some situations however emotional and mental health problems may relate to the home environment, and in rarer cases reflect *safeguarding* issues such as domestic violence, child abuse or parental substance misuse. Services need to 'Think Family' and ensure they are alert to safeguarding issues.
- **A life course approach.** A life course approach recognises that there are crucial points in peoples' lives where interventions are potentially more effective or when people are more likely to respond. Among children crucial points of intervention include 'at birth', 'in the early years', 'in the school years' and 'in transition to adulthood'. It is important that preventative interventions are planned across the life course and link with adult services. There is often an arbitrary split between adult and child services. It seems important to have close working and a common strategy across child and adult mental health.
- **Building resilience and emotional and mental wellbeing.** Building resilience and teaching children and young people coping skills are an important part of preventing child and adolescent emotional and mental health problems.

8.2 Targeting interventions to those with the highest levels of need

- **High levels of need.** The prevalence of risk factors for emotional and mental health problems varies between districts, with Ashfield and Mansfield generally having the highest prevalence of risk factors in the county. There are a number of high risk groups such as LAC, young offenders, and those with physical illness and/or disability. It is important to target preventative interventions and resources towards those in higher risk geographical areas and high risk groups.

- **Making the best use of specialist services and limited funds.** Services and funding are limited, and with reported increased demand upon services, ensuring services are used appropriately is key. This HNA has highlighted that demand varies between Tier 2 teams at a district level. This HNA would support differential funding with areas of highest need receiving higher levels of funding.
- **Less common conditions but high cost.** It is important to highlight Eating disorders as a particular condition that can lead to high costs associated with extended inpatient admissions. Eating disorders account for a small percentage of 'reasons for referral' to Tier 2 services, but account for a large proportion of inpatient admissions. Early recognition of eating disorders and management to prevent the need for admissions appears important.
- **Looked after children.** A notable trend within Nottinghamshire has been the considerable increase in numbers LAC. This increase could reflect changes in the prevalence of abuse and neglect, but is also likely to reflect changes in social services and thresholds for children going into care. This considerable increase in numbers increases demand on LAC and CAMHS services.

8.3 Services and Care Pathways: Getting the right care from the right team

- **Children and young people with 'behaviour problems'.** 'Behaviour' was the commonest reason for referral to Tier 2 CAMHS. Many stakeholders reported concerns about appropriateness of referrals for 'behaviour' as not all these children have a mental health problem, but nonetheless families are looking for help and support. There is a need to further explore these issues with patients, families, schools, and service providers to understand 'need', 'service provision' and where gaps are. Potentially there is a need for a 'behaviour pathway' to assist patients, families and referrers to identify the most appropriate services for the child or young person.
- **Appropriateness and quality of referrals.** In some cases referrals coming via the SPA are poor quality, giving little clinical information or information that allows assessment of risk. Providing clear information about how to refer to CAMHS, and/or the use of a common referral form could improve referrals.
- **Children on the boundaries of services.** A gap in current service provision appears to be when children do not meet the threshold for Tier 3 CAMHS but require longer term work. Tier 2 has been commissioned to provide short interventions. Another gap are children on the edge of care who are very vulnerable but do not meet the criteria to be seen by the LAC CAMHS team.
- **'Walking with people, not carrying people'.** At times it appears to be important to manage patient and family's expectations of services, and manage expectations about the point at which patients are discharged from CAMHS.
- **Changes to the SPA.** There are proposed changes to the SPA where Tier 2 teams will review referrals, rather than referrals being reviewed in Tier 3. This change appears appropriate based upon the high percentage of referrals to the SPA that are for Tier 2 teams. Concerns were raised about capacity of some Tier 2 teams to screen referrals and any risks of the change. It will be important to monitor this change over time.
- **Movement of patients between Tiers of CAMHS.** Teams within Tier 2 and 3 CAMHS use different computer systems and in some cases different assessment forms. Some of these differences are related to different employers. Where possible, ways to ensure smooth transition between Tier 2 and 3 CAMHS should be developed. In particular, ensuring assessments are not repeated where not necessary

8.4 Supporting and building staff

- **CAMHS Workforce.** Central to CAMHS is the staff working within it. There are a number of workforce challenges that face CAMHS, which include recruitment and retention of staff and the

continued development and training of staff. In some teams unfilled posts appear to have increased waiting lists and increased pressure on the team. Workforce issues are recognised in the City and County CAMHS Workforce Strategy.

- **Training of universal services.** Continued training of universal services is needed to build capacity within Tier 1. Consider methods to engage key professional groups in training (e.g. taking account of time constraints, geography). There appears to be a gap in the provision of training to universal services within Bassetlaw.

8.5 Promoting services to children, families and referrers

- **With children, young people and families.** Knowing where to go and how to get help is important for children, young people and families. It is important to raise awareness of what support is available and how to access it through means of communication appropriate to the target group.
- **With universal services.** There was a perception that those working within universal services were not always aware of available local services or the role of CAMHS. Promoting available services and pathways could support local referrers to provide help and support to families.

