Children and Young People's Mental Health Joint Strategic Needs Assessment 2015

Swindon

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Swindon Borough Council

1. Introduction

Children and adolescent mental health issues have recently been widely recognised as a key issue – over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by the age of 18. The ChildLine Review 2013 -14, "Under Pressure", stated that ChildLine had seen a worrying rise in mental health concerns. Four of the top ten issues children contacted ChildLine about related to mental health and, taken together, these account for more than two thirds of counselling sessions carried out by the organisation. These four issues are: self-harm; suicidal feelings; low self-esteem and unhappiness; (diagnosable[1]) mental health issues. The last category has seen the highest increase in the last year (34%).

Government has recognised that Children and Adolescent Mental Health is a concern and a governmental taskforce was established in 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when it is needed and to improve how children and young people's mental health services are organised, commissioned and provided. The findings of this taskforce have been reported on in the Department of Health 2015 Report "Future in Mind. Promoting, protecting and improving our children and young people's mental health and wellbeing"[2].

Evidence presented to the Taskforce underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. The challenges include:

- Significant gaps in data and information and delays in development of payment and other incentive systems which are critical to driving change in a co-ordinated way
- The treatment gap - Indications that less than 25 -35% of those with a diagnosable mental health condition accessed support
- Difficulties in access with increases in referrals and waiting times and with providers reporting increased complexity and severity of presenting problems.

[1] Diagnosable mental health issues are defined as mental health issues that are prolonged or re-occurring and significantly interfere with the young person being able to lead a normal life.

[2] 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.

- Complexity of current commissioning arrangements, a lack of clear leadership and accountability arrangements for children's mental health across agencies
- Access to crisis, out of hours and liaison psychiatry is variable
- Specific issues facing highly vulnerable groups of children and young people and their families who may find it particularly difficult to access appropriate services

To a greater or lesser extent these are all key issues and challenges within Swindon that commissioners, providers, key stakeholders including children and young people, their parents and carers will need to address. With the current focus on recognition of mental health problems in children and young people, now is a good time to review our current provision and outline how we, in Swindon, would like future services to look.

1.1 Scope and purpose

The present Children and Adolescent Mental Health Service (CAMHS) is due to be re-commissioned in 2017. Swindon is an outlier for a few key child health indicators which may impact on or reflect mental health of Children and Young People in Swindon including: low educational attainment; high number of admissions for self-harm and alcohol misuse; high rates of sexually transmitted infections, e.g. Chlamydia. The findings of the needs assessment will help to inform the commissioning of CAMHS at all levels

This mental health needs assessment will focus on the needs of children and young people from 5 – 18 years but will also include transition to adult services up to the age of 25. It will look at the numbers, characteristics and needs of children and young people at increased risk of mental health problems.

The needs of 0 – 4 year olds are picked up in the Early Years Needs Assessment which includes work on the Perinatal Mental Health Pathway.

This needs assessment will map the array of available services for children and young people and carers. This will include: CAMHS, Targeted Mental Health Services (TaMHS), LIFT Psychology, Sexual Assault Referral Centre (SARC), Educational Psychologists, Youth Offending Team (YOT), UTurn Substance Misuse Service, OnTrak Counselling Service and counselling services in schools and Improving Access to Psychological Therapies (IAPT) for children and young people. The make-up of the workforce providing these services will also be reviewed.

The mental health contribution to universal services will also be reviewed – particularly, Schools, School Nurses, GPs and Children's Services.

The needs assessment will also look at: evidence base of best practice; economic evaluation; early intervention, transition between CAMHS and adult services;

prescribing. The needs assessment will focus on universal, targeted and specialist services. Tertiary services such as residential placements and out of area referrals are commissioned by NHS England and will not be reviewed here in detail.

1.1.1 Areas to be covered – in scope

The following mental health conditions will be considered: eating disorders, depression, suicide and self-harm, conduct, hyperkinetic, emotional, neurotic and other less common mental health disorders.

The needs assessment will also consider the accessibility and appropriateness of the service for different patient groups including those with Learning Disabilities, physical disabilities and medical conditions, autism and ADHD in children and young people of all ages, children in care (CIC), young carers and children and young people with chaotic and complex social needs as well as those from Black and Minority Ethnic (BME) communities.

How parents of children and young people should be supported to play an active role in the management and treatment of mental health conditions.

Mental health and wellbeing in schools — what is already being undertaken in educational settings – schools (primary and secondary), colleges and other educational settings.

1.1.2 Out of Scope

Autism and Attention Deficit Hyperactivity Disorder specific needs and services will be looked at as part of the Paediatric Service Redesign and will, therefore, be out of scope. However, there will be close working with the lead for the redesign and any implications for mental health captured in this needs assessment.

The Best Start JSNA is considering the needs of pregnant women and children under 5 years of age. This will also be considering perinatal and infant mental health and parenting so these areas are out of scope in this Mental Health JSNA. However, it should be highlighted that the Faculty of Public Health[3] state that the most import modifiable risk factor for mental health problems in childhood, and thus in life, in general, is parenting. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent/infant/child relationships, parenting styles including behaviour management and infant and child nutrition (including breast feeding and healthy eating). Parental mental illness and

[3] http://www.fph.org.uk/a_good_start_in_life accessed 20th May 2015

parental lifestyle behaviours such as smoking, drugs and alcohol misuse are important risk factors for childhood mental health problems.

1.2 Working Group

Members of the CYP Mental Health Needs Assessment Working Group:

Frances Mayes – Public Health - SBC Project Lead

Caroline Little – Commissioning - SBC/CCG

Tom Frost – Senior Public Health Intelligence Analyst, SBC

Michelle Maguire – Oxford Health NHS Foundation Trust – CAMHS

Mandy Round - Oxford Health NHS Foundation Trust – CAMHS

Heather Prictor – TaMHS - SBC

Sheila Baxter - Adult CCG mental health commissioner – CCG/SBC

Joy Kennard – Commissioning Children and Families – SBC

Kevin Leaning – YOT, On-Track and Uturn – SBC

Angela Milliken – Health School Manager SBC

1.3 Engagement with key stakeholders

As part of the needs assessment there has been widespread consultation with stakeholders including commissioners, providers, third sector providers, schools, Primary Care, School Nurses and Children's Services.

A specific consultation process with Children and Young People including children in care and Young Carers, parents and carers of children with a mental health problem, A full list of stakeholders consulted is available in Appendix .

2. Context – National and local policy

2.1 National policies

2.1.1 No Health Without Mental Health – A cross government strategy (2011)

In 2011 The Department of Health published 'No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages'. This strategy recognises that "By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate it's effects when it does."[4]

No Health without Mental Health outlined 6 key objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

The national strategy highlights that:

- One in ten children aged between 5 and 16 years has a mental health problem and many continue to have mental health problems into adulthood.

- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.

- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed**)**

Since the start of this needs assessment it has been recognised that more up to date information needs to be available at a national level to help inform commissioning. This piece of work is now beginning at a national level and will include more up to date prevalence rates for keen conditions and a review of the evidence of what works. This will be a useful contribution and should be considered when the review has been completed.

[4] No health without mental health: A cross-government strategy (2011).

2.1.2 Future In Mind - Promoting, protecting and improving our children and young people's mental health and wellbeing (2015)

As outlined in the introduction, in March 2015 the government launched the Future in Mind report which outlines ways to make it easier for children, young people, parents and cares to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

The report focuses on five themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support, a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

The report outlines the government's aspirations for children's mental health to be reached by 2020. These include:

- Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled
- In every part of the country, children and young people have timely access to clinically effective mental health support when they need it.
- A stepped change in how care is delivered moving away from a system defined in terms of the services organisations provide (the tiered model) towards one built around the needs of children, young people and their families.
- Increased use of evidence-based treatments with services rigorously focused on outcomes
- Making mental health support more visible and easily accessible for children and young people
- Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible
- Improving access for parents to evidenced-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.

- A better offer for the most vulnerable children and young people, making It easier for them to access the support that they need when, and where they need it
- Improved transparency and accountability across the whole system, to drive further improvements in outcomes.
- Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

In July 2015 the government released guidance regarding the development of local transformation plans to improve mental health services for children and young people for which there has been identified additional funding. These plans will focus on:

- Building capacity and capability across the system
- Rolling out the children and young people's Improving Access to Psychological Therapies programmes.
- Developing evidence based community eating disorder services for children and young people
- Improving Perinatal Care
- Bring education and local CAMHS services together around the needs of the individual child through a joint mental health training programme.
- Local transformation plans will be required outlining how local areas will contribute to achieving the national ambitions and principles. Plans should include a commitment to transparency, service transformation and monitoring improvement.

Swindon's local strategy should ensure these principles are met.

2.2 Local policies

2.2.1 Swindon Health and Wellbeing Strategy 2013 - 2016

This outlines the vision that "Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities". The five priority outcomes for the 3 year strategy are:

1. Every child and young person in Swindon has a healthy start in life
2. Adults and older people in Swindon are living healthier and more independent lives

3. Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems and offenders)

4. Improved mental health, wellbeing and resilience for all

5. Creation of sustainable environments in which communities can flourish

2.2.2 One Swindon – Stronger Together

Recognises the change required by local public sector services in the face of economically challenging times. It outlines the need for all organisations, individuals and communities to work together to ensure that Swindon is the best place it can be.

One Swindon key priorities are:

1. We can all benefit from a growing economy and a better town centre
2. I like where I live
3. Everyone is enjoying sports, leisure and cultural opportunities.
4. Living independently, protected from harm, leading healthy lives and making a positive contribution

2.2.3 The strengthening families programme

The Strengthening Families Programme brings together practitioners, processes, practice and systems from Social Care, Early Help, Child Health and other agencies and communities to develop a multi-disciplinary approach, bringing together a range of professional stills and expertise to work with the whole family, allowing the most vulnerable to be prioritised early and avoid longer term, more damaging, impacts and so hold demand pressures on the service.

Practitioners work with families to help them develop their own capacity to resolve their own problems. Children and young people who are able to live in their own families, communities and schools are more likely to do well in school and grow up to be confident and resilient.

2.2.4 The local safeguarding children board's strategic business plan 2014 - 15

Highlighted the need to have detailed strategies and comprehensive approaches to tackle domestic abuse, parental substance misuse and/or alcohol abuse and mental health (the toxic trio), to keep children and young people safe and promote effective interventions to those who are at risk. This included monitoring and training of staff and volunteers working with families affected by the 'toxic trio'. The business plan highlighted the need for the performance subgroup to enable a deep dive into

specific issues to identify improvement in services and outcomes for children affected by domestic violence, substance misuse and mental health problems.

2.2.5 Swindon children and young people's early support strategy 2013 - 2016

Acknowledges the extensive evidence to support the fact that it is better to identify and deal with problems early, with a holistic response for children and families, rather than responding when the issues become more serious and complex, and when children and young people may require more specialist support.

The Statement of Early Help is set around three key areas:

- **Prevention** describes the vision that children in Swindon have the best start in life and grow up in supportive, confident and resilient families and communities.

- **Targeted early help** will be offered where parents have lost confidence in their parenting ability or where relationships come under pressure, to support families to adapt to a potentially new situation. The support should be practical, direct, targeted support when parents most need help. Through support for families, children grow up safe, stable and healthy and make a contribution to their community.

- **Specialist support and treatment** will be provided to ensure that children have timely access to health services. Integrated care is provided for children and young people with long-term health conditions, disability or complex needs, and there is effective transition in to adult services for those young people who need continued support. Children are protected from harm. This section focuses on children in need including disabled children and those with significant special educational needs.

2.2.6 The Swindon children's services position statement (March 2014)

Highlights six priorities which include the need to develop pioneering, innovative and transformative work; ensuring timely decision making with regard to safeguarding and promoting the welfare of children; measuring the impact and effectiveness of early help; ensuring high quality care planning, placement, permanence and pathway planning for children in carer and care leavers; improving attainment of young people at age 16 -19 narrowing the gap in inequalities; and co-producing good outcomes with our service users an our communities.

The Swindon Children's Services Position Statement March (2014) highlights the emphasis that Swindon has on early help and intervention. There is a focus on a range of interventions such as the Family Nurse Partnership and The Families First Programme which has led to Swindon's Troubled Families initiative.

3. Who is affected, who is most at risk?

3.1 Children and young people in Swindon – overview

3.1.1 Population – overview and background

The population figures below are for the resident population of Swindon Unitary Authority (UA) only. However, the prevalence figures in section 3.2 are calculated for Swindon UA (residents) and Swindon CCG (registered) populations. The CCG population includes the area of Shrivenham which is outside the UA boundary and represents an additional 2800 0 – 19 year olds, which equates to about 5%.

Population

In 2014, the number of under 18's in Swindon UA was 48,604 and made up 22.5% of the total population.

	Swindon	South West	Statistical Neighbour	England
All ages	215,799	5,423,303	259,245	53,316,618
0-4	15,063	307,400	20,509	3,430,957
5-9	13,785	299,165	19,199	3,272,365
10-14	12,011	281,891	16,021	2,973,055
15-19	12,548	320,186	14,882	3,230,954
Under 18's	48,604	1,076,406	65,229	11,591,701
% of population	22.5%	19.8%	25.2%	21.7%

Priory Vale, St Andrews and Walcot and Park North were the wards in Swindon UA with the highest proportions of children in their population.

Ward name	Number of 0-17s	% of ward population (2013)
Priory Vale	3,634	29.2%
St Andrews	3,139	27.9%
Walcot and Park North	3,407	25.6%
Penhill and Upper Stratton	2,865	23.9%
Liden, Eldene and Park South	2,728	23.6%
Shaw	2,598	23.3%
Rodbourne Cheney	2,672	22.9%
Gorse Hill and Pinehurst	2,923	22.8%
Haydon Wick	2,777	22.2%
Mannington and Western	2,293	21.9%
Lydiard and Freshbrook	2,356	21.8%
Central	2,677	21.0%
Ridgeway	689	20.9%
Old Town	1,993	20.6%

Wroughton and Wichelstowe	1,626	20.2%
St Margaret and South Marston	2,260	19.6%
Blunsdon and Highworth	2,091	19.3%
Covingham and Dorcan	2,056	18.8%
Eastcott	2,087	18.8%
Chiseldon and Lawn	1,102	18.5%

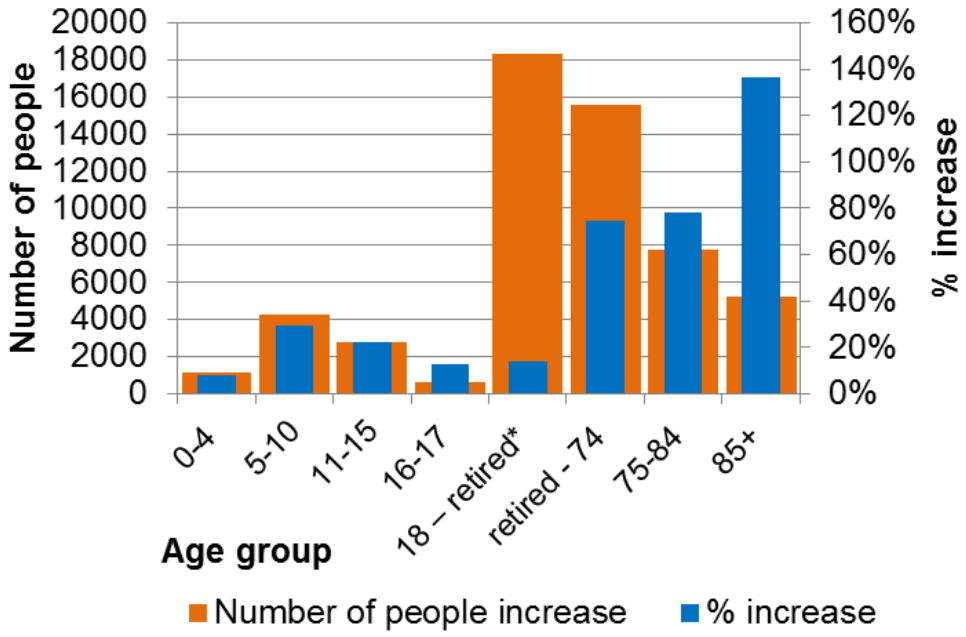
The ethnic group with the highest proportion of the population under 18 years is White at over 85% (2011 Census).

	Under 18	% of total
White	39,793	85.5%
Asian/Asian British	3,637	7.8%
Mixed/multiple ethnic group	2,077	4.5%
Black/African/Caribbean/Black British	815	1.8%
Other ethnic group	201	0.4%

Between 2001 and 2011, the under 18 population of Swindon increased from 42,084 to 46,523 (10.5%). During the same period people aged 18-64 years increased by 18% and those over 65 by 16%. The higher increases in these older age groups account for the relative decrease in the proportion of the population under 18 between 2001 and 2011 (23.4% to 22.2%). The increases in Swindon for are higher in all age groups than the England and South West averages.

Between 2011 and 2031, the 0-18 year old population in Swindon is projected to increase from 49,100 to 58,300 (19%). Over the same period, the school-age (5-18) population is projected to grow from 34,900 to 43,000 (23%)[i].

Projected population increases: Swindon, 2011 to 2031



Office for National Statistics (ONS) has estimated Swindon's total population will increase by 26% from 2012 to 2037. This is higher than for England overall (16%) and the South West (16%). For children and young people (0-19 years) Swindon's numbers are projected to increase by 17.5% over the same period compared to 9.3% for England and 10% for the South West is 10%.

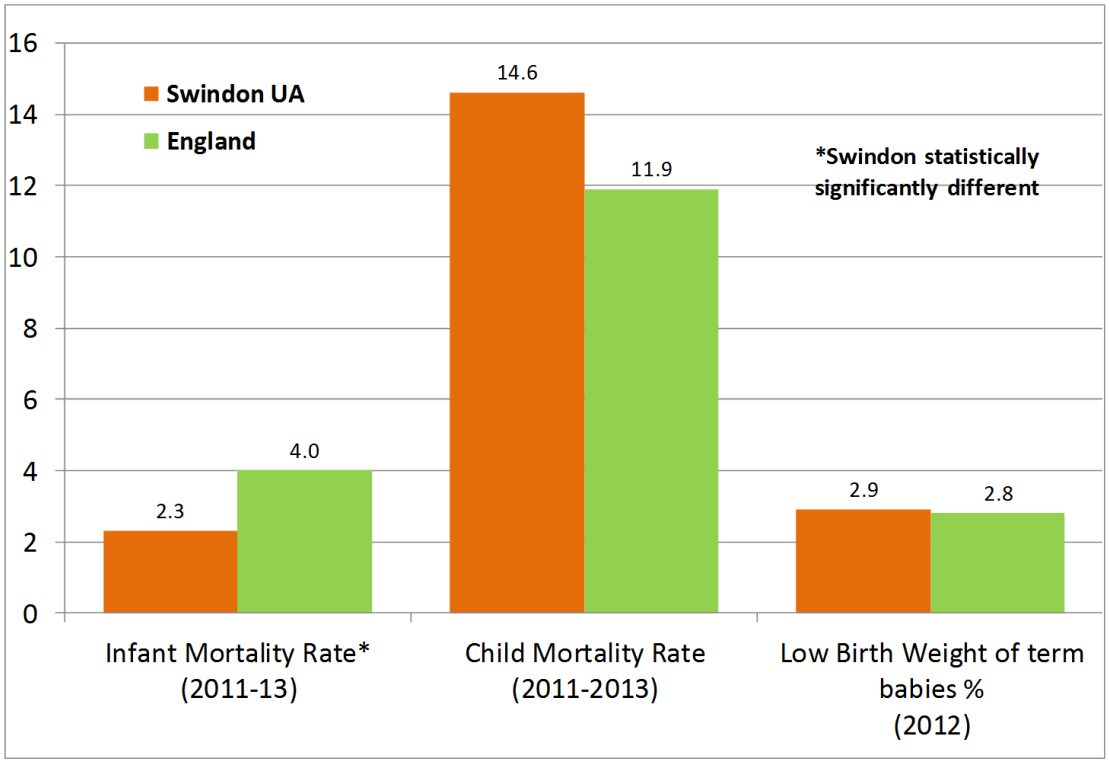
Average life expectancy at birth in Swindon UA, has increased from 80.0 to 82.8 years for females over the decade to 2011-13, while for males over the same period, the increase has been from 76.4 to 79.3 years. These levels of life expectancy are similar to those for England as a whole.

3.1.2 Health and wellbeing indicators

The level of child poverty is better than the England average (19.2%) with 15.9% of children under 16 living in poverty in Swindon (2012).

The infant mortality rate in Swindon (2011-2013) is significantly lower than the national figure and the child mortality rate (2011-2013) and the low birth weight % for term babies (2012) are similar to those for England.

Infant and Child Mortality, and Low Birth Weight in Swindon & England



2,923 babies were born in Swindon UA in 2014, around 100 of these were born to women aged under 18 or women aged 40 or above. Swindon's general fertility rate in 2014 was 67.9 births per 1,000 women aged 15-44. This was higher than England (62.2). Multiple births account for around 3% of live births nationally.

Children in Swindon have average levels of obesity (2013/2014). 24.1% of children in Reception Year and 33.1% of those in Year 6 were found to be obese or overweight in 2013/14.

Swindon's under 18s conception rate (24.4 per 1,000 in 2013) is similar to that for England (24.3) and the under 16s conception rate (4.3 per 1000 in 2011-13) is below the England rate (5.5%). However, the rate of sexually transmitted infections (STIs) in young people is still higher than the national average.

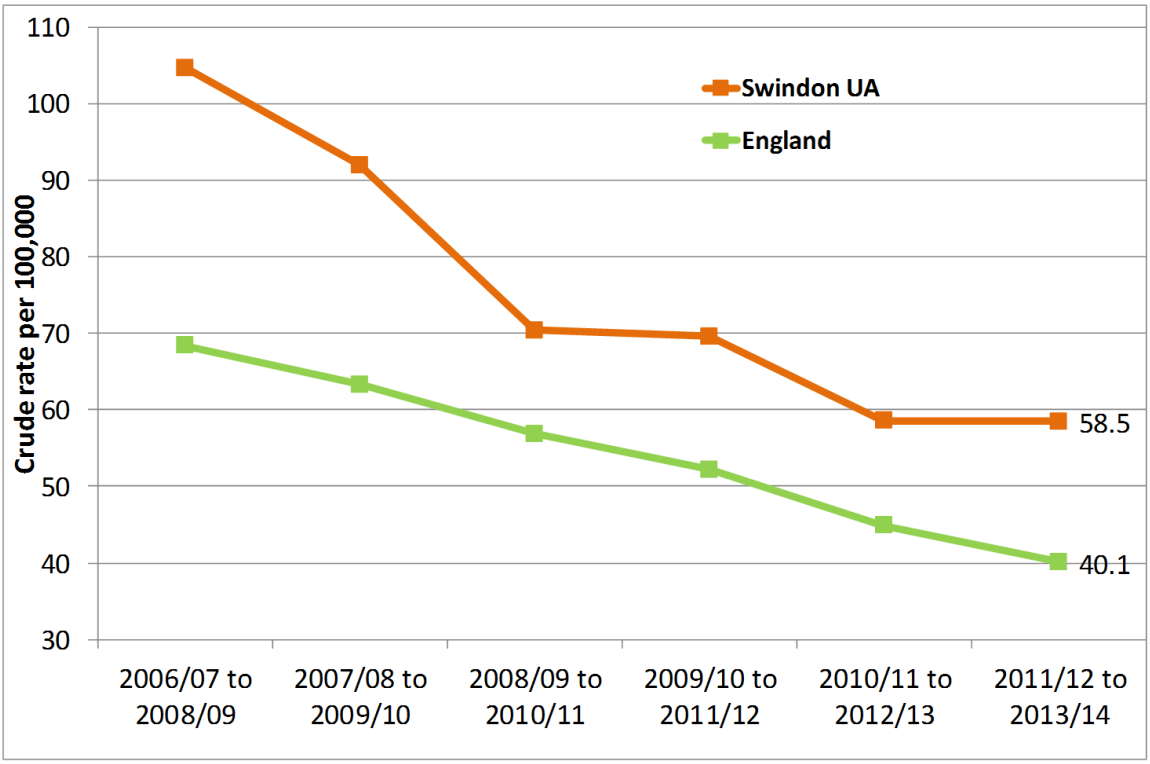
In Swindon, there are an estimated 88 blind or partially sighted children aged 0-16 and 45 aged 17-25.

