Emotional and Mental Health of Children and Young People

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Summary

Mental health has been defined as 'the strength and capacity of our minds to grow and develop, to be able to overcome difficulties and challenges and to make the most of our abilities and opportunities' (Young Minds, 2006).

Good mental and emotional health is essential to enable children and young people to fulfil their potential and achieve positive health, social and educational outcomes. Unlike many health problems, mental illness tends to start early and persists into and throughout adulthood.

There has been increasing national recognition and evidence of the importance of prioritising the mental and emotional wellbeing of children and young people. There is also compelling evidence of the effectiveness of interventions to improve children and young people's resilience and emotional wellbeing, beginning in pregnancy through to adolescent years and beyond.

Evidence at a national level suggests that the emotional health and wellbeing of children and young people is deteriorating. There is limited data locally and nationally on the prevalence of mental health problems in children and young people, meaning the exact prevalence in Nottinghamshire is not known. Population estimates for Nottinghamshire are therefore based on the most comprehensive data available whilst also taking into account variations due to known risk factors for mental disorders

This section considers local prevalence levels, risk factors for emotional and mental health problems, current local service provision and considerations for the future.

Full JSNA report

What do we know?

1. Who is at risk of and why?

Good mental and emotional health is essential to enable children and young people to fulfil their potential. At a national level there is evidence to suggest that the emotional health and wellbeing of children and young people has deteriorated significantly over the past 25 years (Collishaw *et al,* 2004). Poor mental health in childhood and adolescence can have far reaching consequences on health, social and educational outcomes; mental health problems in childhood are associated with lower educational achievement, missing off school, school exclusion, risky behaviours (e.g. smoking, drug use), poor physical health, self-harm and suicide. Unlike many other health problems, mental illness tends to start early and persist into and throughout adulthood. It is recognised that approximately half of all lifetime mental health problems start by the age of 14 (Department of Health, 2011a). Mental health is a national priority, as highlighted in the Government's mental health strategy '*No Health Without Mental Health*'. The strategy outlines the importance of intervening early with children and families (HM Government, 2012). Child and Adolescent Mental Health Services (CAMHS) is a term used to refer to all services that enhance the emotional and mental health of children and young people and that provide care for those suffering with mental health problems.

Risk factors for emotional and mental health problems

The factors that affect mental and emotional health are complex, ranging from individual biological factors to complex societal issues. The ONS carried out a 3 year follow up study to examine risk factors for the development and persistence of emotional and conduct disorders (Parry-Langdon, 2008). Key findings suggested that:

- **Family and household characteristics** were significantly associated with the onset of emotional and conduct disorders. For example, children were more likely to develop an emotional or behavioural disorder if they were living in rented housing, with no parent in employment, on a low household income. Poor maternal mental health was found to be associated with the persistence of emotional and conduct disorders.
- **Children who face three or more adverse life events** such as parental divorce, serious illness or bereavement were more likely to develop an emotional disorder.

Table 3 summarises child, parental and household risk factors identified from ONS studies of child mental disorders and a review carried out by the Department of Health (Department of Health, 2011a; Green *et al*, 2004; Parry-Langdon, 2008).

Table 3: Child, Parental and Household Risk Factors for Child and Adolescent Mental Health Problems

Child Factors	Parental Factors	Household Factors
• Male • Increasing age • Child abuse • Use of cannabis • Adolescent dating violence	• Poor parental mental health • Parental unemployment • Parents without qualifications • Lone parent • Poor parenting skills • Stress, alcohol or drug use during pregnancy • In receipt of disability living allowance	• Low household income • Living in deprived area • Living in socially rented or privately rented accommodation

Sources: Green *et al* (2004). Department of Health (2011a).

Several data sources have been used to assess the prevalence of these risk factors in Nottinghamshire. Further detail can be found in a health needs assessment of '*The Mental Health and Emotional Wellbeing of Children and Adolescents in Nottinghamshire'* carried out in 2013 (Baker, 2013). The risk factors examined are most evident in Ashfield and Mansfield. For example:

- **Deprivation**. There are 27,950 children and young people aged 0-19 in Nottinghamshire living in poverty, for the equivalent of 17.1% of all children and young people in the County. This percentage is lower that the England average; however, a higher percentage of children live in poverty in Mansfield and Ashfield (and in smaller pockets in other areas of the County) than when compared this national average.
- **Lone parents**. There are 21,632 lone parent families in Nottinghamshire, with the highest numbers in Ashfield (3,981), Gedling (3,398) and Mansfield (3,320). Ashfield (7.9%) and Mansfield (7.4%) have a higher prevalence of lone parent households than the England average of 7.1%.
- **Living in socially rented housing.** Mansfield has the highest proportion of households living in socially rented accommodation (18.2%), a higher proportion than the East Midlands and England averages. All other districts have a lower percentage of households in socially rented housing compared to the England average.
- **Parental unemployment**. There are 11,748 households in Nottinghamshire with dependent children where there is no adult in employment. Numbers were highest in Ashfield (2,530), Mansfield (2,187) and Bassetlaw (1,708). The prevalence of parental unemployment was above the England average of 4.0% in Ashfield (5.0%) and Mansfield (4.9%).
- **Long term health conditions or disability**. There are 15,310 households with dependent children living with someone with a long-term health condition or disability in Nottinghamshire. Highest numbers of these households are in Ashfield (2,681), Mansfield (2,484) and Bassetlaw (2,279).
- **Domestic violence** crime rates are highest in Mansfield (15.4 per 1000 women), Ashfield (13.5 per 1000 women) and Bassetlaw (11.7 per 1000 women).
- **Parental mental health problems**. In 2011 there were 9027 live births in Nottinghamshire. It is estimated that between 903 and 1354 of the mothers of these

babies will have perinatal mental health problems. Estimated rates of common mental health disorders among adults are highest in Mansfield (155.1/1000) and Ashfield (150.9/1000).