8.6 Improving local data sources on child and adolescent mental health

- **Local data.** Currently data fed back to the Integrated Joint Commissioning Group is primarily process data from Tier 2. It is felt there is a need for further data, including data from Tier 3 and outcome data to help support commissioners. Work is being carried out at a national level on a minimum dataset for CAMHS. There is also greater use of outcome measures such as SDQ and The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA).
- **Transitions.** A commonly cited concern is about the transition of children from CAMHS to adult services. No routine data are available to identify how many children successfully transition to adult services or how many experience difficulties. An audit of a cohort of children who need to transition to adult care could allow assessment of where particular gaps or difficulties are.
- **National data.** The most comprehensive data on child and adolescent mental health needs comes from ONS surveys. Estimates from these surveys may under- or overestimate numbers of children and young people with mental health problems at a local level (e.g. particularly for districts). At a national level, the development of a model adjusting for risk factors, such as deprivation, could help local areas to produce more accurate estimates of the level of need in their local area.

8.7 Commissioning of CAMHS and Local Strategy

Changes in commissioning arrangements for both CAMHS and Adult Mental Health Services have occurred as a result of the Health and Social Care Act (2012). It is important to ensure discussion and collaboration between CAMHS and Adult Mental Health commissioners across Nottinghamshire County and Nottingham City to ensure (1) good transitions between CAMHS and adult services, (2) collaborative working on care pathways, and (3) identification of priorities.

Those delivering CAMHS services can face relatively complex commissioning arrangements due to the different organisations involved in commissioning CAMHS. As far as possible commissioners need to ensure they integrate and develop common strategies to facilitate effective delivery by the providers.

Summary: Chapter 8 Gaps and Priorities for Action

The important issues or gaps identified from this HNA are:

- **Prevention: Breaking the cycle and taking a life course approach.** Many of the risk factors for child emotional and mental health are linked to the environment they live and grow up in. There is a need to break the cycle, intervene early, 'Think Family' and build emotional and mental resilience.
- **Targeting those with the highest needs.** Preventative interventions (e.g. parenting courses) and CAMHS services need to be targeted to those with the highest levels of need. Groups identified with high levels of need are children and young people living in Mansfield and Ashfield, looked after children and young offenders. Another group to target are those with conditions that are less common but lead to very high healthcare costs (e.g. eating disorders).
- **Services and Pathways.** An identified gap was longer term work for children who did not meet the threshold for Tier 3. 'Behaviour' is a common referral to Tier 2 CAMHS and was identified as a key issue that needed further work and discussion with stakeholders.
- **Supporting and building staff.** Having a sufficient workforce to meet the needs of the population is a key issue. There have been challenges with recruitment to some CAMHS teams. It is important to build and develop universal staff to manage emotional and mental health problems and recognise them early.
- **Promoting services to children, families and referrers.** It is important to ensure universal services, children, young people and families are aware of the services available to support and improve emotional and mental health. It is important to provide information to local referrers to help them support and manage children and families.
- **Improving local data sources on child and adolescent mental health.** Data fed back to the Integrated Joint Commissioning Group tends to be process data, with little evidence of outcomes. Suitable outcome measures need to be identified that take account of the complexities of mental health services.
- **Commissioning of CAMHS and Local Strategy.** There are several commissioners involved in the four tiers of CAMHS services, particularly taking account of the City and County. There are also some changes in commissioning arrangements as a result of the Health and Social Care Act. Commissioners need to ensure they integrate and develop common strategies where possible.

9 Recommendations

9.1 Prevention: Breaking the cycle and taking a life course approach to preventing emotional and mental health problems

- Review parenting course provision and ensure evidence based parenting programmes are targeted to areas of highest need.
- Investigate current management and screening for perinatal mental health conditions.
- Work with schools to implement evidence based interventions to promote emotional and mental wellbeing, anti-bullying interventions, educational/self-help materials for children and parents, and counselling-type interventions. In particular:
 - Roll out the 'Emotional Health and Wellbeing Provision Map' that helps schools to track the progress of specific pupils.
 - Promote the delivery of resilience building and 'coping skills' work within schools.
 - Promote the delivery of emotional learning and problem solving programmes among school children in high risk areas for behavioural and conduct disorders in accordance with NICE guidance. Ashfield and Mansfield are areas with high levels of deprivation and risk factors.
 - Roll out effective interventions identified through the TaMHS programme; the Zippy's Friends programme in Years 2 and 3, and the Circle of Adults programme.
 - Promote 'whole school approaches' to the prevention of bullying.
- Promote a 'Think Family' approach within services:
 - Encouraging adult services to consider the needs of children, (in particular safeguarding issues).
 - Encourage children's services to consider parental mental health and substance misuse as a factor affecting child emotional and mental health, and to signpost/refer to appropriate services.
- Work with multiagency partners to reduce or mitigate risk factors for child mental health problems (e.g. parental unemployment, child poverty, domestic violence). Raise awareness among these teams and services of their role in improving child emotional and mental health and ensure links are made to child mental health in relevant policy and strategy.