In Swindon, in 2013/14, 96.6% of girls aged 12-13 received all three doses of the Human Papilloma Virus (HPV) vaccine, the highest coverage in the country.

214 children were subject to a child protection plan at 31st March 2014, up from 147 in 12/13. This is a 45.6% increase. Swindon now has a higher rate (44.7 per 10,000 population under 18) than the national average (42.1) and statistical neighbours (40.1). 250 children were in care in Swindon in 2014, this equates to 53 per 10,000, lower than the national rate of 60 per 10,000.

The rate of alcohol-specific hospital admissions for Swindon young people is about a third higher than for England (2011/12 to 2013/14), though the number of young people involved is in itself not large.

Alcohol-Specific Hospital Admissions per 100,000 for under 18 year olds



The rate of hospital admissions for self-harm in young people aged 10 to 24 years is significantly higher than in England as a whole. As this is a persistent trend, admissions in Swindon are being audited to ascertain whether this is due to high levels of distress in the population or to clinical arrangements and decision-making in Swindon.

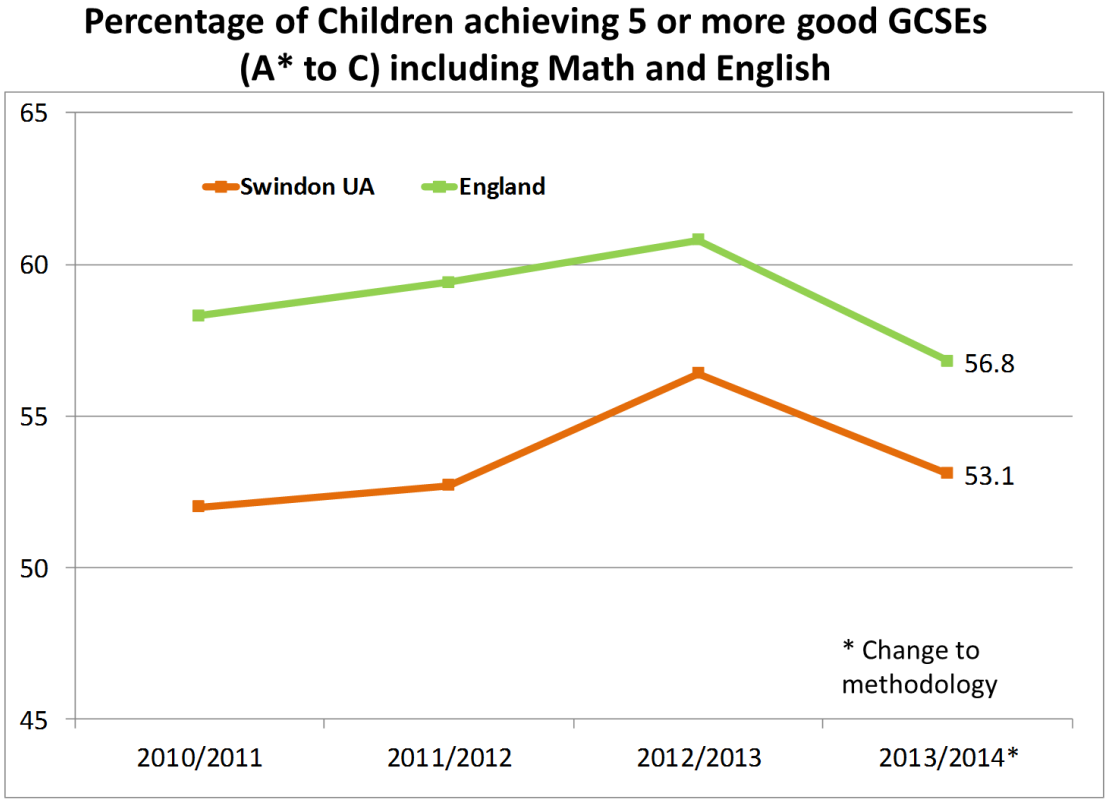
In Swindon, in 2013/14, there were 415 hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 and 389 in those aged 15-24. Admission rates were similar to England rates for 0-14s but higher than England for 15-24s.

Children in Swindon aged 5 were found (in 2011/12) to have similar levels of tooth decay (0.82 decayed, filled or missing teeth (dfmt) on average) to England overall (0.94 dfmt). 24.1% of 5 years in Swindon had at least one decayed, filled or missing tooth.

In 2013/14, 60.6% of Swindon children achieved a good level of development at the end of the foundation stage of schooling, a similar proportion to England (60.4%).

There are 64 primary schools, 11 secondary schools and 7 special schools in Swindon[ii]. Further and higher education in the Swindon area is provided by New College, Oxford Brookes University and Swindon College.

53.1% of Swindon pupils achieved 5 or more A*-C GCSEs or equivalents (including English and Maths) at the end of Year 11 in 2013/14. This compares to 56.8% in England and 46% in Swindon in 2008/09.



Swindon's attainment gap (between disadvantaged pupils and their peers) at the end of Year 11 was 29 % points in 2013/14, up from 27.1 % points in 2012/13 and slightly higher than the national average (27% points).

In 2014, in Swindon, there were 430 16-18 year olds not in employment, education or training (NEET). This was 5.6% of this age group. Nationally, 4.7% of 16-18 are NEETs.

Smoking prevalance data[5] at age 15 shows that in Swindon there are significantly fewer regular smokers than the England average and similar numbers of current and occational smokers. This is shown in the table below.

	Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	7.5	8.2	14.9		3.4
Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	4.2	5.5	11.1		1.3
Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	3.3	2.7	7.6		0.6

3.2 Numbers of children and young people affected by mental health problems

It should be noted that national prevalence data for children and young people's mental health problems is based on research undertaken some time ago (1996, 2004). This is the most up to date prevalence estimates. There are currently plans nationally to update these figures when this is completed the estimates below will be reviewed.

[5] http://www.tobaccoprofiles.info/profile/tobacco-control/data#page/1/gid/1938132886/pat/6/par/E12000009/ati/102/are/E06000030 taken from the WAY survey

Prevalence of clinically significant mental health disorders by personal characteristics for children and young people aged 5 -16[6]

Condition	National prevalence rate	Estimated number for Swindon UA*	Estimated for Swindon CCG registered population**
Any Clinical Diagnosable mental disorder***	10%	3,054	3,226
Emotional Disorder	4%	1,222	1,290
(3% anxiety Disorder)	(3%)	(916)	(968)
(1% depression)	(1%)	(305)	(323)
Conduct Disorder	6%	1,833	1,936
Hyperkinetic disorder	2%	611	645
Less common disorders (including autism, tics, eating disorder and mutism)	1%	305	323

Notes:
* Based on 2013 mid-year population estimates for Swindon UA (ONS) 5-16 years.
** Swindon CCG practice population as of 31/03/14 (figures for 15 and 16 years as an average of 15-19 year olds)
*** Some individuals have more than one diagnosable condition.

Some children experience more than one mental health problem (comorbidity). This can make assessment, diagnosis and treatment more complex. A 2004 survey[7] found that one in five of the children with a mental disorder were diagnosed with more than one of the main categories of mental disorder. This figure represented 1.9% of all children. The most common combinations were conduct and emotional disorder and conduct and hyperkinetic disorder.

Mental health disorders in childhood can have high levels of persistence:

- 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder still had the problem three years later according to a national study
- persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively)
- young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood.

[6] Mental health of children and young people in Great Britain, 2004 Green et al Palgrave MacMillan 2005

[7] Mental health of children and young people in Great Britain, 2004 Green et al Palgrave MacMillan 2005

3.2.1 Prevalence estimates[8]

Indicator	Period	Swindon Count
Prevalence of ptental eating disors amoung young people: Estimated number of 16 – 24 year olds	2013	2885
Prevalence of ADHD among young people: Estimated number of 16 – 24 year olds	2013	3038
Children who require Tier 3[9] CAMHS: estimated number of Children <17	2012	880
Children who require Tier 4[10] CAMHS: estimated number of children <17	2014	40

*The prevalence estimates for those requiring CAMHS are defined as "estimates of the numbers of children aged 17 years and under who may experience mental health problems appropriate to a response from CAMHS in the local authority as per Kurtz, Z. (1996) Treating children well : a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.". The estimated prevalence rates in the Kurtz report are:

Tier	Prevalence
1	15.000%
2	7.000%
3	1.850%
4	0.075%

[8] http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#gid/1938132753/pat/6/ati/102/page/1/par/E12000009/are/E06000030/iid/90826/age/217/sex/4

[9] Tier 3 CAMHS refers to Specialist Secondary Care Mental Health Services

[10] Tier 4 CAMHS refers to Tertiary Care specialist inpatient Mental Health Services

3.2.2 Health indicators[11]

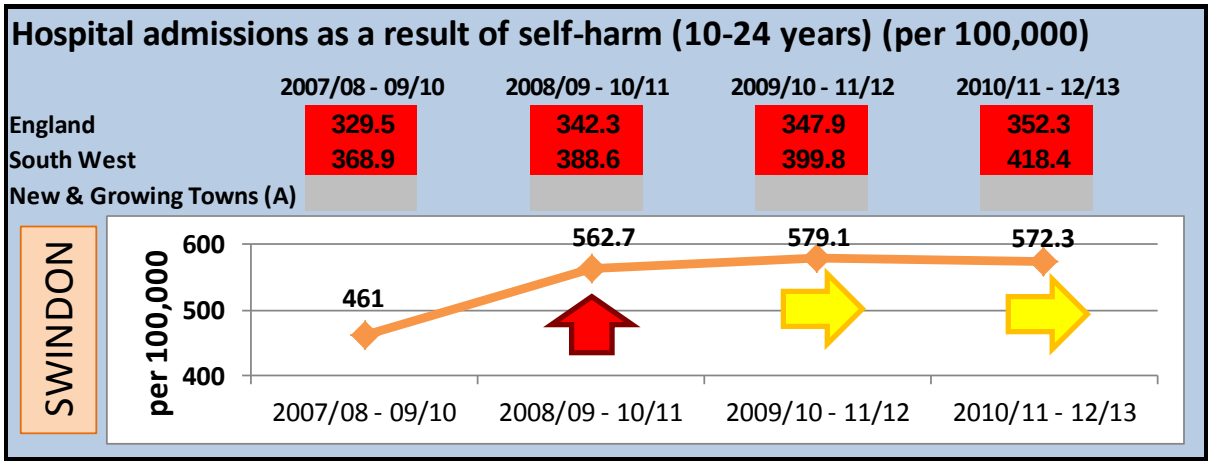
Compared with benchmark: Lower Similar Higher
Data quality: Significant concerns Some concerns Robust
* a note is attached to the value, hover over to see more details

Benchmark Value
Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Swindon		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Child admissions for mental health: rate per 100,000 aged 0 -17 years	2013/14	31	64.6	77.0	87.2	25.6		391.6
Young people hospital admissions for self-harm: rate per 100,000 aged 10 - 24	2010/11 - 12/13	640	572.3	418.4	352.3	97.9		917.8
Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18	2010/11 - 12/13	82	58.6	51.2	42.7	14.6		113.5
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	2011/12 - 13/14	93	125.4	84.7	81.3	22.8		264.1
Child hospital admissions for unintentional and deliberate injuries: rate per 10,000 children 0-14	2013/14	415	103.1	110.6	112.2	64.4		214.1
Young people hospital admissions for unintentional and deliberate injuries: rate per 10,000 young people 15-24	2013/14	389	158.6	147.0	136.7	69.6		291.8

Swindon's overall admssion rate for mental health issues for those aged 0-17 is similar to the England rate. However, Swindon's admission rates for self harm (10-24 year olds), alchol specific conditions (under 18s) and admissions for substance misuse are higher than the England rates.

3.2.3 Self harm



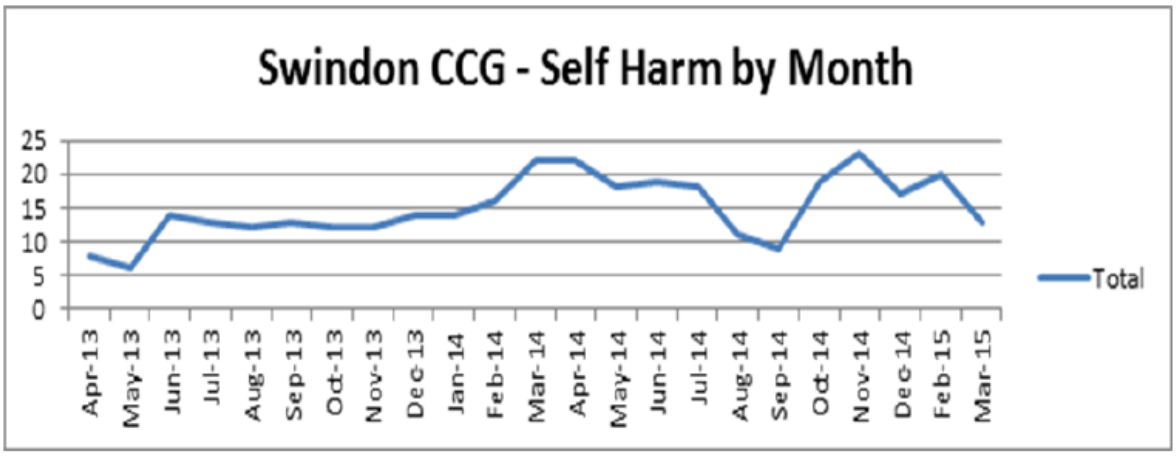
[11] Source:

http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/1/gid/1938132754/pat/6/par/E12000009/ati/102/are/E06000030

The Public Health Outcome Framework documentation says that there will be a new self-harm indicator: The indicator will have two elements:

- 2.10i Attendances at A&E for self-harm per 100,000 population
- 2.10ii Percentage of attendances at A&E for self-harm that received a psychosocial assessment

Great Western Hospital report that there has been an increase in the number of Swindon GP registered patients, under 18s attending A&E where self-harm is indicated. In 2013/14 GWH report that for Swindon GP registered patients, there were 156 attendances and 125 admissions and in 2014/15 this had increased to 204 attendances and 142 admissions. However, a step change in data in a couple of quarters during 2013/14 and 2014/15 may indicate that there was a change in coding or recording during this period. The report also indicates that some patients are admitted more than once and in one case 17 times which could also explain some of the apparent rise. Early indications show that this increase may be reducing during quarter 4 2014/15.



3.2.4 Eating disorders

Eating disorders include a range of different conditions where an individual has a profound and debilitating unhealthy relationship with food these include anorexia nervosa, bulimia nervosa and binge eating but also can include eating disorders which may be associated with pure obesity.

The Governmental Children and Young People's Mental Health and Wellbeing Taskforce report 2014 stated that Anorexia nervosa is the third most common chronic illness of adolescence and has the highest morbidity and mortality of all psychiatric disorders. Eating disorders is one of the, if not the most common, reason

for CAMHS inpatients admissions. The best evidenced based treatments are outpatient treatments[12].

The current government[2] have pledged £150 million over the next five years in England to improve services for children and young people with mental health problems, with a particular emphasis on eating disorders. This will include continuing development of new access and waiting time standards for eating disorder. As mentioned above the evidence base, both clinical and economic, for conditions, such as eating disorders, self-harm or autistic spectrum disorders is not as strong as for some other mental health conditions, but the moral and ethical arguments to care, research and build an evidence base are undeniable.

In Swindon there were 5 admissions for U19s for anorexia nervosa in 13/14 and 2 more for other eating disorders. These are cases where the eating disorder was the primary diagnosis associated with admission. It was also mentioned in one of the secondary diagnosis fields in a further 13 cases.

3.2.5 Emotional health and wellbeing

In 2011 a Child Health Related Behaviour Survey was undertaken in Swindon which gave an indication of emotional health. 1,365 pupils took part in 6 primary and 4 secondary schools. The children ranged from 8 – 15 and slightly more girls (700) than boys (665) completed the survey. The survey found: 27% of pupils reported that they felt afraid to go to school because of bullying at least sometimes. 27% said they had been bullied at or near school in the last 12 months. Younger pupils reported higher rates than older pupils. 72% thought that their school took bullying seriously. 58% of pupils said that they worried at least 'quite a lot' about a problem.

Top worries for Years 8/9 (% concerned)

Boys		**Girls**	
Exams and tests	26%	Exams and tests	39%
Family problems	20%	Their looks	17%
Career problems	17%	Family problems	29%
Their looks	17%	Health problems	25%

Top worries for Year 10 (% concerned)

Boys		**Girls**	
Exams and tests	33%	Exams and tests	60%

[12] Dr Dasha Nicholls quoted in the Health Committee - Third Report
Children's and adolescents' mental health and CAMHS October 2014
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34210.htm

Career problems	21%	Their looks	40%
Family problems	19%	Family problems	35%
Money problems	18%	School work	32%

The issues concerning the young people contacting ChildLine (nationally) during 2013 -14 are shown in the table below. Family relationships, bullying and low self-esteem featured high for both girls and boys. Sex/relationships/puberty/sexual health also featured as a key issue for both girls (7%) and boys (11%), sexual abuse and on-line sexual abuse was also deemed a key concern for boys (5%) and girls and for boys gender and sexual identify was a concern (4%).

ChildLine 2013 -14 Top ten issues for Girls

Issue		**Total Number contacting ChildLine**	**Percentage of girls contacts**
1.	Family relationships	18,144	12%
2.	Low self-esteem/unhappiness	16,300	11%
3.	Bullying/online bullying	13,622	9%
4.	Self-harm	13,015	9%
5.	Sex/relationships/puberty/sexual health	10,003	7%
6.	Suicidal	9,833	7%
7.	Friendship issues	8,306	6%
8.	Mental health conditions	6,981	5%
9.	Sexual abuse and online sexual abuse	6,278	4%
10.	School/education problems	5,899	4%

ChildLine 2013 -14 Top ten issues for Boys

Issue		Total Number contacting ChildLine	Percentage of boys contacts
1.	Bullying/online bullying	5,454	14%
2.	Family relationships	4,719	12%
3.	Sex/relationships/puberty/sexual health	4,185	11%
4.	Low self-esteem/unhappiness	3,005	8%
5.	Physical abuse	2,743	7%
6.	Sexual abuse and online sexual abuse	2,054	5%
7.	School/education problems	1,707	4%
8.	Sexual and gender identity	1,641	4%
9.	Suicidal	1,574	4%
10.	Friendship issues	1,541	4%

3.2.6 Health inequalities

The Prince's Trust undertook a national survey of 2,161 young people aged 16 to 25 during Oct – Nov 2013[13]. The report highlights that those young people experiencing unemployment are:

- twice as likely as their peers to have been prescribed anti-depressants: 25% for those who have been unemployed for 6 months or more against 11% of their peers.
- 40% of jobless young people say they have faced symptoms of mental illness – including suicidal thoughts, feelings of self-loathing and panic attacks as a direct result of their unemployment.
- 9% of young people believe they have nothing to live for this jumps to 21% of those who are long term unemployed.
- 32% of long-term unemployed young people have felt suicidal compared to 26% of their peers.
- that young people who struggle at school are more likely to face depression; are less happy in all areas of their lives.
- of those with fewer than 5 GCSEs, 21% admit to drinking or taking drugs to get them through the day against 4% of their peers.

[13] The Prince's Trust Macquarie Youth Index 2014

- 9% of all young people agree that life is not worth living. This rises to 20% of those with fewer than 5 GCSEs graded A*-C.
- that young people who grew up in poverty are more likely to have experienced the following:
    - Suicidal thoughts
    - Self-harm
    - Panic attacks
    - Being prescribed anti-depressants
    - Feelings of self-loathing
    - Insomnia
    - Difficulties controlling their anger.

3.3 Key determinants/risk factors (what are the causes or contributory factors)

This section introduces the key determinants/risk factors and provides estimates for the local Swindon population at risk.

Certain groups in the population are at higher risk of mental health issues, these include:

- Young carers
- Lesbian, Gay, Bisexual, Transgender and Questioning young people
- Number/estimates of refugees and asylum seeker
- Travellers Gypsies Roma
- Young people transitioning from children's to adult's services
- Young offenders
- Children in Care
- Care leavers
- Children in Need
- Children in poverty
- Homeless families
- Children with parents in prison
- Children misusing substances
- Children experiencing sexual exploitation
- Children of parents with mental health issues
- Children of parents with substance misuse issues and mental health problems and domestic violence

While children and young people in these groups may be at higher risk, this does not mean that as individuals they are all equally vulnerable to mental health problems. A range of protective factors in the individual, in the family and in the community influence whether a child or young person will either not experience problems or will not be significantly affected by them, particularly if receiving consistent support from an adult whom they trust.

3.3.1 Young carers

The Royal College of Psychiatrists[14] (2012) state that 68% of women and 57% of men with a mental illness are parents.

There are currently 467 young carers registered with Swindon Young Carers Centre, 54% are under 13 and 47% between the ages of 13 and 17 years. 147 of these young carers support a family member who has a mental health issue.

It is important that these children and young people get access to services and support that they require, as national research has shown that they are more likely to be children in need, are more likely to experience health problems or developmental delay and may even require alternative care at times. 30% of children who have

[14] http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/parentalmentalillness.aspx

parents with a mental health problem will experience mental health problems themselves during adolescence.

3.3.2 Lesbian, gay, bisexual, transgender and questioning young people

There are no local estimates of the numbers of people in Swindon's population who belong to the lesbian, gay, bisexual and transgender (LGB&T) groups. In the ONS Integrated Household Survey (IHS) in 2012, 1.5% of the sample reported that their self-perceived sexual identity was lesbian, gay or bisexual. However, the percentage of people belonging to a LGB&T group is commonly taken as being about 6%[15] in the UK, by public sector and the third sector, as this allows for people who are reluctant to report on their sexuality in surveys, or whose behaviour or feelings of attraction are not necessarily captured well by survey techniques. If we apply that percentage to the local population it would suggest that approximately 12,000 people in Swindon belong to the LGB&T groups, 3,000 of these would be under the age of 18.

3.3.3 Number/estimates of refugees and asylum seekers

It is difficult to estimate the number of children seeking refugee or asylum locally. Those who are unaccompanied are placed in care and will be included in the section on children in care below. In addition estimates from Clearsprings housing provider for those on Section 95 which indicates that there are 43 children included in this cohort.

3.3.4 Travellers gypsies roma

In Swindon, in 2013/14, 15 children (0.06%) of state primary and secondary children were from the Gypsy/Roma ethnic group (of whose ethnic group is classified)[16]. This is slightly lower than the South west (0.16%) and England (0.25%) figures.

