

Children and young people's mental health and wellbeing needs assessment

February 2016



**Brighton and Hove
Clinical Commissioning Group**



**Brighton & Hove
City Council**

Children and young people’s mental health and wellbeing needs assessment – Brighton & Hove 2016

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Glossary

ABICCUS	Acquired Brain Injury Children’s Community Service
A&E	Accident and Emergency Department
ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Services
ASB	Anti-social Behaviour
ASC	Autistic Spectrum Conditions
ASD	Autistic Spectrum Disorder
B&H	Brighton and Hove
BHCC	Brighton & Hove City Council
BICS	Brighton Integrated Care Service
BME	Black and Minority Ethnic Groups
BSUH	Brighton and Sussex University Hospitals NHS Trust
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CG	Clinical Guideline
CHIMAT	National Child and Maternal Health Intelligence Network
CLDT	Community Learning Disability Team
CSE	Child Sexual Exploitation
CSU	Commissioning Support Unit
CVS	Community and Voluntary Sector
CYP	Children and Young People
DBT	Dialectical Behaviour Therapy
DLA	Disability Living Allowance
DNA	Did Not Attend
DV	Domestic Violence
EDS	Eating Disorder Service
EIP	Early Intervention in Psychosis
FAST	Families and Schools Together
F.E.	Further Education
FFT	Functional Family Therapy Team
GP	General Practitioner
IAPT	Increasing Access to Psychological Therapies
ID	Identity
IMD	Index of Multiple Deprivation
ITF	Integrated Team for Families
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Children
LD	Learning Disabilities
LGBT	Lesbian, gay, bisexual and Transgender
LGBU	Lesbian, gay, bisexual and unsure
LSCB	Local Safeguarding Children Board
LSE	London School of Economics

LSOA	Lower Super Output Area
MCP	Multispeciality Community Provider
MDT	Multidisciplinary Team
MH	Mental Health
MUPS	Medically unexplained physical symptoms
MYE	Mid Year Estimates
NEF	New Economics Foundation
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NSF	National Service Framework
NEET	Not in employment, education or training
OCD	Obsessional Compulsive Disorder
ODD	Oppositional Defiant Disorder
ONS	Office of National Statistics
OOH	Out of Hours
OT	Occupational Therapist
PaCC	Parent Carers' Council
PATHS	Promoting Alternative Thinking Strategies
PH	Public Health
PMHW	Primary Mental Health Worker
PPSS	Paediatric Psychology Support Service
PRESENS	Pre School Special Educational Needs Service
PTSD	Post traumatic stress disorder
Q	Quarter
RACH	Royal Alexandra Children's Hospital
RCT	Randomised Control Trial
SAWSS	Safe and Well at School Survey
SDQ	Strength and Difficulties Questionnaire
SEND	Special Educational Needs and Disabilities
SENCO	Special Educational Needs Co-ordinator
SPFT	Sussex Partnership NHS Foundation Trust
SSV	Seaside View
TAF	Team around the Family
TAPA	Teen to Adult Personal Advisers Service
TFC	Treatment Foster Care
UCL	University College London
UKRP	UK Resilience Programme
WTE	Whole Time Equivalent
YAC	Youth Advice Centre
YMCA	Young Men's Christian Association
YOS	Youth Offending Service
YPC	Young People's Centre

1. Introduction and background

Children and young people's mental health and wellbeing are important for the future life chances of each individual. Over half of all mental ill health starts by the age of fourteen and seventy-five percent of cases have developed by the age of eighteen years.¹ For those affected it can have a negative impact on their physical health, education and work prospects and increases the chances of shortening the length of their life.

The aim of this Joint Strategic Needs Assessment (JSNA) is to identify the mental health and wellbeing needs of children and young people (0-25 years) in Brighton & Hove. It is also to review this in light of existing assets within the City and provide evidence on the most effective ways of addressing the identified needs, and then to recommend priorities and actions for commissioners to consider.

The JSNA was led by Public Health with support from Brighton & Hove Clinical Commissioning Group's (CCG) Commissioner for Children and Young People's Mental Health. It was overseen by a multi-agency steering group which included representation of parents and children and young people through the Youth Council. The needs assessment was conducted between February and December 2015.

This report draws together information which has been gathered using the following main approaches:

- A review of relevant published research
- An analysis of data on risk factors, prevalence and of service data
- A qualitative analysis of the voice of local children and young people, and their parents/carers gathered from people in the city via an online survey and through focus groups
- A qualitative analysis of semi-structured interviews with professionals and other stakeholders to collate their voice.

The information collected is being used to help inform the children and young people's mental health services review and development of the Local Transformation Plan.² The publication *Future in Mind (2015)*³ stressed the importance of good evidence based data to inform the allocation of resources to children and young people's mental health and wellbeing services and the need to engage children, young people and their parents in the future development of services.

This JSNA covers Tiers 1-3 Child and Adolescent Mental Health Services in Brighton and Hove (*fig. 3 page 40 for information on Tiers*) which are provided by a range of statutory and non-statutory organisations including health, education, social care and voluntary sector. It does not include Tier 4 services in depth because these are commissioned by NHS England rather than Brighton & Hove CCG and City Council.

The term CAMHS is often used as short hand for all Child and Adolescent Mental Health Services. It should be noted though that people use this term in different ways. For some it means all services from Tiers 1 to 4, while for others it relates to the specialist health services of Tiers 3 and 4. For this reason it can be a confusing term and where possible in this report it has been used in the context of the specific Tier to which it is referring.

2. Key issues and gaps

2.1. Key issues and gaps related to data and evidence

This needs assessment has identified a number of issues and gaps related to data and evidence. These include a lack of information on the ethnicity of children and young people with mental health problems in the City, including the mental health needs of young migrants, refugees and asylum seekers. Not all schools based counselling services make their activity and outcomes data systematically available to assist commissioners with service planning. A lack of standardised recording of outcomes or user feedback across Tiers 1 and 2. The number of 16-17 year olds recorded as transitioning to mental health services is also low and requires further investigation, as this is data which could assist commissioners in developing and monitoring transition.

2.2. Prevalence and service provision issues

There are some gaps in prevalence data: mental health prevalence data is not available by geographic locations; there is little reliable data on the prevalence rate of mental health disorders in preschool children (although population risk factors give an indication of how at risk under 3s are of having poor social and emotional wellbeing. The Department of Health are devising developmental outcomes for two to two and a half year olds as part of the Public Health Outcomes Framework 2016) and there is limited data available on the prevalence of medically unexplained physical symptoms in children and young people in Brighton & Hove.

Some of the factors in Brighton & Hove that increase the risk of developing mental health problems include: the higher than average number of families that are statutorily homeless; the high percentage of children in care; the high proportion of young people who are not in education, employment or training, particularly those with special educational needs and disabilities; and those living in a household at high risk of domestic violence.

Issues identified that may have implications for service provision include the projected increase in the 10-14 year old cohort by 11.5% over the next ten years. This will increase the need for school based mental health promotion and counselling services to meet the needs of this age group. The current increasing demand for counselling has led to the closure of waiting lists on occasions. Tier 3 and some Tier 2 services are seeing an upward trend in referrals, as well as an increase in their complexity and severity. Referrals to Tier 3 have increased by 11%, with a 29% increase in referrals to the Teen to Adult Personal Advisers (TAPA) service. Referrals to the Urgent Help service have increased by 48% since 2010/11. There have been an increasing number of children and young people presenting to services with depression and anxiety. Attendance rates at A&E for self-harm have increased since

2011/12 and the rate of hospital admissions amongst 10-24 year olds is higher than for England. LGBU individuals in schools and colleges are at greater risk of self-harm.

Brighton & Hove is ranked low compared to other local authorities for the psychological wellbeing of Children in Care.

There is a gender divide in the presentation to and use of mental health services, with more females than males accessing services, particularly counselling.

Children, young people, parents and some professionals expressed the view that they could not access services because of high eligibility thresholds and where they were eligible they faced long waits for appointments. They wanted early help and support when they needed it, including within schools. They wanted services to be more young people friendly, listening, locally accessible, with improved information and choice in treatments provided. They wanted better communication between professionals and improvements in the service provision for transition into adult mental health services.

3. Recommendations for commissioners' consideration (outcomes and strategies to achieve them)

The issues highlighted in this JSNA mirror many of those found at a national level in Future in Mind.³ These include the gap between increasing need and availability of treatment services; accessibility difficulties with long waits for referrals and appointments; variable access to out of hours services and specific issues for vulnerable groups of children. Public Health England recommendations to local authorities for improving the health and wellbeing of young people included: holistic services; focus on prevention and intervention; support to build resilience; appropriate support at each Tier; no wrong door; all staff appropriately trained to deliver assessment and interventions that are needed and young people friendly settings. These issues have been incorporated within local recommendations for Brighton and Hove in Section 3.1. in five main themes:

1. Increase early intervention and prevention
2. Develop integrated care pathways and working together
3. Increase accessibility of services
4. Increase support for parents/carers
5. Commissioning for outcomes.

3.1. Recommendations for commissioners' consideration (outcomes and strategies to achieve them)

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
a) Increase early Intervention and prevention	a) Children, young people, parents and carers told us they want early help and support with their mental health and wellbeing difficulties from GPs, and Schools.	Pages 65, 70, 74, 81, 83, 87	<p>Right Here are working with GPs on auditing how Primary Care can improve support to young people with mental health/emotional wellbeing issues.</p> <p>A Locally Commissioned Service for children and young people with complex needs is being developed in primary care. An all ages Primary Mental Health Service (Wellbeing) will make more early intervention resources available to GPs.</p> <p>Public Health Schools Programme includes help and support for emotional health and</p>	<p>1. GPs protected training time to include knowledge of CYPs mental health, local services and how best to provide support.</p> <p>2. Work closely with schools and children's centres to improve support for children's mental health and emotional wellbeing issues.</p> <p>3. Work with schools to understand the school counselling provision to ensure equity and access can be improved across the City.</p> <p>4. To be linked into provision for early help and support across</p>	<p>Commissioners, GPs</p> <p>Commissioners, Schools, Children's Centres</p> <p>Commissioners, Schools</p> <p>CCG, Early Help Hub</p>

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
			wellbeing.	agencies and services.	
	b) Need for help and support at early life stages before mental health difficulties have arisen.	Pages 27, 32	Early access to help is a key element of the Happiness: Brighton & Hove Mental Health and Wellbeing Strategy. ⁴ A specialist perinatal mental health service is provided which includes some parent infant psychology support.	5. Learn from the whole school approach to mental health and emotional wellbeing pilot in 3 secondary schools and joint training between schools and CAMHS in 11 schools across the City and roll out as effectively as possible within available resources.	CCG Commissioners, Children's Services, BHCC and Public Health
	c) Some individuals are at increased risk of depression, and	Pages 36,57	Support within the Royal	6. Review how far local perinatal mental health services meet the vision set out in The 1001 Critical Days ⁵ report and further develop parent infant psychology services for example scoping the attachment training needs of the health and early years workforce linking with	CCG Commissioner, Perinatal mental health services.

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
	<p>anxiety in the current economic climate. Some services have increased numbers of referrals for complex mental health problems including self-harm.</p> <p>d) Young people are at increased risk of developing mental health problems due to difficulties around accommodation, employment, family breakdown, domestic violence, parental mental ill health and engaging with services.</p>	Pages 62, 63	Alex Children's Hospital has been established (Nov 2015) with the implementation of a Paediatric Mental Health Liaison Team.	<p>Children's Centres.</p> <p>7. Continue to implement interventions to promote resilience e.g. Five Ways to Wellbeing, develop and implement the Mental Health Strategy.</p> <p>8. Develop a crisis response service especially focused on out of hours support</p> <p>9. The Youth Review should consider the possibility of youth services providing alternative services models (e.g. a one stop shop model), bringing together support with accommodation, employment and mental health</p>	<p>Commissioners and service providers.</p> <p>Commissioners and SPFT</p> <p>Commissioners and Youth Service, 3rd Sector</p>

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
				10. Consider how Teenage to Adult Personal Advisor (TAPA) model and service can be further resourced and changed to provide improved support, particularly for those who do not engage with the service.	Commissioners, SPFT
b) Develop integrated Care Pathways and Working Together	a)There is evidence that the needs of specific groups are not being met within services e.g. Autistic Spectrum Conditions, Learning Disability, Eating Disorders, Gender Identity, Substance misuse, Medically Unexplained Physical Symptoms, Children in Care and those in Transition between CYP and adult services.	Page 18, 19, 79, 80, 81, 84, 87, 88 Page 93	CYP ASC Scrutiny recommendations are being implemented to clarify the pathway and joint working on autism. A Sussex wide Community Eating Disorder Service is currently developing and commissioning a service model as part of the Transformation Plan. A Children and Young People’s Mental Health and Wellbeing Partnership group has	11. Commissioners to ensure these unmet needs are addressed as part of the development of future integrated pathways. 12. Develop a whole system forum and opportunities for sharing information and understanding between agencies.	Commissioners Commissioners and providers

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
	b) Need for a high level integrated commissioning pathway		been established.	13. Adopt a high level integrated commissioning pathway as outlined by NHS England in 2015, in the Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tier 2/3)	Commissioners and providers
c) Increase accessibility of services	<p>a) Information and support available in one place</p> <p>b) A proportion of young people make initial contact with a service but then decide not to proceed with allocated counselling sessions.</p>	<p>Pages 42, 65, 76, 77, 84, 87</p> <p>Page 68, 82</p>	<p>Many websites are available that attempt to signpost and direct you to the right support such as “Where to go for?”, “Find Get Give” and online counselling (E-Motion)</p> <p>The Teenage to Adult Personal Advisors (TAPA) service is already established.</p>	<p>14. Review online provision (involving young people and carers/parents) to ensure information and support are easy to access.</p> <p>15. Review the settings CAMHS are provided in to ensure they are youth friendly.</p> <p>16. Further develop mental health resources</p>	<p>Commissioners and providers</p> <p>SPFT</p> <p>CCG, Public Health and Children’s</p>

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
	<p>There is dissatisfaction with the current appointment and assessment process in Tier 3. Some professionals felt the Choice and Partnership Approach (CAPA) was not designed for their complex case loads.</p> <p>c) Target in an appropriate way those at risk groups who have a low uptake of services. i.e. LGB, Young Men, CYP with a Gender Identity issue, and those who don't visit the GP.</p>	Page 45	Right Here has investigated barriers to counselling for young men and how to make GP Practices more youth friendly.	<p>in schools and youth settings.</p> <p>17. Review and change the current service model and resource to ensure that those CYP who do not attend their appointments (DNA) are followed up, and remain engaged with their treatment.</p> <p>18. Consider how services can be targeted and delivered in an appropriate way to be acceptable to these groups.</p>	<p>Services work in partnership with schools and youth services.</p> <p>Commissioners and providers</p> <p>Commissioners and providers</p>

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
d) Increase support for parents/carers	a) Parents and carers did not feel involved in their child's care	Page 75	Highlighted in the Local Transformation Plan as an issue to be addressed	19. Ensure implementation of the proposed health promotion post identified in the Transformation Plan to improve parent/carer reported knowledge and support. 20. Work with parents and carers to develop support models (including online resources) e.g. peer support	Commissioners Commissioners and providers
	b) Young people and parents/carers of children with autistic spectrum conditions (ASC) felt there was a lack of information and support available for them.	Pages 71, 79,80,82	An ASC working group has been established with a clear action plan.	21. Develop a support package as part of the care pathway for parents with CYP with ASC but no mental health problem. Requires whole system approach, not just mental health services (includes Children's Services).	Commissioners and providers

Key Themes	Issues identified by JSNA	Evidence	Progress so far	Recommendation	Who?
e) Commissioning for outcomes	There is a lack of consistent and outcomes focused data collection across services and across the whole system.	Page 41,43, 46	Both commissioners and providers have committed to implementing Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) and joining the London and South East learning Collaborative, as indicated in the Local Transformation Plan.	22. Implement the principles of outcomes focused data collection used in CYP IAPT.	Commissioners, all providers in conjunction with children, young people and their families.
			A whole system workshop has been held (Oct 2015) outlining next steps.	23. Introduce outcomes focused commissioning.	Commissioners

4. The roles of legislation and policy

This section looks at the national and local policy context of child and adolescent mental health and wellbeing support and provision.

4.1. National

Improving children and young people's mental health has been high on the national policy agenda in recent years and many documents have been published to provide guidance on the development of services including: *Together we stand*(1995),⁶ *Children in Mind*(1999),⁷ *Every Child Matters*(2003),⁸ *The NSF for Children, Young People and Maternity Services*(2004),⁹ *National CAMHS Review*(2008)¹⁰ *No Health without Mental Health* (2011),¹¹ *Making mental health services more effective and accessible* (2013),¹² *Closing the gap* (2014).¹³

The most recent publication of relevance for this JSNA is *Future in Mind* (2015).¹⁴ This reported the recommendations of the Children and Young People's Mental Health and Wellbeing Taskforce to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

Evidence presented to the Taskforce highlighted the complexity and severity of challenges facing Children and Adolescent Mental Health Services (CAMHS). These include:

- Gaps in data and information and delays in the development of payment and other incentive systems
- The gap between rising need and available treatment
- Difficulties in access due to increases in referrals and waiting times
- Complexity of current commissioning arrangements
- Variable access to crisis, out of hours and liaison psychiatry services
- Specific issues facing highly vulnerable groups of children.

To address these issues the report sets out a number of aspirations the Government would like to see achieved by 2020.

- Improve public awareness of children and young people's mental health, to create less fear and stigma/discrimination
- Having access to clinically effective mental health support when needed – including access and waiting time standards
- Move away from the Tiered model of care, to a child centred model based on need – with in most cases the CCG acting as lead commissioner working collaboratively with the local authority. Transition from children's to adult's services should be based on a child's needs rather than age
- Outcomes focused services using evidence based treatments.

The NHS *Five Year Forward View*¹⁵ was also published in 2015 and included a focus on prevention, access and quality. Aspects pertinent to children and young people's mental

health services included: the need for support for new mothers and babies; mental health promotion within schools and getting help early to stop mental health problems escalating.

The Public Health England framework, *Improving young people's health and wellbeing (2015)*¹⁶ makes recommendations about what local authorities should be offering to children and young people, which is also relevant within the context of this JSNA.

- A holistic health and wellbeing offer which addresses all factors affecting the young person rather than single health issues
- A focus on prevention as well as intervention
- Support to help build their resilience and life skills working with others including schools, families and communities
- Provision of appropriate levels of support across universal, targeted and specialist services
- A “no wrong door” service approach so that young people may access or be referred to the service they need regardless of which organisation/service they initially contact
- That staff and organisations are trained and are delivering services in age appropriate, young people friendly settings.

4.2. Local context

In Brighton & Hove several key documents have been produced to support improving children and young people's mental health.

4.2.1. Happiness: Brighton & Hove Mental Health and Wellbeing Strategy. Brighton & Hove CCG and Brighton & Hove City Council. 2014¹⁷

This Strategy applies to all ages and covers the period from 2014-2017. Its focus is on improving resilience and mental wellbeing and preventing mental ill health, as well as ensuring there are responsive high quality services and support available. It promotes the *Five Ways to Wellbeing* (Connect, Learn, Be active, Take notice, Give) as the means to promoting personal resilience. The action plan includes the following actions related to children and young people:

- Working through the Public Health Schools Programme to promote and support emotional and mental health in students and parents and increase onsite access to Tier 2 support
- Facilitating access to early help through online counselling, Early Help Hub, Triple P parenting programme and support for parents carers and families living with mental ill health
- Working with youth providers to target the prevention of self-harm
- By working with children, young people and families, ensure services are children and young people friendly, and carry out a service review
- Developing proposals for models of care across Transition from child to adult mental health services.

4.2.2. Brighton & Hove Early Help Partnership Strategy 2013 -2017

This Strategy outlines five priorities for delivering evidence based early interventions for children and families, co-ordinated through an Early Help Hub. The priorities are:

- Establishment of an Early Help Hub, to improve the assessment of problems facing children and families and to ensure prompt access to the right support services
- Delivering evidence-based Early Help of high quality and value for money
- Implementing a workforce development strategy to support the delivery of priorities in the Early Help Strategy, focusing on building capacity and skills of the children's workforce to deliver effective Early Help
- Developing parenting capacity across the city and increasing the engagement of all parents and carers
- Improving services around key issues for parents and families which impact on outcomes for children and young people.

4.2.3. Services for Children with Autism Scrutiny Panel report. April 2014. BHCC

This Scrutiny Panel report examined the services available for children with autism in the City, including those that are provided by the Integrated Child Development and Disability Centre at Seaside View. It makes a number of recommendations relating to CAMHS. These include:

- Seaside View and CAMHS should have a nominated keyworker specifically for autism
- A clear pathway is needed in CAMHS for children and young people with autism but no learning disability or mental health issue
- Home support packages should be developed with parents
- Seaside View and CAMHS need to make sure parents are at the centre of services and comprehensive feedback systems for parents and publicly accessible monitoring procedures should be put in place
- A clear and unambiguous statement should be made of where responsibility lies for performance at all CAMHS Tiers
- Assessments of need shouldn't be wholly clinic based but should include assessments in home and social environments
- Where appropriate reports by private educational psychologists should be accepted by CAMHS as sources of information.

4.2.4. Right Here – How to provide youth-friendly mental health and wellbeing services

Right Here was originally a five year, £6m initiative jointly managed by the Paul Hamlyn Foundation and the Mental Health Foundation running from 2009 to 2014 and continues to operate as a mental wellbeing project. It aims to develop new approaches to supporting mental health and wellbeing for young people in the UK aged 16-25 years focusing on intervening early to help young people at risk of developing mental health problems and to tackling the stigma associated with mental health that often prevents young people seeking help. It originally operated across four different projects in Newham, Brighton & Hove, Sheffield and Fermanagh.¹⁸

This report identifies barriers to youth friendly mental health and wellbeing services and makes the following recommendations:

- Extend CAMHS up to 25 years and include help with physical and social issues, not just mental health. Creative responses are needed to extend CAMHS provision, e.g. including the third sector and youth counselling as part of the early intervention care pathway. Developing multi-professional CAMHS Tier 2 hubs to include substance misuse and sexual health workers
- Improve Transition to adult mental health services by talking to young people about their fears; advance planning; building relationships with services to be Transitioned to; flexibility over age of Transition; alternative support for those who don't meet the threshold criteria for adult services; follow-up young people who disengage from adult services; redesign the care pathway for autistic spectrum conditions
- Make Adult Mental Health Services young people friendly by involving young people in designing promotion materials; activities rather than services will draw young people in; simplify the referral and assessment process.

4.2.4.1. Evaluation of Right Here. November 2014¹⁹

This qualitative report identifies key achievements from the four Right Here sites.

- Experienced youth workers were able to combine youth work with mental health expertise, in their support of young people
- A range of creative techniques were developed for getting mental health messages across to young people and commissioners based on a participatory co-production approach with young people
- Where appropriate projects delivered gender based activities
- Young people were supported to have mature informed debate with health care commissioners and practitioners.

In Brighton and Hove, Right Here continues to provide resilience building activities for young people. These include: creative arts, walk and talk, anger management, a mental health promotion group to combat stigma, young men's health champions and creation of digital tools such as the *Where to go for?*²⁰ web site.

4.2.5. SEND Review report (Special Educational Needs and Disabilities, including Behavioural, Emotional and Social Difficulties). BHCC and Brighton & Hove CCG. February 2015.

In July 2015, the Health and Wellbeing Board agreed to the direction of travel for the SEND review, including its recommendations to merge the review of services for children and young people with special educational needs and disabilities with the review of services for children and young people with learning disabilities, due to their overlaps. The vision is the development of integrated education, health and care and a person centred approach. The SEND report made recommendations relating to six areas to be implemented by September 2016, these included: Joint commissioning; integrated service delivery; support for families with disabled children; learning and achievement for children with SEND; Transition to adulthood and emotional and mental health.

4.2.6. Local CAMHS Transformation Plan. 2015

An allocation of £250 million a year for the next five years was announced in the 2015 budget to Transform child and adolescent mental health services across the country. This is to be spent on building capacity and capability in services and rolling out of the children's and young people's IAPT Service. A further £30 million a year has also been allocated nationally to establish specialist community eating disorder teams. The release of funding to Brighton & Hove CCG is contingent upon the submission of a local Transformation plan. Once approved this represents £373,000 per annum of the Transformation money and an additional £149,000 for eating disorder services. The Eating Disorders Service is part of a Sussex wide network, delivered through a virtual team in 2016/17.

The Transformation Plan has been based upon the emerging findings of this JSNA, a whole system review involving children, young people, families and staff (including schools). It has also been approved by the Health and Wellbeing Board. From 2016/17, funding will be invested in: digital communications; crisis and out of hours care; children in care; preparation for CYP IAPT; extending TAPA service; extending primary mental health workers in schools; extending outreach counselling in youth settings. As well as developing an all ages community Eating Disorders Service.

Investments have already been made into perinatal mental health services and mental health liaison services at Brighton and Sussex University Hospitals NHS Trust (BSUH).

5. Who's at risk and why?

Key issues

- A higher proportion of the Brighton & Hove population are aged 20-25 years compared with England or the South East, which is important because a higher proportion of the population will be experiencing a time of Transition. This can be critical in determining whether earlier mental health problems persist into adulthood. It is also a time when serious mental illnesses like psychosis can become apparent.
- Boys are more likely to have a mental health disorder than girls.
- Brighton & Hove compares less favourably than England or the South East in a number of potential risk factors for developing mental health problems in children and young people.
 - A higher rate of statutory homeless households with dependent children
 - The 19th highest rate of Children in Care in England
 - A higher proportion of young people than the South East who are not in employment, education or training
 - There are a higher proportion of pupils with Special Educational Needs than nationally
 - The proportion of children living in households at risk of domestic violence has increased by 17% between 2013/14 and 2014/15.
- It is not known what the ethnic composition is of children and young people with mental health problems in Brighton & Hove.

This section of the report outlines the evidence on which groups of children and young people are more, or less, at risk of mental health problems. It also describes those groups within Brighton & Hove.

The information is organised around individual risk factors, but it should be noted that multiple risk factors may be experienced by children and young people, and a combination of these may compound the risk of mental health issues.

5.1. Demographic risk factors

Some demographic factors can contribute to an increased risk of mental health problems in children and young people. This section also includes those that relate to 'protected characteristics' under the Equality Act 2010.

5.1.1. Age

- 1 in 10 children aged 5-16 years has a diagnosable mental health problem and 50% of lifetime cases of diagnosable mental illness begin by age 14²¹

- 94,920 children and young people are aged 0-25 in Brighton & Hove (2013)
- 11% are aged 0-9 years (England and the South East both 12%)
- 11% are aged 10-19 (England and the South East both 12%)
- 13% are aged 20-25 (n=35,911) (England 8%, and South East 7%).

5.1.2. Gender

- Boys are more likely to have a mental disorder than girls. 10% of 5-10 year old boys and 5% of girls have a mental disorder and 13% of 11-16 year old boys and 10% of girls²²
- There are 47,036 females under 25 years in Brighton & Hove and 47,884 males (MYE 2013)
- Boys outnumber girls in the general population until the 15-19 and 20-25 age groups when the trend reverses.

5.1.3. Gender identity

- National studies have found high rates of depression, stress and anxiety in the Trans¹ population. Trans people aged under 26 are twice as likely to attempt suicide.^{23, 24}
- The Brighton & Hove Trans Needs Assessment reported that an estimated 1.2% of the Brighton & Hove adult population identify as Trans (likely to be an underestimate) and that the age distribution is younger than the overall population²⁵
- The Safe and Well at School Survey (SAWSS) 2014 reported that 3% of 14-16 year olds in Brighton & Hove did not/did not always identify with the gender they were assigned at birth.

5.1.4. Ethnicity

- Data taken from the 2004 ONS survey of child and adolescent mental health shows that mental health problems vary with ethnicity. Nationally the prevalence of mental health disorders in Black children aged 11-16 years is 14% compared to 11.5% for White children. There is lower prevalence amongst Indian adolescents, approximately 3%²⁶
- The ethnic composition of children and young people with mental health problems in Brighton and Hove is not known
- 7,375 (24%) of Brighton & Hove School pupils are Black and Minority Ethnic groups, compared to 28% nationally.

¹ The Brighton & Hove Trans Needs Assessment defines trans as “an umbrella term to describe people whose gender identity differs from their assigned sex at birth.”

5.1.5. Religion

- Children and young people can be at risk of developing mental health problems if they experience discrimination as a result of their religion²⁷
- Brighton & Hove has a high proportion of young people with no religion. The 2011 Census showed of 0-24 year olds - 30,641 (35%) were Christians, 2,786 (3%) were Muslims, and 44,155 had no religion (50%). This compared with 32% 0-24 year olds with no religion in England and 36% in the South East.

5.1.6. Sexual orientation

- Gay, lesbian and bisexual people are at higher risk than heterosexual people of mental health problems, substance misuse and dependence, suicide, suicidal ideation and deliberate self-harm²⁸
- The SAWS Survey 2014 reported that 3% of 11-14 year olds described themselves as LGB and 5% of 14-16 year olds.

5.1.7. Children with a disability (including physical disability, learning disability, autism and Medically Unexplained Physical Symptoms)

- Children with a physical disability have a two-fold increased risk of emotional/conduct disorders (characterised by serious antisocial behaviour, including aggressive, destructive and deceitful behaviour and violation of rules²).
- Children with a learning disability have a six and a half fold increased risk of mental health problems, an increased risk of developing psychological problems, two fold increased risk of experiencing anxiety disorders and six fold increased risk of experiencing conduct disorders.²⁹
- People with Autistic Spectrum Conditions (ASC) have high levels of additional needs with 70% having at least one other mental or behavioural disorder and 40% having at least two disorders, most commonly anxiety, Attention Deficit Disorder (ADHD) and Oppositional Defiant Disorder (ODD).³⁰
- In Brighton & Hove there are 1,812 people aged under 25 on the Compass database (March 2015) most of whom have long term conditions. 32% on the database have autism.
- It is estimated that 140 children and young people in Brighton & Hove aged 5-9 have a learning disability (2014), 300 aged 10-14 and 440 aged 15-19.³¹
- 1 in 10 children have Medically Unexplained Physical Symptoms (MUPS). This overlaps with long term conditions and³² can contribute to depression and anxiety.³³ No data is currently available on the prevalence of MUPS amongst children and young people locally.

5.2. Wider risk factors

There are a large number of other factors that can increase the vulnerability of children and young people to experiencing mental health problems. These include: being a migrant, refugee or asylum seeker, living in lone parent households, living in child poverty, attending a short stay school, being home educated, being a young carer, having parents in prison, having low educational attainment, school exclusion or absenteeism, missing from home or care, having a teenage pregnancy or being a teenage parent. More details on these wider risk factors can be found in Appendix 1, as well as protective factors that help in developing resilience against mental ill health.

Table 1 Risk Factors

Factor	Degree of risk	Brighton & Hove context
<i>Homelessness</i>	<ul style="list-style-type: none"> • Young homeless people have twice the risk of depression. • 27% have a diagnosed mental health condition, compared to 7% of non-homeless young people. • They are also at increased risk of suicide, alcohol and drug problems.³⁴ 	<ul style="list-style-type: none"> • The 2014 Brighton & Hove Homeless Health Needs Audit, included 55 people aged 16-25 years, 29% of whom had a diagnosed mental health condition. Depression was the most common condition. • Of all the 16-25 year olds in the survey 13 (26%) had suicidal feelings and 10 (20%) had experienced self-harm. • In 2013/14 there were 317 statutory homeless households with dependent children or pregnant women in Brighton & Hove, a rate of 2.6 per 1,000 households. This is higher than the national average of 1.7 per 1,000 households.³⁵
<i>Children in Care</i>	<ul style="list-style-type: none"> • Nationally, an estimated 45% of Children in Care have a mental health disorder³⁶ • Children in Care are nearly five times more likely to have a mental health disorder than all children 	<ul style="list-style-type: none"> • In December 2014, there were 476 Children in Care. • The Children in Care rate is 95 per 10,000 population compared to 60 per 10,000

Factor	Degree of risk	Brighton & Hove context
	<ul style="list-style-type: none"> • They have a six to seven-fold increased risk of conduct disorder • Four to five- fold increased risk of suicide attempt as an adult.³⁷ 	<p>nationally and 63.5 for comparator authorities. The city's rate was ranked joint 19th highest in England (out of 152) in 2014.</p>
<i>Fostered and adopted children</i>	<ul style="list-style-type: none"> • Children adopted or fostered from care are likely to have experienced trauma or loss and have additional needs resulting from physical, emotional, or mental health difficulties or disabilities.³⁸ 	<ul style="list-style-type: none"> • 46 formerly looked after children were adopted in the year ending 31st August 2015. • 314 children in care were fostered and 51 were placed with family and friends carers at 31st August 2015. 212 (58.1%) were in placements outside of Brighton and Hove. 23 (6.3%) placements were outside of Sussex.
<i>Young offenders</i>	<ul style="list-style-type: none"> • Young offenders have a three-fold increased risk of mental health disorders • Approximately 95% of young people in detention have a mental health problem and 80% have more than one.³⁹ 	<ul style="list-style-type: none"> • There were 47, first time young offenders in 2014/15. • Brighton & Hove has a lower rate of first time young offenders (218 per 100,000 for 10-17 population) compared to 356 for the South East and 402 for England⁴⁰ • Case load data for the Youth Offending Service indicates the majority of offenders were male (69% in Q1 and 84% in Q3 2014/15) • Of 88 clients screened for mental health issues by YOS over 6 months in 2014/15, 18 presented with emotional and behavioural difficulties, 9 anxiety and 7 depression.

Factor	Degree of risk	Brighton & Hove context
<i>Not in employment, education or training (NEET)</i>	<ul style="list-style-type: none"> • Being unemployed or not in training or education between the ages of 16 -18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health. • A Princes Trust study found young people not in work aged 16-25 are less likely to be happy.⁴¹ 	<ul style="list-style-type: none"> • The proportion of 16-18 year olds who were not in employment, education or training has decreased from 5.6% in 2014/15 to 4.7% in 2015/16; this is slightly above the proportion in the South East (3.8%). The three month rolling average for England was 4.2% in January 2016. • 16% of 16-18 year olds with SEND were unemployed, not in training or education (Dec 2014) , higher than England (10%) and South East (9%).This figure rises to 42% of 20 year olds with SEND in Brighton & Hove.⁴²
<i>Pupils with Special Educational Needs</i>	<ul style="list-style-type: none"> • Pupils with statements of Special Educational Needs have a three-fold increased risk of conduct disorder.⁴³ 	<ul style="list-style-type: none"> • A higher proportion of pupils (21%) have SEND compared to 17% nationally. • 3% have a Statement or Education, Health & Care Plan (the same as England) and 18% have SEND without a statement or Education, Health & Care Plan (compared to 15% in England). • 27% had a specific learning difficulty, 21% had speech, language and communication needs, 18% had social, emotional and mental health needs and 12% had moderate learning difficulties as their primary need.⁴⁴
<i>Bullying</i>	<ul style="list-style-type: none"> • Generally children who are bullied have one or more of the following risk factors: are LGBT, have a disability, socially isolated, perceived as being different to peers, or seen as weak, or are depressed, anxious, have low self-esteem, or 	<ul style="list-style-type: none"> • There has been a reduction in the proportion of pupils reporting bullying in primary from 23% in 2009 to 15% in 2014. There has been a reduction in bullying in secondary schools from 26% in 2005 to 12% in 2014. Appearance was

Factor	Degree of risk	Brighton & Hove context
	<p>have few friends.</p> <ul style="list-style-type: none"> Children who are bullies tend to be either well connected to peers and like to dominate or are isolated from others, anxious and depressed and do not have empathy with the emotions of others.⁴⁵ 	<p>perceived to be the most common reason for bullying.⁴⁶</p> <ul style="list-style-type: none"> Those receiving extra help were more likely to have experienced bullying (25%) or to be a bully (13%). Girls (14%) and those who did not identify with gender the they were assigned with at birth (20%) were more likely to have experienced bullying than boys (11%). LGBU students are more likely to be bullied (44%) than heterosexual students (11%).
<i>Alcohol and drugs</i>	<ul style="list-style-type: none"> Alcohol misuse has links to depression, anxiety, personality disorders and psychosis. People self-medicate with alcohol when they are feeling anxious or depressed. Substance misuse can increase the risks of developing psychosis, depression or anxiety. It can make symptoms worse for an existing mental disorder, and can also trigger mental illness where there is an inherited family risk factor.⁴⁷ 	<ul style="list-style-type: none"> An estimated 1,019 per 100,000 11-25year olds were admitted to hospital for alcohol misuse in 2014/15 – a decrease from 1,454 per 100,000 in 2011/12. 30 (15%) clients aged 18-25 in treatment with substance misuse services in 2014/15 were identified with dual diagnosis. 24 (15%) of under 18s in treatment with ru-ok? In June 2015 had a dual diagnosis.⁴⁸ Locally groups of pupils who are more likely to have tried alcohol than all pupils are: older pupils; White British; those who have tried drugs; those who have had sex. Groups more likely to have tried drugs are: boys; older pupils; those who get extra help; have tried alcohol; young carers.