9.2 Services and Care Pathways

- This HNA supports the realignment of investment in Tier 2 CAMHS teams according to the level of need so that Mansfield and Ashfield receive a higher level of funding at Tier 2.
- Carry out focused work on 'Behaviour', including engagement with families, schools and other stakeholders to understand the needs of children with 'behaviour problems'. Develop a 'Behaviour pathway'.
- Carry out further work to explore reported increases in self-harm cases.
- Promote the use of a standard referral form for Tier 2/3 CAMHS, to guide referrers on the information to provide, and support triage of referrals from the SPA.
- Integrate IAPT into care pathways and promote to referrers.
- Monitor changes in the SPA to ensure the new system is working effectively, cases are being assigned to the right team and Tier 2 teams have sufficient capacity to review the referrals.

- Ensure collaborative working across Tiers of CAMHS to ensure smooth transition of patients between Tiers and to minimise duplication of assessments.
- Ensure the adoption of evidence based guidelines (e.g. NICE recently published conduct disorder and antisocial behaviour guidance) for the management of emotional and mental health problems within universal services and CAMHS.

9.3 Supporting and building staff

- Commissioners and providers need to recognise particular difficulties related to the recruitment of CAMHS workers, and attempt to minimise these issues to ensure adequate staffing.
- Ensure CAMHS across Tiers 2-4 staff have access to training opportunities and continued professional development opportunities.
- Continue delivery of training to universal services. Consider targeted training to meet the needs of particular professional groups within universal services.

9.4 Promoting services to children, families and referrers

- Consider ways to promote mental health and wellbeing among children and young people (e.g. online resources or social media). Ensure CAMHS service leaflets and information are made available and promoted across the county.
- Ensure information about how to refer to CAMHS and pathways is readily available and easily accessible. For example, via a central website.
- Ensure key universal services are updated about new evidence based guidelines of relevance to their practise.

9.5 Improving local data on child and adolescent mental health

- Develop a core dataset to be reviewed at the Integrated Commissioning Group, taking account of the development of a national CAMHS minimum dataset and the use of outcome measures such as HoNOSCA.

9.6 Commissioning of CAMHS and Local Strategy

- Ensure collaboration of CAMHS commissioners and Adult Mental Health commissioners to minimise difficulties with transitioning children to adult mental health services.
- Contribute to the development of the 'No Health without Mental Health' strategy. Develop and update the Nottinghamshire CAMHS strategy, taking account of the 'No Health without Mental Health' strategy.

9.7 Areas for further work

Through this HNA, areas of further work were identified which include:

- **Transitions Audit.** Consider auditing a sample of young people referred to adult services, to assess numbers of young people who successfully enter adult services, and areas for improvement or learning.

- **Condition specific HNAs.** HNAs have been carried out on specific topics such as ADHD among adults. In future, condition specific HNAs could be carried out for all ages to support comprehensive provision of services across all ages, and minimise transition issues.
- **Tier 1 service mapping.** Tier 1 services within Districts could be mapped and disseminated/made available to local referrers (e.g. GPs, schools, social care), patients and families to facilitate easy identification of available services to meet their needs.
- **Feedback from children, young people, families and schools.** This HNA was broad in scope and so it was not possible to carry out extensive engagement. Focused engagement work could be carried out on particular issues such as “Behaviour” or specific services.
- **Self-Harm.** More detailed analysis of available data and insight from service providers is needed to further explore concerns raised about large increases in the numbers of children self-harming.
- **Analysis of Tier 3 data.** Information governance changes at a national level currently limit the ability of commissioners to access patient identifiable data. As a result there are some limitations with the Tier 3 data presented. Once information governance issues have been resolved nationally, further data analysis could be carried out.

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APPENDICES

Appendix 1: Matrix of Evidence Based Interventions by Age

This matrix was originally developed by Paula Simpson, NHS Knowsley and further developed by Sharon McAteer, NHS Halton as part of Merseyside’s “Children and young people’s emotional health and wellbeing needs assessment” Liverpool Public Health Observatory 2012. It maps out evidence based interventions across the Tiers of CAMHS and by age of child.

Children and Young People’s Emotional Health and Wellbeing Needs Assessment Evidence Based Interventions Matrix					
Level of Need	Age Range				Source of Evidence
	0-4 years	5-10 years	11-15 years	16-19 years	
Tier 1 (universal)	Healthy Child Programme 0-5	Healthy Child Programme 5-19			Ages 0-5: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@d_h/@en/@ps/documents/digitalasset/dh_118525.pdf Ages 5-19: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107566
	Routine postnatal care of women and their babies (includes 'mental health & wellbeing')				http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf
	NICE CG110 Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors				http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110
	Positive parenting -				http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
		NICE PH7 Schools-based interventions on alcohol			http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7