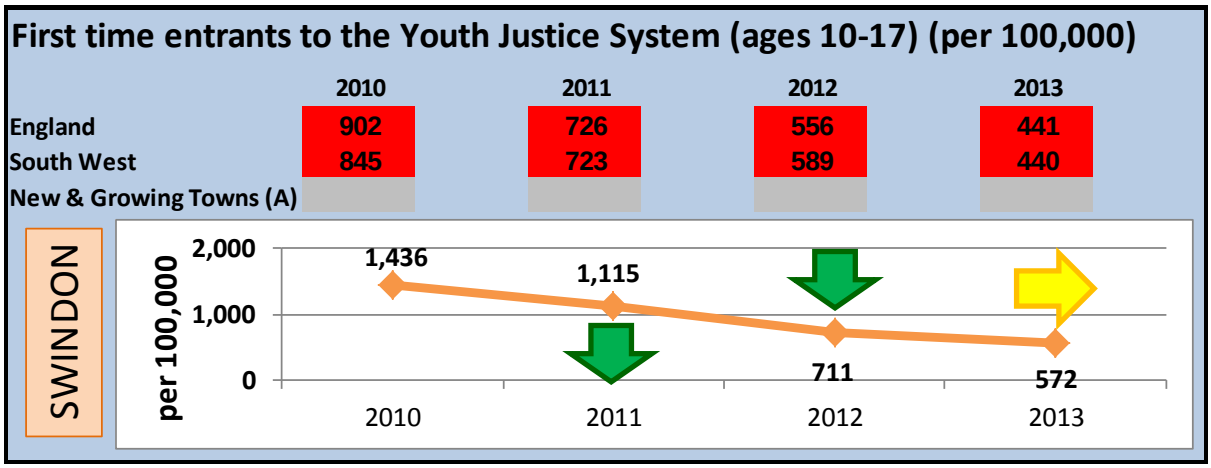
3.3.5 Young offenders

Young offenders are at risk of higher than usual rates of mental health problems for three main reasons. The original risk factors that led them to offending are also predictors for mental ill-health; various aspects of offending and associated risk taking behaviour itself may cause mental health problems; and interactions with the criminal justice system are stressful and can lead to mental health problems. Figures in the literature indicate that rates of mental health problems to be at least three times higher for those in the criminal justice system in the general population

[15] http://www.theguardian.com/uk/2005/dec/11/gayrights.immigrationpolicy

[16] School Census, Department for Education

and for young people in the criminal justice system prevalence can be as high as 81% for those in custody[17].



3.3.6 Children in care

'Children in Care' refers to all children under the age of 18 being looked after by the local authority. Sometimes the term 'Looked after Children' is used. When they become looked after, children in care usually live with foster carers; some will live in residential children's homes.

In Swindon there were 252 children in care at the end of December 2013. This equates to 52.2 per 10,000 population under 18 compared with 60 nationally[18]. In March 2014 there were 252 children in care and of these 143 were male and 109 female.

The Swindon Strategy for Children in Care 2014 -16 has 7 priorities. Priority 4 recognises the need to improve the health, wellbeing and mental health of children in care. Swindon strives to implement the statutory guidance on Promoting Health and Wellbeing of Looked After Children DOH 2009 and Quality Standard for the Health and Wellbeing of Looked After Children and Young People (Nice 2013).

3.3.7 Care leavers

Care leavers are those who have been in care for at least 13 weeks from the age of 14 onwards. Government policy states that support for care leavers should be provided up to the age of 21 or until they have completed their education if this is longer.

[17] The mental health needs of young offenders. The Mental Health Foundation Updates Volume 3 issue 18 2002

[18] Swindon Strategy of Children in Care and Care Leavers 2014 -16. Swindon Borough Council

3.3.8 Children in need[19]

In Swindon, in 2014, there were 338 Children in Need per 10,000 this compares to a national rate of 346/10,000 and a statistical neighbour rate of 329/10,000[20]. The number of children subject to a protection plan in Swindon is also similar to the nationally and statistical neighbour rates. In 2014, the rate was 44.7 per 10,000 in Swindon, compared to 42.1 per 10,000 nationally and 40.1 per 10,000 for Swindon's statistical neighbours.

3.3.9 Children in poverty

The Child Health Profile March 2014 indicates that in Swindon, 17.3% of those under the age of 16 years were living in poverty in 2011. This was slightly above the regional average of 16.2% but lower than the national average of 20.6%.

3.3.10 Homeless families

In June 2015 there were 207 statutory homeless families in temporary accommodation. The number of families in temporary accommodation has risen by 25% over the previous year and the number of households accepted as homeless has increased by 50%. At the end of February 2015 there was 1 family in Bed and Breakfast accommodation. It is expected that this increase is likely to continue.

3.3.11 Children with parents in prison

Children with a parent in prison are more likely to be at risk of developing mental health problems. The charity, Barnardo's estimate[21] that 200,000 children in England and Wales are affected by parent parental imprisonment at any one time. They highlight that no official figures exist and they are not routinely collected and families are unlikely to reveal themselves for fear of social stigma and bullying and so they remain hidden from local services. The report suggests that more than three times as many children are affected by parental imprisonment than the number in

[19] Section 17 of the Children Act 1989 defines a child as being in need in law if:

- He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA;
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA;
- He or she has a disability.

[20] www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

[21] "On the Outside – Identifying and Supporting Children with a Parent in Prison" Barnardo's May 2014

care and they are twice as likely to experience conduct or mental health problems and less likely to do well at school.

3.3.12 Children misusing substances

The links between mental health and substance misuse are well established. In Swindon there is higher than national average use of cannabis amongst our children and young people. Their first misuse of substances appears to be later than the national average with 54% of those in treatment being aged 14 -15. There are strong links between cannabis misuse and psychosis. There is also a higher than national average female cohort presenting at substance misuse services. There is some evidence that there is a reciprocal, causal association between the misuse of cannabis and tobacco[22].

3.3.13 Child sexual exploitation and sexual abuse

There are no accurate figures on the number of children and young people being sexually exploited in the UK. However, it is recognised as a growing issue that the children and young people being exploited are becoming younger. Both males and females are at risk but some estimates show that girls and young women are six times as likely as boys and young men to be exploited. It is recognised that exploitation among males is likely to be underestimated. For more information go to: http://swindonjsna.co.uk/dna/child-sex-exploitation or http://swindonjsna.co.uk/dna/sexual-health-needs-assessment

The NSPCC report that 16.5% of 11-17 year olds reported being sexually abused at some point in their childhood[23]. The report estimates that those who experience childhood sexual abuse were twice as likely to experience depression and Post Traumatic Stress Disorder and three times as likely to attempt suicide or self-harm.

3.3.14 Parents with mental health problems

Evidence shows that children whose parents have a mental health problem are more likely to develop a mental health problem themselves[24]. Both maternal and paternal mental health is important and can have an effect on the mental health and wellbeing of their offspring. Maternal mental health both during pregnancy and post-natally can have a significant impact on bonding and parenting and the mental wellbeing of babies. 14% of mothers in the UK experience depression. Fathers also experience

[22] Badiani etal (2015 Drugs and Alcohol Dependence vol 150 p69 -76 (May 2015)

[23] Aliya Saied-Tessier 2014 Estimating the cost of sexual abuse in the UK p14

[24] Hay et al 2008, Pawlby et al 2009, O'Connor et all 2003, NICE CG Postnatal Care 2006

depression. A recent study found that 4 per cent of fathers experience depression during the first year of their child's life. Having a partner who is depressed can be a trigger: 24-50 per cent of new fathers with depressed partners were depressed themselves[25].

Locally, about 30% of children in care have a parent with a mental health problem.

3.3.15 Parents with substance misuse issues and mental health problems and domestic violence

In 2009, it was estimated that around 30% of children under the age of 16 years, in the UK were estimated to be living with a at least one binge drinking adult, 8% with an illicit drug using adult, 0.6% with an injecting drug user and 4% with an adult defined as a problem drinker with a co-morbid mental health problem. It was also estimated that around 1% witnessed violence directed at a parent as a result of another adult's alcohol use. Evidence shows that children and young people whose parents have a mental health problem are more likely to develop a mental health problem themselves[26].

Research undertaken in 2011 indicated that more than one quarter of babies under one year of age may be at increased risk of harm from living with a parent, who is either a problem drinker; a class A drug user (past year), has a common mental health disorder or has experienced domestic violence in the past year.

In Swindon, in 2013, there were 2,911 live births so applying the research findings to Swindon this would equate to 728 babies who may be at increased risk[27].

Exposure to hostility and conflict in the home is a major risk factor for child mental health problems, particularly for conduct disorder in boys[28]. Many children, especially those who have otherwise received satisfactory care, internalise and develop emotional disorders such as depression, anxiety and low self-esteem. Boys are more likely to externalise and develop aggressive behaviour, identifying with the aggressor. Girls occasionally become aggressive but are more likely to become depressed and withdrawn[29].

[25] NSPCC 2011 All Babies Count

[26] Manning et al (2009) New estimates of the number of children living with substance misusing parents: results from UK national household surveys BMC Public Health 8:9:377

[27] Manning 2011 Estimates of the number of infants under the age of on year) living with substance misusing parents.

[28] Domestic Violence Royal College of Psychiatrists Council report 2002 Rutter and Quinton 1984 is cited in this report.

In the 2011/2012 British Crime Survey, 31% of women and 18% of men aged 16-59 said they had experienced DA during their lifetime, while 7.4% of women and 4.8% of men had experienced it within the past year.

Based on this, it has been estimated that in Swindon, 4,800 women and 3,200 men aged 16-59 have been victims of DA within the past year. The Domestic Violence and Abuse JSNA: The impact on children and young people undertaken in January 2014 estimate that in Swindon about 1,000 children aged under 11 and about 400 between 11 and 17 will have been exposed to domestic violence within the past year.

4. What services do children and young people use?

4.1 Summary of locally commissioned services

Specialist Secondary care CAMHS services provided by Oxford Health:

- Specialist CAMHS assessment and treatment
- Outreach Service for Children and Adolescents service (OSCA)
- Community Learning Disability Service

A targeted low level intervention CAMHS services:

TaMHS provided by SBC:

- Single point of access for GPs
- Parenting programmes
- Traded services to schools including assessments, support and training.

On Trak Youth Counselling Service (SBC)

SARC Counselling Service

NSPCC – Letting the Future In

Universal services who contribute to promoting, maintaining and improving mental health and identifying mental health problems in children and young people.

Schools, GP services, Youth Services, Health Visitors, School Nurses, Educational Psychologists, STEP, sMASH.

Caseload summary

Provider	Service	Latest caseload	Estimated annual referrals	Waiting times
CAMHS: Oxford Health Specialist	All secondary care level	775 (Jan 15)	575 (13/14)	
	Specialist CAMHS assessment and treatment			
	Outreach Service for Children and Adolescents service (OSCA)	100 (Jan 15)	244 (13/14)	
	Community Learning Disability Service	257 (average 2013/14)		
LIFT Psychology	Targeted Psychology Service	180 (16-18) 749 (19-25) (2014)		
TaMHS	Targeted services	1106 (Dec 14)		
	Single point of access for GPs			
	Parenting programmes			
	Traded services to schools including assessments, support and training			
On Trak	Youth Counselling Service	53 (April 15)	130 (14/15)	
Mediation Plus*	5-18 Counselling Service		32 (13/14)	3-4 months
NSPCC	Letting the future in			None
Swindon Ten to Eighteen project	STEP	60-70	150 per year	42 waiting
Swindon Mentoring and self-harm	sMASH	100 average		20-30 waiting for 3-6 months

*Non-commissioned service

Ignoring double counting the approximate total caseload was 775 for specialist and around 2,100 for targeted services (including LIFT). This compared to an estimated 3,000 young people with any clinically significant mental health disorder and an estimated 880 who may experience mental health problems appropriate to a response from secondary care specialist CAMHS (see prevalence section). This indicates that there could potentially be 100 individuals that may require a specialist service who are not accessing it.

Much of this needs assessment refers to CAMHS in its generic term which may include all mental health service provision. However, locally the specialist service is known as the CAMHS service and the majority of targeted services are provided by the TaMHS service. Through much of the document the context should enable the

reader to determine if the local CAMHS specialist service is being referred to or if the term is referring to more generic CAMHS.

4.2 Details of commissioned services

4.2.1 Tertiary – CAMHS

This service is provided by Oxford Health NHS Trust in Swindon. It is commissioned by NHS England and will not form part of this Needs Assessment.

4.2.2 Secondary care specialist – CAMHS

Service description

Secondary care specialist CAMHS services are provided by Oxford Health, offering:

- Specialist CAMHS assessment and treatment
- The Outreach Service for Children and Adolescents service (OSCA),
- The Community Learning Disability Service

The core business of Specialist CAMHS is the specialist assessment and treatment of serious mental health disturbances and associated risks in young people under the age of 18 years.

The primary role of OSCA is to work intensively with children and young people experiencing a complex range of behavioural, emotional and mental health needs to prevent escalation of at risk behaviours, and to work towards recovery. The key objectives are to:

- Support children/young people in stable placements, either at home or in care
- Reduce the numbers of children requiring to be accommodated by the local authority
- Reduce the need for out of area placements

OSCA delivers a number of therapeutic interventions ranging from high intensity DBT, family work, CBT, solution focused therapy, parenting support, engagement work etc.

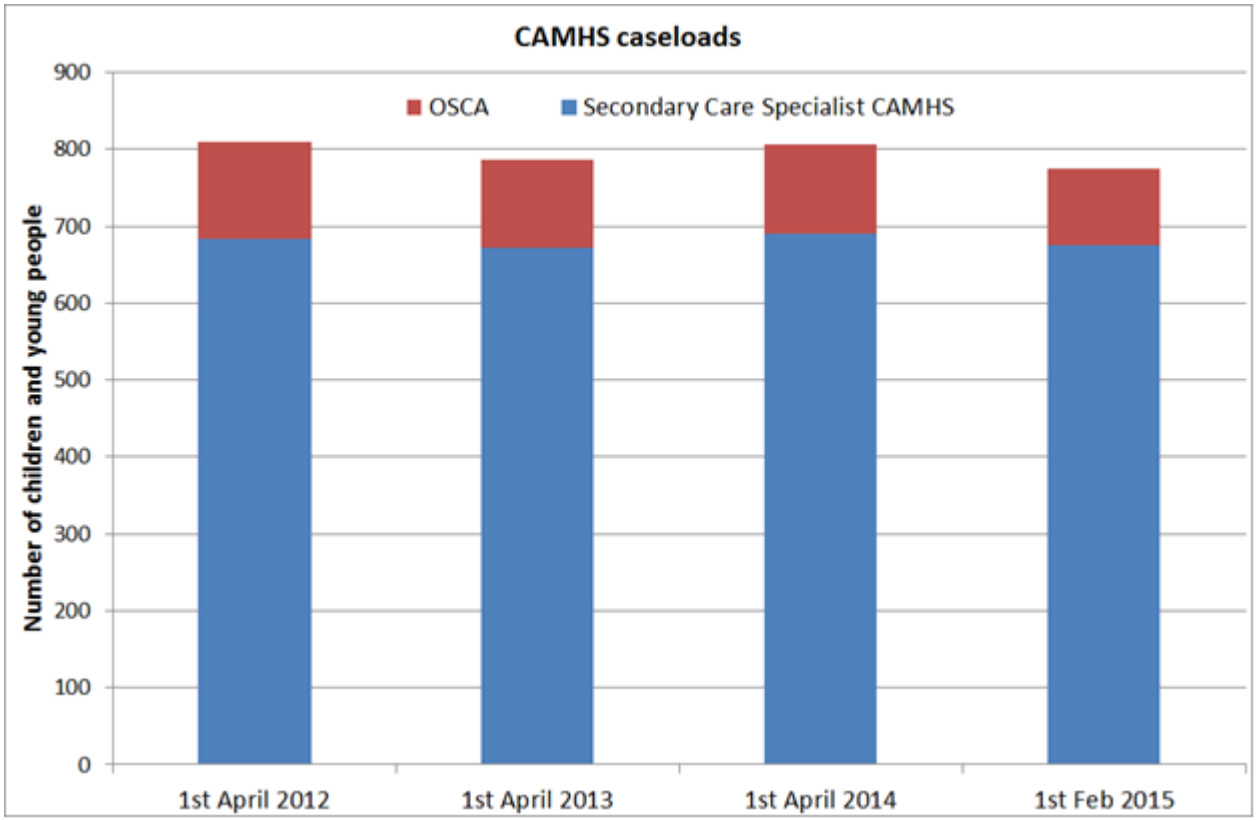
The Community LD Team has two roles: providing a specialist mental health service to children and young people with a learning disability; and providing a specialist community nursing and special school nursing service around health needs associated with a more complex learning disability.

Specialist CAMHS and Wiltshire Police have worked in partnership to produce a protocol for working with a young people experiencing mental health distress or

crisis. When an officers responds to a young person in significant mental health distress or crisis, the officer contacts CAMHS from the scene by phone to discuss risk and consider alternative options to a S136 detention. CAMHS professionals are available 24 hours a day, 7 days a week for telephone consultation. Emergency mental health assessments can be offered in response to serious concerns immediately, or within 24 hours as agreed with parents/carers and other professionals.

An appropriate 'Place of Safety' at a location other than a police station for children and young people under the age of 18 years, detained under section 136 of the Mental Health Act is located at Sandalwood Court. Oxford Health provides CAMHS support to this facility.

CAMHS Specialist and OSCA caseload



Note: Specialist Secondary Care figures do not include OSCA data which is analysed separately

The OSCA caseload and the specialist CAMHS caseload has remained at the same level since 2012.

On 1st February 2015 males make up 53% of those receiving a specialist service but only 40% of those receiving an OSCA service. Since 2012, the proportion of males receiving services has generally declined. Looking at current caseload and age at

referral there are 98 patients under 5, across all teams in Swindon (OSCA, LD, Specialist Secondary Care CAMHS, IAPT etc.). 56% of the current [1/2/15] Specialist Secondary Care CAMHS caseload is between the ages of 12 and 18, 28% between 6 and 11 and a further 16% under 6. 89% of the OSCA clients are in the 12 to 18 age group.

In 2013/14, the Specialist Secondary Care CAMHS service accepted 330 referrals in 2013/14 and discharged the same number; however its caseload was around double this number (690 on 1/4/13) indicating that many clients remain on the caseload for a long time. In 2013/14, clients received an average of 11 treatment sessions. The opposite situation was observed for OSCA which accepted 244 referrals in 2013/14 and discharged 243 compared to a caseload snapshot of about half this (117 on 1/4/13). This would indicate most clients were discharged within a year. In 2013/14, clients received an average of 15 treatment sessions prior to completing treatment.

Source of referrals, 2013/14

Source	**CAMHS Specialist Service (excluding OSCA)**	**OSCA**
Education Service	8%	1%
General medical practitioner	31%	1%
Hospital-based Paediatrics	9%	44%
Internal - Community Mental Health Team (Child and Adolescent Mental Health)	28%	44%
Other	24%	10%

Waiting times

The waiting times for a CAMHS assessment at present exceed the target to be seen within 4 weeks. On average during 2014/15 (April – Feb) only 60% of referrals were seen within 4 weeks and only an average of 87% were seen within 8 weeks. In February 2015 the waiting times appears to be getting longer with only 50% being seen within 4 weeks and 77% within 8 weeks. However, 100% of referrals started treatment within 18 weeks. 99% of those referred to the OSCA team were assessed within 4 weeks.

Outcomes

The majority (87%) of Specialist Secondary Care CAMHS clients were discharged on professional advice in 2013/14, a further 11% of patients move away or don't attend treatment. Inappropriate referrals have dropped from 21 (5%) in 2011/12 to less than 5 in 2013/14 and in 2014/15 to date. 95% of OSCA clients were discharged on professional advice.

4.2.3 Learning disability (LD) team

The CAMHS Learning Disability Team had a caseload of 237 in 2012/13, 104 of which were managed in special school settings.

- Average caseload for LD 13/14 (Inc. School Nurse) = 257
- Average referrals to LD 13/14 (Inc. school nurse) = 10 per month
- No of individual clients seen in LD in 13/14 = 233

4.2.4 Out of area placements for Swindon inpatients

When a child or young person is sectioned under the Mental Health Act and requires hospitalisation, a bed will be sought at the nearest inpatient facility with capacity. Tertiary inpatient services are currently commissioned by NHS England and therefore out of scope of this needs assessment. Occasionally, a child or young person's needs cannot be met either locally by community services or through an inpatient admission. Such needs are very complex and will very rarely only be mental health related – children will have complex social needs and sometimes educational needs as well. In these instances residential placements are commissioned, often within a specialist provision, for example for young people with Eating Disorders, those at high risk of harm to themselves or others or those who have suffered from abuse. Over the past 2 years, whilst the numbers of placements has remained stable, commissioners have noticed an increase in the levels of complexity for young people requiring residential placements, often resulting in very difficult placements searches with most providers not able to accommodate such high levels of need. The result is little choice in options for the young person and a very high cost provision.

4.2.5 Targeted Mental Health Service (TaMHS)

Service description

TaMHS have been providing targeted mental health services to children and young people in Swindon since 2011. The service comprises 3 elements:

1 Single point of access for GPs (0-18)

The TaMHS team receive about 1,200 referrals per year which are screened, triaged and assessed. They offer 4 – 6 week short term intervention to treat mild to moderate mental health issues such as anxiety; low self-esteem, loss, low mood and bullying. TaMHS are commissioned to carry a caseload of 40 individuals.

2 Parenting programmes

Parenting and ADHD Pathway and Family Links Nurturing programmes
TaMHS also provide a twelve week parenting programme which is an accredited course. The course can be delivered to groups up to 12-14 individuals and TaMHS team have about 60 referrals per term. This year 5 groups have been run.

Each Children's Centre has an allocated amount of core time (one session a month/term). This time can be used for staff training or consultation or even direct contract with parents. This service was also provided to all primary and secondary schools up until January 2014; however it is now a traded service with schools.