- **Parental substance misuse**. Estimates by the Nottinghamshire Drug and Alcohol Action Team suggest that up to 4,266 children and young people are affected by parental illicit drug use across the county, and between 13,271 and 21,565 are affected by parental problematic alcohol use.

High risk groups

A review by the Department of Health for the '*No Health without Mental Health'* strategy identified a number of groups of children and young people who are significantly more likely to experience mental health problems than the general population (Department of Health, 2011a). Estimated numbers of these high risk groups of children in Nottinghamshire are shown in Table 4.

Table 4: High Risk Groups of Children and Young People

Risk Group	Estimated risk of mental disorder	Estimated number of risk group living in Nottinghamshire
Children with a learning disability	6.5 fold increased risk of mental health problems	• Estimates suggest there could be between 7,000 and 12,000 children and young people with some form of disability in Nottinghamshire. • Numbers of claimants of disability living allowance among 0-24 year olds were highest in Ashfield, Mansfield and Newark and Sherwood in 2011.
Children with special educational needs	3 fold increase in conduct disorders	• In 2011 there were 16,478 children requiring 'School Action', 4,872 children requiring 'School Action Plus' and 1,223 children who were statemented. • The commonest SEN were 'behaviour, emotional and social difficulties', 'moderate learning difficulties' and 'autistic spectrum disorder'.
Children with physical illness	2 fold increased risk of emotional/conduct disorders over a 3 year period	Estimated numbers of children with chronic conditions have been calculated from national data: • 70 children with Cystic Fibrosis • 70 children with Sickle Cell Disease • 240 children with Crohn's disease • 360 children with diabetes mellitus • 280 children with a cancer such as Leukaemia • 10,690 children with asthma
Homeless Young People	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation	• Rate of homelessness among children and families in Nottinghamshire in 2011/12 was 0.9 per 1000 households. This is lower than the averages for the East Midlands (1.6 per 1000) and England (1.7 per 1000).
Lesbian, gay, bisexual or transgender Young People	7 fold increased risk of suicide attempts in young lesbians 18 fold increased risk of suicide attempts in young gay men	• Numbers are unknown.
Young offenders	18 fold increased risk of suicide for men in custody aged 15-17 40 fold increased risk of	• Between Jan and Dec 2011 there were 1390 young people in the youth justice system. • While rates of first time entrants to youth justice system have reduced, they remain significantly higher in

	suicide in women in custody aged <25 3 fold increased risk of mental disorders	Nottinghamshire (929 per 100,000) than the England average (712 per 100,000).
Looked after children	5 fold increased risk of any childhood mental disorder 6-7 fold increased risk of conduct disorder 4-5 fold increased risk of suicide attempt as an adult	• 891 looked after children in Feb 2013 • Numbers have increased considerably, from 440 in March 2007 to 800 in March 2012 • Numbers are highest in Ashfield (198) and Mansfield (187).
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes	• There are no local data sources on numbers of children with a parent in prison. Using national data, it is estimated that about 8000 school aged children and young people in Nottinghamshire will see their father imprisoned during their school years.

Source: Department of Health (2011a).

2. Size of the issue locally

Prevalence of mental health problems

Mental health ranges from mental wellbeing to severe and enduring mental disorders that cause considerable distress and interfere with relationships and daily functioning. There is limited data on the incidence and prevalence of mental health problems in children and young people, particularly for less severe mental health problems that are not reported to services or that are managed within universal services such as primary care or schools. Thus, the exact prevalence of mental health problems among children and young people in Nottinghamshire is not known. The most comprehensive data on the prevalence and risk factors for mental health disorders among children and young people comes from a large national survey carried out by the Office for National Statistics (ONS) in 2004 (Green *et al*, 2004). This survey focused on school-aged children living in private households and found that one in ten school-aged children in Great Britain had a clinically recognisable mental health disorder. Among those surveyed 6% had a conduct disorder, 4% had an emotional disorder (e.g. anxiety or depression), 2% had a hyperkinetic disorder (e.g. ADHD) and 1% had a less common disorder (e.g. eating disorders, tics). Boys were more likely than girls to have a mental health disorder and in particular, were more likely to suffer from conduct or hyperkinetic disorders. Girls were slightly more likely to have an emotional disorder than boys. The prevalence of mental health disorders was higher in the 11-16 age group than the 5-10 year old age group.

Using national data from the 2004 ONS survey, the number of children and young people with 'any mental disorder' in Nottinghamshire can be estimated, and broken down by district (Table 1). These estimates need to be treated with caution since they do not take into account the variation in the prevalence of risk factors for mental disorders across the County. For example, the prevalence of mental health disorders is higher among those living in deprived areas. In Nottinghamshire, Ashfield and Mansfield are the two most deprived districts, with a higher percentage of children living in poverty in these two districts than the England average. Therefore calculating the numbers of children with a mental health disorder based on national rates may underestimate the actual numbers affected in these

districts. Table 2 shows estimated numbers of children with emotional, conduct, hyperkinetic and 'less common' disorders in Nottinghamshire, by district.

Table 1: Estimated numbers of children aged 5-16 in Nottinghamshire with 'any mental health disorder'

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

Source: Child and Maternal Health Observatory, population based on the 2011 Census
Note: 'Any mental health disorder' includes emotional, conduct, hyperkinetic and less common disorders.