	0-4 years	5-10 years	11-16	Source of Evidence
		<i>'Resilience and Results: How to improve the emotional and mental wellbeing of children and young people in your school'.</i> Guide for schools from the Children and Young People's Mental Health Coalition (2012).		http://tinyurl.com/93qpvue
		NICE PH12 social and emotional wellbeing in primary education	NICE PH 20 social and emotional wellbeing in secondary education	http://publications.nice.org.uk/social-and-emotional-wellbeing-in-primary-education-ph12 http://publications.nice.org.uk/social-and-emotional-wellbeing-in-secondary-education-ph20
			NICE PH4 Interventions to reduce substance misuse among vulnerable young people	http://publications.nice.org.uk/interventions-to-reduce-substance-misuse-among-vulnerable-young-people-ph4
	NICE PH17 Promoting physical activity for children and young people			http://publications.nice.org.uk/promoting-physical-activity-for-children-and-young-people-ph17
	Training for non-mental health professionals			http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
	NICE CG45: Antenatal and postnatal mental health/depression (overlaps into Tier 2)			http://publications.nice.org.uk/antenatal-and-postnatal-mental-health-cg45
Tier 2 (targeted)	Family Nurse Partnership Programme			http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf
	NICE CG89 When to suspect child maltreatment			http://publications.nice.org.uk/when-to-suspect-child-maltreatment-cg89
	NICE TA102 Parent-training/education programmes in the management of children with conduct disorders			http://publications.nice.org.uk/parent-trainingeducation-programmes-in-the-management-of-children-with-conduct-disorders-ta102

	5-10 years	5-19	Source of Evidence
	NICE PH28 Looked After Children		http://publications.nice.org.uk/looked-after-children-and-young-people-ph28
	NICE CG128 Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum		http://publications.nice.org.uk/autism-diagnosis-in-children-and-young-people-cg128
	NICE CG28: Depression in children and young people: Identification and management in primary, community and secondary care		http://publications.nice.org.uk/depression-in-children-and-young-people-cg28
	Talking therapies: A four-year plan of action. Department of Health, 2011:		http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123759
Tier 3 (specialist)	Family Nurse Partnership Programme		http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf
		NICE CG16 Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	http://www.nice.org.uk/guidance/CG16 <i>note on short & long term self harm guidance: no age group given although likely to cover from 11 years onwards mostly. Guidance covers any age of person who self harms, child or adult.</i>
Tier 4 (highly specialist)		NICE 131 Self-harm: longer-term management	http://publications.nice.org.uk/self-harm-longer-term-management-cg133
		NICE CG77 Antisocial personality disorder. Although mostly about treatment of adults it does include prevention amongst children & adolescents	http://publications.nice.org.uk/antisocial-personality-disorder-cg77
		NICE CG72 Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults	http://publications.nice.org.uk/attention-deficit-hyperactivity-disorder-cg72

Appendix 2: Data Sources to Understand Need and Demand for Services

There are no routine data sources that provide estimates of the incidence and prevalence of mental and emotional health conditions among children and young people. Routine data on service use is limited as it tends to only represent those with more severe illness, and is affected by a wide range of factors that affect service uptake (e.g. patient factors, service availability). Data sources are listed below highlighting their use as part of this CAMHS HNA.

Data Source	What can the data source tell us?	Data source useful for this CAMHS HNA?
Primary care data	-Primary care data on consultations and diagnoses are not routinely available for analysis. -Data are available from the Quality Outcomes Framework on certain mental health problems (depression, LD, schizophrenia etc). Unfortunately, it is not possible to identify children from the published data from QoF.	No. QoF data is useful to look at adult mental health.
Primary care prescription data	-Cost or units prescribed of specified drugs for GP practices or CCGs. -Can look at prescribing over time.	No. The available data cannot be separated for adults and children, and is only presented as cost or units of prescriptions (i.e. you cannot identify how many individuals have been prescribed the drug). An extension of the HNA could be to request prescribing data for specific drugs primarily used in children.
Secondary care data	-Admissions to hospital for mental health problems such as self-harm. -Data from CAMHS services. Can assess use of outpatient and inpatient CAMHS services across Tiers 2-4.	Yes. -Data reflects service use and service demand. This does not necessarily reflect <u>need</u> .
National surveys	-Estimates of the prevalence of mental health problems	Yes. ONS have carried out a number of large scale surveys that provide the most comprehensive data on child mental health. These estimates can be applied to the local population to estimate numbers of children and young people with particular disorders. The limitation with this method is that the prevalence of risk factors may vary between Nottinghamshire and England leading to underestimation or overestimation of numbers of cases.
Local surveys	-There have been no local surveys of the mental health of children and young people in Nottinghamshire.	No
Mortality data	-Numbers of suicides among children and young people	Yes. Highly accurate due to the processes of investigating and registering deaths. Suicide numbers among children and young people are small but represent a very severe end of mental illness.
Census	-Demographics of the population. -Prevalence of risk factors within the population. -Changes in prevalence of risk factors over time (between censuses).	Yes. Census recently carried out so likely to be highly accurate.