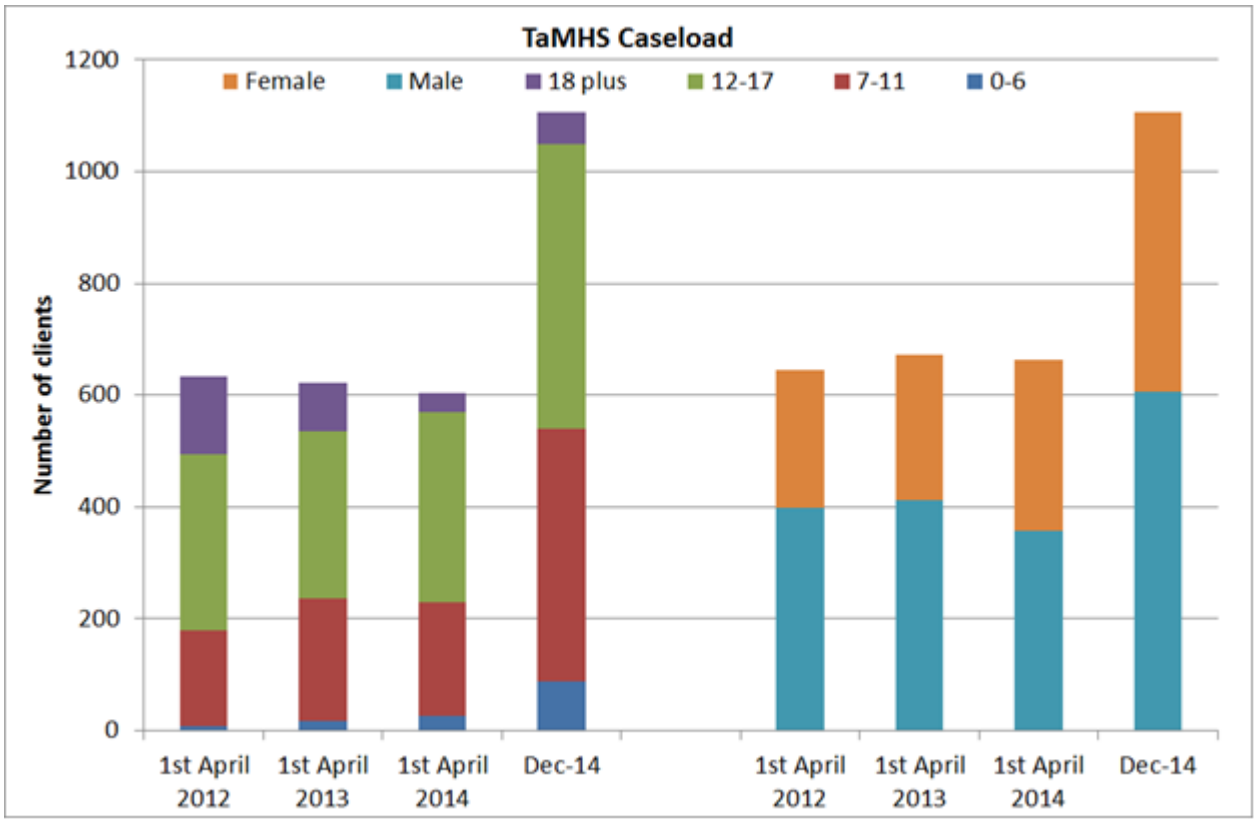
3 Traded services to schools including:

- Support and training for staff
- Interventions with pupils using Cognitive Behaviour Therapy
- Group work in schools to tackle common issues such as anxiety
- Self-referral system to nurture groups

The schools now contract directly with the TaMHS service and pupils are seen at their school. In 2011 TaMHS traded £123,000 worth of traded services with 20 schools. By 2014/15 this has more than doubled to £290,000 with 56 schools and colleges across Swindon, delivering bespoke packages to meet the needs of the individual settings. TaMHS have already seen additional demand for 2015/16 with new schools buying services for the first time. TaMHS are continuing to develop relationships with all schools and colleges across Swindon raising awareness of mental health issues and delivering early interventions to children and young people. Only one cluster of schools use an alternative provider.

Patients assessed as needing a more specialist service are referred to CAMHS provided by Oxford Health Service.

TaMHS Caseload



The TaMHS caseload remained similar from April 2012 to April 2014 but has rapidly increased up to December 2014 and is now almost double historic levels.

The majority of referrals to TaMHS come from three sources. In 2014/15 (to date) 56% were from GPs, 7% from Schools and 36% from other sources including Community Paediatricians.

TaMHS REFERALS -2011 - 2015 (excluding traded services)

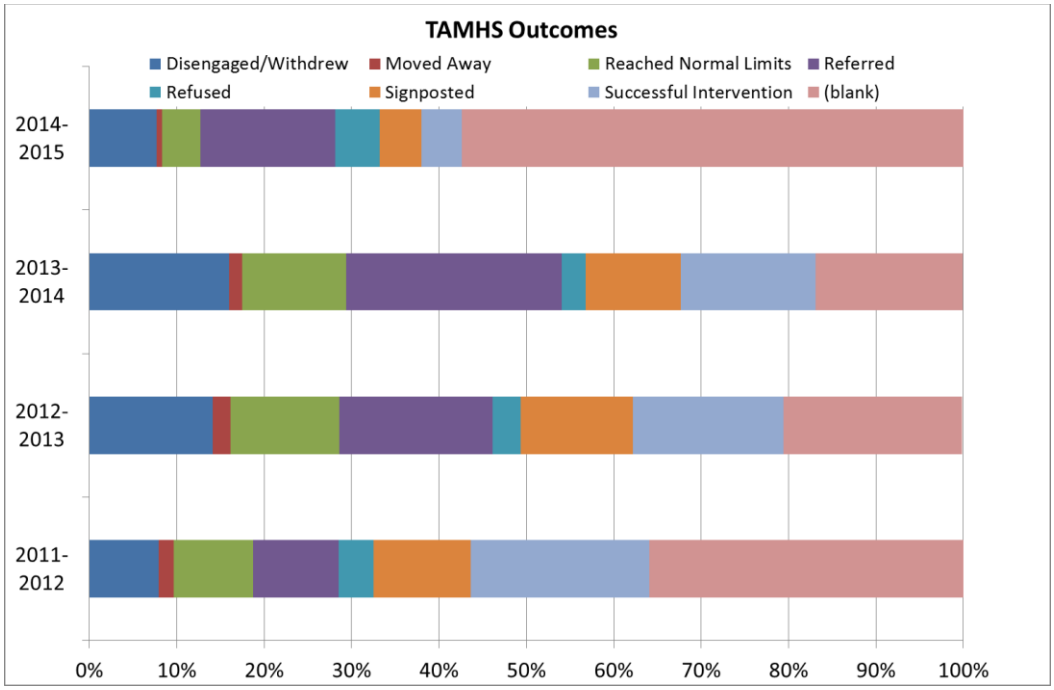
Year	GPs	Schools	Other	Total Referrals	% increase year on year for total referrals.	% increase year on year for GPs
Totals Sept 11 - Aug 12	489	135	307	931		
Totals Sept 12 - Aug 13	576	121	285	977	4.94%	17.79%
Totals Sept 13 - Aug 14	603	51	319	973	-0.41%	4.69%
Totals Sept 14 - July 15*	615	77	398	1090*	12.02%*	1.99%*

* Part Year Sept - mid July

Waiting times

Waiting times vary according to need but can be long if the need is deemed not to be urgent. At present there were 561 children and young people on the waiting list to be seen.

Outcomes



4.2.6 On Trak youth counselling service

Service description

On-Trak offer 1-1 counselling to young people aged 14 – 19 years of age who live, work or study in the Borough of Swindon. Young people are encouraged to refer themselves to the service but sometimes they are referred by parents or guardians. They are often signposted to the service by GPs.

During 2013 – 14 On Trak received 133 referrals. This was up from 126 in 2012-13. The average waiting time for assessment was 38 days and on average the waiting time from assessment to treatment was 145 days (4.8 months). This would equate to a young person on average waiting 6 months for treatment. However, those at greatest need are prioritised. Of the 133 referrals 101 were female and 112 white. The average number of sessions a young person had was 21 in 2013/14 and provisional

figures for 2014/15 show this may have increased to over 30, however anecdotally most have 6 – 8 sessions.

On Trak's caseload on 1st April 2014 was 53 [email communication]. This information cannot be routinely extracted from the On Trak database.

Referrals

Source	2013/14	2014/15 (to end Dec)
Self	23	8
Parent	36	18
Health	40	33
Education	4	1
Other	30	21
Total	**133**	**81**

In 2014/15, 20 of the 130 referrals were not assessed because they didn't engage with the service. Of the remaining 110, a further 7 did not continue after assessment.

4.2.7 Other services and community assets

4.2.7.1 LIFT Psychology

Service description

LIFT Psychology is a targeted/specialist service which offers a range of IAPT based interventions, including group sessions; courses; computer based Cognitive Behaviour Therapies; 1-1 counselling and self-help interventions such as books or websites. LIFT Psychology is predominately an adult IAPT service but offers some provision for 16 – 18 year olds, including a Young Health Minds group at New College.

At New College it has been recognised there is a group of students with autism and Asperger's who have mental health issues and a specific group has been developed to address these.

During 2013 LIFT saw 206 individuals 16 -18 years of age and 907 19 -25 year olds. In 2014 this reduced slightly to 180 16 -18 year olds and 749 19 -25 year olds. For 2013 and 2014 combined 28.7% of the 16 -18 year old caseload was male compared with 71.3% female. For the 19 – 25 year old age group 35% were male and 65% female. 95% of the 16 – 18 year olds were White compared to 92% of the 19 – 25 year olds, so other ethnicities were poorly represented. 83% were seen for Depressive episode, Generalised Anxiety Disorder or Mixed Anxiety and Depressive

Disorder. The recovery rate was around 41% which is in line with the adult population seen by LIFT. (Full details, please see Appendix 2).

In line with the adult caseload for LIFT Psychology, the severity of mental health problem was comparatively high with regards to other IAPT services. A detailed analysis of the 58, 16 -18 year old attending LIFT from January – October 2014 showed that 31 of the 58 had conditions in Cluster 5[30] and above and a further 21 were in Cluster 4. A very small number, less than five were in clusters 6 and 7 and the severity of the conditions affecting these individuals required a disproportionate amount of resource.

4.2.7.2 Mediation Plus: 5-18 counselling service

Service description

The service aims to help children and young people cope with the emotional impact of parental separation. It offers short term (6 sessions), 1-1 face to face counselling using creative therapy appropriate to age. Issues of separation, anger, loss and confusion are addressed and both the resident and non-resident parents are also seen separately. Those over the age of 14 can self-refer, otherwise a parent must refer the child. During 2013/14 children were signposted from GPs, schools, social workers, TaMHS, and parent support staff. Others had heard of the service through word of mouth.

During 2013/14 the service saw 32 children and 49 parents (all of the 49 were parents of the 32 children). From April – October 2014 the service had seen 18 children (7 boys and 11 girls) and 27 parents so for the current financial year the figures are likely to be similar to 2013/14. There is currently a 3-4 month waiting list. This service is no longer being provided in Swindon. This was a non-commissioned service

4.2.7.3 NSPCC Letting the future in

Service description

The NSPCC provide a longer term (24 - 30 sessions), therapeutic counselling service for children and young people aged 4 – 17 years who have experienced sexual abuse. The carer of the child/young person also has 6 – 8 sessions to explore the issues and how they can effectively support the young person.

[30] For an explanation of clusters please see Appendix 2 LIFT Referral Data

The NSPCC also provide several services in Swindon with regard to parenting – Baby Steps, Parents under Pressure and a full parenting programme.

At present there is no waiting list for the service.

4.2.7.4 Sexual Assault Referral Centre (SARC) counselling service for those aged 13 -16 years

Service description
SARC employ an individual specialist sexual assault counsellor for 7.5 hours per week (covering Swindon and Wiltshire) to provide timely and specialist support for those between the age of 13 -16 years of age who have experienced sexual assault. During 2014/15 they provided intensive support for 6 Swindon individuals. There are currently no waiting times.

4.2.7.5 Swindon Ten to Eighteen Project (STEP)

Service description
STEP is charity and a referral only service. Referrals come predominately from professionals – schools, CAMHS, TaMHS, Social Services. Occasionally STEP will accept a referral from a parent or family member.

STEP offers group work not 1-1 interventions. Over the past few years the focus has shifted from preventative to more therapeutic interventions.

Various groups are offered (12 per group):

- Junior Step 7 – 9 year olds – 15 week intervention (once a week 2 hrs). Focuses mainly on social skills.

- Longer term therapeutic groups with those 10 – 18 yrs (mainly 10 -15 yrs). Individuals can stay in group work for between 6 – 18 months. Groups are run three evenings a week following school term format and focus on a particular theme such as anger management, actions and consequences, negotiation skills etc. This will depend on the needs of the children at the time.

- An Aspiration Group for 14+. This is particularly aimed at those at risk of exclusion from school or in the community. This is a 15 week intervention. (Start February 2014)

- A respite group on Saturday mornings for disabled children.

STEP also offers some outreach work at Schools – e.g. Nyland School (C&YP to be seen at STEP), and a primary school (STEP to attend the school). They have also delivered after school clubs in Schools.

At present, STEP have 42 children and young people on the waiting list and these individuals may have to wait up to 6 months although those with most need are prioritised and can be seen as quickly at 2 weeks. On average STEP have about 60 – 70 individuals on their caseload at any one time.

4.2.7.6 Swindon Mentoring and Self-Harm (SMASH)

Service description
SMASH is a charity in Swindon offering a youth mentoring service for 13 – 18 year olds. Since 1999 it has been bringing children and young people together with willing and committed volunteers who can support, advise and listen to them in a sustained long term relationship. Giving them the chance to become everything they can be, sometimes when no one else believes that they can. The Youth Mentoring Service is an open referral service which means that any professional organisation can refer a young person. Usually young people are referred by schools, Children's Services or TaMHS.

SMASH introduced the Memory Makers project in 2013. Memory Makers works with children aged 9 to 12, focusing on creating positive and happy memories in their young lives. Memory Makers work one-to-one in a long term relationship with a child, meeting regularly and taking part in simple activities to help them to gain confidence and self-esteem, resilience and hope. Referrals to this service are through schools.

SMASH have a caseload of 100 children and young people at any one time and see on average about 150 individuals a year. On average there is a waiting list of 20-30 individuals who wait between 3 and 6 months to access a volunteer.

4.3 Universal services

GPs offer support to those experiencing low level mental health problems but they report that schools often now refer children directly to TaMHS traded services. For the small number of schools not purchasing traded services, the GP can provide a useful referral route. GPs continue to see and support children and young people with mental health conditions and refer as appropriate through the single point of access to Secondary CAMHS or TaMHS.

School nurses have a presence in every school. They give a universal offer, providing a weekly morning clinic at each secondary school where they can see up to eight people for either physical or mental health problem. They can also offer appointments outside of this time if it is urgent. Pupils can self-refer to the school nursing service or they can be referred by school staff. School nurses do not generally offer long term work with individuals because of the unpredictability of

demands on their service. There is a lead school nurse for mental health who liaises with other school nurses keeping them up to date and delivering training as required.

Most of the school nurse interventions are at secondary school level and there is less provision at primary school level. There is some limited 1-1 work for years 5 and 6. The focus in primary schools is more on working with parents to help them improve their child's mental health and wellbeing.

The school nurses also mentioned Nurture groups in schools run by Teaching Assistants who were originally trained by CAMHS.

Educational Psychologists (EP) provide an assessment service with some limited capacity to deliver interventions. EPs provide consultation, work systematically within the Early Help and Statutory processes, providing strategies and advice for individual pupils, their parents or carers and those working with them. EPs also deliver training.

Health visitors work with families and siblings and although their focus tends to be on those of pre-school age they can provide a useful resource as they know the whole family and may well have worked with children who develop mental health problems during school years. Work the health visitors undertake with the under-fives will be picked up in the Early Years Needs Assessment.

5. Evaluation of services children and young people use

Commissioned

5.1 Secondary Specialist – CAMHS

CAMHS services were tendered in Swindon in 2009 and the new service model is now fully operational. This has seen an increase in community based responses, a decrease in admissions and only 1 new CAMHS out of area placement. Caseloads have remained consistent across the secondary specialist services and the OSCA Team and are relatively high compared to other local CAMHS teams (despite being lower than the estimated level of need above). This is attributed to retaining patients for longer due to lack of shared prescribing in Swindon General Practices and the complexity of cases which has increased.

Children attending special schools in Swindon requiring specialist nursing services have increased in numbers and complexity over the past decade. Increased level of provision of Specialist Nursing for children attending special schools has been implemented from September 2013 to March 2014, whilst a complex case needs assessment takes place.

The SDQ is used to monitor emotional wellbeing. The Designated Nurse monitors outcomes of children with high scores and uses this information with social Workers, foster carers and CAMHS to plan intervention for an individual child, young person or

care leaver. There are regular meetings between the Designated Nurse and CAMHS / TaMHS team to monitor individual cases and review services. There was a named CAMHS worker for Children in Care and this helped to improve services and timescales. This post was made redundant which means there is a less transparent pathway for this vulnerable group.

LIFT expressed concerns about the mental health of those leaving care and the difficulties that they face. This is often picked up later in the adult IAPT service. Sometimes if these issues are not addressed these mental health problems can escalate to emergent personality disorders. LIFT use a screening tool to identify the proportion of their clients who would be diagnosable with a severe or emergent personality disorder. 8% had a severe personality disorder and 40% had a moderate disorder. Personality disorder can often emerge from early attachment issues, leading to conduct disorder and then personality disorder. There is an opportunity to intervene with those with emergent personality disorders to address these issues. It may be that this work could be targeted at high risk groups such as care leavers. A similar successful project is being run in Somerset and good results and savings have been realised. The programme can be resource intensive and requires joined up working with all agencies such as GP, social services etc.

Newly developed 'Swindon multi-agency guidelines for professional working with children and young people who self-harm' were launched at the Swindon Self Harm conference in March 2013 and disseminated to all staff groups.

The CAMHS services have been developing closer working relationships with Children's Services through attendance at social care team meeting and participation in Partnership Meetings, with the aim to develop joint training, development and networking opportunities.

LIFT Psychology felt that there was more work that could be done with CAMHS to ensure that more joined up working took place, particularly for those 17 year olds who may not reach the adult secondary care service thresholds. However, it was important that CAMHS recognised that LIFT Psychology does not provide a Care Programme Approach but an opt-in service.

The Educational Psychology service report that there is good working practices between CAMHS and the Educational Psychology team particularly in relation to the Neuro-developmental assessment clinics. The EPs also report that once a child accesses the CAMHS service they receive a very good level of care. The CAMHS OSCA service was particularly highlighted as working very and well and engaging children who would otherwise be unable to access services. The EPs said that their relationship with the clinical psychiatrists was very good.

However, the EPs did report that they felt criteria for CAMHS/TaMHS services were unclear and inconsistent and that accessing CAMHS can require "tenacity". EPs would welcome the opportunity to work closer with the Clinical Psychology team to improve partnership working and a better understanding of the referral requirements.

TaMHS practitioners thought that the working arrangements between CAMHS and TaMHS generally good, particularly between TaMHS and the OSCA service which was seen as a very beneficial service within Swindon. There were some concerns expressed about access to Learning Disability CAMHS which was considered particularly difficult. Some practitioners felt that the TaMHS triage and assessment was not accepted by CAMHS so it was not really a single point of access. The interface between CAMHS and TaMHS works well in some cases but it appears less clear and standardised in others. It was felt that further clarification and review of referral criteria was needed.

In addition, it was pointed out that the flow of information between CAMHS and TaMHS could be improved. At present TaMHS provide the Single Point of Access for CAMHS (targeted and secondary care specialist) services. (GPs and Great Western Hospital Paediatricians can refer direct to secondary specialist CAMHS in urgent situations and those who have been discharged from CAMHS can self-refer back if they have been seen within the last 12 months.) TaMHS triage the referrals and either refer directly on to CAMHS or provide support in TaMHS. Some cases that need further discussion are taken to the Joint Referral Meeting where further interventions from TaMHS may be recommended or referrals are accepted by Secondary Specialist CAMHS (see pathway in Appendix 3**).**

If the referral is accepted by CAMHS at that meeting the case is closed to TaMHS. The patient is the placed on a waiting list to see a CAMHS practitioner. Some TaMHS workers felt that they did not get sufficient feedback from CAMHS regarding referrals they had made and were sometimes contacted several weeks later by the child or parent telling them that they had not yet been seen by CAMHS or that following assessment by CAMHS no further service was offered. Some TaMHS workers only know the outcome if they are told by the child or parent/carer. Some TaMHS workers thought that if they knew that there would be a long wait for the individual to be seen they felt they may be able to offer some support until they were seen by CAMHS which would make it a more seamless service. However, TaMHS are limited by the number of sessions that they can offer.

The TaMHS practitioners also highlighted that the CAMHS and TaMHS teams do not use the same assessment tools or the same data management IT system so there are no joint records and practitioners both from CAMHS and TaMHS cannot see the whole mental health record for the individual.

At present, unlike for adults, there is no CAMHS hospital liaison service at GWH. Current provision is through the OSCA service that only provides urgent cover within 24 hours for those presenting with self-harm. Sometimes, if demand on a particular day is high, routine appointments have to be cancelled in order to accommodate this

service. There is no “Responsible Clinician” commissioned to provide governance at GWH.

5.1.1 Complex cases

Following the recent (2014) CQC visit, there was a review of complex case consultations. There was concern raised by CAMHS that the case consultations were not being held frequently enough to enable children and young people access appropriate services in a timely manner.

The review, undertaken by Oxford Health, made the following recommendations:

- Complex case consultations should be held on a weekly basis.
- Referrers should be able to send Children in Care directly to CAMHS avoiding the need for assessment by TaMHS.
- Verbal reports should be accepted to avoid delay in referral awaiting a written report.
- Invite young person to the consultations where appropriate to ensure their voice is heard.
- Review of the role of OSCA in providing information consultation to CIC social work teams to ensure cases aren’t referred to CAMHS where the child’s needs are not of a mental health nature
- Offer Designated LAC Nurse a standing invitation to consultation in order that external oversight provides assurance around the identification of need and timely response in CAMHS and wider system
- Formally review process in March.

5.1.2 Mental Health Crisis Care Concordat

Partners in Swindon have signed the Mental Health Crisis Care Concordat which pledges that we will work together to improve the system of care and support so that that people in crisis because of a mental health condition are kept safe. In addition, partners will work together to prevent crises happening whenever possible, through intervening at an early stage. In 2014/15, there were 4 under 18s who were detained under a S136 and taken to Sandalwood Court Place of Safety. The last under 18 who was taken into police custody was in 2012.

In Swindon the CAMHS service:

- Has good working links with the police. There is regular liaison between CAMHS and Wiltshire Police to ensure appropriate response times and action for vulnerable young people in crisis.
- Are working with the 111 out of hours service to ensure they are aware of the pathways to CAMHS services that are available out of hours.
- Continue to work with South West Ambulance Service to ensure timely transfer of those under 18 to specialist settings for treatment.
- Will review the memorandum of understanding between the Court Liaison and Diversion Service to ensure appropriate assessment of those under 18.

- Will work with TaMHS and commissioners to ensure a seamless pathway through services and address waiting times.
- Ensure IAPT services are available by training and retaining IAPT trained staff.
- Ensure liaison between GWH, Children's Services and CAMHS by sharing information on patients with mental health concerns who attend ED, admitted and on discharge.
- Will contribute to data collection and monthly review of the use of places of safety

An action plan has been developed and a working group, which includes CAMHS, established to oversee the implementation of the concordat.

5.2 Targeted Mental Health Service (TaMHS)

The TaMHS Service is highly valued by schools and this was reflected in the findings of the schools consultation for this JSNA. The increase in trade for the TaMHS service from schools is also reflective of the value they place on the service. The TaMHS Service is the top traded service within the Council.

The TaMHS team were all particularly positive about the traded services element of their work and saw their multi-disciplinary team as a real strength. The links that practitioners form with schools can be very productive and ensure earlier intervention. TaMHS being integrated into the community is very important and a strength of the service. The link develops trust between the schools and the TaMHS services. The TaMHS service also value the links with school nurses, health visitors and educational psychologist and can share information on additional siblings that may be affected.

The traded services provided are complex and vary between schools as does the amount of time that they purchase. Data collection is also complex and difficult to reflect the full range of service provision which can include: 1: 1 work, group work, staff supervision and training etc. This complexity in different provision between schools and GP practices, together with difficulties with data collection and monitoring, makes it difficult to ascertain a true picture of provision of mental health services in Swindon and ascertain if they are meeting need. In addition, it is difficult to demonstrate true outcomes from interventions. In addition to the inconsistency of schools trading with TaMHS, the practitioners pointed out that the relationship with schools can vary greatly and is very dependent on the ethos of the school. This may lead to an inequitable service.

Practitioners also highlighted that it could be difficult to compartmentalise core and traded services. The traded service model works so well that some practitioners felt it was prioritised above core service referrals.