Table 2: Estimated number of children in Nottinghamshire with a specific types of mental health disorder

Type of Disorder	Children aged 5-10	Children aged 11-16
Emotional disorders	1223	2792
Conduct disorders	2498	3685
Hyperkinetic disorders	816	781
Less common disorders	663	781

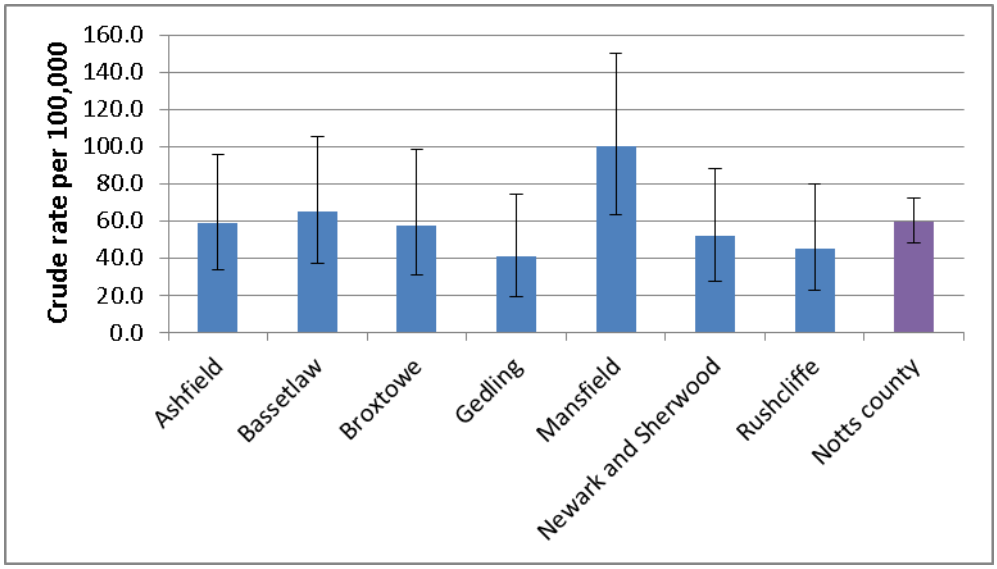
Source: Child and Maternal Health Observatory, based on the 2011 Census

Estimates of the prevalence of mental disorders among preschool children are less robust, and studies suggest prevalence could vary as widely as 10% to 19.6% (Egger and Angold, 2004; Mental Health Foundation). Applying these two estimated prevalence figures to the Nottinghamshire child population suggests that between 3586 and 7028 children aged 2-5 could have a mental health problem.

Self-Harm and Suicide

Self-harm is not confined to particular age groups and occurs in people of all ages with children as young as eight having been found to have hurt themselves (Royal College of Psychiatrists, 2010). Risk factors for self-harm in childhood are varied but include physical or sexual abuse, alcohol problems in childhood, existence of coexisting mental health disorders (e.g. depression) and difficult relationships with friends or family. Self-harm is more common in adolescent females than males and those who repeatedly self-harm are at believed to be at increased risk of suicide. Figure 1 shows crude rates of hospital admissions as a consequence of self-harm among children and young people. The highest rate is evident in Mansfield followed by Bassetlaw, although the differences in rates are not statistically significant due to the small numbers. However, it must be noted that the rates shown in Figure 1 underestimate the true burden of self-harm among children and young people, as the data excludes those individuals seen in primary care or within CAMHS. In addition, self-harm is often carried out in secret and so may not come to medical attention.

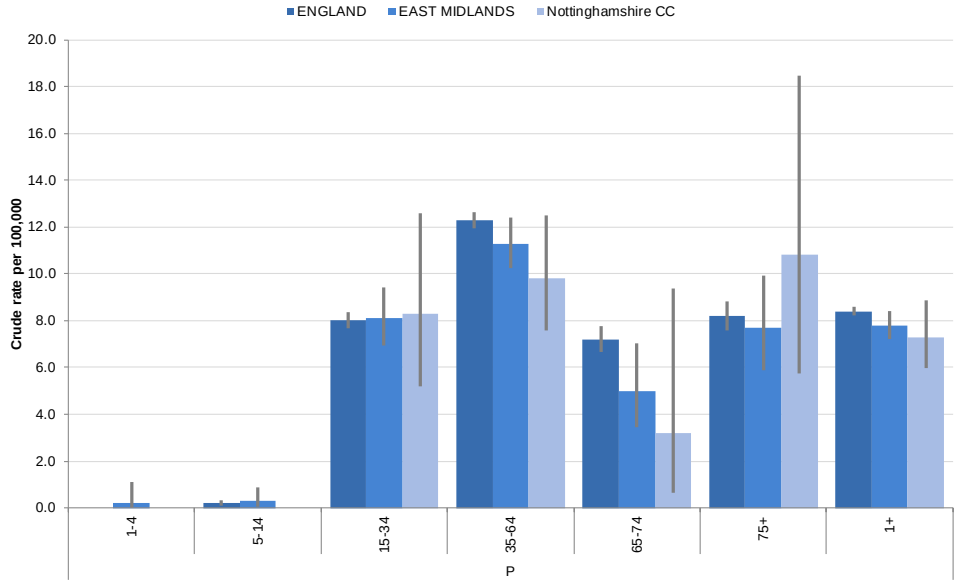
Figure 1: Crude rate of hospital admissions for self-harm among children and young people aged 0-18 by local authority (2012)



Source: Hospital Episode Statistics, 2012

Numbers of suicides among children and young people are low. Figure 2 shows the rates of suicide for Nottinghamshire, the East Midlands and England by age for 2008-10. As can be seen, the crude rate of suicide is low in under 15 year olds, but rises steeply in the 15-34 year old age group.

Figure 2: Suicides in Nottinghamshire, compared to the East Midlands and England, 2008-2010



Source: Health and Social Care Information Centre (2008-10)

Local analysis of data from the Child Death Overview Panel on cases of suicide among children between 2009 and 2012, has been carried out (Nathan, 2012). Broad findings include:

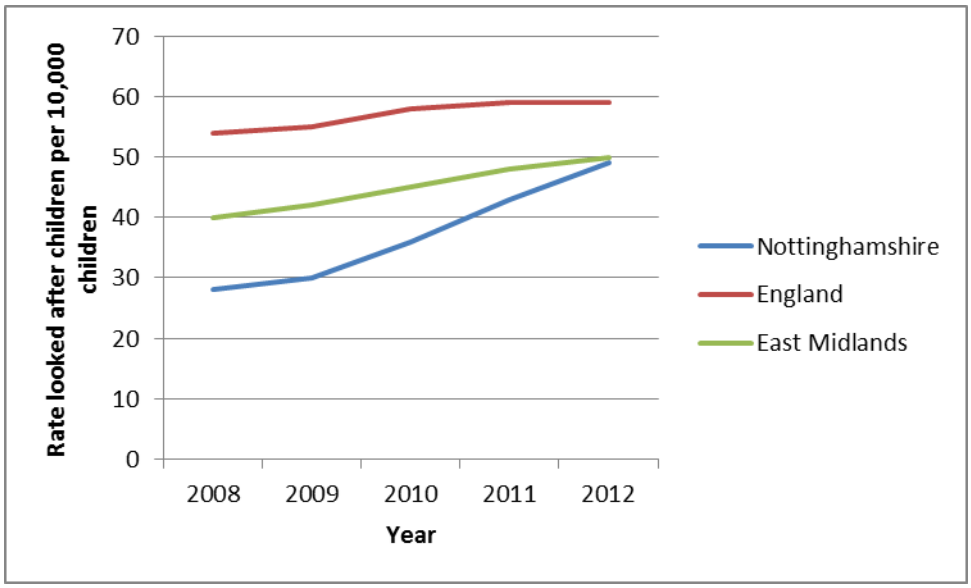
- Recognition of two main groups of young people committing suicide: (1) Those with recognised needs and service involvement from CAMHS/ other services and (2) A group of young people often invisible to services carrying out impulsive acts.
- The vast majority die by asphyxiation (from hanging/ligatures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

2. How do we compare with others?

There is limited data that allows comparison of the emotional and mental wellbeing of children and young people in Nottinghamshire with other areas. The main comparisons that can be made are based on comparing the prevalence of risk factors for emotional and mental health problems. Nationally, co-ordinated CAMHS mapping exercises were carried out until 2009/10 but this data is now out of date.

Looked after children and young offenders are groups of children and young people recognised as having a particularly high risk of emotional and mental health problems. Estimates indicate that about 45% and 40% respectively have a mental health disorder. Compared to the East Midlands and England, Nottinghamshire has a lower proportion of looked after children but this has increased sharply since 2009, as shown in Figure 3, a trend which is different from the national picture. In relation to young offenders, the rate of first time entrants to youth justice system is significantly higher in Nottinghamshire (929 per 100,000) compared to the England average (712 per 100,000).

Figure 3: Rate of looked after children per 10,000 children



Source: Data from the Department for Education. 2008-2012

3. Trends (national/local) and projections of need/service use

National trends

Evidence suggests that substantial rises in the prevalence of mental health problems among children and young people have occurred over the last two to three decades. The most robust evidence comes from a study by Collishaw *et al* (2004) which used data from 3 national surveys, the National Child Development Study, the 1970 Birth Cohort Study and the 1999 British Child and Adolescent Mental Health Survey, each of which involved the completion of a questionnaire by parents, describing their child's symptoms. The authors found a continued rise in conduct problems for both boys and girls over the 25 year study period, in which reported emotional problems increased among both boys and girls between the mid-1980s and 1999. No clear trend in adolescent hyperactivity for either boys or girls was established in any of the three surveys.

National service utilisation data from specialist mental health services in England has shown more than a 40% rise in referral rates between 2003 and 2009/10 (National CAMHS Support Service, 2011).

Local Trends

The 0-19 year old population in Nottinghamshire is expected to increase by an average of 3.5% over the next ten years, with the highest projected increases in Rushcliffe (6.4%) and Newark & Sherwood (5.0%) and the lowest in Bassetlaw (0.9%) and Broxtowe (1.0%). The largest increases are expected in the 5-9 year old population (+17.3% by 2021). A proportionate increase in need and demand on services can be expected as a direct consequence of such a population rise.

Notable trends within Nottinghamshire include:

- Numbers of children with ADHD and autistic spectrum disorder (ASD) are reported to have increased. Data from the Nottinghamshire Inclusion Support Service shows a progressive increase in the numbers of children diagnosed with autism between 1999 and 2009.

- Numbers of children being seen for self-harm by both the Nottinghamshire South and Nottinghamshire North self-harm services have increased considerably; the services have reported an increase in the numbers of both urgent and complex self-harm cases.

- The numbers of looked after children in Nottinghamshire has increased considerably from 440 in March 2007 to 800 in March 2012.

4. Targets and performance

Despite there not being an indicator specific to child and adolescent mental health within the Public Health Outcomes Framework, there are several related indicators as listed below (Department of Health, 2012):

Indicator 1.01 Children in poverty
Indicator 1.04 First time entrants to the youth justice system
Indicator 1.05 16-18 year olds not in education not in training
Indicator 2.08 Emotional wellbeing of looked after children
Indicator 2.23 Self-reported wellbeing (measured for those 16 years and over).
Indicator 4.10 Suicide rate (all ages, adults and children)

5. National and Local strategies

Key national strategies and policies relating to child and adolescent emotional and mental health include:

- The National Service Framework for Children, Young People and Maternity Services (2004).
- No Health Without Mental Health: A Cross Government Mental Health Outcomes Strategy For People of All Ages (2011).
- 'Talking Therapies- A four-year plan of action'. Department of Health (2011). This strategy outlines the Government's commitment to expand access to psychological therapies to include a specific programme to meet the needs of children and young people, building on learning from the Improving Access to Psychological Therapies (IAPT) programme.

Locally, the emotional and mental health of children and young people is highlighted as a priority in the:

- Nottinghamshire Children, Young People and Families Plan 2014 to 2016.
- Nottinghamshire Health and Wellbeing Strategy 2014-17.

6. Local Views

As part of the health needs assessment of the emotional and mental health of children and young people carried out in 2013 (Baker, 2013), 20 stakeholders (commissioners, providers and universal services) were interviewed about the perceived needs of children and young

people in Nottinghamshire, current service provision and gaps in this provision. Key findings included:

- Reported increases in children referred to CAMHS for behaviour problems, ADHD and ASD. Many stakeholders reported that behavioural problems were sometimes inappropriately referred to CAMHS and that universal services require more support in order to manage these cases.
- Reported increases in self-harm cases, particularly in terms of the complexity of the cases.
- A need for early intervention and work with families in order to try to break the cycle of risk factors leading to mental health problems in children. Often emotional and mental health issues seen by CAMHS were perceived to be rooted in societal and generational problems which could not easily be addressed by CAMHS services alone.
- A lack of capacity in some CAMHS services. In some teams, particularly Tier 2 district teams, staff shortages were leading to high waiting times.
- A need for clear pathways and a clear understanding of the role of CAMHS among families and referrers. Poor quality referrals to CAMHS provide insufficient information about the child's history or symptoms to allow assessment of risk, resulting in a time consuming process for CAMHS staff to contact referrers for further information.
- A need for services to be more targeted to those areas with the highest levels of need. It was felt there was a need to understand which children or specific conditions really needed targeting.

7. Current activity and service provision

CAMHS services are split into four tiers:

Tier 1 CAMHS is provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services. There are no readily available data sources to assess Tier 1 service use.

Tier 2 CAMHS is provided by specialists working in community and primary care settings in a uni-disciplinary way. They offer consultation to families and other practitioners, outreach to identify severe and complex needs, and training to practitioners at Tier 1. Within Nottinghamshire, the District Emotional Health and Wellbeing Service has teams based in Ashfield, Broxtowe, Gelding, Mansfield, Newark and Sherwood and Rushcliffe, whilst Bassetlaw is covered by the Bassetlaw Emotional Wellbeing Team.

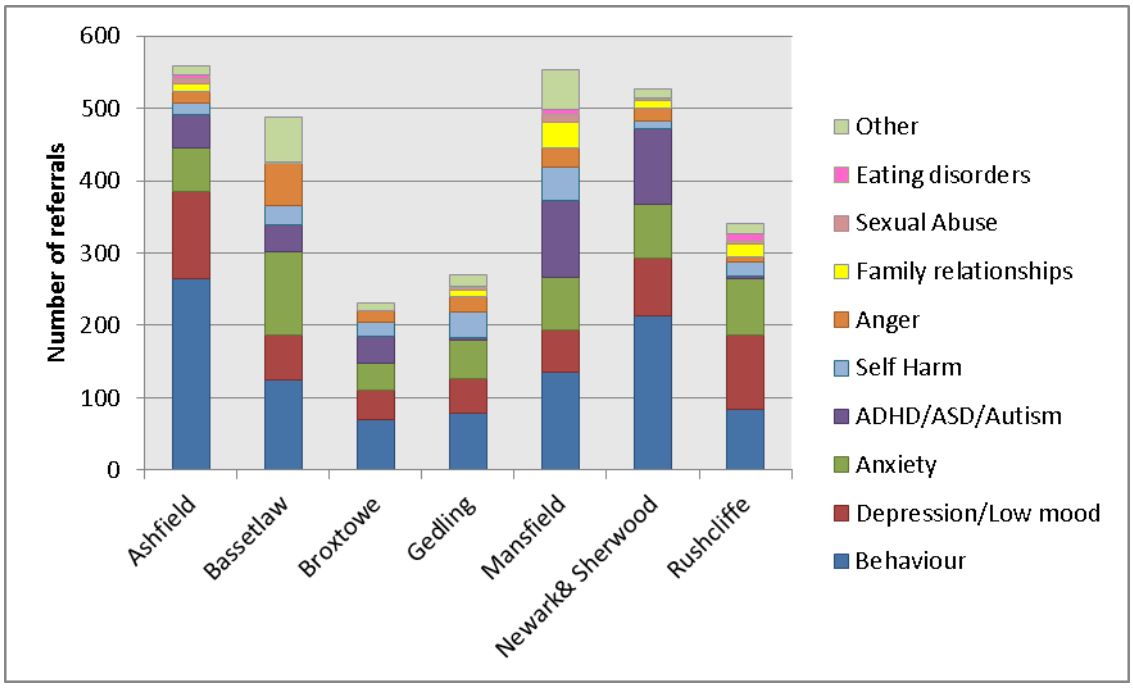
In 2012/13 there were 2967 referrals to Tier 2 district teams. Numbers of referrals were highest in Ashfield (559), Mansfield (554) and Newark and Sherwood (527). The most common 'reasons for referral' were 'behaviour', 'depression/low mood' and 'anxiety', although the patterns varied by district (Figure 4).

Table 5: Referrals to Tier 2 District CAMHS Teams 2012/13

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

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

Figure 4: Reason for referral to Tier 2 CAMHS, 2012/13



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

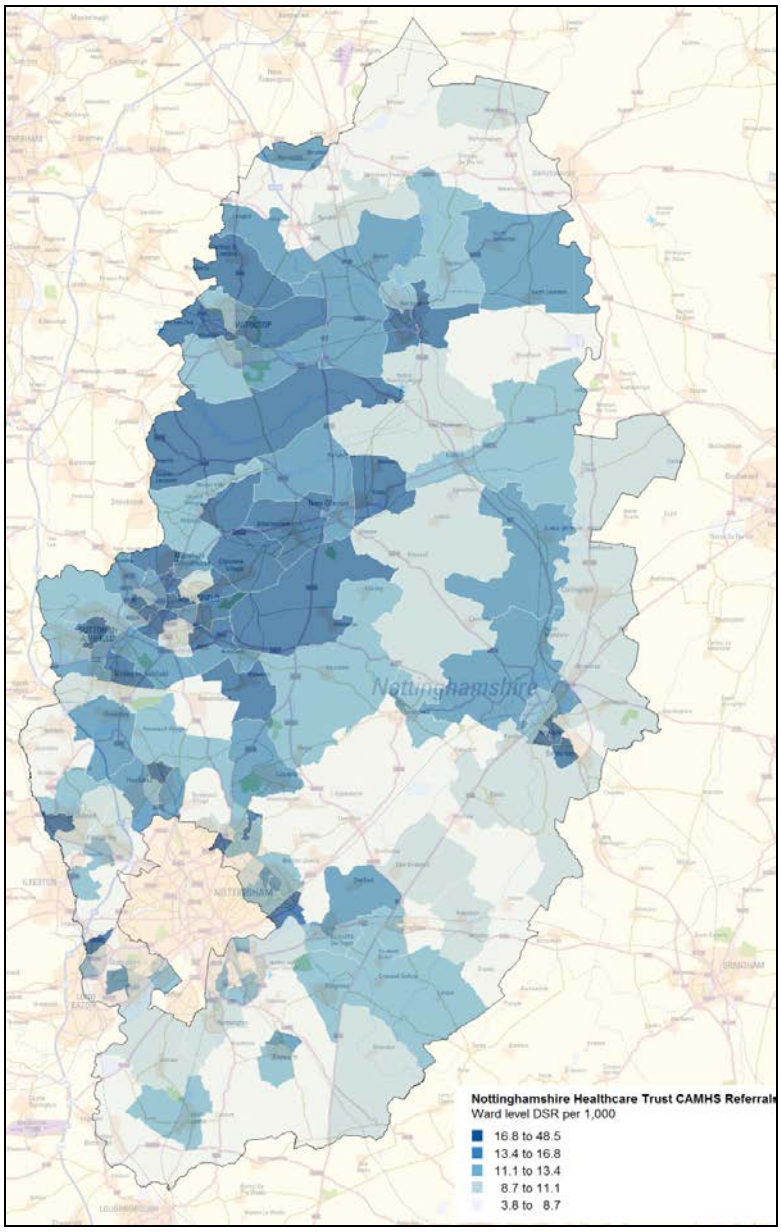
Tier 3 CAMHS services are provided by a multi-disciplinary team working in community mental health clinics, child psychiatry outpatient services or community settings. A number of services in Nottinghamshire make up Tier 3 CAHMs (Table 6), which offer a specialised service for those with more severe, complex and persistent disorders.

Table 6: Description of Tier 3 CAMHS Services

Service	Service description
Specialist Community CAMHS	2 teams cover Nottinghamshire County South and Nottinghamshire County North. Clinics run at Thorneywood (Nottingham), Mansfield, Newark and Worksop. Teams work with children and young people aged 0-18 experiencing a range of complex mental health disorders, such as depression, OCD, self-harm, eating disorders.
Neuro-developmental Disorders Team	Team sees children and young people with neurodevelopmental disorders who present with mental health disorders (e.g. ADHD, Tics and Tourette's, acquired organic brain disorders). This team is based at the Queen's Medical Centre (QMC), Nottingham.
Self-Harm Team	Team provides comprehensive risk assessment and short term follow up to young people under 16 admitted to a paediatric ward at QMC following an episode of self-harm. In the North of the County, Specialist Community CAMHS staff provide cover to Bassetlaw and King's Mill Hospital, assessing and providing follow up to those presenting with self-harm.
Paediatric Liaison	Provides assessment, management and joint management of children and young people experiencing behavioural, emotional or psychiatric disorders in the context of acute, chronic and terminal illness. This team is based at QMC.
Head2Head	Head2Head provides: -**A Youth Justice Team**. Providing services for young people subject to a criminal order who are presenting with a mental health issue. -**Dual Diagnosis Team**. Children and young people who have a mental health disorder and are also using drugs or alcohol. -**Early Intervention in Psychosis Team**. People aged between 14 and 35 who present with symptoms that are indicative of a first episode of psychosis. -**Young People who Sexually Harm Others Team**. Young people who have significant mental health problems or learning disabilities and have sexually harmed others. This team provides a Countywide service for children and young people in a number of locations including GP practices, youth centres and at home.
Looked After Children's Team	The multidisciplinary team provides a countywide service to children and young people who are looked after or who have been adopted, and their families/ networks. The team manages Tier 2-4 cases, meaning that a broad range of mental health problems are covered. Children are referred to the team if they have a high score on the Strengths and Difficulties Questionnaire undertaken when children first come into care.
Intensive Interventions Team	This new service is continuing to run after its pilot ended in July 2012. It aims to provide intensive interventions to support community teams or prevent admissions (supports Tiers 3 and 4). The team is based at Thorneywood, Nottingham.
Specialist Learning Disability Service	This service is available for children and young people with learning disabilities who are experiencing severe and debilitating mental health problems and associated impacts.
Eating Disorder Service (Pilot)	This is an outpatient service, currently being piloted, which works with young people presenting with eating disorders.

Figure 5 shows referral rates to Tier 3 CAMHS at ward level. The pattern of referrals largely mirrors deprivation levels across the county.

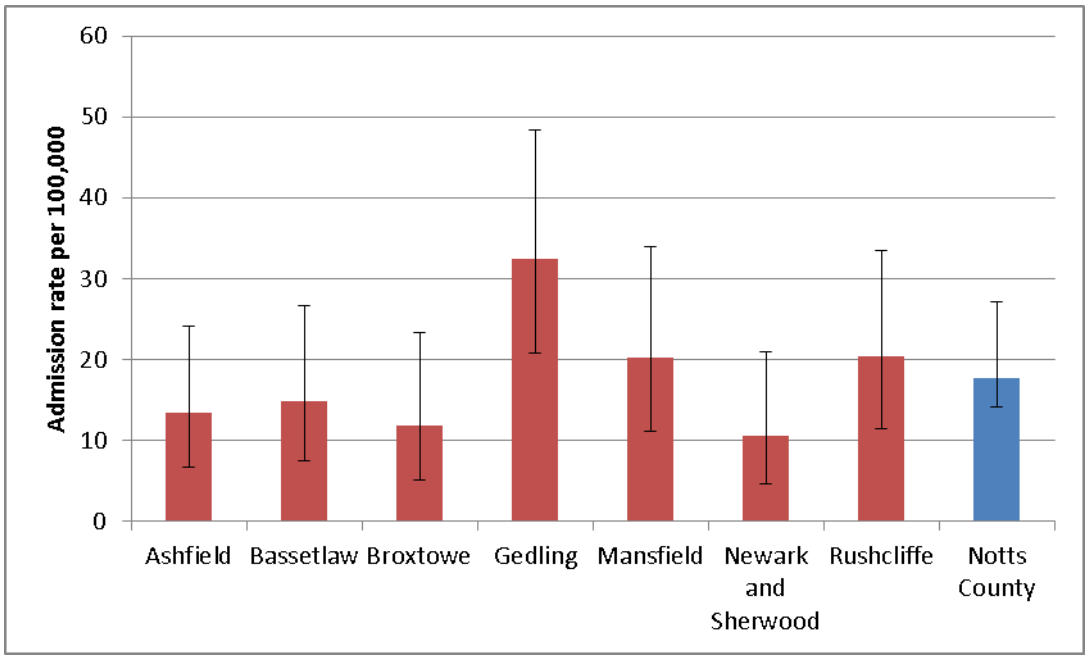
Figure 5: Directly standardised referral rates to Tier 3 CAMHS 2009-2011



Source: Nottinghamshire Healthcare Trust, 2009- 2011

Tier 4 CAMHS includes highly specialised inpatient care. The Thorneywood inpatient unity provides Tier 4 inpatient services to young people from Nottinghamshire, Derbyshire, Nottingham City and other areas. Over three years (2010-2012) there were 91 admissions to the Thorneywood inpatient unit of 77 individual young people from Nottinghamshire. Figure 6 shows the crude admission rate of children and young people to the Tier 4 CAMHS inpatient unit according to district. The districts with the highest crude admission rates were Gedling (32.4 per 100,000), Rushcliffe (20.3 per 100,000) and Mansfield (20.3 per 100,000). The most common diagnoses were 'eating disorders', 'developmental disorders' and 'depression'.

Figure 6: Crude Admission rate into Tier 4 Inpatient Services according to district, 2010-2012



Sources: Nottinghamshire Healthcare Trust, ONS Census 2011

What does this tell us?

8. What are the key inequalities?

There has been no equality impact assessment undertaken for child emotional and mental health. Mental illness is both a consequence and a cause of poverty. National data indicates that the prevalence of mental health problems is higher among children and young people living in deprived areas, whilst many of the other risk factors for mental health problems are strongly associated with deprivation, including parental unemployment, low income, living in social housing, and adverse life events. In addition, parental mental health problems are associated with poorer child mental health.

9. Where are the gaps in service?

- **Interventions to prevent emotional and mental health problems.** Within Nottinghamshire, many children and young people are exposed to risk factors for emotional and mental health problems from birth. In some areas there is a clustering of interrelated risk factors, and as issues can be entrenched in families over generations there is a need to break the cycle, intervene early and collaborate across agencies to build emotional and mental resilience.

- **Targeting of services and interventions.** There are different levels of need and service use across Nottinghamshire. The current configuration of Tier 2 CAMHS services does not take into account these different levels of need. Preventative interventions (e.g. parenting courses) and CAMHS services need to be targeted at those with the highest levels of need. Another group of children to target is those with less common conditions that lead to very high healthcare costs, for example those with eating disorders, who account for a small percentage of Tier 2 referrals, but a large proportion of inpatient admissions. This emphasises the need for the early recognition and management of eating disorders to prevent the need for admission.

- **Getting the right care from the right team.** There is concern about high numbers of referrals for 'behaviour' problems and increasing numbers of self-harm cases. There is a need to further explore these issues to understand how best to meet the needs of these children and their families, and establish which services (across Tiers 1, 2 and 3 of CAMHS) best meet their needs.

- **Supporting and building the workforce.** A well trained workforce of sufficient capacity is essential for the delivery of an effective CAMHS service across the four tiers. There is a need to ensure that both the CAMHS workforce and those working in universal services have access to training and development opportunities. There is recognition that staff training within universal services in Bassetlaw requires development.

10. Where are the gaps in knowledge?

Data relating to the provision of emotional health and wellbeing support to children and young people through universal services is not routinely collected. This is in part because such a wide range of agencies are included in the universal tier. However stakeholders, including those at the universal level (e.g. school nursing), have reported an increase in self-harm cases and in the complexity of these cases. Further data and insight from services is required to explore this pattern.

Nationally it is recognised that difficulties may exist when a young person moves from CAMHS to adult mental health services transition. This in part relates to different configurations of CAMHS and adult mental health services. There are no local data on numbers of young people who successfully transition to adult services, or where there are problems. A local audit of children transitioning to adult services is required to explore this issue.

11. What are the risks of not delivering targets?

There is a strong case for investing in the prevention of child emotional and mental health problems, both socially and economically. There is evidence to suggest mental health difficulties can lead to a number of negative consequences with damaging economic and social implications (The Mental Health Foundation, 2004), including:

- Low academic achievement.
- Adult psychiatric problems.
- Unwanted pregnancy, criminal conviction.
- Persistence of personality traits that are not conducive to success in the labour market.

Several studies have attempted to calculate the economic costs of mental health problems among children:

- Scott *et al* (2001) found that the cumulative costs of public service use through to adulthood by individuals with 'troubled behaviour' as children were 10 times higher than for those with no problems. Conduct disorder was the most significant predictor, with greatest costs incurred for crime, followed by extra educational provision, foster and residential care, and state benefits.
- A review by the World Health Organisation identified 5 UK studies that attempted to estimate the costs of mental illness during childhood and adolescence (World Health Organisation, 2008). The mean annual cost of mental illnesses estimated by the five studies, ranged between £11,030 and £59,130 per child.
- It has been estimated that the lifetime cost of a one year cohort of children with conduct disorders (6% child population) is about £5.2 billion (Department of Health, 2011b).

Together these data support the need for the early identification of poor emotional and mental health in children and young people and the delivery of evidence-based interventions so that the potential social and economic burden can be minimised.

12. What is on the horizon?

- The introduction of IAPT for children and young people within Nottinghamshire.

- Outcomes of the CAMHS pathway review across Nottingham City and Nottinghamshire County which commenced in October 2013.

- Outcomes of the national Tier 4 CAMHS review and the Health Select Committee Inquiry into children's and adolescent mental health and CAMHS in Autumn 2014

What should we be doing next?

1. Take a life course approach to preventing emotional and mental health problems among children and young people.

- Review parenting course provision and assess gaps in current provision.
- Investigate current management and screening for perinatal mental health conditions.
- Work with schools to implement evidence based interventions that build emotional resilience, promote emotional and mental wellbeing and reduce bullying.
- Promote a 'Think Family' approach within services.
- Work with multiagency partners to reduce or mitigate risk factors for child mental health problems (e.g. parental unemployment, child poverty, domestic violence) by raising awareness among these partners, of their role in improving child emotional and mental health.

2. Develop and improve services and care pathways

- Carry out a multiagency review of Tiers 1, 2 and 3 CAMHS services, involving service users.
- Embed IAPT principles into existing care pathways and services.
- Ensure collaborative working across Tiers of CAMHS to ensure smooth transition of patients between Tiers and to minimise the duplication of assessments.

3. Support and build the workforce

- Extend the delivery of training to universal services to cover Bassetlaw.
- Consider targeted training to meet the needs of particular professional groups within universal services.

4. Promote services to children, families and referrers.

- Consider ways to promote mental health and wellbeing among children and young people (e.g. online resources or social media).
- Ensure information about how and when to refer to CAMHS and pathways is readily available and easily accessible, for example, via the Pathway to Provision.
- Ensure key universal services are updated about new evidence based guidelines relevant to their practise.

5. Improve data on CAMHS services' performance and outcomes

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

6. Develop a mental health strategy across the life course

- Work with adult mental health commissioners in the development of a '*No Health without Mental Health*' local strategy across the life course.

Together these actions will improve the quality of services that promote emotional wellbeing and good mental health in Nottinghamshire. They will help to ensure that there is good access to responsive and evidence-based services across the county and that there is an appropriately trained workforce in place to deliver this.

References

Baker, R. (2013). The emotional wellbeing and mental health of children and young people in Nottinghamshire. A health needs assessment.

Collishaw, S., Maughan, B., Goodman, R. and Pickles, A. (2004). Time trends in adolescent mental health. *Journal of child psychology and psychiatry, and allied disciplines* **45**, 1350–62.

Department of Health. (2011a). No Health Without Mental Health: A cross- Government mental health outcomes strategy for people of all ages. Annex B - Evidence Base Supporting document to: No Health without Mental Health.

Department of Health. (2011b). No health without mental health: A cross- Government mental health outcomes strategy for people of all ages. Supporting document – The economic case for improving efficiency and quality in mental health.

Department of Health. (2012). Public Health Outcomes Framework Data Tool. Available online http://www.phoutcomes.info

Egger, H. & Angold, A. The Preschool age Psychiatric Assessment (PAPA): A structured parent interview for diagnosing disorders in preschool children. *Handbook of infant, toddler, and preschool mental health assessment,* 223–243 (2004).

Green, H., McGinnity, A., Meltzer, H., Ford, T. & Goodman, R. (2004). Mental Health of Children and Young People in Great Britain, 2004. Office for National Statistics.

HM Government. (2012). *No Health Without Mental Health.* A cross-government mental health outcomes strategy for people of all ages.

Nathan, D. (2012). Analysis of suicides in Nottinghamshire.

National CAMHS Support Service. (2011). Better Mental Health Outcomes for Children and Young People. A Resource Directory for Commissioners. Available online www.chimat.org.uk/camhs/commissioners

Parry-Langdon, N. (2008). Three years on: Survey of the development and emotional well-being of children and young people. Office for National Statistics.

Royal College of Psychiatrists. (2010). Self-harm, suicide and risk: helping people who self-harm. Final Report of a Working Group.

Scott, S. and Spender, Q. *et al.* (2001). Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice *British Medical Journal* Vol. 323, pp.194.

The Mental Health Foundation. Infants need mental health checks.

The Mental Health Foundation. (2004). Lifetime impacts. Childhood and Adolescent Mental Health: understanding the lifetime impacts.

World Health Organisation. (2008). Social Cohesion for Mental Well-being among Adolescents.

Supporting Documents

This JSNA chapter is based on a comprehensive health needs assessment carried out in 2013, “The emotional wellbeing and mental health of children and young people in Nottinghamshire. A health needs assessment”. Further detail can be found in this document.