Appendix 3: Estimated number of children in Nottinghamshire with a mental health disorder, according to disorder type, district and gender

Type of disorder	District	Estimate of number of children aged 5-10 with each disorder in Nottinghamshire County			Estimate of number of children aged 11-16 with each disorder in Nottinghamshire County		
		Male	Female	All	Male	Female	All
Emotional Disorder	Ashfield	91	100	195	179	256	434
	Bassetlaw	81	89	172	171	244	414
	Broxtowe	73	80	156	150	217	366
	Gedling	83	89	176	165	237	400
	Mansfield	75	80	160	149	220	366
	Newark and Sherwood	86	94	184	170	244	416
	Rushcliffe	88	91	180	163	234	396
Conduct Disorders	Ashfield	286	112	399	363	214	573
	Bassetlaw	255	100	351	347	204	546
	Broxtowe	228	89	318	305	182	483
	Gedling	261	99	359	334	198	528
	Mansfield	235	89	327	301	184	483
	Newark and Sherwood	269	105	376	343	204	549
	Rushcliffe	275	102	368	330	196	523
Hyperkinetic disorders	Ashfield	112	16	130	108	17	122
	Bassetlaw	100	14	115	103	16	116
	Broxtowe	89	13	104	90	14	102
	Gedling	102	14	117	99	16	112
	Mansfield	92	13	107	89	14	102
	Newark and Sherwood	105	15	123	102	16	116
	Rushcliffe	107	15	120	98	15	111
Less common disorders	Ashfield	91	16	106	72	46	122
	Bassetlaw	81	14	93	68	44	116
	Broxtowe	73	13	84	60	39	102
	Gedling	83	14	95	66	43	112
	Mansfield	75	13	87	60	40	102
	Newark and Sherwood	86	15	100	68	44	116
	Rushcliffe	88	15	98	65	42	111

Source: ChiMat [accessed March 2013]. Estimates from applying prevalence of each disorder to local populations from the 2011 Census.

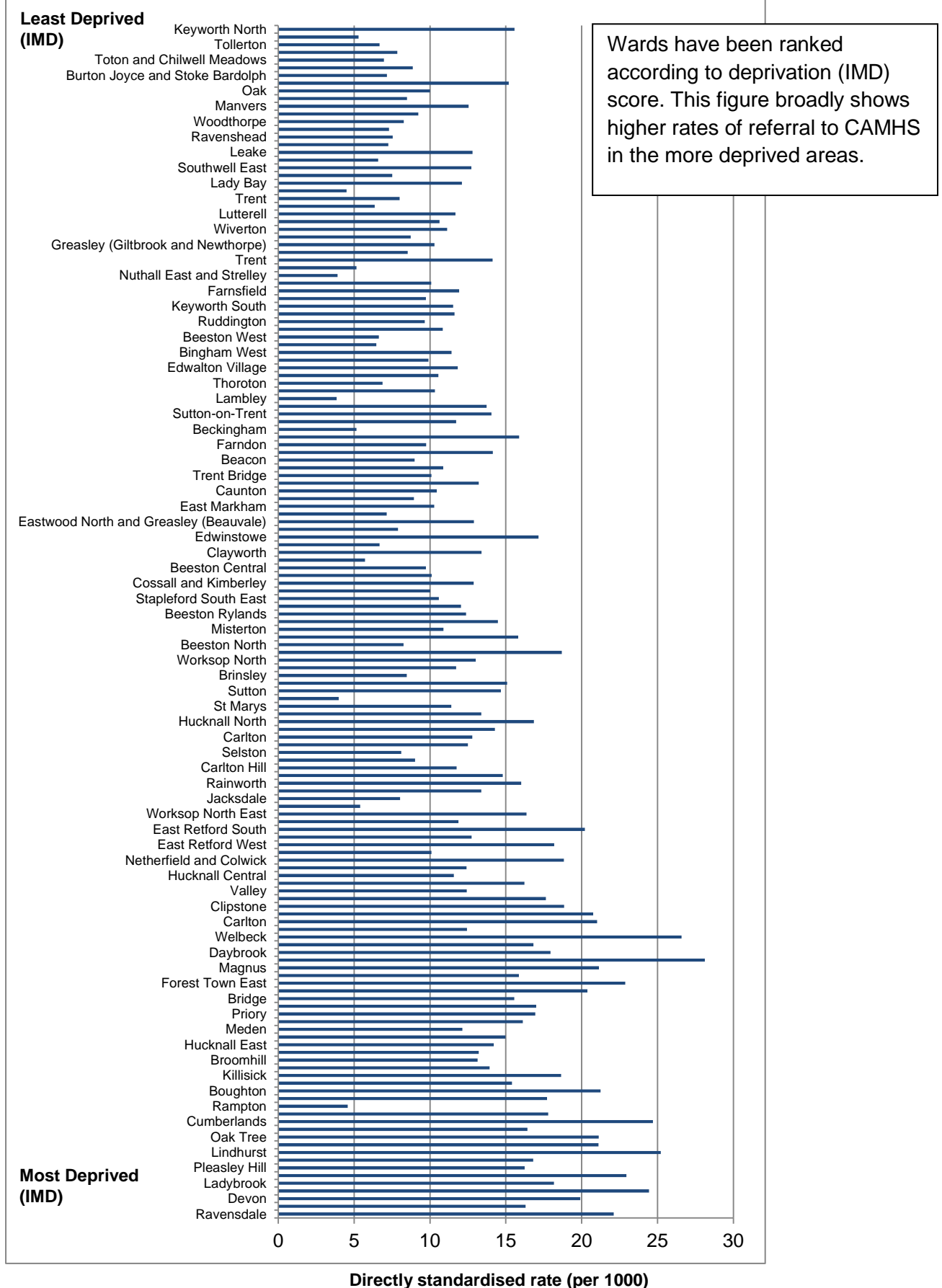
The above table gives detailed estimates of numbers of children with different disorders according to district.