Many practitioners for TaMHS work term time only contracts which fit in well with demand from schools. However, it sometimes means that individuals with more complex needs are delayed treatment if the end of term is approaching. Some term

time only staff follow individual cases up through the holiday but this is on an ad hoc basis. Much of the core work gets picked up during school holiday periods.

Schools using traded services tend to have a slightly higher proportion of their pupils receiving mental health services but this may be greatly influenced by the presence of "special schools." This is therefore appropriate to need. There does not appear to be a disadvantage to pupils in terms of number of service involvements between the schools that have traded services and ones that do not.

However:

- It cannot be currently determined whether the service is equitable as the need in each school is unknown.
- The availability of services within each school for the pupils concerned was not able to be reflected in the above analysis, i.e. because the school does not have traded services, it is unknown if the pupils are having to wait longer for appointments or unable to access appointments.
- There are no outcomes included in the data that was analysed and therefore the effectiveness of service was not evaluated.
- The level of mental health services in schools that do not buy in traded services may vary. For example, some may have their own counsellors.
- Traded services may not address the needs of the children who need services most.

GP services point out that the waiting times for assessment from TaMHS can be long and after assessment some children are put on a waiting list for treatment or interventions which can also be a long wait. It was acknowledged that urgent cases are fast tracked. The stakeholder consultation indicated that GPs are now slightly removed from children and young people's mental health services as much of the referral now takes place through schools and sometimes the GP is not even informed that the referral has taken place. This complexity of referral was also highlighted by the School Nurses who stated that they are not always informed when a young person is discharged from a service so they are not aware and cannot offer support within the school as follow up. It was highlighted that the Court Liaison Service is very supportive of young people but again the service is accessed through schools so GPs are not always aware of interventions undertaken.

The school nursing service reported that they work closely with the TaMHS team and in general have a good working relationship. School nurses have to complete an Early Help record prior to referral to TaMHS. TaMHS is the main referral agency used although occasionally a young person may be signposted to ON-TRAK. Very occasionally School Nurses can phone CAMHS to discuss a case but this is unusual and most referrals go through TaMHS. The School Nurses also highlighted that referrals to TaMHS can depend on good relationships between particular nurses and TaMHS workers and sometimes referrals could wait for up to four months. Referrals through the school nurses are less frequent now as schools are using traded service time. The school nurses also thought that there was a lack of knowledge and understanding regarding referral to TaMHS. They felt that some people felt that all emotional health issues need specialist mental health intervention but actually

sometimes it is “ok to feel sad” for a while. They felt that training could be offer regarding to raise awareness of what needs to be referred and what is part of natural emotional life.

The Educational Psychology Service highlighted the long waits for assessment and interventions and the inconsistency of trading between schools and TaMHS led to a patchy service and highlighted that the Pupil Referral Unit does not trade with TaMHS although their pupils have a high need.

The TaMHS team valued the limited amount of group work that was delivered particularly social skills; education and behaviour; parenting; and domestic violence group work. This was considered to be an area for potential development.

5.3 Swindon Ten to Eighteen Project (STEP)

STEP have a good working relationship with CAMHS and TaMHS and sometimes work alongside a TaMHS worker. If STEP feels that a Child or Young Person needs more mental health intervention they will refer back to the GP suggesting referral to CAMHS. However, they are more likely to receive referrals from CAMHS/TaMHS than to make referrals to them. A weekly (or monthly) report is sent on to the primary referrer and / or family.

STEP is staffed by paid workers and volunteers. The paid workers have degrees in youth work and the volunteers and assistants can work towards or have a level three qualification in youth work. Some of the paid workers have additional training in an area of interest such as sexual health, drugs and alcohol etc. Some may have done the on-line Child Psychology Education Psychology. None have more formal mental health training although this would be welcomed. STEP would also welcome more joined up working and co-ordination with TaMHS to ensure that approaches are aligned and not contradictory for the young person.

5.4 On-Trak youth counselling service

A review of On-Trak service undertaken in 2014 highlighted that the service lacked capacity to see the large and increasingly complex caseload. The service was well regarded by service users. The report made 3 recommendations:

- To address the staffing and admin capacity of the service
- To support the development of a pilot project to share triage and assessments with the TaMHS service
- Ensure that the location of On-Trak remains acceptable to young people.

LIFT Psychology described a good working relationship with ON-Trak and felt that the two services were complementary with the LIFT service providing more CBT and Solutions Focus therapies and ON-Trak taking a more person centred approach.

The TaMHS team welcomed the pilot project to integrate the ON-Trak service and align it to the TaMHS service. It was hoped that this would improve the single point of access, capacity and avoid duplication in service provision.

5.5 Other services and community assets

5.5.1 LIFT Psychology (targeted/specialist service)

LIFT reported that the 16 -18 year olds are likely to attend the Young Healthy Minds Groups but those over 18 are happy to attend the groups for adults and get good outcomes from these groups. It was felt that groups are very good vehicles for tackling common mental health conditions for young people as it gives opportunities for them to mix with their peer group and make friends.

LIFT report that various schools are interested in Mindfulness which is a good way to provide opportunities for both genders to engage with techniques to regulate emotion and manage anger. This may be more accessible to boys and young men who do not choose to access talking therapies. There could also be opportunities to develop anger management courses to enable young men to access mental health services and address the gender gap. It was felt that this could be done in conjunction with ON-Trak and YOT and that more opportunities for young people to attend groups rather than individual counselling may give opportunities for the young people to mix with their own peer group rather than focusing on 1-1 counselling with an adult. Off the Record in Bristol provides more group sessions and peer to peer support.

LIFT run two eating disorder groups. One focuses on preparation to engage in treatment and the second focuses on techniques to address eating disorders. LIFT felt that there was an opportunity to do more work in schools with regard to eating disorders and focus not just on anorexia and bulimia but also on over eating.

In the past LIFT has been involved in the development and running of themed workshops in colleges. These include workshops on bereavement, self-harm, eating disorders, exam stress, panic, drugs and alcohol. The workshops were well received and normalised some feelings that individual students all experienced.

5.5.2 Mediation Plus: 5-18 counselling service

Funding for this service is through CLASSP which gets its funding from the national lottery. This funding ended at the end of March 2015. Currently the service is seeking more funding. In the past this service has gone in to schools to provide services to primary care children but all services are now delivered from Milton Road. Older children prefer to access the service out of school. Evaluation of the service is undertaken through parents and young people and is both quantitative and qualitative. Qualitative evaluation is very positive. This service is now no longer active in Swindon. This could leave a gap in service or put additional demand onto existing services. It also reduces further the involvement of the third sector in meeting the mental health needs of children in Swindon.

5.5.3 NSPCC Letting the future in

The Letting The Future In Project has been running for two years in Swindon as part of a fully evaluated project. The evaluation is being undertaken by Durham and Manchester Universities. Evaluation of effectiveness is undertaken using the Trauma symptom checklist. As the project is being formally evaluated using a randomised control trial this has had an impact on waiting lists in the past. However, at present there is no waiting list for the service.

5.5.4 PASH at Mind (Preservation Around Self Harm)

PASH offers a wide range of information, advice and guidance about self-harm. They also provide I – 1 support and counselling face to face or by telephone for those over 16 years of age who self-harm.

5.6 Services for vulnerable groups - viewpoint

5.6.1 Children in care

The Children in Care Team reported that for those children who meet the threshold the service provided by the CAMH Service was good. However, the team were not always able to access the service for all their children particularly if the referral comes from the social work team when a child is in crisis. At present, the Designated Nurse meets with the CAMHS and TaMHS team to discuss and review cases of CIC and these services will allow some fast tracking access from the Designated Nurse. Often for children who are not stable in their placement access to CAMHS is problematic as therapeutic interventions cannot be undertaken until the child is stable. Some progress has been made regarding partnership working to ensure the needs of CIC are met. However, more needs to be done with regard to information sharing, and offering support to those to ensure placements are settled before therapeutic work can begin.

GPs point out that they are not always aware that a child presenting is a Looked After Child so are unable to ensure that appropriate additional, support is available or highlight this to CAMHS.

A placement support service provided by CAMHS was in place and provided a good service to improve placement stability and work with foster parents to develop skills to support children in their care and begin some therapeutic interventions to aid stabilisation. This service was highly valued by the Designated Nurse but was lost when the service was re-commissioned. Since the Designated Nurse highlighted in her annual report that the introduction of the complex case consultation model has led to delays in children and young people in care accessing support there has been an increase in the number of available sessions. The Designated Nurse is now monitoring the waiting times between referral and the complex case consultation and also internal waiting times for services such as psychotherapy. CAMHS also raised concerns about changes to the children in care team.

The OSCA CAMHS outreach team works with children, some of which are children in care who require an extra layer of support to access services. Many have parents who have mental health problems and have a negative association with mental health services. This service works well but does not take the place of the Placement Support Service.

Another gap in the service is lower level mental health and wellbeing support and early intervention. Some other areas have specific mental health and wellbeing services for children in care but in Swindon this is not easily accessible. The TaMHS service is very school orientated and based on traded services so if the school in question does not purchase the traded service from TaMHS there sometimes is no targeted support available. Currently the children in care team do not link particularly to ON-Trak but do sometimes refer to NSPCC particularly if they have a child who has experienced sexual abuse.

Children in care have high rates of self-harm and foster parents often find this very difficult to cope with and can lead to placement breakdown. GWH do inform the Designated Nurse about all admissions for children in care. More support for foster carers on self-harm and other common mental health problems, e.g. attachment is required.

Current plans to reorganise children's services will mean that there is no specific children in care team and the team is spread throughout four localities. This could mean fewer liaisons between the designated nurse and the social work team.

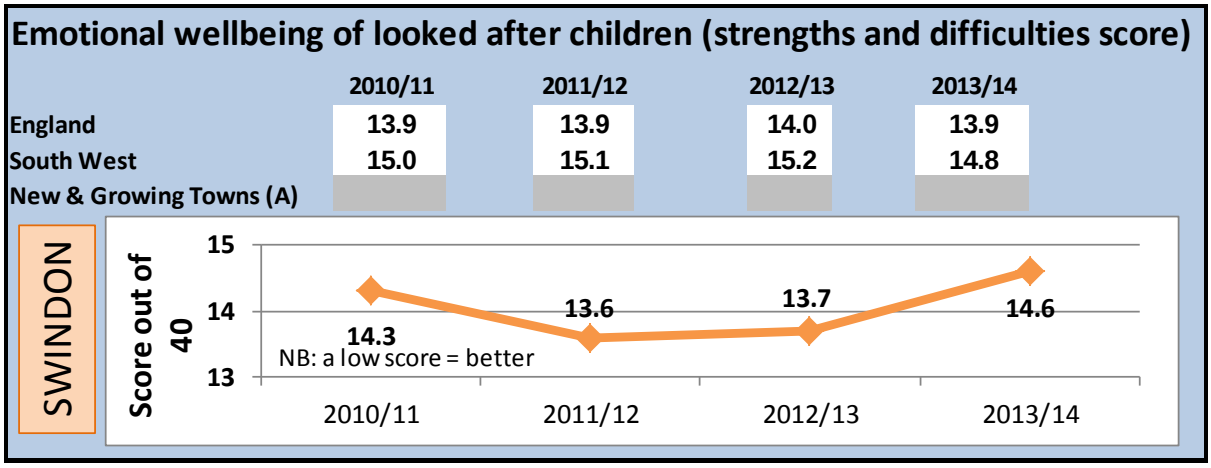
The Care Quality Commission inspection which took place in February 2014 made some recommendations for mental health service provision. These included:

- That children and young people including those who are looked after have timely access to CAMHS early help and specialist services.
- That the pilot complex case consultations are held sufficiently frequently to avoid delays in young people accessing appropriate services and are subject to effective evaluation to determine impact.
- Where looked after children are engaged with CAMHS, progress reports are submitted to the looked after children's health team as requested.

Mental health difficulties for children in care aged 4 -17 years, are monitored nationally using the Strengths and Difficulties Questionnaire (SDQ) to screen for mental health and emotional wellbeing levels. (The lower the score the less likely that the child is suffering from mental health or emotional problems. Score 0 -13 low need, 14 -16 borderline, and 17 – 40 high need.) 91% of those eligible for the assessment had received one which was higher than the national average of 71%. However, there was an increase in the average score from 13.7 in 2012/13 to 14.6 in 2013/14. The average

score nationally is 13.9 and in the South West it is 14.8[31]. This would indicate that children and young people in care have higher levels of poor mental health and emotional wellbeing in Swindon.

In addition there had also been an increase in the number of children in care in Swindon who had a high SDQ score (i.e. above 17) from 41% in 2013/14 to 46% in 2013/14. Of those with a high SDQ score only 49% were open to CAMHS or were in a specialist placement which included therapy. Further work has been undertaken to ascertain how the mental health needs of those not open to CAMHS or specialist placement were being met[32].



5.6.2 Counselling provision for under 16s though Sexual Assault Referral Centre (SARC)

During 2013 it was highlighted that those under 16 years of age who had experiences sexual assault did not have access to a specialist counselling service. A counselling service for those over 16 years of age through SARC was available from LIFT psychology. Waiting times for children and young people primary and secondary care counselling services were long and young people who had experienced sexual assault did not necessarily meet the referral criteria set by CAMHS.

In March 2014 a pilot project was started at SARC, to provide counselling services to those age 13 -16 years of age. During 2014/15, the counsellor has worked

[31] Swindon Joint Health and Wellbeing Strategy update report 2015 (Public Health Outcomes Framework indicator 2.08)

[32] Annual report – Health and Wellbeing and mental health of children and young people in Care. March 2013 – April 2014. SBC

intensively with 6 children with positive outcomes and funding has been extended until 2016 while service secures longer term funding. This will include application to charities but also discussions with NHS England who commissions Sexual Health Referral Centre Services which includes adult counselling services.

5.6.3 Perinatal mental health services for those under 18.

Perinatal mental health is outside of the scope of this needs assessment and will be covered in the Best Start needs assessment. However, it should be highlighted here that considerable work has taken place over the last year to develop pathways, improve services and role descriptions with regard to co-ordinating peri-natal mental health services locally. There has been considerable focus on those over 18 years of age during this process but it has been highlighted that the risk of depression is almost twice as high amongst teenage mothers. Consultation undertaken as part of the development of the Swindon Integrated Perinatal Mental Health pathway has identified that teenage mothers have specific needs related to perinatal mental health. This is in part because they are not eligible for adult mental health services until they reach the age of 18. It is likely that a specific mental health pathway will be needed for this group.

5.6.4 Support for children and young people who are bereaved

Currently Cruse does not provide a local service for children who are affected by bereavement. However, Swindon Cruse Bereavement care has merged with branches in Bath and Salisbury and is looking to expand the services currently offered which may include a service for children and young people. There is a new project called TreeTops which is about to be launched to provide a bereavement service to Children and Young People.

5.7 Mental health in schools

A full review of mental health and wellbeing was undertaken in schools in Swindon by the Health School Co-Ordinator. The review was to ascertain from school staff their confidence in identifying and supporting mental and emotional health and wellbeing, identifying the external agencies schools are working with and identifying gaps in knowledge, support or capacity.

A short survey was developed and distributed to primary and secondary schools in Swindon and of the 80 schools in Swindon, 48 completed the survey. This was a completion rate of 60%. The key findings are summarised below. The full report can obtained on request from jsna@swindon.gov.uk.

General awareness of mental and emotional health and wellbeing:

- 75% of schools responding reported that they had designated member of staff responsible for mental health and wellbeing and 69% said they had a co-ordinated approached to raising awareness of mental and emotional wellbeing. 61% of schools thought that their students had an awareness of mental and emotional health and wellbeing.

- Schools use a range of strategies to raise awareness including
  - Discrete lessons as part of PSHE
  - Use of SEAL or equivalent curriculum
  - Assemblies
  - Lessons in other curriculum areas.

- Bullying (100%) and self-esteem, resilience, anxiety and healthy relationships (90%+) were the most universally delivered topics. Other topics covered included: self-harm, eating disorders and general mental health awareness. These topics were mainly covered in Secondary schools.

Identifying children and young people with mental and/or emotional health needs:

- 100% of schools were confident that teachers and tutors were able to identify students with mental and/or emotional health needs and 97% of schools also reported that parents often identified these issues. 17 Schools (or 35%) also reported that other students and peers also highlighted concerns about their peers to staff. However, when asked if staff in schools were trained to identify students with mental and /or emotional health needs only 46% felt that staff were sufficiently trained and the majority (56%) reported that they were not.

Strategies used to support children and young people:

- These included group and individual support by trained staff, the use of nurture rooms, and the use of school counsellors. Other strategies mentioned included: TaMHS, Parent support advisers, Behavioural, emotional and social difficulties outreach, use of Pets as Therapy (PAT) dog and ALERT[33] programmes.

- However, only 42% of schools reported that staff were sufficiently trained to support such students and 58% said that they were not.

- The majority (98%) reported that they referred children and young people to external services and many referred to school counsellors (51%) or trained staff in school (69%).

[33] https://www.alertprogram.com/

Training requirements:

- Schools reported that the large majority (83%) of staff training on mental health was provided by an external training course. INSET had been used by 54% of schools to deliver training with on-line courses and subscriptions to agencies playing a minor role. Respondents overwhelmingly agreed that staff would benefit from additional training. This question also stimulated most comments:

- With regard to external agencies a range of organisations were mentioned. 98% of the schools who responded were engaged with TaMHS, 96% with the Educational Psychology service and 64% mentioned CAMHS. Half of respondents had referred students to their GP. Other agencies mentioned included: STEP; young carers; NSPCC, Family therapists and Parent Support Advisors.

Accessibility:

- Most schools reported that there was no difference in accessibility between the genders or different ethnic groups. In general, they reported that children in care and young carers tended to have their needs escalated more quickly and the majority of schools had specific pathways in place. However, a few schools commented on having little experience of this area.

- Communication links between schools, parents and TaMHS were widely reported as being “good” or “usually good”. However, communications, with CAMHS were far poorer with only 30% reporting they felt these communications were good. The communication between schools and GPs fared worst with only 15% of schools reporting these as good.

What works well?

- When asked what works well with regard to mental health and wellbeing many schools mentioned a co-ordinated approach with external agencies and families; the buying in of TaMHS and staff awareness and good communication.

What could be improved?

- The answers to this question fell into three main categories. The first and most mentioned category was:

    1. The need to improve access to and communication with mental health services:

        - Quicker referrals, more capacity within services and better access to CAMHS
        - Improved pathways into CAMHS/TaMHS, improved joint working and the need for regular updates from external agencies. A school also mentioned that the multi-agency approach created gaps in the system.

    2. Schools wanted to see additional funding for mental health and wellbeing.

    3. The third category related to the need to raise awareness of mental health issues either to promote an open culture of mental health, improve training for staff or provide information for parents on what was available.

- Schools also mentioned the need to improve communication between schools, GPs and Community Paediatric teams.

Focus group:

- In addition to the survey a focus group of Personal and Social Health Education (PSHE) leads was held. Findings from the focus group included:

    - Staff felt that mental and emotional health problems were increasing. They mentioned self-harm as a specific issue.
    - They had concerns about body image issues and pornography.
    - Teachers felt ill prepared and under-trained to support students particularly within the time available during the school day.
    - Most schools had a school counsellor and staff generally knew where to signpost students to.
    - PSHE leads had a difference of views on school nurses as a resource. Some said they would refer to the schools nurse and others were unaware of their school nurse service and what the role was.

- PSHE leads had a lack of awareness of the TaMHS or CAMHS referral pathways or their work and in general were not particularly well informed about mental and emotional health unless they had a personal interest.

Special schools:

- In general, the special schools reported better experience of mental health and well-being within the school compared to mainstream schools. On the whole, they felt well trained and supported; they had good relationships with external agencies including community disability teams, school nurses and other external professionals. They did acknowledge the need for additional resources.

Conclusions from the school review.

- A number of themes emerged from the review, most notable of which was the desire for more training to help enable staff in schools gaining knowledge and confidence to support children and young people with mental and emotional health and wellbeing. This included schools where good practice is already in place as they acknowledge the need to update their knowledge and skills and the need to be able to signpost of external agencies.

- Schools generally had a better relationship with TaMHS than CAMHS which is probably not surprising as TaMHS actively promotes traded services with schools. However, schools did have concerns about the need to improve access, communication and waiting times to mental health services; to develop better pathways between services and improve capacity within the services. They had concerns that the multi-agency approach could create gaps in the system. Schools highlighted the perceived increase in demand for mental health and emotional wellbeing support and limited funding for this.

- The promotion of resources both local and on line for schools, parents and professionals would also be welcomed. These need to be at both a universal and targeted level. These could include national and local resources, sharing of good practice and access to on-line resources. Schools highlighted the need to share best practice.

- Finally, it was recognised that bullying can be a key trigger leading to poor mental health. Much good work has taken place in Swindon over recent years and it was acknowledged that this should remain a strong focus within schools.

5.7.1 Hospital School and Home Education

- There is a hospital school and Home Education service in Swindon providing education to those unable to attend school due to health conditions. The service is provided for 5 – 18 year olds during term time. This service does

provide support to those with mental health problems either on the ward possibly following an admission for self-harm or at home for those who are unable to attend school. The service has seen an increase in the number of children they see following an episode of self-harm.

6. Transition from CAMHS to adult mental health services

The national Joint Commissioning Panel for Mental Health[34] highlights the challenges facing young people aged 16 -18 and their vulnerability. This is a period that young people go through psychological change and can be transitioning not only between CAMHS and AMHS but also in education and other areas in their lives. The report highlights the importance of a joined up and flexible transition service which addresses structural and procedural difficulties arising from cultural differences between Child and adult services. They point out that effective commissioning of transition services should lead to reduced numbers of young people lost to services at this critical time and reduce periods of untreated illness and poor outcomes. Transition plans should include the needs of young people with mental health problems, whose needs are primarily met within education, social care and non-statutory agencies and should also include services for children in out of area placements.

Evidence that young people often struggle to move between services, and in particular that they are poorly supported when they are referred by CAMHS to AMHS, has been highlighted in a number of government reports and policy guidance.[35,36,37.] The current National Mental Health Strategy[4] states that service transition from CAMHS to adult services can be improved by planning early, listening to young people, providing appropriate and accessible information and focusing on outcomes and joint commissioning.

[34] http://www.jcpmh.info/wp-content/uploads/jcpmh-CAMHStransitions-guide.pdf

[35] Department of Health (DH) (2004) 'Report on the implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services', London: DH.

[36] Department for Children, Schools and Families (DCSF)/Department of Health (DH) (2008) 'Children and young people in mind: the final report of the National CAMHS Review', London: DCSF/DH.

[37] National Advisory Council for Children's Mental Health and Psychological Wellbeing (2010) 'One Year On', London: DH/DCSF.

SCIE[38] have produced 10 top principles for mental health service transitions for young people. These include:

1) The young person, family and carers, where appropriate and with the young person's consent should be fully involved and the process should be transparent.
2) Planning should begin as early as possible and at least six months prior to discharge from CAMHS.
3) Referral should be to age-appropriate and accessible services. Not all young people will transfer to adult mental health services and may need additional or alternative support – non-health settings, voluntary sector, and primary care.
4) The wider context of young people's lives should be taken into account to contribute to improving their mental health.
5) Collaborative working between professionals and agencies to provide co-ordinated and joined-up care.
6) Make service transition a flexible, managed process, with planning and assessments, continuity of care and follow-up. A period of shared or parallel care is good practice.