Factor	Degree of risk	Brighton & Hove context
		<ul style="list-style-type: none"> Groups who are more likely to have tried drugs and alcohol are: LGB pupils; pupils who have truanted; been excluded; bullied someone; tried smoking; had sex; tried gambling and those who are not happy.

Parental risk factors

Factor	Degree of risk	Brighton & Hove context
<i>Perinatal mental health</i>	<ul style="list-style-type: none"> Poor maternal mental health in pregnancy and during the postnatal period can have serious consequences for the health and wellbeing of the baby, as well as the mother and family. It is estimated 10-15% of new mothers suffer some form of perinatal mental health difficulty.⁴⁹ The most common perinatal mental health problem is post-natal depression.⁵⁰ It is estimated that 10-20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth.⁵¹ 	<ul style="list-style-type: none"> In 2013/14 it was estimated 10 women in Brighton & Hove had postpartum psychosis; 10 chronic serious mental illness; 85 severe depressive illness; 280-415 mild to moderate depression and anxiety; 85 PTSD; 415- 830 adjustment disorders and distress. In 2014/15, 215 referrals were made to Sussex Partnership Foundation NHS Trust Specialist Perinatal Mental Health Service. 38% were for depression, 26% anxiety and 16% post-natal depression (16%).
<i>Children with parents who have mental health issues</i>	<ul style="list-style-type: none"> Up to 18% of children in the UK live with a parent who has a mental health problem 33% -66% children whose parents have mental health problems will develop problems in childhood or adult life Children whose mothers had mental health 	<ul style="list-style-type: none"> There is no data on the parental status of those receiving mental health support The Brighton & Hove Health Counts Survey 2012 showed that those with children in the household are significantly more likely to report a medium to high level of happiness

Factor	Degree of risk	Brighton & Hove context
	<p>problems are more than twice as likely to develop emotional disorders</p> <ul style="list-style-type: none"> Children of depressed parents have a 50% risk of developing depression by age 20.⁵² 	<ul style="list-style-type: none"> There's no significant difference between those with or without children for anxiety, being at risk of major depression, or self-harm.
Factor	Degree of risk	Brighton & Hove context
<i>Children of parents with substance misuse problems</i>	<ul style="list-style-type: none"> Living with a parent with a substance misuse problem can result in the child developing behavioural problems, problem drinking and is associated with risk taking behaviours. Approximately 30% of children under the age of 16 live with at least one adult binge drinker and 22% with a hazardous drinker.⁵³ 	<ul style="list-style-type: none"> From 2011-14, on average 17% of adults in drug and alcohol treatment were parents.^b In 2014, 438 per 100,000 children aged 0-17 lived with a client in drug treatment. In the 2014 SAWS Survey 206 (2.5%) pupils were concerned about their parent/carer currently using alcohol and 64 (0.8%) were concerned about their parent/carer currently using drugs. They were more likely to feel: anxious, sad, lonely, out of control, or angry and less likely to feel confident or happy.
<i>Domestic and sexual violence and abuse and violence against women and girls</i>	<ul style="list-style-type: none"> Specific impacts on mental health and emotional wellbeing can include post-traumatic stress disorder, anxiety and panic attacks, depression, social phobia, substance abuse, eating disorders, self-harm and suicide⁵⁴ Violence witnessed or experienced in the home can normalise violence in future relationships for both girls and boys.⁵⁵ 	<ul style="list-style-type: none"> 53% of child in need episodes assessed in the year ending 31st March 2015 by Children's Social Services flagged domestic violence as a factor (aimed at either children or other adults in the households). This compares with 48% nationally. In 2014/15, 25% (454) of recorded domestic violence had a victim aged 16-25. 78% had a female victim.

^b For the purposes of this review this includes those recorded were children living with other family members, living with partner, all the children live with the client and some children living with client.

Factor	Degree of risk	Brighton & Hove context
		<ul style="list-style-type: none"> • In 2014/15, 361 children were in households of clients identified at high risk of domestic violence, an increase of 17% compared with 2013/14. • In 2014/15, 352 police recorded sexual offences had victims under the age of 26 (87% female) and 70 referrals were made to the Sexual Assault Referral Centre, for 14-25 year olds (92% female). • Most respondents aged 14-16 years to the SAWS Survey 2014 had not experienced (78%) or witnessed (66%) adolescent dating violence but 34% reported that they had.⁵⁶
<i>Child sexual exploitation (CSE)</i>	<ul style="list-style-type: none"> • Children who have been the victims of child sexual exploitation had a 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, 5.5-fold increased risk of substance misuse. • They have a 7.8-fold increased risk of recurrent depression as an adult and 9.9-fold increased risk of adult PTSD.⁵⁷ 	<ul style="list-style-type: none"> • In 2014, the police identified 58 under 18s in Brighton & Hove as victims or at risk of CSE.⁵⁸ • There were 100 police recorded sexual offences against under 18s between November 2013 and October 2014. Over half of the sexual offences against under 18s showed some level of online interaction between victim and perpetrator. • At the end of Q4 2014/15, there were 14 Sussex Police Operation Kite (Sussex Police operation to combat child sexual exploitation) cases open, down from 21 the previous quarter. A total of 27 new cases were considered in 2014/15. • 13 missing children under 18 have been a subject of Operation Kite (2013/14).

6. The level of need in the population of Brighton & Hove

Key issues

- There are an estimated 2,795 children in Brighton & Hove aged 5-16 years with a mental health problem
- There is a gender divide in the presentation of mental health problems in children and young people
 - Boys aged 5-16 years are twice as likely as girls to have a conduct disorder. They are also more likely to have hyperkinetic and multiple mental health conditions
 - Young men are more likely to complete suicide than women. 25 out of 31 suicides for under-25s, between 2003-10, were male
 - Girls are twice as likely as boys to have a neurotic disorder; are three times more likely to self-harm and are more likely to have an eating disorder.
- In Brighton & Hove schools and college surveys LGBU young people were at greater risk of self-harm.

6.1. Prevalence of mental health problems

6.1.1. Perinatal mental health

- Perinatal mental health problems affect between 10% and 20% of women at some point during pregnancy and during the first year after birth. Conditions range from mild to moderate anxiety and depression to bipolar disorder, post-traumatic stress disorder and postpartum psychosis.
- It is a leading cause of maternal death. Over half the women who die have a previous history of severe mental illness and half of the deaths are caused by suicide.
- It can negatively affect the child, compromising healthy emotional, cognitive and physical development, with long-term consequences.
- It is estimated that perinatal depression, anxiety and psychosis have a long-term cost to society of £8.1 billion for each one year cohort of births in the UK, nearly three quarters (72%) of which relates to adverse impacts on the child.⁵⁹

Table 2: Rates of perinatal mental health issues per 1,000 maternities

Perinatal Mental Health Issue	Rate per 1,000 maternities	B&H estimated number of perinatal mental health issues based upon rates 2013/14
Postpartum psychosis	2/1000	10
Chronic serious mental illness	2/1000	10
Severe depressive illness	30/1000	85
Mild – moderate depressive illness and anxiety	100-150/1000	280-415
Post-traumatic stress disorder	30/1000	85
Adjustment disorders and distress	150-300/1000	415-830

Source: Joint Commissioning Panel for Mental Health⁶⁰ source of deliveries Hospital Episode Statistics, Health and Social Care Information Centre.⁶¹

Table 2 shows the number of women in Brighton & Hove expected to experience mental health problems during pregnancy or the postnatal period based upon the number of women giving birth in the city and applying the national prevalence rates. They do not take account of socioeconomic or other factors which may introduce local variation.

6.1.2. Pre-school children

There is little data available about prevalence rates for mental health disorders in pre-school age children.

6.1.3. School-age children

- Boys aged 5-16 years are more likely to have experience of mental health problems (11%) than girls (8%)⁶²
- 8% of 5 to 10 year old children are likely to experience mental health problems
- 11% of 11 to 16 year old children are likely to experience mental health problems.

The following tables show the estimated number of school age children with mental health disorders, which is then further broken down into conduct, hyperkinetic, emotional and neurotic disorders in Brighton & Hove. (The numbers in these tables do not add up to the numbers in Table 3 because some children have more than one disorder).

Table 3: Estimated number of children and young people with mental health disorders in Brighton & Hove by age group and sex (based upon 2014 mid year estimates)

	5-10 years	11-16 years	5-16 years
Boys	795	940	1,730
Girls	375	695	1,070
All	1,165	1,630	2,795

Source: CHIMAT Service Snapshot – Child and Adolescent Mental Health Services (CAMHS); Brighton & Hove. Estimates based on Green et al prevalence rates 2004, GP registered population and MYE 2014. (Note that the numbers in the age groups 5-10 years and 11-16 years do not add up to those in the 5-16 year age group as the rates are different within each age group).

Table 4: Estimated number of males and females aged 5-16 years with conduct disorders in Brighton & Hove based upon 2014 mid-year population estimates (characterised by serious antisocial behaviour, including aggressive, destructive and deceitful behaviour and violation of rules)

	5-10 years	11-16 years	5-16 years
Boys	560	570	1,130
Girls	205	340	545
All	765	905	1,670

Source: CHIMAT Service Snapshot – Child and Adolescent Mental Health Services (CAMHS) Brighton & Hove ONS MYE 2014 and GP registered population.⁶³

Table 5: Estimated number of males and females aged 5-16 years with hyperkinetic disorders in Brighton & Hove based upon 2014 mid-year population estimates (characterised by hyperactivity, impulsiveness, inattention)

	5-10 years	11-16 years	5-16 years
Boys	220	175	395
Girls	40	35	75
All	255	210	465

Source: CHIMAT Service Snapshot – Child and Adolescent Mental Health Services (CAMHS) Brighton & Hove ONS MYE 2014 and GP registered population.⁶⁴

Table 6: Estimated number of males and females aged 5-16 years with emotional disorders in Brighton & Hove based upon 2014 mid-year population estimates (depression, separation anxiety, specific phobias, social phobia and generalised anxiety)

	5-10 years	11-16 years	5-16 years
Boys	155	325	480
Girls	190	420	610
All	340	745	1,085

Source: CHIMAT Service Snapshot – Child and Adolescent Mental Health Services (CAMHS) Brighton & Hove ONS MYE 2014 and GP registered population.⁶⁵

Table 7: Estimated number of males and females aged 16 to 19 with neurotic disorders in Brighton & Hove, based upon 2014 mid-year population estimates (mixed anxiety and depression, generalised anxiety disorder, phobias, OCD, panic disorders)

	Mixed anxiety & depression disorder (2014)	Generalised anxiety disorder (2014)	Depressive episode	All phobias (2014)	O.C.D. (2014)	Panic disorder (2014)	Any neurotic disorder (2014)
Males 16-19	350	110	65	45	65	35	585
Females 16-19	860	80	190	150	65	45	1,330

Source: Office for National Statistics mid-year population estimates for 2014. Singleton, N. et al (2001).

6.1.4. Children with mental health co-morbidity

- 1.9% of all children have more than one diagnosed mental disorder. The most common combination is conduct and emotional disorders.⁶⁶
- 77% of children with multiple disorders are boys, reflecting the high proportion of children with conduct disorders in this group.
- Children diagnosed with multiple disorders are more likely to have a physical or developmental problem, be behind with their schooling, and be in the bottom quartile on a scale measuring strengths compared with those with a single disorder.
- It is estimated 559 children aged 5-16 years in Brighton & Hove will have multiple mental disorders. (Based on CHIMat estimates 2014)
- The local charity Amaze supports the parents and carers of children and young people under 25 with special educational needs and disabilities. Amaze manages Brighton and Hove's disabled children's register (called the Compass) on behalf of Brighton & Hove City Council. Membership of register is voluntary, and it is estimated that the register accounts for at least 70% of those who would be eligible (Compass data is compared with Disability Living Allowance take-up in the City). On March 31st 2015, there were 1,812 under 25s on the database. Of these, 21% has emotional and behavioural difficulties, 15% anxiety, 4% attachment disorders, 4% other mental health problems and 3% depression. Some children have more than one condition and so can be counted more than once in these figures.

Table 8: Children and young people under 25 registered on the Compass database for emotional and mental health issues March 2015.

Condition	Number of children and young people
Emotional and behavioural difficulties	382
Anxiety	268
Attachment disorder	77
Other mental health problems	71
Depression	62
Total	860

Source: Amaze, Compass database

Those registered on the Compass database for mental health problems tend to have a slightly older age profile than all those registered on the database as a whole, reflecting the increased diagnosis of mental health problems as children get older. The highest proportion of children and young people registered for all of the mental health conditions in Table 8 were in the 11-16 age group. The most common conditions were for emotional and behavioural difficulties and anxiety.

6.1.5. Children with learning difficulties and mental health problems

Applying national estimates, there are an estimated 360 children and young people with a learning difficulty and mental health problem in Brighton & Hove. Half of these are in the 15-19 years age group.

Table 9: Children and young people aged 5-19 years in Brighton & Hove with a learning difficulty and mental health problem.

	5-9 years	10-14 years	15-19 years	All
B&H children with Learning Difficulty and MH problem	60	120	180	360

Source: Foundation for People with Learning Disabilities (2002), GP registered patient population and MYE 2014.

6.1.6. Self-harm

The majority of people who self-harm are aged 11-25 years. A Scottish self-report survey (2009) in schools found 14% of pupils aged 15-16 years claimed to have self-harmed and the Health Behaviour of School Aged Children Survey 2015 reported 22% of 15 year olds in the study had self-harmed. Rates were three times higher in girls than boys.⁶⁷ The Brighton & Hove Safe and Well at School and Further Education Surveys 2014 asked whether pupils hurt themselves. (The data from the Further Education Survey should be treated with caution as it is not a representative sample of all school sixth forms and colleges across the city).

Table 10: Prevalence of self-harm in Brighton & Hove education survey data

	% Reporting self-harm	Years 10-11 (14 to 16 years)	Years 12 -13 (16- 19 years)
All		7%	4%
Gender	Girls	11%	6%
	Boys	3%	2%
Sexual orientation	Heterosexual	5%	3%
	LGB	33%	22%
	Unsure of sexual orientation	10%	-
Bullying	Bullied pupils	16%	-

Source: Safe and Well at School Survey 2014 and Safe and Well Further Education Survey.

Other pupils who reported self-harm in secondary schools included those who had been drunk, tried non-prescription drugs and deliberately missed lessons. Of those who had self-harmed in secondary schools 64% knew who could help, compared to 78% in Further Education (F.E.) and 38% had asked for help in secondary schools, compared to 51% in F.E.

Responses by individual ethnic group were too small for analysis, but White British and BME students had similar prevalence rates in both surveys.

The Brighton & Hove Local Safeguarding Children Board (LSCB) made recommendations in a Learning Review in 2015 related to self-harm. They included the need for Public Health to share the evaluation of its Emotional Health and Wellbeing interventions focusing on self-harm (as part of the Public Health Schools Programme) with the LSCB, to give them assurance that frontline staff in schools had sufficient training and skills to support children who self-harm.

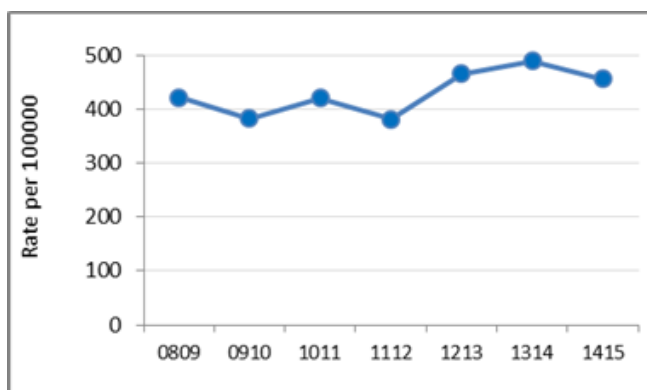
The Health Counts Survey 2012 of local residents reported that 19% of 18- 24 year olds had self-harmed (n=39), including 28% of females and 7% of males.

The Allsorts Youth Project provides support to under 26s who identify as lesbian, gay, bisexual, Trans*, unsure (LGBTU). This group is at greater risk of self-harm. In 2013/14, self-harm was raised in 59 one-to -one support sessions (8%) and in 4% of drop in sessions. A survey of 32 LGBTU 16-25 year olds in 2014/15 found that 34% (n=11) had injured or harmed themselves in the preceding three months. A similar survey of 13 under 16s found 61% (n= 8) had injured or harmed themselves in the preceding three months.

6.1.6.1. A&E attendance as a result of self-harm (10-17 years)

- There were 97 A&E attendances for self-harm in 2014/15 in the 10-17 years age group.⁶⁸
- The attendance rate for self-harm has risen from 381 (in 2011/12) to 456 per 100,000 0-17 year olds in 2014/15. This represents a slight upward trend in the attendance rate since 2008/09 but it is not statistically significant, and could be due to better recording. (Figure 1).

Figure 1: A&E attendances for self-harm for 10-17 years olds in Brighton & Hove, per 100,000 10-17 year olds, 2008/09 to 2014/15



Source: Hospital Episode Statistics, ONS mid- year estimates.

- 70% of attendances are for the 15-17 years age group.

The rest of this A&E analysis is based upon attendances between March 2014 and February 2015

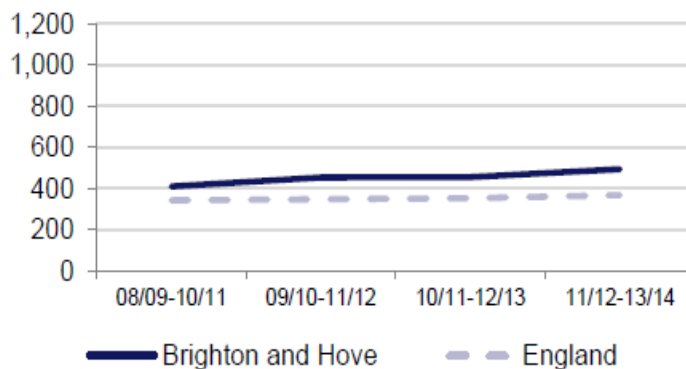
- 83% of first attendances are made by girls
- There is no association with deprivation, young people from all areas of the city were as likely to attend A&E for self-harm
- 37% were admitted to hospital from A&E
- Most self-harm took place at home in the evenings.

Approximately half of first attendances did not have a specific diagnosis coded. The main diagnoses with a code were: poisoning with either drugs or alcohol (27 attendances), psychiatric conditions (six young people) and social problems (including chronic alcoholism or homelessness) for fewer than five young people.

6.1.6.2. Hospital admissions for self-harm

- There were 338 hospital admissions for self-harm in 2013/14. There were 189 admissions between April 2014 and February 2015 although it is too early to say whether this represents a downward trend
- The rate of self-harm admissions in 2013/14 for 10-24 years is 507 per 100,000. This is higher than England at 412 per 100,000 (Figure 2)
- 75% of admissions in 2014/15 were for girls, and 30% of admissions were aged 14-17 years
- There were no recorded inpatient admissions for under 14s.

Figure 2. Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10-24 years)



Data source: Hospital Episode Statistics, Health and Social Care Information Centre

6.1.7. Suicide

The national suicide rate amongst teenagers is lower than the general population, but some young people are more at risk i.e. those with existing mental health problems or behavioural disorders, substance misusers, family breakdown, abuse, neglect or mental health problems or suicide in the family. Children in Care, care leavers and young people in the Youth Justice System are also at increased risk.⁶⁹

Table 11. Suicides in 16-25 year olds from 2003-2010 Coroner's data.

Total suicides 16-25 years	31(8% of all suicides)
% 16-19 years	29% (n=9)
% 20-25 years	71% (n=22)
% Men	83% (n=25)

Death registration data from the Office for National Statistics (ONS) provides information on suicides and undetermined injuries for residents of Brighton & Hove, and includes deaths which took place outside of the city. Between 2006 and 2013 there were 22 suicides of people under 26 years, including 17 (77%) 20-25 year olds. 18 (81%) out of the 22 suicides were male.

The YMCA Downlink Group receives safeguarding alerts for young people under 26 years with suicidal ideation. In 2014/15 they received 50 alerts, 19 of these alerts came from the schools counselling services and 11 from the Youth Advice Centre. In the three months from April to June 2015, 22 alerts were received. It is felt that this increase was due to better recording. 58% of the alerts in 2014/15 were for females and 42% were for males.

The Allsorts Youth Project provides support to under-26s who identify as LGBTU. This group is at greater risk of suicide. In 2013/14, suicide was raised in 23 one-to-one support sessions (3%) and in 2% of drop in sessions. A survey of 32 LGBTU 16-25 year olds in 2014/15 found 41% (n=13) had contemplated suicide in the preceding three months. A similar survey of 13 under 16s found 38% (n= 5) had contemplated suicide in the preceding three months.

6.1.8. Eating disorders

The average age for the start of an eating disorder is in the mid-teens. It is estimated that 1 in 250 females and 1 in 2,000 males will experience anorexia nervosa, as an adolescent or young adult and five times this number will suffer from bulimia nervosa. The annual incidence rate for any eating disorder in the UK is estimated to be 164.5 per 100,000 girls aged 15-19 years.⁷⁰ The estimated prevalence of potential eating disorders in young people aged 16-24 years in Brighton & Hove was 5,967 in 2013 based on prevalence given in the Adult Psychiatric Morbidity Survey 2007. This figure does not make adjustments for local characteristics which may have an impact on prevalence.⁷¹

6.2. Self-reported happiness and enjoying school

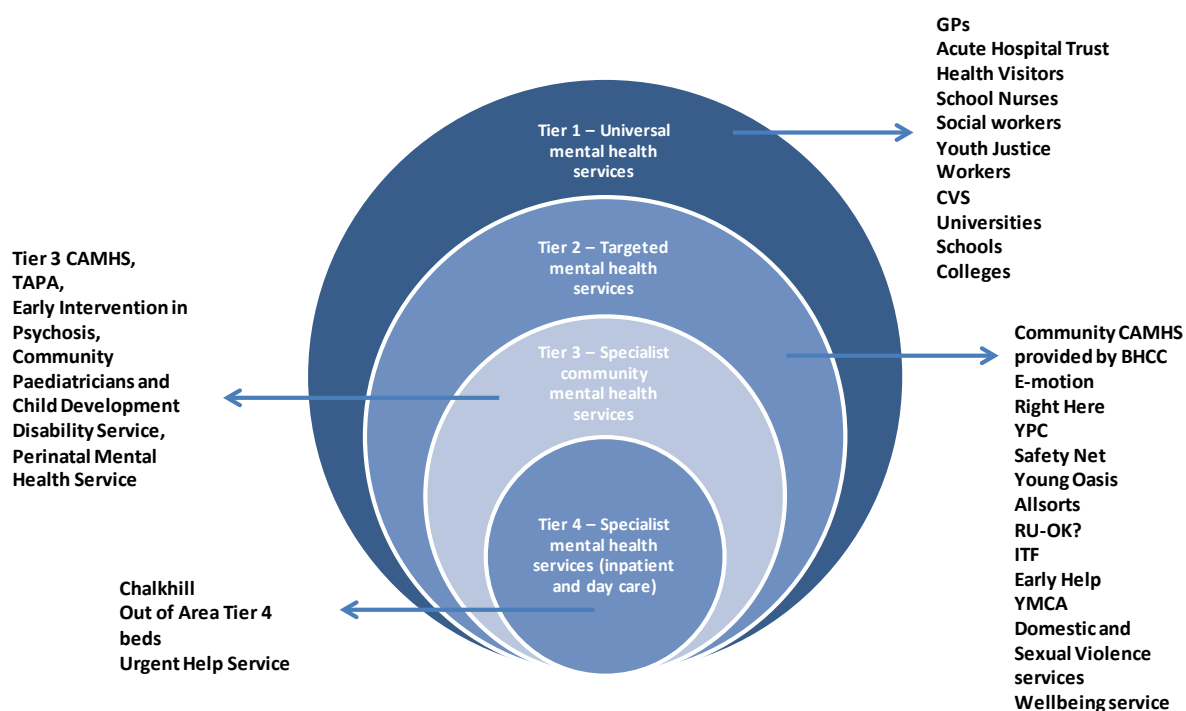
Children spend a significant amount of their time at school and their happiness within school is an important part of their life. Local data on this is captured as part of the Safe and Well at School Survey (SAWSS).

- The 2014 primary school survey reported that 93% of pupils were happy with their life at the moment and 90% enjoyed coming to school
- The secondary school survey reported that 94% felt happy often or sometimes and 79% enjoyed coming to school
- Anxiety increased with age from 52% feeling anxious often or sometimes in 11-12 year olds rising to 73% in 17-18 year olds
- Those who were happy less often include:
 - Girls
 - Young carers
 - Those with gender identity issues
 - Lesbian, Gay, Bisexual and Unsure
 - Truants/excluded
 - Bullied/bullies
 - Those who have tried alcohol, smoking, drugs, sex.
- There was no difference in happiness by ethnic group.

6.3. Estimated need for services at each Tier

Child and Adolescent Mental Health Services (CAMHS) in England are delivered through a four-tiered system which spans health promotion and primary prevention, through to specialist and inpatient care. Figure 3 shows examples of services at each Tier.

Figure 3: CAMHS Tiers with examples of services in each Tier



Source: Brighton and Hove Clinical Commissioning Group.

Definitions of Tiers: Problems and services in child and adolescent mental health are categorised as:

Tier 1: universally encountered and can be addressed in everyday settings

Tier 2: require consultation, targeted or individual support

Tier 3: require the involvement of specialist support

Tier 4: highly specialist/inpatient

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1-4 have been provided by Kurtz (1996).⁷² These estimates have been widely used although there are some technical issues with its application, the paper’s age and its sources. Table 12 shows these estimates for the population aged 17 and under in Brighton & Hove.

Table 12: Estimated number of children and young people aged 17 and under who may experience mental health problems appropriate to a response from CAMHS, Brighton & Hove, 2014

	Tier 1	Tier 2	Tier 3	Tier 4
<i>Prevalence estimates Kurtz (1996)</i>	15%	7%	1.85%	0.075%
Brighton & Hove	7,645	3,570	945	40

Source: Rates applied to Office for National Statistics mid-year population estimates for 2014. Kurtz, Z. (1996)

7. Services in relation to need

Key Issues – Tiers 1 and 2

- The 10-14 age group is projected to increase but service mapping indicates that more services are targeted at older teenagers and young people
- Counselling services are primarily accessed by girls
- The demand for counselling services has risen
- A large proportion of voluntary sector Tier 2 counselling clients are in the 17-25 years transition age group
- There is no systematic reporting of schools based counselling services data so we do not know the true extent of demand for counselling in Tiers 1 and 2
- There is no standardised recording of outcomes or user feedback across services
- 49% of referrals to Tier 2 CAMHS are made by GPs and 16% by schools.

This section outlines how services within Brighton & Hove are meeting the mental health and wellbeing needs of the children and young people's population. Services are provided across different Tiers according to the level of need (including the need for specialist input). Needs which are met primarily by the community and voluntary sector in Tiers 1 and 2 have been mapped in Appendix 2.

7.1. Tier 1 Universal Services

Tier 1 services are mainly provided by professionals whose main role is not in mental health, such as GPs, health visitors, paediatricians, social workers, teachers, youth workers and juvenile justice workers. The focus is on early identification and prevention of mental health and emotional wellbeing problems.

Appendix 2 shows service mapping of sixty-two services provided at Tiers 1 and 2 that aim to improve children and young people's emotional health and mental wellbeing. The information have been taken from the 'Where to go for' ⁷³ website (information for children and young people on local services) and *Local Offer* ⁷⁴ website (Brighton & Hove City Council website on services for children with SEND aged 0-25 years) and the Children's Services *Costed Directory of Effective Interventions Phase 4* ⁷⁵ (Directory of effective and promising interventions that are provided through Children's Services). When analysed for accessibility by age range, twenty one different age bandings for access are found, many of which overlap. When the age groups are categorised by school admission age ranges, the majority of services available are for the secondary age group (29), followed by 20 services for the 16-25 years groups and 15 for the 18 plus age group. There were 14 services for the primary age group and 11 for the early years. The commissioners may want to review whether there is sufficient capacity within services for 10-14 year olds, as this age group is

expected to increase by 11.5% by 2024. (This mapping may not be comprehensive so these figures should be treated with caution and some services were counted more than once as they covered different school settings so the numbers do not tally with actual service numbers).

In terms of gender the majority of services were open to all genders, with only two services specifically for males (Men Get Eating Disorders Too and Mankind) and two for females (counselling for women at the Survivors' Network and Brighton Oasis Project). Activity data from service providers indicates that the majority of users of counselling services tend to be female and that the Young People's Centre mainly had referrals for girls. Boys of school age are more likely to have experience of a mental health problem than girls (11.4% compared to 7.7% for girls).⁶⁰ This may suggest a need for services to be targeted more at boys and provided in a format that appeals to them – more activity based than talking orientated.⁷⁶

Most services included in the mapping are based in central Brighton (25). Some of these services provide outreach to other areas of the city. Seventeen services worked in locations across the City and sixteen were targeted in the east. Only seven services were based in the west of the City and no services had a Portslade postcode or appeared to target people living in this area. Mental health prevalence data is not available by geographic area but the data for children on Tier 3 caseloads in March 2015 showed that after Woodingdean and East Brighton, Moulsecoomb and North Portslade wards were the areas with the next highest number of children on caseloads (see Figure 12 page 55). Commissioners may want to consider exploring this further.

7.2. Tier 2 Targeted Services

Tier 2 consists of targeted provision for children and young people who have identified needs and/ or are considered 'at risk'. These services are provided by mental health professionals working in primary care and other community settings, for example, psychologists and counsellors in GP practices, paediatric clinics, schools and youth services. Tier 2 also includes practitioners and services from community CAMHS delivered by Brighton & Hove City Council who provide initial contact, assessments and treatment for children and young people. Some of these have been included in Appendix 2 but more detail is given below of types of needs being addressed by services where the data was available.

7.2.1. Counselling services

Currently there is no formal pathway for accessing counselling services. Children and young people can access counselling in which ever setting they find most appropriate - at school, community based youth service, University service or on-line.

- **Schools** – The majority of schools in the city make provision for their own counselling services. There is no comprehensive data available on counselling activity within schools and colleges in the city.
- **Universities** - Counselling services for students are provided by the Universities of Sussex and Brighton. The University of Brighton provided therapeutic support to 1,449 people in 2013-14; this was a 10 % increase on 2012-13. 65% of clients were female. The average time between contact and assessment was six days. The largest presenting problems were anxiety and depression (34%). No activity data is available for the University of Sussex.
- **Community based**
 - **Young People’s Centre (YPC)** – The YPC is provided by Impact Initiatives and offers free counselling to 13-25 year olds living in Brighton and Hove. YPC had a 38% increase in assessments in 2014-15 compared to 2012-13, with 181 counselling assessments.
 - The waiting time for assessment was 2-4 weeks, with the waiting list closed at times due to excess demand. 65% attended assessments but approximately one third Did Not Attend. Of those assessed 65% went onto a waiting list for counselling in 2014-15, this is a decrease of 15% compared to 2013-14.
 - The latest data available on sources of referrals is for 2013-14, when 30% of referrals were from CAMHS or the Wellbeing Service an 18% increase since 2009/10. 21% of referrals were from GPs.
 - 75% of clients were female.
 - 49% were aged 21-25, followed by 31% 17-20 years and 20% 13-16 years.
 - The majority were White British (86%), 14% were LGBT, 11% had disabilities, 30% physical health issues, 38% were in education, 32% were not in education or employment and 30% were employed.
 - Presenting conditions included: mental health issues including anxiety and depression (72%); a combination of issues and needs including self-harm and suicidal thoughts, substance misuse, domestic violence going alongside anxiety and depression. 75% had relationship issues, mainly with parents. 28% had difficulty attending work or education; 28% were going through some form of Transition and 20% had bereavement issues.
 - In 2013-14, 87% of clients recorded positive outcomes and 24% no longer needed mental health services.
 - Many young people had been referred due to issues with employment and accommodation causing anxiety and depression, after counselling 42% were significantly able to change their life circumstances.
 - **Dialogue and East Brighton YPC** – Both Dialogue @65 Blatchington Road and East Brighton YPC are part of the YMCA services in Brighton & Hove and

provide 27 hours of counselling services a week to young people aged 13-25 years.

- 101 people had counselling in 2014/15, with 175 people on the waiting list. The average wait is 51 days. 66% of referrals were for females and the average age is 18 years. 32% of referrals were from GPs, 23% from YMCA staff, 16% self-referrals, 15% parents, and 6% CAMHS.
- 19% (136) of counselling sessions in 2014-15 were cancelled or DNA.

- **Online counselling**

- **E-motion** – E-motion is a free online counselling project for young people aged 13-25 years who live in Brighton & Hove. It is a partnership project between the Young People’s Centre and Youth Advice Centre. It received 117 referrals in 2014-15, 84 (72%) led to assessments and 65 received counselling (55%). There was no waiting list and 86% had counselling within a week. 25 (21%) did not reply to an initial response.
 - 87% of referrals were for females and 12% males.
 - Most referrals were in the 13- 16 age group (46%), followed by the 20-25s (29%) and 17-19s (25%).
 - Over half lived in central Brighton (BN1, 48%) east Brighton (BN2, 31%) and west Brighton/Hove (BN3, 14%). Only 4% were from Portslade (BN41).
 - The main presenting condition were anxiety (75%), depression (54%), suicidal thoughts (33%), self-harm (30%), hearing voices (10%), abuse (9%) and bereavement (7%).
 - 34% of clients worked with reported being able to return to work or education and 26% no longer needed mental health services.

- **Refugees, Asylum Seekers and Migrants** – The Wellbeing Service provides a counsellor for refugees, asylum seekers and migrants in the city. In 2014-15 (October to September) six asylum seekers aged 18 -25 years received counselling. Countries of origin included Afghanistan, Morocco, Sri Lanka and Iran. The main presenting issue was Post Traumatic Stress Disorder.

Local counselling services have seen an increase in demand demonstrated by a 38% increase in assessments for YPC and a 10% increase in counselling at the University of Brighton. It is also reflected in the periodic closure of waiting list for YPC and one to three month plus waits to access some services. Both the University of Brighton and E-motion are quicker, able to start the counselling process after a week but the proportion following through from initial contact to counselling is lower for E-motion (55%). GPs, CAMHS and Wellbeing services make up 30 -50% of referrals and referrals by CAMHS to YPC have increased by 18% since 2009/10.

The services are predominantly used by females ranging from 65-87% of users. Commissioners should consider how counselling services can meet the needs of males too. The main issues presented are anxiety and depression, with accommodation, employment and relationship issues having a role, together with Transitions and bereavement. A large proportion of clients are in the 17-25 age group and would no longer be eligible for support from specialist CAMHS and may not be eligible for Adult Mental Health Services. Where outcomes are reported, services say 24%-26% of clients report they no longer need mental health services after counselling.

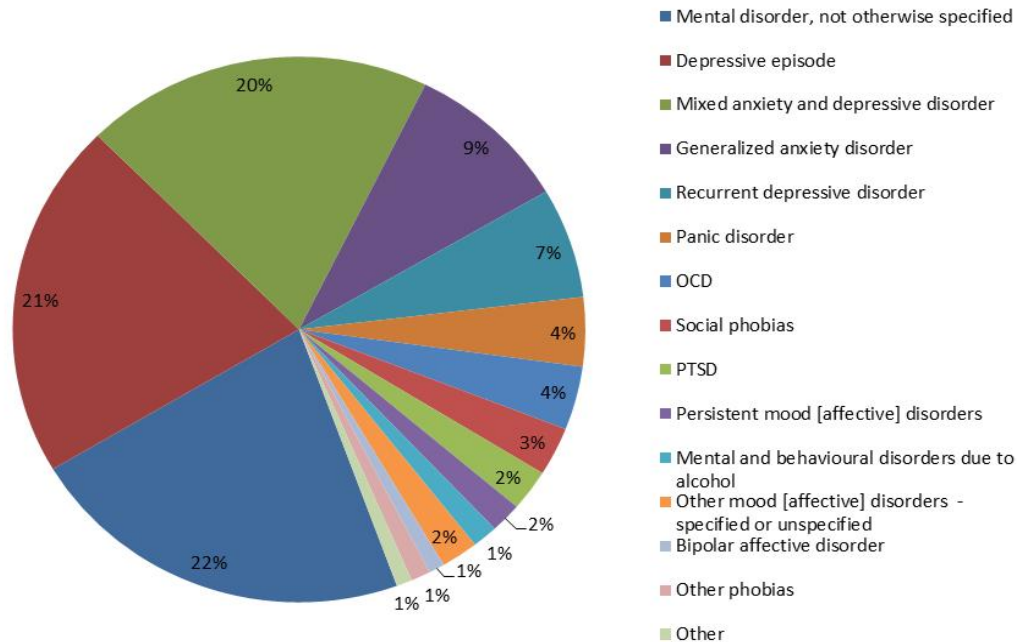
Evidence suggests counselling provides a significant role in supporting people in the community and reducing demand for more specialist CAMHS provision. This is only possible though if the capacity is able to meet the increasing demand. Other counselling issues commissioners may want to explore further include: what the balance between online and face to face counselling should be to relieve the pressure on face to face services; the consistent collation of data to aid service planning; how counselling can meet the needs of males and whether there are any equity issues related to Portslade.

7.2.2. Primary care based mental health services

- The Brighton & Hove Wellbeing Service provides primary care based mental health service for over 18s, treating lower level mental health problems including low mood, stress, anxiety and depression in clinics across the city. The service also offers therapy over the phone, and a wide range of courses.
 - In 2014/15, the service received 2,200 referrals from young people aged 19-25. However, one individual can have more than one referral to the service, as there are three parts to the Wellbeing Service (Psychological Wellbeing Practitioners, Primary Care Mental Health Practitioners and the Community Wellbeing Team), each requiring a separate referral.
 - 1,535 individuals aged 19-25 accessed the services in 2014/15 –accounting for 19% of all patients accessing the service. Of these, 1,419 had at least one finished appointment. 116 patients did not get seen, this may be because they were signposted to another service following triage.
 - In 2014/15, 40% of referrals were made Talking Therapy (581 finished appointments); 36% Primary Care Mental Health Worker (524 finished appointments);21% Psychological Wellbeing Practitioner (314 finished appointments), and 3% Community Team. Individuals may be offered more than one service (therefore finished appointments do not reflect the number of individuals seen by the service).
 - The highest proportion of referrals had a provisional diagnosis of ‘mental disorder – not otherwise specified’ (22%), or a provisional diagnosis of a depressive episode (21%) or mixed anxiety and depressive disorder (20%).

Recording of provisional diagnosis has only been mandatory since November 2014 and data is from January – June 2015.

Figure 4: Provisional diagnosis for referrals of 19-25 year olds to the Wellbeing Service, Jan – June 2015 (n=904), Brighton & Hove



Source: Brighton and Hove Wellbeing Service

As stated earlier the estimated number of people aged 17 and under with mental health problems in Tier 2 is 3,570 (Kurtz 1996).⁷¹ The figures above for the Wellbeing Service are for 19-25 year olds and show 2,200 young people were referred in 2014/15 just for this age cohort and may be a reflection that a high proportion of young people still need Tier 2 mental health services after they are 18.

At the time of data collection for the JSNA no outcomes data for the Wellbeing Service was available.

7.2.3. Early interventions for children and young people with multiple mental health and complex needs

7.2.3.1. Early Help Hub

The Early Help Hub was established in September 2014 as a co-ordinated means for people to access early help for children, young people and families, who do not meet the threshold for social work. One referral is made and reviewed at the weekly allocations meeting, which decides upon the most appropriate agency to respond to the referral.

The most common risk factor requiring early help (September 2014 to July 2015) was for emotional wellbeing (57%). During this time 1,538 referrals were made: 68% aged 11-18,

26% aged 5-10 years and 11% under 5 years. 53% of referrals were for males and 47% were females.

Figure 5: Risk indicators for Early Help referrals, September 2014 – July 2015, Brighton & Hove



Source: Early Help Hub Performance Report July 2015 Note: Clients can have more than one risk indicator. Risk indicators are completed and risk is assessed by the referrer.

In 2014 42% of those with emotional wellbeing problems also had school attendance issues, 34% physical health issues, 27% issues to do with domestic violence and abuse, 25% needs around anti-social behaviour and crime, 20% school exclusion issues, 19% SEN, 16% at risk of not being in employment or education and 14% substance misuse issues.

7.2.3.2. Integrated Team for Families

The Integrated Team for Families is a multi-agency service that responds to people with complex and multiple needs. This team has an assertive outreach model to work with families intensively. Analysis of data relating to 75 families worked with in 2014 in Brighton & Hove showed that 19% of children had a diagnosed mental health problem, compared to 21% in the South East and 19% for England. This contrasts with key worker assessments which identified 32% having a mental health problem, compared to 30% in the South East and 26% in England. 17% of young people in Brighton & Hove had substance misuse issues compared to 16% in the South East and 14% in England.

7.2.4. Children in Care

There were 476 Children in Care in Brighton & Hove on December 31st 2014. The City has the 19th highest rate for Children in Care in England. Data from the Virtual School (established to support Children in Care to progress educationally) indicates that 65% of school age Children in Care had a Special Educational Need in 2013/14, including 21% who had a statement. This is a lower proportion Children in Care with a statement than our

comparators and the South East. Strength and Difficulties Questionnaires for 4 to 16 year olds indicate that the psychological wellbeing of Children in Care has improved from 15.2 in 2013 to 14.8 in 2014 but is still above the national average of 13.9. Brighton & Hove is ranked the 105th lowest authority for this in England.

The Young Oasis Project provides a therapy service for children whose parents misuse drugs or alcohol. The proportion of Children in Care being referred to this service for therapy has risen from 16% of referrals in 2009/10, to 40% in 2014/15.

Over a 24 month period, on average 48% of women using the Young Women's Alcohol Project were care leavers.

7.2.5. Substance misuse and mental health needs

Substance misuse services for under-18s in Brighton & Hove are provided by Ru-ok? Data collected in 2014/15 indicates that:

- 41% of clients were also using mental health services, in September 2014
- The Ru-ok? CAMHS nurse holds a caseload of approximately 7-15 people
- The main presenting conditions are: anxiety, low mood and depression
- Approximately three times as many females as males used the service
- Clients are mainly White British and aged 14-17 years
- In 2014/15, Ru-ok? clients had slightly lower needs around mental health (13%) and self-harm (13%) compared to both nationally (17%).

The Local Safeguarding Board (LSCB) made a recommendation in a Learning Review in 2015 concerning substance misuse and called for public health to include it in this JSNA. It was a request for agencies to explore how well they address the needs of children and young people who engage in risky behaviour such as substance misuse. As well as the efficacy of arrangements for information sharing about assessments for adolescents with mental health or substance misuse problems.

7.3. Access to specialist child and adolescent mental health services

7.3.1. Single point of access triage data

The Tier 3 CAMHS team (provided by Sussex Partnership NHS Trust) and the Tier 2 Community CAMHS team (provided by Brighton & Hove City Council) work closely together to support children and young people with emotional and mental health needs through one single point of access. When a referral is received, a decision is made on what would be the most appropriate service using the information given on the referral form. All referrals for mental health support in Brighton & Hove go to a central weekly triage meeting that is attended by both Tier 3 and Tier 2 staff.

Table 13. Referrals received by the single point of access in 2014/15 and the outcomes of triage.

Number of referrals	Tier 2	Tier 3	External agencies	Signposted at pre-referral	Back to referrer for more information	Closed or inappropriate
1,767	24%	35%	13%	1%	9%	20%

Source: Single point of access triage data 2014/15.

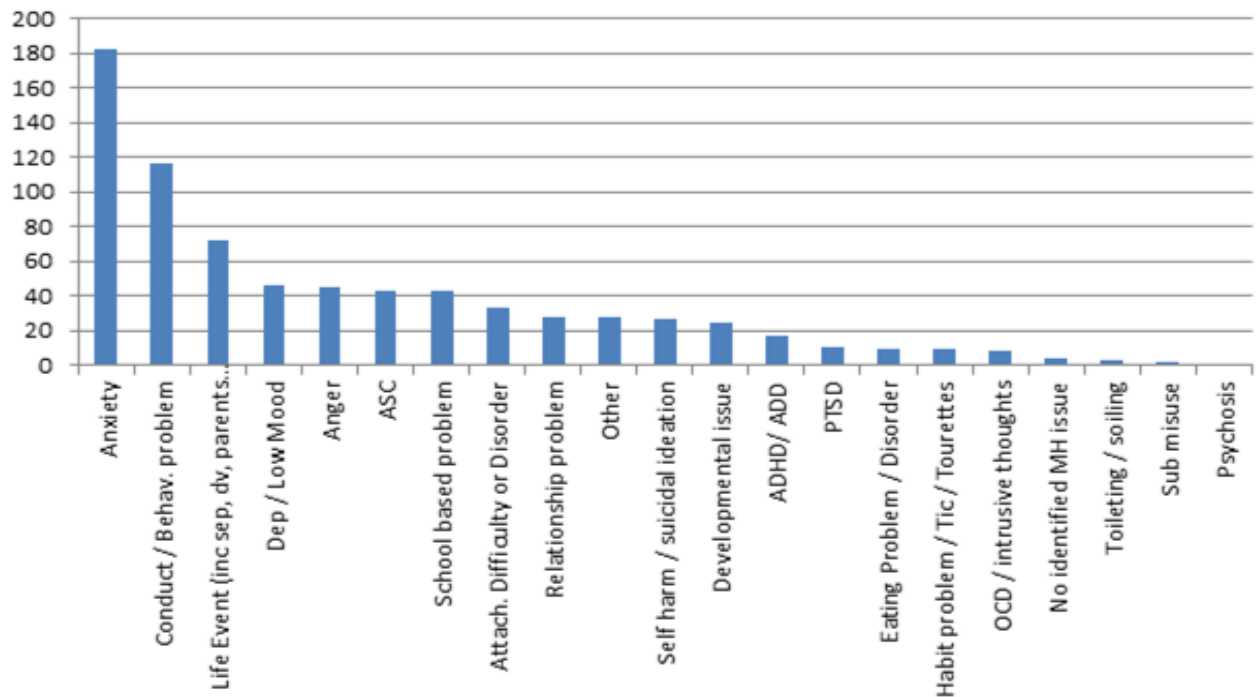
- 3% of these cases had an open Common Assessment Framework (CAF). The CAF is a process for gathering and recording information about a child for whom a practitioner has concerns in a standard format, identifying the needs of the child and how the needs can be met. The CAF was developed so that practitioners in all agencies working with children could communicate and work more effectively together.
- Further data for Tier 3 CAMHS can be found in Section 7.4.

7.3.2. Tier 2 Community CAMHS data

Tier 2 Community CAMHS provide a targeted response to mental health and emotional wellbeing for issues such as ADHD, stress, anxiety, phobias, ASC, eating disorder, family difficulties, school refusal, mood changes, and bereavement and grief.

Of those cases closed in 2014/15 reasons for referral to the Tier 2 Community CAMHS service are shown in Figure 6.

Figure 6: Needs identified in cases closed, Community CAMHS, April 2014 – March 2015 (n=754), Brighton & Hove

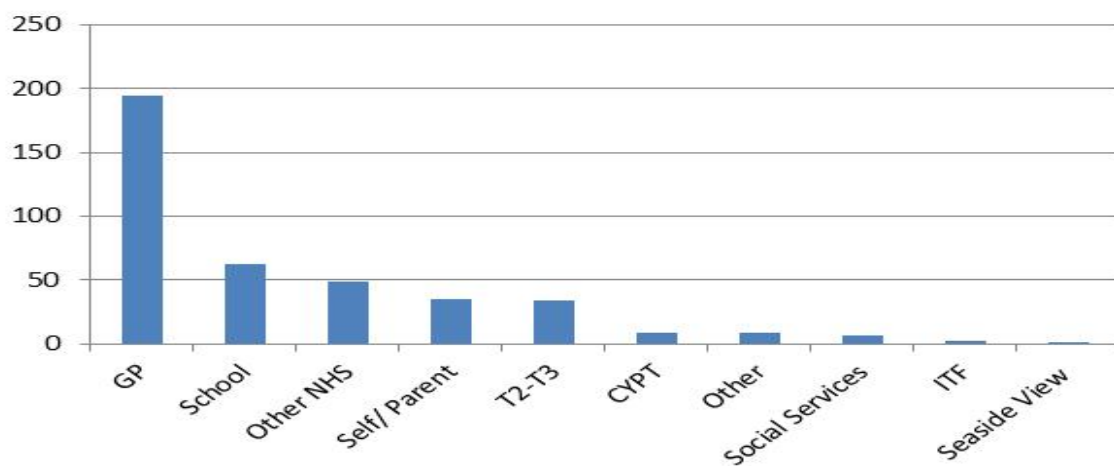


Source: Tier 2 Community CAMHS Closing Data

The most common needs were

- Anxiety (24% of cases)
- Conduct/behavioural problems (15% of cases)
- Experience of life events such as separation, domestic violence or parental substance misuse (10% of cases).

Figure 7: Referral sources for cases closed in 2014-15, Community CAMHS (n=399), Brighton & Hove



Source: Tier 2 Community CAMHS Closing Data

- Almost half of referrals (49%) were from GPs, 16% schools and 12% other NHS departments.

Of 407 cases closed in 2014/15:

- 76 (19%) were recorded as having a parent with a mental health issue
- 43 (11%) were recorded as having experienced domestic violence
- 43 (11%) were recorded as having poor health
- 19 (5%) were recorded as having a caring role
- 20 (5%) were on a child in need plan
- 9 (2%) were on a child protection plan
- Fewer than five were children in care, adopted or on a special guardianship order or residence order respectively
- Of 43 young people asked about substance misuse, nine identified substance misuse, and 12 alcohol use (of which five were identified as 'problem use').

7.3.2.1. Feedback and outcome measures

The service collects feedback following treatment via Strength and Difficulties Questionnaire (SDQ) scores and on the user experience via feedback forms.

- Feedback forms on the user experience stated that 89% would recommend the Tier 2 Community CAMHS service to others.
- SDQ scores showed significant improvement in 83% of cases in 2013 and in 90% of cases in 2014.⁷⁷

7.4. Tier 3 Specialist Community CAMHS services

CAMHS Tier 3 is the specialist, community-based mental health team in Brighton & Hove (non-inpatient service) for 0-18 year olds. It is provided by Sussex Partnership NHS Trust and includes a number of specialist teams, including Teen to Adult Personal Advisers (TAPA), Early Intervention in Psychosis, Community Paediatricians, Child Development Disability Service and Perinatal Mental Health Services.

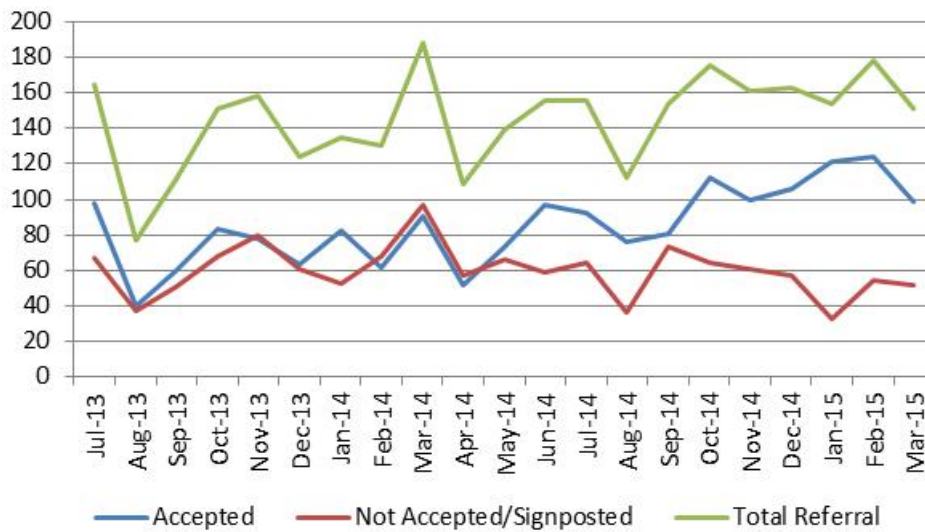
Key Issues – Tier 3

- There were 910 Tier 3 CAMHS cases open in March 2015, 32 of whom were Children in Care
- Referrals to Tier 3 have increased by 11% and 29% to the TAPA (14-25 years) service between Oct/Mar 2013/14 and Oct/Mar 2014/15
- 50% of referrals are from GPs and 15% from schools
- There are slightly more boys (56%) than girls (44%) referred to Tier 3
- The 10-14 age group has the highest rate of patients per 1,000 population
- Children and young people living in the most deprived quintile in the city are one and half times more likely to be treated by Tier 3 CAMHS
- Waits for routine and emergency appointments are quicker than comparators areas and most people have a four week or less wait between referral and assessment
- A small number of 16-17 year olds are recorded as having transitioned to adult mental health services and more investigation is required to understand why this is low.
- Increased demand and long waits on specialist pathways can lead to a raising of eligibility criteria for accessing services
- Some clinical settings in Tier 3 need to be more young people friendly

7.4.1. Referrals

- There has been an 11% increase in the total number of referrals received in October-March 2014/15 compared to the same period in 2013/14.
- Referral data is currently only available from July 2013 onwards and full year comparisons are therefore not possible. During this time referrals peaked in March 2014.

Figure 8: Referrals to Tier 3 CAMHS July 2013 to March 2015, Brighton & Hove



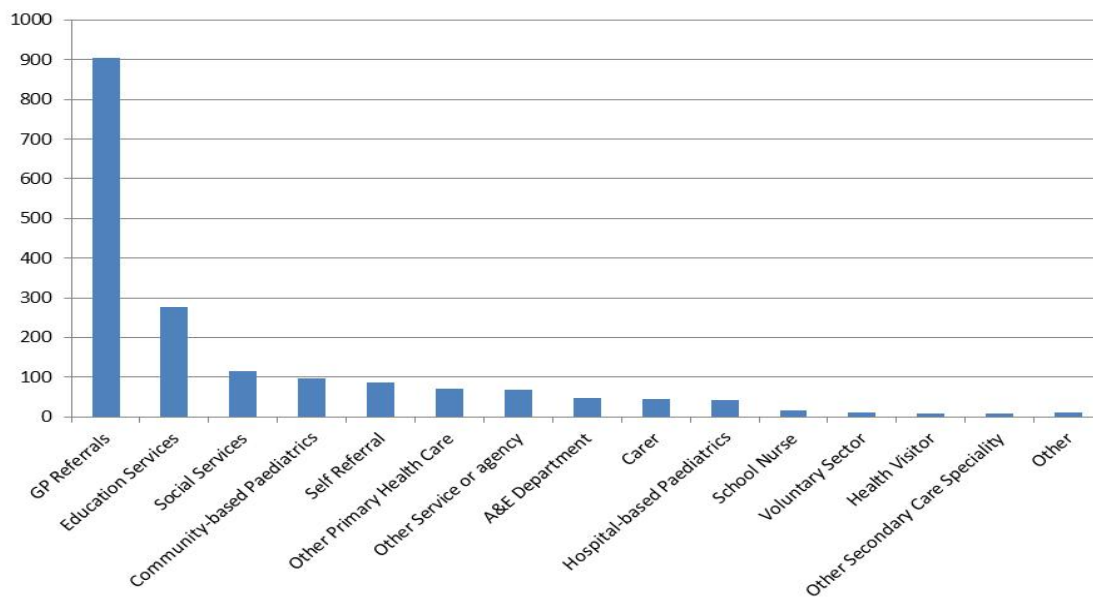
Source: CSU performance data

- An increased number of referrals were accepted in Oct 2014 to Mar 2015 (67%) compared to Oct 2013 to Mar 2014 (52%).
- A lower proportion of referrals were either not accepted or signposted between October 2014-March 2015 (33%) compared to 48% for the same period in 2013-14.

7.4.1.1 Sources of new referrals to Tier 3 CAMHS

- In 2014/15 referrals came from
 - GPs (50%)
 - Education (15%)
 - Social services (6%)
 - Others: police, probation, court liaison and diversion service, drugs misuse agencies, out of area agencies, other independent sector mental health services and Transfers from other mental health trusts.

Figure 9: Tier 3 CAMHS referral sources 2014/15 (n=1,809), Brighton & Hove

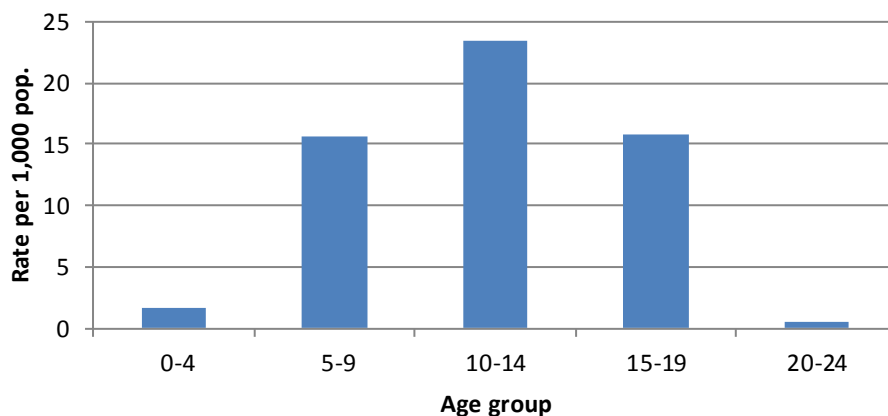


Source: CSU performance data

7.4.2. Caseload

- Tier 3 CAMHS had 910 cases open in Brighton & Hove at the end of March 2015
- 44% of CAMHS patients were female, and 56% were male at the end of March 2015
- The 10-14 age groups had the highest rate of service use.

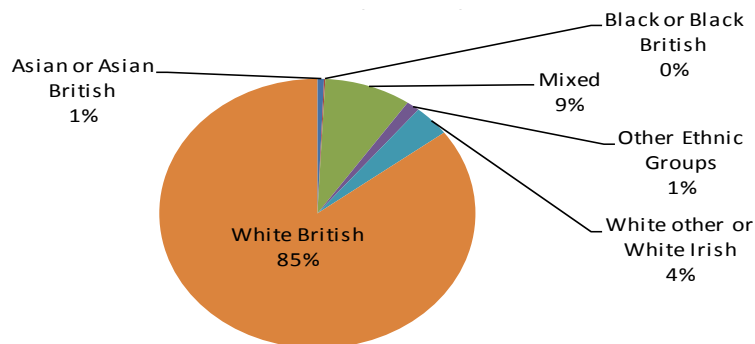
Figure 10: Tier 3 CAMHS caseload, rate per 1,000 population by age group, March 2015, Brighton & Hove



Source: CSU performance data

- 85% of patients were White British and 15% were from BME groups.

Figure 11: Tier 3 CAMHS caseload, by ethnic group (%), March 2015, Brighton & Hove

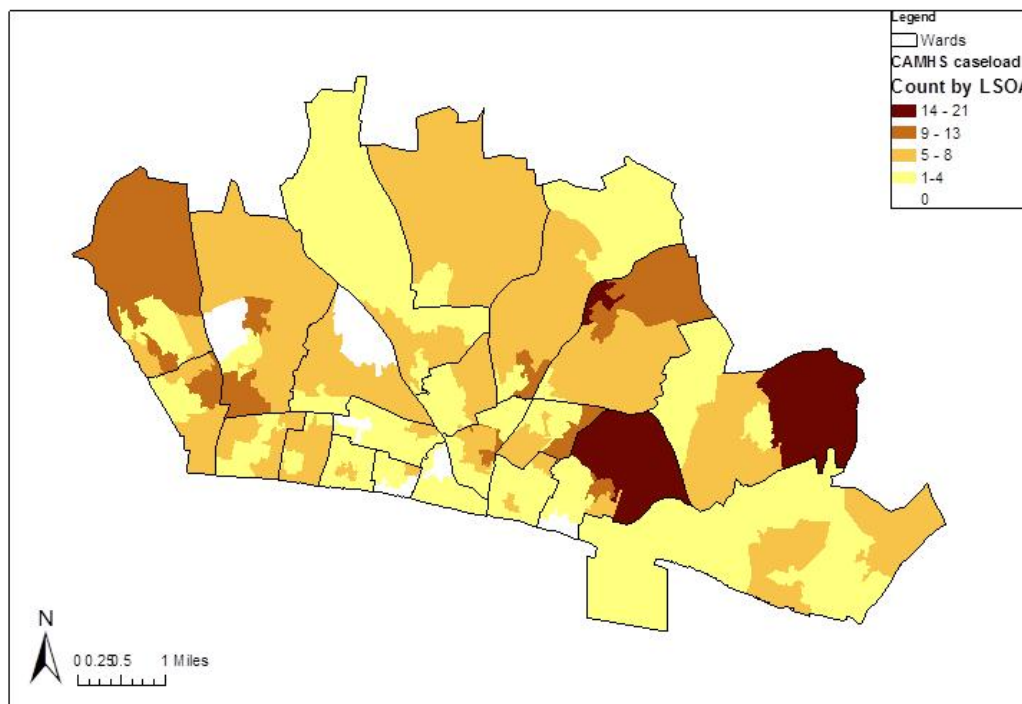


Source: CSU performance data

- There were 32 Children in Care on the Tier 3 CAMHS caseload, and five Children in Care placed out of area.
- The average time on the Tier 3 CAMHS caseload was 622 days.

7.4.3. Tier 3 CAMHS service users by Lower Super Output Area (LSOA)

Figure 12: Brighton & Hove Tier 3 CAMHS caseload as of 31st March 2015 by LSOA



Source: SPFT CAMHS caseload data. 31st March 2015.

- Young people from across the city are accessing Tier 3 CAMHS. (79 records are excluded from the above map where Brighton & Hove Tier 3 CAMHS patients live outside of the city boundary)

- Analysis by Index of Multiple Deprivation (IMD) 2015 shows that children and young people living in the 20% most deprived areas of the City are 1.5 times more likely to be treated by Tier 3 CAMHS (although this is not a strong relationship)
- North Portslade has the second highest number of children on caseloads. This may need further exploration as Tier 2 has less services in this area.

7.4.4. Waiting times

- 99.7% of referrals waited from 0-4 weeks between referral and assessment (2014/15)
- 91.2% (n=498) waited from 0-4 weeks between referral and first treatment, 7.9% (n=43) waited from 5-13 weeks between assessment and first treatment, 0.9% (n=5) waited from 14-18 weeks between assessment and first treatment.

7.4.5. Benchmarking

Table 12. Tiers 1-3 CAMHS –Benchmarking data 2014/15

	Brighton & Hove	National average	Comparators average ^{d, 78}
Max waiting time for routine appointments	12 weeks	21weeks	34 weeks
Max waiting time for emergency appointments	1 day	11 days	7 days
Did Not Attend rate	6%	11%	7%

Source: Stephen Watkins, NHS Benchmarking Network, 3rd July 2015

Brighton & Hove Tiers 1-3 CAMHS had shorter waits for routine and emergency appointments than nationally or comparators in 2014/15. They also had a lower DNA rate.

7.4.6. 16-17 year olds in Transition

- Only eight young people made the Transition from CAMHS to Adult Mental Health Services caseloads between December 2013 and August 2015. Prior to this data was not recorded.

7.4.7. Teen to Adult Personal Advisors (TAPA)

- Sussex Partnership NHS Foundation Trust TAPA workers provide direct mental health support to young people and young adults aged 14-25 and advice, consultation and

^d Other areas in the benchmarking group include: Berkshire, the Isle of Wight, Oxford, and Surrey and borders.

training to professionals and young people. TAPA workers attend a number of drop-in sessions in different locations in the City, such as at All Sorts, YPC and the YAC.

- Referrals to TAPA increased by 29% since 2012/13 and 7% since 2013/14. The numbers of referrals being accepted have also increased from 110 in 2012/13, to 133 in 2013/14 and 142 referrals accepted in 2014/15. The number of young people discharged has decreased by 16% from 146 in 2013/14 to 122 young people in 2014/15.

7.4.8. Early Intervention in Psychosis Service (14-35 year olds)

- Early Intervention services support individuals experiencing a first episode of psychosis who have not had any antipsychotic treatment or have been treated for less than one year.
- 123 referrals were made to the EIP service in 2014/15 and 39 (32%) were accepted.
- The average wait from referral to assessment was nine days.

7.4.9. Children and young people with physical and mental health problems

7.4.9.1 Admissions to Royal Alexandra's Children's Hospital

Over a two year period from June 2012-June 2014, there were 127 admissions for psychiatric issues (excluding deliberate self-harm).

- 63% of admissions were for psychiatric disorders and 37% for behavioural disturbance due to alcohol or drugs
- Of those admitted for psychiatric disorders, 50% had anorexia, 13% unspecified disorders, 11% depressive or psychotic, 9% anxiety/panic/ASD/ADHD, 8% conversion/somatoform disorders, 1% manic episodes.

7.4.9.2. Paediatric Psychology Support Service (PPSS)

- The PPSS looks after the mental and emotional wellbeing of children with long-term physical health conditions through: monthly parent drop-ins, a therapy group for young people living with chronic illness (funded by Rocking Horse) and a ten week group for young people living with chronic pain, and relaxation workshops for primary age children.
- 92 referrals were accepted for Brighton & Hove patients between January and December 2014.
- 22% were for anxiety, 17% adaption, adjustment or loss issues, 15% pain management and 13% Medically Unexplained Physical Symptoms.

7.4.10. Children and young people with mental ill health and learning disabilities

The CAMHS learning disability service is based at the Seaside View Child Development Centre. The Team consists of a family and systemic psychotherapist, a senior assistant

psychologist, and a part-time clinical psychologist and consultant child and adolescent psychiatrist.

- 75 children and young people (0-18 years) were on the case load in August 2015
- Young people in Transition to adult services are seen jointly with the Community Learning Disability Team
- CAMHS Learning Disability Team also provide training, consultation and outreach to Tudor House and Drove Road, council residential respite services; Downs Park, Downs View, Hillside and Cedar Centre Schools.
- The CAMHS LD Team also jointly run a ten week Positive Behaviour group for parents.

7.5. Tier 4 CAMHS services

Key issues – Tier 4

- 20% of admissions to Tier 4 (Chalkhill) are for eating disorders
- Urgent Help Service referrals have increased by 48% since 2010/11. 59% of referrals are for depression and 40% self-harm
- 68% of referrals to the Urgent Help service are for females.

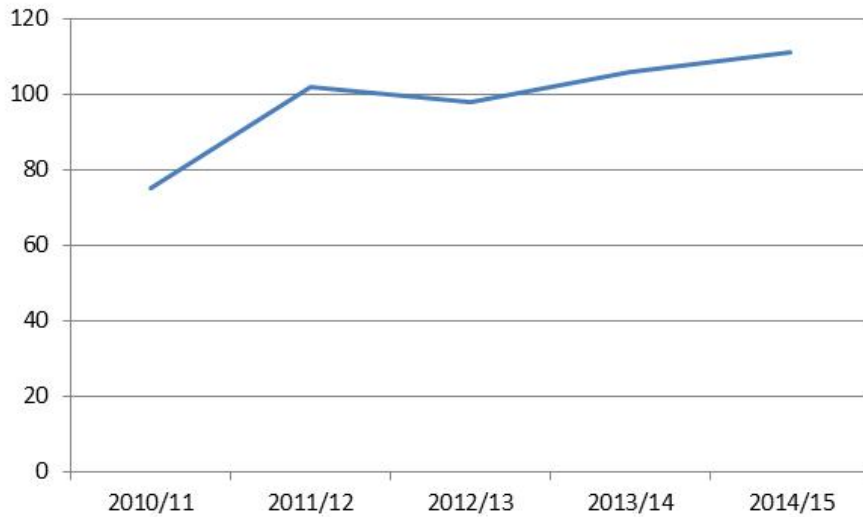
- Tier 4 CAMHS have been commissioned by NHS England since April 2013. They include: day and inpatient services, intensive care units, low secure inpatient units, eating disorder services, and inpatient learning disability services.
- Chalkhill, in Haywards Heath is the nearest NHS England CAMHS Tier 4 unit. It has 16 beds and the usual age of admission is between 12 and 18 years. It has a 95% occupancy rate.
- Between 2010-2015, 20% of admissions to Chalkhill were for eating disorders, 14% for depressive episodes, 11% bipolar disorder and 8% anxiety disorders.
- It was agreed that services commissioned by NHS England are outside the scope of this needs assessment apart from the Urgent Help Service which also includes Tier 3 and is partly commissioned and funded by Sussex CCGs.

7.5.1. The Urgent Help Service

- The Urgent Help Service is a link between Tier 4 and Tier 3 and aims to prevent hospital admission.
- It provides intensive visits to acutely ill children within their own homes over a four to eight week period and supports them on admission to and discharge Tier 4.

- It operates 09:00-20:00 weekdays, with a Chalkhill-based weekend service.

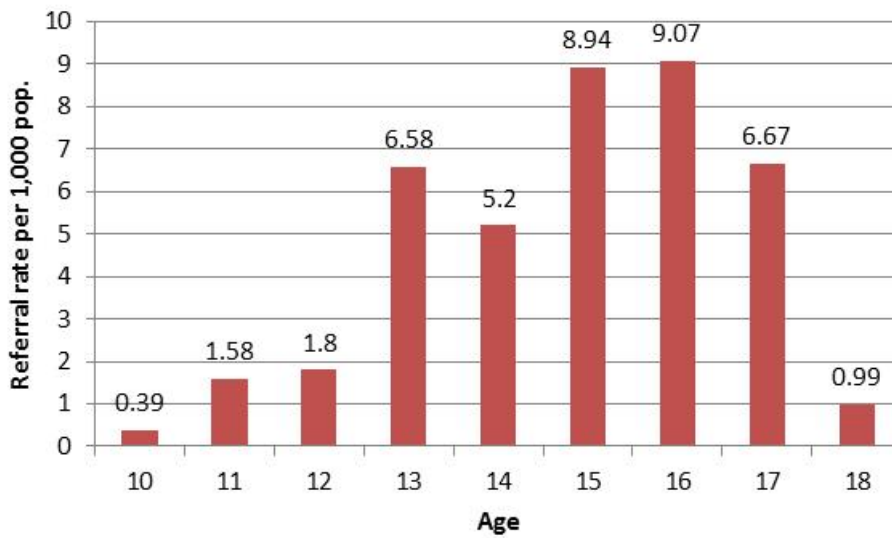
Figure 13: Number of referrals to Urgent Help Service 2010/11 – 2014/15 (n=492), Brighton & Hove



Source: Urgent Help Service referral data

- 111 referrals were made to Urgent Help from Brighton & Hove in 2014/15 – a 48% increase since 2010/11 and 4.7% increase since 2013/14. This may be due to better recording.
- 58% of referrals in 2014/15 came from Tier 3 Community CAMHS Team, 16% A&E, and 10% hospital based paediatrics. Others included: other secondary care specialities, other services or agencies, social services, GPs, and self-referrals.
- 68% of referrals were female, 32% were male (2014/15).

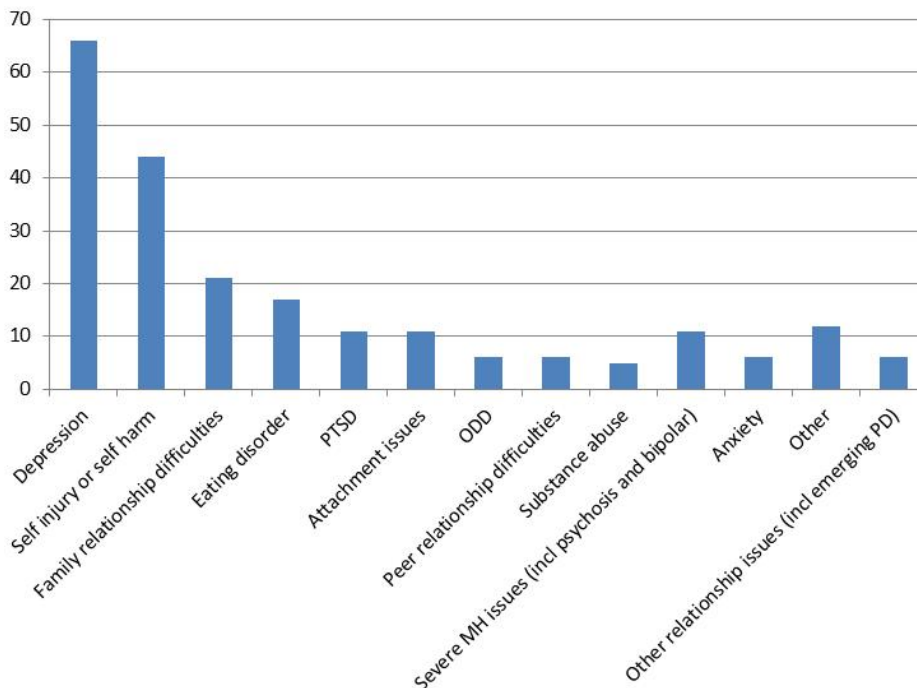
Figure 14: Age of Urgent Help referrals, rate per 1,000 pop. 2014/15 Brighton & Hove



Source: Urgent Help Service referral data

- 15 and 16 year olds had the highest rate of referrals.
- 80% of referrals were White British and 20% BME.

Figure 15: Presenting issues for referrals to the Urgent Help Service, 2014/15 (n=222), Brighton & Hove



Source: Urgent Help Service referral data

7.5.1.1. Reasons for referral 2014/15

- 59% of referrals were for depression (patients will often present with more than one recorded issue)
- 40% of referrals were for self-harm or self-injury
- 19% of referrals were for family relationship difficulties and another 5% were for peer or other relationship difficulties
- 15% of referrals were for eating disorders
- 10% of referrals were for PTSD, attachment issues, or severe mental health difficulties.

7.5.1.2. Length of stay

- The average length of stay with the Urgent Help Service was 69 days.

8. Projected needs in 3-5 years and 5-10 years in Brighton & Hove

Key Issues

- The 10-14 age group is projected to increase by 11.5% (1,500) by 2024; this will place an increased demand on schools for prevention, as well as meeting the emotional and mental health needs of pupils in this age group. More support will also need to be given to parents and carers
- The 20-24 age group is projected to decrease by 7.5% (2,300) by 2024, this may help to increase capacity within counselling services for young people
- Tier 3 and some Tier 2 CAMHS services are seeing an upward trend in referrals as well as an increase in the complexity and severity of referrals
- Current trends suggest that there is increasing need related to children and young people with depression, anxiety, self-harm, and suicidal thoughts
- Mental health conditions are accompanied by complex social issues such as domestic violence, parental substance misuse and the impact of the economic down turn on accommodation and employment.

Population projections have an essential role in assessing the future need for services for children and young people in the City.

- The resident population is projected to increase to 298,400 by 2024, a 6.7% increase compared to 2014 (an increase of 18,700 people)
- The 0-19 population is predicted to increase by 5% (3,000 more children and young people) between 2014 and 2024
- The largest increase is seen in the 10-14 age group, where there is a projected increase of 11.5% (or 1,500 children and young people)
- The 20-24 age group is projected to decrease by 7.5% (2,300 people).
- The number of births per year in the city is projected to be approximately 3,300 per year from 2014 to 2024.

Table 13: Predicted population change by age group 2014 to 2024, Brighton & Hove

Age	2014	2024	Difference (n)	Difference (%)
All ages	279,700	298,400	18,700	6.70%
0-4	15,300	15,400	100	0.70%
5-9	14,100	14,800	700	5.00%
10-14	13,000	14,500	1,500	11.50%
15-19	16,500	17,200	700	4.20%
20-24	30,800	28,500	-2,300	-7.50%

Source: ONS 2012 based projections

There are currently no robust projections available about the future prevalence of mental health conditions amongst children and young people.

However, local service data has shown recent increases around the needs of the following groups:

- The number of children and young people presenting to services with depression and anxiety
- The number of children and young people seeking help around self-harm and suicidal ideation
- The number of children and young people seeking help who have mental health problems alongside complex issues such as domestic violence or substance misuse
- Children and young people with mental health problems linked to the economic downturn and issues such as employment or accommodation
- Children and young people with complex needs referred for therapy as a result of parental substance misuse

In addition, there has been an increase in the number of referrals to Tier 3 CAMHS in 2014/15 - an 11% increase in the number of referrals in the last six months of 2014/15 compared with the same time period the previous year. Some Tier 2 services also report an increase in the number of referrals, and particularly in the severity and complexity of referrals received.

9. Views of the public

Key issues – Children, young people and parents/carers

- The views of 165 children and young people and 235 parents/carers were captured for the JSNA through focus groups and an online survey
- Children, young people and parents/carers wanted easier ways to find out about help: lists, online, through schools
- They wanted early help and support when they needed it, including within schools
- Many children, young people and parents/carers had negative experiences of Tier 2 and 3 CAMHS services, including: lack of early intervention, long waits for assessment, not being listened to, poor communication between professionals and lack of a joined up service
- Some people felt Tier 3 CAMHS was not young people friendly
- Children, young people and parents/carers were dissatisfied with transition to adult mental health services and services no longer being available after the age of 18
- The ideal service would be friendly, listening, and local and offer a choice of treatments.

The views of the public in this context relates to the children and young people who use the mental health and emotional wellbeing services in Brighton & Hove and their parents/carers. It is important that their first-hand knowledge of using services has a role in influencing any future service developments. Their views have been gathered by using a variety of methods: a literature review of existing user led service consultations; focus groups and an on-line survey.

9.1. Literature review

A request was made to local services for copies of any recent reports or documents they had written about children and young people's mental health and emotional wellbeing services. A summary of the documents received and the key issues covered are included in Appendix 3. These included views from Mind Me Up, BME Young People's project, Parents feedback to CAMHS Learning Disability Services, Amaze, Parents of Children with disabilities, Right Here, Mind LiVE consultation, Amaze and PACC, parents feedback on CAMHS family support worker service, Dialogue Counselling service report, feedback on YPC counselling service, Moving on from CAMHS Mind focus group, WiSE mental health and child sexual exploitation and Healthwatch report on patients' experience of CAMHS.

Some of the issues highlighted in these papers that needed improvement include: communication and information; Transparency about services; involvement of young people and parents in service planning; Transition to adult services; training for parents and carers; service user led training for professionals; shorter waiting times for CAMHS and counselling services. These issues were used to inform the questions asked in the subsequent focus groups.

9.2. Views of children, young people and parents/carers

The views of children, young people and carers were collected by a variety of methods. Focus groups were held with 70 children and young people and 20 parents/carers and an online survey which had responses from 95 young people and 215 parents/carers. The general public were targeted via the online survey which was promoted through schools and current or previous users of CAMHS were targeted through the focus groups.

The high representation of views from LGBT people in some responses is due to a number of focus groups being run by Allsorts; which means there may be some sample bias and the views expressed may not necessarily reflect those of all children and young people using mental health and wellbeing services. For more details on the methodology used and characteristics of respondents see Appendix 4. Detailed analysis of the key themes emerging can be found in Appendix 5.

9.2.1. Times when young people most felt they needed help

The times when young people in the online survey most felt that they needed help were:

- If they were anxious or worried (79%)
- If they were not feeling good about themselves (74%)
- If they did not feel able to cope (74%)
- If they were feeling sad a lot of the time (72%)
- If they were feeling stressed (e.g. due to exams) (56%)
- If they were being bullied or experienced prejudice (55%)

Whilst other times were cited by fewer than half of young people other times included if they were:

- Feeling like they wanted to harm themselves (47%)
- Feeling suicidal (41%)
- Moving from primary to secondary school (36%)
- Finding it hard to behave (34%)
- Having eating problems (not able to eat, eating too much or binge eating) (32%)
- Being hurt or abused in some way (27%) or someone in their family was being hurt or abused (17%)
- Someone in their family was very unwell (24%), had died (24%) or if their parents had separated (18%).

More than one in five young people experienced the following and did not know where to go for help:

- Not feeling good about themselves
- Not feeling able to cope*
- Feeling anxious or worried*
- Were being bullied or experienced prejudice*
- Feeling sad a lot of the time*

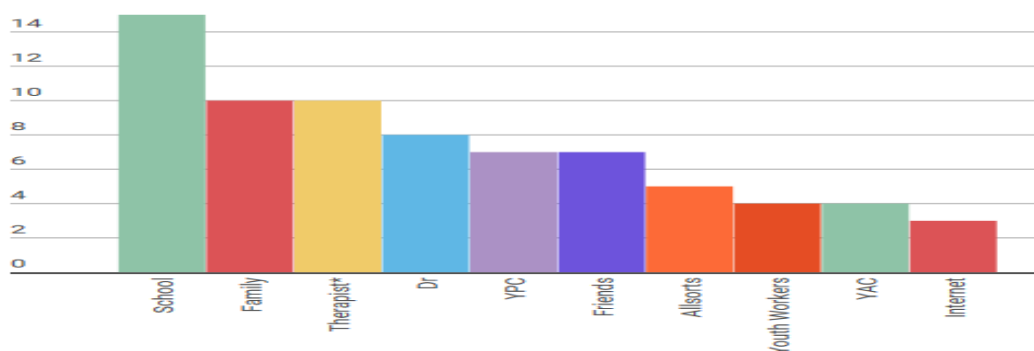
For those with an asterisk (*) above, another one in five (or more) young people responding to the survey experienced the following and tried to access help but said that they did not receive help.

Young people in the focus groups identified that: earlier intervention, schools understanding Trans, listening services and information on services would have helped if offered sooner (45 comments)

Parents/carers (online survey) felt the most common times when help was needed were the same but in each case the percentage of parents or carers saying that their young person had experienced these issues were lower than those stated by young people themselves. Parents and carers were also more likely to know where to go for help. More than one in five parents said that they had tried to get help for their young person but did not receive it in the following instances: if they didn't feel able to cope; were feeling anxious or worried or; were not feeling good about themselves (self-esteem).

9.2.2. Sources of support when feeling stressed

123 comments were made by children and young people in focus groups about sources of support they had when feeling stressed.



* also includes counsellor and psychologist

“A great worker at CAMHS and connections really helped me.” (Young person online survey)

“The Brilliant staff at all my child's schools. Who understood his needs and wellbeing from his first day to his last the support and advice was fantastic.” (Parent/care online survey)

Respondents to the online survey were also most commonly using the above services: 48% GP, 35% counselling and 29% youth drop-ins. Approximately one in ten respondents had used Tier 2 CAMHS, a similar percentage had used Tier 3 CAMHS and between 11-16% of respondents had used acute services (such as A&E or the Royal Alex Children’s Hospital) in the last year. When young people received help at times of stress, they mostly felt that the support that they received helped a little or a lot. They particularly valued support when:

- Moving from primary to secondary school (81%)
- If they were feeling anxious or worried (71%)
- If they were feeling stressed (70%).

Responses were less positive for support received for the following:

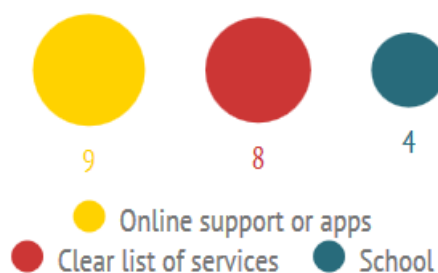
- If they wanted to harm themselves (54%)
- If they were being bullied or experienced prejudice (48%)
- If they were feeling suicidal (44% said the support received helped a little or a lot).

The services which young people were most aware of included youth drop-ins, counselling in the community and voluntary sector, counselling in school and their GP surgery (for all these services fewer than one in five were not aware of these local services). However, over a third of respondents were unaware of support in schools (other than counselling) or on-line counselling (for example E-Motion). As may be expected many more were unaware of the different levels of CAMHS services in the city and use of these services is lower than for the previous services mentioned.

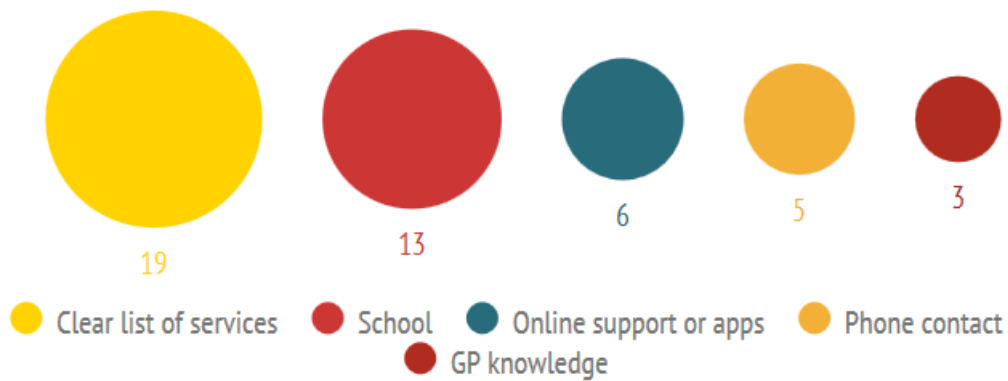
9.2.3. Finding out about help

There were 84 comments from young people and parents/carers online about the need to make it easier to find out about help. Both young people, and their parents and carers said they would like a clear list of services for different needs, and importantly that it is available in one place. For young people in particular, they wanted support available online and/or through apps. Parents / carers wanted more information available through schools on what support is available and how to access it.

24 comments were made by young people in the online survey about easier ways to find out about help.

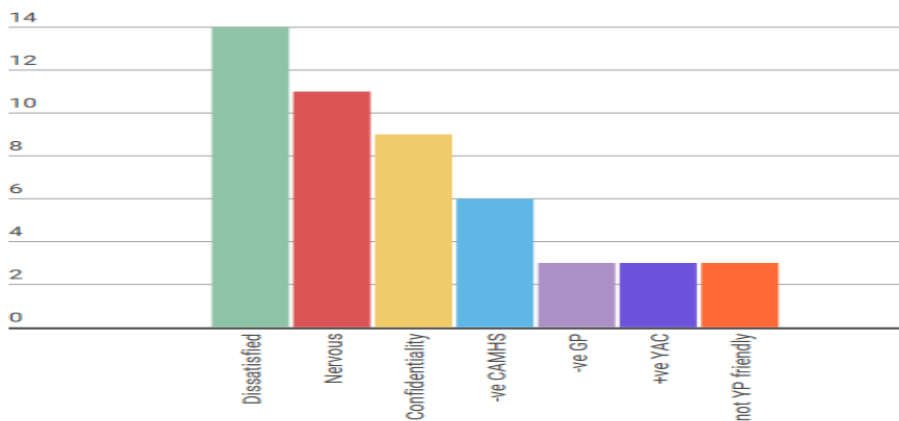


60 comments were made by parents in the online survey about easier ways to find out about help.



9.2.4. Feelings at first appointment or assessment

(CYP Focus groups 79 comments)

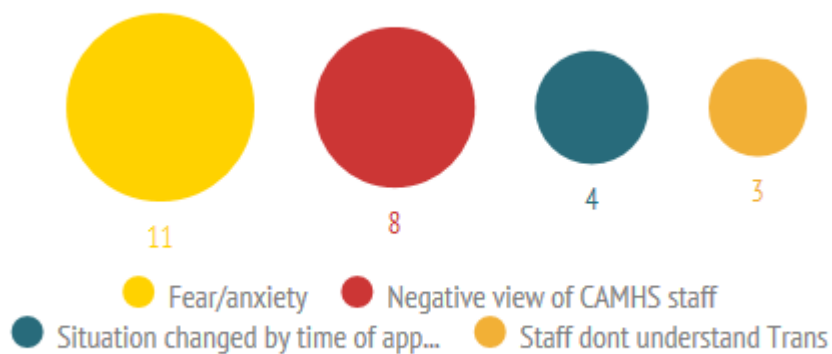


“I feel that the waiting time was quite long, especially when I was in a desperate situation. It was 3 months until I had an assessment for counselling It was a further 3 months until I started counselling with YAC. However, I understand that there are a lot of people who seek counselling.” (Young person online survey)

Children and young people were dissatisfied with the appointment and assessment process due to long waits, purpose not being explained and having to repeat everything. They felt the environment of Tier 3 CAMHS was not young people friendly.

9.2.5. Reasons for not attending appointments or dropping out of treatment

(CYP Focus groups 96 comments)

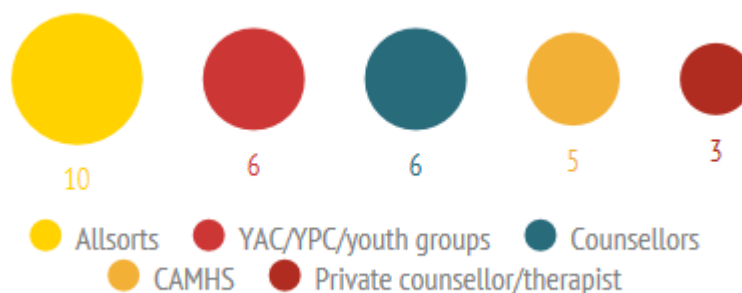


Children and young people felt fear and anxiety because they didn't know what to expect, had a fear of the diagnosis or of being told off, after missing an appointment. Some found CAMHS staff patronising, too old to relate to, had a blunt manner or they would have preferred to have someone of a different gender. Sometimes their situation had changed by the time the appointment arrived or they had started to feel better.

Reasons for keeping an appointment were friendly and welcoming staff and feeling that it had helped.

9.2.6. Services that have helped the most

(CYP Focus groups 63 comments)



Services were found helpful where they were reliable, consistent, trusting and listening. The parents' focus group made 17 comments about services that they felt worked well. The most commonly repeated ones were Tier 3 CAMHS (5 comments) and the Tier 3 CAMHS

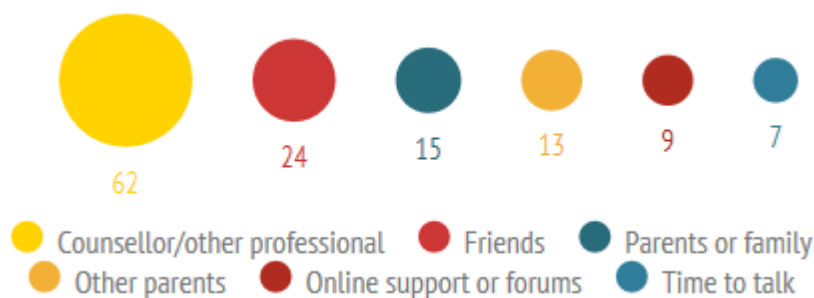
Learning Disability Team. Over the previous year some parents felt they had a good relationship with CAMHS, being copied into letters, having Acquired Brain Injury Children’s Community Service (ABICCUS) involvement set up following discharge from hospital for a head injury and quick response to concerns about gender identity. Some were positive about the CAMHS Learning Disability behaviour course pilot, monthly visits to school by CAMHS Learning Disability Team and counselling at one school.

The online survey asked young people, parents and carers about what had helped them, rather than which services in particular.

9.2.7.1. What helped most? (Young people 52 comments)



9.2.7.2. What helped most? (Parents/carers 108 comments)



For both young people, parents and carers, the thing that helped most was a counsellor or other professional. These other professionals included schools staff and GPs amongst others.

“Someone listening to me and helping me understand the reasons why i was feeling the way i was. Teaching me strategies for when i feel like i can't cope.” (Young person online survey)

“Relationship with her therapist and sharing information, concerns with her” (Parent/carer online survey)

The online survey also asked young people and parents about what else would have helped. Young people made 41 comments the most frequent ones being: More help at school, not having to wait so long, being taken seriously/listened to. Parents made 83 comments and also wanted more help at school and shorter waits, as well as more joined up pathways, more awareness, better signposting and long term support including a parent forum.

“prompt responses from social services/mental health services. Less buck passing and referring on. Someone who would actually do something not just pass me on to someone else. when you need help you can't wait 2 weeks plus before anyone even gets back to you.”
(Parent/carer)

Young people and parents/carers in the online survey also identified characteristics that they felt made a good service.

9.2.8. Characteristics of good services

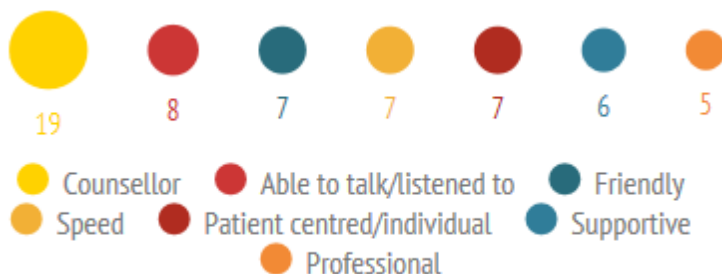
45 comments were made by young people in the online survey.



“They actually listened to you” (Young person online survey)

“I was able to see the same person each week and my counsellor was very suited to understanding my issues, they took into account what I needed.” (Young person online survey)

96 comments were made by parents/carers in the online survey.

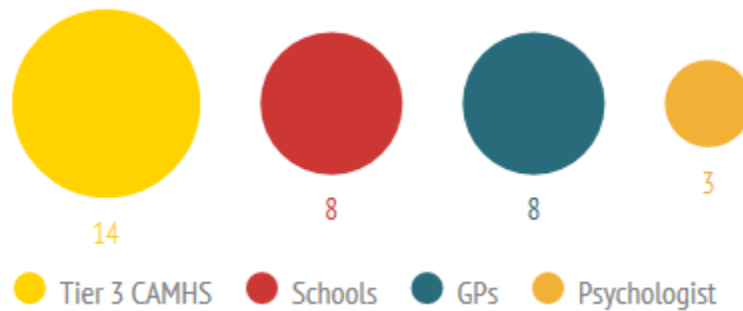


The parents comments online agreed with the young people above about what constituted a good service. Many of them also included the need for a patient centred service.

“School were very supportive and took the issues seriously and arranged counselling and were available for my child and communicated v well with me (parent/carer online survey)”

9.2.9. Services which didn't meet needs and could have been better

(CYP Focus groups 72 comments)



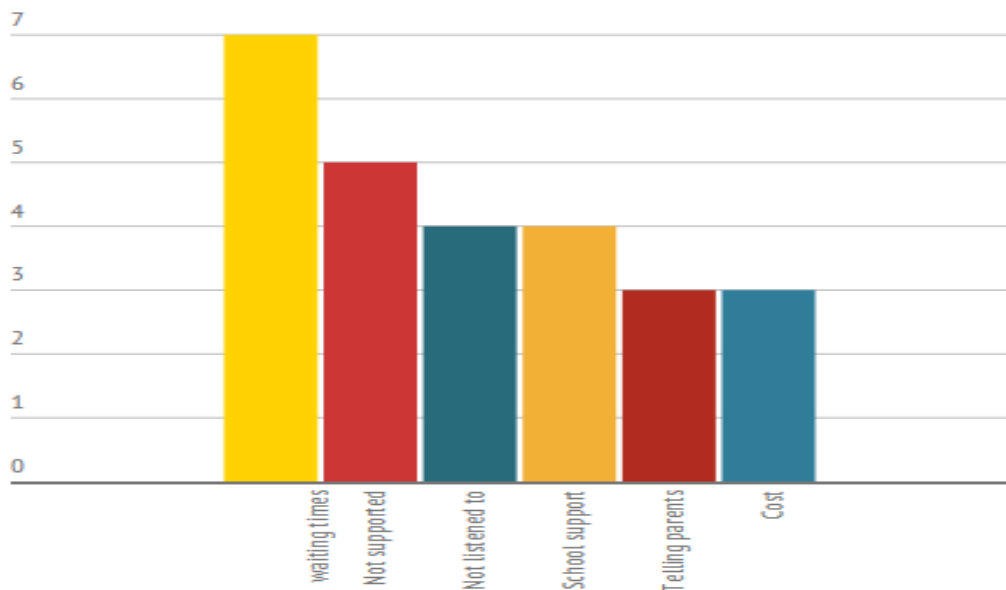
Some children and young people had negative experiences of Tier 3 CAMHS: feeling patronised, not understood or listened to and asked unrelated questions – having a poor relationship with their worker, or feeling they had to "fit their box." Some children and young people reported that the service was too - symptom focused, unreliable with cancelled appointments, not accessible, and they felt they were discharged too soon. There was a lack of understanding of Trans issues and frustration that mental health problems weren't treated whilst waiting to be seen by the gender clinic.

Some had negative views of services provided in the school setting, with concerns about confidentiality and being seen by their friends if seen at school. They felt the support they had received through schools was infrequent and repeated what they already knew. They were critical that help was only available if a person could actually make it into school. Some felt that schools didn't care about wellbeing, didn't follow through on actions or find time to talk. More help was needed with bullying; a better understanding of Trans issues was needed and mental health issues should be taught before Year 10.

Some respondents said that GPs “*had to be pushed*” to offer support and needed more training in specifics. They were also critical of seeing a different GP each time and being given some worrying medication advice.

The online survey asked what was bad generally, rather than specific services that didn't meet needs but the comments made reflected those made in the focus groups.

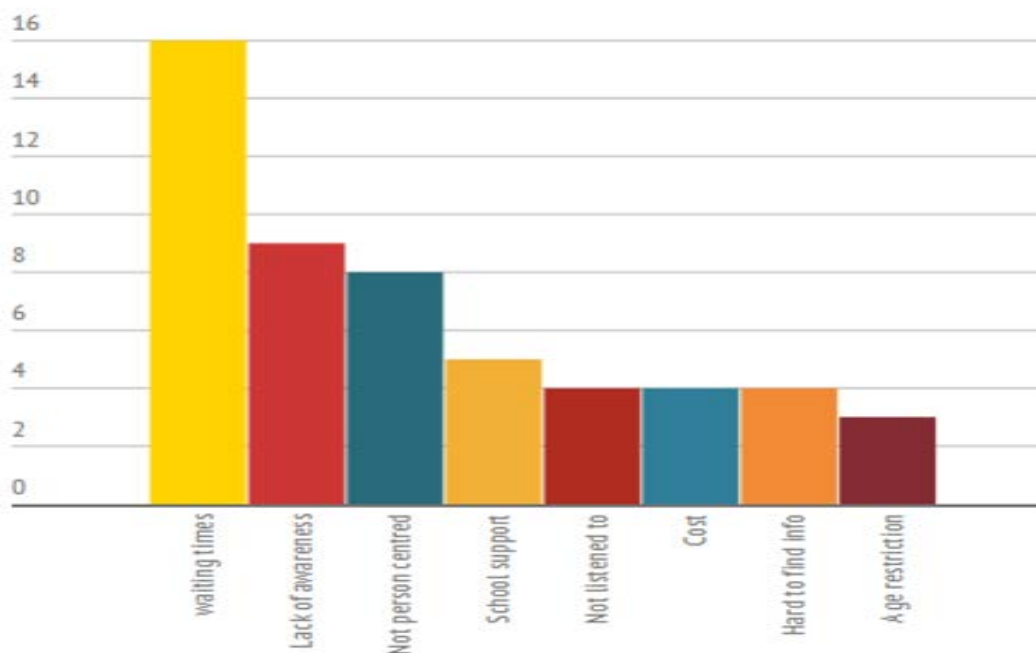
Young people made 49 comments about things that were bad about services.



“The waiting list for counselling was so long and I needed treatment as soon as possible so I had to go private.” (Young person online survey)

“CAMHS – my worker was really judgemental and had a go at me if I missed an appointment or didn’t do my homework... GP not really taking me seriously before 18 and not knowing enough about mental health issues.” (Young person online survey)

Parents/carers made 82 comments about things that were bad with services



*“Sometimes feel dictated by protocol, rather than tailoring responses to individual families.”
(Parent/carer online survey)*

Both young people and parents thought waiting times were bad as well as not feeling supported or listened to. Parents also thought there was a lack of awareness of young people’s mental health and that services weren’t person centred.

Transition was also an area that was not thought to work well by either young people or parents.

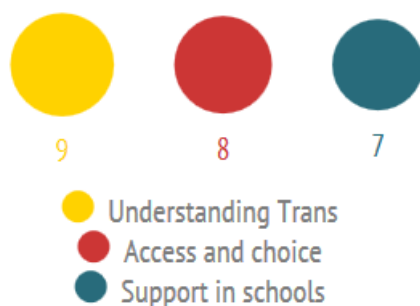
“The Transition from CAMHS to the adult mental health team was really difficult and i didn't feel supported enough. I didn't really like the adult service so i stopped getting support in this way.” (Young person online survey)

“We have taken quite a big financial hit navigating through difficult waters so a well resourced CAMHS which responds quickly and follows a person through without the crazy fracture which occurs at Transition/18yrs I don't think anyone can say that we have had an effective CAMHS Service for quite a while now, which is partly about resourcing, but also about the way it is set up.” (Parent/Carer online survey)

Focus group parents/carers expressed 28 views about services they thought worked less well. Some parents had negative views about CAMHS: long waits, no out of hours’ service, the assessment process, rationing of service, no long term care, early discharge, difficulty in seeing a psychiatrist, with Tier thresholds, poor communication and admin and lack of treatment choice. Some felt schools didn’t provide enough early intervention, educational psychologists or SENCOs. 32 different comments were made by parents about gaps in services but three parents cited support with self-harm and three a lack of educational psychologists.

9.2.10. Could have been better

(CYP Focus groups 75 comments)

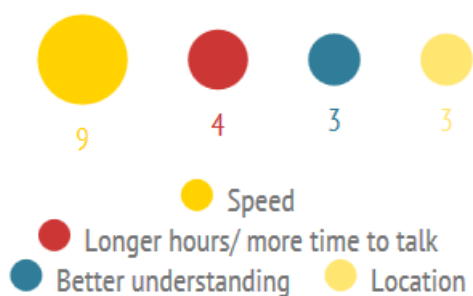


Children and young people felt there could have been better understanding of Trans issues by CAMHS staff. More flexible and accessible service with a choice of treatment options

would have been better - including drop-ins after school, evening appointments, more going on locally, choice between Cognitive Behavioural Therapy, art or play therapy and fun activities.

School support would be better with quicker access to counselling, youth workers in schools to help with bullying, advertising services in school journals, teachers treating everyone the same, teachers trained in mental health issues and improved school management of self-harm - including training children and young people.

In the online survey 37 comments were made by young people about things that could have been better. These also included quicker access to services as well as better location of services.



Parents completing the online survey also wanted speedier access to services, more counselling or support in schools, more mental health awareness and better co-ordination of services.

“Communication and speed of referrals could have been much better. Also keeping parents informed of diagnosis, and advice on how to manage during this difficult time for the family”. (Parent/carer online survey)

9.2.11. Parents’ involvement in child’s treatment

In the parents focus groups 15 parents commented that they were not involved in their child’s treatment by CAMHS, GPs or the school. The six that said they were involved spoke about being given information on courses, re-contacting services, and written information on CAMHS services. Other forms of involvement were attending the child's first appointment, and having a six weekly appointment for themselves.

9.2.12. Parents’ satisfaction with professionals

Eleven negative comments were made by parents in focus groups. Parents reported feeling frustrated and exhausted in “battling for help”. They had to complain due to lack of response. Some said that the initial contact from their GP was poor, some professionals lacked knowledge, some schools didn’t communicate well and there was “no flow” between services. Some lacked confidence in the psychiatrist, felt it was implied the child was getting

better (despite lack of evidence) to justify withdrawing access to services and some complained about rude reception staff. A more positive comment was made that professionals were fantastic, prompt and offering a range of services.

9.2.13. Top priorities for an ideal service

Both children and young people and parents were asked in their focus groups what their top priorities would be for an ideal service. Children and young people made 70 different comments, apart from the following.



Children and young people would like a friendly, listening, welcoming service, with non-judgemental staff. They would like clinics to be local, with a comfortable and safe environment. They want a range of treatment options, activities and groups. They want an accessible service with an easy appointment system giving a choice of times and shorter waits. They want flexibility, including outreach, out of hours telephone contact, and email.

Parents made 41 comments. They wanted more resources, clearer signposting, referral and assessment processes, and more flexible and accessible services, quicker and earlier help, listening to parents, more expertise and joined up services.

9.3. Healthwatch

The views of children and young people about local CAMHS have also been collated by Healthwatch, in their report *Putting the Pieces Together (2014)*.⁷⁹ This paper is a review of recently collated research on CAMHS services in Brighton & Hove. The overarching issues highlighted by the review include: Transition from child to adult mental health services; obtaining a diagnosis; continuity of therapist; therapeutic support for parents and access to support in a crisis. Eight recommendations are made for improving the service.

- Inform GPs of services available and how to refer

- Information pack on entering CAMHS – outlining rights, complaints, expectations and information on support available from community and voluntary organisations
- Ensure MDT approach to diagnosis including young person and carer
- CAMHS should review their assessment criteria to meet the needs of children with wide ranging symptoms mild impairments on the Autism Spectrum
- Prioritise continuity of therapist and provide information on how to change a therapist
- Review the effectiveness of parenting skills versus therapeutic interventions for parent carers
- Make young people and people who support them aware of current crisis options and review out of hours support for gaps
- Create a comprehensive policy around Transition.

9.4. Brighton & Hove Trans Needs Assessment. 2015.

Trans issues were voiced in the Allsorts focus groups and have been included in the above analysis. This builds upon the findings of the Trans Needs Assessment (2015). This made the following recommendations based on the comments of young Trans people:

- The fragmentation of the CAMHS pathway makes it hard for families and children to understand. A review of the pathway involving CAMHS, Primary care, Allsorts, schools and service users was recommended
- Need for specialist counselling for Trans children and young people, particularly for those under 11
- The role of Tier 2 in schools needs to be strengthened, with more awareness of the Brighton Hove Trans* Inclusion Schools Toolkit
- Need for more training about gender identity for professionals working with children and young people
- CAMHS also need to promote information to support parents of Trans and gender questioning children
- Higher education should take further steps to tackle Transphobia and promote Trans equality.

10. Views of professionals

Key Issues

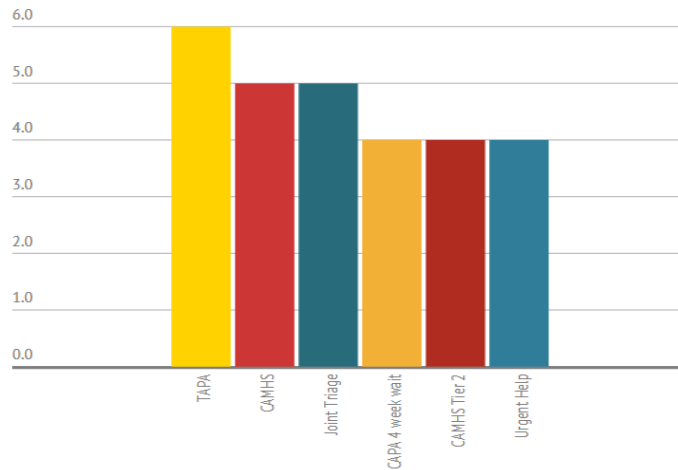
- The views of 62 professionals from the statutory and voluntary sector were captured for the JSNA through face to face interviews, telephone interviews and a survey of GPs.
- Many of the issues identified by children, young people and parents were also highlighted by the professionals' voice. Including the need for:
 - Improved information about services
 - More early intervention and prevention
 - More accessible services
 - Improved transition to adult mental health services
 - More choice in treatment and therapies
 - A young people friendly service
 - Greater involvement of parents/carers where appropriate
- Other issues included gaps in specialist services, and the Tier 3 service model not always meeting the client's needs.
- Young people with autism, self-harm, learning disabilities, children in care, ADHD, eating disorders and challenging behaviour were identified as having unmet needs.
- The need for more integrated working between child and adult learning disability services was identified, including named care co-ordinators and joined up pathways for transition.

10.1. Interviews with professionals

Collecting the views of service providers about children and young peoples' mental health and emotional wellbeing provision, is important in getting a broad overview of unmet needs in the city and how well current systems are working to address these. The views of professionals were captured by carrying out 26 semi-structured interviews, 2 telephone interviews, a survey of 34 GPs at a Practice Learning Set event and by reviewing written comments and notes of relevant meetings that have been received. The face to face and telephone interviews consisted of 11 question areas. Details of participants are included in Appendix 4.

10.1.1 What works well?

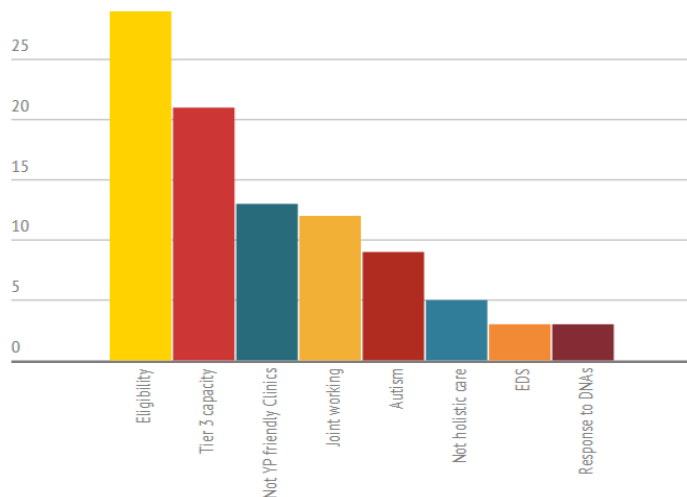
Several aspects of the current service were felt to work well. Those that were mentioned more than three times out of 46 comments included: (Professionals Interviews 46 comments)



“There’s a lot of support in the city, is stuff there – it’s good compared to other areas.”

10.1.2. What works less well?

The following areas were identified as working less well. (Professionals interviews 115 comments)



“Bring CAMHS out of the clinic. Expertise should be more community based and in schools.”

- **There is a lack of clarity around the referral system and eligibility criteria and the thresholds are too high** – GPs commented that their referrals were often rejected by the joint Tier 2 and 3 triage without a clear reason. Sometimes other services were signposted for a referral instead, but it wasn’t clear who should be instigating this. It was also felt eligibility criteria were too high and were unclear. GPs were also unsure

about the role and competency levels of school counsellors; the pathway for family therapy/counselling and felt a consistent response to self-harm was lacking

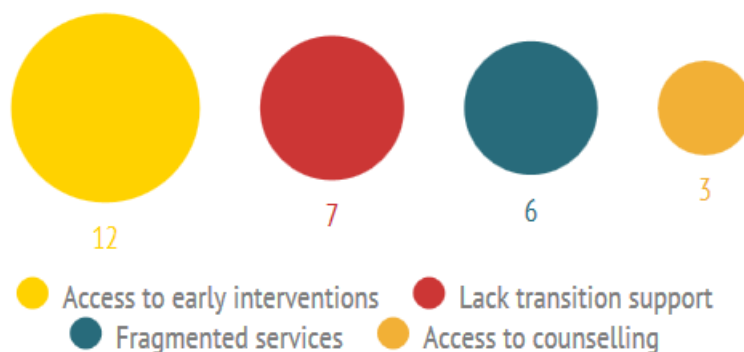
- **The capacity within CAMHS is insufficient to meet demand** – There was a perception that the capacity within Tier3 CAMHS was insufficient to meet demand. This had an impact on the accessibility of services, reflected in waiting lists for CAMHS assessments and a lack of availability of Psychiatrists. Tier 2 also had long waits for school and community counselling services and there weren't felt to be enough primary mental health workers
- **The clinic based structure of Tier 3 is not young person friendly** – it was felt that Tier 3 venues needed to be more based within the community, designed with young people at the centre so that the environment felt more welcoming and less stigmatising
- **There are difficulties in getting autism and ADHD diagnosis and post diagnostic treatment.** As autism and Attention Deficit Hyperactivity Disorder are judged to be a lower risk than some other conditions they have longer waits for diagnostic assessment. Also once diagnosed with autism, support was only available to those with a co-morbid mental health condition
- **Lack of a holistic approach** – The distinction made by CAMHS between behavioural problems/conduct disorders and mental ill health meant that social care needs were not always being addressed
- **Lack of joint working** – The need for improvements in working relationships were cited in several areas: schools and GPs need to share information and CAMHS need to offer ongoing information and support to schools; GPs and CAMHS and Psychiatry and Paediatric Consultants could also have closer working relationships
- **Problems with the eating disorder service-** There was a lack of co-ordination in the eating disorder service and not enough services for those who were not yet “ill enough” to receive CAMHS services
- **Lack of flexibility in appointment system** – Vulnerable hard to reach children and young people who missed more than three appointments were not being followed up.

10.1.3. What are the gaps?

95 comments were made about gaps in services but only 4 of these related to Tier 1 and mainly related to a lack of information. These included: GPs not being young people friendly; GPs not knowing where to refer to for children who needed behavioural support; GPs wanting a central information point or description of care pathways, so that they know where to refer to.

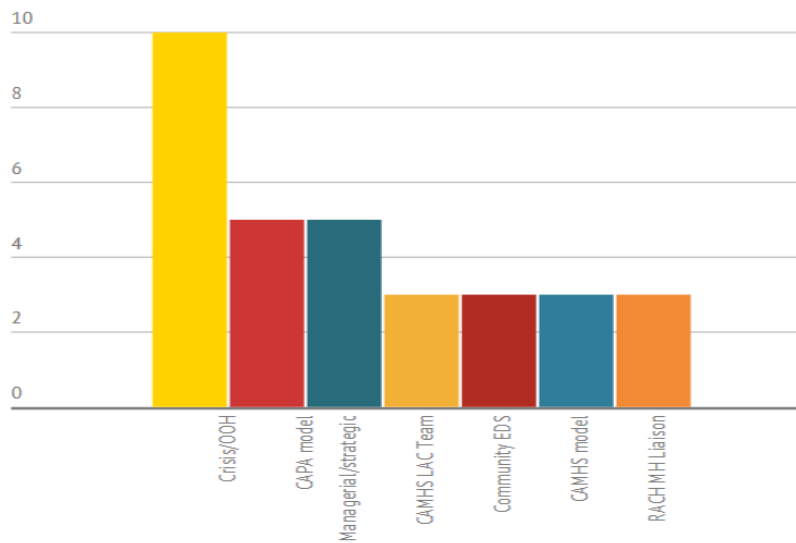
10.1.4. What are the gaps in Tier 2?

(Professionals interviews 95 comments)



- **Access to counselling** – There is not enough school counselling available and some children fall into the gap between school counselling and CAMHS services
- **Access to early interventions** – Not enough capacity or early interventions; no family therapy apart from in Tier 3; lack of support for children out of control at home but not school; lack of CAMHS outreach workers in schools; not enough primary mental health support; gap left by Connexions service in support for deprived areas; services don't meet the needs of boys and young men
- **Fragmented services** - Early Help and early intervention aren't linked up; No interface between YMCA and Early Help; Tier 2 aren't joined up enough with Tier 3; Youth Offending Service (YOS) and Ru-ok? get few referrals from Tier 2 or Tier 3; Difficult to get CAMHS to attend school TAF meetings (Team Around the Family); Poor communication between CAMHS support workers (school setting)
- **Lack of support at stages of Transition** – More support is needed at the primary/secondary school stage of Transition and for the Transition to adult mental health services (AMHS). AMHS don't attend CPA Transition planning meetings and don't understand the needs of 18-25 year olds. Different services also have different threshold for moving to adult services.

10.1.5. What are the gaps in Tier 3? (Professionals Interviews 95 comments)



- **Gaps in service provision** – Gaps in specialist areas of provision were identified including: out of hours/crisis service provision; Community Eating Disorders Service; Paediatric Mental Health Liaison Service at The Royal Alex Children’s Hospital in Brighton; no dedicated CAMHS Children in Care team, instead Children in Care are seen as part of the Tier 3 team; lack of specialist support for early years.

There was a gap in providing immediate support for self-harm, suicide ideation, depression and anxiety.

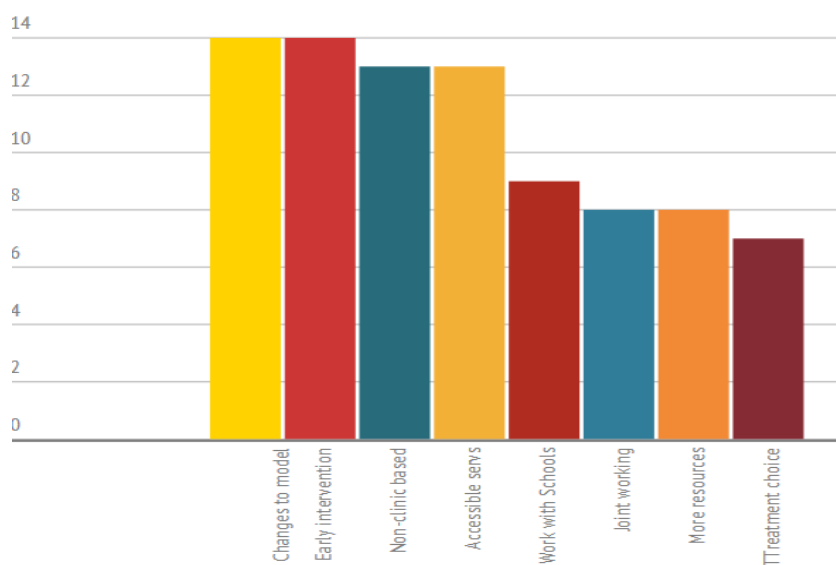
Some aspects of service had delays or didn’t meet demand: long waits for ASC and Attention Deficit Hyperactivity Disorder diagnoses; Parents are asking for assessments for Pathological Demand Avoidance (PDA) – not a commissioned service; The Functional Family Team (FFT) no longer getting referrals from Royal Alex as social worker no longer based there; services don’t meet the needs of boys and young men; no parents support group for Attention Deficit Hyperactivity Disorder;

Psychiatrist time would be optimised more with better links to Tier 1 school nurses for medication monitoring and more nurses to “hold” cases to free up psychiatrist capacity.

- **Service model issues** – The CAPA model is not designed to work with the comorbidities or the long term complex cases Tier 3 sees and the assessment process does not allow for a rapport to be built up with the young person. The CAMHS model does not reflect the working of modern life, and lacks flexibility in its working hours and access criteria.
- **Managerial gaps** - CAMHS don’t take parents seriously enough; managerial and strategic gaps – in strategic use of psychologists; management of vacancies caused

by maternity leave and sickness absence needs improving; Tier 3 CAMHS staff need training in LGB and Transgender issues, and school staff need mental health awareness training.

10.1.6. How could the Children and Young People’s Mental Health and Wellbeing services be improved? (Professionals interviews 94 comments)

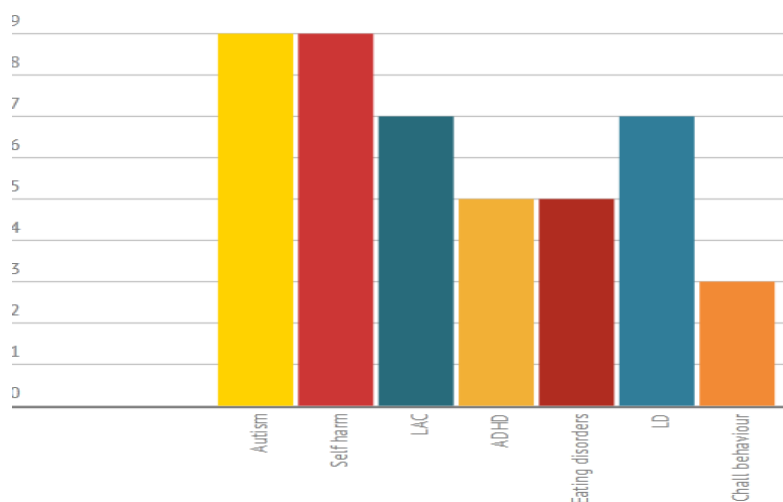


- **Make changes to the service model** – Have a more holistic service, Tier 3 needs to be more outcomes focused and have a complete restyle if the culture is to change; Clinical overview/co-ordination of Tiers 1-3; Young people’s voices at the centre of everything; Extend Tiers 2 and 3 triage to Early help Hub/Multidisciplinary team format; CAMHS to evaluate how it disempowers children; a model with an ongoing relationship with a family rather than numerous interventions by variety of agencies would be more effective; Home support for parents.
- **More focus on earlier intervention/prevention** – Services would be improved by more focus on early intervention/prevention work; teach children from early years up to manage their feelings; CAMHS drop-in service for early years staff; more training for Tier 1 early years staff on who and when to refer; engage parents of children on the Triple P programme; more Parent Infants Psychotherapy. CAMHS to contribute more to the needs of children with emotional and behavioural problems.
- **A non-clinic based CAMHS service** – The current CAMHS service would be more accessible if the physical location was more community based and more outreach focused and assertively following up those that don’t attend their appointments.
- **More accessible service** – Lower thresholds for accessing services, have shorter waiting times and more out of hours services in Tier 3. Have clearer pathways for

self-harm and eating disorders. Map the provision CAMHS has to offer and have better signposting. Have better co-ordinated self-help information.

- **Work with schools** – Comments included that CAMHS could become a school based service, with school staff trained in the early signs of mental health problems and managing self-harm and CAMHS staff outreaching into schools. CAMHS staff should also participate in the Team Around the Family meetings.
- **Improved joint working** - CAMHS to work jointly with Seaside view/other services e.g. hospital; More integration and joint assessments with social workers; Specialist CAMHS team embedded in Children in Care service; more integration of early years' service with CAMHS; maintain Tier 3 lead Psychologists meetings with YAC and YPC; closer working with the voluntary sector, including the use of volunteers in creative activities.
- **Improvements in staffing and resources** – Better resources and an increase in staff and capacity are needed. Vacancy filling needs to be speeded up. Staff need training and better understanding of BME, LGBT, disabled children, ASC and Attention Deficit Hyperactivity Disorder, more nursing in all teams and named CAMHS keyworkers.
- **More choice in treatment and therapies** – More choice in treatment and therapies that could be accessed were requested, including: solution focused support, more family therapy and more non-clinical non-clinic based interventions - social prescribing, physical activity, activity based counselling, peer support work.

10.1.5. Groups whose needs aren't being met (Professionals interviews 80 comments)



The following children and young people were each identified as having unmet needs by at least three or more people: those with autistic spectrum conditions, people who self-harm, eating disorders, Attention Deficit Hyperactivity Disorder, children with challenging behaviour, children with a learning disability with severe challenging behaviour/mental health issues/complex autism, 18- 25 year old young people, children in care - including

those up for adoption/adopted or placed with grandparents, and care leavers, children below the eligibility threshold for services with moderate learning disabilities or behavioural problems.

10.1.7. How do professionals make parents and children aware of support that is available to them locally? (Professionals interviews 35 comments)

- **Internet** – Several examples were given of how the internet could help parents find support, including: Right Here, CAMHS website, *Where to go for? Find, Get, Give*, as well as the use of social media by schools.
- **Signposting by professionals** – Professionals (GPs) signpost but in a “scattergun way.” Targeted information is sent to schools.

“Don’t know where else to go. CAMHS gave nothing and their GP only knows about CAMHS.”

10.1.8. How involved are parents/children in their care and treatment? (Professionals interviews 11 comments)

- **Professionals feel they involve parents where appropriate.** CAMHS involve them as part of the Choice and Partnership appointments and TAPA and Functional Family Team work with difficult to engage families. The Pre-school Special Educational Needs Service (PRESENS) involve parents in the early years by leaving notes for parents at settings where they have seen children and by carrying out home visits. Primary mental health workers involve parents where appropriate and the YMCA counselling service involves parents of primary aged children.
- **Parents don’t always feel they are involved** – illustrated by the comments made by parents below. It was also commented that where parents are involved, they don’t get any individual support.

“They’re not. They’re the third party, you’re observed and you’re watched and then told and not actively involved.”

“They don’t make it feel like a partnership”.

10.1.9. How is the Transition to adult mental health services managed? (Professionals interviews 40 comments)

- **Transition works well** - 7 comments were made about Transition working well in relation to Early intervention in Psychosis, IAPT, TAPA and PRESENS, play and learn groups and schools using the pupil premium for Transition.

“The EIP service treats 14 -25 year olds and is good at bridging the gap”

“Adult IAPT services are better at making links between adult and young people’s mental health services.”

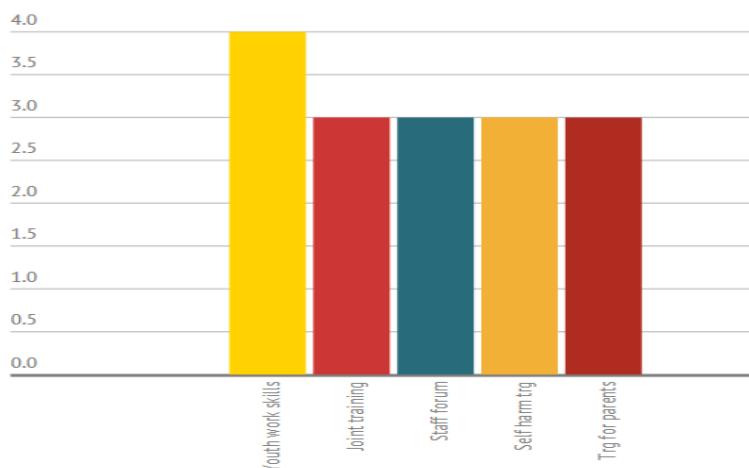
- **Transition needs improving** – 17 comments were made about Transition needing improvement. The Transition process is not seamless, the Adult Mental Health Services need to engage more with CAMHS, so that Transition is a two way process but they won't get involved until the young person has left CAMHS. This means the young person doesn't get enough preparation and support around Transition and aren't being followed up if they drop out of the adult service after Transition. People would rather see the service extend up to 25 years. The present system is inconsistent with Education, Health and Social care plans going up to 25 years.

“Needs to be joined up between CAMHS and AMHS, there’s no Transition. You don’t lose your GP at 18 years, potentially this is a time when problems get worse”.(Parent)

“Children’s services engage young people but adult mental health services are much more blunt and young people struggle with this. 18/19 year olds find it cold, functional, dogmatic – can be a culture shock.”

10.1.10. Unmet training needs that would help to improve the CAMHS pathway.

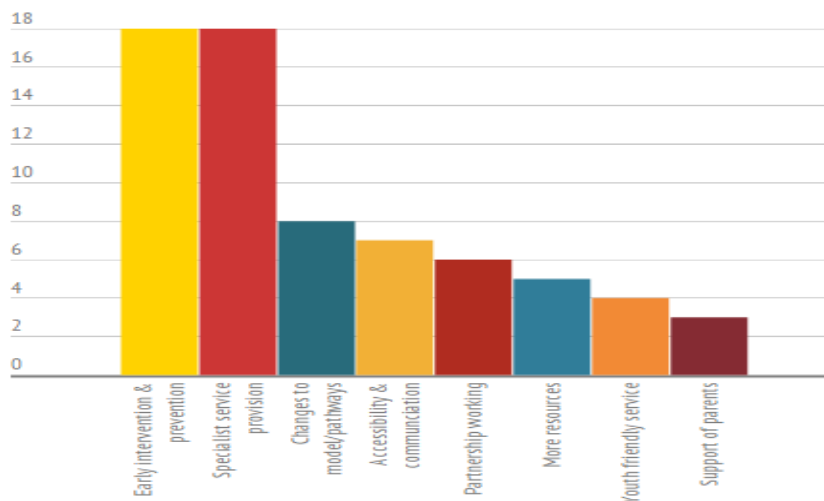
(Professionals interviews 33 comments)



- **Professionals’ training needs** – A need for more joint training between health and social care was identified e.g. the Urgent Help and Functional Family Therapy teams could learn from each other and Brighton and Sussex Universities Hospitals NHS Trust (BSUH) need a better understanding of what CAMHS can do. A forum for CAMHS staff would be useful to enable everyone to work towards the same remit and understand each other’s problems. Health professionals and primary care staff in particular need training in working with young people and learning the same skills used by youth workers and advocates . The most frequently cited condition that staff need training in was self-harm, including Dialectical Behaviour Therapy (DBT) for Tier 3 staff.

- **Young people and Parents’ training needs** – Training that was suggested as a benefit to young people included a Recovery College, and training by Right Here for parents, as well mental health workshop in schools for parents.

10.1.11. Commissioning priorities for improving services (Professionals interviews 76 comments)



“Services have all got into silos. It would be nice to improve communication between different agencies – health, social service and education.”

- **Early Intervention and Prevention** – Early intervention and prevention were most frequently cited as commissioning priorities. This included more investment in Tier 2 services with hubs for counsellors, primary mental health workers and youth workers and more schools with CAMHS outreach workers.
- **Specialist service provision** – A range of services were mentioned as commissioning priorities, the most frequently mentioned was a Paediatric Mental Health Liaison Service at the Royal Alex Hospital in Brighton.
- **Improve pathways and service model** – A range of comments were made relating to pathways and service models. Professionals suggested there’s a need for more flexible services with clear pathways into and between services and greater Transparency about Tier 3 services. CAMHS should work in a consultative way through networks and pathways. Have case workers for complex cases to provide continuity. More use should be made of the flexibility offered by the voluntary sector. A Youth information Advice and Counselling service was suggested as a model for a youth hub offering health services and support.
- **Improve accessibility of services** – Tier 3 CAMHS should be more community based and have clinics and outreach into schools. Communication could be better, including online and availability of email advice from psychiatrists. GPs and hospital

staff need to know where they can refer to apart from CAMHS. Information about services including eligibility thresholds should be shared.

- **Better partnership working** - Better partnership working between Tier 2 and 3 and with Community Paediatricians – in other areas they “hold” and prescribe for Attention Deficit Hyperactivity Disorder patients.
- **Resources** – More staff and resources, including more strategic use of CAMHS resources.
- **A youth friendly service** – Young people need to be at the heart of the service, with the support offered reflecting their needs. This needs a consistent relationship with mental health services to develop and immediate responses being offered, including reduced waits for therapy.
- **More support for parents** – A range of comments was made about improving services for parents. Including providing support and information for parents, looking after children with a mental health problem from an early age – telephone support, out of hours support, direct work with parents.

10.1.12. Issues relating to CAMHS services for children and young people with learning disabilities

10.1.12.1. What works less well?

Seven comments were made about this. There were a range of issues that were felt to work less well, including children with learning disabilities being placed out of area that did not get a formulation of their needs. It was felt the local CAMHS Learning Disability services were fragmented with no overall care co-ordination or single plan, or integrated working with schools, accommodation, parents and children.

10.1.12.2. What are the gaps in CAMHS Learning Disability Services?

Four comments were made about the gaps. These included: individual needs assessments need to include recommendations on how unmet needs can be addressed. Sixteen year olds were felt to be at risk from making poor choices because they weren't being assessed under the Mental Capacity Act. No care co-ordination of clinical interventions for out of area placements integrated with CAMHS Learning Disability Team.

10.1.12.3. How could the CAMHS Learning Disability Service be improved?

Nine comments were made including: more integrated working between child and adult services would improve the Transition, as would care co-ordinators for complex and high risk cases, planning ahead for adult services. CAMHS Learning Disability Services also need to prepare young people for the adult ways of working e.g. positive behaviour model. As well as joint commissioning of OTs in the CAMHS Learning Disability team.

10.1.12.4. Unmet training needs

Two comments related to training needs. Challenging behaviour training across adult and child mental health services need to be reviewed for consistency. The CAMHS Learning Disability service needs training in the Mental Capacity Act.

10.1.12.5. Improvements needed to Transition in CAMHS Learning Disability Service

Five comments were made about Transition and CAMHS Learning Disability Services. Some aspects of Transition planning are good like the Transition Forum where high risk cases coming up are discussed, but staff need more time to plan for Transition. A recent service evaluation of Transition recommended a Transition guide for staff be developed with the Adult Community Learning Disability Team; better information at an early stage for families; build better links with the relevant teams, including a regular interagency workshop on Transitions; a post with dedicated time in the CAMHS Learning Disability Team to lead on Transitions.

“Transition protocols are confusing and convoluted.”

“The young people fall under the care of many different organisations with different statutory obligations and different guidance... which makes it difficult.”

10.1.12.6. Commissioning priorities for improving services

Six comments were made about the priorities for improving CAMHS Learning Disability services. These largely reflected the responses made to the previous questions: Earlier identification of risk for complex cases; Integrated, holistic needs assessment and planning; Named care co-ordinators – including out of area placements; CAMHS clinical input into the quality of residential care; Reduced number of out of area placements; Commission a pathway for 16-18 year olds with Learning Disabilities that takes account of statutory obligations.

10.2. Views and recommendations from formal groups

10.2.1. Children’s Services Partnership Forum

This new forum focuses on the work of all children’s services across the city. An event was held in December 2014 to share understanding of children and young people’s emotional wellbeing and mental health; understand what support is available and where the pressure points are, including Transition; understanding the contribution of universal services to mental health and to inform the development of an emotional health and wellbeing strategy for children and young people. A range of issues were discussed at the Forum and subsequent Youth Council Event in January 2015. Common themes raised included:

- Cost and poor outcomes for vulnerable adolescents
- Joined up services
- Links with adult services through Transition and for parent/carers/families

- A child friendly city
- Data sharing
- Domestic violence and neglect
- The voice of children and young people
- Safeguarding
- Children at risk of sexual exploitation and missing children.

10.2.2. The Local Safeguarding Children Board – Learning Review 2015

Two recent Learning Reviews have led to the development of action plans which reflect some of the points made in the professional interviews. These include the following points related to Tier 3 CAMHS:

- Professionals are not empowered and enabled to meet and discuss clients when needed because of the lack of consent for developing a clear long term plan
- It may be that diagnosis of a condition predetermines treatment response when a more holistic approach would enable treatment to address all aspects of behaviour
- Assertive outreach services are more likely to engage young people than an appointment based system
- It may be that risk taking behaviour by adolescents is normalised around alcohol and drugs, making the interagency response less robust
- Dual Diagnosis services are structured around legal definitions of a child/adult, rather than meeting their support needs regardless of age
- Mechanisms to make repeat prescribing of routine medication accessible, means insufficient attention is paid to repeat prescribing of controlled drugs.

The Learning Review called for public health to include the above findings in this JSNA and any review of CAMHS development and commissioning. The findings should also be shared with sexual health and substance misuse commissioners. More generally it commented that there is inadequate choice in emotional wellbeing support and mental health service provision to meet the preferences of many young people – medical focus is the only option. The Learning Review also asked the Local Safeguarding Children Board to reflect on whether there was an “organisational deafness” which minimises the chances of really hearing what teenagers are saying when they express concerns about their friends.

11. Evidence of effectiveness in addressing needs (What works)

A literature search was undertaken for this needs assessment to look for evidence and good practice on effective delivery systems and services models for CAMHS services. The methods used included a literature search by the Brighton and Sussex Library and Knowledge Service, using the search terms – children, mental health, service, best practice, models and Google, Gov.uk and NICE Evidence Search Engines. A desk top search was also undertaken to include any grey literature.

11.1. Models of care

11.1.1. The Four Tier model

In England, Child and Adolescent Mental Health Services are provided through a four Tier framework described as a stepped model of care. This model was developed in 1995⁸⁰ and is based upon the concept of the child or young person stepping up or down a Tier according to the complexity of their mental health needs. The four Tiers span health promotion and primary prevention, to specialist inpatient care. The mental health needs of most children and young people will fall within Tiers 1 and 2 but some needs will be more complex and will require treatment from practitioners across Tiers at the same time. The model was not intended as a rigid template, but as a conceptual framework for commissioning a comprehensive range of services, to meet all the mental health needs of children and young people in an area, with clear referral routes between Tiers.

Conceptual models for the delivery of child and adolescent mental health services were considered within the **CAMHS Review 2008**.⁸¹ This recognised that the four Tiers model is well embedded within the culture and systems of health services. Children's services have also seen a move to the concept of universal, targeted and specialist services. Both models aim to enable a child to receive services from more than one category at the same time and can be delivered by public, private or third sector providers. It was also noted that during the Review some calls were made to abandon the four Tier model, for there to be consistency across all children's services. The Review concluded that to do so at that time would increase rather than decrease confusion over terminology.

In 2013, NICE cited the stepped care approach as its preferred model of care in its guidance for the **Social and Emotional Wellbeing of Children and Young People**.⁸²

“Schools and local authority children's services should work closely with child and adolescent mental health and other services to develop and agree local protocols. These should support a stepped care approach to preventing and managing mental health problems – as defined in care for children and young people with depression in the NICE 'Depression' pathway.”

One of the main areas of weakness in the current four Tier model is the period of Transition from child to adult mental health services when a young person reaches 18 years. This can be a time when young people fall out of engagement with services due to lack of joined up care pathways, lack of flexibility and young people not meeting thresholds for adult services. **The Joint Commissioning Panel for Mental Health 2012**⁸³ investigated what a good Transition would look like from child to adult mental health services. It stated that there is no prescribed best practice model to meet the needs of young people in Transition and that services need to relate to local need and circumstances. It recommends three main service models either working singly or in combination.⁸⁴

- A designated stand alone Transition service e.g. The Wirral 16-19 Transition Service
- A designated Transitions team within an existing Adult Mental Health Service or CAMHS e.g. Northamptonshire Dedicated Transitions Service Team (For 15-18 years with developmental conditions)
- Designated staff trained in working with young people seconded to Adult Mental Health Services e.g. Leeds CAMHS service.

The guidance also cites City and Hackney's extended CAMHS service as an example of good practice. This has extended the Tier 3 service provision to young people aged 18-25 years to support them through Transition. It mainly works with young people who don't meet the threshold for adult services but are thought to need support from a mental health service. It supports young people with developmental needs who need a period of support before Transition to adult services. It maintains contact with the young person until they are fully engaged and is a part of wider CAMHS, working in partnership with primary and social care, youth services, adult services, third sector and local education colleges. The extended CAMHS model provides support for emotional and psychological problems in the family and social environment; neurodevelopmental disorders such as Asperger's Syndrome and ADHD; mild learning disabilities; depression; anxiety disorders; self-harm; eating disorders and conduct disorders. Those with active psychosis are referred to the Early Intervention in Psychosis Team and those who are 18+ and suicidal or need the Care Programme Approach are referred to Adult Mental Health Services. The Joint Commissioning Panel for Mental Health recommended that Transition protocols should be person-centred; enable continuity of care; offer flexibility in decision making; have sufficient detail in operational procedures to ensure efficacy and consistency.

11.1.1. Integrated commissioning models

What Good Looks Like (2011)⁸⁵ considers the available opportunities to improve local commissioning and delivery systems, to achieve better outcomes for children and young people's emotional wellbeing and mental health. The document reviews the whole system, from prevention through to specialist services and recommends good practice to include:

- Joint Commissioning – commissioning specialist CAMHS as part of a whole system of provision, so that a mix of provision is jointly commissioned
- Strong partnership commissioning with specified delivery roles and responsibilities

- Performance dashboard which is analysed and prioritised
- Staff trained in strengthening resilience and promoting mental health and staff resilience supported
- A range of 'doors' to mental health services – access to mental health services to include Common Assessment, Targeted Mental Health in Schools (TaMHS) and Primary Mental Health staff. This is supplemented by easy access to advice, direct from specialist CAMHS. For example, a telephone number for brief guidance from clinicians, to be accessed by GPs, teachers etc. A single point of access is helpful to improve the co-ordination of pathways but should not be the only point of access
- Primary mental health services should be provided in the community by specialist teams but should work jointly with schools and integrated teams
- Joint pathways integrating educational and clinical approaches for people with autism and ADHD
- Service user participation
- Use CAMHS referral data to identify schools/areas which may need more support and roll-out most cost –effective elements from local TaMHS projects into schools
- Co-locate staff and services to enable specialist CAMHS to have highly developed relationships and networks
- Use a variety of media to communicate information on services to children and young people, parents and professionals
- Children's Centres should have access to specialist mental health guidance and advice to support early years intervention
- Perinatal mental health services should go beyond clinical provision for mothers and offer advice/guidance to midwives, children centre staff and health visitors.

In January 2015, NHS England published the **Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)**. The sample specification describes a high level integrated commissioning pathway which includes: self-care, mental health promotion, training, early intervention, access to treatment/interventions, Transition and discharge – including consultation and liaison. It lists relevant NICE Quality Standards and the minimum provision for Transition of care protocol. This should include a written and agreed care plan post CAMHS: at least one joint meeting between CAMHS key worker and new service key worker prior to Transition; follow up within 6 months of Transition to ensure appropriate interventions are in place; if no further treatment is planned, agree a written care plan so that the young person/family/carer know what to do should they become unwell again; develop a specific protocol for those going to primary care.

Youth Access has outlined the characteristics of an effective young people's service in **YIACS: an integrated health and wellbeing model (2014)**⁸⁶ and **Making integration a reality (2014)**.⁸⁷ They report that 78% of young people prefer to use advice services aimed at young people and 80% feel it's important to get help with everything that's troubling you in one place. 85% would design mental health services for young people to go up to 25 years. They cite ten reasons from commissioning Youth Information, Advice and Counselling Services.

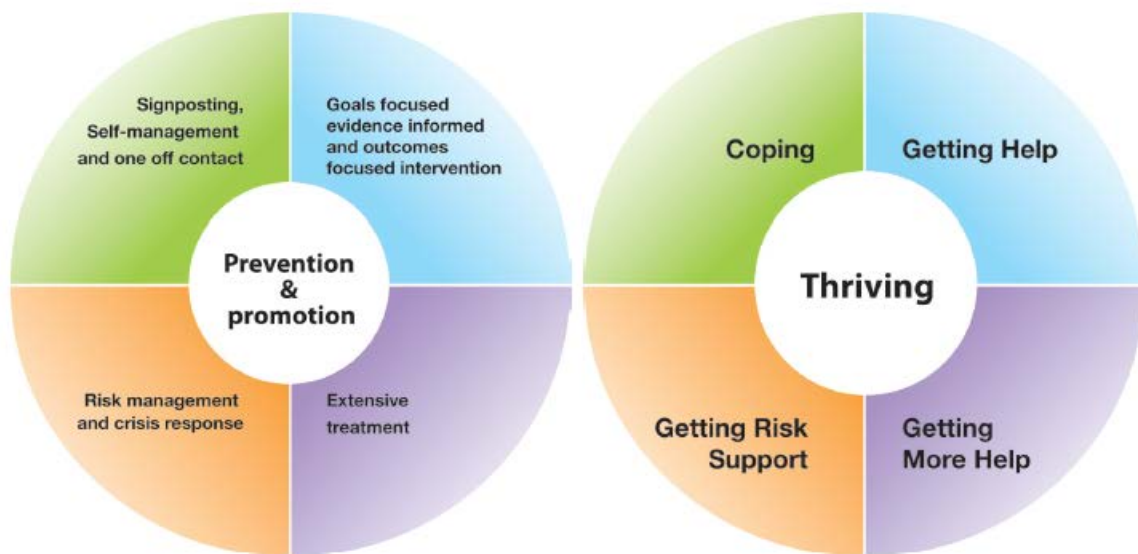
- The “under one roof” approach addresses all young people’s issues at one stop – including social welfare, health and wellbeing and debt, housing and benefits advice which can have a positive effect on mental health
- Non-stigmatising settings, accessible and trusted by young people
- Engage hard to reach vulnerable people
- Address common service gaps and tackle Transitions up to 25 years
- Youth Counselling service and their involvement in CYPIAPT can help those who don’t reach entry level thresholds for CAMHS
- Validated outcome tools show they get excellent outcomes – improving mental and physical health, reducing youth homelessness, unemployment and crime
- Cost effective
- High quality
- Co-designed and delivered by young people in the community
- Complement statutory services.

To be effective all the following elements need to be commissioned if young people’s services are to meet their needs:

- Service is dedicated to young people
- Wide age range (11-25) to tackle Transitions
- Holistic support on a range of inter-related issues
- Complementary interventions delivered under one roof
- Informal and non-stigmatising setting
- Flexible provision – with a drop-in service at its heart
- A social developmental (rather than overly clinical) approach.
- Voluntary participation of users
- Confidential, free and independent
- Focus on early intervention and prevention
- Continuity of help
- User participation.

In the recently published **Future in Mind (2015)**⁸⁸ report the proposal is made to move away from the Tiers model of CAMHS towards local models of seamless care pathways and support. This is because children and young people and professionals who engaged in the discussions with the taskforce did not feel the Tiers model put the child at the heart of the service. The Tiers acted as barriers between services with young people falling through the gaps, or having to fit the service, rather than the service adapting to meet their changing needs. An alternative model that is highlighted is the **Thrive Model**.⁸⁹ This seeks to replace an escalator model of increasing severity or complexity with one that identifies resource-homogenous groups who share a conceptual framework as to their current needs and choices.

THRIVE model



The image describes the input offered for each group and the one on the right describes the state of being of people in that group. Each of the four groupings is distinct in terms of needs and/or choices of the individuals within each group:

- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group
- The groups are not distinguished by severity of need or type of problem

The middle designation of “thriving” is included to indicate the wider community needs of the population supported by the prevention and promotion initiatives.

Coping – This group would include children, young people and families adjusting to life circumstances with mild or temporary difficulties. Provision would be interventions to support resilience provided within an educational or community setting. Education would be likely to be the key provider but with input from the most experienced health staff, to provide decision making about how to help people in this group and to help determine whose needs can be met by this approach.

Getting Help – This group would include children, young people and families who would benefit from focused evidence based treatment with clear aims and criteria for assessing whether aims have been achieved. This would include children and young people who fell under the NICE guidance remit. Health would lead on provision bring in specialists in different treatments. At the outset an explicit agreement would be made of what a successful outcome looked like, a timeframe for achievement and what would happen if this was not achieved.

Getting More Help - This group would include children, young people and families who would benefit from extensive long term or intensive treatment, which may include inpatient

care and outpatient provision. Young people with psychosis, eating disorders and emerging personality disorders are likely to require significant input. This provision will be health led with input from specialised health workers for different treatments.

Getting risk support - This group would include children, young people and families who are currently unable to benefit from evidence based treatment but remain a significant concern and risk. This group may routinely have crises but are not able to make use of help offered, or where it has been offered it has not made a difference. These people may self-harm or have emerging personality disorders or ongoing issues that have not yet responded to treatment. This group will require significant input. Services will need to collaborate closely and be clear who the lead is. This may often be social care. Health input should be from staff trained to work with this group and skilled in shared thinking with colleagues in social care but with explicit understanding that it is not a health treatment that is being offered.

Thriving – Services should aim to help everyone thrive by helping with prevention, promotion and awareness raising work in the community, including consultation and training.

The **Five Year Forward View (2014)**⁹⁰ outlined a range of care models for delivering integrated care, one of which was the Multispecialty Community Provider (MCP). This has formed the basis of a multi-agency bid by BICS, GPs, Sussex Community NHS Trust, Brighton & Hove City Council, Sussex Partnership NHS Foundation Trust and Brighton & Hove Community Works, to be part of a national programme.⁹¹ An MCP provides multi-disciplinary person centred integrated holistic care embedded within GP Practices and based on GP Clusters. The care would be delivered by a partnership of organisations that would be collectively responsible for achieving outcomes of care, rather than the GP on their own. If this model is adopted locally it may have an impact on the future shape of community based child and adolescent mental health services and how they are delivered.

11.1.3. Children’s IAPT model (Children and Young People – Increasing Access to Psychological Therapies)

The CYP-IAPT model is based on a core set of principles that seek to improve the quality of children and young people’s mental health services, and have been used to underpin the Transformation Plans outlined in Future in Mind. The core CYP-IAPT principles are:

- Better evidence based practice
- Better collaborative practice – goal focused and client centred interventions, using feedback tools
- Better service user participation
- Better cross agency working

- More accountable services – by monitoring clinical outcomes to demonstrate effectiveness
- Increase awareness of the importance of emotional wellbeing and decrease stigma.

CYP-IAPT is a national programme funded by NHS England and HEE. Areas that wish to adopt it form multi-agency partnerships of statutory and voluntary services and join together in a Learning Collaborative to learn the core principles. Service changes are achieved via training staff in the core principles and a range of evidence based therapies, which are then applied to all care pathways and presenting problems. The Collaborative has a role in facilitating service change through support and challenge. The ways of working with CYP-IAPT are similar to that of the Recovery model in adult mental health services.

11.1.4. Examples of local service models: Norfolk, Birmingham, Liverpool, Streatham

- **Norfolk and Suffolk NHS Foundation Trust** – The Trust has redesigned its service to provide a 0-25 specialist mental health service. This has increased access and engagement, created innovation and a focus on outcomes. It has been developed in co-production with the Youth Council and raised the voice of young people. It engages young people with the service through its website <http://whatsthedealwith.co.uk/home>. It has also focused on Transition and integration across pathways.
- **Forward Thinking Birmingham** – Is a service model being developed by Birmingham South Central CCG and is a mental health service for 0-25 year old children and young people. It's based around Prevention – including challenging stigma, free and easy advice online and in the community, training for frontline staff and support for community initiatives; Access – 24/7 Access centre, online directory of services and city centre hub for advice and support; Choice – based around personal goals, choice of flexible online, community and home based care to urgent and inpatient care. And appointments offered at a time and place that suits the individual; Integration and Joined up care with partners, including education. <https://forwardthinkingbirmingham.org.uk/content/about-us-0>
- **Liverpool** – Liverpool has a Child and Adolescent Mental Health Partnership, which brings together the key partners in commissioning CAMHS. It has a single point of access through Alder Hey Children's Hospital and has a CAMHS passport to avoid duplication of assessment.^e There is also a website which provides a single point of access for training and information. The Partnership offers a wide range of training to front line workers and has a named care co-ordinator for complex cases. There's a flexible approach to appointments including home visits, telephone, out of hours and weekend cover. 90% of service users have positive experiences and improved outcomes. <http://www.freshcamhs.org/feel-better/>

^e NHS England has developed a CAMHS passport template for use when children and young people transition from one service to another. <https://www.england.nhs.uk/mentalhealth/cyp/iapt/>

- **Streatham** – The “Well Centre” is a one-stop health shop that supports 13-20 year olds in London. Youth workers, GPs and counsellors can all be accessed under one roof. Young people were involved in the design of the health centre and there is a Youth Panel. Initial assessments are made by a GP and Youth Worker, to identify medical, mental health and social issues early on. The centre can provide assessment and treatment for a wide range of physical and mental health conditions. <http://www.thewellcentre.org/>

11.2. Effective emotional, health and behavioural interventions

The National Institute for Health Care Excellence (NICE) provides guidelines on effective interventions for managing emotional, health and behavioural issues in relation to children and young people. These have been summarised below.

Overview of guidelines and technology appraisals affecting CAMHS²

PUBLISHED CLINICAL GUIDELINES				
No.	TITLE	AGE RANGE	ISSUE DATE	REVIEW
CG 38	Bipolar disorder management of bipolar disorder in adults, children and adolescents in primary and secondary care	Full age range	July 2006	July 2010
http://guidance.nice.org.uk/cg38				
CG 28	Depression in children identification and management of depression in children and young people in primary, community and secondary care	5 – 18 yrs	September 2005	September 2009
http://guidance.nice.org.uk/CG28				
CG 9	Eating disorders core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders	8 years +	January 2004	TBC
http://guidance.nice.org.uk/CG9				
CG 31	Obsessive-compulsive disorder core interventions in the treatment of OCD and body dysmorphic disorder (BDD)	Full age range	September 2005	November 2009
http://guidance.nice.org.uk/CG31				
CG 26	Post-traumatic stress disorder (PTSD) management of PTSD in adults and children in primary and secondary care	Full age range	March 2005	March 2009
http://www.nice.org.uk/Guidance/CG26				
CG 1	Schizophrenia core interventions in the treatment and management of schizophrenia in primary and secondary care	Working age adults	December 2002	Current
http://www.nice.org.uk/Guidance/CG1				
CG 16	Self-harm short-term physical and psychological management and secondary prevention in primary and secondary care	Full age range	July 2004	July 2008
http://guidance.nice.org.uk/CG16				
CG 25	Violence short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency settings	16 years +	February 2005	February 2009
http://www.nice.org.uk/Guidance/CG25				

CLINICAL GUIDELINES IN DEVELOPMENT				
No.	TITLE	AGE RANGE	EXPECTED	REVIEW
W 10	Attention deficit hyperactivity disorder (ADHD) pharmacological and psychological interventions in children, young people and adults	All ages	February 2008	4 years
http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11632				
W 15	Autism in children and adolescents recognition, referral and diagnosis in children and adolescents	TBC	February 2011	4 years
http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11826				
W 12	Personality disorders - borderline Early identification, clarification and confirmation of diagnostic criteria, treatment pathways	All ages	January 2009	4 years
http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11651				

PUBLISHED TECHNOLOGY APPRAISALS				
No.	TITLE	AGE RANGE	ISSUE DATE	REVIEW
TA 98	Attention deficit hyperactivity disorder methylphenidate, atomoxetine and dexamfetamine (review)	0-18	March 2006	March 2009
http://www.nice.org.uk/Guidance/TA98				
TA 102	Conduct disorders in children parent-training/education programmes	12 years and under	July 2006	September 2007
http://www.nice.org.uk/Guidance/TA102				
TA 97	Depression and anxiety computerised cognitive behaviour therapy (CCBT)	All ages	February 2006	September 2008
http://www.nice.org.uk/Guidance/TA97				
TA 43	Schizophrenia atypical antipsychotics	Working age adults	June 2002	May 2005
http://www.nice.org.uk/Guidance/TA43				

PUBLISHED PUBLIC HEALTH INTERVENTION GUIDANCE				
PH 4	Interventions to reduce substance misuse among vulnerable young people helping young people access support & services, effective individual, family & group support	25 years and under	March 2007	March 2010
		http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11379		
PH 7	School-based interventions on alcohol encouraging children not to drink, delaying the age of drinking onset, reducing harm caused	School age	November 2007	TBC
		http://www.nice.org.uk/Guidance/PH7		
PH 12	Social and emotional wellbeing in primary education protect children against emotional and behavioural problems, violence and crime, pregnancy, misuse of drugs & alcohol	4-11 TBC	December 2007	
		http://www.nice.org.uk/Guidance/PH12		

PUBLIC HEALTH INTERVENTION GUIDANCE IN DEVELOPMENT				
W 16	Promoting the social and emotional wellbeing of young people in secondary education	11-18 TBC	July 2009	TBC
		http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11883		

11.2.1. Additions since 2009

- **Social and emotional wellbeing in secondary education.** Six recommendations cover strategy, key principles and conditions, working in partnership with parents, families and young people, the curriculum, training and professional development. With the intention of developing happy, confident in control young people, who can problem solve and have good relationships with others. PH 20. September 2009.
- **Looked after children and young people.** How organisations, professionals and carers can work together to help looked after children and young people reach their full potential. Includes dedicated services to promote the mental health and emotional wellbeing of children and young people in care. PH 28 October 2010.
- **Pregnancy and complex social factors.** CG 110 September 2010
- **Social and emotional wellbeing in early years.** Guidance on home visiting, childcare and early education in under 5s. PH40. October 2012.
- **Antisocial behaviour and conduct disorder in children and young people:** recognition, intervention and management. Effective care and treatment options including psychosocial and pharmacological interventions. CG 158. March 2013.
- **Autism.** The management and support of children and young people on the autism spectrum. CG 170. August 2013.
- **Psychosis and schizophrenia in children and young people.** Recognition and management. CG 155. January 2013.
- **Antenatal and postnatal mental health:** Clinical management and service guidance. CG 192. December 2014

- **Children’s attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. NICE guidelines [NG26]**

Covers the identification, assessment and treatment of attachment difficulties in children and young people up to 18 who are adopted from care, in special guardianship, looked after by local authorities in foster homes (including kinship foster care), residential units and other accommodation, or on the edge of care. It aims to address the many emotional and psychological needs of children and young people in these situations, including those resulting from maltreatment.

11.2.2. In development

- **Attention Deficit Hyperactivity Disorder.** Update January 2018
- **Attention Deficit Hyperactivity Disorder (Standing Committee B Update)** February 2016
- **Psychosis and Schizophrenia in Children and Young People (update)** May 2016

11.3. Evidence base for preventative interventions

A literature review was undertaken by Brighton and Sussex Library and Knowledge Service, to find the evidence base for interventions that could be delivered in Tiers 1 and 2 to prevent children and young people’s emerging mental health and behavioural issues getting worse while awaiting specialist treatment.⁹²

A study by the National Institute for Health Service Research identified and evaluated types of self-care support available to children, young people and their parents. They found mental health self-care support interventions for this group were modestly effective in the short to medium term. Effective self-care support services are: flexible; straightforward to access; non-judgemental; welcoming organisations and staff; provide time and attention; opportunities to learn and practise self-care skills and have systems of peer support. Families want choice and flexibility in the provision of such interventions and a continuing relationship with services after the nominal therapy. Those delivering self-care support need to have specific child-centred attributes.⁹³

A number of the studies reviewed suggested that there was a role for mobile technology to play in prevention. A study by Reid 2013⁹⁴ conducted an RCT in primary care of 163, 14 -24 year olds where mood, stress and daily activity were monitored by mobile phone and sent to the GP, compared to only daily activity being monitored. The results showed the intervention programme increased understanding of patient mental health, assisted in decisions about medication/referral and helped in diagnosis compared to the comparison group. It concluded that the mobile intervention assisted GPs in the assessment and management of youth mental health problems in primary care. A study by Kauer 2012⁹⁵ examined a mobile phone self-monitoring tool used by young people with mild or more depressive symptoms to investigate the relationship between self-monitoring and

emotional self-awareness. It found that self-monitoring in this group increased emotional self-awareness and decreased depressive symptoms and suggested that mobile phone self-monitoring programmes were ideally suited to first step intervention programmes for depression. A systematic review of internet-based prevention and treatment programmes for anxiety and depression in children and adolescents (Calear 2010)⁹⁶ also found emerging support for the effectiveness of these CBT base programmes in reducing anxiety and depression in children and young people. The programmes were delivered via schools, primary care, mental health clinics and open access websites.

A study by the Cochrane Database for Systematic Reviews found that access to media based CBT for children with behaviour disorders, could have a moderate effect as an adjunct to medication.⁹⁷ A range of interventions both improve children's mental health and are cost saving to the public sector. These include parenting groups for conduct disorders,⁹⁸ group based CBT for anxiety in adolescents⁹⁹ and schools based social and emotional learning programmes. To achieve the best value for money children's mental health services need to reach out to those who need them the most and be delivered to a high standard. There is not yet enough evidence about cost-effectiveness of interventions for Autistic Spectrum Conditions, Self-harm or eating disorders.

In the Best Start at Home,¹⁰⁰ the Dartington Social Research Unit reviewed UK based early interventions for 0-5 year olds, which enhanced the parent-child interaction with a view to improving attachment and parental sensitivity; social and emotional development and language and communication. It highlights 32 programmes that could operate in the UK and have information on effectiveness.

11.3.1 Children in Care.

Children and young people in care (looked after) are one of the most at risk groups for developing mental health problems. The library undertook a literature review to identify effective interventions for children in care.¹⁰¹ NICE guidance in relation to children and young people in care includes a pathway for promoting their mental health and emotional wellbeing. Stages in the pathway include ensuring personal quality of life; providing treatment and care for particular mental health disorders; providing dedicated mental health services; supporting the Transition to adult mental health services; commission integrated teams including CAMHS professionals; ensure CAMHS are sensitive to the needs of BME children; support unaccompanied children and young people to access specialist psychological services; ensure young people entering secure accommodation or custody have access to specialist assessment services.¹⁰²

A systematic review by the Cochrane database in 2008 found evidence of effectiveness for Treatment Foster Care (TFC).¹⁰³ This is a foster family intervention that aims to provide young people with an individually tailored programme designed to bring positive change in their lives. It's based on five USA studies that included young delinquents or children with

behavioural problems or in state mental hospitals. Results indicated some clinically meaningful decrease in anti-social behaviour, number of days spent running away from placements, number of criminal referrals and time spent in locked settings. Young people in TFC spent more time in treatment and at home over the long term. There were also improvements in school attendance, homework completion and finding work. A subsequent review in 2011 also found TFC a promising intervention but called for further research due to the limited number of studies it included.¹⁰⁴

11.3.2. Five Ways to Wellbeing.

The Five Ways to Well-Being - Connect, Be Active, Take Notice, Keep Learning and Give were identified by the New Economics Foundation (NEF) as a means of promoting mental well-being and have been included in reports such as No Health Without Mental Health. However the evidence base for this was based on adults, so NEF and the Children's Society have undertaken research to explore the extent this framework might also be relevant to children.¹⁰⁵ This found that the Five Ways were relevant for children but the evidence for Give was weaker. No evidence was found of a relationship with well-being for: chatting to friends by social media or phone; caring for family members or volunteering. The individual activities most strongly associated with well-being were: Noticing and enjoying one's surroundings (Take notice); teaching yourself new things (Keep learning); talking to family about things that matter (Connect); reading for fun (Keep learning). There was some indication that boys participated more in Be Active activities than girls, whilst girls participated more in Keep learning, Give and Take Notice. Older children participated in fewer of the Five Ways activities but were more likely to engage in Connect than younger children.

11.3.3. Examples of local good practice

Local good practice that has been shown to have a positive impact on the mental health of young people and their parents/carers includes the Compass Card and DLA service provided by Amaze who work with families with a child with a disability or long term condition. Children and young people who are registered on the Compass database get a Compass leisure card which gives them discounts, offers and freebies at local leisure outlets such as cinemas, libraries, farms, bowling alleys, libraries and gyms. An independent evaluation of The Compass by J B Eventus in November 2014 found that having a Compass Card had a significant effect on the whole family's wellbeing. Parent carers reported a wide range of impacts on their lives as a result of the Compass Card including reduced stress, leading to improved mental health for both themselves and their child(ren) with additional needs; Improved resilience and coping strategies; Improved behaviour, communications and life skills for their child(ren) with additional needs; Crisis prevention and a reduced need for social care assessments and ongoing support. 72% of parent carers felt having a Compass Card had helped reduce stress and 83% felt it improved their quality of life.

The report estimated the Compass has an economic impact in the city of over £1m per year and represents £11.88 in economic and social value for every £1 spent on the scheme by Brighton and Hove City Council.

The DLA service run by Amaze sends expert staff or volunteers to parent carers' homes to help them complete disability benefits claims forms. The project earned £3m pounds for local families in DLA and associated benefits in the last year alone. Costing just £74k per year to run, this means that every £1 that is spent on the service generates £44 for local families.

An independent evaluation by the University of Brighton's School of Applied Social Science in 2012 recommended to commissioners that the DLA project be considered a *“highly effective mental health intervention for carers of disabled children as it helps validate their experience and begins to boost and support their resilience and self-esteem, in addition to providing obvious financial benefits.”*

Brighton & Hove has an evidence based child parent psychotherapy intervention in the PIP. This places a strong emphasis on developing early attachment in 0-2 year olds, to prevent the development of mental health problems later on.¹⁰⁶ There is however some debate as to the evidence for its effectiveness. Bauer argues that treatment of the symptoms of mental ill health in the mother/parent alone could be sufficient to mitigate risks to the child and that there is limited evidence of the impact of dyadic interventions.¹⁰⁷ The Cochrane review also highlighted a significant gap in the evidence of PIP's effectiveness. It also raised questions about the likely differential impact of PIP on differing population, suggesting that only high risk populations (perinatal mental ill health, extreme risk of emotional harm/attachment failure) may benefit.¹⁰⁸

Brighton & Hove has also had 33 staff at Children's Centres trained in baby massage by Massage for Babies between 2007 and 2010. This intervention has an impact when used with mothers with depression but systematic review evidence suggests it has no impact at a universal level but that it may have more potential for change with higher risk groups.¹⁰⁹

11.3.4. What works – Education

The library undertook a literature search of effective interventions to promote the mental health and wellbeing of children and young people.¹¹⁰ Aspects of this are relevant for education. A number of systematic reviews have been undertaken to support NICE PH Guidance: PH12 Social and Emotional Wellbeing in Primary Education;¹¹¹ PH40 Social and emotional wellbeing: early years.¹¹² Evidence included on the benefits of a whole school approach and parental involvement in implementing emotional and wellbeing programmes in primary schools include the example of “Zippy's Friends” in Ireland, which was successfully implemented in disadvantaged primary schools and had a significant positive impact on emotional literacy, hyperactivity and coping skills but not on conduct problems

and prosocial behaviour.¹¹³The UCL Institute of Health Equity has reviewed the actions that can be taken in schools to build resilience for all children and young people and reduce inequalities in resilience. The approaches recommended include improving achievements, promoting healthy behaviour, ensuring a smooth Transition, supporting parents and carers, supporting teachers and staff, promoting good relationships with peers, adopting whole school approaches and the school acting as a community hub.¹¹⁴

There is evidence from the USA that children aged 4-6 in primary schools that delivered PATHS (Promoting Alternative Thinking Strategies) displayed significantly better emotional wellbeing and more positive social behaviours compared to children in schools where it did not run.¹¹⁵

The Triple P (Positive Parenting Programme), designed to improve the behaviour of 4- 14 years olds has been shown to have a positive effect on children's behaviours and emotions, as well as parents' belief and confidence in their own abilities.¹¹⁶

Families and Schools Together (FAST) is an evidence based group programme designed to build protective factors to enhance young children's resilience and the learning readiness for primary school. Supportive relationships between parent and child, and families, school and the community mean a child is less likely to fail at school, abuse drugs and alcohol, demonstrate delinquent or antisocial youth behaviours, experience child abuse and neglect, or to develop mental health problems. FAST invites all children and their family in a year group as they transition into school (usually located in a low-income community) to participate in a voluntary programme. Up to 40 families are served at a school in one programme cycle. It is recognised as an effective parenting programme in the UK and in the US it is recognised by the National Registry of Effective Programmes and Practice¹¹⁷.

Systematic reviews were conducted by Centre for reviews and dissemination¹¹⁸ and Cochrane Database¹¹⁹ on whole school approaches to building resilience and for improving the health and wellbeing and academic achievement of students. The former found that insufficient long-term evaluation had been done to provide evidence of effectiveness of programmes to enhance resilience among school staff and students and the impact on parents. While the latter found no evidence of effect for a whole school approach on depression. Studies within the review suggested a whole school change can be difficult to establish and sustain and that focussing on one or two active ingredients may be more successful¹²⁰.

The national Me and My School Programme of Targeted Mental Health Support for Schools¹²¹ ran from 2008-2011 and the evaluation found that in RCTs primary schools with TaMHS showed significant reductions in behavioural problems for pupils with this issue compared to schools not implementing TaMHS. But there was no impact for emotional issues or for behavioural or emotional problems for secondary pupils. Evidence-based self-help booklets given to primary pupils with behaviour problems also helped to reduce their behaviour problems. Greater reductions in behaviour problems in secondary pupils were

associated with closer interagency working including the use of Common Assessment Framework and more positive links with CAMHS.

The UK Resilience Programme (UKRP)¹²² aimed to improve children’s psychological wellbeing by building resilience and promoting accurate thinking. The evaluation of a trial amongst Year 7 pupils in three local authorities found significant short term improvement in depression symptom scores, school attendance rates, and attainment in English. Weekly workshops had the greatest impact. The most impact was seen in pupils who had free school meals, were below the key stage two attainment target and who had the worst initial symptoms of depression or anxiety. The effects only lasted for the academic year.

The document “**What Works in Promoting Social and Emotional Wellbeing and Responding to Mental Health Problems in Schools?**”¹²³ summarises evidence from international research, systematic reviews and control trials evaluations and evaluations of work in schools as to what works in promoting positive social and emotional wellbeing in schools and tackling the mental health problems of pupils in more serious difficulty. This includes:

- Adopting whole school thinking – a whole school approach; start with a positive and universal focus on wellbeing; develop a supportive school and classroom climate and ethos; identify and intervene early; take a long term approach; promote the wellbeing of staff and tackle staff stress
- Engage the whole community – promote pupil voice and peer learning; involve parents, carers and families
- Prioritise professional learning and staff development – understand risk and resilience to actively respond to problems and difficulties; help students with predictable change and Transitions
- Implement targeted programmes and interventions –use a range of leaders for specific programmes; teach social and emotional skills;
- Develop supportive policy – provide clear boundaries and robust policies
- Connect appropriately with approaches to behaviour management – understand the causes of behaviour
- Implement targeted responses and identify specialist pathways – provide clear pathways of help and referral; provide more intense work on skills work for those with difficulties.

The **CASCADE Framework for Collaborative Working between Schools and Mental Health Providers**¹²⁴ has been developed by the Anna Freud Centre to support partners involved in supporting children and young people’s mental health. It focusses on the following key elements of partnership working: **C**larity on roles, remit and responsibilities of partner organisations; **A**greed best use of key points of contact in schools and CAMHS; **S**tructures to support shared planning and collaborative working; **C**ommon approach to outcome measures for children and young people; **A**bility to continue to learn and draw on best practice; **D**evelopment of integrated working to promote rapid and better access to support; **E**vidence based approach to intervention.

MindEd¹²⁵ is a free online resource that can be used professionals, including teachers and health and youth workers, who work with children and young people and want to increase their knowledge about children and young people's mental health and wellbeing.

The University of Brighton was commissioned by East Sussex County Council in 2015 to explore with young people their views and experiences of health and wellbeing. One strand of this research project included a qualitative study of emotional wellbeing and resilience amongst 23 young people in a range of educational and youth settings. This found that most young people were not familiar with the term "resilience" or why it might be useful to them. Despite this some young people were using strategies to achieve resilience and the participants felt there were ways schools could help support resilience. These included providing relaxation or "time-out" spaces separate to areas that were used for exclusion. The opportunity to engage in more non-traditional physical activities; for peer led mentoring and support systems and to feel that the school listened to them was also recommended.¹²⁶

Public Health England has published "Improving school readiness. Creating a better start for London"¹²⁷ highlighting the importance of school readiness and how investing in this can create savings for the NHS, education and criminal justice system. School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. Children who lack school readiness by the age of five 'struggle' with social skills, reading, maths, physical skills, which in turn can lead to low educational outcomes, crime, ill health and death. Interventions that improve school readiness include: good maternal health; learning activities (speaking to your baby and reading to your child); enhancing physical activity; parenting support programmes; high-quality early education.

School based counselling is one of the most prevalent forms of psychological therapy in the UK and it is recommended by NICE for mild depression. Clients are commonly aged 13-15 years, white and female and presenting with family problems, or anger for boys. Its strengths are that it is accessible, increasing the extent to which young people have independent professionals to talk to about difficulties in their lives. It could be enhanced by being more evidence based, making greater use of outcome monitoring, increasing equity of access to BME groups, increasing service user involvement and closer working with other mental health services. This could be achieved by developing competences and having accreditation for counsellors, as well as access to e-learning resources.¹²⁸ These recommendations by Strathclyde University have been reiterated in the Department of Education document "Counselling in Schools: a blue print for the future" (2015).

12.3.5. Examples of local good practice - Examples of good practice within the educational setting in Brighton & Hove include the recently approved bid for participation in the NHS England and Department of Education CAMHS and Schools Link Pilot Scheme. This consists of eight primary schools participating in a 12 month pilot to raise awareness and knowledge

of mental health issues in schools. This will complement work already underway in three secondary schools which have a Primary Mental Health Worker (PMHW) attached to each school to support the mental health and wellbeing of students. They provide appointment and drop-in based services, reflective practice and bespoke training and workshops. Each school will have a named head of mental health to link with the PMHW and mental health services.

The Public Health Schools Programme takes a whole school approach to promoting emotional health and wellbeing. This includes developing a whole school culture. There is a focus on teacher training to support the delivery of emotional health and wellbeing within the curriculum, including training and designing strategies and interventions on self-harm for schools. Training is being developed on effective working between CAMHS and schools, including looking at referral processes and the effective use of E-motion, school nurses and the mental health counselling service. Small group support is provided through Right Here to secondary schools and the resilience hub music workshops in secondary and primary schools. Support for parents and carers is provided through groups for issues such as self-harm and Youtube video clips. Work is being developed to enable the student voice to develop health promotion messages, through initiatives such as the social media project.

Interventions in primary schools to promote emotional mental health and wellbeing include the development of an Assembly format to deliver the Five Ways to Wellbeing message, alongside Walk to School week. This has been delivered in 5 primary schools. Focus groups of children have also helped develop a Mood Boosting reading list to help children with issues to do with friendship, family and bereavement. Workshops have been held on coping with separation for parents and teachers. Five schools have the “Zipzap” after school club focusing on the importance of nutrition, exercise and routines, whilst holiday clubs also promote the Five Ways to Wellbeing message.

The University of Sussex Students’ Union runs the Role Models project. This was originally funded by the Mental Wellbeing Innovation Fund in 2014/15. The project is delivered by volunteer students and aims to give secondary school students a safe space to talk on a one-to-one basis about Personal, Social and Health Education topics, to increase their self-confidence and understanding of well-being through peer led workshops. The project is currently being delivered in partnership with Brighton Aldridge Community Academy.

11.4. Evidence of cost effectiveness

The London School of Economics reviewed the cost effectiveness of a range of evidence based health promotion interventions in 2011, several of which were pertinent for children and young people’s mental health.¹²⁹

It found Health Visiting interventions to reduce post natal depression was cost effective and significantly improved the quality of life for mothers. It does not reduce net costs over a one

year period but does increase productivity for those returning to work. The intervention may produce savings in the medium to long term.

Parenting programmes were found to be cost saving to the public sector, to the NHS alone - with the main benefits accruing to the NHS and criminal justice system over the long term. Savings exceed the cost of the intervention by 8 to 1 over 25 years.

There's a strong case that school based social and emotional learning programmes to prevent conduct disorders are cost saving to the public sector, particularly the criminal justice system and NHS. Education services are likely to recoup the costs of intervention in five years.

On the limited evidence available inexpensive anti-bullying interventions appear to offer good value for money in the long term, based on improved future earnings.

12. Funding

Table 13 shows the funding allocated by Brighton & Hove CCG for children and young people's mental health and wellbeing contracts in 2014/15.

Table 13. Brighton & Hove CCG children and young people's mental health and wellbeing contracts 2014/15

Specification	Amount
SPFT bock contract broken down by	£2,438,964
Youth Offending Team	£162,242
SLD development	£268,319
TAPA	£202,008
RUOK	£42,816
T3 CAMHS	£1,763,580
LD CAMHS at SSV (SPFT)	£49,076
Neurodevelopmental psychologist at SSV (SPFT)	£36,000
Early Intervention Psychosis service (SPFT) (aged 14-35 years)	£756,000
LAC post in T2 CAMHS (BHCC)	£41,000
Youth Advice Centre (YMCA) – counselling (aged 14 – 25 years)	£46,000
Health & Wellbeing Manager (Right Here) aged 14-25 years	£35,000
E-Motion (YMCA and Impact Initiatives) aged 14-25 years	£50,000
Wellbeing in East Brighton (YMCA) – counselling (aged 14-25 years)	£10,500
Young People's Centre – Counselling (Impact) – counselling aged 14-25 years	£38,000
Wellbeing in East Brighton (Impact) aged 14-25 years	£10,500
Protective behaviours (Safety Net)	£43,000
Psychotherapist at Homewood College	£29,616
Domestic Violence and child psychotherapy (RISE)	£40,000
Therapeutic support for children of sexual abuse (under 14 years)	£68,320

Table 14. BHCC – Children’s Services and mental health and wellbeing contracts (2014/15)

Specification	Amount
Impact initiatives – counselling service between 13-19	£19,000
Mind Brighton & Hove advocacy service between 13-19	£27,596
Safety Net Ltd family work in community CAMHS	£40, 139
YMCA Downslink group – family work in community CAMHS	£67, 600
SPFT – art psychotherapist post for LAC	£55,000

Table 15. BHCC – Public Health Mental Health and Wellbeing Contracts 2014/15.

Specification	Amount
Non-recurrent projects costs for work in primary and in secondary schools on self-harm/emotional health and wellbeing.	£13,700
Chances for change funded projects (ends October 2015), Impact Initiatives and Food Partnership.	£110,000

Brighton & Hove CCG has a block contract with Sussex Partnership Foundation NHS Trust of £2,439,964 (2013/14) for the provision of Tier 3 CAMHS and specialist provision. Funding of £373,000 per annum has been released to the CCG by central government for each of the next five years, to implement the Transformation Plan to improve local child and adolescent mental health services. In addition Brighton & Hove CCG has received £149,000 to help fund a Sussex wide Community Eating Disorders Service, delivered through a virtual team in 2016/17.

13. Issues related to workforce

13.1. Workforce recommendations compared to actual numbers

Standard 9 of the 2007 National Service Framework made specific recommendations on workforce numbers.¹³⁰

- A Tier 3 CAMHS service with teaching responsibilities and providing evidence based **interventions for 0-17 year olds would need a minimum of 20 WTE per 100,000** population and a non-teaching service 15 WTE per 100,000 population (These figures do not include youth offending or substance misuse work).

The Royal College of Psychiatry makes the following recommendation:

- A 0-18th birthday service of 20 WTE per 100,000 should be able to manage 40 new referrals per WTE per year, in an average UK population of average deprivation, where under 20% of the population are under 18. A clinician working with complex caseloads requiring intensive input, will have less capacity than one who practises brief therapies with less complex cases. Skill mix is also an important factor in the capacity to manage case loads.¹³¹

In 2013/14, CAMHS Tiers 1-3 across Sussex had 60 WTE per 100,000 population. This is the same as the national figure in the same time period, and slightly above the average of 58 WTE per 100,000 population seen amongst the CAMHS benchmarking group.

Brighton & Hove CCG has submitted a Transformation Plan to the Department of Health to release funding to enable the building of capacity and capability within child and adolescent mental health services. Elements of this plan are contingent upon the recruitment of staff. As Transformation Plans are being implemented simultaneously across the country, there is a risk that it will not be possible to recruit to some posts.

The interviews with professionals carried out for this needs assessment suggested that services in Tier 3 were placed under pressure due to the length of time it took to fill vacancies/cover maternity leave and the impact of sickness absence.

14. Unmet needs, service gaps and over-provision

This needs assessment has identified a range of unmet needs and service gaps in relation to children and young people's mental health and wellbeing services.

14.1. Services for under 5s

- Health Visitors need more systematic training in infant mental health
- Health Visitors need more training in using evidence based tools
- Children's Centres and PreSENS lack specialist support from CAMHS with attachment issues
- There is no Pre SENS service available in school holidays
- PreSENS lack training in the mental health needs of 2 year olds.

14.2. Services for Primary School aged children

- CAMHS staff don't always attend TAF (Team around the family) meetings with schools
- Schools don't have good links with GP Practices
- Children, young people, parents and professionals want earlier interventions and more preventative work.

14.3. Services for Secondary School aged children

- Teachers need to be trained in mental health awareness
- Schools need a mental health crisis pathway to follow
- Schools need a better understanding of Trans issues and mental health.

14.4. Services for young people

- There's no one stop shop/Community Eating Disorders Service for young people with eating disorders to go to
- Lack of flexibility in Tier 3 CAMHS appointments system means young people do not attend
- There is a lack of outreach to young people who miss appointments
- Gaps around Transition – young people need more support and to know what the pathway into adult services is after discharge from CAMHS. Need support if Adult Mental Health Services (AMHS) don't take them on.
- No single point of information for young people to access about sources of support available
- Young people want services that listen
- Young people want friendly CAMHS staff, with a choice of gender and age of staff they see
- There is a lack of response to the impact of social media on young people.

14.5. Other issues

- There is no service for children and young people with autism who do not have a mental health problem
- Eligibility criteria for Tier 2 CAMHS lack clarity
- No alternative to clinic based appointments in Tier 3 CAMHS
- Limited out of hours service
- Distinctions between conduct disorders and social care and mental health disorders do not provide holistic care
- Care pathways aren't joined up across services and Tiers
- Lack of clarity around referral criteria from primary care to Tiers 2 and 3
- Voluntary sector don't always keep GPs informed about referrals they have received
- GPs are not confident about managing and treating self-harm
- The competency levels of different counselling staff need clarifying
- The children and young people's mental health and wellbeing system has some barriers to entry, with differing eligibility criteria, numerous assessments but no coordination across the whole system
- It is difficult to get hold of an on-call psychiatrist as professionals are unclear about the pathway
- Data collection on the number of CYP accessing counselling services in the City needs improving
- CAMHS services don't collect data in a consistent outcomes focused way
- There is no specialist service to support children who have experienced significant loss/bereavement
- There is no mental health specialist provision embedded within the Children in Care team
- There are gaps in joint working by professionals across the CAMHS Tiers
- It is not known what the unmet mental health needs of young refugees, asylum seekers and vulnerable migrants are
- Difficulties with capacity in Tier 3 are exacerbated by sickness absence and delays in filling vacancies.

14.6. Specific groups with unmet needs

- CYP with autism
- Children in care
- CYP with a learning disability placed out of area
- CYP with self-harm or suicide ideation
- CYP with conduct disorders/aggression
- CYP with eating disorders

- CYP with Medically Unexplained Physical Symptoms
- CYP without a diagnosed severe mental health disorder
- CYP with Attention Deficit Hyperactivity Disorder
- CYP with depression
- CYP with anxiety
- Access for boys and young men
- CYP with Pathological Demand Avoidance
- CYP who are refugees, asylum seekers or vulnerable migrants
- CYP who are homeless
- CYP who are LGB or have gender identity issues.

15. Recommendations for further needs assessment

Future needs assessments should consider the mental health needs of young migrants, refugees and asylum seekers; as well as the ethnicity of children and young people with mental health problems and how far mental health services meet the needs of different genders.

16. Key contacts

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17. Key supporting documents

Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health and NHS England. March 2015.

Happiness: Brighton & Hove Mental Health and Wellbeing Strategy. Brighton & Hove CCG and Brighton & Hove City Council. 2014

Brighton & Hove CCG. *Children and Young People's Mental Health and Wellbeing. Transformation Plan. 2015-2020.*

18. Acknowledgements

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19. APPENDIX 1. Wider risk factors for developing mental health and emotional wellbeing problems in children and young people and protective factors.

Factor	Degree of risk	Brighton & Hove context
<i>Migrants, Refugees and Asylum Seekers</i>	<ul style="list-style-type: none"> Depression and anxiety are common amongst asylum seekers, and PTSD is often greatly under diagnosed.¹³² 	<ul style="list-style-type: none"> There is limited data available about young migrants, refugees and asylum seekers locally. Since February 2015, Brighton & Hove City Council has supported 9 Children in Care, and 24 Care Leavers who arrived in the UK as unaccompanied asylum seeking children/young people. This does not account for others placed by other local authorities.
<i>Child poverty</i>	<ul style="list-style-type: none"> Children in poor households are three times as likely to have mental health problems as children in well-off households.¹³³ 	<ul style="list-style-type: none"> 17% (7,735) of children in Brighton & Hove under 16 were living in families in receipt of out of work benefit or tax credits where their reported income is less than 60% of the median income (2012). This compares with an England average of 19.2%.¹³⁴
<i>Young carers</i>	<ul style="list-style-type: none"> A substantial numbers of young carers report mental health problems such as eating disorders, difficulty in sleeping and self-harm. A quarter of young carers aged 14-25 (26%) were bullied at school because of their caring role, and 38% reported having a mental health problem.¹³⁵ The Care Act 2014 requires the care and support needs of adult carers to be included as part of transition planning. 	<ul style="list-style-type: none"> There were 455 young carers known to the local authority who were caring for an adult at the beginning of April 2015. Young carers in the secondary school survey were significantly less likely to say they were often or sometimes happy (87% vs. 94% of non-carers), as well as more likely to say they were often or sometimes very sad/depressed (46% vs. 30%).

Parental risk factors

<i>Children with parents in prison</i>	<ul style="list-style-type: none">• Children with a parent in prison are twice as likely as other children to experience conduct and mental health problems.¹³⁶	<ul style="list-style-type: none">• There are approximately 2,500 children across Sussex with a parent in prison - specific data for Brighton & Hove is not available.¹³⁷• Between October 2014 and July 2015, Sussex Prisoners families engaged in support sessions with 57 families in the Brighton, 97 in Hove, and 73 families in Lewes court.⁵
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⁵ Not all of these will be for cases of Brighton & Hove residents as these courts hear trials for all Sussex residents

Associated factors

Factor	Degree of risk	Brighton & Hove context
<i>Educational attainment</i>	<ul style="list-style-type: none"> The longer-term impacts of mental health problems in childhood and adolescence include an association with poorer educational attainment and employment prospects.¹³⁸ 	<ul style="list-style-type: none"> 60% of children in Brighton & Hove achieved a good level of development by the end of reception - in line with national figures, and comparators. (2014) 22% of SEN pupils with achieved a good level of development at the end of reception, compared with 66% of non-SEN, a gap of 44 percentage points. 53.6% achieved 5+ A* to C grades at GCSE including English & Maths – lower than the national average (56.6%), and statistical neighbours (58.3%). 26.3% of Children in Care achieved 5+ A*-C GCSEs - higher than both the national average (12.0%) and that of comparators (14.1%).
<i>School absenteeism</i>	<ul style="list-style-type: none"> Psychiatric conditions related to extensive school absences include anxiety, depressive and disruptive behaviour disorders. School refusal is associated with anxiety disturbances and truancy associated with conduct disturbances.¹³⁹ 	<ul style="list-style-type: none"> The level of persistent absence from primary schools in Brighton & Hove at 2% is comparable to England and the South East (2013-14). This has decreased from 3.1% in 2011-12. The level of persistent absence in secondary schools is 6.4%, higher than the South East (5.7%) and England (5.3%)(2013-14). The level of persistent absence has fallen in Brighton & Hove from 8.5% in 2012-13 and 9.3% in 2011-12.
<i>School exclusions</i>	<ul style="list-style-type: none"> The relationship between early learning difficulties, exclusion from school and crime, has been described as a ‘downward spiral’. Children who lack basic 	<ul style="list-style-type: none"> 6% (1,900) of the school age population were excluded in Brighton & Hove 2012/13. This compares with 4% in the South East, and across

	<p>literacy and numeracy skills develop low self-esteem and become disillusioned with education, leaving school early.¹⁴⁰</p>	<p>England.</p> <ul style="list-style-type: none"> • The number of fixed term exclusions in Brighton & Hove has fallen from 2,150 in 2010/11. • There were 20 permanent exclusions, (0.05% of the school population). Mainly in secondary schools.¹⁴¹
<i>Missing children</i>	<ul style="list-style-type: none"> • Children who go missing may develop mental health problems such as depression as a result of their experience. • 64% of missing cases are estimated to be under 18. A third of all missing people are aged 15-17 year olds. • Looked after children are three times more likely to run away than other children. • Children who go missing are at serious risk of physical abuse, sexual exploitation and stealing to survive.¹⁴² 	<ul style="list-style-type: none"> • 121 children were reported missing in Brighton & Hove in 2013-14. A large number are repeat incidents for the same children. • The number of missing children reported has decreased since 2011/12 but the number of incidents reported to the police has increased by 17% since 2011/12. • 58% of missing children were female • Missing children peaked in the 14-15 year old age bracket, with a rate of 11 per 1,000 population.¹⁴³
<i>Teenage pregnancy and teenage parents</i>	<ul style="list-style-type: none"> • Teenage mothers have three times the rate of postnatal depression of older mothers and a higher risk of poor mental health for three years after the birth.¹⁴⁴ 	<ul style="list-style-type: none"> • The teenage conception rate for under 18s was 25 per 1,000 females aged 15-17 in 2013. A 48% reduction since 1998. • There were 99 conceptions to under 18s in Brighton & Hove in 2013, compared with 187 in 1998. • There were 83 mothers aged under 20 known to the local authority in December 2014, down from 103 in December 2013.¹⁴⁵

<i>Protective Factors</i>	National Evidence	Brighton & Hove Context
<i>Participation in physical activity</i>	<ul style="list-style-type: none"> Physical activity in childhood has benefits for physical, mental and social health. It improves concentration and self-esteem, and can also improve school attendance, behaviour and attainment.¹⁴⁶ 	<ul style="list-style-type: none"> Older, students, girls, LGB students and students unsure of their sexual orientation, those who need extra help, young carers, those who say they are not happy, those who have truanted, been excluded, been bullied or been a bully and those who have tried smoking, alcohol, drugs or had sex are all more likely to have done less than an hour of physical activity in school in the last week.
<i>Smoking</i>	<ul style="list-style-type: none"> Those aged 11-15 who smoke tobacco are 6 times more likely to develop serious psychological distress.¹⁴⁷ Anxiety and depression may be factors in smoking initiation. Studies with young people found anxiety and depression were strong predictors of smoking experimentation and transition to daily smoking.¹⁴⁸ 	<ul style="list-style-type: none"> 98% of primary school children (aged 9-11) had never tried smoking (SAWS 2014). The percentage of pupils who have never tried a cigarette has increased for 11-14 year olds (from 80% to 87%), and for 14-16 year olds (51% to 58%). 77% of 11-16 year olds have never smoked the same as England.¹⁴⁹ 38% of students had never smoked in Further Education. Smoking is more common with age and in: LGB students; those who say they are not happy; those who have truanted or been excluded; and those who have tried alcohol, drugs or had sex. Girls are more likely to be regular or occasional smokers than boys.

*Participation in
community
activities*

- Participation in social and voluntary activities, sport and exercise is associated with higher levels of life satisfaction.¹⁵⁰
- 76% of Key Stage 3 pupils in the Safe and Well at School Survey had taken part in some form of activity out of school as part of a club/ group run by an adult in the last four weeks.
- 61% had taken part in a sport or physical activity, 23% in a music activity, 14% in an arts activity and 24% in other activities (pupils could chose more than one type of activity).

20. APPENDIX 2 - Children and Young people’s Mental Health and emotional wellbeing Service Mapping – Tier 1 and 2 provision in Brighton & Hove (Taken from *Where to go for website, Local Offer and Costed Directory of Effective Interventions Phase 4*).

Organisation	Description	Post code	Area	Age group	Gender
Survivors’ Network	Survivors' Network is a registered charity that aims to reduce sexual violence and its impact on survivors' lives. Offers a range of services including a drop-in and helpline, 1-1 counselling, work specifically targeted at young people and an Independent Sexual Violence Advocacy (ISVA) service to help those who have, or are considering, reporting to the police.	BN1 1EE	Central Brighton	14+	F
Pavilions Substance Misuse	Pavilions is the new adult Drug & Alcohol Service for Brighton & Hove. It is available to anyone concerned about their drug or alcohol use, or for the families & carers supporting those struggling with substance misuse.	BN1 4SF	Central Brighton	18+	All
Men Get Eating Disorders Too	Charity for men with eating disorders including their carers and families.	BN1 EXG	Central Brighton	18+	M
Self-managed learning college	Support for young people aged 9-16 who prefer to have an education that responds to their needs - instead of going to school. The College operates out of the Brighton Youth Centre.	BN2 OJR	East Brighton	9-16	All
Amaze	Information, advice and support to parents of children with special needs and disabilities in Brighton and Hove –some services are available to young people direct.	BN1 3XG	Central Brighton	0-24	All
The Power Group: self-advocacy for young people with LD	A self-advocacy group for people with learning difficulties to talk about things they want to and to feedback information to other services what things interest them.	BN2 OJR	East Brighton	9-16	All

Mind out	Mental health service run by and LGBT and queer people with lived experience of mental health issues. Provides advice, information and advocacy support. Runs a weekly peer support group programme as well as a peer mentoring project. We have an out of hours online instant chat service. Mind Out also runs training for service providers.	BN1 3XG	Central Brighton	18+	All
Bodhisattva Meditation Centre	Mindfulness meditation for beginners and advanced as well as teachings about Buddhism. Toddlers and parents classes, after school kids class, lunchtime and evening drop in classes, half day and weekend courses and retreats.		West Brighton		All
Clock Tower Sanctuary	Support for 16 - 25 year olds who are homeless or insecurely housed.	BN1 1RH	Central Brighton	16-25	All
Mosaic	Community group for Black & Mixed Parentage families. Under 5's stay and play group; social inclusion workshop for primary schools; Social Inclusion Workshop, Women & Girl's Football Project.	BN1 3XG	Central Brighton		All
Pathways to health	Ear Acupuncture	BN1 3XG	Central Brighton		All
Hangleton & Knoll Project	A youth project operating in the Hangleton and Knoll area, supporting young people to become involved in the community, make changes and run their own groups and activities.		Central Brighton, Hangleton, Knoll, Whitehawk, Moulsecoomb	13-25	All
The Rock Clinic	Co-operative association of psychotherapists and counsellors, yoga teachers and complementary therapists providing accessible therapy to the community.	BN1 2PG BN2 5TA	East and central Brighton	16+	All
Young People's Centre (YPC)	The Young People's Centre is a free space for young people, a safe haven to come and relax, chat to people and volunteers: Access to Internet and cheap meals; Support and information; Sexual health and relationship support; activities and workshops; support with CV's and job hunting; space to talk to staff; free counselling service and access to TAPA mental health worker.	BN1 1AE	Central Brighton	13-25	All

Adventure Unlimited	Aims to enrich the lives of children and young people, especially those from disadvantaged backgrounds: Holiday and weekend adventures; Looked-after children; Activities for young people with disabilities; Adventure activities for 13-19 year olds	BN2 OJR	Central Brighton	5-25	All
Allsorts	Project in Brighton to support and empower LGBTU young people under 26 Weekly Drop-In includes games, art activities and workshops A range of Groups and Activities. Community Volunteer Programme LGBT youth volunteering programme, called Young People's Voice (YPV) Telephone, email and one to one support to LGBTU young people. Homophobia/biphobia/transphobia awareness training for staff at schools, colleges, youth services and other statutory and community organisations. Trained peer educators help run LGBT Youth Awareness workshops for young people at local schools, colleges and youth projects. Teen To Adult Personal Advisor (TAPA) one to one sessions.	BN1 1AE	Central Brighton	13-25	All
Aspire	ASpire supports adults with Asperger syndrome, High Functioning Autism and similar social issues through mentoring and group activities. 1:1 volunteer mentors matched with adults (16+) with Asperger syndrome. Asperger syndrome social group Training services – mentoring and ASD	BN3 2JQ	West Brighton	16+	All
Assert	Charity supporting adults (16+) with Asperger syndrome (AS) and High-Functioning Autism (HFA) Ad-hoc support and advice Advocacy; Liaison with statutory services; Awareness-raising; Benefits advice and support; Social Inclusion events – drop-ins and monthly activities. Volunteer support for members Assistance with gaining a local voluntary placement for members.	BN1 3XG	Central Brighton	16+	All

	Training for volunteers who wish to support Assert's work Support for parents/carers Website and newsletter				
BME YPP	Provides support, information & advice. BME only spaces. Drop in. Positive activities, sports, arts, street-dance, trips. Opportunities for volunteering. Black History Month activities. Education Support Groups in schools.	BN1 4GD	Central Brighton	11-25	All BME
Bridge Community Education Centre	The Bridge is a safe and friendly place where you can find new interests, meet new people, learn new skills and hold events. We offer: courses and workshops a free and confidential information and advice service careers advice and help with preparing for, finding and keeping work practical support with the costs of learning, including childcare costs volunteering opportunities social activities and groups cafe and catering services – for the community and local businesses room and venue hire with free off street parking and free wifi. Based in Moulsecoomb.	BN2 4PN	East Brighton	16+	All
Brief Intervention Service	The service provides 1-1 service interventions which are tailored to meet the needs of the wide range of client groups identified. The service also works alongside primary health care providers to access as many people as possible within the city who may be drinking above safer recommended limits. BIS offer up to four sessions of advice and information regarding alcohol consumption. BIS will refer on to other agencies as appropriate.	BN2 5NP and BN3 3JE	East and West Brighton	16+	All
Brighton & Hove Youth Service	Youth Workers offer 1-1 support for young people aged 13-19 (or up to the age of 25 if the young person has special needs) Mentoring and coaching for young people to help them work through issues Signposting or referral to other services The Youth Service also provides	All over the city	All over the city.	13 -19 or 25(special needs)	All

	evening youth club sessions for young people aged 13-19 years (or up to the age of 25 if the young person has special needs)				
Brighton Hope Group	Provides an opportunity to meet and communicate with fellow depression sufferers.	BN3 4FH	West Brighton	All ages	All
Samaritans	Samaritans provides confidential emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including those that may lead to suicide.	BN2 9NA	East Brighton	All ages	All
Brighton Oasis Project	Women's only service supporting young female substance misusers. 1 to 1 support in drop in service. Open Access. Young Women's Group for women experiencing problematic drug or alcohol use. The group is intended as a supplementary activity available for young women to include in their care plan. All those attending will need a key worker either from adult services or RU OK. If some are receiving counselling only and do not have a key worker the counsellor will need to agree to provide any extra support required.	BN2 9NA	East Brighton	18-25	Women
Brighton & Hove Eating Disorders Peer Support Service	Peer Support Service offers three groups for adults eighteen and over affected by eating disorders in men, women and carers living in Brighton and Hove.	BN1 3XG	Central Brighton	18+	All
Buckingham Road Drop-in	NHS Mental Health drop-in, part of the Community Mental Health Centre	BN1 3RJ	Central Brighton	16+	All
Cannabis Cessation and reduction service	Information and advice service for those affected by cannabis use	BN1 4GB	Central Brighton	18+	All
Care Co-ops	Supporting people with learning disabilities and mental health support needs, to live full and active lives	BN2 4QN	East Brighton	18+	All
Clermont Therapeutic Services	Therapeutic service for children under 14 who are the victims of sexual assault				
Counselling @65	Offering counselling support to young people aged 13 – 25 in the Brighton & Hove area.	BN3 3YJ	West Brighton	13-25	All
Counselling & Wellbeing Project Moulsecoomb	Free 1-1 confidential counselling in Moulsecoomb for young people aged 13-25 and living in the area. To support young people to find their own solutions and strengths	BN2 4RW	East Brighton	13-25	All

	to whatever issues or challenges they are facing.				
Counselling & Wellbeing Project Whitehawk	A wellbeing project for people aged 13-25		East Brighton	13-25	All
Crew Club	Providing opportunities and a safe place for young people	BN2 5QW	East Brighton	7-19	All
Deans Youth Project Woodingdean	Youth clubs, centre based, outreach and detached sessions	BN2 6BB	East Brighton	11-19 up to 25 with special needs	All
Expert Patients Living Well Course	Courses on improving living quality with a long term health condition		Various locations	18+	All
Mankind	Counselling for men who have experienced any form of sexual violation		Hove	16+	Men
Mind	Promoting mental health in the community offering advocacy, advice and information for people with emotional or mental health difficulties	BN1 4GQ	Central Brighton	Community Advocacy 18-65 Speak your Mind 11-19 LiVE 18+	All
Buckingham Rd Community Mental Health Centre	Supports people with mental health problems and their carers, family and friends. The Drop-In is a friendly and informal place to come and find out about a range of services, gain support and meet new people	BN1 3RJ	Central Brighton	16+	All
Rhythmix	Music charity for young people	BN1 3XG	Central Brighton	0-18 up to 25 for people with special needs	All
Right Here	Free resilience building activities for 16 – 25 year olds in Brighton and Hove	BN3 3YJ	West Brighton	16-25	All
Rise	Domestic abuse prevention project runs Rising Star sessions with 6-11 year olds focusing on Protective Behaviours				
RU-ok	ru-ok? is the young person's substance misuse service for Brighton & Hove. We provide free, confidential help and advice to young people and their families	BN1 2RU	Central Brighton	Under 18	All
Speak Your Mind YP advocacy	Provides advocacy for young people who have emotional and wellbeing issues	BN1 4GQ	Central Brighton	11-19	All
Sussex Mental Health Line	An out of hours telephone service for mental health help		Across Sussex	Any age	All
Threshold	Provides support, advice and	BN1	Central	18+	All

	accommodation for people with mental health needs.	1EB	Brighton		
Whitehawk Inn	Working with the people of East Brighton to develop and fulfil their aspirations for success in their own lives, their families and the community	BN2 5NS	East Brighton	16+	All
Wise Project	A service for young women and young men aged 13 – 25 at risk of or experiencing sexual exploitation.	BN3 2BE	West Brighton	13-25	All
Young Oasis	Brighton Oasis Project aims to improve the lives and maximise the potential of the diverse range of women, children and young people affected by substance misuse.	BN2 9RA	East Brighton	0-25	All
Youth Advice Centre	Information, advice, guidance and support for young people	BN1 2RA	Central Brighton	13-25	All
Early Help Hub	Provides co-ordinated early help interventions and support for families and children who don't meet the threshold for social work interventions.		City wide	0-18	All
Community CAMHS	Provides a targeted response to mental health and emotional wellbeing .		City wide	0-18	All
Integrated Team for Families	Using support and enforcement and working in partnership with families we work to reduce anti social behaviour, youth crime, and increase access to education, training or work		City wide	Under 18	All
Parenting Team/Triple P	Evidence based positive parenting programme		City wide	Under 18	All
Dialogue	Schools-based counselling service in 53 of the City's schools accessible by Reception through to Y13. Community based counselling service for 13-25 year olds. Online counselling for 13-25 year olds. Family support services attached to Longhill and Patcham High Schools		City wide	Under 18	All
Extra Time	Provides high-quality, affordable out-of-school activities for children and young people with disabilities, in a safe, fun environment working closely with parents/carers, school staff and other professionals		City wide	5-19	All
Safety Net	Assist with behavioural, social and emotional difficulties whilst supporting family needs, as well as all children who are vulnerable to bullying behaviours fitting into the school age range. Interventions include Safer Transitions to Secondary School, Personal Safety Sessions for Year 6 and Assertiveness		City wide	5-16	All

	Project (SNAP)				
Baby massage	To improve attachment between parent and child, for mothers assessed with low mood/PND	Sure Start	City wide	0-1	All
Nurture groups	6 week group for children who are displaying difficult or challenging behaviour towards a sibling, pet or other family member and children who find it difficult to show emotion.	Sure Start	City wide	3-5	All
Post natal depression support – listening visits and groups	6 sessions for mothers assessed as low mood following birth of baby and CBT therapy support group.	Sure Start	City wide	0-1	All
Domestic abuse intervention for parents of 0-5 child	Risk of emotional harm to parent and child discussed	Sure Start	City wide	0-5	All
Baby and You	Early years visitor outreach to support parental skills and attachment.	Sure Start	City wide	0-6 months	All
Teenage Parents (non Family Nurse Partnership)	Interventions to support the child's emotional, social, physical and cognitive development.	Sure Start	City wide	Under 18s	Teenage parents
Family Bereavement Support	Listening visits, including siblings following death of a child.	Sure Start	City wide	0-5	All
Parent Infant Psychotherapy	Service strengthens the attachment between parent and child to increase infant security.		City wide	0-2	All

21. Appendix 3 Local services reports on user views of CAMHS

DOCUMENT	ISSUES COVERED
<p>Notes of April 2014 Mind Me Up meeting (Mind's Young People's Involvement Group)</p> <p>Children and Young People with Mental Health problems</p>	<p>Social Media – professionals should use Twitter to get messages about mental health to young people</p> <p>Primary Care – Ways in which GPs aren't helpful</p> <p>Mental Wellbeing Strategy comments – vulnerable people at school don't get help, EWOs can be unhelpful</p> <p>Online counselling difficult if not used to talking about feelings; diagnosis not possible; can't tell tone of written word may get offended; privacy, confidentiality & access to PC.</p> <p>Right Here- like this want more, walk and talk, anger management needs funding</p> <p>TAPA – like this want more</p> <p>Continuity of worker seen needed</p> <p>Specialist pathways – good</p> <p>Autism – those not far enough on spectrum have problems</p> <p>Carers/young carers neglected</p>
<p>BME Young People's Project – Consultation on Mental Wellbeing Strategy – 16-25 years</p> <p>BME</p>	<p>What makes you feel good? – family, friends, exercise, music, reading, travel, cultural awareness, healthy eating, fashion.</p> <p>Things that stress people – Academic work, exams, relationships, money, parental expectations, bullying at school, not getting on with parents</p> <p>Things that help stress – meditation, walks, hobbies, church, BMEYPP, holidays, talking to self in mirror, mindfulness, yoga, capoeira, martial arts</p> <p>Usage of mental health services to help with mental wellbeing – most hadn't used any services. Some didn't know where to go if they did need help or didn't feel confident of using services they didn't know</p> <p>Services that help with mental wellbeing – counselling, youth workers at the BMEYPP – listen and non-judgemental.</p> <p>How services could be improved – Reassurance that counselling is confidential, share notes. Workers need to relate to young people, not talk down and use language they understand. BME workers shouldn't be too professional</p> <p>Suggestions for promoting mental wellbeing- Mental health campaigns should involve and represent young BME people.</p>
<p>Feedback to CAMHS LD after Partnership Charter Assessment</p> <p>Learning disabilities & MH</p>	<p>Assets of CAMHS LD Service – clear, accessible information, developing clear care pathways, child focused assessments involving parents and family needs considered.</p> <p>Weaknesses – Changes implemented as a result of parents post card survey need to be fed back to parents.</p> <p>Parents need the opportunity to say what they think of service</p> <p>Parents need greater involvement in developing services and designing service leaflets and consistent involvement in reviews</p> <p>Parents need clarity on information sharing between branches of NHS</p> <p>Parents need information on who's who in organisation</p> <p>Parents need access to other services to make informed choices</p>

	Professionals need training in working with parents and children.
Amaze – Parents’ Experience of Planning and Preparing for their Young Person’s Future into Adulthood. June 2014 (15% of respondents children had emotional, behavioural or mental health problems) Children &YP with disabilities	<p>Lack of support with transition- Some parents reported they didn’t get support from social services as child has to be in extreme need, left to cope on own.</p> <p>Schools, SENCOS, Amaze, YES and Mascot mentioned as having a role helping in transition</p> <p>9% who say their child currently uses CAMHS said it had been explained to them how their child would be supported in Adult mental health</p> <p>Better coordination needed between services</p>
“Talk Health.” Parent Carers’ Views on Health Services in B&H 2012 Children with disabilities	<p>Report by parents of children that have disabilities</p> <p>Top three recommendations</p> <p>Improved parent participation- on HWBB, CCG Children’s Review Board. Standardised parent feedback should be required across all health services. Parent carers should evaluate “health” services using the Partnership Charter – CAMHS has done so and should use as part of wider parents review of CAMHS</p> <p>Increased resources for services –community support and specialist posts</p> <p>Improved communication and transparency</p> <p>CAMHS Assets – Listening to parent concerns in the New Parent Group; Specialist nurse offer home visits making parents feel supported and understood.</p> <p>Weaknesses – hard service to access and difficult to negotiate Long waits for assessment, with no support during the wait. Service is disempowering and parents not treated as equals. Psychiatric language used is a barrier to understanding</p> <p>Recommendations Parents be involved in developing information on CAMHS – who does what, eligibility User satisfaction survey results presented to Disabled Children’s Partnership Board and Health and Wellbeing Board Transparency about care pathways and waiting times Psychiatrists to be trained in the parents’ journey Autism specialist needed Set up network for parents of children with severe behavioural difficulties, for support and professional input.</p> <p>City wide code of practice for GPs on disabled children’s transition, as they take over their care at 18.</p>
RIGHT HERE. Young people’s views and experiences of GP services in relation to emotional and mental health – average 17.2 yrs (172 consulted) Survey from 2008-09	<p>Appointment systems – convoluted and confusing. Long waits on phone and to get appointment</p> <p>Surgery environment – Young People (YP) value friendly, helpful, competent, positive staff and automated booking in systems. Don’t like rude or indiscrete receptionists and overcrowded waiting rooms.</p> <p>Treatment – Referrals to other service take a long time</p>

<p>Primary Care</p>	<p>GPs too quick to prescribe rather than look at alternatives Online repeat prescription service useful Valued seeing GPs who knew about YP support services Want more time with GP Relationship with GP –Value GPs that listen, friendly, approachable, caring who allow time and offer holistic approach to emotional and mental health. No technical language. Non-judgmental and shares treatment decision making with YP. Confidentiality – YP unclear of confidentiality rules Mental Health - Want to talk to GP or be referred to professional/counsellor to discuss MH problems but only half felt comfortable talking to GP about mental health. GPs don't take emotional/mental health seriously or take YP seriously Service improvements – More online facilities and information to take away YP involved in service planning and monitoring – “young experts” Post appointment feedback surveys YP train practice staff Clearer information and explanations – particularly when referred to CAMHS More YP centred/designed GP practices Easy registration where you like Information on health care rights and confidentiality</p>
<p>RIGHT HERE. Young People and Self harm: Perceptions and understanding. January 2014</p> <p>Self-harm</p>	<p>Age of onset of self-harm –This was perceived to be around 13 years or younger Type of self-harm – A spectrum that ranges from deliberate self injury like cutting to piercing/tattoos Reasons for self-harm – Internal and external. Internal- sense of control, release, feeling alive, hormonal changes, cry for help, Self-image, self- esteem, coping mechanism. External – social media, society, teenage years of transition. Self-harm as communication – Perceived as a form of communication, possibly a way of asking for help but not attention seeking. Difficult to talk about. Gains- It provides release and sense of control Consequences – varies from individual, circumstances and reasons for self harming Response to disclosure – College staff not confident or sure what to do. Medical staff confident and have clear referral pathways. Supported accommodation staff confident would want to offer support. Support services – national websites, college counselling service, CAMHS, RUOK, local services – YAC YPC, Right Here, MIND Training- College staff, doctors and supported accommodation staff would all value more training. Recommendations – Information Guide for YP on self-harm; Training for professionals by YP in self-harm; Increase awareness of Where to go for? web site; audit of existing self-harm service and what's needed; clear referral pathways for professionals on self-harm.</p>

<p>RIGHT HERE. “A Voice and a Choice” Feb 2013</p> <p>National workshop feedback</p>	<p>Report of a one day workshop on the national Right Here programme - Right Here projects delivered included recreational activities; therapeutic activities; awareness raising activities; participatory activities.</p> <p>5 most important themes of Right Here are:</p> <ul style="list-style-type: none"> • Holistic approach • Engage and involve young people, don't patronise • Follow a life course approach that doesn't stop at 18 years • Help young people be the best they can • Services to be in the communities where YP are. <p>Recommendations – Transformative mental health services driven by skilled youth workers and YP; Real involvement and collaboration of YP; Understand and advocate for community based services; Recognise the importance of place and space; Understand the importance of relationships; Build Social Capital.</p>
<p>RIGHT HERE. A Voice and Choice for young people's mental health. Case studies.</p> <p>Case studies</p>	<p>Case studies from the different national project site including B&H. Describes the development of the YP's Research and Evaluation Group and its research on GPs and self-harm.</p>
<p>RIGHT HERE. Barriers to counselling for young men in Brighton & Hove. March 2015.</p>	<p>In March 2015, RIGHT HERE published a report on the barriers to counselling for young men in Brighton & Hove. An online survey, as well as focus groups with 13-25 year old males were carried out. 20% of respondents cited peer influence and 29% stigma around counselling as a reason for them not to access services, despite saying that they themselves would not think less of others. When asked what would prevent participants from accessing counselling, the two dominant responses were:</p> <ul style="list-style-type: none"> • The (perceived) cost of counselling (74.4%) • The fear of getting a mental health diagnosis (41.9%) <p>Nearly half of the participants involved said that gender is irrelevant when accessing counselling (48.4%). However the other half of participants were split with nearly a third of the participants opting for a female counsellor (32.3%) compared to the remaining 19.4% choosing male.</p>
<p>Feedback from Mind LiVE consultation on YP's mental health services in B&H – January 2015.</p> <p>Children and Young People's mental health services feedback</p>	<p>Focus group and online survey with 17 people – 6 people 18 +, 7 carers, 4 workers asking for views on what services work well, gaps, improvements needed and transition.</p> <p>Works well – skills of individual workers. Someone to talk to on a regular basis. TAPA workers during transition</p> <p>Gaps – Lack of support and information for parent/carers. Support with making transition to adult services. Little information on other services. Waiting lists for counselling. YP with ASC had difficulty accessing mental health support.</p> <p>Improvements – More information and sign posting to other services. Services to bridge young people and adult services.</p>

<p>Amaze and Parent Carers' Council</p> <p>Survey of parents/carers of what's important for the mental health of their disabled child with special needs or themselves. – Feb/March 2014</p> <p>Children with disabilities</p>	<p>88 people responded to online survey or focus groups 90% had accessed CAMHS but their average satisfaction rating was 4 out of 10.</p> <p>Organisations that support young people are valued – Mind, RuOK, Extratime. TAPA</p> <p>Parent carers felt CAMHS didn't listen to them or value their experience/knowledge.</p> <p>Want more joined up working and early intervention in community Want more information to be shared with them and more focus on activities rather than treatment.</p> <p>Recommendations – Increase CAMHS knowledge of children with disabilities; clarify help CAMHS can offer with autism; CAMHS to be more flexible and child centred; communicate better to families about transition to adult MH services</p>
<p>RIGHT HERE Report into wellbeing of 16-25 year olds in B&H March 2014</p> <p>YP wellbeing</p>	<p>Online and face-to face survey of 276 young people about how they look after their well being</p> <p>Recommendations to do with mental wellbeing</p> <ul style="list-style-type: none"> -Better signposting to sports/activities -Access to diverse activities/courses and information on volunteering -GPs and health professionals to be trained in supporting and diagnosing YP, treat them as individuals and offer more time for appointments and shorter waiting times -More education for YP in mental health awareness
<p>YMCA Downslink Group Monitoring Report July – December 2014. Cnty CAMHS.</p> <p>Parents feedback on CAMHS Family Support Worker service</p>	<p>Anonymous feedback is received from parents using the Family Support Worker service. Presenting issues seen by the service include: anxiety, anger, behaviour difficulties, low parental confidence. 223 families seen during this period and 367 Children and Young People.</p> <p>Over half the families rate the service and relationship with key worker as excellent. 80% felt communication, understanding and response to their needs by key worker was excellent. Most felt fully involved and consulted and all would recommend the services. Comments include positive effect on children of parents receiving training in resilience and behaviour management. Time to Talk sessions at schools valued as open access and early intervention. Comments on things that would assist parents include less disjointed services; at least one 1-2-1 intervention for child; shorter wait for assessment by CAMHS and Seaside View. Overall very positive feedback about service and staff.</p>
<p>Dialogue – Schools, Colleges & Community Counselling Service Report 2013-14.</p> <p>CYP feedback on counselling service</p>	<p>2,159 CYP seen. Providing counselling, exam stress workshops, peer listening training and support, bereavement support, Yr 6 transition groups, reflective practice supervision for staff and child protection. Main presenting issues Primary: anxiety, family separation, anger, self-esteem/confidence, relationships with family members. Secondary: as above plus low mood</p> <p>Feedback from Primary School Children includes: value having someone to talk to privately about things and ideas it gives for</p>

	dealing with negative thinking, anger, bereavement. Secondary School children's feedback: Reduces stress being able to talk to someone, a chance to calm down. Primary parents/carers/staff report improved confidence in children and better at coping in situations.
Dialogue – Community Counselling Provision 2013-14	Doesn't differentiate between feedback for services in B&H and elsewhere
YPC Counselling Service 2013/14. 13-25 years feedback on counselling service	Reasons given by parents, agencies for referral to YPC -Shorter waiting times for assessment and treatment compared to NHS -Provides a support group for those transitioning to adult MH services -YP friendly environment easier to engage with -People want to work on underlying causes of anxiety and depression -YP counsellors trained to work appropriately with YP -Colleges/unis have many students with complex needs and need to refer on. 51% of students who used service completed post counselling questionnaire. Service was kind, respectful and made them more confident, happier, and comfortable in self. 99% would recommend to a friend.
Moving on from CAMHS – Mind Focus group, August 2014 Under 18s feedback on using CAMHS and transition	Experience of using CAMHS 1-3. Positives: Continuity of therapists; quality of therapies; listening skills of staff; liaison with school Gaps : crisis support; out of hours; access to care plans/diagnosis; choice of therapy and psychiatrist; staff cover; no transition support; engagement with older education/university services; signposting to community services; communication with family; no support in getting to appointments; medication support; no info on rights Recommendations: Extended service up to 26 yrs Signposting; out of hours support; better communications across services; info pack for new patients; involvement and choice in care planning; co-ordination between education settings; appointments to fit in with education; clearer diagnoses; carers/families suicide training, better support, involvement in care; transition to include formal handover, joint appointments and follow up by CAMHS; GPs to know about services those leaving CAMHS can use; CAMHS notes to go to AMHS.
YMCA Downslink Group The WiSE Project June 2015 Paper on the mental health support needs of children and young people who are victims of sexual exploitation	This paper was written to inform the JSNA about the unmet mental health needs of children and young people who are sexually exploited. It uses case studies and recommendations from serious case reviews to evidence this. Issues highlighted: Children and young people need an immediate and prompt response at the time they are ready to engage with mental health services. Victims of child sexual exploitation are extremely vulnerable and early intervention is crucial to prevent ongoing harm. Hard to engage children with emerging attachment issues and personality disorders won't engage with the CAMHS

	<p>office based appointment system but need to be seen at an early stage to prevent admission to secure settings. Children and young people who are sexually exploited but are unknown to the police may be seeing their GPs. Primary care needs to be trained in the signs of sexual exploitation and know how to respond.</p>
<p>Putting the Pieces Together: An overview of people's experiences of CAMHS services in Brighton & Hove. Healthwatch Brighton and Hove. 2014¹⁵¹</p>	<p>This paper is review of recently collated research on CAMHS services in Brighton & Hove. The overarching issues highlighted by the review include: Transition from child to adult mental health services; obtaining a diagnosis; continuity of therapist; therapeutic support for parents and access to support in a crisis. Eight recommendations are made for improving the service</p> <ul style="list-style-type: none"> -Inform GPs of services available and how to refer -Information pack on entering CAMHS – outlining rights, complaints, expectations and information on support available from community and voluntary organisations -Ensure MDT approach to diagnosis including young person and carer -CAMHS should review their assessment criteria to meet the needs of children with wide ranging symptoms mild impairments on the Autism Spectrum -Prioritise continuity of therapist and provide information on how to change a therapist -Review the effectiveness of parenting skills versus therapeutic interventions for parent carers -Make young people and people who support them aware of current crisis options and review out of hours support for gaps -Create a comprehensive policy around transition.

22. APPENDIX 4 Voice Methodology

Children and Young People's Focus Groups

Sixteen focus groups were held involving approximately 79 children and young people and 20 parents. Focus groups with children and young people were led by: The Youth Council, Oasis Project, TDC, Right Here, Hangleton and Knoll Project, YAC, Mind Me Up, Mind, YPC, YPC/TDC youth work group, Young people's self-harm focus group, Allsorts, TAGS, PACC/Amaze parents group, Downslink YMCA parents' focus group, parents' self-harm focus group. The age range of the young people involved was from 11-25 years. There were 21 males, 23 females, 6 other and 14 transgender and 42 were heterosexual, 14 LGB, unsure or pansexual. 48 were White British (5 BME). The high representation of LGBT people is due to a number of focus groups being run by Allsorts, which means there may be some sample bias and the views expressed may not necessarily reflect those of all children and young people using mental health and wellbeing services.

Parents Focus Groups

Two focus groups were arranged for parents led by Amaze/PACC and Downslink YMCA. Their children ranged from 8-22 years. The parents were asked to consider seven question areas.

Views of young people and their parents/carers from the online surveys

Between June and July 2015, alongside the focus groups held across the city, an online survey for young people, and one for parents/carers was open. There were 95 responses from young people and 215 from parents/carers. We asked a range of questions about what had helped people (both young people and their parents / carers), what else would have helped and easier ways to find out about health. For those who had accessed services we also asked what was good, what could be better and what was bad about those services.

The characteristics of the young people responding to the survey are given below:

- The ages of young people responding ranged from 12 to 28 years. Of the 60 respondents giving their age:
 - 18 were aged 13-15 years
 - 21 were aged 16-19 years and
 - 14 were aged 20-24 years
- More females than males responded, 63% female and 37% male (with fewer than five respondents identifying as trans)
- 80% of respondents giving their ethnicity were White British and 20% from Black and Minority Ethnic (BME groups) compared with 255 of 15-24 year olds living in the city from BME groups according to the 2011 Census
- Around a third of young people responding were lesbian, gay, bisexual, unsure or other (34%) and two thirds were heterosexual (66%)

- 41% of young people responding said that their day to day activities were limited because of a health condition or disability which has lasted, or is expected to last, at least 12 months. As might be expected given the subject of the needs assessment, for 80% of these young people the type of impairment was a mental health condition. There were respondents with many other types of impairment, with the next most common being learning disability.
- 13% of respondents said that they were young carers.

The characteristics of the parents responding to the survey are given below:

- The vast majority of respondents were female (89%) and 11% were male
- 90% were White British and 10% BME
- 95% of respondents identified as heterosexual and 5% lesbian, gay, bisexual or unsure
- 24% said that their day to day activities were limited because of a health condition or disability which has lasted, or is expected to last, at least 12 months. For 37% of people this was a physical impairment, and for 31% a mental health condition.
- 33% identified themselves as carers and for 67% of these carers they were caring for a child with special needs
- The numbers of respondents identifying as trans are too small to present
- The numbers of respondents identifying as a veteran are too small to present

23. APPENDIX 5. Thematic analysis

Children and Young People's Focus Groups Data

Replies with three or more responses

1. Where would you go for help and support if you were having difficulties that were making you feel stressed, worried, low, angry or upset? (123 comments)

Teacher/School/School counselling – 15

Family -10

Therapist/psychologist/counsellor – 10

Doctors -8

YPC-7

Friends -7

YAC-4

Youth workers-4

Internet/forums -3

Allsorts -5

2. Thinking about services that you currently use, or the last service you used, how did you feel at your first appointment or assessment? (79 comments)

Nervous/anxious – 11

Dissatisfied with appointment/assessment process (wait, purpose not explained, repeating everything) – 14

Concerned about confidentiality – 9

Negative experience with CAMHS -6

Negative experience with GP -3

Positive experience with YAC-3

CAMHS environment not YP friendly -3

3. When you were receiving help and support for your difficulties, did you ever think about not attending an appointment or dropping out of your treatment? If so, why? What things made you think about dropping out or deciding to stay? (96 comments)

Main reasons for keeping appointments

Staff are welcoming/friendly – 5

It helps – 4

Main reasons for DNA

Fear/anxiety –not knowing what to expect, fear of diagnosis, being told off – 11

Negative perception of CAMHS staff (patronising, older, gender, blunt manner) – 8

Situation changed by time appt arrives/feel better - 4

CAMHS staff don't understand trans issues -5

4. Which services that you got help from did you find helped you the most and why was that? (63 comments)

Youth groups/YAC/YPC – 6

Counsellors -6

Allsorts- 10

CAMHS -5

Private counsellor/therapist – 3

Being reliable and consistent, trusting, listening was important- 5

5. Was there anything that could have been offered to you sooner to help with your difficulties, if so what? (45 comments)

Earlier intervention/get help sooner – 11

School have a better understanding of trans issues -6

Listening services -4

Information on services -3

6. Which services that you got help from didn't meet your needs and why was that? (72 comments)

GPs - 8 Not trained in specifics; push for support; diff one each time;
worrying mediation advice

Schools -8 Not confidential; don't want to be seen at school in case
friends know; infrequent support and repeats what you know; not taught about MH until Yr
10; need to help more with bullying; only helps if you can get to school; don't care about
wellbeing, don't follow through or find time to talk; don't understand trans issues

CAMHS -14 Patronising, not understanding, you have to fit their box,.
symptom focused, poor relationship with worker, not accessible, discharge too soon, don't
listen, unreliable, cancel appts, ask unrelated questions, wouldn't treat MH probs while
waiting for gender clinic, don't understand Trans

Psychologist -3 poor bedside manner

7. What sort of things could have been done better or in a different way to make them more helpful? (75 comments)

More flexible and accessible services with a choice of treatment options -8 -drop-in services after school, more going on locally, choice of CBT, art, play therapy or fun activities, evening appts

Improved support in schools -7 Quicker access to counselling, youth workers in school to help with bullying, advertise services in school journals, teachers treat everyone the same, train teacher in MH issues, teach children about self-harm, improve school management of self-harm

Better understanding of Trans issues by CAMHS staff -9

8. If you were designing an ideal service to help when you have difficulties that make you feel really worried and low, what would your top three priorities be? (70 comments)

1. Friendly, listening, welcoming staff, non judgemental
2. Comfortable, safe, local location
3. Range of options for treatment, activities and groups available
3. Accessible service – easy to make appts, choice of times, outreach, flexible, out of hours contact by phone, email other, shorter waiting times

Replies with 3 or more responses

1. Over the last year, which parts of child and adolescent mental health and wellbeing services (CAMHS) in Brighton and Hove do you feel have worked well? (17 comments)

CAMHS – 5 - Good relationship with parent, copied into letters, quick response to gender ID, set up ABICCUS involvement

CAMHS LD – 4 Behaviour course pilot, monthly visits to school, counselling at 1 school

2. Over the last year, which parts of the child and adolescent mental health and wellbeing services (CAMHS) in Brighton and Hove do you feel have worked less well? (28 comments)

CAMHS 8 – long waits, lack of out of hours, assessment process, rationing of service, no long term care, not moved up a Tier, early discharge, can't see a psychiatrist, communication with parents, parents feel let down, poor admin communication with parents, lack of choice in treatment

Schools 3 - Not enough Ed Psychs, sencos, early intervention

3. Over the last year, what have been the gaps in child and adolescent mental health and wellbeing services (CAMHS) in Brighton and Hove? (32 comments)

Parents of children who self-harm don't know where to go for support -3

Difficulties in getting Ed Psych input through schools -3

4. When your child was experiencing difficulties in their life that affected their mental health and wellbeing, where did you go for help and support? (27 comments)

GP (2)

CAMHS

Children's Social Care

School (2)

A&E

Family

Seaside View

RUOK

YAC/YPC (2)

Young Minds website/helpline

Amaze

Childline

Neighbour

Private professionals

Solicitor

Police

Fire Service

University Counselling

Internet

Dolphin Clinic
Dialogue Centre
Carers Centre
Changes ahead (Mind Carers support group)
Break4change (for parents receiving abuse from children)

5. In what ways have services involved you in the care given to treat your child's mental health and wellbeing issues? (21 comments)

15 comments were made about **not** being involved in care and treatment of child's mental health by CAMHS, GPs and Schools

Those that were involved had -

- Info on courses
- Info on re-contacting services
- Attending child's first appt
- Parent had appt every 6 weeks – made them feel supported
- Written info from CAMHS
- JSNA focus group

6. How satisfied have you been with the response you have received from professionals when seeking help for your child's mental health and wellbeing issues? (12 comments)

Positive - Fantastic, prompt, range of options

Negative - Frustrated (2)

Imply child getting better when no evidence for this – feels its done to justify withdrawing service.

Exhausting – battling for help

Make complaints due to lack of response – sometimes CAMHS staff suggest it

Rude Receptionist

Lack of confidence in psychiatrist –didn't listen to daughter

Gaps in level of knowledge of professionals

GP initial contact poor

School communication not forthcoming

No flow between services

7. If you were designing an ideal CAMHS service, what would be your top three priorities? (41 comments)

1. More resources – staff, appointments – 5

1. Clearer signposting and referral/assessment process – 5

1. Flexible/accessible service 5 - ability to switch pathways, out of hours, change professional, outreach work, non-clinic based appointments, follow up DNAs

1. More early help -5 quicker response to first contact, short wait for appointments, earlier diagnosis, initial assessment by Tier 3
2. Listen to parents/non-judgemental – 4
3. Better expertise -3
3. Joined up services -3

CAMHS Professionals' interviews data analysis

Face to face Interviews: 26

Telephone interviews: 2

GP PLS Survey: 34

Email comments: 5

Notes of meetings: 6

Comments received by 16.08.15 = Total 72

Organisations included: YMCA counselling service, Wellbeing and Targeted Support, YAC; SPFT Urgent Help Service, General Manager, Tier 3 CAMHS, TAPA, Psychology, Functional Family Therapy, Psychiatry; Seaside View; GPs; Mind me Up; BHCC LD, Community CAMHS, Children's Centre, PRESENS, Children's Services, Children in Care; Amaze; RACH; YOS; YPC; Hertford School: Parents; PRU; Attendance and Behaviour Meeting; Primary and Secondary School Heads meeting; SENCO meetings; Community Woks event, Art therapist, Behaviour Improvement Adviser, Allsorts, Social, Emotional Mental Health in the Early Years meeting.

1,What works well (46 comments)

Once you get into the CAMHS system it works well (5)

Tier 2/3 single point of access/joint triage (5)

TAPA (6)

CAPA – 1st appointment within 4 weeks in Tier 3 (4)

Tier 2 community CAMHS at the council (4)

Urgent Help Service (4)

RUOK (2)

Early Intervention in Psychosis (2)

Partnership work for self-harm, low mood, crisis work –quick response within 2 days.(2)

YAC (2)

YPC(1)

Functional Family Therapy Team (1)

Pre SENS support (1)

Low level issues picked up by schools (1)

CAMHS staff embedded on YOS and RUOK teams (2)

“there is a lot of support in the city, is stuff there –it's good compared to other areas.”

Monthly Tier 2/3 CAMHS/Seaside view Liaison meetings (1)

Community MH Worker – nursery nurse(1)

CAMHS LD (1)

Primary Mental Health Workers in Schools (1)

2.What works less well (115 comments)

Clinic based Tier 3 structure is not young person friendly

Tier 3 clinic structure (3)

Venues need to be community based to meet needs (3)

CAMHS is a static service, young people have to go to them, difficult adolescents won't do this(2)

Going to clinic and sitting in waiting room is stigmatising

CAMHS venues need to be set up with young people at the centre

Tier 3 CAMHS is commissioned to provide a very clinical service

Tier 3 family therapy is clinic based rather than in the home

Tier 3 needs better links with the community

Appointments outside school mean return to school rate is low

Lack of clarity in referral system and eligibility criteria and thresholds too high

The way GP referrals are rejected by Tier 2/3 triage – lack of clarity on signposting follow up, or reasons for turning down.(11)

CAMHS referral thresholds too high (4)

Tier 2/3 eligibility criteria unclear (4)

Confusion over CAMHS wanting referrals from GPs rather than schools and then giving schools no feedback (2)

Parents have no information about the referral process and what to expect

Lack of clarity around Tier 2 eligibility criteria

Pre-referral consultation telephone is difficult to get through on.

PreSENS find it difficult to access CAMHS and Seaside View –referrals get turned down

Lack of capacity leads to GP referrals bouncing back

High referral thresholds for Tier 3 place children at risk of school exclusion

Communication and access, long wait between referrals and response

Schools and YAC have to hold more YP as service thresholds are raised

Capacity within CAMHS is insufficient to meet demand

Mismatch between demand and capacity in Tier 3 (7)

Waiting lists for CAMHS assessments (5)

Lack of availability of Psychiatrists (3)

Primary MH workers aren't enough of them to be accessible

No help for families with low level mental health problems

Long 12 week wait for assessments

School and community counselling services have long waits.

Tier 3 CAMHS don't have capacity to support families with ASC diagnosis

CAMHS too busy to attend multi agency meetings

Difficulties with getting an autism diagnosis and post diagnosis treatment

ADHD and ASC have long waits for diagnostic assessment as lower risk conditions (3)

No support for people diagnosed with ASC unless they have a mental health condition too (2)

Long waits for autism assessment without explanations

Group based talking therapies for autism not appropriate
Problems for parents in getting autism diagnosed and information about it once diagnosed
CAMHS can't refer children with autism aged 0-6 to neurodisability post at Seaside view – has to be by paediatrician

Social care and holistic treatment issues

Access to crisis social care for Urgent Help Team is difficult
CAMHS don't address social care issues
RACH outpatients don't give a holistic view to GPs
Issue of referrals for conduct disorders – behavioural and not mental health problem
CAMHS divide between mental health and behavioural issues

Lack of joint working

Links between schools and GPs – sharing of information (3)
Lack of ongoing support and information for schools from CAMHS (2)
SPFT don't work with partners, put up barriers, are numbers focussed
Lack of working relationship between GPs and CAMHS
No working relationship between Psychiatry service and RACH Paediatric Consultants
RUOK/YOS embedded CAMHS staff have difficulty getting support from Tier 3 CAMHS
LAC service doesn't work well – long waits for treatment, lack of information and difficult getting outcome data
Tier 3 needs to be more responsive
Schools told CAMHS can't be identified as a need on Education and Health Care Plans

Problems with eating disorders service

Not enough services for those with eating disorders who have a BMI 16/17 – not ill enough for CAMHS (2)
Eating Disorders service – lack of co-ordinated care

Lack of flexibility in care pathway

The response to hard to reach/DNAs (2)
Tier 3 pathway not flexible enough – if you miss 3 appointments you're out.

Other

Management of vacancies by SPFT – maternity leave (2)
Transition planning – AMHS don't attend CPA meeting if client is under 18 years.(2)
CYP with significant MH probs are seen by trainees (2)
Open Door policy for returning patients – narrow, go back to GP
First meeting with CAMHS is very time consuming and assessment is full on.
Lack of clarity about school counselling role and competency by GPs
Family therapy/counselling pathway unclear to GPs
Lack of consistent response to self-harm to GPs
The Psychiatrist Service – YP don't understand what they do
Difficult to get a service for 16-17 year olds
A&E send YAC referrals for suicide ideation back to YAC

Anxious/phobic YP don't want to go to anxiety groups
Nowhere for PreSENs to go to for help with attachment issues
No parents group for ADHD at Tier 3
Tier 3 didn't complete the feedback loop on user involvement
Shared care protocol with GPs responsible for blood tests is an anomaly

3.What are the gaps (95 comments)

Tier 1

GPs aren't young people friendly
GPs don't know where to refer children with behavioural problems
Need a central access point for GPs for all services
Need information sheet/epathway describing all services and where to go for help

Tier 2

Earlier prevention work needed
Increase in self-harm in Tier 2
Children not asked about trauma experience to explain behaviour in Tier 2

Management

No clinical co-ordination or evaluation of Tier 2 services

Counselling

Counselling competencies need to be matched across to individual needs
Not enough school counselling available
Too many children fall between the gap between schools counselling and CAMHS options

Gaps in services

Not enough early intervention or capacity in lower Tiers (2)
No family therapy apart from Tier 3 (2)
Lack of support for children who are out of control at home but not school (2)
Lack of CAMHS outreach workers in schools
Gap left by Connexions service in support to deprived areas
Not enough primary mental health support in Tier 2
Needs mental health awareness training for staff in schools
Need for more family/systemic based (attachment) programmes in Tier 2.
Services don't meet the needs of boys and young men

Gaps in joint working/communication

Early Help and Early Intervention aren't linked up
No interface between YMCA and Early Help
Tier 2 aren't joined up enough with Tier 3
YOS and RUOK get few referrals from Tier 2 or Tier 3
Difficult to get CAMHS to attend school TAF meetings (Team Around the Family)

Poor communication between CAMHS support workers (school setting)

Transitions

AMHS don't understand the needs of 18-25 year olds (2)

Support at primary/secondary school transition stage (2)

Different services have different thresholds for moving to adult services e.g RACH (17.5)

Transition from CAMHS to AMHS

RUOK was originally commissioned to go up to 25 years but only goes up to 18 years

Tier 3

Gaps in service provision

Lack of out of hours/crisis service provision (10)

No one stop Community Eating Disorders Service – impacts on Urgent Help Team work, reduces capacity for other work (3)

No MH Liaison Service at Royal Alex (3)

Lack of specialist support for early years (2)

Long waits for ASC and ADHD diagnoses (2)

No dedicated CAMHS LAC team (3)

Parents are asking for assessments for PDA – not a commissioned service

FFT no longer getting referrals from RACH as SW no longer based there/loss of social worker at RACH (2)

Lack of immediate support for self-harm, suicide ideation, depression and anxiety

Services don't meet the needs of boys and young men

No specific support and advice after an autism diagnosis, unless there are other health needs.

Psychiatrists would like better links with Tier 1 school nurses for medication monitoring

Psychiatrists would like nurses to “hold” cases to give them more capacity

Transitions

For 18+ group lack of co-ordination for people who need to move between Wellbeing and Assessment and Treatment Service

For 18+ difficult to get them into PD service

Service model issues

CAMHS model not designed for comorbidities (3)

CAMHS model doesn't reflect modern society (3).e.g.m/c 2.2 , flexible hours/access

Lack of flexibility in eligibility criteria

Not a holistic service around child and family – no co-ordination of the different parts and assessment criteria

YP aren't involved in service development

CAMHS Assessment process doesn't allow for rapport to be built with YP

CAMHS reject GP referrals without assessing people

CAPA model not designed to work with the type of long term complex cases Tier 3 see (2)

Draft CEDS pathway doesn't include psychiatrists and is all age, unlike NICE anorexia guidance.

Management issues

CAMHS don't take parents seriously enough (2)
Managerial and strategic gaps – in strategic use of psychologists
Sickness absence
Staff need training in LGBT and Trans issues, MH and YP.

Other

Lack of response to impact of social media (2)
Reluctance to diagnose at an early age means some conditions like psychosis go under the radar
MASH don't pick up wellbeing
YP aren't MH literate
No support for children over summer holidays from PRESENS
Long waits, not accessible.
No good support for parents' mental health

4. Improvements (94 comments)

Changes to service model

More holistic service (3)
Tier 3 use goals based outcomes measures/review usefulness of outcome measures (3) e.g. be more outcomes focused
Tier 3 needs a complete restyle (2) – staff need to change for the culture to change.
Clinical overview/co-ordination of Tiers 1-3
Young people's voices at the centre of everything
Extend Tiers 2 and 3 triage to Early help Hub/MDT format
CAMHS to evaluate how it disempowers children
Ongoing relationship with a family rather than numerous interventions by variety of agencies more effective
Home support for parents

Working with schools

School staff trained in early signs of MH problems/managing self-harm (2)
CAMHS outreach into schools(2)
CAMHS to engage in school TAF meetings (2)
A school based service(2)
Wellbeing health assessments for school staff

Early intervention/prevention

Earlier interventions /prevention work (6)
Teach children from early years up to manage feelings (3) e.g emotional regulation, self-harm, stress
CAMHS to contribute more to the needs of children with emotional and behavioural problems
More Parent Infants Psychotherapy
CAMHS drop-in service for early years staff
More training for Tier 1 early years staff on who and when to refer
Engage parents of children on Triple P programme

Joint working

CAMHS to work jointly with Seaside view/other services (3) e.g. hospital
More integration and joint assessments with social workers
More CAMHS on site presence at hospital –liaison/ltc service, MDT clinics
Specialist CAMHS team embedded in LAC service
More integration of early years service with CAMHS
Maintain Tier 3 lead Psychologists meetings with YAC and YPC

Working with voluntary sector

Connexions type service
Use of volunteers to offer more creative activities
More multi-agency working with vol sector

Choice in treatment/therapies

Solution focused support (2)
Non-clinical alternatives for YP: social prescribing, physical activity, activities, peer work
Non-clinic based counselling via activities
Easier access to Eating Disorder Service for 13-18 years, with family therapy.
More systemic and family therapy
Peer support group models

Engaging hard to reach

Better venues for CAMHS (6) e.g clinics in Moulsecoomb, community
Tier 3 to be less clinic based and work in community/outreach (5)
Robustly follow up DNAs/assertive outreach service (2)

Management issues

Better resources, increase staff and capacity (4)
Clear pathways for self-harm and eating disorders(2)
Provision mapping – what does CAMHS offer(2)
Understand pathway from GP perspective/other referrers perspective(2)
Speed up process for filling vacancies
Make staff more inclusive – training and understanding of BME, LGBT and disabled children
More Tier 1 and 2 services
Better training on ASC and ADHD
Fund service for children that fall between tiers 3 and 4
More nursing in all teams
Having a named CAMHS keyworker

Improve accessibility

Shorter waiting lists (3)
More accessible service (2)
Tier 3 more flexible - out of hours service
Shorter waiting times for referrals

Other

Work with YP on mh impact of social media
Youth Approved Stamp for GP Practices

5. Groups whose needs aren't being met (80 comments)

Autism

ASC (9)

Children with autism and MH problems

Older Young People

18-25 year olds (3)

Angry young men

18 year olds –too old for CAMHS and AMHS don't want them to become part of adult system

Children in Care

LAC(3) – no specialist CAMHS team

Children up for adoption or adopted

Children placed with grandparents

18+ Care Leavers

LAC with LD placed out of area

Learning Disability

LD with severe challenging behaviour/mh issues/ complex autism (3)

Children just below the eligibility threshold for services (3) - moderate LD, behaviour probs but no LD

Learning disabled

LAC with LD placed out of area

Other conditions

Self-harm (9)

Eating disorders (5)

ADHD (5)

Children with challenging behaviour (3) e.g. Emotional needs rather than behavioural needs

Children who don't go to school (home educated, refusers, anxiety)

Overdose children in A&E (2) e.g. groups requiring MH liaison work

LTCs (3)

Children with severe attachment disorders

Illness of no medical origin

Chronic pain groups

Pathological Demand Avoidance

Gender identity disorder

PD

Anxiety/depression

YP with complex MH conditions

Disabled children supported by Seaside View

Other groups

Children just below the eligibility threshold for services (4) - moderate LD, behaviour probs but no LD LGBT(2)

Children of parents who refuse to recognise there's a problem

Homeless YP

Sexually exploited CYP

BME families

Vulnerable girls

Hard to engage

Children under 12 months old

Schools concerns about children

6. Parents knowledge of local services and support (35 comments)

Internet

Google/Websites (2)

Right Here internet guide

CAMHS website

Where to go for? website

Find, Get, Give website

School uses social media

Signposting by professionals

Professionals (GPs) signpost but in a scattergun way (5)

Targeted info sent to schools (4)

YAC can signpost (2)

Hospital services don't know what Tier 1 (vol orgs) services to signpost to

"Don't know where else to go. CAMHS gave nothing and their GP only knows about CAMHS"

Healthy Child Model and Health Visitors inform parents

Nurses are good at signposting to 3rd sector, GPs only know the clinical stuff

YPC signposts

Families only know of services like RISE, Oasis if told by social workers

Children's Centre send school info about talks/courses

Information on ASC given out before appointments

Parents given information packs at CHOICE appointments

Other

Friends (2)

Leaflets (2)

Mind /Young Minds

Difficult to know where to get support from for self-harm if not familiar with MH services

Only support is medication, is no alternative

"Services in B&H work quite hard to publicise themselves, but don't know if they are connected up."

Early Help process

“They always say they are not aware. Not sure how much this is about publicity or lack of sufficiency.”

Parents say service is fragmented, don't get advice on where to go if child not eligible.

7. How involved are parents/children in treatment (11 comments)

Professionals feel they involve parents where appropriate

CAMHS involve parents - CAMHS have Choice/Partnership appointments as part of CAPA, also TAPA and FFT where families are difficult to engage. (4)

Parents always involved with primary age children and have Right Here, and feedback at end of counselling sessions for older YP– YMCA counselling

Primary Mental Health Workers involve parents where appropriate.

PRESENS involve parents in work they do – leave notes in the setting where they see a child for parents to see and make home visits.

Parents don't always feel they're involved

“They're not. They're the third party, you're observed and you're watched and then told and not actively involved.” (Parent)

“They don't make it feel like a partnership” (Parent)

Difficulties with parental involvement

Where parents are involved they don't get any individual support.

Sometime parents can be part of the difficulty.

“Young man who killed himself didn't want information sharing with parents. We need to be clearer about engaging with parents and parameters around this.”

8. Transition to AMHS (40 comments)

Positive views on transition

EIP service treats 14-25 year olds and is good at bridging the gap. (2)

It's better than it was.

Not an issue for FFT

Adult IAPT services are better at making links between adult and YP mental health services.

TAPA and YPC good at supporting YP with this.

Early Years is positive

Some schools use the pupil premium for transition (into primary school)

Play and learn groups prepare children for going to nursery.

PRESENS do transition meeting with school and family and every child has a transition report – changing model to have teacher attaching themselves to a school so they can follow child through

Negative views on transition

Most people would rather see service extend up to 25 years (6)

AMHS need to engage with CAMHS more, should be two way thing. (3)

Not enough preparation and support for YP transferring (2)

Needs to be more assertive follow up of YP who drop out from CAMHS/AMHS (2)
“It needs to be made to feel seamless, rather than more assessments and thresholds.”(2)
AMHS won’t get involved until YP has finished with CAMHS (2)
“Needs to be joined up between CAMHS and AMHS, there’s no transition. You don’t lose your GP at 18 years, potentially this is a time when problems get worse.” (Parent)(2)
Transition is a particularly difficult – AMHS have different eligibility criteria. (2)
AMHS need YP service of its own
More of a barrier than it used to be.
“Ending CAMHS after education , rather than based on education is much better.”
Transition should be part of AMHS performance management.
“It might ease pressure on the 30,000 students in the city if there were a specialist transition service”.
“There used to be a lot of transition work but not so much now. TAPA is not a team she hears about much anymore, which is worrying.” (YOS)
“ Children’s services engage YP but adult MH services are much more blunt and YP struggle with this. 18/19 year olds find it cold, functional, dogmatic – can be a culture shock.”
YAC find it hard to refer their older clients into AMHS – they get referred back, it’s easier if they’re hard to engage because then they can use TAPA.
Health, education and social care plans go up to 25 years, so don’t fit the present system.
Children with ADHD are discharged back to GP as there is a 2 year waiting list

9. Unmet training needs (33 comments)

Professionals

More joint training across health and social care (3)e.g. Urgent Help and FFT Teams could learn from each other, BSUH need better understanding of what CAMHS can do
A forum for everyone to work to the same remit (3)
Train health professionals in skills youth workers and advocates use with YP (2)
Primary care need training in child mental health.
Primary care, CAMHS and 3rd Sector need to be trained to understand what they each do
Tier 2 Community CAMHS has no training budget for CPD – have to fund their own
Tier 3 no budget for PDP
Good practice working in brief modalities
GPs need more training on working with YP
PRESENS –more training on child mental health – under 2s.
YOS and S/W case workers need more systemic ways of working with family
Partnership working with families
SPFT have “My Learning” includes essential training but things like radicalisation and trans training need to be repeated.

Conditions

Train staff in self-harm (3) e.g. DBT for Tier 3
BSUH medics need training in MH aspects of medically unexplained symptoms
Train staff in eating disorders
Train staff in ASC awareness

HVs need training in using tools to measure attachment behaviour
Challenging behaviour and autism
Social media (2)

Young People

Recovery College for YP

Parents

Training for parents e.g Right Here and Chalkhill (3)
Run workshops for parents in schools about mental health

10. Commissioning priorities (76 comments)

Early Intervention and prevention

Early intervention and prevention work (7)
Invest more resources into Tier 2 (3)
Have hubs with counsellors, PMHWS and Youth Workers to meet YP holistic needs (2)
More schools with CAMHS outreach workers (2) e.g. PMHWS, Family Support Workers
Train HVs in who to refer to for problems beyond their remit
Perinatal mental health services
Bereavement service for children who have experienced trauma and loss
Support for families at key developmental stages

Specialist service provision

Liaison Service at the Royal Alex (3)
Self-harm(2) – should be in Tier 2
An integrated Community Eating Disorders Team
Children with emotional and behavioural difficulties, who don't get a MH diagnosis and fall into a gap.
Advocate type role to follow up DNAs
ADHD
ASC
Challenging behaviour/conduct disorders
Autism Champion
Boys and men
Assertive outreach role to coordinate care and follow-up patients for GPs
Psychiatry input to TAPA
Admin and Support Worker for TAPA
More FFT Teams
Specialist team in LAC services.

Pathway/service model

Free up CAMHS to work in an MDT Consultative Model in networks and pathways
Clear pathways into and between services
Increase transparency about service provided by CAMHS Tier 3

Commissioning to make use of flexibility in 3rd sector

Reduce wait for therapy

More flexible services

Better referrals from schools/GPs

Case worker for complex cases to provide continuity

“complex families need something more, present system must feel like a sausage factory”

Better partnership working

Look at how Tier 2 and 3rd sector can work jointly with Tier 3.(2)

Partnership working (2)

Better understanding of the problems from everyone’s view point

Community Paediatricians in other areas hold and prescribe for ADHD patients

Transition

Transition (2)

Communication/accessibility

Better communication(2)

CAMHs more community based (2)

Email advice from Psychiatrists

Tier 3 should outreach

Clinics in schools

Support for parents

Support and information for parents looking after children with a MH prob from an early age.

Telephone support for families, including out of hours

More direct work with parents e.g. Time Out for Parents ASC

Resources

More staff and resources (3)

Commissioners need to tell us what they want and resource it.

More strategic use of CAMHS resources

Youth friendly service

YP need consistent relationship with MH services (2)

Support to reflect a young person’s needs

YP at heart of service

Other

Professionals to oversee the work of non-professionals

Creative application of therapeutic care in visual/performance assessments

Look at what works well and build on it

11. Issues that need to be included not already mentioned (20 comments)

Develop a Youth Hub

Develop a YIACS model for health and support front door (Youth Information Advice and Counselling)

Have a Youth Hub where teachers can go for advice and peer support

Commissioning

Joint commissioning when CYP services are retendered – Youth Review and Supported Accommodation Review

Common outcome measures and standards across commissioning organisations

Look at Children's IAPT for B&H

Not enough investment in LAC children

Performance report data to be included in JSNA

Additional support and funding – inclusion grant funding works well

There's a positive relationship between commissioners and voluntary and community sector.

CAMHS decisions are resource rather than needs driven

CAMHS communications and pathways need review.

Improve information sharing

GPs need to know where to refer to rather than straight to CAMHS

Hosp medics need to know what support is available apart from CAMHS

"Services have all got into silos. It would be nice to improve communication between different agencies – health, social service and education".

Agencies need to share their eligibility thresholds

Share information about services that are available and how to access – including CAMHS – Big leaflet

Other

Accessible counselling service in all schools with pathway to and from GPs

Find out what families want

Flag up trigger points for suicide

Children need input at an earlier stage particularly for eating disorders

What works less well – CAMHS LD (6 comments)

Clients don't get formulation of their needs by CAMHS whilst in out of area placements

Severe challenging behaviour is managed rather than treated

Local CAMHS role is fragmented with no overall care co-ordination or single plan

Doesn't work in an integrated way across the whole system with schools, accommodation, parents and children

Don't have a positive behaviour approach and only recently engaged with preventative model

Children placed out of area.

What are the gaps CAMHS LD (3 comments)

No care coordination of clinical interventions for out of area placements integrated with CAMHS LD
Individual needs assessments need to include recommendations on how unmet needs can be addressed

16 year olds aren't being assessed under the Mental Capacity Act or DOLS– at risk of poor choices

Improvements CAMHS LD (8 comments)

More integrated services (2) e.g. adult and children's services

Care co-ordinator for complex and high risk cases, planning ahead for adult services

Full LD Team

Application of Mental Capacity Act

Better Transition working

Better resourced team – would have positive impact on number of LAC

Need joint commissioning of OTs in CAMHS LD Team

Transition LD (5 comments)

LD side do this very well

Not very well managed

Need care co-ordination by CAMHS LD so that single needs assessment developed and followed through by adult LD service

CAMHS LD needs to prepare YP for adult ways of working .e.g. positive behaviour model

CAMHS LD has a forum for cases coming up for transition from 14 years

Training LD (2 comments)

Need to review challenging behaviour training for consistency across adult and child MH services.

Mental Capacity Act

DOLS

Commissioning priorities LD (6 comments)

Earlier identification of risk for complex cases

Integrated, holistic needs assessment and planning

Named care co-ordinators – including out of area placements

CAMHS clinical input into the quality of residential care

Reduce number of PWLD placed out of area

Commission path for 16-18 year olds with LD that takes account of statutory obligations

19. References

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