Appendix 4: Reasons for referral to Tier 2 CAMHS. (All referrals)

Reason for referral to Tier 2 CAMHS	Number of referrals 2012/13
Acquired and organic brain disorders	*
ADHD/ASD/Autism	338
Anger	172
Anxiety / anxiety disorders/ adjustment reasons	494
Attachment Issues	13
Behaviour	975
Bereavement and loss	7
Child abuse and neglect	5
Depression/Low mood	519
Eating Disorders	30
Family relationships	85
Obsessive Behaviour	15
Phobia / OCD	24
Other psychoses	25
Post Traumatic Stress Disorder	*
Psychiatric and neurodevelopmental disorders with LD	*
School Phobia	5
Self Esteem	9
Self Harm	178
Sexual Abuse	32
Sleep	11
Substance Misuse	*
Tics and Tourettes	6
Toileting	15
Transition support	5
Vulnerable Children	*
Blank	28
Grand Total	3004

*Numbers less than 5 have been suppressed

Appendix 5: Referrals to Tier 3 CAMHS, DSR per 1000 by ward (2009-2011)



Appendix 6: Interviews with stakeholders

Interviews were carried out either in person or over the phone with the following stakeholders:

- **Laurence Jones**, Group Manager - Targeted Support & Youth Justice Services. Nottinghamshire County Council.
- **Sally Handley**, Senior Public Health Manager, Nottinghamshire County Council.
- **Mary Jarrett**, Troubled Families Co-ordinator, Nottinghamshire County Council.
- **Karl Philips**, Team Manager. CAMHS Emotional Health and Well-being Team Children, Families and Cultural Services Department Nottinghamshire County Council
- **Ros Hill**, District Lead Rushcliffe, Emotional Health and Wellbeing Team
- **Rebecca Stephenson**, Training Lead/Practitioner, Gedling EHWPB Team
- **Gillian Newcombe**, District Lead DEWHS, Broxtowe
- **Yvonne Cottingham**, Team Manager, County CAMHS Children Looked After & Adoption Team
- **Wayne Bradford**, Interim Service Manager CAMHS County Health Partnerships & Service Manager Specialist Community CAMHS
- **Dr Lucy Morley**, Consultant Child and Adolescent Psychiatrist & Clinical Lead for CAMHS
- **Marie Armstrong**, Nurse Consultant SSD - CAMHS - Self-harm team
- **Samantha Sykes**, Clinical Nurse Specialist and Service Lead for:
The Head 2 Head Team; Intensive Interventions Team and Child Psychotherapy in CAMHS.
- **Dr Lisa Hirst**, General Practitioner
- **Dr Trez Jordan**, Clinical Director, Bassetlaw Health Partnership. General Practitioner.
- **Dr Dilip Nathan**, Consultant Community Paediatrician
- **Anne Pridgeon**, Senior Public Health Manager
- **Karon Glynn**, Assistant Director Mental Health and Learning Disabilities, NHS Newark and Sherwood Clinical Commissioning Group.
- **Charlotte Wilkinson**, Commissioning Officer, NHS Newark and Sherwood CCG.
- **Fay Bush**, Director of CASY
- **Maureen Taylor**, Director of Mustard Seed

Appendix 7: Engagement with young people, Youth Council (2013)

CASE STUDIES

"I would not only worry about 'normal things' like my exams, but I'd also worry about what people thought of me, about my family and my future. It brought me sleepless nights of waking up in a hot sweat, feeling overwhelmed and out of control."

WHERE WOULD YOU GO FOR HELP?

- Doctor
- Psychiatrist
- Parents

"I wish people could understand how I feel. Sometimes I go all silly and hyperactive but I do not mean to do it. I get mad sometimes for no reason and can't control it. I struggle to concentrate and pay attention in school."

- Doctor
- School nurse
- Teacher
- Parents
- Pastoral care
- Youth worker

"When I was 12, I started getting overwhelming feelings which I didn't know how to deal with and I didn't tell anyone. Lots of arguments would happen between me and my mum because I couldn't say what was happening to me. I remember getting really upset and the next thing I knew I was running scissors up my arms..."

- Get sectioned
- School nurse
- Doctors
- Child physiologist
- Youth worker
- Councillor
- Therapist
- Parents
- Parental care

"When I got to secondary school is when the bullying really started. Kids would call me all sorts of names and would tease me. The teachers didn't seem to notice. It completely tore me apart. Even kids who said they were my friends would join in bullying when it started. I just felt so alone. I was really angry all of the time because of what had happened to me."

- Pastoral care
- School teachers
- Councillor
- People you trust
- CAHMS
- Lonely
- Cyber bullying
- Parents
- Child exploitation and online protection

"To begin with I wanted to be eight stone, then when I was 8 stone that wasn't good enough and I wanted to be 7 stone. At 7 stone, things still didn't seem to be getting better, so I went down to 6 stone."