Swindon

In 2012/13, 424 clients aged 17 or over, were discharged from TaMHS, in 2013/14 it was 354 and in 2014/15, 211. It's not recorded whether these young people were transferred to adult services or referred to LIFT.

There is recognition between both commissioners and providers that improvements can be made to the transition process between CAMHS and AMHS. For many young people, transfer from CAMHS to AMHS may not be appropriate but there should be a planned discharge and alternative support mechanism put in place. Consultation with GPs also highlights concerns about the transitions process with reports of children and young people receiving holistic support from CAMHS and then discharged back to primary care. Sometimes these patients will require re-referral to adult mental health services. There may be a role for LIFT Psychology to provide support as they are commissioned to provide interventions from 16 years of age. The opt in ethos of LIFT may be an issue for some young people but including LIFT in CAMHS Transition meetings would be beneficial even though at present these follow a Care Programme Approach which LIFT does not adopt.

Work has begun on assessing the current position of CAMHS and AMHS transition processes. A self-assessment process has highlighted the need to:

[38] http://www.scie.org.uk/publications/guides/guide44/introduction/toptenprinciples.asp

- Review the current transitions policy and operational policies which would include a focus on meeting the needs of children and young people and their carers and involving them in decision making about their care. Services need to demonstrate flexibility in referral criteria in order to meet these needs and commissioners need work together to ensure funding follows the patient.

- Identify Transition champions in CAMHS and AMHS services. These should be identified all levels of the relevant organisations with protected time to review cases and attend and contribute to a local transitions forum or network.

- Ensure information is available for young people and their families/carers on transition, including the transition lead in relevant agencies. The young person and their family/carer, where appropriate, should have a copy of their care plan and a meeting to go through the plan and when, how and who to ask for help once they have left CAMHS. Information should also be available to clinicians on relevant local resources that may offer support to a young person.

- Develop an audit process to ensure services are meeting the transition needs of young people. This audit process will assess services against the protocol standards and should include the needs of specific care groups. The results of the audit should be shared at Board level in both the provider and commissioning organisations.

- Ensure data systems are in place to ensure the safe transfer of data between services. Services should specify and ensure the appropriate transfer of information between agencies. This should include case notes, referral letters and risk assessments. Report should be in place to monitor outcomes for young people with on-going needs at the point of transition and for those who remain in CAMHS post 18 year of age or those in AMHS below the age of 18 year.

- Provide joint training programmes between CAMHS and AMHS to promote a better understanding of roles and remits within services. Training should be available for AMHS staff in adolescent development, models of working with young people, family therapy and neurodevelopmental disorders particularly Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder.

- Develop an alternative care pathway for those who do not meet the adult mental health threshold. This should include multi-agency involvement in the development of the pathway and policies with support for non-AMHS providers and the third sector.

Particular account should be taken of those transitioning from the CAMHS Early Intervention Service due to reaching the age of 18 years. The needs of these patients need to be addressed with transition to adult services.

Much work is being undertaken in Swindon on developing perinatal mental health pathways and multi-agency roles. The needs of mothers under the age of 18 years, need to be taken into consideration to ensure that those who do become pregnant and need mental health interventions receive these from the most appropriate provider.

7. Evidence of effectiveness and cost effectiveness - What is best practice?

7.1 NICE Guidance

NICE have produced Guidance on a range of topics relating to Mental Health and Wellbeing. These are summarised below.

7.1.1 Looked-after Children and Young People October (2010) PH28

This guidance aims to improve the quality of life (this, the physical health, social, educational and emotional wellbeing) of looked after children and young people. The guidance recommends that there are dedicated services to promote the mental health and emotional wellbeing of children and young people in care or moving to independent living. It goes on to state that "evidence suggests that early intervention to promote mental health and welling can prevention the escalation of challenging behaviours and reduce the risk of placement breakdown. Flexible and accessible mental health services are needed that offer skilled interventions to looked-after children and young people and their carers. These services should have the capacity and expertise to work with black and minority ethnic children and unaccompanied asylum-seeking children and young people who have particular needs."

Quality Standard for the health and wellbeing of looked-after children and young people (QS31 April 2013)

Some looked after children and young people have positive experiences in the care system and achieve good outcomes. However, looked after children are more likely to experienced deprivation and poverty, abuse or neglect. About 60% of children and young people who are looked after in England are reported to have emotional and mental health problems.

The eight quality standards are:

1) Looked-after children and young people experience warm, nurturing care.

2) Looked after children and young people receive care from services and professionals that work collaboratively

3) Looked-after children and young people live in stable placements that take about of their needs and preferences

4) Looked-after children and young people have on-going opportunities to explore and make sense of their identity and relationships.

5) Looked-after children and young people receive specialist and dedicated services within agreed timescales.

6) Looked-after children and young people who move across local authority or health boundaries continue to receive the services they need.

7) Looked-after children and young people are supported to fulfil their potential

8) Care leavers move to independence at their own pace.

All these standards contribute to the emotional and mental wellbeing of those being looked after but number 5 particularly highlights the need to ensure that local arrangements are in place for case management and treatment to continue for looked-after young people moving from children to adult mental health services, until a handover with an assessment and completed care plan has been developed with adult services.

NSPCC impact and evidence[39]

This review found that there is evidence that many of the children who are in care do better if they remain there and are not returned home.

7.1.2 Smoking, obesity, alcohol and immunisations

Smoking Cessation in secondary care: acute, maternity and mental health services. PH guidance 48 November 2013

Smoking prevalence is particularly high among people with mental health problems, and has changed little in this group in the past 20 years. Smoking is twice as common among people with mental disorders and more so in those with more severe disease. A third of all cigarettes smoked in England are smoked by people with a mental health disorder. Most of the reduction in life expectancy among people with serious mental illness is attributable to smoking [40].

[39] What works in prevention and treating poor mental health in looked after children? Nikki Luke, Ian Sinclair Matt Woolgar and Judy Sebba August 2014. NSPCC

[40] Royal College of Physicians, Royal College of Psychiatrists. Smoking and mental London RCP, 2013 Royal College of Psychiatrist Council Report CR178.

PH Guidance 48 outlines robust guidance and recommendations for smoking cessation in mental health settings including CAMHS. It includes the need to develop and communicate smoke free policies including the need to provide written and verbal information about these policies to those who may need to attend services. Services need to be able to identify people who smoke and offer help and advice for them, their carers, family and household members to stop smoking. There needs to be referral pathways between mental health services and stop smoking services and mental health settings should also provide training to front line staff in stop smoking. Hospital settings need to identify and clinical or medical director lead for stop smoking and provide intensive stop smoking support for people using acute service and stock Varenicline, Bupropion and a range of licenced nicotine-containing products. In addition services should be aware of the need to adjust dosages for people who have stopped smoking and ensure that people who are using drugs that are affected by smoking (stopping smoking) are monitored and dosages adjusted if appropriate. All staff should be offered support to stop smoking.

Managing overweight and obesity among children and young people: lifestyle weight management services PH 47 October 2013.

In 2011 in England, around 3 out of 10 boys and girls aged 2 to 15 years were either overweight or obese. The proportion of those who are overweight has remained largely unchanged since the mid-1990s. In the 2011/2012 school year, around 23% of children in reception and 34% in year 6 were either overweight or obese. Around 9.5% and 19%, respectively, were obese.

In addition, there is evidence that childhood obesity impacts on self-esteem and quality of life (Griffiths et al. 2010). In adolescence, it has been associated with depression (Sjoberg et al. 2005). Overweight and obese children are likely to experience bullying and stigma (Griffiths et al. 2006) which can also impact on their self-esteem.

Recommendation 4 in this guidance refers to the need to enable the identification of children and young people whose mental wellbeing is being affected by their weight. For example, whether there are any signs of psychological distress, depression, bulimia, self-harming or other mental health problems related to their weight. Weight management services need to be able to refer the child or young person to their GP for assessment and treatment and if appropriate for onward referral to CAMHS. Weight management programmes need to take in to account the child or young person's self-esteem, self-perception and any previous attempts to manage their weight. Provide opportunities in either a group or one-to-one session, for them to talk about any victimisation or distress if they wish. (This includes any history of bullying or teasing).

NICE Guidelines: Interventions to reduce substance misuse among vulnerable young people PH4 (2007)

This guidance points out that vulnerable and disadvantaged children and young people aged under 25 who are at risk of misusing substances include those with behavioural, mental or social problems. It is important that it is recognised that those

with mental and emotional health problems including low self-esteem and depression are more at risk of misusing substances. There is no strong evidence on effective interventions to prevent substance misuse in children and young people with mental health problems but this group was seen as a priority for further research.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Nice Clinical Guidance 115.

This guideline is aimed at adults and children and young people aged 10 -17. There is recognition within the guideline that there are often co-morbidities between alcohol misuse and mental health problems. The Guideline states:

- "For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder[3]. "

Special consideration should be given to children and young people who misuse alcohol and all children and young people aged 10 – 15 years should be referred to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs, if their alcohol misuse is associated with physical, psychological, educational and social problems and/or comorbid drug misuse.

When considering referral to CAMHS for young people aged 16–17 years who misuse alcohol, use the same referral criteria as for adults (see section 1.2.2 of the guidance).

Reducing differences in the uptake of immunisations PH Guidance 21

This guidance is about improving uptake of childhood immunisations and improving the uptake in children who are less likely to start and complete their immunisation programme. Recommendation 5 is to target groups at risk of not being fully immunised and includes a recommendation that nurses working in child and adolescent mental health services, young offender institutions and secure units have a role to play in enabling those in their care to access immunisations.

7.1.3 Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively PH 50 February 2014

Domestic violence and abuse cost the UK an estimated £15.7 billion in 2008[41]. At least 29.9% of women and 17% of men in England and Wales have, at some point,

[41] Walby 2009 in NICE public health guidance 50

experienced domestic violence.[42] Domestic violence impacts on children and young people on various levels. It should be remembered that the risk of experiencing domestic violence or abuse is increased in women aged 16 -24 years and men aged 16 -19 years[42] and those with a mental health problem[43]. Domestic violence rates are particularly high between transgender people (80%)[44] and bisexual, gay and lesbian people (38.4%)[45]. Partner violence is also prevalent in young people's relationships. In the UK in 2009, 72% of girls and 51% of boys aged 13 -16 reported experiencing emotional violence in an intimate partner relationship. 31% of girls and 16% of boys reported sexual violence and 25 % of girls and 18% of boys experienced physical violence[46] Young people in same sex relationships were at greater risk than those in heterosexual relationships.

Domestic violence and abuse between parents is the most frequently reported form of trauma for children[46]. In the UK 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse during their childhood. Around 3% of those aged under 17 reported exposure to it in the past 12 months[47]

The impact of living in a household where there is a regime of intimidation, control and violence differs by children's development age. However, whatever their age, it has an impact on their mental, emotional and psychological heath and their social and education development. It also affects their likelihood of experiencing or becoming a perpetrator of domestic violence and abuse as an adult and well as exposing them directly to physical harm.[48]

The Programme Development Group (PGD) for this guidance recognised the negative impact that domestic violence and abuse can have on children and young people and that the provision of effective intervention and support may reduce the likelihood of them ben affected by or perpetration of domestic violence and abuse in adulthood. The PGD noted the importance of working concurrently with both the non-abusive parent or carer and child, rather than just focusing on the parent. The PGD also recognised that services need to make provision for support to all family types and that evaluation of interventions is important to build evidence of effectiveness. The PGD also noted the importance of ensuring that services are appropriate to the age, gender and developmental stage of the children of young person. For example teenagers may not want to be seen at the same time as their non-abusive parent or carer.

[42] Smith et al 2012 in NICE public health guidance 50.

[43] Teveillion et al 2012 in NICE public Health guidance 50.

[44] Roch et al.2010 in NICE Public Health guidance 50.

[45] Donovan et al 2006 in NICE Public Health guidance 50

[46] Meltzer et al 2009 in NICE Public Health Guidance 50

[47] Radford et al 2011 in NICE Public Health Guidance 50.

[48] Stanley 2011; Holt et al 2008 in NICE Public Health Guidance 50

The Public Health Guidance provides 17 recommendations but the two most relevant to children and young people are:

Recommendation 10: identify and, where necessary, refer children and young people affected by domestic violence and abuse. This highlights the need for safeguarding policies and outlines the need for services:

- to ensure that staff can recognise the indictors of domestic violence and abuse and understand how it affects children and young people.
- Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly. The violence and abuse may be happening in their own intimate relationships or among adults they know or live with.
- Put clear information-sharing protocols in place to ensure staff gather and share information and have a clear picture of the child or young person's circumstances, risks and needs.
- Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse.
- Ensure staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether or not a referral would be appropriate.
- Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.
- Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse.
- Monitor these policies and services with regard to children's and young people's needs.

Recommendation 11 Provide specialist domestic violence and abuse services for children and young people

Those responsible for safeguarding children, and commissioners and providers of specialist services for children and young people affected by domestic violence and abuse should:

- Address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety. This includes the wider educational, behavioural and social effects.

- Provide a coordinated package of care and support that takes individual preferences and needs into account.
- Ensure the support matches the child's developmental stage (for example, infant, pre-adolescent or adolescent). Interventions should be timely and should continue over a long enough period to achieve lasting effects. Recognise that long-term interventions are more effective.
- Provide interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer. This may involve individual or group sessions, or both. The sessions should include advocacy, therapy and other support that addresses the impact of domestic violence and abuse on parenting. Sessions should be delivered to children and their non-abusive parent or carer in parallel, or together.
- Provide support and services for children and young people experiencing domestic violence and abuse in their own intimate relationships.

7.2 NICE Guidance relating to mental health conditions

There are several pieces of NICE clinical guidelines and quality statements relating to conditions covered by this needs assessment. These include:

Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care NICE Guidelines CG 38 2006

Psychosis and schizophrenia in children and young people: Recognition and management CG 155 January 2013

Depression in children and young people Clinical Guidelines 28 September 2005 and Quality Standard 48 September 2013.

Borderline Personality Disorder Clinical Guidelines 78 January 2009

Psychosis and co-existing substance misuse Clinical Guidelines 120 March 2011

Self-harm and long term management Clinical Guidelines 133 November 2011

Antisocial behaviour and conduct disorders in children and young people – recognition, intervention and management Clinical Guidelines 158 March 2013 and Quality Standards 59 April 2014

Social anxiety disorder, recognition, assessment and treatment. Clinical guidelines 159 May 2013

Social and Emotional wellbeing in Secondary Education Public Health Guidance 20 September 2009

This guidance is for those who have a direct or indirect role in and responsibility for, the social and emotional wellbeing of young people in secondary education. This will include Children and Adolescent Mental Health Services. This is important because

good social, emotional and psychological health helps protect young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol[49, 50 , 51]. It can also help them to learn and achieve academically, thus affecting their long-term social and economic wellbeing. This guidance is aimed at an organisational, universal approach to help promotion the Social and emotional health of young people but also aims to provide additional support for those at risk (or already showing signs) of problems

The recommendations include the need to develop an organisation-wide, strategic framework to promote social and emotional wellbeing. This will include the need to ensure secondary education establishments have access to the specialist skills, advice and support they require. This may include child and adolescent mental health services. Secondary education establishments have a way to systematically assess the social and emotional wellbeing of their pupils and be able to access specialist services so problems can be addressed as soon as they occur. The curriculum within secondary educational establishments should promote positive behaviours and successful relationships that help reduce disruptive behaviour and bullying. Those working in (and with) education and children's and youth services, including CAMHS should work in partnership with young people, carers, and other family members to promote young people's social and emotional wellbeing. All practitioners should ensure their training and continuing professional development includes an understanding of social and emotional wellbeing and the skills needed to develop it in young people.

The scope of this needs assessment does not include Autism or ADHD. However, there are several pieces of NICE guidance and quality standards that refer to these conditions and outline the significant role that Child and Adolescent Mental Health Services have in provision of services for individuals who have these conditions and their families. The guidance includes:

Autism: the management and support of children and young people on the autistic spectrum disorder Clinical Guidance 170 August 2013

Autism: recognition, referral and diagnosis of children and young people on the autism spectrum (NICE clinical guideline 128)

Autism: recognition, referral, diagnosis and management of adults on the autism spectrum (NICE clinical guideline 142).

Attention Deficit Hyperactivity disorder and Clinical Guidelines 72 September 2008 Quality Standards 39 July 2013

7.3 Good practice in prevention in schools

[49] Adi et al 2007 in NICE Public Health Guidance 20, September 2009

[50] Colman et al. 2009 In NICE Public Health Guidance 20, September 2009

[51] Graham and Power 2003 in NICE Public Health Guidance 20, September 2009

In order to help prevent significant mental ill-health and promotion good emotional health there are some key skills that can improve the resilience of children and young people. These include the need to develop good communication and problem solving skills and also promoting the ability to seek help. Young Minds have produced excellent resources regarding the building of resilience and academic resilience[52].

In March 2015 two reports from the Department for Education were released. The first entitled Counselling in Schools: a blue print for the future[53] is non-statutory advice to help school leaders set up and improve counselling services in primary and secondary schools. The report recognises that effective counselling is part of a whole schools approach to mental health and wellbeing. The report states that it is Department for Educations strong expectation that over time all schools should make counselling service available to their pupils and that this should be done in context to a whole schools approach to improving mental health and wellbeing. This should include: improving wellbeing and resilience; raising awareness of a mental health issues through the curriculum; promoting staff health wellbeing; reducing stigma around mental health; interaction with the pastoral system and the importance of the leadership role. The guidance is evidenced-based and schools should be encouraged to review their current counselling provision in line with the guidance.

The second piece of guidance produced in March 2015, from the Department for Education, is entitled "Mental health and behaviour in schools".[54] This non-statutory advice outlines what schools can do and how to support a child or young person whose behaviour may be related to an unmet mental health need. The advice recognises that 1 in 10 children and young people aged 5 – 16 have a clinically diagnosed mental health problem and 1 in 7 has less severe problems. The advice and practical tools that DfE have developed will help schools promote positive mental health in their pupils and identify and address those with less severe problems at an early stage and build their resilience. It will also help schools to identify and support those with more severe needs and help them refer appropriately to specialist agencies such as CAMHS.

The key points of the guidance are:

- In order to help their pupils succeed, schools have a role to play in support them to be resilient and mentally healthy

[52] http://www.youngminds.org.uk/training_services/young_minds_in_schools/wellbeing/risk_and_resilience

http://www.youngminds.org.uk/training_services/academic_resilience

[53] Department for Education Counselling in schools: a blueprint for the future. Departmental advice for school leaders and counsellors (March 2015).

[54] Department for Eduction Mental health and behaviour in schools – Departmental advice for school staff March 2015.

- Where severe problems occur schools should expect the child to get support elsewhere as well
- Schools should ensure that pupils and their families participate as fully as possible in decisions
- Schools can use the Strengths and Difficulties Questionnaire to help them judge whether individual pupils might be suffering from a diagnosable mental health problem
- There are resources available to help school staff support good mental health and emotion wellbeing
- Schools should consider if their pupils would benefit from the offer of schools counselling services.
- There are things that schools can do - including for all their pupils, for hose showing early signs of problems and for families exposed to several risk factors – to intervene early and strengthen resilience.
- Schools can influence the health services that are commissioned locally through their local Health and Wellbeing Board
- There are national organisations offering materials, health and advice to help schools promote mental health and intervene early to support pupils experiencing difficulties.

Schools could be supported by Healthy Schools to implement this guidance.

7.4 Good practice in transition

In January 2015 a suite of documents were produced by NHS England giving guidance to commissioners and providers on models of transfer of and discharge from Care Protocol for young people with mental health problems in transition from CAMHS. This included a NHS Standard Contract sample protocol and Model Service Specification.

The Joint Commissioning Panel for Mental Health has also produced guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services. http://www.jcpmh.info/wp-content/uploads/jcpmh-CAMHStransitions-guide.pdf

7.5 Economic case for tackling mental health problems in children and young people

The follow information has been taken from the Centre for Mental Health Report[55] cited in the governmental report Future in Mind[2]

In 2012/13 NHS expenditure on child and adolescent mental health disorders was estimated to be £700 million or 6% of the total spend on mental health. Between 2006/7 and 2012/13, the proportion of mental health spending on children and young people has fallen compared to adults.

There is increasing evidence regarding the costs of the four most common mental health conditions: Conduct disorders; anxiety; depression and hyperkinetic disorders. A review by the Centre for Mental Health[8] showed that for all these conditions there are interventions that are not only effective in improving outcomes but also good value for money. The measureable benefits mainly take the form of savings in future spending on health and other public services and increases in future earnings. The report highlights that these benefits are over and above the more tangible benefits of improved wellbeing and quality of life that are the fundamental justification of investment in children's mental health.

7.5.1 Conduct disorder

There is good evidence that, if well implemented, a number of interventions can improve the outcomes of children with early behavioural problems. It has been estimated that children with early conduct disorder are 10 times more costly to the public sector by the age of 28 than other children[56] and impose lifetime costs on society as a whole of around £260,000 per child[57]. These very high, long-term costs imply that only a small improvement in outcome is need to support a value for money case for intervention. A range of programmes also demonstrate positive effected on adolescent conduct problems but interventions for this age group tend to be more complex and resource intensive than for younger children. Even though the interventions for adolescent children are more intensive and expensive to deliver than earlier intervention these programmes continue to represent good value, with an average return of around £13 for every £1 invested. The report sums up that overall, the interventions for conduct disorder represent excellent value for money, with the cost of intervention being very low relative to the potential benefits.

[55] Kahn, L, Parsonage M and Stubs J Investing in Children's mental health A review of the evidence on the costs and benefits of increased service provision (2014) Centre for Mental Health.

[56] Scott S, Kapp M et al (2001) Financial cost of social exclusion: follow-up study of anti-social children into adulthood. British Medical Hournal 323, 28 July 2001

[57] Parsonage M, Khan L and &Saunders A (2014) Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention. London: Centre for Mental Health.

Summary of interventions for conduct disorder

Condition	Name of intervention	Age targeted	Cost per Child	Benefit: cost ratio
Conduct disorder in the early years				
	Family Nurse Partnership	<2 years	£7560	2:1
	Group parenting programme	3 -12	£1200	3:1
	Individual parenting programme (e.g. Parent Child Interaction Therapy	2 -14 years	£1800	2:1
	School-based interventions (E.g. Good Behaviour Game	6 -8 years	£108	27:1
	Whole-school anti-bullying interventions	School-age	£75	14:1
Conduct Disorder in adolescence				
	Aggression replacement Therapy	12 – 18 years	£1260	22:1
	Functional Family Therapy	11 -18 years	£2555	12:1
	Multi-systemic therapy	12 – 17 years	£9730	2:1
	Multi-dimensional treatment fostering	12 – 18 years	£7820	3:1

7.5.2 Anxiety disorders

Anxiety disorder covers a range of conditions including generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), social anxiety disorder, post-traumatic stress disorder (PTSD) and specific phobias. They are the most common childhood psychiatric conditions, occurring in 2.2% of 5 -10 year olds and 4.4% of 11 -16 year olds. Prevalence is higher among girls than boys. Although these conditions are very common they are often unrecognised and undiagnosed.

Various forms of Cognitive Behavioural Therapy (CBT) have demonstrated some effectiveness in reducing anxiety in children and young people. Generally, CBT is administered by a trained therapist and may involve both parent and child sessions. When working with younger children, interventions are sometimes delivered via the parent. Thus parents are provided with the information and taught the skills to deliver behavioural therapy to their children. CBT for anxiety can be implemented in group, individual and remote settings.

An evidence-based group CBT programme, working the groups of children of similar ages, cost £252 per person[58], which make the cost of intervention very low. Its total benefits per participant are estimated at £7,761. For every £1 spent, £31 is generated in measureable benefits, mainly in the form of higher earnings and reduced health care costs via reduction in anxiety.

Group parent CBT is also cost effective, saving £10 for every £1 spent. Individual CBT is less cost effective than delivery in group settings and children may miss out on social benefits of the group environment on their anxiety.

In addition, well implemented, school-based interventions such as Social and Emotional Learning Programme (SEL), have been show to prevent and reduce anxiety in children.

Overall, these interventions are good value for money with the benefits of the interventions out weighing the costs. However, there is limited evidence on value for money for non-CBT based interventions.

Summary of interventions for anxiety disorders

Intervention	**Age range targeted**	**Cost per child**	**Benefit: Cost ratio**
Group cognitive behavioural therapy for children	5 – 18 years	£252	31:1
Group cognitive behaviour therapy via parents	15 – 18 (typically 10)	£175	10:1

7.5.3 Depression

Depression is less common than anxiety, particularly among young children, but is an increasingly prevalent problem in adolescence, affecting 1.4% of all those aged 11 -16 (Green et al 2005). Twice as many girls affected as boys.

Children with depression are much more likely than other children to be from disadvantaged backgrounds and have parents with poor physical and mental health

[58] Social research Unit (2013) Investing in Children available at: http://investinginchildren.eu.

(NICE 2005). More than 95% of major depressive episodes in young people arise in those with long-term psychosocial difficulties such as parental divorce, domestic violence, abuse and school difficulties.

In about 30% of cases, depression in children and young people continues in adulthood, leading to long-term social maladjustment and increased risk of suicide (NICE 2005).

There is evidence that some psychological interventions, particularly Cognitive, Behavioural Therapy (CBT) are effective both in reducing depressive symptoms and in preventing depression from occurring among young people. The effect size varies from small for individual CBT to medium for group CBT. There is insufficient evidence to show whether these changes are sustained long-term.

CBT delivered in a group setting is estimated to cost £229 per participant, making the cost of intervention low compared with the potential benefits. The total benefits of group CBT are estimated at £7,252 per participant, including higher earnings and lower costs to the NHS and education system. This intervention is excellent value for money, with benefits of £32 for every £1 invested. Individual CBT is less cost effective than group-based programmes, mainly because of the much higher cost per participant (£2061) but there are some situations where this approach may be more appropriate, for example because the young person/family has very complex needs or access to a group setting is problematic. Overall, the benefits of individual CBT still outweigh the costs by a factor of 2:1.

CBT based interventions for preventing depression in young people exhibiting sub-threshold depressive symptoms or with risk factors may also be effective. However, research into the value for money of prevention programmes is limited. The available evidence suggests that both group and individual CBT for the treatment of children with depression are good value for money.

Summary of Interventions for depression

Intervention	**Age range targeted**	**Cost per child**	**Benefit: cost ratio**
Group cognitive behavioural therapy	12 -18	£229	32:1
Individual cognitive behavioural therapy	12 – 18	£2061	2:1

There are a number of childhood mental health problems where there is insufficient evidence to demonstrate the effectiveness or value for money of interventions. These include: Autistic Spectrum disorder; self-harm and eating disorders.

8. What do people think?

8.1 'Under Pressure' ChildLine Review 2013-14

During 2013 -14 ChildLine counselled 280,064 children and supported a further 10,915 who had serious concerns about another child[59]. The ChildLine Review 2013 -14, "Under Pressure", states that ChildLine has seen a worrying rise in mental health concerns. Four of the top ten issues children contact ChildLine about relate to mental health and taken together these account for more than two thirds of counselling sessions carried out by ChildLine. These four issues are: self-harm; suicidal feelings; low self-esteem and unhappiness; and (diagnosable) mental health issues that are prolonged or re-occurring and significantly interfere with the young person being able to lead a normal life. The last category has seen the highest increase in the last year (34%).

The three main worries were family relationships, low self-esteem and unhappiness and self-harm. For the first time, school and education problems appeared in the top ten concerns with 200% increase in counselling about exam stress. Since 2012/13 there has been a 15% increase in counselling about eating disorders and a 21% increase for body image issues.

The ChildLine website received over 3 million visits – 29% more than in 2012/13. Online counselling continued to grow, rising from 59% in 2012/13 to 68% in 2013/14.

Looking in more detail at those accessing ChildLine about mental health conditions, the report states that this issue has seen the largest increase in contacts over the last year. In addition to accessing direct support, a large number of young people were seeking information about these subjects. For example, the ChildLine website pages on 'Depression and feeling sad' received almost 52,000 views and their online video about depression was viewed more than 24,000 times. The mental health message board (peer to peer support) also received 56,000 visits. Common topics included: Obsessive Compulsive Disorder; bipolar disorder;, suicidal feelings; psychiatric hospitalisation and hearing voices. There was a 6:1 girl boy ratio of counselling about mental health conditions and 98% were between 12 and 18 years of age- 55% were between the age of 12 -15 and 43% 16 -18 yrs.

There was also a cohort who contacted ChildLine because they had concerns about someone else's mental health. A common problem was that they wanted to help their parent but did not know how.

[59] ChildLine Review 2013 -14 Under Pressure What has affected Children in March 2013 to April 14 NSPCC

8.2 Local ways of involving people

This needs assessments has taken into consideration a range of views from different stakeholders:

1. Provider services views were sought either through 1: 1 interviews, telephone interviews, or small groups. The following services were consulted:

    - CAMHS
    - TaMHS
    - ON-Trak
    - Swindon Ten to Eighteen Project (STEP)
    - 5-18 Counselling service
    - Primary Care
    - Swindon Mentoring and Self-Harm (SMASH)
    - NSPCC
    - LIFT Psychology
    - School Nurses
    - Children In Care – Designated Nurse
    - Commissioners
    - Educational Psychology

2. Schools were consulted in a discrete piece of work and all schools were sent questionnaires to complete. Schools were offered the opportunity to comment further which some schools did. In addition a focus group of PHSE leads was also held.

3. Children and young people were consulted through a discrete piece of work with the Youth Forum and STEP and CAMHS/TaMHS. Two groups were held. One with young people who had not had contact with TaMHS or CAMHS (16 young people) and the second one with young people who had experience of one or the other or both services (19). The questionnaire used to inform the discussion is included in Appendix 1

4. Parents and carers were consulted through a discrete piece of work with CAMHS and TaMHS. This was done on an individual 1-1 basis either over the phone, face to face or by email. They were asked three questions about their experience of CAMHS/TaMHS services. What went well? What could be improved? Are there any gaps in provision? A total of 17 parents and carers were contacted.

5. Each year the Members of UK Youth Parliament (UKYP) debate topics in Parliament to decide their campaigns for the following year. Before this happens young people from across the UK need to decide on topics they feel are relevant. Swindon's young people contributed to this by taking part in the Make Your Mark ballots through schools across Swindon during November

2014. Improving mental health services was voted the fourth most important topic.

8.3 Key issues raised

8.3.1 Service providers and commissioners

Capacity: All service providers and most other stakeholders raised concerns about capacity within the system to support and treat children and young people with mental health problems. Most services had waiting lists some of which were very long. Services all raised concerns about individual cases that became more complex whilst waiting for a specialist mental health service. Practitioners thought that a squeeze of capacity in more universal services, such as youth services, social services and health visitors has had an impact on the number of referrals they get. It is increasingly difficult to get access to early intervention services.

The disjointed nature of the Traded and Core service provision in Swindon also raised concerns. Although the vast majority of stakeholders supported the involvement of schools in commissioning and integrating mental health services into the schools, there were concerns about inequity in access to services, inconsistency in services being provided, lack of provision outside schools and school term times. There were suggestions that rolling out TaMHS into GP surgeries or localities may provide a more equitable, accessible service.

The complexity mentioned above together with the provision within CAMHS and lack of data collected and reported by the TaMHS service makes it difficult, at present to ascertain if the service is effective and the outcomes of service provision. It is difficult to assess if it is meeting the needs of children and young people in Swindon.

Single Point of Access/Joint assessment clinics: the triage service provided by TaMHS was raised as a concern. Children potentially need to wait for their initial assessment and then wait again for initial treatment with TaMHS. If the treatment provided was unsuccessful the child is referred to CAMHS and may need to wait for another assessment and then treatment. This could potentially lead to a waiting time of over six months although more urgent cases were fast tracked. There were mixed reports on the joint assessment clinics and while some thought they were working well, others felt that there was no standardisation or acceptance criteria to CAMHS and that if TaMHS triage and assessment was not accepted by CAMHS so it was not really a single point of access. There was universal recognition that the service would be improved if it was more seamless.

Information flows: In addition the flow of information between CAMHS and TaMHS and TaMHS and universal services could be improved. Some work has already been done in the area but TaMHS workers still report that they cannot access information on referrals, waiting times or outcomes of young people they refer to CAMHS which can make it difficult to ensure a seamless service. Sometimes TaMHS only know the outcome if they are told by the child or parent/carer. The School Nursing service also thought that information sharing was a problem as they are not informed when individuals are discharged and cannot offer support. Lack of information sharing between A&E and the school nursing service was also

considered to be a risk. Practitioners thought that sometimes young people disengage whilst they wait to be seen by services which can be detrimental. GPs reported that if referral to TaMHS was made through schools they often were not aware of it. GPs are informed of all referrals accepted by CAMHS regardless of the referrer.

Some practitioners highlighted that CAMHS and TaMHS do not use the same assessment tools or the same data management IT system so there are no joint records and practitioners both from CAMHS and TaMHS cannot see the whole mental health record for the individual.

Secondary Care Specialist CAMHS also highlighted the gap in CAMHS hospital liaison and "responsible clinician" role provided at GWH.

Several stakeholders raised the importance of tackling stigma and raising awareness of the mental health issues. It was acknowledge by several services and young people that improving training on mental health issues for universal or non-specialist mental health service could reduce the stigma associated with mental health, improve identification of mental health problems and reduce inappropriate referrals.

8.3.2 Children and young people consultation

Group one – no experience of CAMHS or TaMHS Services.

The findings of the survey showed that of those who completed the questionnaire most would turn to family (36%), friends (32%) and school (21%) if they felt down/unhappy or thought they had a mental health problem or were depressed or stressed. 11% said they would see help from their doctor or Step.

Only 19% of those surveyed had heard of CAMHS and 25% had heard of TaMHS. 56% had not heard of either service. Of those who had heard of these services 57% did not really know what sort of help they offered. Only 38% of respondents thought they would know who to ask for or how to get help if they need support from these services.

75% of respondents thought that a local information website for young people about mental health issues and services would be helpful. They would like to see information on Depression, Self-harm, suicidal thoughts and feelings and how to get help (including phone numbers), more general information on how to get help for yourself or others, relationships, bullying and how to get help, dealing with angry feelings without annoying others, who you can talk to about stress and symptoms of mental illness.

When asked how they thought mental health services could best promote themselves 36% said through social media, with 23% suggesting posters, 23% suggesting leaflets and 18% suggesting through events. Some also suggested newspapers and local media but this was a small number.

When asked how else mental health services across Swindon could be improved they suggested:

- Make them more accessible
- Provide more information on line about what is available
- Have a drop in service where you can talk to someone (face to face) – instant access to services.

Group 2 – those who have received TaMHS and/or CAMHS services

The first question asked was “did you know where to get the support you wanted”. Only 30% answered yes and 40% answered no (30% answered that they knew where to get some sort of support). This aligns to the responses in the first group where 38% thought they would know where to go to for help.

Interestingly, those who had experience of the CAMHS/TaMHS service sought help from family (30%), school (30%), their GP (20%) and Step/youth workers (10%). This group did not mention friends which 32% of group one did.

Young people wait quite a while before they decide to seek help. Only 15% sought help in less than a month after realising they needed help. In fact only 35% sought help in less than six months (1-3 months 15% 3-6 months 5%). A further 10% sought help in 6-12 months but 35% waited more than a year before seeking help and 20% were not sure how long they waited.

The reasons they gave for not seeking help included:

- Not wanting to be judged
- Having trust issues
- Passed from pillar to post (2)
- People not believing I needed help (2)
- Long waiting lists
- Did not know what services were available to me
- Services were not available for my year in school
- Admitting that I needed help (3)

Once young people did ask for help 55% thought they got help soon enough and 45% felt they didn’t. 68% reported that they were seen within a couple of months (24% were seen within weeks) but 12% reported that they had waited 6 months or more and 20% said they had waited over a year.

When asked if young people had received enough information about the service before attending 46% thought that they had. However, 12% felt they had received some information but not enough and 42% felt that they did not receive enough information. Of those 42% who answered no they would have liked to know what was going to happen to them and who they were going to see. Most of those asked (43%) wanted to get this information face to face. 37% thought a leaflet or letter would be the best way of receiving the information (20% leaflet and 17% letter).

14% thought a website would be the best way of receiving the information and 6% would have liked a phone call. 63% said they did not know what to expect at the first session.

66% reported that sessions were run at a time and place that was good for them. The 34% who reported that the sessions were not convenient and they reported that:

- They would have preferred the worker to come to me
- They would have preferred more flexibility in setting time and place
- They were told when they had to attend and no one bothered to check it was ok
- They would have liked the appointment closer.

60% reported that it was easy to contact someone from the service if they needed to. 28% said it wasn't and that they would have liked a quicker response or had received a negative response when things were at crisis.

The respondents were asked what they thought of the staff at the service they received. They were asked to score the staff out of 10 for various criteria. The scores are reported below:

Friendly = 7.3/10	Professional = 7/10	Helpful = 6.1 /10
Understanding 6.9/10	Available = 5.3 /10	Caring = 7.1/10
Easy to talk to =6.9 /10	Good listening = 7.1 /10	Good advice = 7.2/10
Trusted = 7.3 /10	Not judgemental = 6.6 /10	Average staff score = 6.8/10

So for the majority of criteria the score for staff was around 7 out of 10 but staff score less well on being available (5.3/10), helpful (6.1/10) and being non-judgemental 6.6/10. Individual respondents also reported that staff had been rude and stubborn; very unhelpful; and that CAMHS services elsewhere had been far more effective.

50% of respondents reported that the service had helped them with a further 25% reporting that it had partially helped them. 25% thought that the service had not helped.

62% of the respondents reported that they understood how confidentiality worked and 32% reported they didn't.

When asked if they thought that a support service at school or in their local area would have prevented them needing to access TaMHS/CAMHS 60% said no. 35% said that thought it would have done.

Finally this group was asked about their thoughts on information that should be made available for young people in Swindon about mental health issues. 100% thought there should be information available (37% wanted this information to be available on a website and 63% wanting a leaflet). Other ideas suggested were: Facebook, social media, TV advertising, Schools (information boards, webpages and assemblies) and billboards.

They thought the information should include:

- What services do, more general information about the services and what is available;
- What is the process when you access services;
- How do you access services – where are they and how to get in contact;
- Details of what support is available locally;
- Details of different illnesses;
- What it is like from the young person's viewpoint.

The consultation also highlighted the need to employ staff who could relate to teenagers and their issues.

8.3.3 Parents and carers

The parent and carer consultation was undertaken by both CAMHS and TaMHS services. The findings below are divided by those who had received each service. A total of 17 parents and carers responded (10 from TaMHS and 7 from CAMHS). Some had experienced services from both providers.

The things that parents and carers valued most about CAMHS were that the service was:

- Understanding, non-judgemental and friendly and listened well.
- Consistently offered support
- Professional and staff were dedicated
- Able to liaise with the school/college with regard to the patient
- Good at providing continuity and regular appointments
- Helpful in developing techniques for managing problems

The things that parents and carers valued about TaMHS were that the service:

- Provided good support for both the patient and their parent/carer
- Made patients feel comfortable, listened to and understood
- Valued the needs and opinions of the young people
- Helped young people develop strategies to manage feelings and develop skills
- Signposted to other services
- Offered a quick and accessible service
- Was confidential, open and honest
- Offer a professional and supportive service
- Was responsive and staff approachable

- Provided good parenting groups
- Provided initial home visits

Parents and carers were then asked what could be improved. Those with experience of the CAMHS service thought that there could be:

- More appointments more frequently
- Appointments outside school hours
- Clinics nearer to home rather than in central Swindon
- More specific nutritional information
- Quicker access – shorter waiting times
- Better seating
- A greater range of therapeutic interventions

Those with experience of TaMHS thought there could be:

- More time and more sessions
- Longer term interventions
- Shorter waiting times (for some, others expressed good access and waiting times)
- A shorter length of time between assessment and allocation of a worker
- Better and more consistent information on the waiting times
- Better signage to Palm Tree Lodge

Finally parents and carers were asked about gaps in service. Many expressed that they did not thing there were gaps in services but others thought that:

- It would be beneficial to have an in-house care service to allow parents time to go out when their child was at risk
- They needed a shared treatment plan outlining goals and progress towards those goals at the start of treatment
- It would be useful to have mobile/text reminders not to self-harm and positive endorsements and encouragement
- Additional financial resources were required to provide more services and cut waiting times.
- There should be improved communication to parents and carers about how and where to get help and what is available
- They had to proactively chase up referrals to ensure their child got access
- The response their child got from all services when they attended for self-harm overdose was unsupportive and unhelpful
- There should be more support at home to develop parenting skills.

Generally, the responses of the parents and carers were very positive:

One parent stated:

"The service was excellent. I was provided with regular updates and clear communication throughout. Every matter was dealt with very professionally and the outcomes were better than we could have hoped."

9. What the Future looks like?

Between 2011 and 2031, the 0- 18 year old population in Swindon is projected to increase from 49,100 to 58,300 (19%). This is a significant increase and higher than the projections for England and the South West. However, they are lower than the increases forecast in older age groups. This means all services for children and young people are likely to experience a steady increase in client numbers in the next decade or two. Alongside the population growth will be a substantial programme of housing development in and around Swindon, which will provide opportunities to ensure children and families are fully integrated into new or existing communities.

The make-up of various vulnerable groups identified as at higher risk of emotional and mental health problems is also changing. The number of young carers has risen sharply between the 2001 and 2011 censuses. The number of Children in Need and number of children subject to Child Protection Plans have risen in recent years but the number of children in care has remained stable. The number of young offenders has decreased in the last few years but this may reflect that they are being kept out of the youth justice system rather than being at lower risk. Nationally, there have recently been rises in the number of homeless families and in those placed.

If current trends continue there will be less young people requiring hospital admissions for reasons connected to alcohol but more because of self-harm. However, the data these trends are based on is fairly short-term and subject to service and coding influences and therefore may not accurately reflect underlying need.

The research that underpins estimates of prevalence of significant mental health disorders and numbers requiring CAMHS tier 3[60] services is becoming increasingly out of date and is long overdue for a refresh. This may significantly change the national prevalence estimates and hence the local estimates of affected young people based on these estimates. This is being addressed nationally but we need to ensure that when this review is complete these new estimates are used to review estimated prevalence rates in Swindon

The arrival of the digital age poses new threats to children and young people's mental health or at least new manifestations of existing threats. Violent video games, the sharing of indecent images on mobile phones, cyber-bullying and websites advocating anorexia and self-harm all pose a danger to the mental wellbeing of children and young people, according to a Commons health select committee

[60] Tier 3 refers to Specialist Secondary Care CAMHS

report[61]. However, the internet can also be a valuable source of support for children and young people with mental health problems.

The CAMHS services have seen an increase in the demand to access services out of hours, urgent or emergency referrals. This was reflected nationally in the Commons select committee report 2014/15[61]. Locally the CAMHS service has seen an increased demand through A&E and although through the police. This in part could reflect the success of partners recognising mental health issues in children and young people and referring to services but also indicates the need for services to be commissioned to ensure a timely and responsive out of ours provision which does not impact on routine appointments.

TaMHS have also recognised an increase in demand for services not only from schools but also from GPs and Paediatric services. With the increase in awareness and expectations of mental health services, we would expect demand for services to continue to increase. We could also expect that if people access services as soon as they are aware of their mental health requirement the complexity of cases may decrease. It is therefore essential that the focus for TaMHS service remains on early intervention. In order to meet demand at a lower level will require the involvement of universal services such schools, school nurses and the public health work force.

National trends include a drive to reduce the number of hospital admissions and provide more care closer to home in the community; promote parity of esteem between mental and physical health and ensure the personalisation of services to ensure that the service meets the needs of the patient. This last issue was highlighted as a key priority by the children and young people's consultation. The government has pledged to improve waiting times particularly for Early Intervention in Psychosis and also eating disorders.

Whilst there has been a national commitment to increased funding for CAMHS, local budgets continue to be strained and there is a need to make significant savings locally over the next five years, particularly for Swindon Borough Council. A reduction in other support services may therefore see an increase in demand for CAMHS and TaMHS. The Council is committed to the traded services in schools model and this is likely to be expanded over the coming years. The impact of this on service access will need to be considered carefully to ensure that needs continue to be met. Budget constraints and national policy are likely to result in increased joint working between the CCG and SBC in order to plan and deliver services in a more efficient manner.

[61] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34202.htm

10. Conclusions and recommendations

10.1 Summary of key points

This Joint Strategic Needs Assessment has highlighted the increase in demand for Children and Adolescent Mental Health Services at all levels and also an increase in the complexity of those accessing services. There are waiting times for all CAMHS services, although those with urgent need are fast tracked through to the appropriate service. This does mean that those with identified but non-urgent needs may wait considerable time for assessment and treatment during which time their condition may deteriorate. The Service User consultation also highlighted that some young people wait a long time before they even seek help, so from recognising that there is a problem to accessing treatment can be a long time during which a simple mental health issue may have deteriorated into a more complex condition. Parents and carers also highlighted the need to address waiting times. The economic evaluation showed that group work can be very cost effective and may provide a solution to capacity issues within the service and earlier intervention. The Needs Assessment has highlighted that the complexity of those accessing services has led to an increase in the time young people remain in treatment. This relates not only accessing Targeted and specialist mental health services but also residential placements. The needs assessment estimated that there may be an additional 100 children and young people who require, but are not receiving a mental health service.

The TaMHS and specialist CAMHS services have distinct service provision but have also developed a good working relationship, with TaMHS offering the single point of access to services and holding joint assessments with CAMHS to ensure those needing CAMHS receive the service they require. The Needs Assessment has highlighted issues with the current single point of access and joint assessment process which contributes to the long waiting times experienced by young people. Currently CAMHS and TaMHS do not use the same risk assessment tools or information system so sharing of information is limited and there maybe duplication in the assessment process. The service practitioners highlighted that there is still work to be done in order to provide a seamless transition between the CAMHS and TaMHS service and improve the joint working, part of which is to review referral criteria.

The needs assessment has highlighted some groups of children and young people who are at particular risk of developing mental health problems. These include, but are not restricted to children of parents with mental health problems and substance misuse, children in care, those who have suffered abuse, sexual abuse or exploitation, refugee and asylum seekers, those who have experienced bereavement or family breakdown, domestic violence, children in need and poverty and young carers. It is essential that in order to give these children the best chance of recovery access to treatment and information sharing should be prioritised. Stakeholders highlighted concerns about the mental health of those leaving care and the difficulties that they face. The local Primary Care Psychology Service (LIFT) pointed out that this is often picked up later in their service and if left untreated can escalate to emergent personality disorder. An audit undertaken by LIFT showed that 48% of their clients had severe or moderate personality disorder. Personality disorder can

often emerge from early attachment issues, leading to conduct disorder and then on to personality disorder. There are examples of good practice within the South West to intervene with those with emergent personality disorder to address these issues. Those leaving care are at particular risk.