- Doctors
- Eating disorder clinic
- Youth worker
- Someone else has to notice
- Lock them in a chippy
- School nurse

"My dad died suddenly leaving just me, my mum and brother. I really struggled afterwards. I felt tired even with the simplest things, getting up in the morning seemed pointless and a hassle. I felt low and often wanted to cry."

- CAMHS
- Teacher
- Base 51 Ngy
- School Counselling
- Bereavement Counselling
- Wouldn't want to go to school
- School health
- G.P
- Youth workers you can trust


Appendix 8: Example of CAMHS Referral form and Booklet, Leeds CAMHS

www.leedscommunityhealthcare.nhs.uk/what_we_do/children_and_family_services/camhs/professionals/referrals/

NHS
Leeds Community Healthcare

Leeds Child and Adolescent Mental Health Service (CAMHS)

Information for professionals



Children and Family Services

About our service

The core purpose of the Leeds Child and Adolescent Mental Health Service (CAMHS) is to improve the emotional wellbeing and mental health of the most troubled children and young people in our city.

Our service seeks to target direct clinical resources to those who have the greatest mental health difficulties. The referral criteria outlined in this document will enable us to achieve this. By doing this we will be in a stronger position to support staff in universal and targeted services who work with children and young people with mental health difficulties.

The Tier 2 service (0-16 teams) and the Tier 3 service have been integrated to provide a specialist CAMHS service across the city.

How to access the service


The service is provided for children and young people up to the age of 18. Please see the diagram in the centre pages for information about care pathways including referral criteria. Referrers to the service include health professionals, educational psychologists and Common Assessment Framework (CAF) lead professionals. For further details you can also visit www.camhs.leeds.nhs.uk.

As a specialist service, CAMHS is commissioned to work with those children in most need of mental health services. It therefore does not offer a service for normal reactions to adverse life events (e.g. bereavement, parental separation) or for difficulties that occur within the normal range of child development.

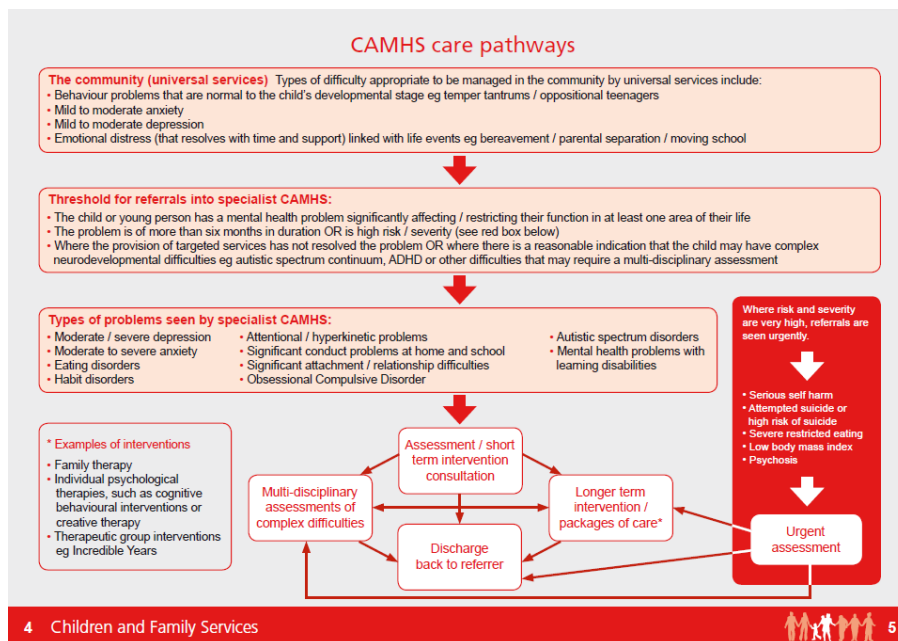
Before they are referred to CAMHS, a child or family may be sufficiently helped through targeted services such as children's centres and extended services. Visit www.thefamilyhubleeds.org for information on local services.

If you as a referrer have safeguarding concerns about a child or young person, guidance can be found on the Children Leeds website at www.childrenleeds.org.uk which will help you decide what to do.

- Common Assessment Framework (CAF) referrals:** where a CAF has identified psychological distress in a child or young person living in adverse circumstances, the child/family may or may not be able to benefit from CAMHS input. In these situations we recommend discussion with your local CAMHS team referral manager/s (see contact details on page 8).
- Social work referrals:** children and young people (including looked after children) who have ongoing social work input should be referred by their social worker to CAMHS via the Therapeutic Services Prioritisation Panel, unless the presentation is urgent, in which case a telephone referral should be made (see contact details on page 8).
- Urgent referrals:** Please see urgent referral box overleaf for guidance. These should be made by telephone during office hours. Outside office hours a child or young person should be brought to Accident & Emergency.
- Children with learning disabilities:** Children with identified learning disabilities may be referred through CAMHS through the normal pathways and do not have to be referred by their social worker to the Prioritisation Panel unless there are also safeguarding concerns.