During the development of this needs assessment organisations in Swindon signed the mental health crisis care concordat. CAMHS services recognised the need to ensure out of hours services such as 111 are aware of pathways to access CAMHS out of hours. It is essential that children and young people in crisis receive an appropriate and timely response and those under section are taken to a place of safety for assessment. The Memorandum of Understanding (MOU) between Court Liaison and Diversion Services and CAMHS has recently been signed in February 2015. This should be monitored to ensure that this MOU is effective in supporting Young People. Other issues to improve crisis care include: ensuring seamless pathways between TaMHS and CAMHS; ensuring the appropriate skills mix of CAMHS staff with regard to Improving Access to Psychology Therapies and models of care; improving partnership working with GWH, Children's Services and CAMHS to ensure the needs of the patient are met on admission and discharge from hospital. There issues are being picked up and reviewed in the Crisis Care Concordat Action Plan so will not be included in the recommendations below but should be acknowledged as an important piece of work with regard to meeting the needs of children and young people with Mental Health conditions.

Eating disorders, specifically anorexia nervosa is the third most common chronic illness of adolescence and as the highest morbidity and mortality of all psychiatric disorders. Government has pledged additional funding to tackle waiting times for eating disorder services and governmental task groups have highlighted the difficulty of moving inpatient funding for eating disorders to outpatient treatment which has a better evidence base. The impact that social media has had on the increase in prevalence of eating disorders should be taken into account when tackling this issue. In Swindon eating disorders have been recognised as a significant issue and access to treatment and waiting time, as we have seen elsewhere is an issue.

In Swindon attendances and admissions for self-harm at GWH have increased year on year and are significantly higher than the national and regional rates. A range of interventions including the self-harm register at GWH which collects data about those attending A&E, together with the development of information packs and follow up postcard scheme are all interventions to target support at those who need it most and reduce admissions and repeat attendances at GWH. It has also been highlighted that there is no routine hospital liaison service for those under 18 years of age at GWH and the increase in attendances has sometimes had an effect on urgent provision by OSCA impacting on routine appointments. Information sharing between GWH and School Nursing service on those who have attended had ceased during the time that this needs assessment was undertaken but there are plans to reintroduce it. There is also a Quality Premium payment that has been agreed for Swindon to reduce attendance and admission for self-harm in Swindon. This should be done in line with best practice guidance and ensure that patients receive an effective and supportive experience when attending A&E.

Lack of information sharing between different partner organisations was also highlighted as detrimental to the service that children and young people receive.

Various stakeholders during the consultation phase of the needs assessment highlighted the need for better information. These included information sharing between: GPs and TaMHS, TaMHS and CAMHS, GWH and School Nurses, TaMHS/CAMHS and School Nurses, and adult mental health services and CAMHS. This is key to making sure the needs of the most venerable are met, avoiding duplication of services and ensuring children and young people do not fall between the gaps in services.

Many stakeholders raised the need for additional training for staff working with children and young people with regard to mental health so they can gain knowledge and confidence to offer support. For universal services such as A&E, GPs, Paediatric services, schools, and youth services additional awareness, knowledge and understanding of mental health conditions and services may lead to more appropriate referrals and speed up access to services where appropriate. Raising awareness of local, national and on-line resources for schools, parents and professionals and sharing best practice between schools will enable more informed support to be offered. Recognising the difference between behavioural and mental health issues is key to this and will enable more appropriate interventions to be offered by a range of providers. Anti-bullying work is also key to preventing mental health problems and this has been recognised and acted upon in schools in Swindon. It is key to take a whole schools approach to mental health.

Associated with this is the need to tackle stigma regarding mental health services and raise awareness of the signs and symptoms for young people. Consultation with children and young people highlighted that many of them (56%) had never heard of CAMHS or TaMHS and many of them did not know where to turn for help and support. Alongside the resources mentioned above which are aimed at those working with or supporting young people, young people themselves require information and resources to find out more about their own mental health and emotional wellbeing. Parents and Carers also expressed the need to have more information on how and where to access support and information on what services were available. There is a need for an innovative programme of awareness raising should be developed building on the information gathered from the service users (and their parents/carers) for this report. This should include the use of social media, on-line resources; work in schools and better liaison and visibility of mental health services. Parity of esteem between physical and mental health service should be considered in conjunction with this.

The TaMHS traded service model, alongside the core service provision, offers many benefits for schools to be able to purchase bespoke services meeting the requirements of their pupils. It also gives opportunities to raise awareness and knowledge of mental health issues in schools. However, the disparate commissioning of a complex range of services makes it a challenge to evaluate service provision, demonstrate value for money, outcomes and effectiveness of interventions. During the needs assessment it has become obvious that the collection of data for the TaMHS service is key to quantifying service provision and outcomes and demonstrating to commissioners that the needs of the whole population including vulnerable groups and those who attend schools not commissioning TaMHS are met. Work has commenced on developing a minimum

dataset. This should be done in conjunction with the national minimum dataset outlined in the transformation plans.

The visibility and accessibility of mental health services has been outlined above and aligned to this is the fact that Primary Care services are beginning to feel removed from the provision of mental health support for children and young people. In order to address this, the location of CAMHS/TaMHS services in primary care settings could be explored. Moving these services into community, locality or primary care settings such as GP practices could improve work relationships and breakdown some of the perceived inequity in traded service provision. Children and young people stated that they would like services to be more flexible and closer to home.

There was also recognition of the need to improve the transition of service users from CAMHS to adult mental health services (AMHS). As part of this needs assessment the CAMHS and AMHS services together with commissioners undertook a self-assessment of transition between services currently. This highlighted the need to: improve transition and operational polices and pathways; identifying transition champions in both services; ensure information is available to young people and their families/carers on the transition process; develop an audit and monitoring process to assess services against the standards; ensure data systems are in place to ensure safe transfer of data; provide joint training programmes and develop alternative care pathways for those who do not meet the AMHS threshold. Particular account should be given to those transitioning out of the CAMHS Early Intervention Service. In order to prevent future demand on services it is essential to ensure the needs of those between 16 and 25 years of age are met by CAMHS and Adult services in-line with best practice guidance highlighted in this needs assessment. This may include improving partnership working between CAMHS and LIFT.

Finally, it should be remembered that this needs assessment does not cover the needs of children under the age of 4 yrs. The mental health needs of this cohort will be picked up in the Early Years Needs Assessment and Perinatal mental health service review. Any recommendations from these two pieces of work should be considered in any strategy development or commissioning.

10.2 Recommendations

These recommendations should be read in conjunction with the summary of key points outlined above in 10.1.

1. **Address waiting times, access to services and capacity** within children and adolescent mental health services at both specialist and targeted levels. The focus should be on early intervention with the aim of reducing the periods of time in treatment and complexity of cases. This should include a review of the single point of access and joint assessment clinic, alongside the internal CAMHS pathway, capacity and demand review and include the staffing mix and working practice between CAMHS and TaMHS. This should be undertaken by CAMHS and TaMHS in conjunction with commissioners.

2. **Increase group based provision.** Service providers and commissioners should explore opportunities for increasing group work where possible particularly with regard to treatment for anxiety and depression**.**

3. **Raise awareness and training for universal service providers** in conjunction with early intervention. Many stakeholders raised the need for additional training for staff working with children and young people with regard to mental health so that they can gain knowledge and confidence to offer support and can identify children and young people requiring more specialist interventions. This will reduce inappropriate referrals. This would also include the promotion of mental health and wellbeing resources for schools, parents and professionals. These could include national and local resources, sharing of good practice and access to on-line resources.

4. **Strengthen commissioning** of mental health services undertaken by schools to ensure services are evidenced based, follow best practice guidance and meet the needs of young people. Schools highlighted the need to share best practice.

5. **Consider the integration of mental health services into local or primary care settings.** In order to make children and adolescent mental health services more visible and accessible, the viability of moving mental health services into community, local or primary care settings should be explored. TaMHS felt that the links into GP practices could improve working relationships and address some of the perceived inequity in their traded service provision. Children and young people also highlighted that they would like services to be more flexible and closer to home.

6. **Prioritise vulnerable groups**. Ensure access to mental health services for vulnerable children and young people mentioned in this report. This will include sustainable counselling provision through SARC and perinatal mental health needs of those under 18, and those with emergent personality disorder.

7. **Review residential placements**: A full review of review of residential placements should be undertaken with social care and CAMHS to better understand the increasing complexity of cases requiring residential placements. This work should inform the commissioning of local support services and be fed into any wider work around market development with residential providers.

8. **Reduce admissions and attendance for Self-Harm.** This will include the continued implementation and monitoring and data review from the established self-harm register, the introduction of information packs and postcard scheme at GWH, the implementation of CCG quality premium and the reintroduction of information sharing between A&E and school nurses. This will be led by service providers, commissioners and public health. An assessment of the requirement for a hospital liaison provision to include a “Responsible Clinician” role at GWH should be undertaken.

9. **Improve data collection and monitoring information.** A minimum data set for TaMHS needs to be developed, led by TaMHS and Commissioners based on the national minimum dataset as part of transformation plans.

10. **Strengthen Information sharing and referral pathways** between many services including: GPs and TaMHS, TaMHS and CAMHS, GWH and school nurses, TaMHS/CAMHS and school nurses, adult and children's mental health services to mention but a few.

11. **Tackle stigma and raise awareness in children and young people**. Service providers, commissioners, Public Health and children and young people should work together to raise the profile of Mental Health Services, mental health conditions and resilience.

12. **Improve the transition from CAMHS to adult mental health services**. Work building on the self-assessment regarding transition from CAMHS to AMHS needs to be developed to ensure the needs of those between 16 and 25 years are met by CAMHS and Adult services in-line with best practice guidance highlighted in this needs assessment. This should include reviewing the transition and access to adult Early Intervention Services for those leaving CAMHS services at 18. This work will be led by Public Health, Commissioners and service providers.

Appendix

Appendix 1 Consultation Stakeholders

CAMHS

Children and young people (consultation run by STEP)

Designated Nurse (Children In Care)

Educational Psychology

LIFT Psychology Service

Mental Health Commissioners

Parents and Carers (Consultation through CAMHS and TaMHS)

Primary Care

ON TRAK Youth Counselling Service

Schools

School Nurses

STEP

Swindon Sexual Assault Referral Centre

TaMHS

Third Sector providers NSPCC, Mediation Plus 5 – 18 Counselling Service, Cruse, Swindon Mentoring and Self-harm (SMASH)

YOT

Appendix 2 LIFT Referral Data

PATIENTS SEEN BY LIFT SINCE 2008

GENDER	16 - 18 YEAR OLDS (Age at Referral Date)							
	2008	2009	2010	2011	2012	2013	2014	Grand Total
Female	61	75	103	114	118	143	132	746
Male	28	20	32	38	60	63	48	289
Grand Total	**89**	**95**	**135**	**152**	**178**	**206**	**180**	**1035**

GENDER	19 - 25 YEAR OLDS (Age at Referral Date)							
	2008	2009	2010	2011	2012	2013	2014	Grand Total
Female	297	385	365	485	489	580	496	3099
Male	137	154	193	238	291	327	253	1593
Grand Total	**434**	**539**	**558**	**723**	**780**	**907**	**749**	**4690**

ETHNICITY	16 - 18 YEAR OLDS (Age at Referral Date)							
	2008	2009	2010	2011	2012	2013	2014	Grand Total
Asian or Asian British		1	2	1	3	4	1	12
Black or Black British	1					1	1	3
Missing	1	8	12	2	3			26
Mixed	2	1	1	6	7	2	4	23
Not Stated	9	1		5		2	1	18
Other Ethnic Groups				1	1	1	3	6
White	76	84	120	137	164	196	170	947
Grand Total	**89**	**95**	**135**	**152**	**178**	**206**	**180**	**1035**

ETHNICITY	19 - 25 YEAR OLDS (Age at Referral Date)							
	2008	2009	2010	2011	2012	2013	2014	Grand Total
Asian or Asian British	5	10	7	10	23	18	18	91
Black or Black British	1	3	3	7	7	11	7	39
Missing	14	22	19	22	7	7	5	96
Mixed	4	17	12	18	24	19	15	109
Not known	1							1
Not Stated	22	15	3	13	2	8	5	68
Other Ethnic Groups	2	2	3	2	3	9	7	28
White	385	470	511	651	714	835	692	4262
Grand Total	**434**	**539**	**558**	**723**	**780**	**907**	**749**	**4690**

Mental Health Service Care Cluster Descriptions (organic is not relevant to this needs assessment)

	Care Cluster	Description	Likely diagnoses
NON PSYCHOTIC	1	This group has definite by minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms	May not attract a formal diagnosis but may include mild symptoms of: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder.
	2	This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention or previously been successfully treated at a higher level but are re-presenting with low level symptoms.	Likely to include: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder.
	3	Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis).	Likely to include F32 Depressive Episode (non psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F50 Eating Disorder.
	4	This group is characterised by severe depression and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.	Likely to include: F32 Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder
	5	This group will be severely depressed and/or anxious and/or other. They will not present with distressing	Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress

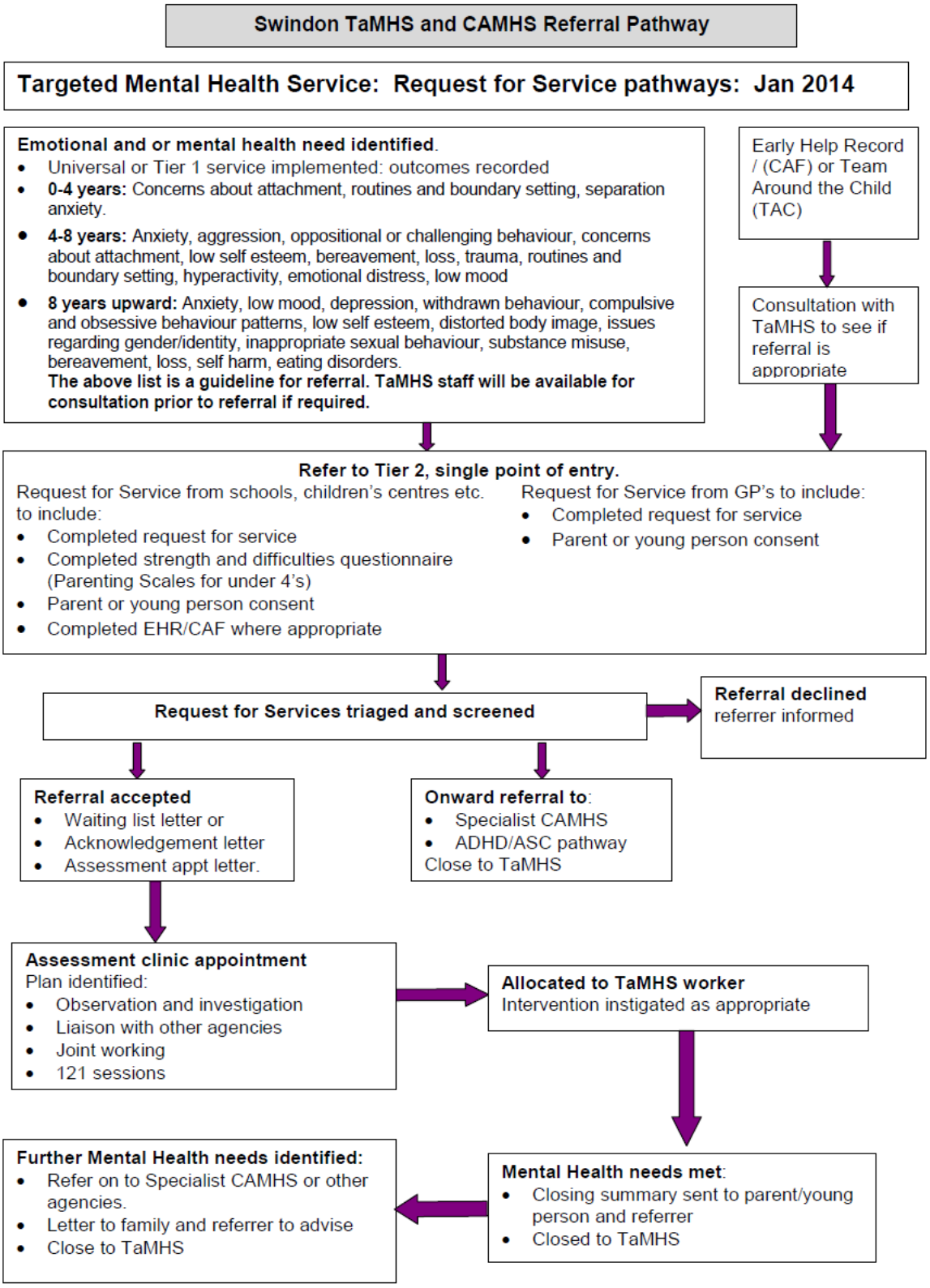
		hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for Non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living.	Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder
	6	Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc., where extreme beliefs are strongly held, some personality disorders and enduring depression.	Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.
	7	This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.	Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.
	8	This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.	Likely to include F60 Personality disorder.
	9	**Blank**	**Blank**
	10	This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed	Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-polar disorder.

		mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will* not be the only problem.	
PSYCHOSIS	**11**	This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.	Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder
	12	This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.	Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders, F30 Manic Episode, F31 Bipolar Affective Disorder
	13	This group will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.	Likely to include, (F20-F29) Schizophrenia, Schizotypal and delusional disorders, F30 Manic Episode, F31 Bipolar Affective Disorder.
	14	They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.	Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders, F30 Manic Episode, F31 bipolar Affective Disorder
	15	This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and	Likely to include, F32.3 Severe depressive episode with psychotic symptoms.

		delusions will be present. It is likely that this group will present a risk of Non-accidental self-injury and have disruption in many areas of their lives.	
	16	This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles *and co-existing* Problem drinking or drug taking. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.	Likely to include, (F10-F19) Mental and behavioural disorders due to psychoactive substance use (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-Polar Disorder
	17	This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable & engage poorly with services.	Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-Polar
O R G A N	**18**	People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been rule out.	Diagnoses likely to include: F00 – Dementia in Alzheimer-s disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere F03 – Unspecified Dementia, Dementia with lewy bodies (DLB),
	19	People who have problems with their memory, and or other aspects of cognitive functioning resulting in	Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental

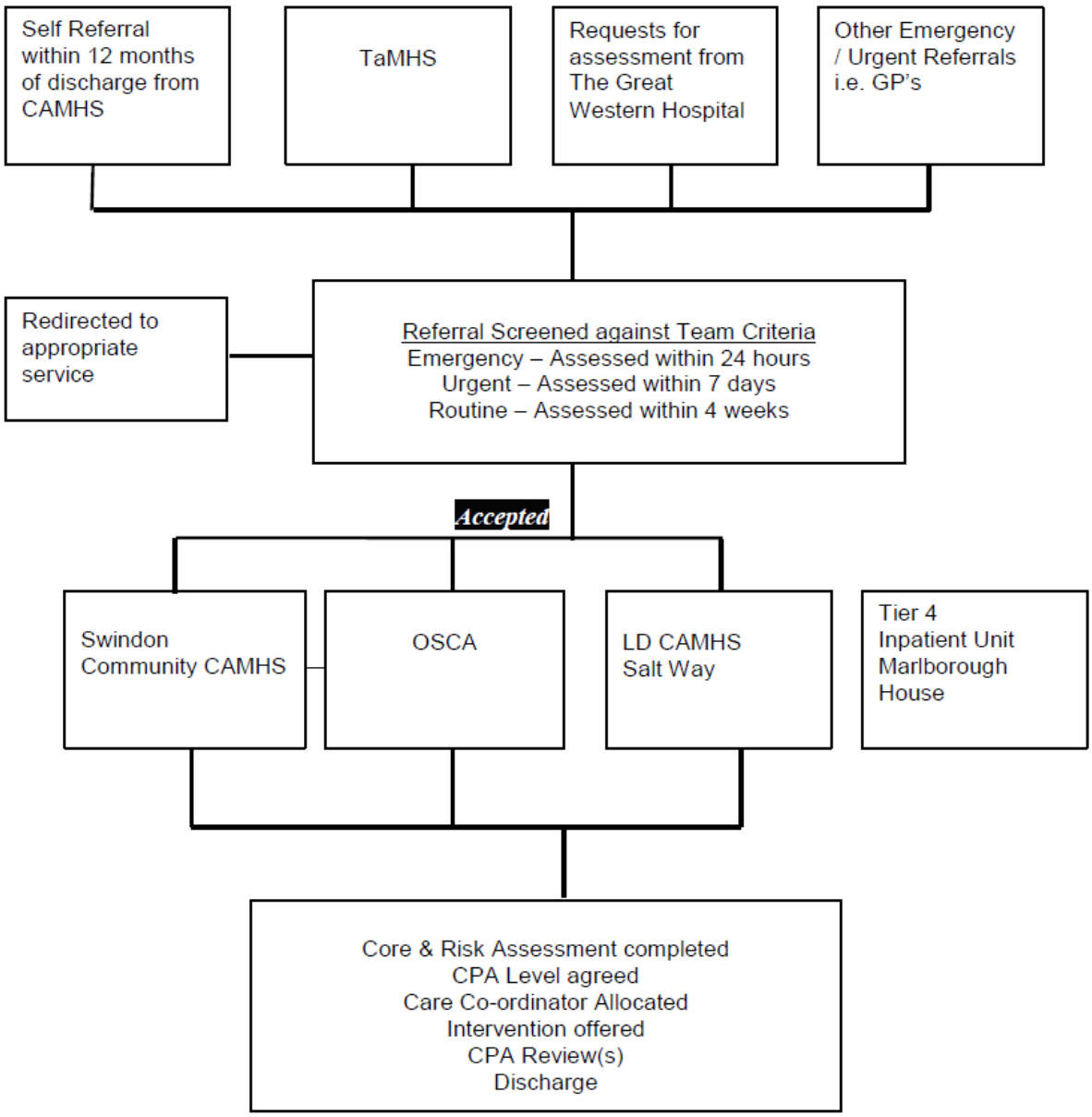
I C		moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.	disorder, Dementia with lewy bodies (DLB), Frontotemporal dementia (FTD)
	20	People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. The may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.	Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with lewy bodies (DLB), Frontotemporal dementia (FTD).
	21	People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.	Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with lewy bodies (DLB), Frontotemporal dementia (FTD)

Appendix 3 CAMHS and TaMHS Referral Pathway



Child & Adolescent Mental Health Service: Request for Service Pathways

Swindon CAMHS
Swindon Outreach Service for Children & Adolescent (OSCA)
Swindon Learning Disability CAMHS (LD CAMHS)



Appendix 4 C&YP Consultation Questionnaire

CAMHS &TaMHS in Swindon

We would like you to take a few minutes to answer some questions about your experience *(please speak to an adult or support worker if you need help with any of the questions)*

Service you attended? TaMHS CAMHS

About you?
Male Female Prefer not to say

Age School

Did you know where to get the support you wanted?
Yes No Not sure

Did you ask anyone to help find you that support?
Family School Friends Internet Other

How long did you wait before trying to get help?

Less than 1 month 1 to 3 months 3 to 6 months

6 to 12 months Over a year

What made it difficult to get support?
Once you asked for help did you get the support you needed soon enough? Yes No

How long did you wait? (Weeks / Months)

[i] Swindon Borough Council Population Projections to 2031 (Policy-led)
http://www.swindonjsna.co.uk/dna/population-projections

[ii] http://www.swindon.gov.uk/el/el-schoolscolleges/el-schoolscolleges-contact/Pages/el-schoolscolleges-contact.aspx