Children and Family Services



Our work with other agencies

In addition to direct clinical work, CAMHS is commissioned:

- To provide consultation on children and young people's mental health for staff working in both universal settings (such as healthcare professionals, school staff or children's centre staff) and with vulnerable groups such as looked after children and those children who present with the most extreme and challenging difficulties.
- To provide a rolling programme of training through the CAMHS training unit on a variety of topics related to children's mental health.



Children and Family Services

Our standards

Our service is based on the following standards:

- We endeavour to work respectfully and collaboratively with children, young people and their families who have contact with our service.
- Safeguarding children and young people is of paramount importance.
- Public and patient involvement is high on our agenda. We provide opportunities for young people and their families to tell us about their experiences of our service and to advise us on proposed changes in service delivery.
- Our priority is to understand each child's or young person's difficulties through consideration of their individual circumstances and characteristics. The assessment informs further action.
- All children and young people identified as needing urgent assessment will be offered an appointment to be seen within 3-5 working days. This includes young people who have attempted suicide or seriously harmed themselves but who were not admitted to hospital.
- All children and young people will have a named clinician allocated to their care.
- The CAMHS staff are committed to working closely with staff in other services and agencies wherever possible and helpful.
- CAMHS provides a mental health assessment prior to discharge for all young people admitted to hospital following an episode of self-harm or attempted suicide. The young person is also offered a follow-up appointment and further intervention as necessary.
- We strive at all times to offer a service informed by the best available evidence and best practice guidance. This is supported by our governance structures.

Children and Family Services

How to refer

Ideally, referrals should be made on the CAMHS referral form with all mandatory fields completed. However a completed Common Assessment Framework or a referral letter that contains the mandatory information will be accepted.

Referral forms can be downloaded from the website: www.camhs.leeds.nhs.uk

Urgent referrals should be made by telephone using the numbers below.

If you are in any doubt about the appropriateness of the referral, please contact your local CAMHS team (details below).

South CAMHS
12a Clarendon Road
Leeds LS2 9NN
Tel: 0113 295 1760
Fax: 0113 295 1761

West CAMHS
Armley Moor Health Centre
95 Town Street
Leeds LS12 3HD
Tel: 0113 295 3491
Fax: 0113 295 3475

East CAMHS
Osmondthorpe One Stop Shop
81a Wykebeck Mount
Leeds LS9 0JE
Tel: 0113 293 6090
Fax: 0113 293 6095

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NHS Leeds Community Healthcare is responsible for providing healthcare services in the Leeds area and is hosted by Leeds Primary Care Trust (NHS Leeds)

Children and Family Services



CHILD AND ADOLESCENT MENTAL HEALTH
REFERRAL FORM

*Fields are mandatory. Failure to complete them will result in the referral being returned

* Referral Date:		* Child's Name:		* Child's DOB:		Age:	
* Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	* Ethnicity:		* Disability:	<input type="checkbox"/> Y <input type="checkbox"/> N	NHS No:	

* Does the child have an allocated Social Worker? Yes / No
(If yes, the social worker needs to make the referral via the Prioritisation Panel)

* School/College Attended: _____
School/College Contact Name: _____
School/College Tel. No. _____

PARENT/CARERS DETAILS				
* Contact Address:		* Parent/Carer Name:		
Child's Address (if different)		* Parent/Carer Name:		
		* Home Tel. No.		
		Work Tel. No.		
		Mobile Tel. No.		
	Other Tel. No.			
* Communication Requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No	Siblings:	Name	DOB/Age
If yes, please specify e.g. interpreter, language, parent/carer special needs				
Religion: _____				

REFERRAL DETAILS				
* Referrer's name				
* Referrer's Profession:		* Referrer's address:		
Is this a re-referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Referrer's Tel:		
* GP Name:		* GP Address:		
GP Tel. No.				
Has referral been discussed with family?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

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CRITERIA FOR REFERRAL TO CAMHS

- The child/young person has a mental health problem significantly affecting/restricting their function in at least one area of their life.
- The problem is of more than 6 months duration **OR** is high risk/severity.
- The family of the referred child is motivated to attend the Child and Adolescent Mental Health Service to help their child.

Specialist CAMHS is commissioned to work with those children in most need of mental health services and therefore does not offer a service: a) for normal reactions to adverse life events (eg bereavement, parental separation), b) for difficulties which occur within the normal age range of child development or, c) for those difficulties that would respond to the provision of targeted services or services accessed through the CAF process.

* When did the problems start?

* Please describe the problem and in what ways the problem is adversely affecting the child and family:
(Please identify specific mental health concerns)

What has been done to address the difficulty?

WHICH OTHER SERVICES / PROFESSIONAL ARE OR HAVE BEEN INVOLVED TO ADDRESS THE PROBLEM?

* NAME	* AGENCY	TELEPHONE NO.

* Do you have safeguarding concerns about this child, or any other risks in this family which would be helpful for us to know about, e.g. parents with a history of violence? Y/N

If so, please describe and detail any action taken:

Risk Factors (if relevant)	Yes	No	If yes please comment
Suicidal thoughts			
Harm to self			
Harm to others			
Self neglect			

What does the referrer/family think will help?

Referral form completed by: (please print)	Signed:	Date: