The emotional and mental health needs of children and young people aged 0 – 18 years old living in Nottingham City

Health Needs Assessment

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Executive Summary

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

1. The importance of child and adolescent emotional and mental health

Good mental and emotional health is essential to enable children and young people to fulfil their potential. Mental and emotional health problems are an important and common group of disorders affecting about 1 in 10 children and young people living in the UK [(1)]. Mental health is best seen as a continuum, ranging from mental wellbeing, to severe and enduring mental disorders that cause considerable distress and interfere with relationships and daily functioning. Mental health problems vary in their nature and severity, and affect individuals differently over time. The factors that affect mental and emotional health are complex, ranging from individual biological factors to complex societal issues. Mental health problems in childhood and adolescence are particularly important due to the far reaching consequences on health, social and educational outcomes. Mental health problems unlike other health problems tend to start early and persist into and throughout adulthood. It is recognised that by the age of 14 about half of all lifetime mental health problems start [(2).]

The aim of this Health Needs Assessment is 'to systematically assess the emotional and mental health needs of children and young people aged 0-18 living in Nottingham City and investigate current service provision.'

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

The total number of children and young people aged 0 – 18 living in Nottingham City is 68,424 with the 0-19 population set to increase by 2.2% in the next 10 years. About 35.1% of children in Nottingham City are living in poverty with an estimated 1 in 5 children experiencing emotional and mental health problems.

Risk factors for emotional and mental health problems are summarised in Box 1. Many of these risk factors tend to cluster together. For example, rates of lone parent families, those living in social or

privately rented accommodation, parents receiving disability allowance and levels of domestic violence are generally highest in Aspley, Bulwell, Bestwood and Bilborough.

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

- Child abuse
- Poor parental mental health
- Parental Substance misuse
- Being in Local Authority care
- Being in local authority care
- Physical or learning disability
- Special Educational Needs
- Not in training education or employment
- Lone parent
- Maternal stress in pregnancy
- Living in deprived areas
- Experiencing Domestic Violence
- Homelessness
- Physical Illness
- Gypsy or Traveller
- Lesbian, gay, bisexual or transgender
- Poor parenting skills
- Low household income
- Living in social housing

RISK FACTORS FOR MENTAL ILLNESS IN CHILDREN AND YOUNG PEOPLE, [2] [4]

Looked after children, young offenders and children who experience or witness domestic violence are recognised to have high risk of emotional and mental health problems with estimates around 45%, 40% and 25% respectively. Numbers of looked after children (LAC) have significantly increased within Nottingham City an increase of 4.5% year on year, and at the end of March 2013 there were 560 LAC in Nottingham, an increase from 540 at the same time in 2012. There were 2066 first time entrants into the Youth Justice system between 2011/2012; the rate in Nottingham is significantly higher than the England average. It is estimated that 3 children in every classroom of 30 have experience of domestic violence. The high numbers of reported domestic violence in Nottingham is one of the highest in the UK which puts huge pressures on resources available. The first year of the Domestic Abuse Referral Team (DART) system in Nottingham has included cases involving 3010 victims and 4236 children, 3000 of whom are under 10 years of age.

Based upon data from the Office of National Statistics, it is estimated that there are 3,778 children and young people aged 5-16 years in Nottingham who have emotional, conduct, hyperkinetic and 'less common' disorders, although due to the risk factors explained above this figure is likely to be an underestimate.

3. Current services; use and views of stakeholders of Child and Adolescent Mental Health Services (CAMHS)

Universal Services/tier 1 is provided by practitioners working in universal services (such as GPs, Health Visitors, teachers and youth workers), who are not necessarily mental health specialists.

Tier 2 CAMHS offers an effective early intervention service to prevent emotional and behavioural difficulties emerging into more complex ones. It is a jointly commissioned service by Nottingham City Council and NHS Nottingham City CCG. In 2012/2013 there were 1301 referrals into tier 2 with the most common reasons for referral being challenging behaviour, low mood and self-harm. Referrals are highest in the north of the city which reflects a larger population of children and young people. There has been a significant increase in the numbers referred for self-harm in 2012/2013 – 2013/2014 and indications for this financial year suggest there has been an increase in the number of children and young people referred for suicidal thoughts.

Tier 3 CAMHS provides specialist multi-disciplinary services for severe and complex child and adolescent mental health problems. In 2012, 163 children and young people were seen in tier 3 CAMHS, of which 113 (69%) were male and 50 (31%) were female. The main reason for referral was self –harm, followed by challenging behaviours and eating disorders.

A self-harm audit conducted on 15 cases of young people who were admitted to Queens Medical Centre (QMC) for self-harm demonstrated some preliminary risk factors, the main ones being poor parental mental health and low attachment. It is anticipated this will be an ongoing audit over 2014 to identify trends and emerging themes in order to implement early intervention.

Tier 4 CAMHs includes highly specialised inpatient care. Between 1st Jan 2010 and 31st December, 2012, 23 young people completed 25 hospital spells. The most common reasons for admission were non mental health diagnoses such as behaviour which require a psychiatric assessment, history of self-harm and eating disorders.

Views of stakeholders

Semi structured interviews with those professionals working with children and young people in Nottingham highlighted:

- A significant number of children are referred for challenging behaviour.

- A significant number of children presenting to services are self-harming.
- There is a need for early intervention and work with families.
- Children and young people within schools are increasingly under pressure to improve their performance.
- All tiers of CAMHS services are at critical point in terms of numbers being referred into the service which is causing significant waiting times.
- There is no out of hours service within the city, hence increasing number of children and young people presenting to Emergency Department (ED) at QMC.

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

Recommendations

Antenatal

- There is still more work which needs to take place within universal services to actively promote the importance of early attachment to all women who are pregnant (Conception to age 2 - the age of opportunity | WAVE Trust) . This should be incorporated into all antenatal appointments. *This recommendation will be fed into the midwifery review and be incorporated into NHS Nottingham City CCG new midwifery specification.*
- Antenatal and perinatal health needs to focus more on emotional and mental health of mothers with the development of specialist mental health midwives to support mothers with post natal depression . This is particularly important due to the link between antenatal anxiety at 32 weeks and the link to behavioural and emotional problems in children. *This recommendation will be fed into NHS Nottingham City CCG midwifery review.*
- Develop universal programmes which address how to parent effectively as part of antenatal care for example based on the Family Partnership programme in the USA. This recommendation will be fed into the Nottingham City Emotional, Mental Health and Wellbeing pathway which is in development.

Early Years

- Utilise the school readiness check at age 4 to undertake an emotional and mental wellbeing check of the child and pass on any information to the school and school health.

School Aged Children

- Systematically deliver evidence based interventions (SEAL programme) within all schools with Nottingham.
- Provide guidelines to schools on how to effectively use the pupil premium for quality emotional and mental health support for pupils

Parents/Family

Systematic support should be provided to families with children and young people who are experiencing domestic violence at all risk levels as assessed by DART. There needs to be recognition of the impact of DV on children's emotional and mental health.

- Ensure all services are linked into Nottingham City Council's Family Support Strategy.
- All adult mental health services should have a Key Performance Indicator to support the emotional and mental health needs of children, particularly when parents are diagnosed with a mental health condition.
- All children's services to consider parental mental health, substance misuse and domestic violence as factors affecting child emotional and mental health and to signpost/refer to appropriate services.

Training

- All primary care (GPs, school nurses and health visitors) and schools (all teachers) should have comprehensive training in the skills and knowledge required to recognise children and families who may be experiencing emotional and mental health problems.

- A comprehensive self-harm training programme should be developed and delivered to all GPs, schools (both primary and secondary including teachers) and school nurses.
- Roll out the Public Health England tool Kit for emotional health in schools.

Child and adolescent mental health services and proposed pathways

- Utilise tier 2/3 service usage data to deliver a multi-disciplinary and skilled community CAMHS pathway provision where the child and young person is at the centre of delivery. This includes appropriate venues for meeting families and children and young people, suitable waiting times to the point of intervention and length of intervention time
- Ensure that the CAMHS pathway systematically supports universal services after the point of referral.
- Identify resources to develop a new CAMHS pathway in light of the increased number of referrals and improve partnership working with adult mental health services.
- Undertake a whole CAMHS workforce review to ensure there are the right skills and competences in relation to working with children and young people who are experiencing emotional and mental health problems.
- Develop a skills and competences quality standard for all CAMHS workforce.
- Develop a multi-agency assessment process with a single point of access which is inclusive of all appropriate referrers into the CAMHS service.
- Support the workforce and service users to smooth transition of patients between tiers and transition to adult services to minimise duplication of assessments.
- All young people who are admitted to QMC over the weekend with self-harm should have the standardised self-harm risk assessment tool undertaken as done by the specialist tier 3 self-harm team.
- Develop an appropriate pathway for children and young people who attend emergency department (ED) for self-harm.
- Track systematically the number of referrals into CAMHS for challenging behaviour to identify if there is a reduction of referrals as a direct result of the development of the emotional, mental health and wellbeing pathway.
- To ensure all referrers into CAMHS are provided with feedback on what intervention has been undertaken with the child and outcome of that intervention.

- The new CAMHS pathway needs to be communicated effectively across all universal services by the provision of comprehensive training, which needs to include explicit knowledge of interventions undertaken by the CAMHS workforce with children/young people.
- Provide a responsive CAMHS service which works into the evenings and weekends to minimise the number of admissions to QMC by young people and the need for inpatient beds.

Waiting times

- All referrals should work towards standardised waiting times and all interventions should be standardised to ensure children and young people are at the heart of the service.

CAMHS specific services

- All looked after children (LAC) undertake a strengths and difficulties questionnaire (SDQ) every 6 months as part of their LAC review. This will ensure that all LAC will be monitored for changes in their emotional and mental health state and subsequently be referred into the CAMHS looked after children team to appropriate interventions

Improving local data on children and young people's mental health

- Develop a core dataset to be reviewed at the CAMHS Executive, taking account of the development of a national CAMHS minimum dataset and the use of outcome measures such as The health of the nation outcomes scale for children and adolescents (HoNOSCA), for more information please go to http://www.liv.ac.uk/honosca/faq.htm.
- A systematic change needs to be implemented across the CAMHS which focuses on the outcome of the child/young person rather than the process. Investigate the possibility of a newly commissioned data system or that existing data systems talk to each other to ensure a smooth referral or transition between tiers of CAMHS for children and young people.

Abbreviations

ED: Emergency Department

ADHD: Attention Deficit Disorder

ASD: Autism Spectrum Disorder

BME: Black Minority Ethnic Group

CAMHS: Child and Adolescent Mental Health Services

CAF: Common Assessment Framework

CBT: Cognitive Behavioural Therapy

CHiMAT: Child and Maternal Health Observatory

DNA: Did Not Attend

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders

GP: General Practitioner

HNA: Health Needs Assessment

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

IMD: Index of Multiple Deprivation

JSNA: Joint Strategic Needs Assessment

LAC: Look after Children

LGBT: Lesbian, Gay, Bisexual, Transgender

MAACS: Multi- Agency Risk Assessment Conferences

NEET: Not in Education, Employment or Training

NICE: National Institute of Clinical Excellence

NSPCC: National Society for Prevention of Cruelty to Children

ONS: Office of National Statistics

OCD: Obsessive Compulsive Disorder

SEAL: Social and Emotional Aspects of Learning

SEN: Special Educational Needs

SDQ: Strengths and Difficulties Questionnaire

SPA: Single Point of Access

1. Introduction

Children and young people's emotional health and wellbeing is a public health priority.

1.1 The importance of child and adolescent mental and emotional health

Good mental and emotional health is essential to enable children and young people to fulfil their potential. Mental and emotional health problems are an important and common group of disorders affecting about 1 in 10 children and young people living in the UK [(1)]. Mental health is best seen as a continuum, ranging from mental wellbeing, to severe and enduring mental disorders that cause considerable distress and interfere with relationships and daily functioning. Mental health problems vary in their nature and severity, and affect individuals differently over time. The factors that affect mental and emotional health are complex, ranging from individual biological factors to complex societal issues. Mental health conditions in childhood and adolescence are particularly important due to the far reaching consequences on health, social and educational outcomes. Mental health problems unlike other health problems tend to start early and persist into and throughout adulthood. It is recognised that by the age of 14 about half of all lifetime mental health problems start [(2)]. This highlights the long term nature of mental illness and the importance of intervening early to prevent mental illness alongside early recognition and treatment.

1.2 Purpose of a health needs assessment (HNA)

A health needs assessment (HNA) is a systematic review of the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities [(3)]**.** HNAs provide evidence about a population in order to inform service planning and resource allocation with the aim of improving health and reducing health inequalities.

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

- Significant changes in the commissioning structures within the NHS that occurred as a result of the Health and Social Care Act (2012)4. Clinical Commissioning Groups (CCGs) have become responsible for the commissioning of healthcare services for the local population, replacing the previous commissioning bodies, Primary Care Trusts (PCTs). In relation to CAMHS, CCGs and Local Authorities (LA) are now responsible for the commissioning of specialist CAMHS services (tiera 2 and 3). NHS England, which commissions specialised

healthcare services, is responsible for commissioning tier 4 (highly specialised) CAMHS. Preventative emotional wellbeing services (tier 1) are commissioned by the Local Authority Public Health function (Nottingham City Council), CCGs (GP services) and NHS England (Health Visiting until April 2015 where it will be transferred over to the LA).

- Recognition nationally and locally of changing patterns of mental health and behavioural disorders among children.
- Recognition that there are increasing numbers children and young people entering into care nationally and locally within Nottingham City.
- Recognition nationally of the importance of mental health, and the publication of the government's strategy, 'No health without mental health'.

1.3 Aim of the HNA

'To systematically assess the emotional and mental health needs of children and young people aged 0-18 living in Nottingham City and investigate current service provision.'

1.4 Objectives of the HNA

1. To review evidence, policy, guidance and data on the emotional and mental health needs of children and young people.
2. To estimate the numbers of children and young people with emotional and mental health needs within Nottingham City.
3. To identify and map the current service provision and to assess the usage, uptake and future uptake of the CAMHs services.
4. To assess the needs children and young people who are at high risk of experiencing emotional and mental health problems.
5. To identify gaps between current service provision and need.
6. To identify the optimum pathway for children and young people who have emotional and mental health conditions.
7. To make recommendations to address identified gaps.

1.5 Scope

The HNA will consider the emotional and mental health needs of children and young people aged 0 – 18 years old living in Nottingham City. This is due to CAMHS being commissioned for children and young people up to the age of 18 years. The focus of this HNA is on understanding population 'need', where 'need is defined as 'the ability to benefit from an intervention.'

1.6 Methods

This HNA uses epidemiological and demographic data whilst also incorporating qualitative views in order to assess the need. This involves:

- A review of the literature as well as the policy context for children and young People emotional and mental health disorders.
- The analysis of epidemiological and demographic data for Nottingham City to describe the prevalence, trend and risk factors for emotional and mental health disorders in children and young people.
- A description of current CAMHS services.
- The analysis of the CAMHS and Nottingham University Hospitals Trust data to depict and understand current patterns of service use.
- The views of stakeholders and service users.

1.7 Structure of the HNA

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

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

Chapter 3: Demography of Children and Young People within Nottingham City. This chapter gives an overview of the demographics for the population of children and young people within Nottingham City.

Chapter 4: Assessing Emotional and Mental Health needs of Children and Young People in Nottingham City. This chapter estimates the numbers of children and young people with emotional and mental health disorders. It also outlines the numbers of children who experience domestic violence and have a parent with a mental health disorder.

Chapter 5: High Risk Groups. This chapter presents data on numbers, prevalence and trend in children and young people in high risk groups including what is known about their mental health needs.

Chapter 6: Current Service Provision. This chapter outlines the Tiers 1 to 4 CAMHS services and available service user data.

Chapter 7: Stakeholder Views. This chapter outlines stakeholder views of the emotional and mental health needs of children and young people and how the current service provision meets their needs

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

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

2 Background

2.1 What is mental health and well-being?

According to the World Health Organisation (WHO) mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.

In terms of children and young people's emotional mental health and well-being, according to the National CAMHS review (2008), children and young people state that it's not just about children being 'happy' but feeling 'in control' or 'feeling balanced,' It's about children and young people "having the resilience, self-awareness, social skills and empathy required to form relationships, enjoys one's own company and deal constructively with the setbacks that everyone faces from time to time," [(1)] The term 'wellbeing' is a broad concept encompassing emotional, psychological and social wellbeing. 'No Health Without Mental Health,' the 2012 cross Government strategy

2.2 What are mental health disorders and mental health problems?

This HNA will use two main terms throughout 'mental health problems' and mental disorder. When discussing children and young people's mental health [(3)].

'Mental Health Problem' a phrase used in this strategy as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health

problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest themselves in different ways at different ages and may present as behavioural problems.

'Mental disorders' a broad term covering mental illness, learning disability and personality disorder and substance misuse. It is more formally defines as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.'

TABLE 1: CLASSIFICATION OF MENTAL DISORDERS

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

Source: NHS Advisory Committee. (1995). Together we stand[1]

It is worth considering that conventional classification systems may fail to distinguish differing levels of need within a diagnosis. As such, they cannot be used in isolation to influence service provision as this requires a consideration of *functional need*. For example, childhood autism may be diagnosed on the basis of the ICD-10 criteria described in FIGURE 1. Knowing this diagnosis would not, however, be sufficient to plan appropriate services to support a child with autism and their family. Service provision would require an appreciation of the level of functional need e.g. degree of impairment in communication, level to which activities of daily living performed, evidence of aggression requiring protection of the individual or others. Therefore, when planning mental health services, mapping of

FIGURE 1: ICD-10 CRITERIA FOR THE DIAGNOSIS OF CHILDHOOD AUTISM

F84 Childhood Autism

A type of pervasive developmental disorder that is defined by: (a) the presence of abnormal or impaired development that is manifest before the age of three years, and (b) the characteristic type of abnormal functioning in all the three areas of psychopathology: reciprocal social interaction, communication, and restricted, stereotyped, repetitive behaviour. In addition to these specific diagnostic features, a range of other nonspecific problems are common, such as phobias, sleeping and eating disturbances, temper tantrums, and (self-directed) aggression.

World Health Organisation ICD Version 2007 Chapter V Mental and Behavioural Disorders (F00-F99)

functional needs will be as important as using a diagnostic classification as this will reflect the actual need for health services.

2.3 What is CAMHS?

CAMHS is the term used for services which contribute towards the emotional and mental health care of children and young people. This term was brought about as a result of the Every Child Matters Policy and the National Service Framework for Children, Young People and Maternity Services. CAMHS has been largely arranged into 4 tiers from universal services delivered by non- mental health staff for example teachers to highly specialised services for children with severe emotional and mental health conditions.

For explanation of the 4 tier system, please see below.

TABLE 2: FOUR TIERED MODEL OF CAMHS

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

Source: CAMHS Review (2008).

2.4 Policy context

There are numerous national policies and reports which outline drivers and context in relation to the emotional health and wellbeing of children and young people

2.4.1 National

CMO Report: Our Children deserve better: Prevention pays (2012)

This report sets out the challenges to the health and wellbeing of children. Chapter 10 within the report focuses on mental health of Children and Young People and sets some key messages for policy which include:

- The investment in and focus on children and young people's mental health should be proportionate to the associated health burden.
- Policy to support parents as well as strengthening parenting skills has the potential to yield the benefits in relation to physical and mental health.
- Service design should recognise the role and importance of schools in relation to children and young people's health in terms of both the potential of schools to foster the development of resilience and providing the opportunities for the delivery of interventions to improve mental health.

Parity of Esteem, Royal College of Psychiatrists (2013)

In essence, 'parity of esteem' is thus best described as: 'Valuing mental health equally with physical health.' The focus of this report is that a 'parity approach' should enable the NHS, Local authority Health and Social Care Services to work together to provide a holistic, 'whole person' response to each individual, whatever their needs. This will ensure that all publicly funded services, including those provided by organisations, **give people's mental health equal status to their physical health needs**. Central to this approach is the fact that there is a strong relationship between mental health and physical health, and that this influence works in both directions. Poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems. Mental health affects physical health and vice versa.

The Good Childhood Report 2013 (The Children's Society)

This report provides an update on research and analysis which has been undertaken by the Children's Society since 2012 and identifies some priorities for future research on children's well-being. These were:

1. To explore in more detail the wellbeing of specific groups of children who may not be represented in general population surveys for example looked after children.
2. To undertake research that explores the connections between wellbeing and other issues in children's lives.
3. To learn more about ways in which children's wellbeing can be enhanced.
4. To continue to monitor children's wellbeing particularly in view of changes in our society

Public Health Outcomes framework (2012)

The Public Health Outcomes Framework, published in January 2012 outlines the desired outcomes and indicators that will be used to assess how well public health is being improved and protected. The indicators not only look at measures of mortality but also aim to assess how well people are living. The indicators related to emotional health and wellbeing of children and young people are:

- Emotional wellbeing of Looked After Children
- Hospital admissions as a result of self-harm

No Health Without Mental health (2011)

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

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

Central to the strategy is the concept of mental health being 'everyone's business' with roles outlined for healthcare, social care, community groups, education, and employers to work to

improve mental health. The strategy outlined that patients, families and carers should be involved in the planning, priority setting and commissioning of services, with the needs of vulnerable groups being considered. In relation to children and young people the strategy outlines that:

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

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

Other older national policies and plans still have relevance to children's and young people's emotional health and wellbeing. It should be acknowledged that some of the recommendations from these reports have been met however there are still areas where there has been little progress.

- **CAMHS Review: Children and Young People in Mind: The final Report of the National CAMHS review (2008)**
- **National Service Framework for Children, Young People and Maternity Services (2004)**
- **Every Child Matters (2003**

2.4.2 Local Policies

The Nottingham Plan

The Nottingham Plan *(Sustainable Community Strategy)* sets out the following as objectives within the *'Family Nottingham'* strategy to ensure that all children and young people thrive and achieve:

- More families will be strong & healthy, providing an enjoyable & safe place for children to grow up.
- Children, young people & families will benefit from early & effective support & protection to empower them to overcome difficulties.

- Children & young people will be healthier, fitter, more emotionally resilient & better able to make mature decisions.
- In addition, within the *'Healthy Nottingham'* Strategy one of the 2020 Headline Targets is:
- To improve mental health and wellbeing across the city

Nottingham City children and young people's plan (Currently being refreshed)

The Vision set out in *Nottingham's children and young people's plan (2010-2014)* is that:

- Children and young people will be healthier, fitter, more emotionally resilient and better able to make mature decisions.

Nottingham City Joint Health and Wellbeing Strategy (2013- 2016)

One of Health and Wellbeing's priorities is Early Intervention: Improving Mental Health. Within this priority two very specific aspects of mental health have been identified by the Health and Wellbeing Board:

- **Improving early years experiences to prevent mental health problems in adulthood**
- **increase the proportion of children referred for specialist Community Paediatrician assessment due to behavioural problems who have been offered access to earlier parenting interventions**

Wellness in Mind, the Nottingham City Mental Health and Wellbeing Strategy (2014-2017) the strategy is currently out for consultation.

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

2.5 Prevalence of mental health problems in children and young people

Regarding prevalence, the most comprehensive statistical surveys in Great Britain have been carried out by The Office for National Statistics in 1999 and again in 2004. The first survey (1999) obtained information about the mental health of 10,500 5-15 year olds living in private households in England, Scotland and Wales. The second survey (2004) included 7,977 children and young people aged 5 – 16 living in England, Scotland and Wales. Both surveys found that one in ten children in Great Britain had a clinically recognisable mental disorder. These were classified in 2004 as shown in TABLE 3 and demonstrate that overall boys were more likely than girls to have a mental disorder with highest prevalence amongst 11-16 year olds. Conduct and hyperkinetic disorders are much more likely in boys than girls, although girls are slightly more liable to suffer from emotional disorders. 1 in 5 children with a mental health problem were found to have more than one clinically recognisable mental disorder [(4)].

The Child and Maternal Health Observatory (CHiMAT) provide local estimates of mental health problems in the UK and uses an average prevalence of 9.6%.

There is no local survey which collects information and data on the emotional health and wellbeing of children and young people who live in Nottingham therefore national prevalence data is used and estimates are calculated for the local population.

TABLE 3: PREVALENCE OF CHILDREN'S MENTAL DISORDERS (CHiMAT) 2004, GB

	5-10 Year Olds		**11-16 Year Olds**		**All 5-16 Year Olds (%)**
	Boys (%)	Girls (%)	Boys (%)	Girls (%)	
Emotional Disorders	2.2	2.5	4.0	6.1	3.7
Conduct Disorders	6.9	2.8	8.1	5.1	5.8
Hyperkinetic Disorders	2.7	0.4	2.4	0.4	1.5
Less Common Disorders	2.2	0.4	1.6	1.1	1.3
Any Disorder	10.2	5.1	12.6	10.3	9.6

Source ONS: (2004). Survey of Psychiatric Morbidity among Adults Living in Private Households

Pre-school Children

According to Gardner and Shaw (2008) [(5)] the evidence for stability and prognostic significance of preschool problems is not particularly strong especially in the under three's as co-morbidities are

very high and there are also concerns about distinguishing normal from abnormal behaviours in this period of rapid change in development and maturation that takes place from birth to age 5. However the author further states that there may be also a disadvantage in not defining disorders in young children, including failure to recognise distress and provide appropriate help. Therefore the estimates discussed in relation to this age group need to be treated with some caution.

Using the DSM-IV criteria, generated from structured interviews with parents in the USA, the prevalence of preschool oppositional defiance disorder (ODD) was estimated at 5%, and attention deficit hyperactivity disorder (ADHD) at 6% (6). Further studies of pre-school children using DSM-III and DSM-IV criteria have estimated prevalence of emotional disorders; these tend to be low for each category: separation anxiety (0.3-5%), social phobia (2-4%) and depression (0-2%). An estimate by the Mental Health Foundation gives a prevalence of mental health problems among the 2 – 5 year olds as 10% [(7)].

School Aged Children

In 1999 ONS carried out a large survey of 10,500 children and young people aged 5-15 years old living in private households. The subsequent survey in 2004 included 7,977 children and young people aged 5-16. Data were collected from young people, parents and teachers to identify if the child or young person met the ICD-10 criteria of a clinically diagnosable mental disorder. These surveys provide the most robust and comprehensive data on the prevalence of mental disorders among children in the UK. Both surveys found that 1 in 10 children (10%) had a clinically diagnosable mental disorder with variation seen according to age, sex and ethnicity.

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

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

The key findings were:

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

According to the Charity Young minds [8] it is estimated that **850,000 children have mental health problem**

- ***Three children in every classroom*** has a diagnosable mental health disorder (and that's just the ones that have been diagnosed).
- ***One in five*** young adults show signs of an **eating disorder.**
- ***One in 12*** **deliberately harm themselves** (and 25,000 of them are hospitalised each year because of this) .
- ***Nearly 80,000*** children and young people suffer from **severe depression.**

The charity states that children and young people are often demonised by society, thousands of children and young people are isolated, unhappy, have eating disorders and self-harm; some even commit suicide. Many are likely to become victims of crime, grow up in dysfunctional families, or left to cope with illness, drugs and/or alcohol issues

Young People Aged 16-19 years

A further ONS survey was carried out between March and September 2000. A two-stage approach to the assessment of mental disorders was used. From this survey, the prevalence of mental health disorders for 16- 19 year old young people can be identified. Table 4 shows the prevalence of certain neurotic disorders for males and females aged 16 – 19.

TABLE 4: PREVALENCE OF NEUROTIC DISORDER AMONG 16-19 YEAR OLDS. PREVALENCE PER 1000 REPORTING IN PAST WEEK: ONS Survey (2000)

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

From Table 4 it can be seen that females have a high prevalence rates of mixed anxiety and depressive disorder and generalised anxiety disorder (124 per 1000 compared to 51 per 1000) and a higher prevalence rates of any neurotic disorder (192 per 1000 compared to 86 per 1000).

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

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

2.6 Trends in mental health problems among children and young people

The UK Office of National Statistics undertook two large scale surveys in 1999 and 2004, looking at child and adolescent mental health. Results for the full age range of children from age 5 to 15 were published in 2008. Based on this new and more recent comparison, the research team concluded that *"The upward trends in rates of UK child adjustment problems noted since the 1970s and 1980s may have plateaued, and possibly begun to be reversed."* [9] They note, however, that the absolute level of difficulties is still considerably higher than it was in the 1970s.

In terms of adolescence, the research team extracted the data for just the older children in this study. Looking only at the adolescents aged 11-15 in both surveys (4,244 and 2,930 individuals), and

focusing on the same difficulties (conduct problems, hyperactivity, and emotional problems), it appeared that ratings of these difficulties either remained stable, or showed small declines between the late 1990s and the mid-2000s [10]. However the information stated within this survey is going against what national and local agencies are stating in terms of the increasing numbers and increasing complexities of mental health problems and overall wellbeing in children and young people.

2.7 Self-harm

It is estimated that one in 12 young people in the UK have self-harmed at some point in their lives, although the figure could be much higher with many people suffering in silence, according to research carried out for Young Minds last year [11]. In addition, ChildLine has reported a 167 per cent increase in counseling sessions where the main concern was self-harm [12].

ChildLine has also found that self-harm is affecting younger children. In 2011/2012, ChildLine reported that self-harm was in the top five concerns for 14-year-olds for the first time. However in the first six months of 2012/2013, this age dropped further with 13-year-olds citing self-harm as one of the top five concerns [12].

The Mental Health Foundation's report [11] found that there is relatively little research or other data on the prevalence of self-harm among young people in the UK or on the reasons why young people self-harm. The report states that the inquiry found that self-harm is a symptom rather than the core problem. It masks underlying emotional and psychological trauma and a successful strategy for responding to self-harm must be based on this fundamental understanding

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. In the vast majority of cases self-harm remains a secretive behaviour that can go on for a long time without being discovered.

Self-harm can involve:

- cutting.
- burning.
- scalding.
- banging or scratching one's own body.

- breaking bones.
- hair pulling.
- Ingesting toxic substances or objects.

Young people who self-harm mainly do so because they have no other way of coping with problems and emotional distress in their lives. This can be to do with factors ranging from bullying to family breakdown, domestic violence (both within the family and experiencing it within a relationship). But self-harm is not a good way of dealing with such problems. It provides only temporary relief and does not deal with the underlying issues.

The research undertaken by Cello for the Charity Young Minds [12] and the Mental Health Foundation stated that the evidence to the reasons why young people self-harm shows that there are a wide range of factors that might contribute. The Mental Health Foundation's report [11] found that there is relatively little research or other data on the prevalence of self-harm among young people in the UK or on the reasons why young people self-harm: Many described how self-harm gets out 'all the hurt, anger and pain' but that relief is so short-lived they do it many times. Crucially young people talked about having no alternatives: Many also explained that their self-harm is about feeling dead inside and that self-harm 'brought them back to life' and made them feel 'something – alive and real'. Because young people often find release or even positives from self-harm it can be difficult to envisage coping with life without it: 'I have found the decision to stop harming myself infinitely more difficult than the decision to start'.

2.8 Risk factors for mental health problems among children and young people

There are numerous risk factors which can affect the emotional and mental health of children and young people. Table 5 outlines data taken from the Department of Health (DH), the Mental Health Review and from the Office of National Statistics (ONS) survey (2004) [4] [2]. Many children who for example live in families with low income, with one parent or with no parent are more prone to emotional and mental health problems, however according to the CAMHS Review [13] it is stated that it is important to emphasise that these are associations and not necessarily direct causes as the majority of children and young people in these circumstances grow and develop without difficulties.

TABLE 5: RISK FACTORS FOR MENTAL ILLNESS IN CHILDREN AND YOUNG PEOPLE , [2] [4]

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

	childhood
HOUSEHOLD RISK FACTORS	
Low household income	Prevalence of mental health disorders 16% (gross weekly income <£100) compared to 5% (gross weekly income ≥£600)
Living in deprived areas	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups
Living in social or privately rented accommodation	Prevalence of mental health disorders 17% (social housing) compared to 7% (private ownership)

2.9 High Risk Groups

There are also children and young people who are significantly more likely to experience emotional and mental health problems than the general population.

- Nearly 50% of children in local authority care have a clinically diagnosable mental health disorder, compared with 10% in the general population [(14)]. This increases to nearly 70% among children living in residential care.
- Children in special schools for behavioural, emotional and social difficulties (BESD schools) or pupil referral units (PRU) are significantly more likely to experience mental health difficulties than the general population [(15)].
- Over a third of children young people with an identified learning disability also have a diagnosable disorder.
- Approximately 40% of children and young people within the youth justice system have a mental health problem [(16)]. This rises to more than 90% for those in custody [(17)].
- Children and young people with a physical disability are twice as likely to develop psychological problems as those without [(18)].
- Teenage mothers are three times more likely than older mothers to suffer post natal depression and mental health problems in the first three years of their baby's life [(19)].
- Young lesbian, gay, bi-sexual, transgender (LGBT) . There is a 7- fold increased risk of suicide attempts in young lesbians and an18- fold increased risk of suicide attempts in young gay men [(20)] .
- Children of prisoners – there is a 3 fold increased risk of antisocial-delinquent outcomes [(21)].

2.10 Mental health problems, risk taking behaviour, associated inequality and influences on adult outcomes

Mental health problems in children and young people are associated with increased rates of a range of risk-taking behaviours in children and young people and influence adult outcomes and inequalities, these include:

- Lower educational attainment.
- Exclusion from school.
- Finding it harder to make friends.
- Risky behaviours (e.g. smoking, alcohol and drug use).
- Poorer physical health.
- More likely to be unemployed.
- Poorer adult mental health-Mental illness unlike other health problems tends to start early and persist into and throughout adulthood. It is recognised that by the age of 14 about half of all lifetime mental health problems start [(2)].
- Antisocial Behaviour.
- Marital problems.
- Substance misuse.

2.11 The financial cost of mental health problems in children and young people

The costs of mental health problems to the economy in England have recently been estimated at a massive £105 billion, and treatment costs are expected to double in the next 20 years [(22)]. Other costs associated are:

- Interventions in families with children at higher risk of conduct disorder would cost £210 million but save £5.2 billion [(23)].
- In 2008/2009 the NHS spent about £10.5 billion (10.8%) of the annual secondary care budget on mental health services for adults and children.

There is also very little evidence to the cost of children's and young people's mental health. WHO undertook a review of the evidence into the economic consequences of child and adolescent mental illness and found only 5 studies ranging from €7376 to €64 703, mean annual costs per child, depending on the ages included and the conditions examined [24]. However what is known is that the majority of mental health problems start by the time a young person is 14 years old and the likelihood this will carry on into adulthood is high therefore the implications on adults services and the cost to adult services is significant. **Therefore prevention and early intervention is required earlier in the life course, including universal services having a significant role in identifying, preventing and intervening early.**

2.12 Evidence of effectiveness: What works to improve the emotional and mental health of children and young people

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

The term 'mental health promotion' is used to describe the process of reducing risk factors for mental health problems, and encouraging healthy behaviours that can help to prevent the onset of mental health problems. Mental health promotion has been shown to be most effective when [25]:

- It intervenes at a crucial point in peoples' lives. In particular the importance of intervening early to prevent the development of mental health disorders is highlighted. This is reflected in the government's 'No Health Without Mental Health' strategy which advocates for a life course approach, recognising the importance of promoting wellbeing in the early years and throughout childhood, adulthood and old age [2].
- Is integrated within different settings. There are a broad range of factors that influence mental health, many of which relate to the wider determinants of health (e.g. family, communities, and environment). To effectively tackle the broad range of factors that influence mental health a multiagency approach is required.
- Uses a combination of methods.
- Involves the social networks of those being targeted (e.g. parents, carers, family).
- It targets those at greater risk.

2.12.2 The link between emotional, social and physical health

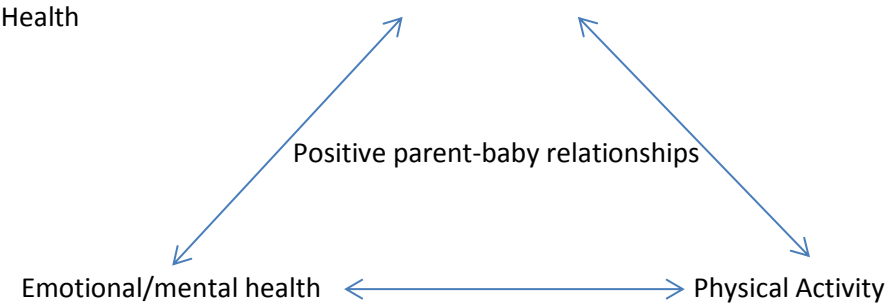


FIGURE 2: THE LINKAGE BETWEEN EMOTIONAL, SOCIAL AND PHYSICAL HEALTH

Failure to promote the secure relationships that underlie emotional health in infancy has a direct result on emotional, social and physical health, both in childhood and in the longer term. By promoting mental health in the first few years of life, beginning in pregnancy, society ensures that as many children as possible grow up to embrace social, physical and emotional health as adolescents and as adults [26].

Attachment is a specific outcome of early care. Through the relationships with their mothers and fathers, children develop an "internal working model" of social relationships ([28]). If an infant experiences her or his parents as a source of warmth and comfort, she or he is more likely to hold a positive self-image and expect positive reactions from others later in life. With a secure attachment, the child has a "secure base" from which to explore, learn and develop independence [29]. Children who have experienced care responsive to their emotional needs since infancy are better able to manage their own feelings and behaviour. Children who are secure in their parents' love and care feel surer of themselves. And, because they feel secure themselves, securely attached children are better able to relate to others. In this way, attachment is related to socio-emotional skills and resilience [30].

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

1. **Promoting maternal health and managing postnatal depression**

Evidenced summarised [26] below suggests that the best outcomes for both mother and baby, in the period after birth, are most likely in circumstances where mothers are:

- Enjoying a well -balanced diet.
- Not experiencing stress or anxiety.
- In a supportive relationship- and not experiencing domestic violence.

- Not smoking, consuming alcohol or misusing illegal substances.
- Not in poor physical, mental or emotional health.
- Not socio-economically disadvantaged.
- At least 20 years old [27].
- Have a supportive birth assistant at the birth itself [27].

The emotional state of the mother during pregnancy in combination with smoking and misuse of alcohol and drugs in pregnancy has been reported to be associated with the child's later development of antisocial behaviour [28]. For example antenatal anxiety at 32 weeks' gestation has been linked to behavioural and emotional problems in the child at age 4 (even after a range of controls including post natal depression) compared to other children and those mothers in the top 15% for anxiety were at double the risk for emotional or behavioural problems, including ADHD and conduct disorder [29] [30].

National Institute of Health and Care Excellence (NICE) (2008) have produced several guidelines on antenatal and postnatal care [31] [32], which recommend that:

Women should be systematically asked about their emotional wellbeing both at antenatal and postnatal appointments and professionals should be aware of signs and symptoms to enable early identification of women with mental health problems or those at risk. This involves asking women about past or present severe mental illnesses, a family history of perinatal mental illness and asking screening questions to detect possible depression at booking visits.

2. Supporting parents and carers to parent effectively

Evidence suggests that parenting behaviour and the quality of the parent-child relationships are strongly associated with children's outcomes. For example, loving, authoritative and responsive parenting is important for building resilience and preventing children developing behaviour problems. Effective, loving and authoritative parents give children confidence, a sense of well-being and self-worth. It also stimulates the brain development and the capacity to learn. Parents who develop an 'open, participative communication, problem-centred coping, non-punitive patterns of parenting and flexibility' tend to manage stress well and families do the same [33] [34] [35]. NICE [36] [37]recommends the use of parenting programmes as part of their guidance on the management of ADHD, conduct disorders and antisocial behaviour. They recommend that parenting programmes should :

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

Examples of evidence based parenting programmes include the Solihull Approach and Triple P Parenting.

3. Promoting social and emotional wellbeing in the early years

Evidence is clear that after a child has been born, physical health is promoted through good nutrition (breastfeeding) and immunisation and that physical and emotional health are interlinked and interdependent. For very young children, secure relationships (i.e. parenting which initially is highly sensitive and responsive to the baby's signals and cues) promote emotional health and have a direct effect on later emotional, social and physical health, both in childhood and in later development. Secure relationships also have effects on cognitive development, physical development ,speech and language development and emotional resilience which then lead to good emotional and mental health [13] [26], all of which culminates in a child who is ready for school and life.

Guidance from NICE on social and emotional wellbeing in the early years recommends the adoption of a life course perspective, recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing [38]. This guideline highlights that:

- Additional support should be given to the most vulnerable children, across maternity, child health, social care, early education and family welfare services.
- Service providers need to develop trusting relationships with vulnerable families, taking account of the child's needs and factors that pose a risk to the child's emotional wellbeing.

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

The Family Nurse Partnership (FNP) is a targeted service for young women under the age of 19 designed to empower and educate them during their first pregnancy through to the early years of their parenthood. FNP practitioners deliver an individually-adjusted curriculum in frequent one-to-one meetings aimed to improve self-efficacy and mitigate the sociological risks of a young, vulnerable woman having her first child.

The local FNP programme in Nottingham has been operational for 5 years and is commissioned to provide a service throughout Nottingham City, however it is widely accepted that the number of young women referred to the FNP for assessment is lower than the number that would be expected.

The primary source of referrals onto the FNP programme is from the midwives who manage the pregnancies of young women and this project evaluated the attitude and perceptions of these midwives toward the FNP, to determine whether their understanding of its role and eligibility criteria is accurate and what is their own experience of dealing with the FNP programme.

4. Working through schools to promote social and emotional skills

Schools have an important role in promoting factors that create resilience; helping to develop skills such as emotional management, self-awareness, optimism, a sense of coherence, social skills and

empathy [39]. Targeted approaches are required for children who are showing early signs of emotional and social difficulties.

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

NICE have published guidelines on the promotion of children's social and emotional wellbeing in primary and secondary schools [40] [41]. NICE recommends the adoption of a comprehensive 'whole school' approach to children's social and emotional wellbeing. This includes recommendations that:

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

A government led initiative, Targeted Mental Health in Schools (TaMHS) was a three year project established in 2008 that ran in selected schools within each local authority. Learning from the national TaMHS evaluation includes [42]:

- Start early – the TaMHS programme led to a greater impact within primary schools compared to secondary schools, particularly on behaviour.
- Self-help materials had a positive impact within primary schools.
- Mental health provision in schools must be fully integrated and understood by all services within the school and form part of school policy.

- The importance of inter-agency working (for example by using of systems such as the Common Assessment Framework) as ways to help address behavioural problems in pupils in secondary schools.
- The need to prioritise the provision of materials to help young people find and access support.
- Educational psychologists appear to be a key group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS.
- Ensuring future roll out of mental health provision in schools uses a common language and is fully integrated with services in schools.

Learning from the Nottinghamshire evaluation of the TaMHS programme highlighted [43]):

- TaMHS improved the 'emotional climate' across the participating schools in the four main areas of delivery i.e. emotionally well pupils, emotionally well-managed support systems; emotionally well-managed staff and emotionally well parents.
- Children with complex need benefit from a structured problem solving tool which drew on multi-agency, multi-disciplinary working. The 'Circle of Adults' is an effective example of this.
- National Research and evaluations have demonstrated the efficacy of 'Zippy's Friends' in increasing resilience and problem-solving skills in key stage 1 pupils.
- That improved training and delivery of training in emotional health and wellbeing leads to improved confidence and competence in teaching staff.

A report by the DH on mental health promotion identified that anti-bullying programmes in schools had shown mixed results, depending on the design of the intervention and how it was implemented [44]. The consensus of literature is that whole school programmes with a range of components operating at different levels within the school are more effective in reducing the prevalence of bullying than curriculum based programmes. Reported benefits of anti-bullying programmes include improvements in the emotional, physical and social health of victims, school attendance and educational attainment, all of which are associated with better long term employment and earnings outcomes.

NICE guidelines on conduct disorders and antisocial behaviour recommend offering targeted emotional learning and problem-solving programmes to children aged 3-7 years in schools where classroom populations have a high proportion of children at risk of developing behavioural or conduct disorders [41]. These include groups of children where a high proportion are deprived, have

low school achievement, have experience of abuse or parental conflict, have divorced or separated parents, have parents with mental health or substance misuse problems, and children with parents in contact with the criminal justice system.

5. Reducing risky behaviours

Children and young people who misuse drugs and alcohol are have an increased risk of experiencing emotional and mental health problems. NICE have published guidelines on 'Interventions to reduce substance misuse among vulnerable young people' [44] and 'school based interventions on alcohol' [45] which include the following recommendations:

Substance misuse [44]***:***

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

Alcohol in schools [45]

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

- Ensuring alcohol education is an integral part of the national science, and personal social and health education curricula.
- Ensuring alcohol education is tailored for different age groups and takes different learning needs into account.
- Introducing a 'whole school' approach to alcohol.
- Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills.

- Where appropriate offer brief advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Where appropriate refer to external services.

It is therefore evident that multi-disciplinary programmes are the most effective interventions in tackling risky behaviours in young people. In Nottingham city the D-Vibe project and Compass service have been shown to be highly effective in working with children and young people in prevention and early intervention and treatment.

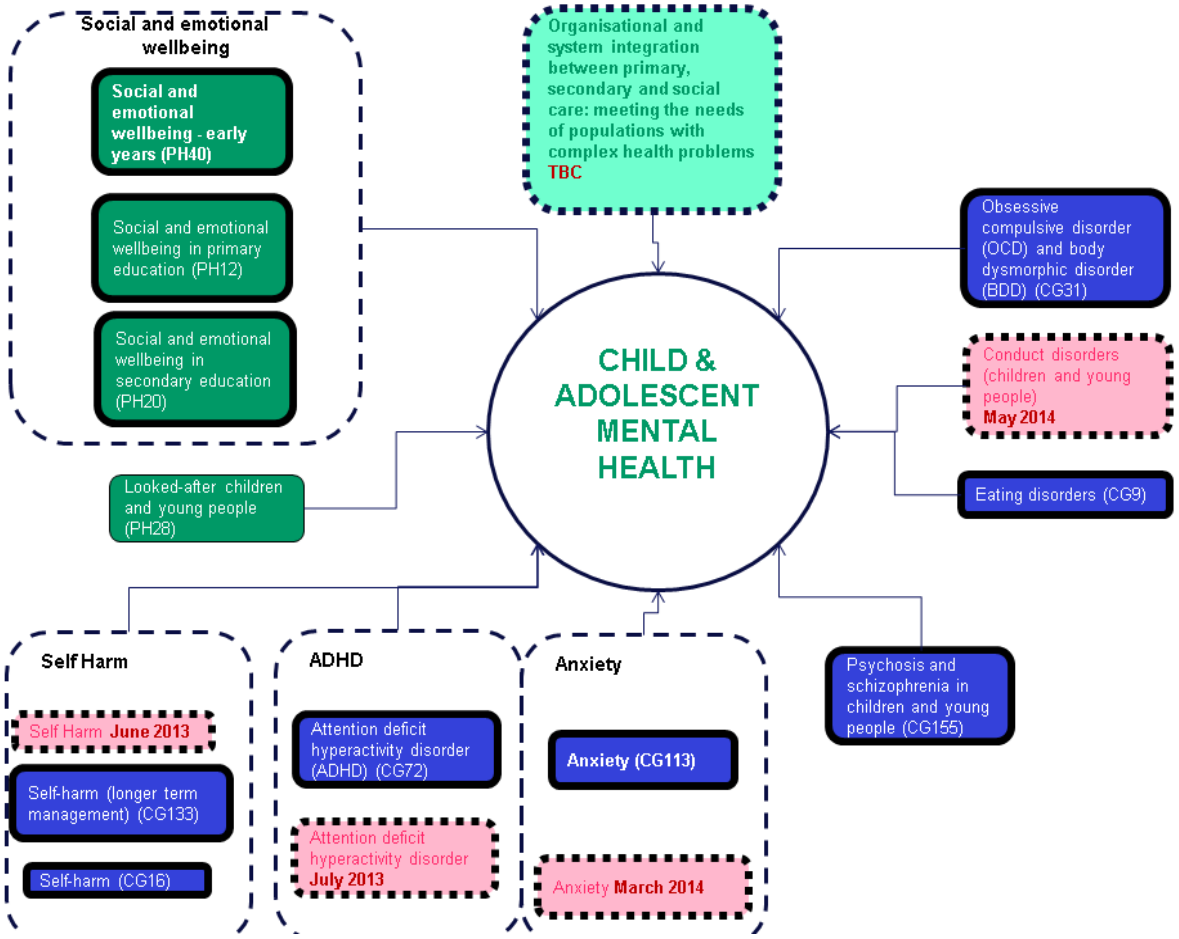
Management of mental health disorders

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

- CG9. Eating Disorders. (2004).
- CG26. Post-traumatic stress disorder. (2005).
- CG28 Depression in Children and Young People (2005).
- CG31. Obsessive Compulsive Disorder and Body Dysmorphic Disorder. (2005).
- CG38. Bipolar disorder. (2006).
- CG72 Attention Deficit Hyperactivity Disorder (2008)
- CG77. Antisocial personality disorder. (2009).
- CG78. Borderline personality disorder: treatment and management. (2009).
- CG89. When to suspect child maltreatment. (2009).
- When to suspect child maltreatment Introduction CG89CG89.(2010).
- CG113. Anxiety. (2011).
- CG128 Autism in Children and Young People (2011)
- CG133. Self-harm: Longer term management. (2011)
- CG155. Psychosis and Schizophrenia in Children and Young People (2013)
- CG158. Conduct Disorders in Children and Young People (2013).
- QS48. Depression in children and young people (2013)

Figure 3 provides an overview of NICE guidelines related to child emotional and mental health. Those shown in pink are guidelines currently in development, with their anticipated publication data shown.

FIGURE 3: SUMMARY OF NICE GUIDANCE ON CHILD AND ADOLESCENT EMOTIONAL AND MENTAL HEALTH



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

2.13 Evidence of effectiveness: Models of service delivery

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

Right Time, Right Place (Massie, 2008)

A report by Massie [46] outlines learning from the national service framework (NSF) CAMHS development projects. Recommendations include:

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

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

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

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

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

- Greater awareness of mental health and how to deal with it sensitively among universal services.
- The importance of building trust.
- Accessible services, in convenient places. A single point of access.

- Being listened to. Having things explained in a straightforward way.
- Being involved.
- Being supported when it's needed, before it reaches crisis point.
- Holistic approach that sees you as an individual.

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

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

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

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

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

Transition to adult services

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

- Recognising the importance of the process.
- Being flexible in the timing of transition.

- Including a period of preparation for the young person and family.
- Ensuring good information transfer.
- Monitoring attendance until the young person is established in adult services.

Guidance on the commissioning of mental health services for young people transitioning to adult services highlights the following [47]:

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

Summary: Chapter 2 Background

Children and Young people's emotional mental health and wellbeing is about not just being happy but feeling in control or feeling balanced. Therefore it is essential that all services from universal services to specialist CAMHS work effectively for the benefit of the child and young person throughout the life course with a focus on early intervention and prevention.

- **CAMHS is the term used for services which contribute towards the emotional and mental health of children and Young People**
- **A four tiered model is used to describe CAMHS services ranging from Tier 1- Universal to Tier 4- highly specialised.**
- **There are several policy documents which work towards improving emotional and mental health of children and young people.**
- **A national survey by the Office for National Statistics has estimated that 1 in 10 school aged children have a mental health disorder (4% emotional disorders, 6% conduct disorders, 2% hyperkinetic disorders and 1% less common disorder). Less reliable estimates are available for pre-school children suggesting the prevalence of mental health problems could range between 10% and 20% in this age group. However taking into account the deprivation levels within Nottingham , levels would be expected to be higher.**
- **At a national level, there is evidence to suggest the prevalence of conduct and emotional disorders is increasing over time.**
- **Risk factors for emotional and mental health problems can be considered at an individual, family and societal level. Many of these risk factors are interrelated and cluster in geographical areas or families (e.g. child poverty, parental unemployment, parental mental health disorders).**
- **High risk groups of children and young people include looked after children, young offenders, those with learning disabilities, the homeless, those with chronic illnesses, those with special educational needs and those experiencing domestic violence.**
- **Emotional and mental health problems have significant long term effects upon educational, social and health outcomes.**
- **It is estimated that one in 12 young people in the UK have self-harmed however this figure could be much higher**
- **There is a strong link between positive parent-baby relationship and positive outcomes, and failure to promote secure relationships can have a direct result of emotional, social and physical health both in childhood and longer term.**
- **Schools have an important role in promoting factors that create resilience; helping to develop skills such as emotional management.**
- **There are a number of NICE guidance which focuses on child and adolescent emotional and mental health.**

3 Nottingham City Child and Adolescent Population

When considering the need for CAMHS within Nottingham City, it is firstly important to investigate the population figures and projections for children and young people including any expected population changes.

3.1 Demography

The total number of children and young people aged 0 – 18 living in Nottingham City is 68,424 as shown in Table 6. Aspley ward has the highest number of children and young people residing there (6,590) followed by Bilborough (4,506) and Berridge (4,480). Children and young people in Nottingham City account for 22.4% of the population in the city.

TABLE 6: POPULATION OF NOTTINGHAM CITY 0 – 18 YEAR OLDS BY WARDS

Area	0-4	5-9	10-14	15-18	Total Population 0-18	Population (all ages)
Arboretum	604	508	444	602	2,158	13,321
Aspley	2,081	1,687	1,595	1,227	6,590	17,622
Basford	1,219	968	958	895	4,040	16,207
Berridge	1,453	1,173	989	865	4,480	18,651
Bestwood	1,382	997	1,010	917	4,306	16,753
Bilborough	1,189	1,139	1,172	1,006	4,506	16,792
Bridge	812	578	539	566	2,495	14,669
Bulwell	1,399	1,092	1,052	899	4,442	16,157
Bulwell Forest	816	724	759	668	2,967	13,614
Clifton North	674	610	677	812	2,773	12,888
Clifton South	954	851	724	697	3,226	13,947
Dales	1,393	1,081	972	801	4,247	16,754
Dunkirk and Lenton	257	195	138	221	811	10,920
Leen Valley	761	740	714	591	2,806	10,702
Mapperley	928	732	826	762	3,248	15,846
Radford and Park	777	565	582	1,052	2,976	21,414
Sherwood	919	779	784	649	3,131	15,414
St Ann's	1,147	888	834	948	3,817	19,316
Wollaton East & Lenton Abbey	318	229	249	1,275	2,071	9,952
Wollaton West	876	893	842	723	3,334	14,741
Nottingham City	**19,959**	**16,429**	**15,860**	**16,176**	**68,424**	**305,680**

Figure 3

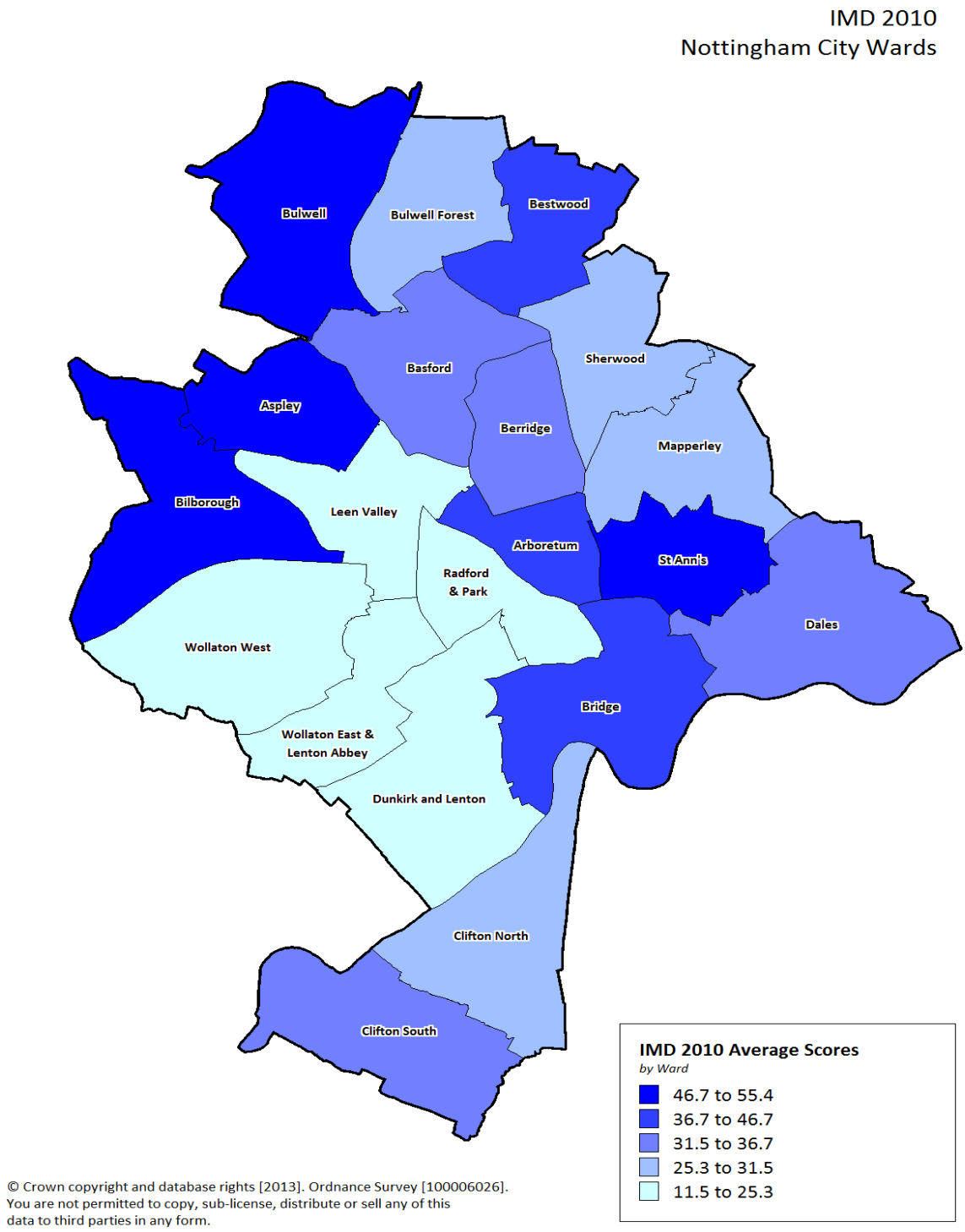
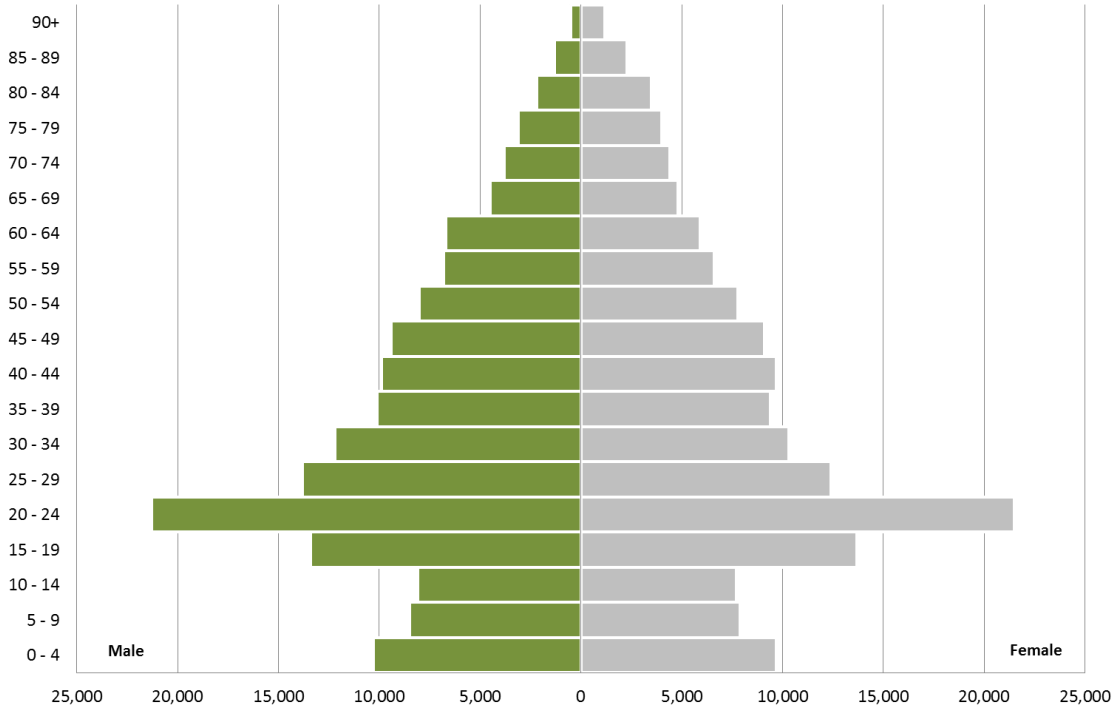


Figure 3 shows a map depicting the Indices of Multiple Deprivation (IMD) scores by ward from 2010 data. It can be seen that 7 wards within Nottingham City (Aspley, Bilborough, Bulwell, Bestwood, Arboretum, St. Ann's and Bridge) all have an IMD score between 46.7 to 55.4 (1 being the least deprived). Overall Nottingham City is the 20th most deprived local authority in England.

Figure 4 shows the population pyramid for Nottingham City, showing a typical shape for a developed country. However it can be seen there is a large number of young people aged 20-24 years; this is due to the two major universities being situated within Nottingham City.

FIGURE 4: POPULATION PYRAMID FOR NOTTINGHAM CITY



Tables 7 & 8 show the population by ward and gender in Nottingham City based on the Census in 2011. It can be seen that **Aspley ward** has the highest percentage of males and females under 18 residing in the city followed by Bilborough, Berridge and Bulwell. It can be noted that the wards with the largest number of children and young people in Nottingham also live in areas of high deprivation as shown in Figure 3.

TABLE 7 & 8: 0 – 18 POPULATION BY WARD AND GENDER IN NOTTINGHAM CITY (CENSUS 2011)

Area	Males	Females	Total
Arboretum	1,096	1,062	2,158
Aspley	3,348	3,242	6,590
Basford	2,082	1,958	4,040
Berridge	2,276	2,204	4,480
Bestwood	2,152	2,154	4,306
Bilborough	2,305	2,201	4,506
Bridge	1,295	1,200	2,495
Bulwell	2,278	2,164	4,442
Bulwell Forest	1,537	1,430	2,967
Clifton North	1,400	1,373	2,773
Clifton South	1,681	1,545	3,226

Dales	2,212	2,035	4,247
Dunkirk and Lenton	435	376	811
Leen Valley	1,460	1,346	2,806
Mapperley	1,653	1,595	3,248
Radford and Park	1,545	1,431	2,976
Sherwood	1,587	1,544	3,131
St Ann's	1,930	1,887	3,817
Wollaton East and Lenton Abbey	1,026	1,045	2,071
Wollaton West	1,715	1,619	3,334
Nottingham City	**35,013**	**33,411**	**68,424**

TABLE 8

Area	Males (% of MALE ward 0-18 pop)	Females (% of FEMALE 0-18 ward pop)	Total (% of 0-18 ward pop)
Arboretum	15.6%	16.9%	16.2%
Aspley	40.5%	34.7%	37.4%
Basford	26.5%	23.5%	24.9%
Berridge	23.7%	24.4%	24.0%
Bestwood	26.8%	24.7%	25.7%
Bilborough	28.9%	24.9%	26.8%
Bridge	16.1%	18.1%	17.0%
Bulwell	29.7%	25.5%	27.5%
Bulwell Forest	23.2%	20.4%	21.8%
Clifton North	22.2%	20.9%	21.5%
Clifton South	24.9%	21.5%	23.1%
Dales	25.5%	25.2%	25.3%
Dunkirk and Lenton	7.2%	7.7%	7.4%
Leen Valley	27.5%	25.0%	26.2%
Mapperley	20.5%	20.5%	20.5%
Radford and Park	13.4%	14.5%	13.9%
Sherwood	20.4%	20.2%	20.3%
St Ann's	19.5%	20.1%	19.8%
Wollaton East and Lenton Abbey	20.5%	21.1%	20.8%
Wollaton West	23.6%	21.7%	22.6%
Nottingham City	**22.8%**	**22.0%**	**22.4%**

Population projections for 0-19 year olds living in Nottingham City

Population projections for Nottingham City have been produced for 0- 19 year olds based on the 2011 census. Please note that as the projections in Table 7 are taken from the 0-19 age group, the population numbers are larger than the population numbers than in Table 6.

Children and young people in Nottingham City account for 22.4% of the population in the city.

TABLE 9: POPULATION PROJECTIONS FOR 0 – 19 YEAR OLDS LIVING IN NOTTINGHAM CITY

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	% change 2011-2021
Nottingham	77,268	77,545	77,509	77,276	77,495	77,676	77,702	77,916	78,111	78,521	78,998	2.2%
East Midlands	1,076,055	1,080,539	1,086,353	1,091,647	1,098,674	1,105,679	1,112,438	1,120,390	1,128,158	1,138,026	1,149,316	6.8%
England	12,710,562	12,773,167	12,860,162	12,947,314	13,050,904	13,148,143	13,240,080	13,343,916	13,451,835	13,575,943	13,713,157	7.9%

3.2 Ethnicity of 0-19 year olds in Nottingham City

Table 10 shows the ethnicity breakdown of Nottingham City by wards for the 0-19 year old. Leen Valley (70.4%) has the highest percentage of 0-19 years who are from Black Minority Ethnic (BME) backgrounds, followed by Berridge (66.2%) then Dales (58.4%). The wards with the smallest percentage of BME groups are Clifton South (15.6%) followed by Clifton North (17.6%).

TABLE 10: ETHNICITY OF 0-19 YEAR OLDS IN NOTTINGHAM CITY

Area	White		Mixed/ multiple ethnic groups		Asian/Asian British		Black/African /Caribbean/ Black British		Other		BME*	
	N°.	%	N°.	%	N°.	%	N°.	%	N°.	%	N°.	%
Arboretum	1,513	47.8%	399	12.6%	780	24.7%	397	12.6%	74	2.3%	1,830	57.9%
Aspley	4,547	66.0%	1,139	16.5%	351	5.1%	819	11.9%	30	0.4%	2,605	37.8%
Basford	2,700	61.7%	788	18.0%	431	9.8%	436	10.0%	23	0.5%	1,795	41.0%
Berridge	1,996	40.9%	557	11.4%	1,798	36.8%	407	8.3%	126	2.6%	3,235	66.2%
Bestwood	3,294	72.6%	636	14.0%	170	3.7%	412	9.1%	23	0.5%	1,383	30.5%
Bilborough	3,241	67.9%	725	15.2%	356	7.5%	410	8.6%	38	0.8%	1,666	34.9%
Bridge	1,339	46.3%	475	16.4%	628	21.7%	362	12.5%	89	3.1%	1,718	59.4%
Bulwell	3,542	75.9%	698	15.0%	109	2.3%	308	6.6%	10	0.2%	1,257	26.9%
Bulwell Forest	2,385	75.7%	357	11.3%	163	5.2%	230	7.3%	16	0.5%	834	26.5%
Clifton North	2,733	84.4%	180	5.6%	214	6.6%	94	2.9%	16	0.5%	571	17.6%
Clifton South	2,946	86.3%	273	8.0%	104	3.0%	75	2.2%	14	0.4%	532	15.6%
Dales	2,110	47.5%	653	14.7%	1,287	29.0%	332	7.5%	63	1.4%	2,597	58.4%

Dunkirk and Lenton	963	60.8%	131	8.3%	311	19.6%	97	6.1%	82	5.2%	688	43.4%
Leen Valley	1,009	34.2%	314	10.7%	1,300	44.1%	185	6.3%	140	4.7%	2,076	70.4%
Mapperley	1,993	56.6%	637	18.1%	468	13.3%	377	10.7%	48	1.4%	1,755	49.8%
Radford and Park	2,501	50.6%	487	9.9%	1,230	24.9%	536	10.9%	184	3.7%	2,741	55.5%
Sherwood	2,188	66.1%	475	14.3%	339	10.2%	263	7.9%	46	1.4%	1,257	38.0%
St Ann's	2,435	49.8%	881	18.0%	738	15.1%	731	14.9%	109	2.2%	2,766	56.5%
Wollaton East & Lenton Abbey	3,060	72.5%	269	6.4%	638	15.1%	181	4.3%	71	1.7%	1,387	32.9%
Wollaton West	2,087	60.2%	269	7.8%	864	24.9%	124	3.6%	125	3.6%	1,470	42.4%
Nottingham City	**48,582**	**61.3%**	**10,343**	**13.0%**	**12,279**	**15.5%**	**6,776**	**8.5%**	**1,327**	**1.7%**	**34,163**	**43.1%**

3.3 Deprivation by Ward in Nottingham City

Table 11 shows the deprivation rank for all Nottingham City wards in relation to how they rank nationally with 1 being the most deprived nationally and 7589 being the least deprived. It can be seen from Table 89 that Aspley is ranked 74 out of 7589 compared to Wollaton West which is 5026 out of 7589.

TABLE 11: DEPRIVATION BY WARD IN NOTTINGHAM CITY

Area	Score IMD (low = less deprived)	Rank out of 7,589 Wards Nationally (1 = most deprived; 7,589 = least deprived)
Aspley	55.40	74
St Ann's	49.72	163
Bulwell	48.69	179
Bilborough	46.75	225
Bestwood	43.04	337
Arboretum	40.60	443
Bridge	37.72	607
Dales	36.68	678
Basford	35.36	755
Clifton South	34.16	844
Berridge	31.65	1047
Mapperley	31.49	1063
Sherwood	28.14	1385
Clifton North	26.86	1542
Bulwell Forest	26.76	1552
Leen Valley	25.25	1762
Radford and Park	25.24	1763
Dunkirk and Lenton	21.82	2254
Wollaton East & Lenton Abbey	14.44	3958
Wollaton West	11.52	5026
Nottingham	34.42	

3.4 Children in Poverty

Table 12 shows the percentage of children living in poverty in Nottingham compared to the East Midlands and England. 35.1% (CI 95%, 34.8-35.6) of Nottingham City children are living in poverty which is significantly worse than in Nottinghamshire County and in England.

TABLE 12: PERCENTAGE OF CHILDREN IN POVERTY (ONS 2011)

Area	Value	Lower CI	Upper CI
England	21.1%	21.1%	21.1%
Nottingham	35.2%	34.8%	35.6%
Nottinghamshire CC	17.8%	17.6%	18%

3.5 Child Health Profile for Nottingham City 2013

Figure 5 is a spine diagram produced by CHiMAT as part of their Child Health Profiles to give an overview of the health and wellbeing of the children and young people of Nottingham City compared to the England average [(48)]. The spine diagram shows the best and worst values across England. The higher value can be on either the left or right of the spine chart depending on the indicator. Current Performance shows how the area is performing compared to the England average (shown as the red line on the chart). The red dot means that the selected area is performing significantly worse than the England average. The green dot means that the selected area is performing significantly better than the England average. From Figure 3 is can be identified that Nottingham City is significantly worse for many of the indicators than England.

FIGURE 5: CHILD HEALTH PROFILE FOR NOTTINGHAM CITY

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

Significantly worse than England average
Not significantly different
Significantly better than England average
Regional average

England average
25th percentile — 75th percentile
range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	**1** Infant mortality rate	27	6.2	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	8	14.1	13.7	23.7	7.5
Health protection	**3** MMR immunisation (by age 2 years)	3,791	88.8	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	4,066	95.3	96.1	85.7	98.8
	5 Children in care immunisations	315	85.1	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	2,231	32.0	35.6	75.2	19.9
Wider determinants of ill health	**7** Children achieving a good level of development at age 5	2,067	58.3	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	1,255	49.6	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	0	0.0	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	540	5.4	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	548	2,436.3	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	18,840	35.2	21.1	45.9	7.4
	13 Family homelessness	488	3.8	1.7	7.4	0.1
	14 Children in care	540	87.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	15	29.7	22.1	47.9	4.4
Health improvement	**16** Low birthweight	405	9.0	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	339	10.9	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	583	22.2	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	15,052	50.5	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	0.9	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	245	54.4	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	82	1.9	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	23	40.4	55.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	32	45.8	69.4	186.3	25.7
Prevention of ill health	**25** Smoking in pregnancy	829	18.5	13.2	29.7	2.9
	26 Breastfeeding initiation	3,094	69.2	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	2,166	46.6	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	11,300	588.2	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	760	121.8	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	103	150.5	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	31	49.7	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	99	158.7	115.5	311.9	26.0

Summary: Chapter 3 Nottingham City Child and Adolescent Population

Children who live in areas of high deprivation are more likely to experience emotional health and mental health problems. In Nottingham City, the majority of children and young people live in areas of deprivation therefore these children are the ones who are at most risk at developing mental health problems which could continue into adult life.

- **The local need for CAMHS is dependent on the needs of the children and young people residing within Nottingham City.**
- **The total number of children and young people aged 0 – 18 living in Nottingham City is 68,424**
- **Aspley ward has the highest number of children and young people residing there (6,590) followed by Bilborough (4,506) and Berridge (4,480). Children and young people in Nottingham City account for 22.4% of the population in the city.**
- **The 0-19 population in Nottingham is set to increase by 2.2% over the next ten years**
- **Lean Valley (70.4%) has the highest percentage of 0-19 years who are from Black Minority Ethnic (BME) groups, followed by Berridge (66.2%) then Dales (58.4%). The wards with the smallest percentage of BME groups are Clifton South (15.6%) followed by Clifton North (17.6%).**
- **Aspley is ranked 74 out of 7589 wards compared to Wollaton West which is 5026 out of 7589 in terms of deprivation with one being the most deprived in England.**
- **35.1% (CI 95%, 34.8-35.6) of Nottingham City children are living in poverty which is significantly worse that in Nottinghamshire County and in England**

4 Assessing Emotional and Mental Health Needs of Children and Young People in Nottingham City

4.1 Prevalence of Mental Health Problems among Children and Young People in Nottingham City.

National prevalence data have been applied to the Nottingham City population to estimate the number of children with mental health problems. The data sources used have been outlined in section 2.5. It is important to note that are several limitations with the data presented:

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

4.1.1 Pre-School aged Children

The estimated numbers and prevalence of mental health problems among pre-school (age 2-5 years) vary considerably from 10% to 19.5% [(6)]. Therefore between 1539 and 3017 of 2 to 5 year old could have a mental health problem (Table 13).

TABLE 13: **ESTIMATED** NUMBERS OF 2 – 5 YEAR OLD CHILDREN WITH ANY MENTAL HEALTH DISORDER [(6)].

Area	Aged 2-5	Estimated number of children aged 2-5 with a mental health problem (Prevalence 10%)	Estimated number of children aged 2-5 with a mental health problem (Prevalence 19.6%)
Arboretum	498	50	98
Aspley	1,585	159	311
Basford	922	92	181

Berridge	1,097	110	215
Bestwood	1,052	105	206
Bilborough	999	100	196
Bridge	603	60	118
Bulwell	1,082	108	212
Bulwell Forest	667	67	131
Clifton North	514	51	101
Clifton South	717	72	141
Dales	1,048	105	205
Dunkirk and Lenton	175	18	34
Leen Valley	614	61	120
Mapperley	704	70	138
Radford and Park	558	56	109
Sherwood	716	72	140
St Ann's	859	86	168
Wollaton East & Lenton Abbey	238	24	47
Wollaton West	745	75	146
Nottingham City	**15,393**	**1,539**	**3,017**

4.2 School aged Children

Using prevalence data from the 2004 ONS survey 'Mental health of children and young people in Great Britain,' Table 14 shows **estimated** numbers of school aged children with mental health disorders in Nottingham 1. The term 'any mental health disorder' includes emotional, conduct, hyperkinetic and less common disorders.

TABLE 14**: ESTIMATED** NUMBER OF CHILDREN AGED 5-16 IN NOTTINGHAM CITY WITH 'ANY MENTAL HEALTH DISORDER ACCORDING TO WARD AND GENDER

Area	Children aged 5-10			Children aged 11-16		
	Male	**Female**	**All**	**Male**	**Female**	**All**
Arboretum	30	15	46	35	27	61
Aspley	102	52	155	120	95	216
Basford	57	30	89	80	58	138
Berridge	70	35	106	74	59	133
Bestwood	63	29	91	79	65	145
Bilborough	71	34	104	96	74	170
Bridge	37	16	52	40	34	75
Bulwell	70	31	100	81	66	147
Bulwell Forest	45	22	67	61	45	106
Clifton North	40	17	57	53	46	99
Clifton South	55	23	76	59	48	107
Dales	66	32	98	79	54	133
Dunkirk and Lenton	13	5	17	13	8	21
Leen Valley	48	22	68	57	45	102
Mapperley	50	20	68	64	56	121

Radford and Park	38	17	53	47	32	79
Sherwood	47	23	70	61	49	111
St Ann's	54	26	80	65	51	117
Wollaton East & Lenton Abbey	15	6	21	21	14	35
Wollaton West	59	25	81	65	54	119
Nottingham City	**1,029**	**479**	**1,500**	**1,250**	**979**	**2,234**

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

Table 15 shows the estimated numbers of children with emotional, conduct, hyperkinetic and 'less common' disorders for Nottingham City.

TABLE 15: **ESTIMATED** NUMBER OF CHILDREN IN NOTTINGHAM WITH A MENTAL HEALTH DISORDER, ACCORDING TO DISORDER TYPE

Type of Disorder	Children aged 5-10	Children aged 11-16	Total (5-16 year olds)
Emotional disorders	468	971	1,439
Conduct disorders	955	1,282	2,237
Hyperkinetic disorders	312	272	584
Less common disorders	253	272	525

4.2.1 Young People aged 16-19

Using data from the 2000 Adult Psychiatric Morbidity Survey, CHiMat have **estimated** numbers of young people aged 16-19 living in Nottingham who would be expected to have a neurotic disorder (Table 16 and 17) [48]. The data have been presented according to ward and type of condition.

TABLE 16**: Estimated** numbers of young males aged 16-19 with a neurotic disorder, according to Ward

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
Arboretum	37	12	7	5	7	4	63
Aspley	32	10	6	4	6	3	55
Basford	25	8	4	3	4	3	43
Berridge	28	9	5	3	5	3	47
Bestwood	23	7	4	3	4	2	39
Bilborough	26	8	5	3	5	3	44
Bridge	23	7	4	3	4	2	38
Bulwell	22	7	4	3	4	2	38
Bulwell Forest	19	6	3	2	3	2	31
Clifton North	27	9	5	3	5	3	46
Clifton South	18	6	3	2	3	2	31
Dales	21	7	4	3	4	2	35

Dunkirk and Lenton	26	8	5	3	5	3	43
Leen Valley	17	5	3	2	3	2	28
Mapperley	19	6	3	2	3	2	32
Radford and Park	71	23	13	9	13	8	120
Sherwood	17	5	3	2	3	2	28
St Ann's	46	14	8	6	8	5	77
Wollaton East & Lenton Abbey	84	27	15	10	15	9	142
Wollaton West	18	6	3	2	3	2	31
Nottingham City	**600**	**189**	**105**	**74**	**105**	**63**	**1,011**

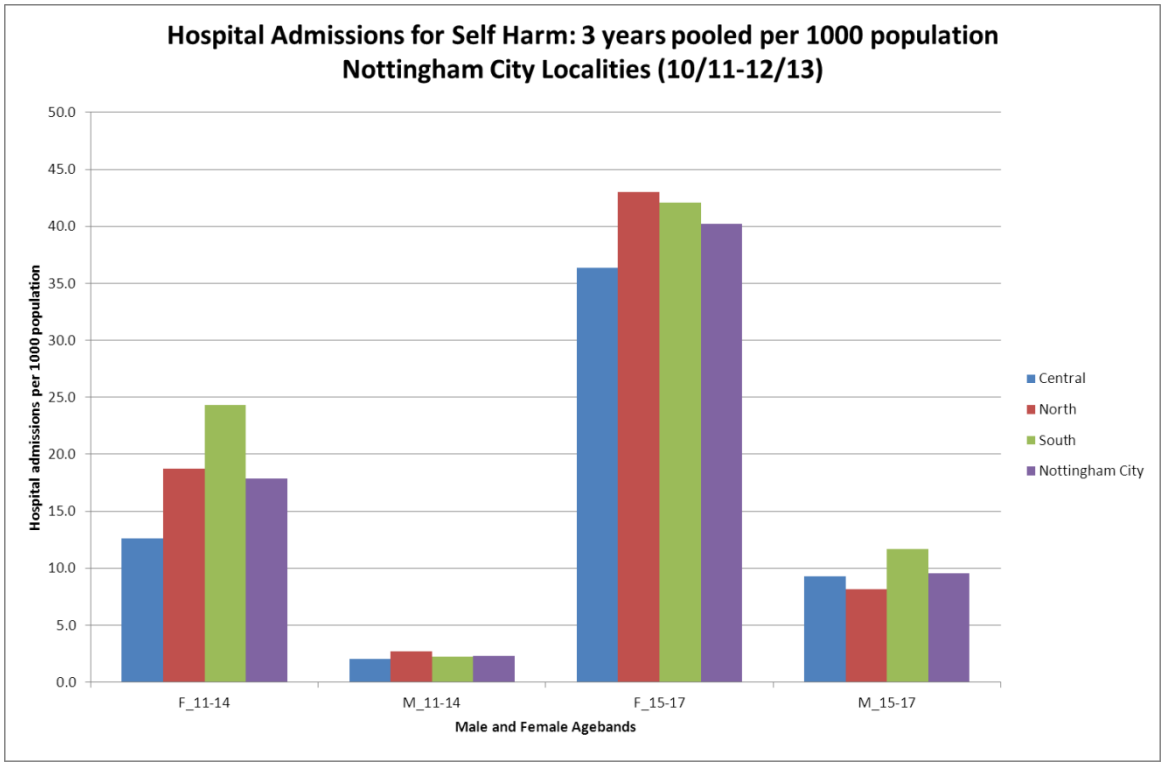
TABLE 17: **ESTIMATED** NUMBERS OF YOUNG FEMALES AGED 16-19 WITH A NEUROTIC DISORDER, ACCORDING TO WARD

	Mixed anxiety and depressive disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
Arboretum	98	9	21	17	7	5	153
Aspley	73	7	16	13	5	4	113
Basford	64	6	14	11	5	3	100
Berridge	66	6	14	11	5	3	103
Bestwood	57	5	12	10	4	3	88
Bilborough	63	6	14	11	5	3	97
Bridge	52	5	11	9	4	3	81
Bulwell	58	5	13	10	4	3	90
Bulwell Forest	42	4	9	7	3	2	65
Clifton North	71	6	15	12	5	4	110
Clifton South	43	4	9	7	3	2	67
Dales	51	5	11	9	4	3	79
Dunkirk and Lenton	56	5	12	10	4	3	87
Leen Valley	33	3	7	6	3	2	52
Mapperley	58	5	13	10	4	3	89
Radford and Park	188	17	41	32	14	9	291
Sherwood	43	4	9	7	3	2	66
St Ann's	121	11	26	21	9	6	188
Wollaton East & Lenton Abbey	216	19	47	37	16	11	336
Wollaton West	38	3	8	7	3	2	60
Nottingham City	**1,493**	**133**	**325**	**256**	**112**	**75**	**2,314**

4.3 Self-harm

From Figure 4 it can been seen that females aged between 15 and 17 years have the highest rate of admissions in the City with the North Locality and South Locality having the higher rates than the overall average for Nottingham City. Females aged between 11-14 years have the next highest rate of admissions with the South Locality being significantly worse than the other locality and the Nottingham City average. Overall it can be seen that self-harm is an emerging public health priority within the city.

FIGURE 6: HOSPITAL ADMISSONS FOR SELF-HARM BY SEX AND BY LOCALITY: 3 YEARS POOLED DATA PER 1000 POPULATION



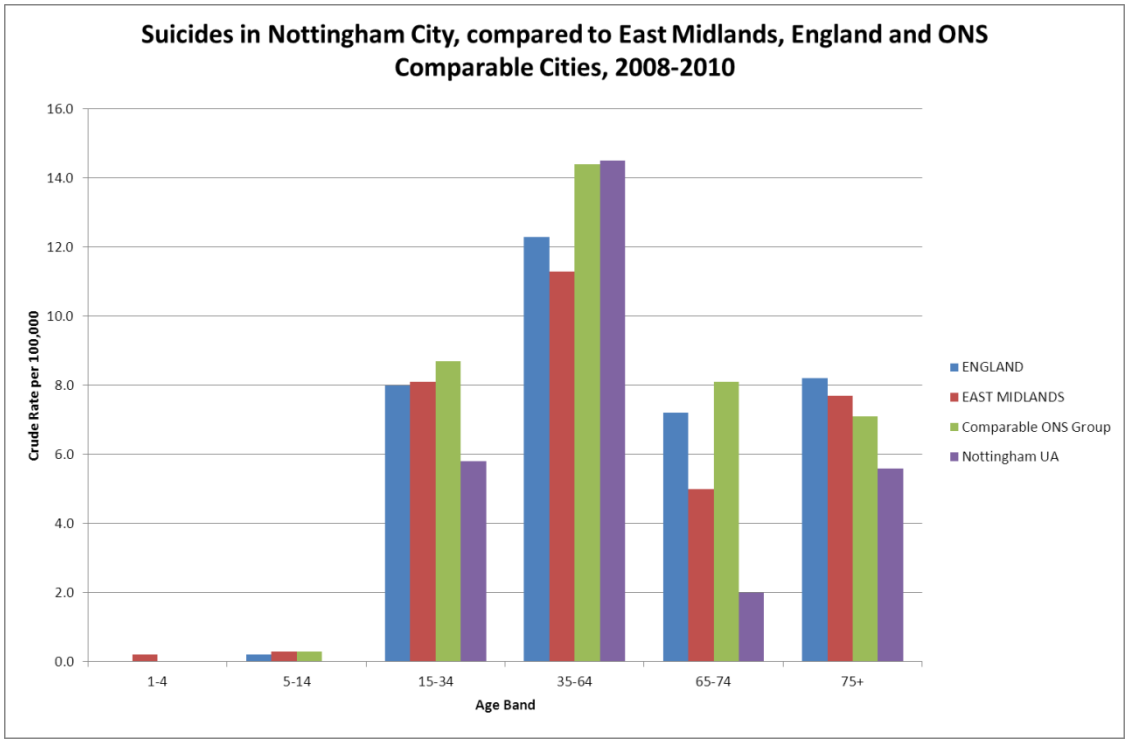
Source: Hospital Episode Statistics (SUS) NHIS Datawarehouse

4.4 Suicide

Numbers of suicides are small among children and young people. Figure 7 shows the rate of suicides in Nottingham City, the East Midland and ONS Clusters according age for 2008-2010. As it can be

seen the crude rate of suicide is low in the 5- 14 years but rises steeply in the 15-35 years old age group.

FIGURE 7: SUICIDES IN NOTTINGHAM CITY, COMPARED TO THE EAST MIDLANDS AND COMPARATOR ONS GROUPS 2008-2010



ONS Cluster includes: Barking and Dagenham, Birmingham, Leicester, Manchester, Sandwell, Wolverhampton.

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

4.5.1 Risk Factor Data from the 2011 Census

Data from the 2011 census allows a picture to be built in relation to the distribution of risk factors for the prevalence of emotional and mental health problems in children and young people. An over view of these risk factors can be seen in Table 20 with colour codes ranking the Nottingham City with low to high prevalence of risk factors.

Lone Parent Families

The prevalence of lone parent families within Nottingham city is 9.5% (taken from the 2011 consensus), this is higher than the East Midlands average (6.7%) and England (7.1%) average. Some

wards within Nottingham have significantly higher prevalence than the overall average in Nottingham city, for example; Aspley ward has 23.5% of lone parents residing there whereas in contrast Dunkirk and Lenton ward only has 2.5% of lone parents residing there.

TABLE 18: NUMBERS OF LONE PARENTS IN NOTTINGHAM CITY ACCORDING TO WARD AND ECONOMIC ACTIVITY

Area	Lone parent in part-time employment: Total	Lone parent in full-time employment: Total	Lone parent not in employment: Total	All lone parent households with dependent children
Arboretum	88	54	158	300
Aspley	452	210	881	1,543
Basford	296	228	370	894
Berridge	173	136	259	568
Bestwood	285	188	486	959
Bilborough	265	162	422	849
Bridge	153	77	223	453
Bulwell	340	181	562	1,083
Bulwell Forest	190	133	215	538
Clifton North	134	91	138	363
Clifton South	218	107	236	561
Dales	201	121	347	669
Dunkirk and Lenton	36	19	39	94
Leen Valley	111	80	144	335
Mapperley	184	141	231	556
Radford and Park	95	61	175	331
Sherwood	176	166	201	543
St Ann's	278	143	464	885
Wollaton East & Lenton Abbey	54	35	71	160
Wollaton West	97	95	81	273
Nottingham City	**3,826**	**2,428**	**5,703**	**11,957**

Source: ONS, 2011.

House tenure

Aspley and St. Ann's has the highest proportion of households in socially rented houses (48.3% and 46.8% respectively) with Nottingham as a whole having 29.7% of all citizens residing in socially rented accommodation compared to 17.7% in England.

TABLE 19: HOUSEHOLDS IN SOCIALLY RENTED HOUSING ACCORDING TO WARD

Area	Total number of households	Number of households in socially rented housing	Percentage of households in socially rented housing (%)
Arboretum	4,915	2,098	42.7%
Aspley	6,554	3,164	48.3%
Basford	7,098	2,008	28.3%
Berridge	7,591	1,252	16.5%

Bestwood	7,564	3,086	40.8%
Bilborough	7,315	3,224	44.1%
Bridge	7,111	2,202	31.0%
Bulwell	7,113	2,874	40.4%
Bulwell Forest	5,927	954	16.1%
Clifton North	5,272	1,027	19.5%
Clifton South	6,248	1,963	31.4%
Dales	7,094	1,897	26.7%
Dunkirk and Lenton	3,738	880	23.5%
Leen Valley	4,189	838	20.0%
Mapperley	7,372	1,472	20.0%
Radford and Park	7,667	2,099	27.4%
Sherwood	6,651	1,210	18.2%
St Ann's	8,445	3,954	46.8%
Wollaton East & Lenton Abbey	2,172	619	28.5%
Wollaton West	6,095	665	10.9%
Nottingham City	**126,131**	**37,486**	**29.7%**

Source: ONS, 2011.

Parental Unemployment

The percentage of households with no parent working in Nottingham City is 6.9%, higher than the average for the East Midlands (0.8%) and England (4.2%). Table 20 show the variation between wards with Aspley (19.1%) and Bulwell (10.9% having the highest percentage of families where no adults are working.

TABLE 20: NUMBERS OF HOUSEHOLDS WITH NO ADULTS IN EMPLOYMENT WITH DEPENDENT CHILDREN

Area	Number of households with no adults in employment with dependent children	Percentage of households with no adults in employment with dependent children (%)
Arboretum	288	5.9%
Aspley	1,252	19.1%
Basford	534	7.5%
Berridge	462	6.1%
Bestwood	650	8.6%
Bilborough	647	8.8%
Bridge	375	5.3%
Bulwell	775	10.9%
Bulwell Forest	293	4.9%
Clifton North	216	4.1%
Clifton South	354	5.7%
Dales	550	7.8%

Dunkirk and Lenton	102	2.7%
Leen Valley	247	5.9%
Mapperley	348	4.7%
Radford and Park	343	4.5%
Sherwood	280	4.2%
St Ann's	665	7.9%
Wollaton East & Lenton Abbey	158	7.3%
Wollaton West	146	2.4%
Nottingham City	**8,685**	**6.9%**

Long Term Illness or Disability

Data presenting in Table 21 and 22 depict households where there are dependent children and where one of the household has a long term illness of disability. Aspley (9.7%) and Bilborough (7.0%) have a higher prevalence of this risk factor than the average for East Midlands (4.6%) and England (4.6%)

TABLE 21: NUMBERS OF HOUSEHOLDS WITH DEPENDENT CHILDREN WHERE ONE PERSON IN HOUSEHOLD HAS A LONG TERM ILLNESS OR DISABILITY

Area	Number of households with dependent children where one person in household has a long-term health problem or disability
Arboretum	203
Aspley	636
Basford	425
Berridge	373
Bestwood	420
Bilborough	509
Bridge	267
Bulwell	427
Bulwell Forest	280
Clifton North	251
Clifton South	291
Dales	443
Dunkirk and Lenton	72
Leen Valley	288
Mapperley	284
Radford and Park	221
Sherwood	311
St Ann's	392
Wollaton East & Lenton Abbey	100
Wollaton West	254
Nottingham City	**6,447**

TABLE 22: PREVALENCE OF RISK FACTORS FOR CHILD AND ADOLESCENT EMOTIONAL AND MENTAL HEALTH DISORDERS (2011)

	Arboretum	Aspley	Basford	Berridge	Bestwood	Bilborough	Bridge	Bulwell	Bulwell Forest	Clifton North	Clifton South	Dales	Dunkirk and Lenton	Leen Valley	Mapperley	Radford and Park	Sherwood	St Ann's	and Lenton Abbey	Wollaton West	Nottingham	East Midlands	England
Lone parent household with dependent children	6.1%	23.5%	12.6%	7.5%	12.7%	11.6%	6.4%	15.2%	9.1%	6.9%	9.0%	9.4%	2.5%	8.0%	7.5%	4.3%	8.2%	10.5%	7.4%	4.5%	9.5%	6.7%	7.1%
%of all households in social rented housing	42.7%	48.3%	28.3%	16.5%	40.8%	44.1%	31.0%	40.4%	16.1%	19.5%	31.4%	26.7%	23.5%	20.0%	20.0%	27.4%	18.2%	46.8%	28.5%	10.9%	29.7%	15.8%	17.7%
% of all households in private rented housing	40.4%	13.2%	17.3%	36.8%	11.6%	8.0%	39.4%	13.6%	11.7%	10.5%	9.0%	24.5%	55.1%	15.3%	29.4%	46.6%	22.3%	27.3%	25.2%	10.9%	23.1%	14.9%	16.8%
Reference person in household from Routine Occupational group	9.3%	21.1%	16.1%	12.1%	20.9%	21.6%	11.4%	20.9%	16.8%	14.7%	21.5%	16.6%	4.9%	13.7%	11.3%	7.0%	12.1%	14.2%	5.0%	6.8%	13.8%	13.6%	11.0%
Households with no adults in employment with dependent children	5.9%	19.1%	7.5%	6.1%	8.6%	8.8%	5.3%	10.9%	4.9%	4.1%	5.7%	7.8%	2.7%	5.9%	4.7%	4.5%	4.2%	7.9%	7.3%	2.4%	6.9%	3.8%	4.2%
Percentage of usual residents over the age of 16 with no qualifications	16.1%	38.1%	29.8%	21.4%	35.7%	41.9%	19.6%	39.2%	29.7%	29.6%	37.9%	29.6%	9.5%	30.4%	20.2%	11.0%	22.1%	25.2%	11.2%	18.2%	25.6%	24.7%	22.5%
One person in household with a long term health problem or disability, with dependent children	4.1%	9.7%	6.0%	4.9%	5.6%	7.0%	3.8%	6.0%	4.7%	4.8%	4.7%	6.2%	1.9%	6.9%	3.9%	2.9%	4.7%	4.6%	4.6%	4.2%	5.1%	4.6%	4.6%

Key



Area with the lowest prevalence of the risk factor

Area with highest prevalence of risk factor

Notes on table:
All data originated from the 2011 Census.
Ward data in this table are ranked according to prevalence, and colour coded to assist rapid interpretation. Please note colours do not indicate statistical significance from the national, regional or local average.

4.5.2 Domestic Violence

Domestic violence is defined as "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners, family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional" [(49)].

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

- It is recognised as a key indicator for child abuse and neglect, with young people experiencing family violence being between 2.9 to 4.4 times more likely to have experienced physical violence and neglect from a caregiver [(50)].
- Estimates suggest that children who have witnessed domestic violence are 2.5 times more likely to develop serious social and behavioural problems than other children [(51)].
- It compromises attachment between parent and child by undermining the developmental need for security and stability.
- It can lead to an internalizing of emotions by the exposed child, which is associated with higher levels of mental health problems.

The British Crime Survey (BCS) indicates that domestic violence is chronically under reported, but research estimates that it:

- Accounts for 16% of all violent crime (source: Crime in England & Wales 2004/05).
- Have more repeat victims than any other crime (on average there have been 35 assaults before a victim calls the police).
- One incident of domestic violence is reported to the police every minute.
- Costs the Country in excess of £23bn per year, of which £3bn falls to public services.
- Claims the lives of two women each week and 30 men per year.
- Is the largest cause of morbidity worldwide in women aged 19-44, greater than war, cancer or motor vehicle accidents.
- One in four women and one in six men will be a victim of domestic violence in their lifetime, with women at greater risk of repeat victimisation, serious injury and fear.

The high numbers of reported domestic violence in Nottingham is one of the highest in the UK which puts huge pressures on resources available. The unmet needs and service gaps have been outlined in detail in section 8 and the commissioning recommendations reflects these gaps.

Multi-Agency Risk Assessment Conference (MARAC) - More victims have been encouraged to report their crime to the police. The MARAC brings local statutory and voluntary agencies together to

protect those women at highest risk from repeat domestic violence. In Nottingham, the top 20 high risk cases are referred to the MARAC every fortnight. The key role at the MARAC is the Independent Domestic Violence Advocates who are commissioned by statutory partners to provide direct support and advocacy to high risk survivors. Representatives from all agencies are attending training to be MARAC champions

In addition in Nottingham City there is the Domestic Abuse Referral Team (DART). The DART is a multi-agency team of people who continue to be employed by their individual agencies (local authority, police and health services) but who are co-located. Co-location is considered the most effective way of building relationships, trust and understanding between agencies so that staff are confident about sharing information

This multi-agency team will deal exclusively with domestic abuse concerns within the City where there are children or a pregnant woman in the household or where a vulnerable adult who meets the threshold for Social Care Services is being subjected to domestic abuse.

The aim of the team is to:

- Make better-informed decisions about risks to children, young people and vulnerable adults as a consequence of improved information sharing across the partnership
- Make decisions more quickly than they have been in the past. This includes identifying cases where early intervention could remove the risk of harm.

There are between 7,000 – 10,000 children in Nottingham at risk from domestic abuse. This means at least 3 in every class of 30 children are at risk or experiencing domestic violence.

Approximately 50% of all children registered and re-registered in Nottingham are living with domestic violence

.

4.5.3 Parental Mental Health Disorders

Research has shown that parental mental health impacts upon the wellbeing of children. For example, in the early years, maternal depression can affect parenting (too intrusive or withdrawn) and the development of secure attachments. The importance of good perinatal mental health is increasingly recognised. NICE estimates that about 10-15% of new mothers suffer some perinatal mental health difficulties [(36)]. Applying these estimates to the numbers of new mothers in

Nottingham City in 2012 suggests that of the 4,408 new mothers, between **441** and **661** may have had a perinatal mental health problem.

TABLE 23: ESTIMATED NUMBER OF NEW MOTHERS WITH PERI-NATAL MENTAL HEALTH PROBLEM (2012)

	Number of Live Births (2012)	**Estimated numbers of new mothers with a perinatal mental health problem**	
		Estimate if prevalence 15%	Estimate if prevalence 10%
ENGLAND	**694,241**	**69424**	**104,136**
EAST MIDLANDS	**55,645**	**5565**	**8,347**
Derby UA	3,756	376	563
Leicester UA	5,273	527	791
Nottingham UA	4,408	441	661
Nottinghamshire	**9,071**	**907**	**1,361**
Ashfield	1,557	156	234
Bassetlaw	1,237	124	186
Broxtowe	1,268	127	190
Gedling	1,256	126	188

Other parental mental health problems have been shown to impact upon child emotional and mental wellbeing. For example, research has shown that children who have a parent with schizophrenia are more likely to experience psychiatric disturbance themselves, more likely to be socially isolated and can experience stress about their parents symptoms [(52)]. Many of the risk factors outlined in this chapter overlap. Parents at increased risk of mental health problems include lone parents, those living in poverty, those who have chronic health problems and those who are unemployed. Local data on numbers of children living in households with a parent who has a mental health problem are not available. From the 2000 Psychiatric Morbidity Survey, it is known that about 23% of adults have a mental health problem [(53)].

Extrapolating the national prevalence reported in the Adult Psychiatric Morbidity Survey (McManus et al 2009), to March 2013 resident population data for Nottingham, provides an estimation of approximately 43,600 adults (age 16-74) experiencing a common mental health problem, and 10,460 (24%) currently receiving treatment. As Nottingham has a higher proportion of women from South Asian communities than the national average, and ranks as the 13th most deprived area in England, then actual numbers of adults with common mental health problems may be higher.

4.5.4 Children with parents in prison

National estimate 7% of children will see fathers imprisoned in their school years. This equates to around 2,500 children of school age in Nottingham City (age 5-15 years).

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

There is considerable evidence that suggests that the more risk factors/variables exist with a household/family the more likely that children and young people may develop a mental health problem. These risk factors include parental mental health, lone parent family, maternal mental health, domestic violence within the household and living in socially rented houses. In Nottingham there are a significant number of children and young people who are exposed to these risk factors which may as a consequence result in developing a mental health problem.

- **The estimated numbers and prevalence of mental health problems among pre-school (age 2-5 years) vary considerably from 10% [7] to 19.6% [6]. Therefore between 1539 and 3017 of 2 to 5 year old could have a mental health problem.**
- 3778 **estimated numbers of school aged children with mental health disorders in Nottingham**
- **Using data from the 2000 Adult Psychiatric Morbidity Survey, CHiMAT have estimated that 1101 young people aged 16-19 living in Nottingham who would be expected to have a neurotic disorder**
- **Females aged between 15 and 17 years have the highest rate of admissions in the City for self-harm.**
- **The prevalence of lone parent families within Nottingham city is 9.5% (taken from the 2011 consensus), this is higher than the East Midlands average (6.7%) and England (7.1%) average.**
- **Nottingham as a whole having 29.7% of all citizens residing in socially rented accommodation compared to 17.7% in England.**
- **The percentage of households with no parent working in Nottingham City is 6.9%, higher than the average for the East Midlands (0.8%) and England (4.2%.**
- **Nottingham City in 2012 suggests that of the 4,408 new mothers, between 441 and 661 may have had a perinatal mental health problem.**
- **Maternal depression can affect parenting (either being too intrusive or withdrawn) and the development of secure attachments.**
- **Other parental mental health problems have been shown to impact upon child emotional and mental wellbeing. For example, research has shown that children who have a parent with schizophrenia are more likely to experience psychiatric disturbance themselves, more likely to be socially isolated and can experience stress about their parents symptoms.**
- **National estimate 7% of children will see fathers imprisoned in their school years. This equates to around 2,500 children of school age in Nottingham City (age 5-15 years).**

5 High Risk Groups

5.1 Looked After Children (LAC)-Children in Care (CiC)

The numbers of children in care within Nottingham have been rising at a rate of 4.5% year on year and at of the end of March 2013 there were 560 LAC in Nottingham (Figure 8), an increase from 540 at the same time in 2012. The majority of the LAC are placed into foster care (76%, Feb 2013). Figure 9 in addition shows that the rate of LAC in Nottingham is significantly higher than the East Midlands and England rate per 10,000 children. Table 24 shows that the number of unaccompanied Asylum seeking children who are looked after has steadily increased from 20 in 2007 to 35 in 2010.

Although numbers of children in care has risen by 4.5% per year, over the same period the city's 0-17 population only increased by 0.2% per year. This indicates the rise in CiC is due to more children in the existing population coming into care rather than being as a result of a population increase.

Age

The most prevalent age groups within the cohort are 16-17 year olds and under 1's. The 15 plus cohort has been the most prevalent since 2008 and is continuing to grow. These three most prevalent age groups (16, 17 and under 1's) make up 34% of the total CiC population.

Gender

The CiC cohort is currently quite evenly distributed in regards to gender, with 52% Male and 48% female. The proportion of females in care has increased from 42% in 07/08, and accounted for 48% of the population since 08/09.

Ethnicity

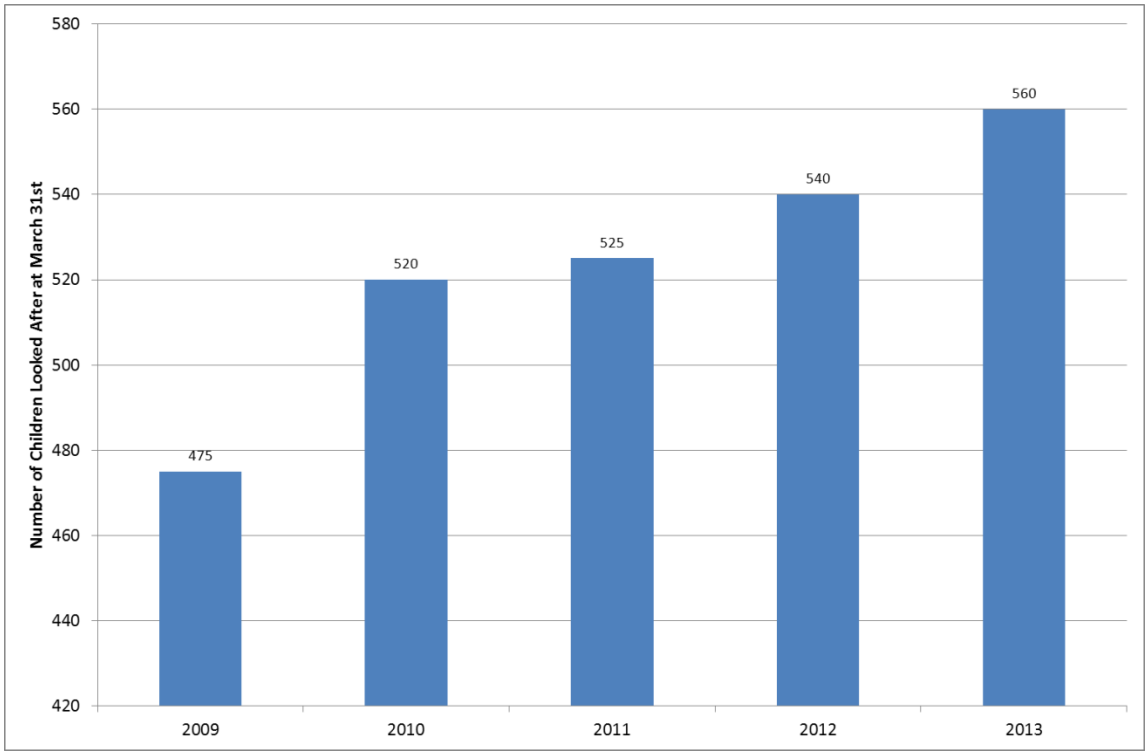
The CiC population is predominantly white with 68% of the cohort being White British, White Irish or White Other. The next largest group is Black, Black British or Black Mixed comprising 21% of the CiC population. 8% are categorised as 'Other' or 'Other Mixed', 3% are 'Asian', 'Asian British' or 'Asian Mixed' and 1% 'Chinese'. The ethnicity of the CiC population has stayed relatively stable over the last 8 years since 2004/5 and it appears in comparison to Nottingham's Black population Black CiC are over represented in the cohort comprising 21% of the cohort relative to only 10% of the general population. The 'Asian' population is under-represented in the CiC cohort, making up only 3% of the care cohort compared to 13% of the general 0-15 population. Similarly, 'White' CiC only make up 68% of the care population compared to 74% of the general 0-15 population in the City.

Need

The majority of Nottingham's CiC are in care with a Need reason of 'Abuse or Neglect' (64%). The next three most common Need reasons accounting for 8-9% of the CiC population each comprise 'Absent Parenting', 'Family Dysfunction', and 'Family in Acute Stress'. 'Disability' of the CiC or 'Parental Illness or Disability' account for 4% each, and 1% of CiC are in care due to 'Socially Unacceptable Behaviour'.

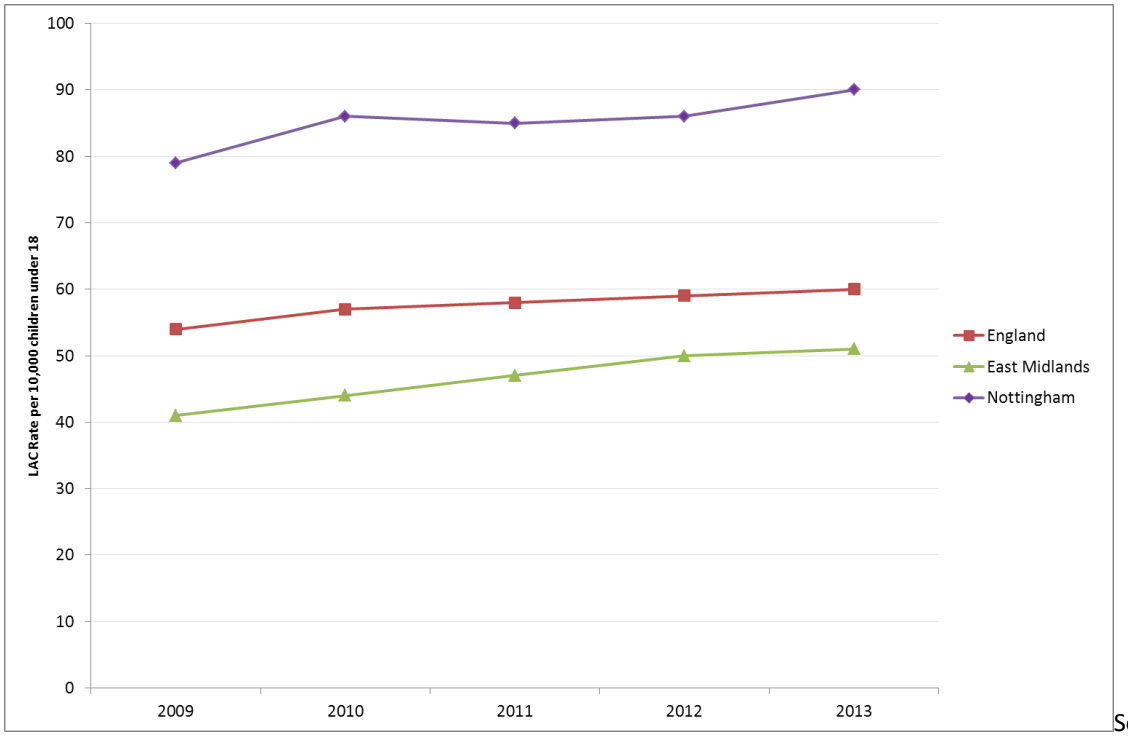
https://www.gov.uk/government/publications/children-looked-after-in-england-including-adoption

FIGURE 8: NUMBER OF CHILDREN LOOKED AFTER BY NOTTINGHAM CITY COUNCIL (2007-2013)



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

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



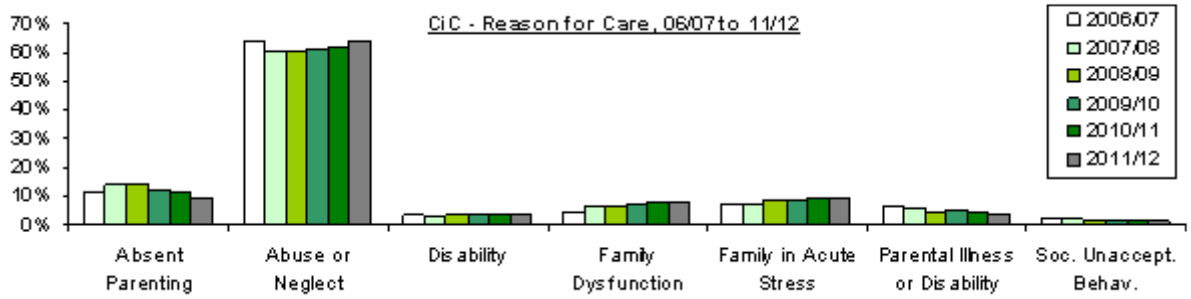
Source: Department for Education (DfE).

TABLE 24: NUMBERS OF UNACCOMPANIED ASYLUM SEEKING CHILDREN LOOKED AFTER

Unaccompanied Asylum Seeking Children looked after at 31 March				
	2007	2008	2009	2010
Nottingham	20	30	35	35

Estimated from a population of LAC of 560 (March, 2013), 271 will be aged between 5 and 15 (based on application of England age break down of LAC, DfE, 2013). Of these, 124 may have one or more mental health disorder; 31 with an emotional disorder, and 24 with a hyperactivity disorder.

FIGURE 8: BREAKDOWN OF REASONS WHY CHILDREN HAVE COME INTO NOTTINGHAM CITY COUNCIL'S CARE SINCE 2006/7.



From 2007/08 there have been increases in the number of CiC with need reasons of 'Abuse or Neglect', 'Family Dysfunction' and 'Family in Acute Stress', and a small decrease in the number in care because of 'parental illness or disability'.

Outcomes

The data in this section relating to educational performance is taken from performance information for looked after and adopted children and young people released by the DfE on 22nd December 2011.

Education – Attendance

In 2010/11 there were 49 CiC (from any LA) attending primary schools in Nottingham. Of this cohort absence levels were 5.2%, an increase from the previous year in which levels were at 3.9% of the cohort. Of CiC attending Nottingham schools, 4.1% were persistently absent compared to 2.6% for non-CiC however at present the reasons for this are unknown.

There has been an improvement in total absenteeism amongst CiC attending secondary schools, a decrease from 9.7% in 2009-10 to 8.8% in 2010-11. There has also been an improvement in persistent absenteeism seeing a decrease from 16.7% being persistently absent in 2009/10 to 10% in 2010/11, still slightly higher than the non-CiC population persistent absence rates at 6.7%.

Emotional and mental health needs of LAC

The emotional and mental health of LAC is affected by both the factors that led them to enter care, and their experiences as a looked after child. A large proportion of LAC enter care because of abuse, neglect or severe family dysfunction [(54)]. For example, the child's parents may have been struggling

with issues such as domestic violence, substance abuse, alcohol abuse, mental health problems or a combination of these factors.

Estimates suggest that about 45% of children in local authority care have a clinically recognisable mental health disorder compared to 10% of the general population [55]. The prevalence of mental health disorders rises to 70% for children living in residential care [55] [14]. Table 25 summarises data from the 2002 ONS survey of the mental health needs of children looked after by local authorities according to the type of disorder and age compared to the general population

TABLE 25: EMOTIONAL AND HEALTH NEEDS OF LOOKED AFTER CHILDREN

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

Source: ONS 2002

5.2 Young carers in Nottingham

The actual number of young carers in Nottingham City is unknown. Those presenting to support agencies are likely to underestimate the true number of children and young people with caring responsibilities. Data from the 2011 census can be used to estimate the number of young carers in Nottingham within the East Midlands, 2.1% of children and young people aged 5-18 were identified as young carers. Applying this to the Nottingham population, this would equate to 1,018 children and young people aged 5-18 acting as carers.

There is some evidence to suggest that the percentage of young people acting as carers may be even higher. In 2010 the BBC surveyed more than 4000 school pupils finding that 8% of those surveyed carried out caring roles such as helping someone to dress, bathe or shower. Based upon this

estimate of 8%, this would mean that there could be up to about 3,877 young carers aged 5-18 in Nottingham City.

Emotional and Mental Health need of young carers

The impact of being a young carer varies according to age and the extent of caring responsibility. The 2011 census showed that the percentage of people reporting 'not good' general health was higher among carers compared to those not providing care, and increased as the number of hours of care provided increased [(56)]. A research briefing by the Social Care Institute for Excellence on the health of young carers identified that:

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

5.3 16-18 year olds Not in Education Employment or Training (NEET)

The percentage of young people NEET in Nottingham City is 6.3% (Table 26), this is significantly higher than average for the East Midlands (4.8%) and England (5.8%). There is however still 6.3% of NEETs whose activity is not known which is lower than the East Midlands (8.2%).

TABLE 26: THE NUMBER OF NEETs

Area	16-18 year olds known to the local authority	Estimated number	Percentage	% whose activity is not known
Nottingham	9,729	610	6.3%	6.3%
East Midlands	156,679	7,520	4.8%	8.2%
England	1,740,115	100,040	5.8%	-

Emotional and mental health needs of young people NEET

Being in education, employment and training between the ages of 16-18 increases a young person's resilience and is essential to their future employability and wellbeing [57]. Being NEET between the ages of 16-18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health.

5.4 Homelessness

The rate of homelessness among children and families accepted as being in priority need in 12/13 was 3.49 per 1000 households in Nottingham City (481 households). Comparatively, rates of homelessness in this group were higher than in the East Midlands (1.74 per 1000 households) and nationally (2.37 per 1000 households).The majority of homeless households were families with dependent children (86%) [58]. These rates will only include children and families who are known to the local authorities and categorised as being in priority need for housing.

Local data are available from an annual survey carried out in Nottingham City and Nottinghamshire County, 'Homeless Watch'

This survey provides a snapshot of people presenting to agencies as being homeless, over the same two week period each year. Findings from the 2012 survey include:

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

(Includes Nottingham City and Nottinghamshire County)

Emotional and mental health needs of homeless children and young people

Children and young people who are homeless are significantly more likely to have delayed development, learning difficulties, and mental health problems, such as sleep disturbance, over activity, anxiety, depression and self-harm. Evidence suggests that compared to the general

population, mental health problems are eight times higher for people living in hostels and bed and breakfast accommodation, and 11 times higher for people who are sleeping rough. Homelessness is also associated with risk taking behaviours such as substance or alcohol misuse. The causes of homelessness are diverse, but can include factors such as domestic violence, family breakdown, going through the asylum process, or being in the criminal justice system. A study by Vostanis *et al* (1998) showed that even after rehousing, two fifths of children and a quarter of mothers had persistent mental health problems [(60).]

5.5 Estimating numbers of Gypsy and Traveller hildren in Nottinghamshire

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

School Census

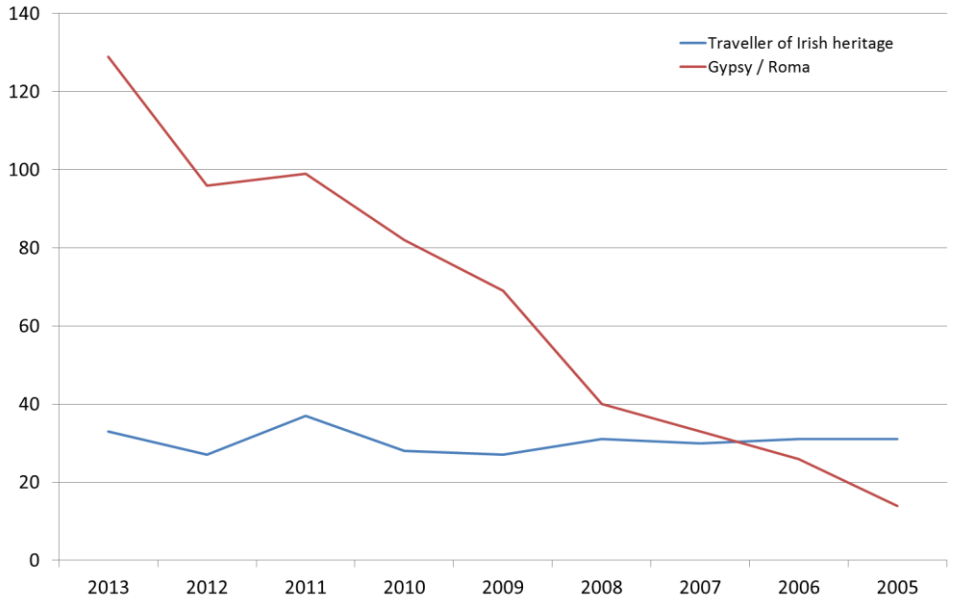
In the 2013 School Census, data on ethnicity was collected for primary and secondary school children, it can be seen in Figure 4 and Table 22 that the number of children from Gypsy/Roma communities has significantly increased in 2013 to 129 from that in 2012 when there were 96 recorded children. The number of children from Irish Traveller heritage has remained relatively static.

Caravan Count

https://www.gov.uk/government/publications/gypsy-and-traveller-caravan-count-january-2012

A caravan count is carried out twice a year in January and June to provide a snapshot of numbers of caravans in each local authority, whether on local authority, private or unauthorised sites. While this does not give numbers of people, it does give an indication of where within the county travellers predominantly reside. Data from the July 2012 Caravan count shows there were 31 caravans in Nottingham City in 2012, this number has been relatively stable for the last 3 years. All were on authorised sites.

FIGURE 9: THE NUMBER OF GYPSY AND IRISH TRAVELLER CHILDREN LIVING IN NOTTINGHAM CITY



Nottingham City, School Census, 2013

TABLE 27: THE NUMBER OF GYPSY AND IRISH TRAVELLER CHILDREN LIVING IN NOTTINGHAM CITY (SCHOOL CENSUS)

	2013	2012	2011	2010	2009	2008	2007	2006	2005
Traveller of Irish heritage	33	27	37	28	27	31	30	31	31
Gypsy / Roma	129	96	99	82	69	40	33	26	14

Emotional and mental health needs of Gypsies and Travellers

There is a paucity of data on the mental health needs of Gypsies and Travellers, particularly in relation to the needs of children. National evidence has shown that Travellers have significantly poorer health status and significantly higher self-reported symptoms of ill health than other UK ethnic minority or economically disadvantaged UK residents [(61)]. The study found that significantly more Gypsies and Travellers reported long term illnesses which limited their daily activities or work (42% versus 31% comparators), and overall health status, as measured using EQ-5D, was significantly worse among Gypsies and Travellers. A qualitative study focusing on the mental health needs of Travellers found that economic and social factors affected their mental wellbeing [(62)]. While it is not possible to easily quantify the mental health of Traveller children, poor physical health and economic and social stresses faced by families could all impact upon child mental health.

5.6 Youth offending

Between 2011-2012 there was a rate of 2066 per 100,000 first time entrants into the youth justice system(Table 28) this is a reduction in the rate from 367 per 100,00 in 2010-2011, however this could be due to the change in the Legal Aid , Sentencing and Punishing of Offender Act 2012 which reduces and simplifies the out of court landscape to provide three types of disposal.

- **Community resolutions.**
- **Youth cautions.**
- **Youth conditional cautions.**

The disposals differ in the level of obligation to assess and intervene.

The decision on which disposal to use would be based on the severity of the offence, previous offending history, likelihood of compliance and will take into account the views of the victim

Disposals may be used in any order even for those who have a previous conviction at court, in line with the adult framework. The minimum appropriate disposal should be used and should include a restorative justice element. Ultimately this may have decreased the number of young people within the youth justice system**.** However the rate of youths offending in Nottingham is significantly higher than the East Midlands and England rate.

TABLE 28: RATE OF FIRST TIME ENTRANTS (PER 100,000) TO THE YOUTH JUSTICE SYSTEM, YOUNG PEOPLE AGED 10-17

Local Authority	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Nottingham	3070	2360	2639	2555	3690	3716	2932	2127	2087	2433	2066
East Midlands	1482	1358	1362	1564	2037	2006	1699	1342	1111	1011	834
England	1636	1511	1602	1756	1976	2050	1862	1493	1180	884	712

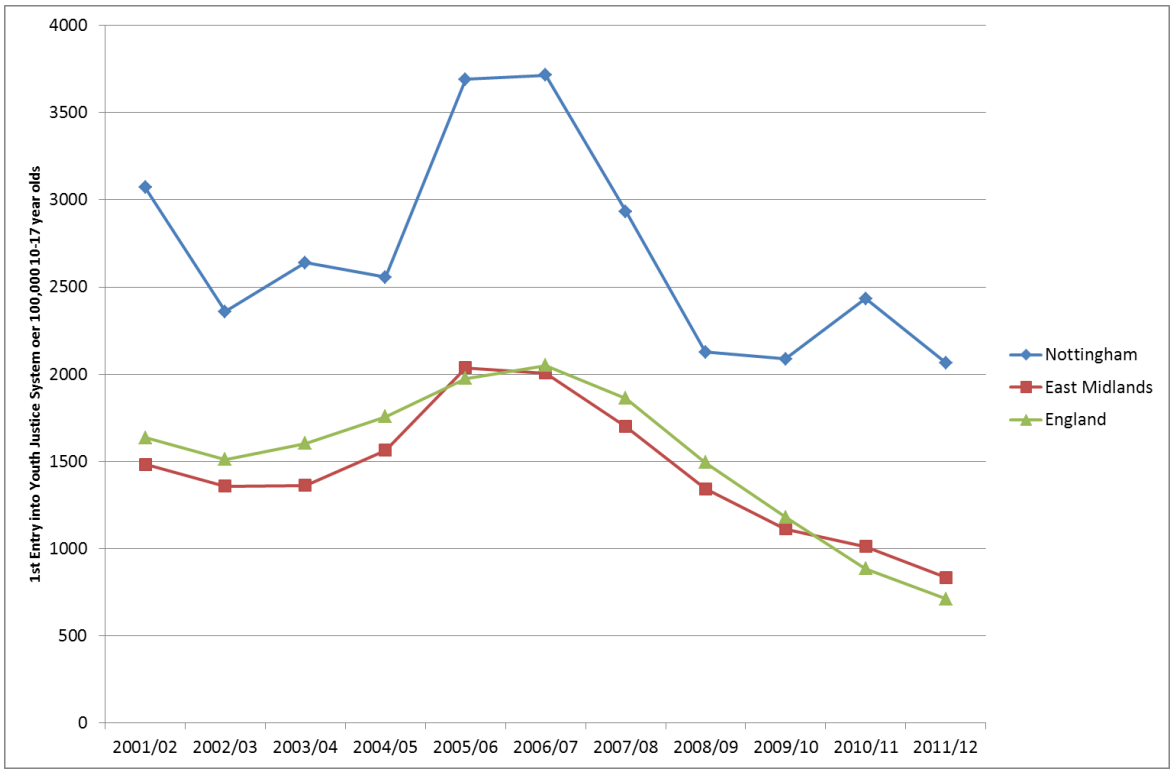
Source DfE https://www.gov.uk/government/publications/youth-justice-statistics

Emotional and mental health needs of young offenders

There are a number of factors that contribute to young offenders having a higher risk of mental health problems than the general population. Firstly, the risk factors for offending behaviour (e.g. deprivation, poor parenting, and problematic behaviour) overlap with risk factors for poor mental health. Secondly, contact with the youth justice system may lead to stress, anxiety, depression and exacerbation of existing mental health problems [(63)]. Thirdly, offending behaviour may be an expression of developing mental health disorders (e.g. emerging personality disorders). The

prevalence of mental health problems among young offenders has been estimated as about 40%, rising to about 90% among those in custody [64]. Vermeiren *et al* (2000) have estimated the prevalence of certain mental health disorders among young offenders [65], as shown in Table 28. Estimates of the number of young offenders with these conditions have been made based upon the 1390 young people in the youth justice system in Nottingham in 2011.

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



Source: https://www.gov.uk/government/publications/youth-justice

TABLE 29: PREVALENCE OF MENTAL HEALTH DISORDERS AMONG YOUNG OFFENDERS

	Estimated prevalence of a mental disorder amongst Youth Offenders (%)	**Estimated number of young offenders with mental disorder in Nottingham (of 778 in 2011/12)**
Conduct Disorders	53	412
ADHD	19	148
Substance Abuse	24	187
Depression	14	109
Psychotic Symptoms	4	31

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

Note: Young people may have more than one disorder

5.7 Children and Young People with a Physical Illness, Physical and Learning Disabilities

There is a direct relationship between special educational needs (SEN) and disability (SEND) levels and poverty within the city. The more deprived wards and neighbourhoods across the City have higher levels of incidence amongst pupils.

Data shows that males are more prevalent in the cognitive and learning disabilities (over 75% male), whereas young people with physical disabilities have a more even gender split

As the disabled population increases, without a commensurate increase in service provision there is a risk that children with a range of SEND, are excluded from their local community, universal and targeted provision, and from appropriate short breaks. Parental consultation has suggested that there is a lack of disability awareness within universal and targeted services and their capacity to successfully include and address the needs of this group of young people. From Table 30 it can be seen that data from ONS shows there are 4368 children within Nottingham City with a disability and of them, 2150 are receiving Disability Loving Allowance.

http://www.nottinghaminsight.org.uk/insight/jsna/children/jsna-disability-and-learning-difficulties-children.aspxce:

TABLE 30: CHILDREN WITH DISABILITIES, NOTTINGHAM CITY

Source	Prevalence	Number of City children (U18)	Number with disability
ONS	7%	62394	4368
Disability Living Allowance U16	11%	20260	2150
SEN			652
Pupils in special schools (2013)			476

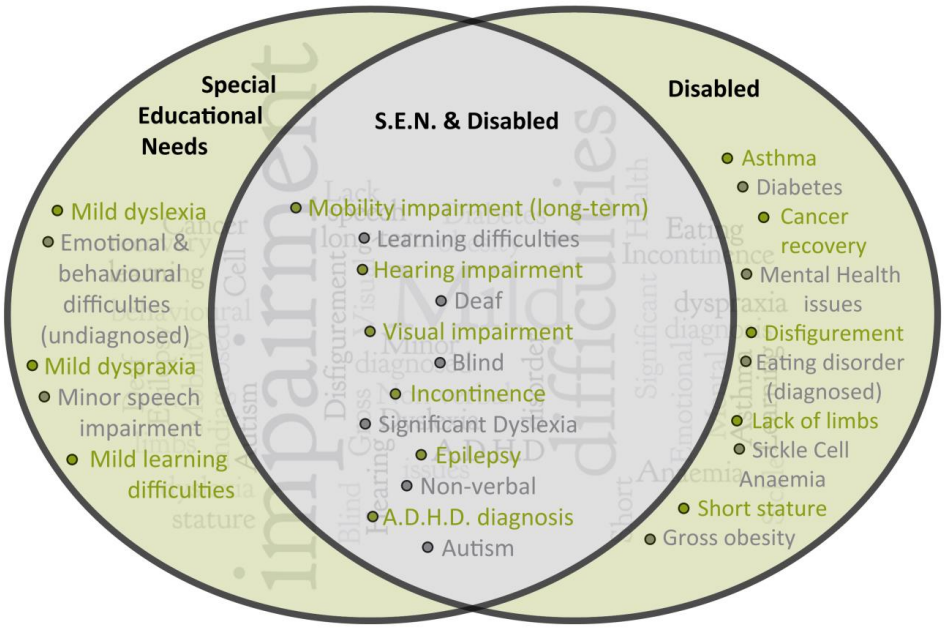
5.8 Children and Young People with Special Educational Needs

Children with a SEN "*have learning difficulties or disabilities that make it more difficult for them to learn or access education than most children of the same age. These children may need extra or different help from that given to other children of the same age… They may have difficulties in*

thinking and understanding, physical or sensory difficulties, emotional and behavioural difficulties, difficulties with speech and language or how they relate to and behave with other people" [66].

From Table 31, it can be seen that there are 43,681 pupils within Nottingham, of this 9,315 have SEN. Of the 9,315, 2398 have no statement however are part of school action (SA) or school action plus. SA is used when there is evidence that a child is not making progress at school and there is a need for action to be taken to meet learning difficulties. SA can include the involvement of extra teachers and may also require the use of different learning materials, special equipment or a different teaching strategy. SA plus is used where SA has not been able to help the child make adequate progress. At SA plus the school will seek external advice from the Local Authority support services, the local clinical commissioning group (CCG) or from social services. For example, this may be advice from a Speech and Language Therapist or specialist advisory services dealing with autism, behavioural Needs etc. SA plus may also include one-to-one support and the involvement of an educational psychologist. Table 32 breaks down this information further into the type of support with school action with the majority of pupils experiencing emotional and behavioural issues (332 within primary and 432 within secondary schools).

FIGURE 11: UNDERSTANDING SEN AND DISABILITY AND WHERE THEY OVERLAP



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

TABLE 31 : NUMBER OF PUPILS WITH SPECIAL EDUCATIONAL NEEDS (SEN), BASED ON PUPILS ATTENDING NOTTINGHAM CITY SCHOOLS

January 2013

Total Pupils	Pupils with statements	Pupils with SEN without statements			Pupils with SEN
	Pupils with statements	Pupils at School Action Plus	Pupils at School Action	Total SEN pupils without statements	Total SEN (4)
43,681	652	2,398	6,041	8,665	9,315

TABLE 32: NUMBER OF PUPILS WITH STATEMENTS OF SPECIAL EDUCATIONAL NEEDS (SEN) OR AT SCHOOL ACTION PLUS BY TYPE OF NEED IN NOTTINGHAM 2013

	Primary School	Secondary School	Special School
Specific Learning Difficulty	52	70	Small numbers
Moderate Learning Difficulty	230	188	31
Severe Learning Difficulty	24	20	111

Profound & Multiple Learning Difficulty	11	small numbers	48
Behaviour, Emotional & Social Difficulties	332	432	79
Speech, Language and Communications Needs	297	43	13
Hearing Impairment	36	35	Small numbers
Visual Impairment	30	20	Small numbers
Multi-Sensory Impairment	Small numbers	Small numbers	Small numbers
Physical Disability	101	37	Small numbers
Autistic Spectrum Disorder	210	150	208
Other Difficulty/Disability	68	67	Small numbers
Total (5)	1,395	1,065	500

NB: CHILDREN ARE ARE ONLY RECORDED BY THEIR PRIMARY NEED

The Department for Education (DfE) are making changes to how children with SEN and their families are supported. Some of the key changes include:

- Replacing the statement of SEN with an education, health and care plan.
- Allowing young people with SEN up to the age of 19 to have an education, health and care plan and, in some cases, up to 25.
- Giving parents and young people the option of a personal budget to buy SEN Support.
- Requiring local authorities to set out a 'local offer' of what support they expect to be available for children and young people with SEN.
- Changing the SEN code of practice.
- New and explicit requirements around the involvement of children, young people and parents in decisions about SEN provision.
- Requiring education and health services to work together to support children with special educational needs through 'joint commissioning' of services.

Emotional and mental health needs of children and young people with Physical Illness, Physical and Learning Disabilities and Special Educational Needs.

A secondary analysis of the 1999 and 2004 Office for National Statistics surveys of the mental health of British children and adolescents assessed the prevalence of psychiatric disorders among those with and without learning difficulties [(67)]. The study found the prevalence of psychiatric disorders was 36% among children with a learning disability compared to 8% among children without, indicating that children with a learning disability had a 6.5 times greater odds of a psychiatric disorder than those without a learning difficulty.

The same study also assessed risk factors for the development of emotional or mental health problems over time. Those with a physical illness were almost twice as likely to have developed an emotional disorder in the three years between the two surveys, than those with no physical illness [68].

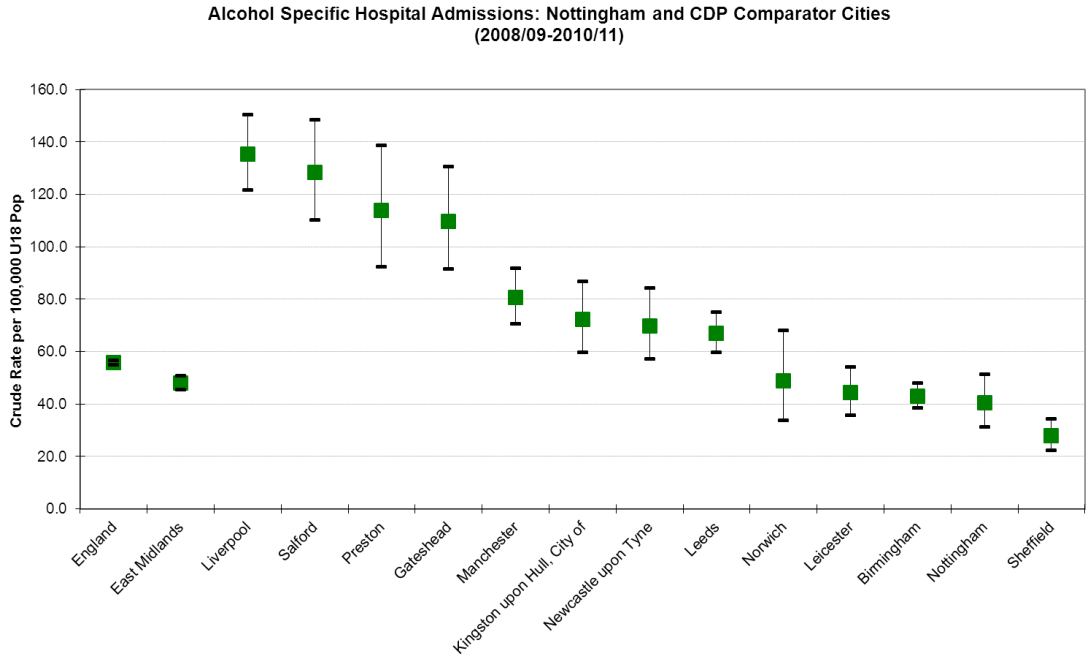
As discussed above ONS has demonstrated that children with a learning disability have a higher prevalence of psychiatric disorders than children without [67]). Other studies have suggested that the relationship between SEN and mental health problems is complex. In some cases, distinguishing symptoms of a mental health problem from the underlying SEN (e.g. ASD, ADHD) can be difficult [69]. Symptoms may be wrongly attributed to the underlying disorder leading mental health problems to be underdiagnosed. Other studies have suggested that those with ADHD, ASD and Asperger Syndrome have high levels of anxiety and depression [70].

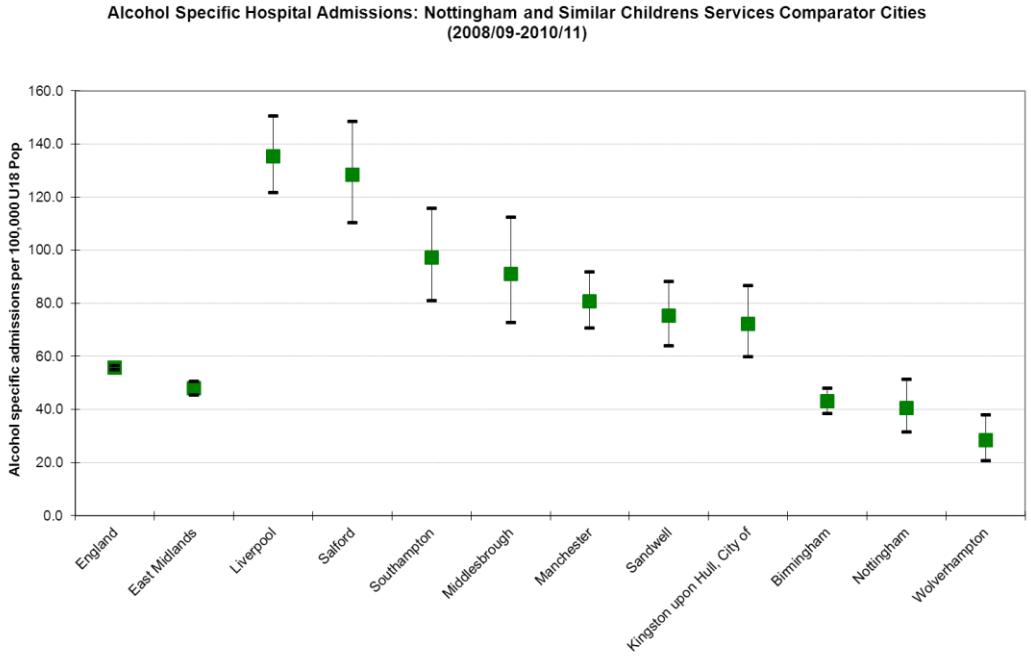
5.9 Children and Young People using Drugs and Alcohol

There are no concrete data on the prevalence of drug and alcohol use among children and young people. Evidence from a national survey carried out in 2011 of 11-15 year olds on the use of alcohol and drugs in England found that [71]:

- 2% of pupils reported having taken drugs in the last year.
- 3% of pupils reported taking drugs at least once a month.
- Cannabis was the most common drug pupils had tried (7.6%).
- Factors associated with drug use in the last year included being male, older, from a Black ethnic group, smoking, drinking alcohol, truancy, exclusion from school and low levels of reported wellbeing.
- 12% of pupils had drunk alcohol in the last week.
- 7% of pupils reported drinking at least once a week.
- Drinking alcohol was more common in older aged children.

FIGURE 12





PUBLIC HEALTH ENGLAND (NWPHO) ALCOHOL PROFILES 2012

TABLE 33: NUMBERS OF ADMISSIONS TO HOSPITAL FOR ALCOHOL SPECIFIC CAUSES IN UNDER 18S, 2008/9-2010/11

CDP Cities	**Number of admissions under 18 for alcohol specific causes (08/09-10/11)**	**Crude Rate per 100,000**	**95% Lower Confidence Limit**	**95% Upper Confidence Limit**
England	18444	55.8	55.0	56.6
East Midlands	1343	48.1	45.5	50.7
Liverpool	348	135.5	121.6	150.4
Salford	180	128.4	110.3	148.6
Preston	98	113.9	92.5	138.8
Gateshead	127	109.8	91.5	130.6
Manchester	233	80.8	70.7	91.8
Kingston upon Hull, City of	117	72.3	59.8	86.7
Newcastle upon Tyne	109	69.8	57.3	84.2
Leeds	306	67.1	59.8	75.0
Norwich	34	48.8	33.8	68.1
Leicester	93	44.3	35.7	54.2
Birmingham	327	43.1	38.5	48.0
Nottingham	**68**	**40.4**	**31.4**	**51.3**
Sheffield	89	28.0	22.5	34.4
Childrens Services Cities				
Liverpool	348	135.5	121.6	150.4
Salford	180	128.4	110.3	148.6
Southampton	126	97.2	81.0	115.8
Middlesbrough	86	91.0	72.8	112.4
Manchester	233	80.8	70.7	91.8
Sandwell	156	75.4	64.1	88.2
Kingston upon Hull, City of	117	72.3	59.8	86.7
Birmingham	327	43.1	38.5	48.0
Nottingham	**68**	**40.4**	**31.4**	**51.3**
Wolverhampton	45	28.4	20.7	38.0

Source: Public Health England (NWPHO) Alcohol Profiles 2012

http://www.nottinghaminsight.org.uk/insight/partnerships/public-health/school-health-profiles.aspx

(*Click to view*)

Nottingham City School Nursing Profiles have collated drug and alcohol data from the D-Vibe survey tool. Not all schools take part in the survey so sample sizes are small.

D-Vibe Online Drug and Alcohol Survey

D-Vibe is a complete data collection, analysis and evaluation tool for drugs issues and education. Developed on effective research models and fully tested and developed with young people and professional users, it is available as a licence for use with schools or organisations wishing to know more about the drug related behaviours, knowledge and experiences of young people.

Children age 11-15

- 18.4 % tried tobacco
- 56% tried alcohol
- 6.5% have been drunk
- 2.1% have tried illegal drugs

Substance misuse

JSNA http://www.nottinghaminsight.org.uk/insight/jsna/children/jsna-substance-misuse-in-children.aspx

By extrapolating the national data from SDD10 and the British Crime Survey (Smith, K & Flatley, J, 2011) for 11-17 year olds prevalence of drug use, we can estimate that between 3,007 to 3,085 (3,046) 11-17 year olds have used drugs in the last year in Nottingham. This will undoubtedly be an under estimate as both surveys relied on self-reporting and only used a sample of the population (albeit large).

Using the British Crime Survey 2010/11 to estimate the number of 16-17 year olds that have used Class A drugs in the last year (5.1%) for Nottingham this would be an estimate of 319. Again this is likely to be an under estimate due to the methodology of the British Crime Survey

There are two specialist drug and alcohol services for young people commissioned for Nottingham City, Compass and Head 2 Head (Dual Diagnosis provision). During 2010/11 there were 361 young people in specialist treatment (301 Compass and 51 Head 2 Head and a further 9 were seen by other services). All data relating to services, unless otherwise stated is extracted from the National Drug Treatment Monitoring System

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

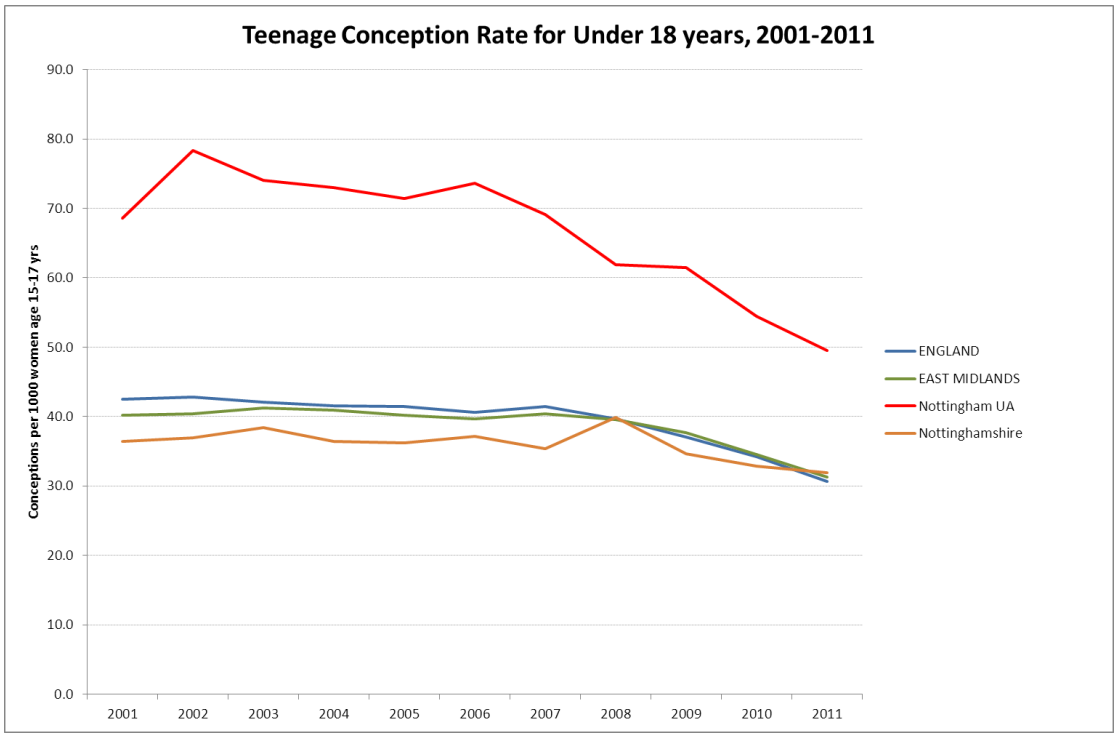
Alcohol and drug use are associated with poorer mental health among children and young people. Recreational drugs are associated with increased risk of suicide, depression and behavioural disorders. Regular use of cannabis has been associated with psychotic symptoms (e.g. hallucinations, anxiety, and paranoia) in about 1 in 10 cannabis users (72). Associations between substance misuse

and mental health disorders are complex. The substances themselves affect mental health, but it is also argued that those with developing symptoms of, for example, schizophrenia or depression, may use drugs or alcohol as a form of 'self-medication'. Drinking during childhood, particularly heavy drinking is associated with a range of problems including physical and mental health problems, alcohol-related accidents, violence, and anti- social behaviour. Young people recognised to have a greater risk of substance misuse include looked after children, children affected by parental substance misuse, young offenders, those excluded from school and homeless young people [73].

5.10 Teenage Mothers

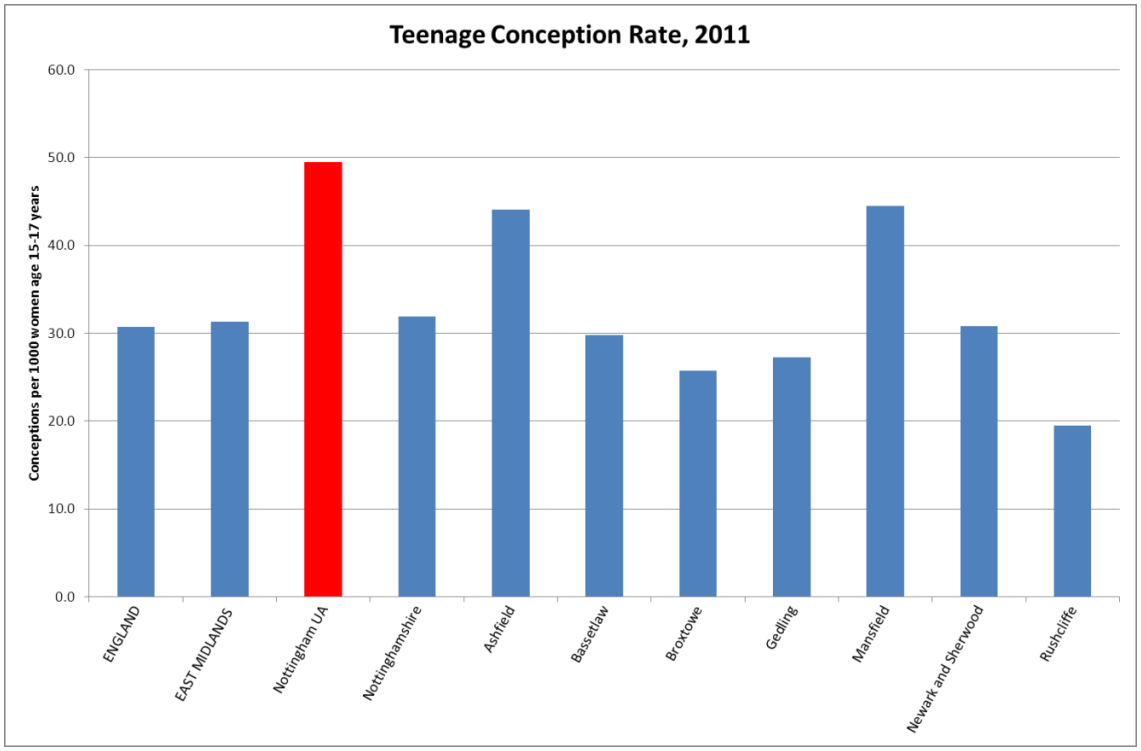
In Nottingham City, 37.6 young women aged under 18 years conceived per 1,000 population in 2012 compared to the national average of 27.7 per 1,000. Of the conceptions in Nottingham City 29.3% led to termination of pregnancy, compared with the national average of 49.3%. Between 2009 – 2012 aggregated under-16 conception rate is 8.9 per 1000; the national average is 6.7. Of these in 2012, 29.3% of teenage conceptions resulted in abortion (this was the second lowest rate after Hull in England, the average was 49.1%).

FIGURE 13: TEENAGE CONCEPTION RATE IN NOTTINGHAM UNDER 18 2001-2011



Source: ONS Conception Statistics, England and Wales, 2011

FIGURE 14: TEENAGE CONCEPTION RATE, 2011



Source: ONS Conception Statistics, England and Wales, 2011

Emotional and mental health needs of teenage mothers

National data has shown that teenage mothers are more likely to suffer from post natal depression and suffer from poorer mental health in the three years after the birth compared with other mothers, they have 30% higher levels of mental illness 2 years after the birth, after which they start to converge to the population average. Being a teenage mother has also been associated with higher risk of partnership breakdown, isolation, living in poor quality housing and lower education achievement [(74)].

Children of teenage mothers are more likely to have behavioural problems, lower educational achievement, greater risk of economic inactivity and increased risk of becoming a teenage mother in turn [(74)].

5.11 Children who are exposed to Domestic Violence or experience Domestic Violence

Witnessing domestic violence during childhood is not uncommon. A survey of 6196 children and young people found that 12% of under 11 year olds, 17.5% of 11-17 year olds, and 23.7% of 18-24 year olds had been exposed to domestic violence between adults in their homes during childhood53. This study also found that 3.2% of under 11s, 2.5% of 11-17 year olds reported exposure to domestic violence in the past year. If applied to the Nottingham City population this would mean that 1,837 children and young people (1,266 under 11 and 571 aged 11-17 have witnessed domestic violence in the last year. Since summer 2012 the domestic abuse referral team (DART) has been supporting a multiagency response to DVA affecting families that include children or vulnerable adults. This information will support the understanding of the current situation in Nottingham for these groups. The first year of the DART system in Nottingham has included cases involving 3010 victims and 4236 children, 3000 of whom are under 10 years of age. The figure of 1,837 estimated children exposure using national prevalence as opposed to the numbers actual children in Nottingham (4236) shows that Nottingham City has significantly more children exposed to domestic violence. Analysis for the Safe from Harm Strategic Commissioning Review identified that Nottingham has over 20% of households in the most deprived 10% of areas nationally but that these represent 40% of calls to the police for domestic incidents.

Various organisations collect information that provide a picture of the extent of domestic abuse in Nottingham, however Police data is the source most consistently collected at a City level. Nottingham Police receive on average 12,000 domestic violence related calls annually of which 2500 are recorded as crimes. 39% of all recorded violence in the city is DVA. 84% of victims of incidents recorded as crimes are women, 16% are men.

The 2011/12 Crime Survey for England and Wales found that young women were much more likely to be victims of sexual assault in the last year and NSPCC research indicates that around 21% of girls and 11% of boys experience some form of childhood sexual abuse.

In 2009 the NSPCC published partner exploitation and violence in young people's intimate relationships.
http://www.nspcc.org.uk/Inform/research/findings/partner_exploitation_and_violence_report_wdf70129.pdf [Accessed 2013])

Emotional and mental health needs of children and young people who are exposed to Domestic Violence or experience Domestic Violence

Children who are exposed to domestic violence have increased risk of experiencing emotional and mental health problems. Rossman (2000) (75) adopted the term "adversity packages" to describe the multiple stressors which can accumulate in the lives of young people exposed to domestic violence, including mental health difficulties. In addition resilience and self- esteem emerges as a critical element underlying the child's ability to developing coping strategies, both of which are significantly affected in children who are exposed to Domestic Violence (76).

US research has identified that teenage partner violence is associated with a range of adverse outcomes for young people, including mental health, depression and suicide (77) . Furthermore, US research has identified a range of risk factors that may increase a teenager's susceptibility to partner violence. These risk factors include previous experiences of parental domestic violence, physical and sexual abuse, and violent peer groups (78).

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

Abuse and neglect are underreported and under detected. A large survey conducted by the National Society for Prevention of Cruelty to Children (NSPCC) [(55)] identified that about 23% of children aged 11-17 who were physically hurt by a parent or guardian did not tell anyone. Sexual abuse by a parent or guardian was even less commonly reported, with a third of children not telling anyone else. When sexually abused by a peer, 82.7% reported having never told anyone else about it. The most comprehensive estimates of the prevalence of abuse for children and young people aged 11-17 come from this survey, and have been applied to the Nottingham City population in Table 34. Clearly these estimates only focus on 11-17 year olds, and so actual numbers are likely to be higher once under 11s are included.

TABLE 34: ESTIMATED PREVALENCE OF ABUSE AMONG 11-17 YEAR OLDS

Abuse	Estimated prevalence 11-17 year olds (NSPCC) (%)	Estimated number of 11-17 in Nottingham
Sexual abuse	16.5	3768
Physical abuse at the hand of parent/guardian	6.9	1576
Experienced severe neglect	9.8	2238
Emotional abuse	6.8	1553

Radford, L. *et al. Child abuse and neglect in the UK today*. (2011) and ONS 2011

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

During 2011/12, there were 436 children who were the subject of a child protection plan (this correlated to 460 children who are looked after) in Nottingham City. Overall however there has been an upward trend both locally and nationally since in 2001/02.

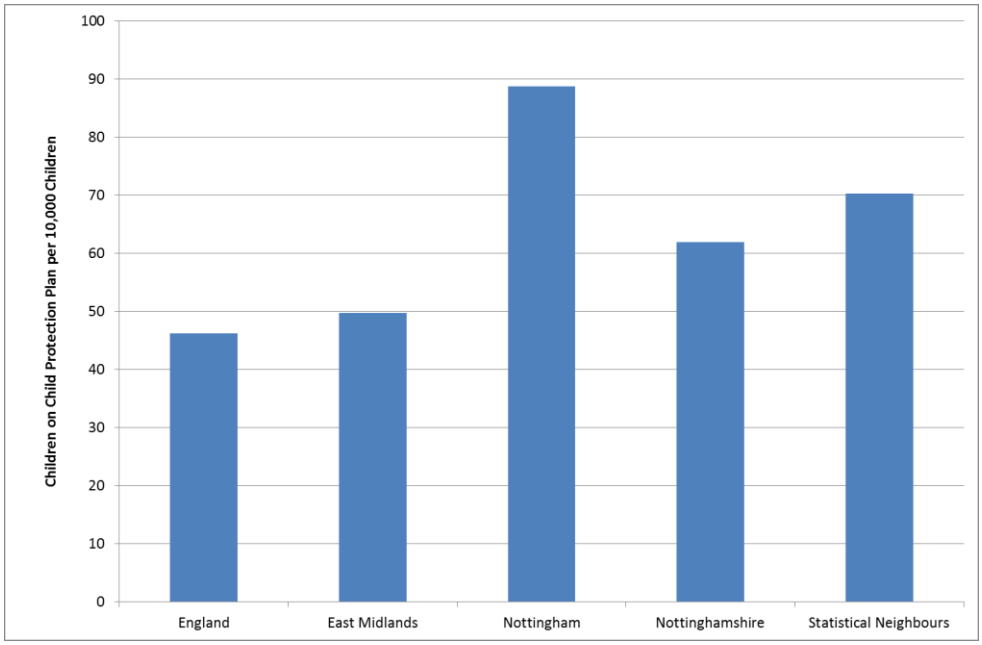
As shown in Table 35 the most common single reason children were the subject of a child protection plan was neglect (46.8% of cases) followed by emotional (39.2%). Figure 15 shows the rate of children with a child protection plan and that Nottingham has a significant higher rate per 1,000 compared to England, the East Midlands and its statistical Neighbours.

TABLE 35: CHILD PROTECTION CATEGORY FOR CHILDREN WITH A CHILD PROTECTION PLAN (31ST MARCH 2013)

Child Protection Category	Number of children	Percentage (%)
Emotional	171	39.2
Neglect	204	46.8
Physical	30	6.9
Sexual	31	7.1
Multiple categories of abuse	0	0.0
	436	100.0

https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013

Figure 15: Rate of children subject to child protection plan during 12/13 per 10,000 children



https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013

Emotional and mental health needs of children and young people who are subject to abuse or have a child protection plan

Child abuse is an important risk factor for child and adult psychiatric morbidity. Studies have demonstrated that those who have experienced abuse have a higher risk of depression (15.5 fold increased risk), suicidal ideation (8.9 fold increased risk) and anxiety (8.1 fold increased risk) during childhood [(23)]. Abuse during childhood can also increase the risk of recurrent depression in adulthood and substance misuse. Witnessing violence in the home or experiencing abuse is recognised to have a long term impact. In a survey of offenders, 41% reported witnessing violence in their home as a child and 29% reported emotional, sexual or physical abuse as a child [(79)].

Research has however shown that not all maltreated children experience mental health problems as adults. Collishaw *et al* (2007) [(9)] identified parental care, adolescent peer relationships, the quality of adult love relationships, and personality style as resilience factors to the effects of abuse [(80)].

Summary: Chapter 5 High Risk Groups

The number of children in Nottingham City who are considered high risk is considerable. Nottingham City has higher than average number of children taken into care, a significant number of children are witness to domestic violence within in the home and have been referred to DART and a higher than national average number of teenage mothers. All these high risk groups of children and young people who reside within Nottingham will have an impact on both health and social care services required to support them..

- **The numbers of CiC within Nottingham have been rising at a rate of 4.5% year on year and as of the end of March 2013 there were 560 LAC in Nottingham.**
- **Although numbers of CiC have risen by 4.5% per year, over the same period the city's 0-17 population only increased by 0.2% per year. This indicates the rise in Children in CiC being as a result of a population increase.**
- **The actual number of young carers in Nottingham City is unknown. Those presenting to support agencies are likely to underestimate the true number of children and young people with caring responsibilities. Data from the 2011 census can be used to estimate the number of young carers in Nottingham within the East Midlands, 2.1% of children and young people aged 5-18 were identified as young carers. Applying this to the Nottingham population, this would equate to 1,018 children and young people aged 5-18 acting as carers.**
- **The percentage of young people NEET in Nottingham City (6.3%) (Table 26) this is significantly higher than average for the East Midlands (4.8%) and England (5.8%).**
- **The rate of homelessness among children and families accepted as being in priority need in 12/13 was 3.49 per 1000 households in Nottingham City (481 households). Comparatively, rates of homelessness in this group were higher than in the East Midlands (1.74 per 1000 households) and nationally (2.37 per 1000 households).**
- **Children and young people who are homeless are significantly more likely to have delayed development, learning difficulties, and mental health problems, such as sleep disturbance, over activity, anxiety, depression and self-harm.**
- **The number of children from Gypsy/Roma Communities has significantly increased in 2013 to 129 from that in 2012 where there were 96 recorded children.**
- **National evidence has shown that Travellers have significantly poorer health status and significantly higher self-reported symptoms of ill health than other UK ethnic minority or economically disadvantaged UK residents.**
- **There are a number of factors that contribute to young offenders having a higher risk of mental health problems than the general population. Firstly, the risk factors for offending behaviour (e.g. deprivation, poor parenting, and problematic behaviour overlap with risk factors for poor mental health.**
- **Evidence from a national survey carried out in 2011 of 11-15 year olds on the use of alcohol and drugs in England found that (71):**
  - **2% of pupils reported having taken drugs in the last year**
  - **3% of pupils reported taking drugs at least once a month**
  - **Cannabis was the most common drug pupils had tried (7.6%)**
- **In Nottingham City (2012 data), 49.5 young women aged under 18 years conceived per 1,000 population in 2011 compared to the national average of 30.7 per 1,000. Of the conceptions in Nottingham City 37% led to termination of pregnancy, compared with the national average of 49.3%.**
- **National data have shown that teenage mothers are more likely to suffer from post natal depression and suffer from poorer mental health in the three years after the birth compared with other mothers—they have 30% higher levels of mental illness 2 years after the birth**
- **Nottingham Police receive on average 12,000 domestic violence related calls annually of**

which 2500 are recorded as crimes. 39% of all recorded violence in the city is DVA. 84% of victims of incidents recorded as crimes are women, 16% are men.

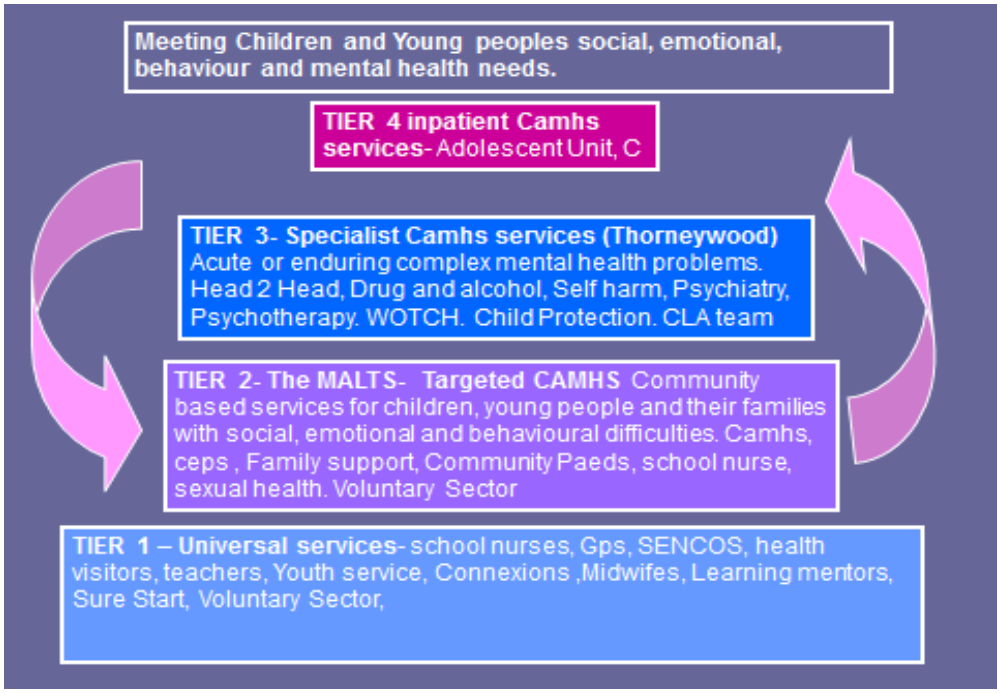
- **The first year of the DART system in Nottingham has included cases involving 3010 victims and 4236 children, 3000 of whom are under 10 years of age**
- **The most comprehensive estimates of the prevalence of abuse for children and young people aged 11-17 come from a survey, and have been applied to the Nottingham city population in Table 34. Clearly these estimates only focus on 11-17 year olds, and so actual numbers will to be higher once under 11s are included.**

6 Current Service Provision

6.1 Overview of Nottingham City CAMHS

Figure 4 shows the overall organisations that make up emotional and mental health services across the 4 –tier model in Nottingham City as outlined in section 2.3. This model is a helpful concept however it must be noted that children do not always fit neatly into the tiers of this model.

FIGURE 16: OVERVIEW OF CAMHS SERVICES IN NOTTINGHAM CITY.



6.2 Tier 1 Services

Tier 1, universal services consist of a broad range of services available to the local population, which help to promote emotional and mental wellbeing, alongside recognising those with more severe mental health needs who need further support. They include GPs, school nurses, health visitors, midwives, schools, early years and youth services.

Universal services refer into Tier 2 CAMHS however many services for example school nurses provide a service for children who do not meet the criteria for referral into tier 2 but who may have some emotional health problems.

Information from school nurses within Nottingham City illustrates the scales of the issue. **Since April 2013 and October 2014 school nurses have seen a total of 557 children with emotional health problems.** Out of the 557 children the reasons for emotional support were:

- Emotional Health – Behaviour = 203
- Emotional Health – Bullying = 24
- Emotional Health – Eating Disorder = 33
- Emotional Health – Low Mood = 130
- Emotional Health – Self Esteem = 106
- Emotional Health – Self Harm = 172

6.2.1 Kooth Counselling

A unique programme commissioned by NHS Nottingham City CCG that provides vulnerable young people, who have emotional or mental health problem, with support when they need it most via an online and face to face service. The service is a bridge between universal services and tier 2 and provides a first line response for children and young people up to the age of 24 experiencing social and emotional problems. The unique online provision enables children and young people to access the site 24/7 with expert counsellors available on line until 10pm at night to provide counselling sessions and opportunity to refer to a face to face session.

6.3 Description of the Single Point of Access (SPA)

6.3.1 Description of SPA

All referrals received by CAMHS (tiers 2-3) are screened at a single point of entry meeting. The SPA consists of a once weekly meeting of representatives from tier 2 and 3 services. Cases are discussed and allocated to the appropriate team. Where referrals are not appropriate for targeted/specialist CAMHS, advice is given to the referrer of alternative services that might be more appropriate. The SPA flowchart is shown below in Figure 5.

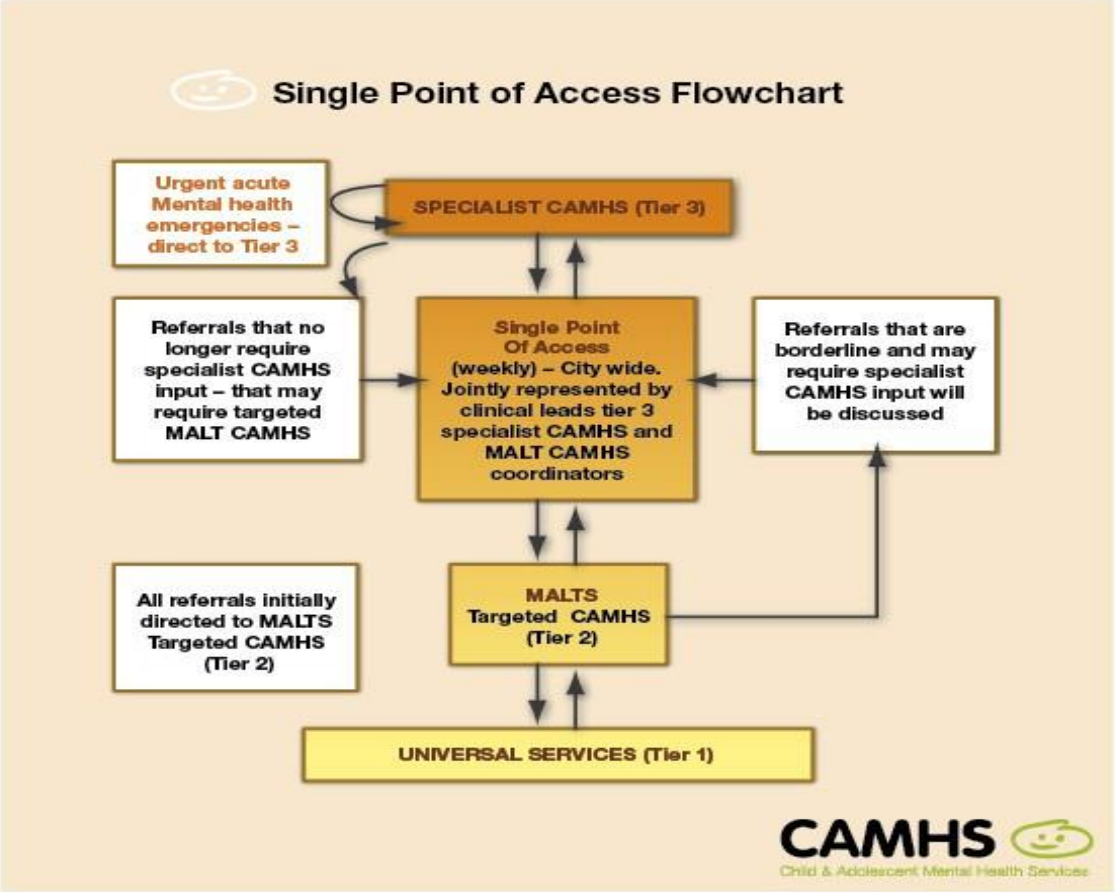
What does the Service need from referrers?

- Completed CAF with the multi- agency action plan and signed consent.

- Supporting additional information such as reports, assessments, and clinic letters.
- SPA completed referral form for agreed health professionals with implied consent.
- Information is essential regarding 'Trilogy of risk'/'Adult mental health, domestic violence and substance misuse' and any additional safeguarding concerns.
- It is essential that key information regarding ethnicity, disability, family structure and any caring responsibilities are identified.
- The child and family or young person must be in agreement with the referral and understand the nature of the service to which they have been referred.
- Parent/carer involvement is preferred, but is not essential for adolescents deemed able to make their own decisions (Please consider Fraser competence guidelines and data information governance/data protection.

There are some alterations to the SPA flow chart. The MALTS are now called Targeted Family Support Teams –CAMHS and the centre square should read ' Single Point Of Access' (weekly) – City wide, jointly represented by Clinical Leads from Tier3 Specialist CAMHS and Tier2 CAMHS Mental Health Specialist

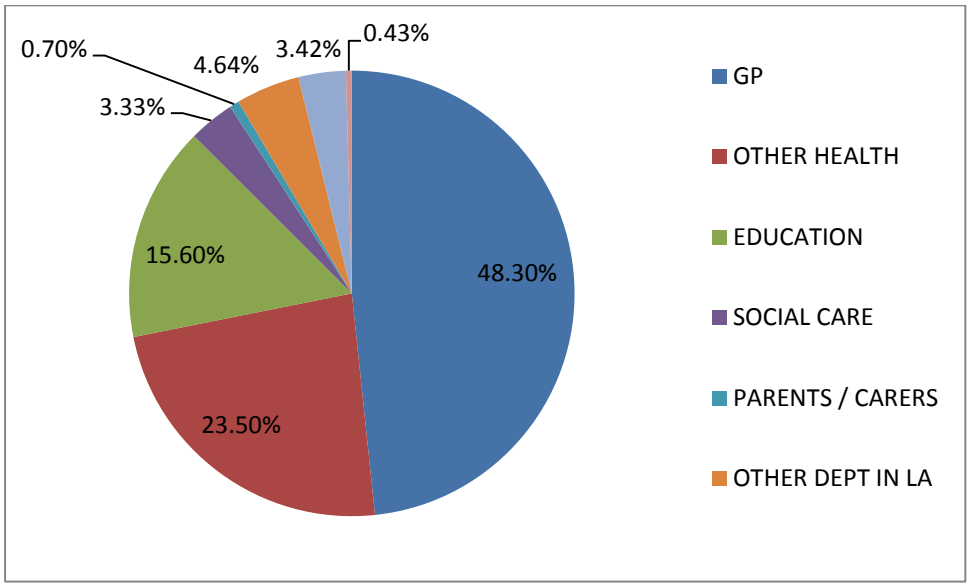
FIGURE 17: CAMHS SINGLE POINT OF ACCESS



6.3.2 Single Point of access data

Between 1st April 2012 and 31st March 31st 2013, **1301** referrals were received by the CAMHS SPA. Figure 18 shows the three most common sources of referrals were from GPs (48.3%), other health (which includes school nurses) (23.50%) and education (15.60%). At the SPA weekly meetings, referrals are made to the most appropriate services. Table 37 shows the outcome and numbers from initial referral into the SPA by each locality in 2012/2013.

FIGURE 18: SOURCE OF REFERRAL TO THE CAMHS SPA 2013/2013



Source: Nottingham City Council, Targeted Family Support Teams- CAMHS

6.4 Tier 2 Services

6.4.1 Description of Tier 2- Targeted Family Support Teams –CAMHS

CAMHS tier 2 is jointly funded by Nottingham City Council and NHS Nottingham City CCG, each agency puts £750,000 per year into the service. Across Nottingham City, there are three Targeted Family Support Teams which provide community focused CAMHS deliver at a targeted level. In addition Tier 2 also provides:

- Assessment of emotional mental health needs.
- Range of family based interventions including Cognitive Behavioural Therapy, Solution Focus Brief Therapy, didactic therapy, systemic family work, group work, parenting support and attachment theory.
- Consultation to schools and other professionals.
- Training
- Drop in sessions and group work at some city schools.
- Sexual health and emotional wellbeing outreach.
- Specialist support identified for young people with LD/ASD presenting with emotional and mental health problems.

TABLE 35: TIER 2 SERVICE DESCRIPTION

Service		Need being met	Spectrum of disorders addressed	Services Provided	Professionals involved in service delivery (How many/how much time)	Where services are located
Targeted Family Support Teams (Director of Service Tim O'Neil)	Behaviour Support Team	Work with schools, children and young people and their families to reduce exclusions and to maximise pupil achievement and attainment.	Social, emotional and behavioural difficulties.	Support in schools to develop behaviour management Support to develop whole school systems, skills and knowledge e.g. training through inset of staff meetings, SEAL De-escalation and PI training, risk assessments Support and intervention for targeted children and young people Observation, feedback and support to develop strategies to re-engage pupils in learning and achievement Support for SEN Co-ordinators to develop plans and reviews, mainstream support grant requests, provision mapping, individual education plans etc.	3 behavioural support team teachers and 3 behaviour support team support workers in each of the 3 Targeted Family Support Teams.	The three Targeted Family Support Teams are based in three areas of the city: North, Central and South. Work with young people takes place in a range of locality settings to ensure accessible and suitable venues for young people to access.
	Community Targeted CAMHS	Aim of the team is to offer an effective early intervention service to prevent emotional and behavioural difficulties emerging into more complex	Anxiety and low mood, difficulties with relationships, non-life threatening self-harm, risk taking behaviour, poor self-esteem, attachment issues, bereavement/separation and loss and a range of difficulties associated with managing emotions and relationships.	Consultation/training and support to schools and other universal and targeted services Support for parents including individual and group based work Assessment of mental health needs with referral to specialist CAMHS where appropriate Therapeutic intervention (individual and group sessions) Specialist work with young people with LD/ASD Specialist CAMHS outreach support to young people attending city sexual health clinics.		

Service		Need being met	Spectrum of disorders addressed	Services Provided	Professionals involved in service delivery (How many/how much time)	Where services are located
		and enduring mental health difficulties.				
	SHARP Team	Working within Schools and individuals to tackle self-harm	Self-harm	Assessment of needs with therapeutic intervention (individual and group sessions). Support and training to schools and health professionals on the issue of self-harm		
	Community Educational Psychology Service (CEPS)	The CEPS delivers an applied psychology service enabling children and young people with complex additional needs to achieve, be health and successfully included in their schools and communities.	Social, emotional and behavioural difficulties.	Provide a dedicated educational psychologist to all Nottingham LA schools, special schools and children centres according to need Link with pre-school settings in meeting individual needs Provide consultation to the wider children and young people services Contribute to school improvement Chair pre-liaison panels Support and promote the participation of children, young people and their parents/carers in making educational decisions Support the voice of the child at transition through person-centred reviews. Monitor the placements of pupils with statements of educational needs attending out of city placements Provide training in child development, social and emotional development, behaviour, syndromes and disorders, pedagogy, psychology of the classroom, school and family Provide support to the LA and schools through research		

6.5 Tier 2 CAMHS Service Data (2012-2013)

Numbers of referrals

1301 referrals were received by the CAMHS. Figure 17 shows the proportion of referrals made by each locality with the North Locality making the most referrals (38.5%), followed by the South Locality (36.7%) and then Central Locality (24.7%). From 2011-2012 there has been increase in referrals from 1293 to 1301 in 2012-2013. It can be seen in Figure 18 that more males are referred into tier 2 than females (699 males and 602 females) and most children and young people are between the ages of 11 – 15 years who are referred (Figure 19).

FIGURE 19: TOTAL TARGETED FAMILY SUPPORT TEAM REFERRALS MADE BY EACH LOCALITY (2012-2013)

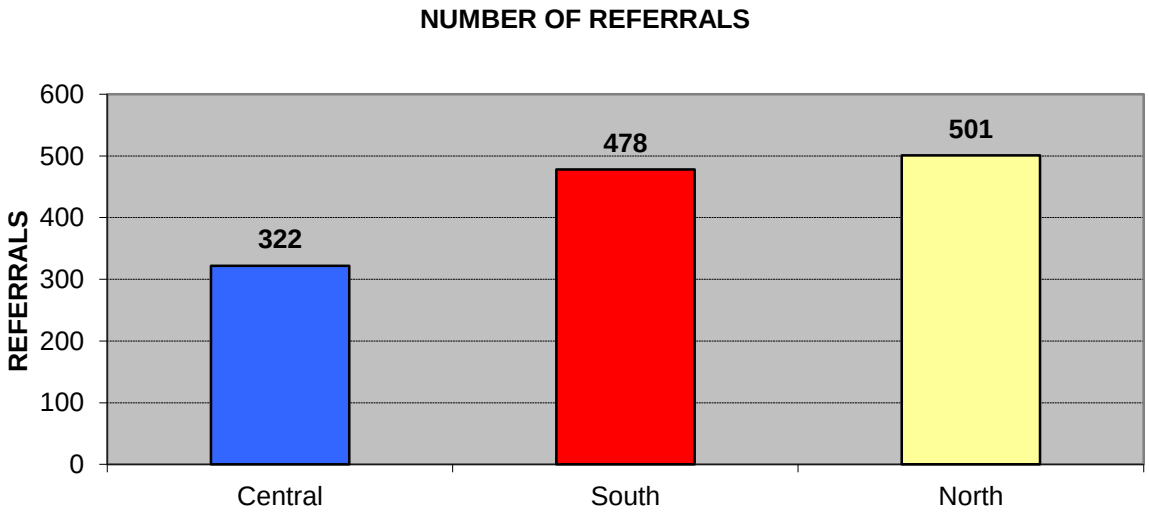


FIGURE 20: GENDER REFERRED INTO TEIR 2 CAMHS (2012-2013)

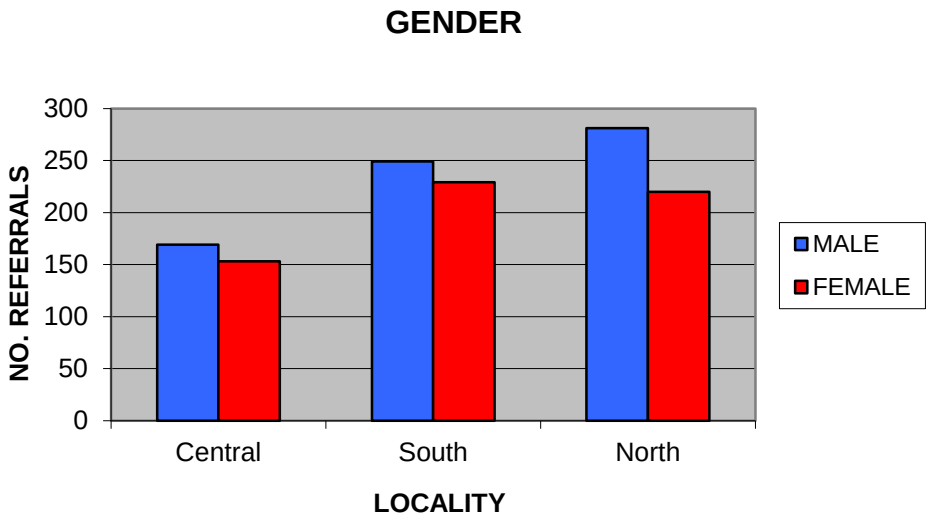
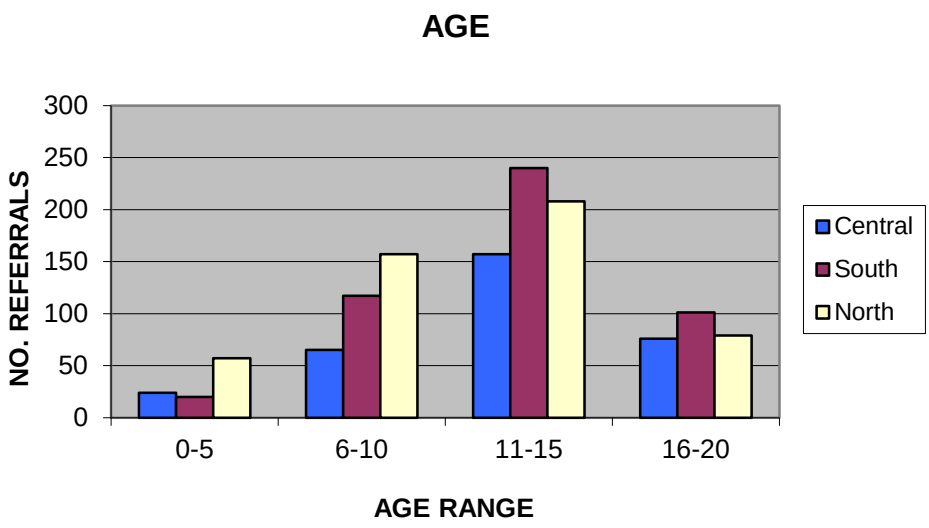


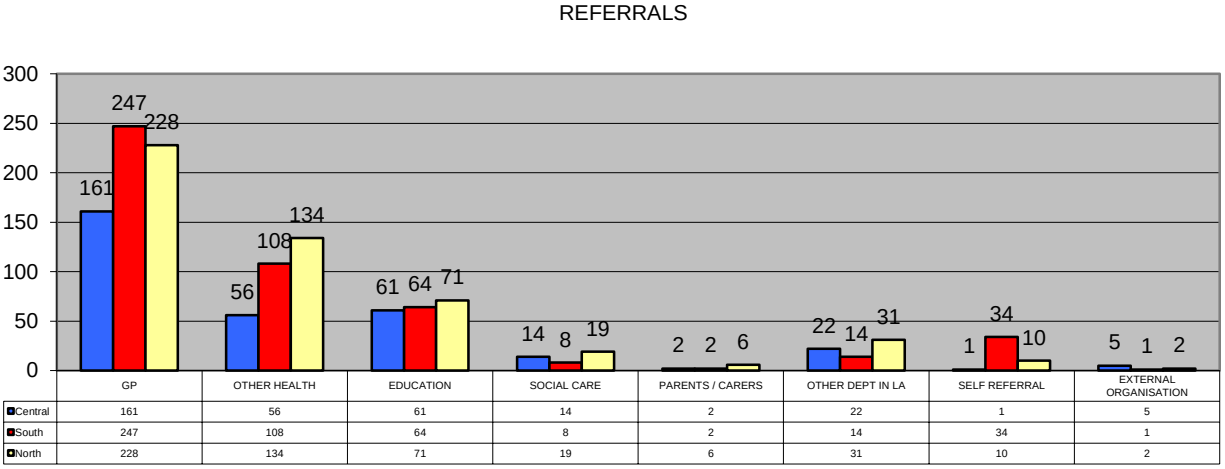
FIGURE 21: AGE RANGE OF REFERRALS INTO TIER 2 (2012-2013)



Origin of Referral

From Figure 19 it can be seen that the majority of referrals into Tier 2 derive from GPs then other Health which would include the School Nurse, followed by Education.

FIGURE 22: ORIGIN OF REFERRAL INTO TIER 2 CAMHS (2012-2013)



	GP	OTHER HEALTH	EDUCATION	SOCIAL CARE	PARENTS / CARERS	OTHER DEPT IN LA	SELF REFERRAL	EXTERNAL ORGANISATION
Central	161	56	61	14	2	22	1	5
South	247	108	64	8	2	14	34	1
North	228	134	71	19	6	31	10	2

Reason for Referral and Outcome of referral

Table 36 shows the initial reasons for referrals and Table 37 show the outcome of the referral. It can be seen from Table 36 that referrals for challenging behaviours were the most common, followed by low mood and then self harm. It must be noted that these reasons for referrals are symptoms children and young people are referred with, not a diagnosis or issues that are revealed when a child

or young people is seen in CAMHS. Table 37 shows the outcome of the initial referral. Working with the family is the most common outcome, followed by working within a children's centre then referral into Tier 3. Only 4.38% of children are referred into tier 2/3 and 7.3% are referred into Tier 3 CAMHS therefore CAMHS tier 2 are holding a significant number of cases within the service.

TABLE 36: REASON FOR REFERRAL (2012-2013)

	Central	South	North
ADHD	18	25	14
ANXIETY	34	50	45
ASD	11	37	31
ATTACHMENT	Small Number	0	Small Number
BEREAVEMENT	4	15	9
CHALLENGING BEHAVIOUR	105	144	207
EATING DISORDER	9	11	8
EMERGING PSYCHOSIS	0	5	Small Number
FAMILY RELATIONSHIP	21	17	18
LEARNING DISABILITY	7	10	9
LOW MOOD	37	62	59
LOW SELF ESTEEM	10	17	9
OCD	6	8	Small Number
NEUROLOGICAL DIFFICULTIES	Small Number	0	Small Number
PHYSICAL HEALTH	0	0	0
SCHOOL ATTENDANCE	Small Number	5	6
SELF HARM	46	52	51
SOILING / ENURISIS	Small Number	Small Number	Small Number
SEXUAL ABUSE	Small Number	Small Number	6
SEXUALISED BEHAVIOUR	0	0	Small Number
SUBSTANCE MISUSE	0	0	Small Number
SUICIDAL THOUGHTS	5	16	8
TRILOGY OF RISK	Small Number	0	5
YOUNG CARER	0	0	0

Source: Nottingham City Council, Targeted Family Support Teams- CAMHS 2013

NB: any number 5 and under within the tables have been changed to 'Small Number.'

TABLE 37: OUTCOME OF REFFERAL (2012-2013)

	Central	South	North
Direct with YP / Child	Small Number	9	Small Number
Direct with family	197	379	342
Consultation	14	13	Small Number
REF - TIER3 CAMHS	40	26	30
Joint TIER2 / TIER3	24	18	11
REF - Children's Centre	40	25	105
Signpost to other Agency	Small Number	8	8
Inappropriate referral	Small Number	0	Small Number

Source: Nottingham City Council, Targeted Family Support Teams- CAMHS 2013

NB: any number 5 and under within the tables have been changed to 'Small Number.'

Data from quarters 1 and 2 and 3 for 2013/2014 suggest there has been a significant increase in referrals to CAMHS Tier 2 with 408 children and young people referred within Quarter 1, 375 in Quarter 2 and 350 in Quarter 3. If the numbers continue to increase on with the same trajectory there will have been 15% increase in the number of referrals for 2013/2014. The majority of referrals within quarters 1, 2 and 3 for 2013/2014 have been for challenging behaviour, low mood and self-harm.

From the referrals for 2012 to date it can be seen that a significant number of young people are worked with within Tier 2 and a only a small number (96 children and young people in 2012/2013 and so far for 2013/2014 78 children and young people) are referred upwards into tier 3, this equates to only 7.3% of the total number of referrals (see Table 38 for outcome of referrals from quarters 1, 2 & 3).

TABLE 38: OUTCOME OF REFERAL FROM QUARTERS 1, 2 & 3 FROM 2013/2014

Outcome of Referral		Total
	Direct with YP / Child	6
	Direct with family	757
	Consultation	53
	Drop in	20
	REF - TIER3 CAMHS	78
	Joint TIER2 / TIER3	31
	REF - Children's Centre	155
	Signpost to other Agency	46

	Inappropriate referral	10

6.6 Nottingham City CAMHS Children Looked After Team

The Children Looked After Team is made up of health and social care professionals. There are currently four NHS Trust employed staff which comprise of a Consultant Psychiatrist, 2 x Clinical Psychologists and one specialist nurse. In addition there are 4 whole time equivalent (WTE) social workers, one WTE art therapist and one WTE Team manager all employed through social care.

The core offer of this team focuses on consultation model for professionals /carers working around the child who is in care stemming from referrals from social workers or from the child. Work can be undertaken directly with the child however this request must come from the child.

The main focus of the work is built around attachment and promoting attachment between the carer whether it is it with a foster carer or a carer within a residential home.

In addition the team also offers consultation for cases where a child or young person has been placed three years post adoption and is living in Nottingham. Cases which fall prior to the three year rule will continue to be held within Tier 3 Community CAMHS.

There are currently as from September 2013 564 children in care and of those 200 are being seen within the CAMHS Children Looked After Team. From Table 30 is can be seen that a significant number of referrals (94.1%) come from Nottingham City Council Social Services.

TABLE 39: REFERRAL SOURCE INTO CAMHS CHILDREN LOOKED AFTER TEAM (2012-2013)

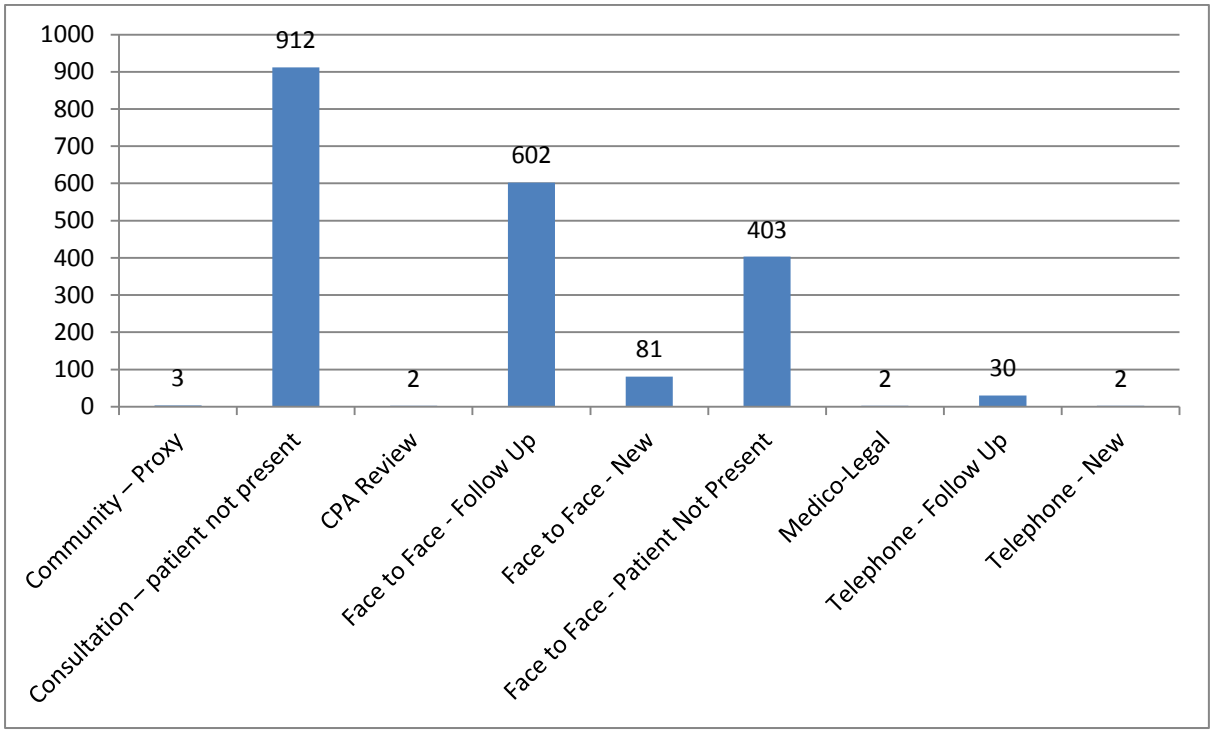
Referral Source	Total Referrals	Percentage Referrals
GP	Small Number	1.8%
Internal Referral	7	4.1%
Social Services	159	94.1%

From Table 40 shows the referral discharge reasons by the CAMHS Children Looked After Team, the majority of referrals (77.4%) into the team completed their treatment however there was 8.1% or 10 children who did not engage.

TABLE 40: REFERRAL DISCHARGE REASONS BY THE CAMHS CHILDREN LOOKED AFTER TEAM (2013-2013)

Discharge Reason	Total Discharge	Percentage Discharged
Client did not engage	10	8.1%
Inappropriate referral	5	4.0%
Moved out of area	Small Number	1.6%
Transferred to another service	11	8.9%
Treatment complete	96	77.4%

FIGURE 23: TYPE OF CONTACT WITHIN THE CAMHS CHILDREN LOOKED AFTER TEAM (2012-2013)



From Figure 30 the majority of consultations by the CAMHS Children Looked After Team were undertaken where the child/ young person was not present followed by face to face follow up meetings then face to face where the child/young person was not present.

6.7 Community Paediatricians

The role of community Paediatricians

Children are referred to the service for a huge variety of reasons that generally fall into three main categories

- medical/physical health concerns including growth concerns
- developmental concerns e.g. developmental delays, ASD, motor co-ordination difficulties

- emotional /behavioural concerns including ADHD

Referrals are now managed centrally via a SPA. The vast majority (>90% estimate) of referrals come from Primary Care via the GP, although they may have been initiated by the school nurse or by a health visitor (HV). Some referrals come direct to the service from CAMHS, usually tier 2 requests for assessment of ASD/ADHD. Some referrals come from hospital colleagues (usually children at risk of or with a long term disability or children with medical conditions that do not require the facilities of the hospital). The service does not accept self-referrals.

Community Paediatricians also see children at the request of social care for safeguarding concerns but these are not dealt with via the SPA and are not included in the figures below.

Between 1 Nov 2012 and 31 October 2013 a total of 1493 referrals were received for the City, of which 17.5% were rejected as inappropriate for the service, leaving a total of 1232 accepted referrals.

Of these, 716 (58%) were for developmental, behavioural or emotional concerns including

- 447 referrals for possible ASD/ADHD (36% of all referrals)
- 161 referrals for general developmental concerns including delay, LD or motor co-ordination difficulties (13% of all referrals)
- 80 referrals for emotional & behavioural difficulties including anxiety, low mood, self-harm but excluding those where ASD/ADHD queried (6.5% of all referrals)
- 27 'Other' – including sleep, tics, school/learning issues (2 % of all referrals)

The other 516 referrals (42%) were for general medical problems including growth concerns, continence issues, musculoskeletal problems, vomiting/GI problems, headaches, pubertal concerns etc.

With regards to referrals for emotional and behavioural difficulties including anxiety and self- harm (but excluding those where ASD or ADHD were queried); a total of 179 referrals were received but of those 99 (55%) were rejected as not appropriate for the service. The majority of referrers were advised to redirect the referral to Children's Centres or CAMHS. Of those accepted, many had been previously rejected by CAMHS and were accepted to prevent further 'bouncing' of referrals.

6.8 Nottingham University Hospital data

All children and young people presenting at the Emergency Department for self-harm will be admitted for assessment. There were 30 young person admissions for Self-harm into Queen's Medical Centre in December 2013 from both Nottingham City and Nottinghamshire County. Of those, 20 were for over doses with an age range from 12 years to 17 years. Within January 2014, there were 47 admissions for self-harm which is 28 more than previous year (January 2013).

6.9 Tier 3 CAMHS

Tier 3 CAMHS is commissioned by NHS Nottingham City CCG and it provides a specialised multi-disciplined service for severe and complex child and adolescent mental health problems and neurodevelopmental disorders. The team provide assessment and treatment to patients and advice to tiers 1 and 2.

In the 2 year period 2011/12 & 2012/13 872 children and young people in tier 3 CAMHS (Table 41).s.). .The most common age group was 11-15 for boys and 16-17 for girls. At all ages there were greater numbers of males seen within tier 3 CAMHS. Table 32 that 66.3% of the Children and Young People referred into CAMHS were of White British Origin followed Multi Ethnic Groups.

6.9.1 TIER 3 Service Description

A service providing high quality evidence-based interventions to those children, young people and their families who are most vulnerable to mental health problems and present with concerns that are assessed as being severe and/or complex in nature.

TABLE 41: TIER 3 SERVICE DESCRIPTION

Service		Catchment Area	Need Being Met	Spectrum of Disorders Addressed	Services Provided	Professionals Involved in Service Delivery	Where services are located
Head to Head (Operational Manager: Samantha Sykes based at Thorneywood)	Youth Justice Team	Nottingham City and Nottinghamshire County South	Young people who are presenting with a tier 2-4 mental health issue and who are subject to a criminal order.	Tier 2-4 mental health problems. High prevalence of conduct disorders, neglect, substance misuse and self-harming.	Assessment and therapeutic engagement, including: prescribing, complex assessments, CBT, counselling, brief therapies, containment, and family work. The YOT Liaisons also attend MAPPA's and Case Reviews.	Registered mental health nurses – 10.2 LD Nurses - 2 Psychiatrist – 1 Social work/probation – 0.2	Young people are offered a choice of where they receive the service. Head to head aims to treat people at home and to minimise admittance to in-patient provision.
	Dual Diagnosis Team		Children and young people who present with significant mental health issues and who are also using drugs or alcohol (co-morbid presentation) or are significantly affected by parental substance misuse. The significant mental health issues have to be interdependent with	Tier 3-4 mental health problems.	Assessment and therapeutic engagement. Referrals received from WAM (What About Me – work with children affected by parental substance misuse) and Compass (Substance misuse service) when there is a significant comorbid mental health		

Service		Catchment Area	Need Being Met	Spectrum of Disorders Addressed	Services Provided	Professionals Involved in Service Delivery	Where services are located
			drug and alcohol use.		problem.		
	Early Intervention in Psychosis Team		People aged between 14 and 35 years who present with symptoms that are indicative of a first episode of psychosis.	Psychosis, or a diagnosis of uncertainty ('watch and wait' brief where appropriate).	Close working relationship with the Adult Mental Health Early Intervention in Psychosis teams across the city and county.		
	Young People who Sexually Harm Others Team		Young people who have been identified to have sexually harmed others, and who have significant mental health issues and LD.	Tier 3-4 mental health problems.	Referrals received from social care and police. Joint assessment by MALT and H2H.		
Specialist Community CAMHS (Manager: Wayne Bradford based at Thorneywood)	Emotional Disorders Team (EDT)	Nottingham City and Nottinghamshire County South	Children and young people from 0-18 who may be experiencing a range of complex and severe mental health difficulties	Significant mental health issues associated with difficult family circumstances and may present with a range of problems including: Depression OCD	Specialist assessment and interventions.	3.7 WTE Band 6 Mental Health Nurses 5 WTE Band 7 Mental Health Nurses 1 WTE Band 6 Psychologist 2.7 WTE Band 8 Psychologists 2.6 WTE Specialist	Thorneywood

Service		Catchment Area	Need Being Met	Spectrum of Disorders Addressed	Services Provided	Professionals Involved in Service Delivery	Where services are located
				PTSD Self-harm Eating disorders Severe attachment, emotional and behavioural disorders associated with child abuse and neglect		Mental Health Workers 0.5 WTE CBT Psychotherapist 3.2 WTE Psychiatrists	
	Neuro-development Disorders Team (NDT)		Children and young people with neurodevelopment disorders who present with mental health problems that are assessed as being severe and or complex in nature	ADHD ASD Tics and Tourette's Psychiatric and Neurodevelopmental disorders in children and young people with Learning disabilities Acquired organic brain disorders (e.g. head injury, post encephalitis, post meningitis, epilepsy)	Specialist assessment and interventions. Work alongside community paediatric team and Child Development Centre at City Hospital		
	Self-Harm Team		Provide comprehensive risk and needs assessment to all young people under 16 years old admitted to a paediatric ward following	Self-harm.	Assessment on the ward at QMC and follow-up in the community.	1 WTE clinical nurse specialist 0.5 WTE nurse consultant	QMC

Service		Catchment Area	Need Being Met	Spectrum of Disorders Addressed	Services Provided	Professionals Involved in Service Delivery	Where services are located
			an episode of self-harm.				
	Paediatric Liaison		Provides direct clinical care including assessment, intervention and joint management of paediatric patients experiencing emotional, behavioural and psychiatric disorders in the context of acute, chronic and terminal illness.	Emotional, behavioural and psychiatric disorders in the context of acute, chronic and terminal illness.	Assessment and therapeutic engagement.	1 Consultant Psychiatrist 1 Systemic Psychotherapist	QMC

6.9.2 Tier 3 Service User Data

This section is based largely on data submitted to NHS Nottingham City CCG from April 2011 to March 2013. It is based on Nottingham City Residents rather than Nottingham City registered patients so may contain activity relating to Nottingham City residents registered with Nottinghamshire County GPs. As a commissioning dataset, it does not include Did Not Attend activity.

Referrals

For the 2 year period 2011/12 & 2012/13, there were 872 patients referred . Table 41 shows the number of referrals by service team.

TABLE 41 REFERRALS 11/12 & 12/13 BY SERVICE TEAM

Service Team	Number of Referrals	% total
CAMHS - County CLA	31	2.6
CAMHS - EDT	121	10.2
CAMHS - Head 2 Head	168	14.2
CAMHS - NDT	Small Number	0.1
CAMHS - Nice ADHD	32	2.7
CAMHS - North	Small Number	0.1
CAMHS - South	378	31.9
CAMHS Day Unit	35	3.0
CAMHS Looked After	141	11.9
CAMHS Paediatric Liaison	71	6.0
CAMHS Paediatric Neurology	26	2.2
CAMHS Psychotherapy	13	1.1
CAMHS Self Harm	168	14.2
All Services	1186	100.0

Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH)

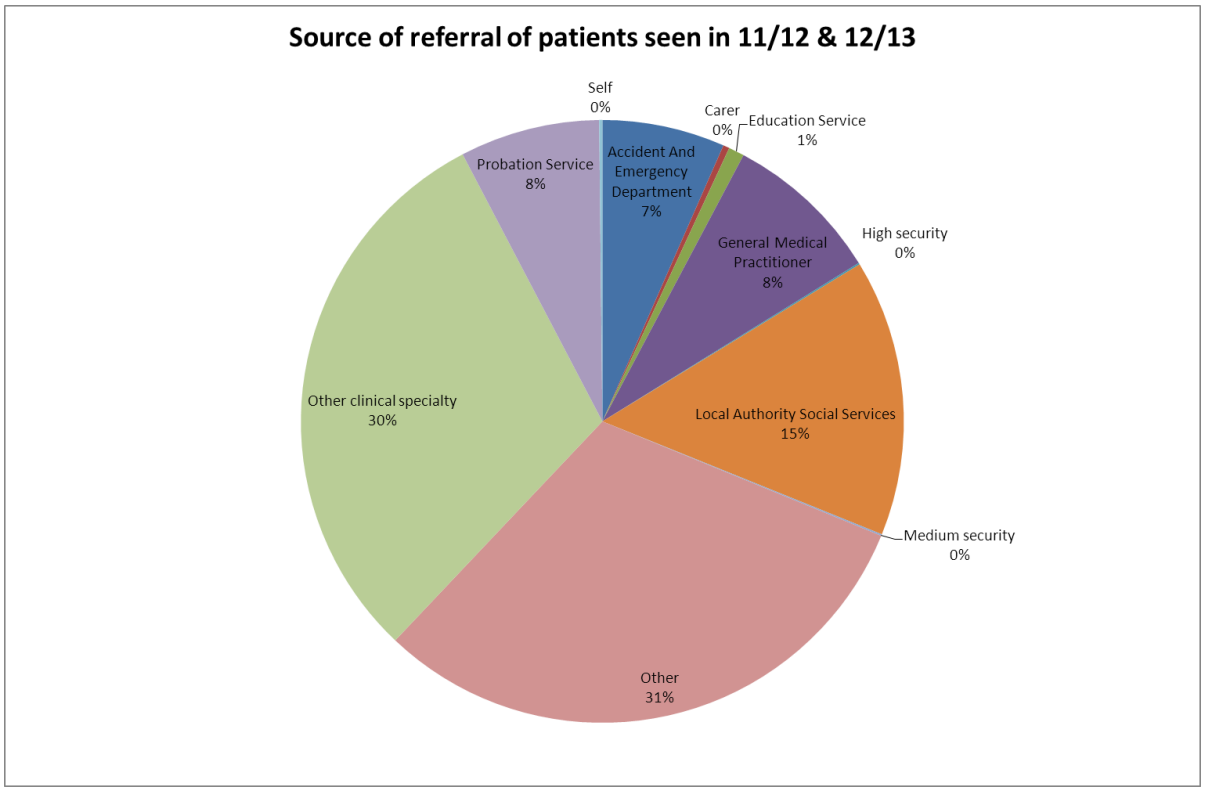
CAMHS EDT –Eating Disorder team

NDT – Neuro developmental team

County CLA – Children Looked After

The majority of referrals were to CAMHS – South followed by Head 2 Head, Self-Harm and Looked After Children. It can be seen in Figure 21 the main source of referrals into tier 3 derive from other internal clinical and non-clinical services followed by social services, the probation services and primary care.

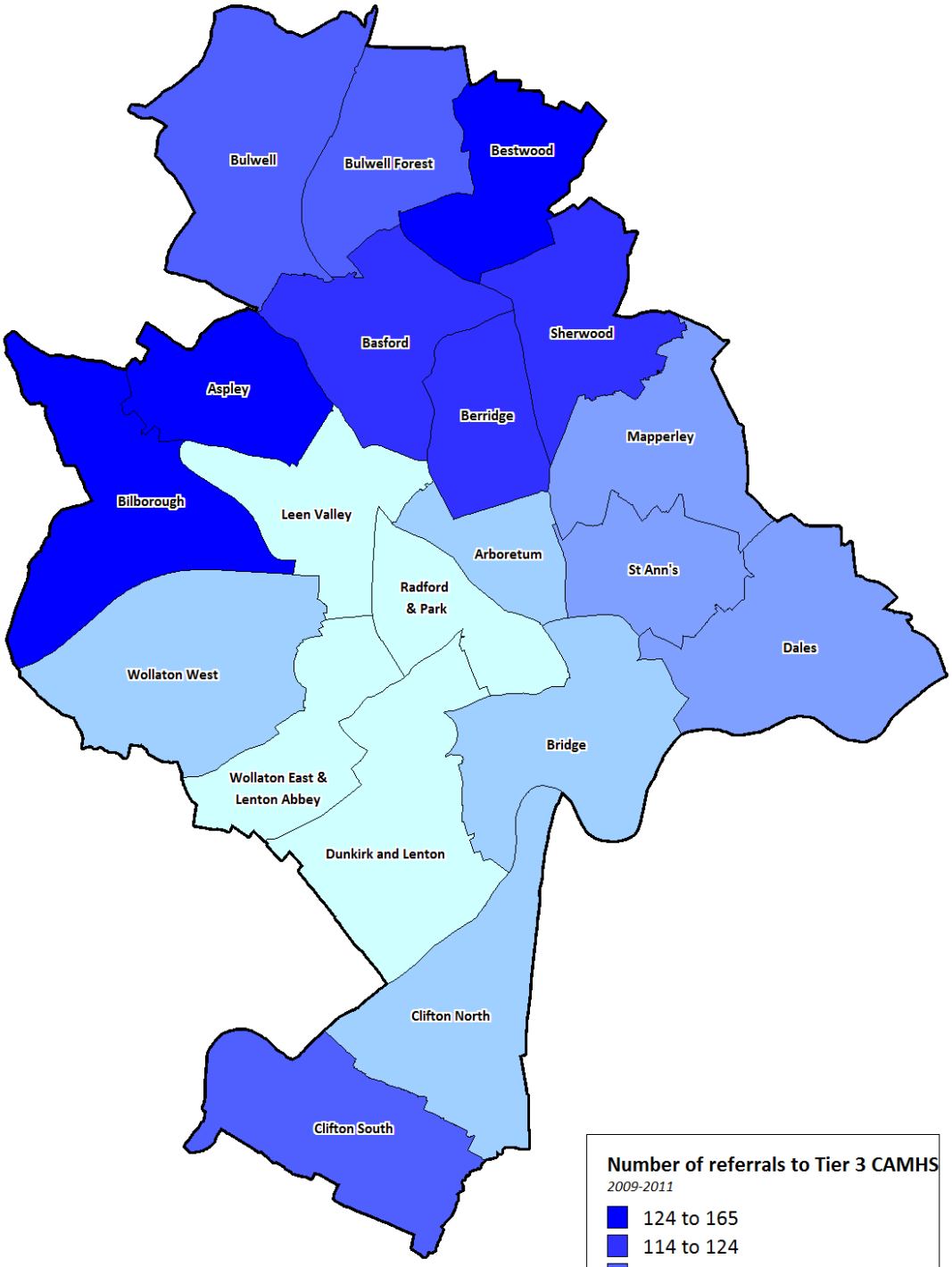
FIGURE 21: SOURCE OF REFERRAL, NOTTINGHAM CITY RESIDENTS, 2011/2012 & 2012/2013 pooled



Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH)

Figure 22 shows the number of referrals into tier 3 mapped by electoral ward in Nottingham City. Table 42 shows the age / sex standardised rate per 1000 population by ward. Sherwood ward has the highest rate per 1000 (8.8-10.1 per 1000), followed by Aspley, Mapperley, Clifton South, Bulwell Forest, Bestwood (7.3-8.8 per 1000). Figure 23 shows the relationship between deprivation and referral rate at ward level. There is only a weak correlation between deprivation and referral to CAMHS in Nottingham City.

FIGURE 22: REFERRALS TO TIER 3 CAMHS 2009-2011



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Table 42 show the directly standardised referral rates into CAMHs tier 3 from the Nottingham City wards. It can be seen that Sherwood ward has the highest standardised rate of referral to tier 3

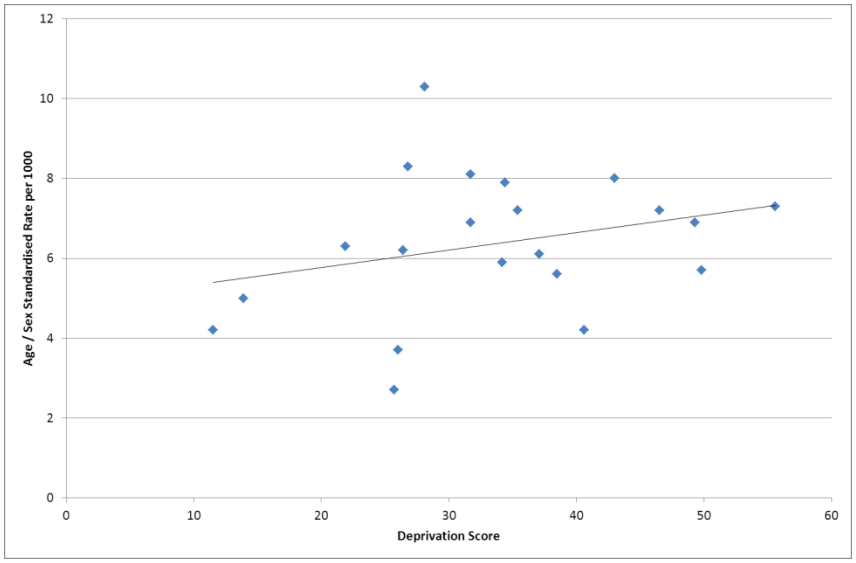
CAMHS (10.3 per 1000) however the confidence intervals are wide from 8.4 to 12.2 per 1000 which means it could suggest a wide variation of the rate. Aspley ward has a lower rate (7.3 per 1000) however the confidence intervals are closer (6.2 per 1000 to 8.4 per 1000) which would suggest that the figure of 7.3 is a truer reflection of the actual rate of referral.

TABLE 42: DIRECTLY STANDARDISED REFERRAL RATES TO TIER 3 CAMHS 2009-2011, (WARDS WITH THE HIGHEST RATES

Ward	Directly Standardised rate of Referral (per 1000)	Lower Confidence Interval	Upper Confidence Interval	Number of events	Deprivation Score
Sherwood	10.3	8.4	12.2	116	28.1
Bulwell Forest	8.3	6.6	10.0	94	26.8
Mapperley	8.1	6.4	9.8	92	31.7
Bestwood	8.0	6.6	9.4	124	43.0
Clifton South	7.9	6.3	9.5	94	34.4
Aspley	7.3	6.2	8.4	165	55.6
Basford	7.2	5.9	8.5	114	35.4
Bilborough	7.2	5.9	8.5	127	46.5
Berridge	6.9	5.7	8.1	119	31.7
Bulwell	6.9	5.6	8.1	110	49.3
Dunkirk and Lenton	6.3	3.5	9.2	24	21.9
Clifton North	6.2	4.7	7.7	81	26.4
Dales	6.1	4.8	7.4	89	37.1
St Anns	5.7	4.5	6.9	91	49.8
Bridge	5.6	4.0	7.1	50	38.5
Wollaton East & Lenton Abbey	5.0	2.8	7.2	33	13.9
Arboretum	4.2	2.9	5.5	52	40.6
Wollaton West	4.2	3.0	5.3	50	11.5
Leen Valley	3.7	2.6	4.8	45	26.0
Radford and Park	2.7	1.7	3.6	46	25.7
Nottingham City	5.9	5.6	6.2	1716	34.2

Source: eHealthscope; Healthcare Trust local dataset April 2009- March 2011

FIGURE 23 RELATIONSHIP BETWEEN WARD DEPRIVATION AND REFERRAL RATE

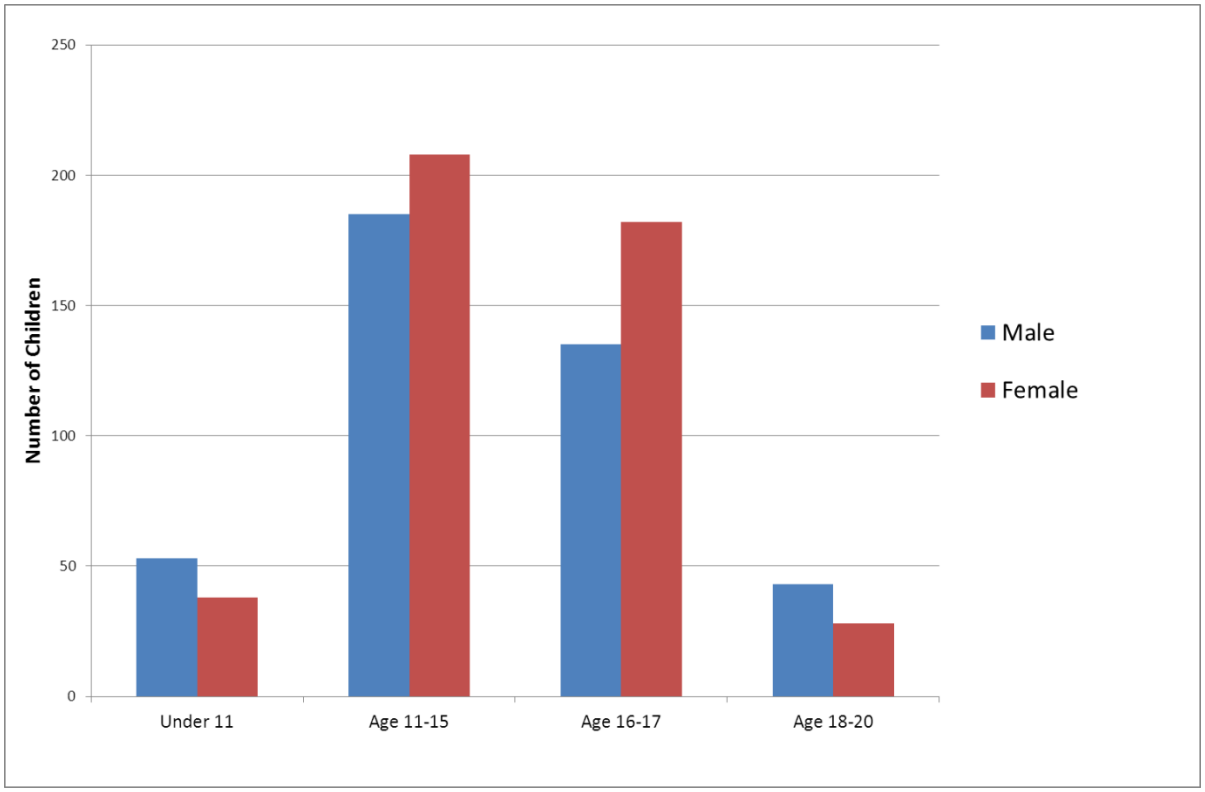


Source: eHealthscope; Healthcare Trust local dataset April 2009- March 2011

Service Activity (Contacts)

In 2011/12 & 2012/13, 872 children and young people under 20 years were seen by the service in 8752 appointments. Figure 24 shows the breakdown by age and sex. Just under half of patients are male and 56% are aged under 16 years.

FIGURE 24: AGE AND GENDER OF CHILDREN AND YOUNG PEOPLE SEEN IN TIER 3 CAMHS (NOTTINGHAM CITY), 11/12 & 12/13 POOLED



Source: Nottingham Healthcare Trust commissioning dataset (NHIS DWH), by age of child at most recent appointment in the 2 year period so that each child is only counted once.

Table 43 shows the ethnic breakdown of patients compared to the city population. Mixed, Asian and Black groups are under-represented compared to the proportion of these groups in the general population. However, a relatively large proportion of the patients have been assigned to 'Other Ethnic Group' though it is not clear what this group consists of?

TABLE 43: ETHNICITY OF CHILDREN SEEN IN TIER 3 CAMHS COMPARED TO THE POPULATION OF NOTTINGHAM CITY

Ethnicity	Number of patients	%	2011 Census (U18)
White British	501	57.5	54.1
White Irish	Small Number	0.5	0.2
White Other White	25	2.9	4.1
Mixed / Multiple Ethnic Groups	78	8.9	14.7
Asian / Asian British	39	4.5	15.7
Black / African / Caribbean /Black British	34	3.9	9.3

Other Ethnic Group	191	21.9	1.8
Grand Total	872	100.0	100

Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH), ONS Census 2011

Table 44 demonstrates that the proportion of tier 3 CAMHS patients follows the gradient from most deprived quintile to the least deprived quintile and reflects the city population.

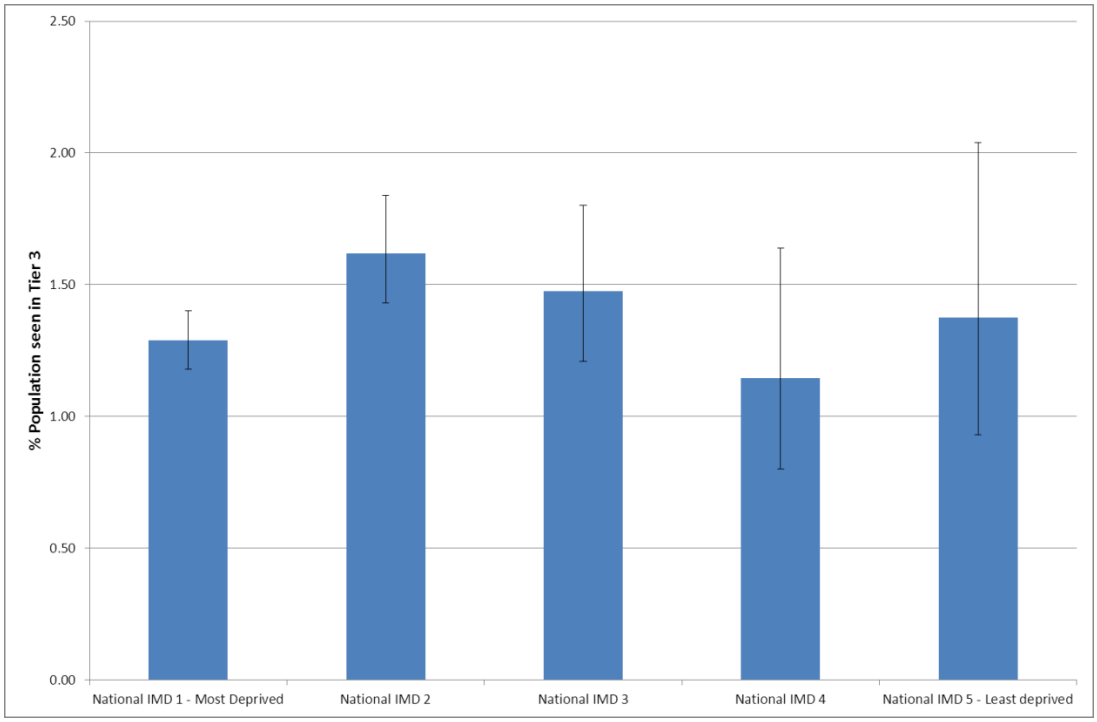
TABLE 44: PATIENTS SEEN IN TIER 3 CAMHS ACCORDING TO DEPRIVATION LEVEL (NATIONAL IMD QUINTILES) (2012)

	Number of Tier 3 CAMHS patients (Under 21)	**% Tier 3 patients**	**Nottingham City Population (U18)**	**% population**
National IMD 1 - Most Deprived	505	57.9	39221	60.8
National IMD 2	235	26.9	14523	22.5
National IMD 3	95	10.9	6444	10.0
National IMD 4	29	3.3	1476	3.9
National IMD 5 - Least deprived	24	2.8	64465	2.7
Total	872	100.0		100

Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH), GP registered population, 2012; IMD 2010

From Figure 23 it can be viewed that 1.3% of the population in the most deprived quintile is being referred into CAMHS Tier 3, in comparison, within Nottinghamshire County 1.1% of the same quintile were seen within Tier 3. However, as the need for CAMHS services may be expected to be greater than average in a very deprived population, this may suggest that deprived children are under-represented in the services.

FIGURE 25: PERCENTAGE OF POPULATION SEEN IN TIER 3 CAMHS ACCORDING TO DEPRIVATION QUINTILE (2012)



Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH)

Approximately one third of children seen in Tier 3 come from each of the 3 localities in the City (Table 45); this does not equate to the distribution of children and young people across the City – 60% of children under 18 live in the North locality and only 13% in City Central.

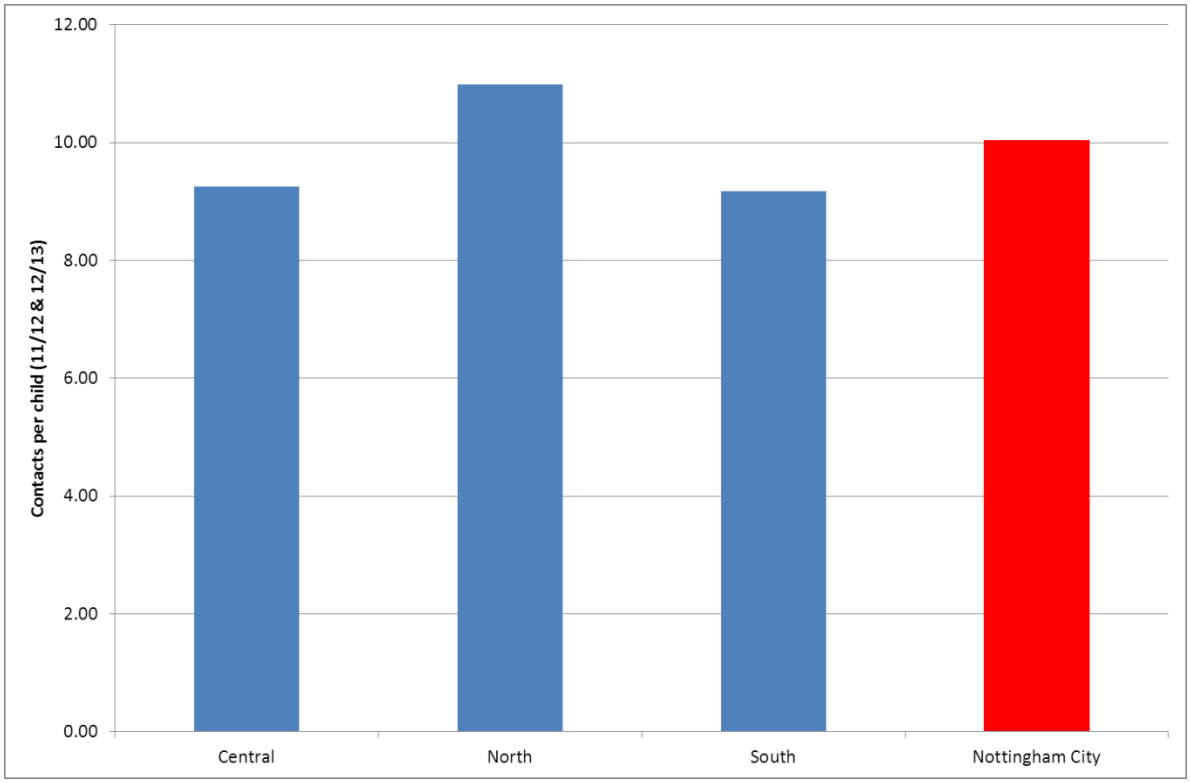
TABLE 45: CHILDREN AND YOUNG PEOPLE SEEN WITHIN TIER 3 CAMHS ACCORDING TO LOCALITY 2011/12 &12/13 POOLED

Locality	Number of children seen in Tier 3	% total	Population Under 18	% Population
Central	276	31.7	8317	3.32
North	338	38.8	38203	0.88
South	271	31.1	15874	1.71
Nottingham City	872	100.0	62394	1.40

Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH), ONS Census 2011

The 872 children seen within tier 3 CAMHS in 11/12 & 12/13 had a total of 8752 consultations, an average of 10 consultations per child. Figure 26 shows the average number of consultations per child according to locality. Consultation rate was broadly similar across localities.

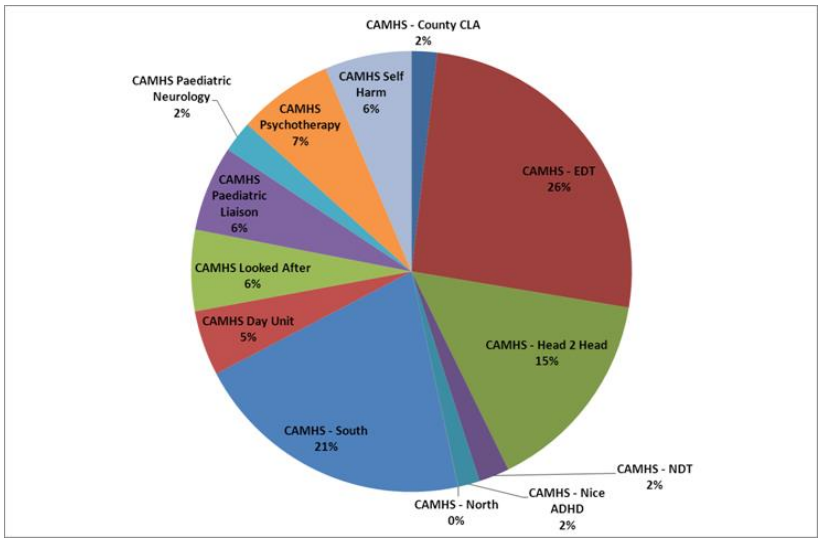
FIGURE 26: AVERAGE NUMBER OF CONSULTATIONS PER CHILD WITH TIER 3 CAMHS ACCORDING TO LOCALITY 2011/12/13



Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH)

Table 46 shows the breakdown of activity by CAMHS service and by appointment type. Almost all consultations (93%) are face to face and 16% of these are new consultations. (Note* NHIS commissioning dataset does not have any data on non-attended appointments). The Eating Disorder Service provides the highest proportion of appointments followed by CAMHS – South and Head 2 Head. In terms of number of patients treated, EDT accounts for 31%, CAMHS South for 33% and Head 2 Head a further 17%. Figure 27 shows the breakdown by service team.

FIGURE 27 NUMBER OF CONTACTS BY CAMHS SERVICE 2011/12 & 12/13



Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH)

TABLE 46: NUMBER OF CONSULTATIONS TO CAMHS SERVICES BY APPOINTMENT TYPE; 2011/12 & 2012/13 POOLED

CAMHS Service	Community – Proxy	CPA Review	Daycare - Scheduled	Face to Face - Follow Up	Face to Face - New	All Activity	Number of patients
CAMHS - County CLA	28	Small number		112	22	163	27
CAMHS - EDT	67	123		1776	289	2255	274
CAMHS - Head 2 Head	Small number	59		1116	147	1324	150
CAMHS - NDT	32			162	Small number	196	28
CAMHS - Nice ADHD				62	78	140	19
CAMHS - North				Small number		Small number	Small number
CAMHS - South	44	84		1448	237	1813	288
CAMHS Day Unit		8	100	282	28	418	37
CAMHS Looked After	13	7		428	73	521	93
CAMHS Paediatric Liaison	Small number	Small number		393	150	549	71
CAMHS Paediatric Neurology	8	Small number		137	55	201	37
CAMHS Psychotherapy		14		583	16	613	20
CAMHS Self Harm	42	Small number	Small number	325	185	558	132
Total	239	304	102	6825	1282	8752	872

Source: Nottingham Healthcare Trust Commissioning dataset (NHIS DWH)

NB: any number 5 and under within the tables have been changed to 'Small Number.'

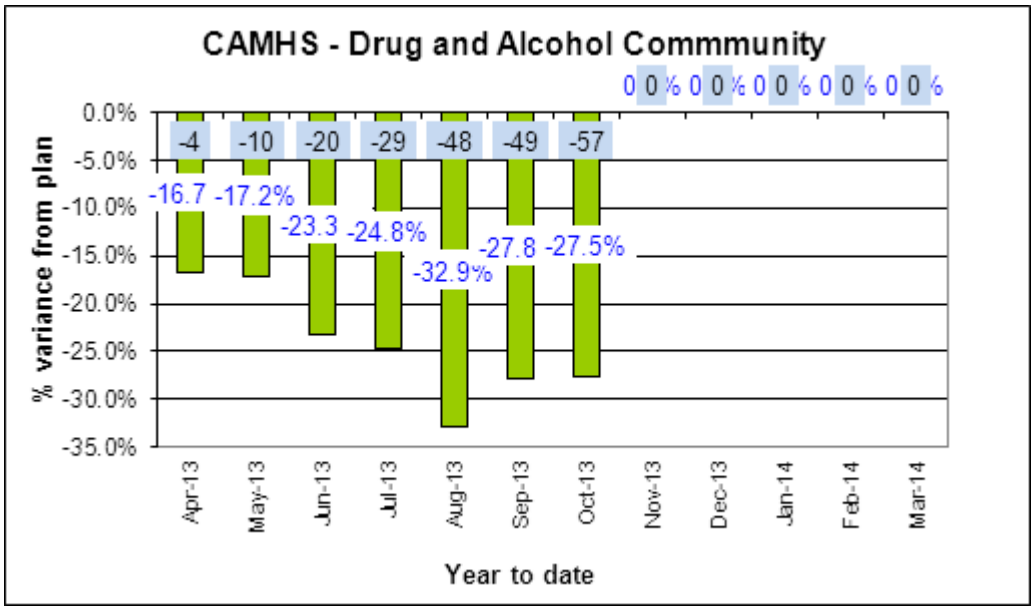
CAMHS EDT –Eating Disorder team
NDT – Neuro developmental team
County CLA – Children Looked After

6.9.3 Head to Head data (H2H)

The Head to Head service is a confidential specialist intervention and treatment for young people up to the age of 18 years of age, whose substance use is impacting on their mental and emotional health (the term Dual Diagnosis is also used). The majority of referrals for the Head to Head service derive from the Youth Offending Team.

Data from the Head to Head service from April 2013 to October 2013 show that 207 sessions were planned for however only 150 sessions were taken up. Figure 28 shows the percentage variation throughout the months where august had the highest percentage variation from planned to actual sessions.

FIGURE 28: % VARIATION FROM PLAN FOR THE HEAD TO HEAD TEAM (2013)



Head 2 Head use RIO system to input data. Significantly RIO only captures data on young people who are already known and open to the team. This means that consultation activity on cases not open/known to H2H is not routinely recorded. The data below in table 47 represents actual contact on cases known to the team who live in the city of Nottingham which have been referred to the H2H team. The data also does not acknowledge the intensity and complexity of the contacts. For example, one contact = one contact irrespective of the length of the contact. So a 30 minute home visit and a 3 hour home visit will be recorded in the same way, as one contact. It also needs to be acknowledged when considering the data that because most contacts are home visits primarily travelling time needs to be taken into consideration.

TABLE 47: HEAD TO HEAD DATA ON THE NUMBER OF YOUNG PEOPLE SEEN AND DNA (2012-2013)

Appointment type/description:	Seen 2012	Seen 2013	DNA 2012	DNA 2013	Canc 2012	Canc 2013
Consultation Pt not present	43	43	Small Numbers	Small Numbers	0	Small Numbers
CPA Review	24	23	Small Numbers	Small Numbers	0	0
Face to Face-Follow up	132	174	32	47	38	29
Face to Face – New	68	72	10	16	8	Small Numbers
Medico Legal	Small Numbers	Small Numbers	0	Small Numbers	0	0
Telephone-Follow up	24	43	Small Numbers	Small Numbers	0	0
Telephone – New.	Small Numbers	4	Small Numbers	0	Small Number	0

NB: any number 5 and under within the tables have been changed to 'Small Number.'

Interventions

H2H provides an assertive outreach model of delivery for children and young people; this is in response to the highly vulnerable and socially excluded group of young people historically not accessing CAMHS. This model of practice which was developed in about 2003 was further reinforced by the children's NSF which suggested that "It is often the children and young people about whom there is most concern, and who are likely to experience the poorest outcomes, who are most reluctant to seek help. Services therefore need to respond flexibly and creatively in order to be able to meet their needs. For some children and young people and their families, initial access may best be provided in a location of their choice (e.g. school, general practice, or home) with the appropriate facilities. Failure to attend clinic-based appointments should not be seen as a lack of motivation or act as a trigger to close a case but as an indication of the need to review the nature of the service offered." Table 48 shows the number of referrals and discharges into the Head 2 Head service.

TABLE 48: NUMBER OF REFERRALS AND DISCHARGES FROM HEAD TO HEAD 2012-2013

Referrals.	Year.
75	2012
109	2013

Discharges.	Year.
80	2012
101	2013

6.9.4 Audit of self-harm admissions to Queens Medical Centre (QMC)

An audit was undertaken of admissions to QMC in January 2014 for self-harm for Nottingham City. In total there were 39 admissions to QMC of children and young people in January and of those 21 were from city children and young people, however only 15 patient's clinical notes were analysed. Information from the self-harm risk assessment tool, which is utilised by the self-harm team, was used to provide the audit information. Analysis was undertaken to identify common risk factors and information which may contribute towards the reasons for the admission for self-harm. The following information was sought from the clinical notes of the 15 admissions:

- Gender.
- Age.
- Previous contact with CAMHS service.
- Bullying.
- Sexual exploitation.
- If there was any one in school the young person would talk to.
- Interest/Hobbies.
- Accessing Social Media Self-harm sites.
- Domestic Violence (witnessed in family or inter-relationship).
- Parental Mental Health issues.
- Where did they get the idea of self-harm.
- Any cultural issues.
- Observed relationship with parent.
- Attachment rating.
- Did the young person inform any one after they self-harmed.
- The hopefulness score.
- How could things be improved for the young person.

As only 15 cases were analysed preliminary results need to be interpreted with some caution however some common risk factors and other relevant information was found which could be used to support children and young people who self-harm.

- 12 out of the 15 cases were female.
- Age range of admissions were from 11 to 16 years of age.
- Some cases mentioned there was someone in school who they could talk to.

- A minority of case were looked after children.
- Sexual exploitation was apparent.
- Some young people had experience of domestic violence.
- The main idea for the self-harm derived from peers, family and internet sites.
- A significant number of young people were being or had been bullied.
- The majority of cased did not inform any one immediately after the event.
- The hopefulness score ranges from 2 (very little hopefulness) to 10 (very hopeful regarding the future).
- There was a range of statements with regards to improving their future from no future at all; this coincided with a low hopefulness scoreand the desire form better mental health.

The most significant findings from the audit were:

- **The significance of parental mental health in particular mothers mental health and this created a parallel with the low attachment rating.**
- **14 out of the 15 had previously self-harmed and some of the young people had been admitted numerous times into QMC.**
- **12 out of the 15 cases had current or previous involvement of CAMHS services.**

6.10 Tier 4 Services

Tier 4 services are commissioned by NHS England and comprises of the Highly Specialised Adolescent Unit at Thorneywood. The Neuropsychiatry Team are commissioned by NHS Nottingham City CCG.

6.10.1 Description of Tier 4

TABLE 49: DESCRIPTION OF TIER 4

Service		Catchment Area	Need Being Met	Spectrum of Disorders Addressed	Services Provided	Professionals Involved in Service Delivery	Where services are located
Highly Specialised Adolescent Unit (Thorneywood)		Nottingham City Nottinghamshire County Derby City Derbyshire County	In-patient treatment for young people with complex or severe mental health problems requiring specialist assessment, with continuous and prolonged observation for life threatening illnesses. The unit provides a service for young people between the ages of 12 and 18 from within Nottinghamshire and Derbyshire	Psychiatric disorder with clear psychiatric symptoms (elated mood, depressed mood, hallucinations and delusions) Eating disorders. Thoughts or behaviours that are so severely disturbed that outpatient treatment is impossible Severe self-harming behaviour Socially unacceptable behaviour that requires psychiatric assessment Behaviour whereby	Multidisciplinary team provides: Comprehensive Assessment Diagnosis 24 hour intense nursing care High levels of observation Risk assessment Individual therapy Group therapy Family therapy Education	Consultant Paediatric Psychiatrists Nursing staff Dietetics Occupational therapist Family Therapists Education	Thorneywood Adolescent Unity (12 bedded inpatient unit)

				it is not known whether it is in relation to a psychiatric illness or to a school or family problem.			
Neuropsychiatry Team			Specialist tertiary district and regional service offering assessment, consultation and treatment of neuropsychiatric disorders in childhood and adolescence up to 18 years of age	Complex ADHD Autistic Spectrum Disorder Tourette's Syndrome and tic disorders Behavioural aspects of epilepsy and other brain disorders Childhood onset psychoses Paediatric psychopharmacology	Specialist expertise Assessment Consultation Treatment Second opinions in highly complex cases	Professor Hollis	Nottingham Universities NHS trust-QMC Campus

Between 1st Jan 2010 and 31st December, 2012, 23 young people completed 25 hospital spells.

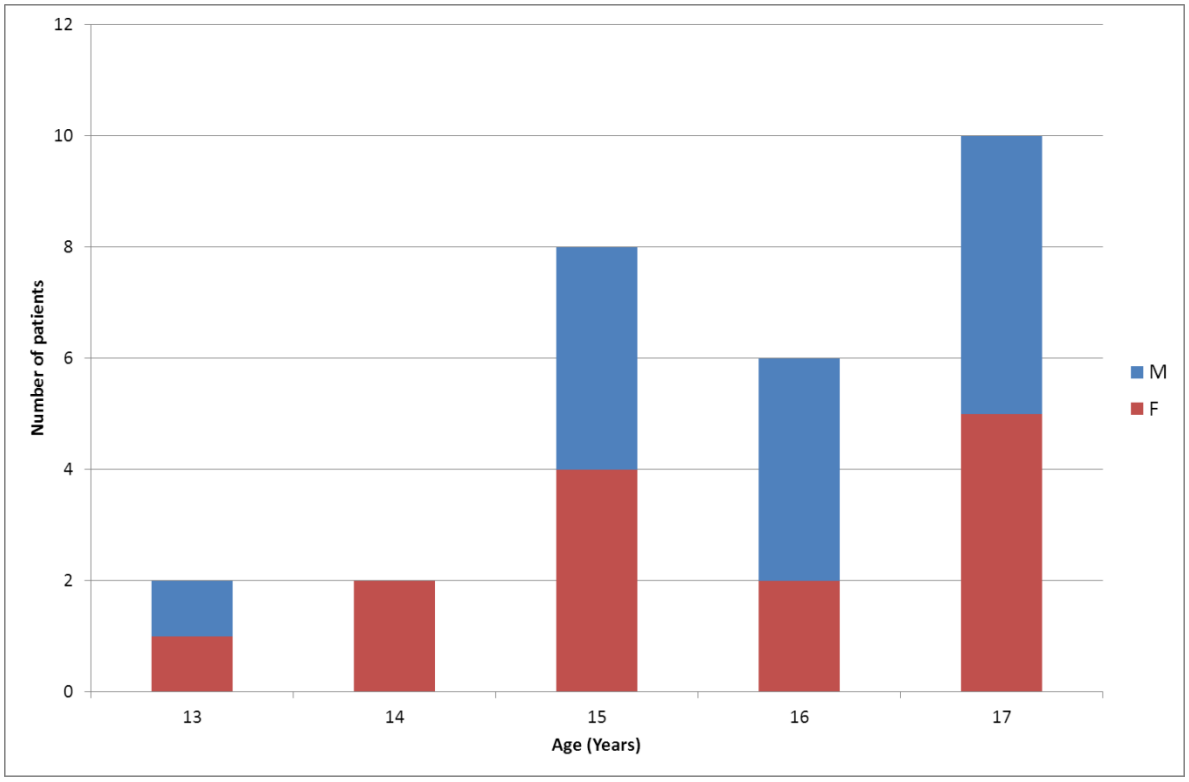
TABLE 50: NUMBER OF ADMISSIONS TO TIER 4 CAMHS, NOTTINGHAM CITY

	Number of patients	Number of admissions
2010	Small Numbers	6
2011	8	9
2012	10	10

Source: Nottinghamshire Healthcare Trust 2010-2012, Nottingham City Residents

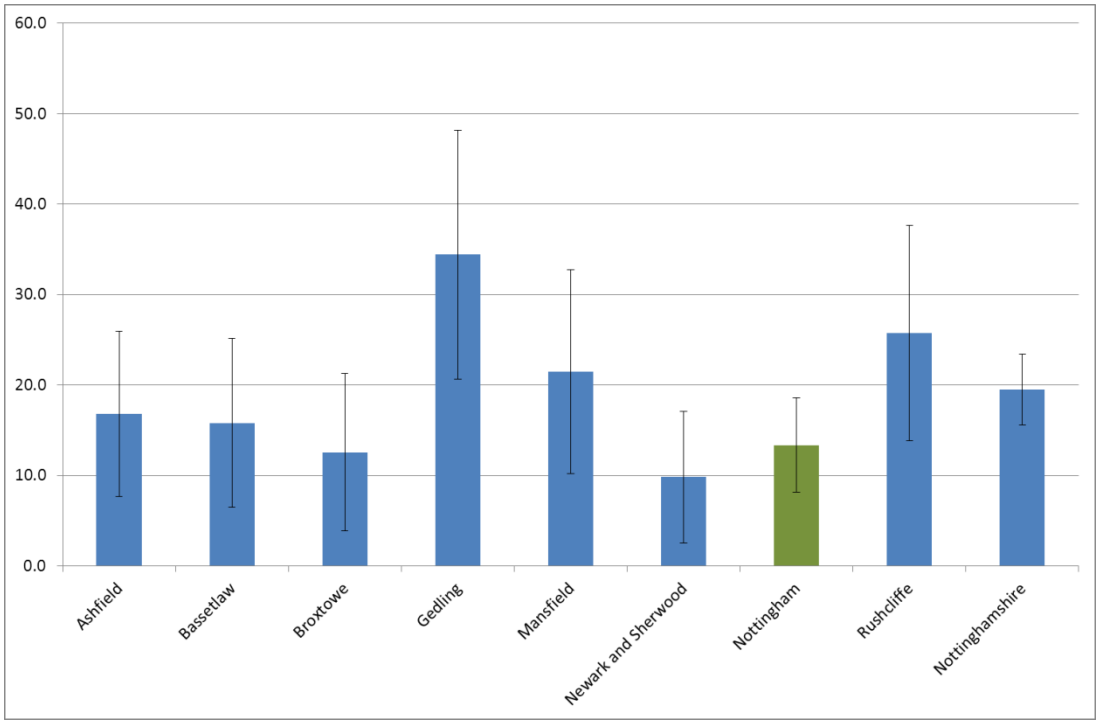
Table 50 shows that patients can be admitted more than once and patients can be admitted in more than one year and so at more than 1 age. From Figure 29 it can be seen that the gender split into Tier 4 are relatively even.

FIGURE 29: AGE AND GENDER OF YOUNG PEOPLE ADMITTED TO INPATIENT CAMHS 2010-2012



Source: Nottinghamshire Healthcare Trust 2010-2012

Figure 30: Crude admission rate into tier 4 inpatient services by District, 2010-2012

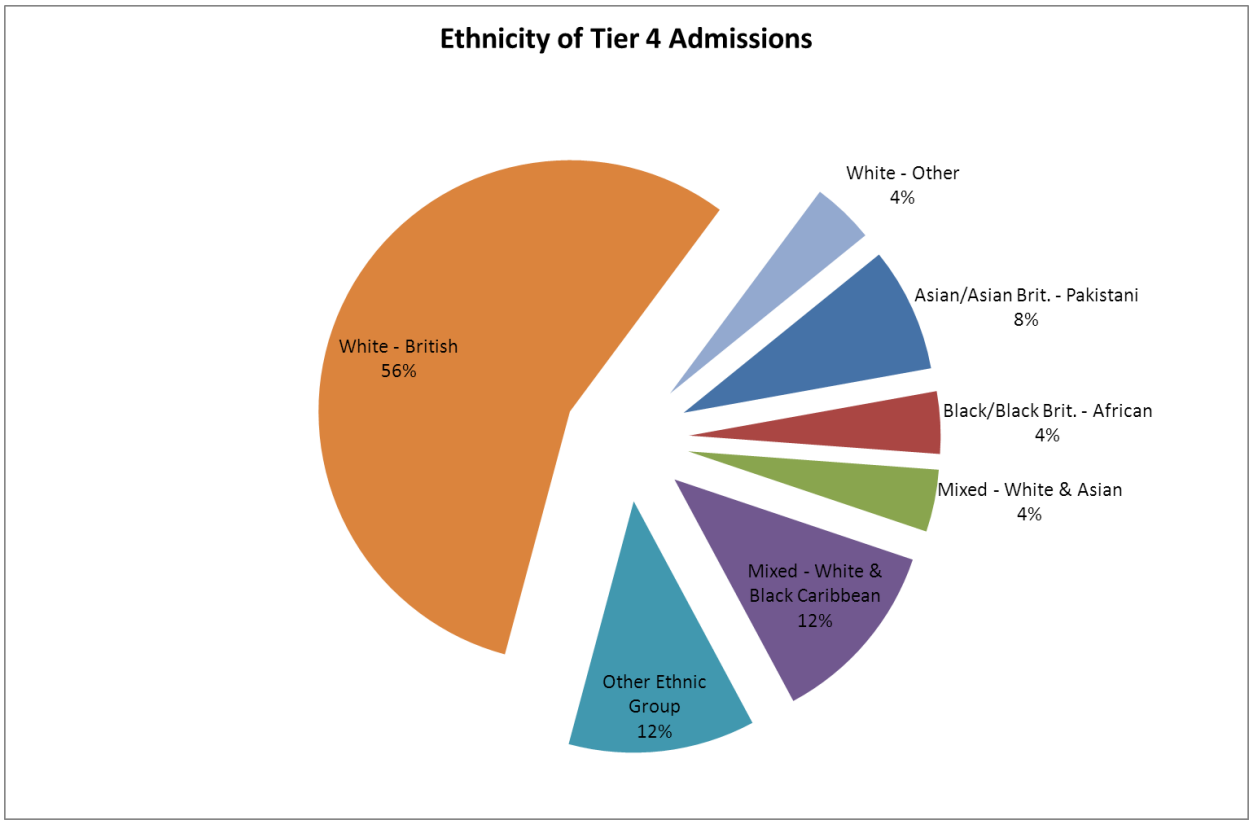


Source: Nottinghamshire Healthcare Trust 2010-2013, ONS Census 2011 Resident population

Figure 30 shows the crude admission rates into tier 4 inpatient services by district between 2010-2012, it can be identified that Gedling has the highest crude rate with Nottingham City ranked seven out of nine. Bearing in mind the deprivation levels within Nottingham City, it could be concluded that crude rates should be higher which may mean that children are being managed more within the community rather than as an inpatient. The main diagnosis's of those young people who were within Tier 4 were 'no mental health diagnosis,' 'history of self-harm,' 'family history of mental and behavioural disorders,' 'eating disorders,' 'developmental disorders,' and 'personality disorders,' however most admissions had more than one diagnosis which indicates the complexity of cases.

Figure 31 identifies the ethnicity of young people admitted to Tier 4 CAMHS with 56% of White British Origin followed by Mixed White & Black Caribbean (12%) and Other Ethnic Group (12%). The mixed White and Black Caribbean ethnic origin group makes up a larger percentage within Tier 4 than within Tiers 2 and 3, therefore conclusions may be drawn than this ethnic origin are not accessing the CAMHS service within the lower tiers and are only picked up within the CAMHS service at crisis point with an inpatient admission.

FIGURE 31: ETHNICITY OF YOUNG PEOPLE ADMITTED TO TIER 4



Source: Nottinghamshire Healthcare Trust 2010-2012

Summary: Chapter 6 Current Service Provision

There are significant number s of children and young people coming through the universal provision and CAMHS tiers 2, 3 and 4 for a wide range of mental health problems. The number of children accessing ED with mental health problems is also on the increase which is causing a knock on effect into the CAMHS services.

Numbers of children being referred into CAMHS and the Community Paediatricians are increasing year on year with a 15% increase of children being referred into Tier from 2011-2012 to 2012-2013.

It has been reported that there is an increase in the complexity of cases coming through the CAMHS service and the self-harm audit identified that parental mental health and in particular mothers mental health was a contributing factor to children self-harming.

- **Between 1st April 2012 and 311st March2013, 1140 referrals were received by the CAMHS SPA. Figure 6 shows the three most common sources of referrals were from GPs (48.3%), other health (which includes school nurses) (23.50%) and Education (15.60%).**
- **The majority of referral are for challenging behaviours were the most, followed by low mood and then self harm.**
- **There are currently as from September 2013 564 children in care and of those 200 are being seen within the CAMHS Children Looked After Team.**
- **Between 1 Nov 2012 and 31 October 2013, community Paediatricians received a total of 1493 referrals, of which 17.5% were rejected as inappropriate for the service, leaving a total of 1232 accepted referrals. The majority of referrals were for behavioural problems.**
- **872 children and young people under 20 years were seen by the tier 3, there were 8752 appointments The main reasons for referral into tier 3 were for self –harm, followed by challenging behaviours and eating disorders.**
- **Between 1st Jan 2010 and 31st December, 2012 23 young people completed 25 hospital spells within Tier 4.**
- **The self-harm audit produced some preliminary risk factors for self-harm; the mains ones being parental mental health.**
- **Most admissions into Tier 4 had more than one diagnosis recorded. It can also be identified the ethnicity of young people admitted to Tier 4 CAMHS with 56%of White British Origin followed by Mixed White & Black Caribbean (12%) and Other Ethnic Group (12%).**

7 Stakeholder Views/ Key Issues and Gap

7.1 Views of Commissioners and Providers

Semi-structured interviews were carried out with stakeholders about the needs and perceptions of the emotional and mental health needs of children and young people, in addition their views of the current service provision. The key issues identified from these interviews are summarised below and have been grouped according to themes

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

Stakeholders identified a number of areas where there are perceived pressures on children and young people which could be a contributing factor towards the increasing number of children experiencing emotional and mental health problems within Nottingham City.

- Welfare reform is contributing towards increasing pressures on families in terms of financial support particularly on those families living in social/private rented accommodation and who are claiming a wide range of benefits from the Government.
- There are an increasing number of children in Nottingham City from within the city boundaries entering into care.
- School pupils are under increasing pressure to attain in Nottingham City.
- Education attainment within Nottingham City is below the England average (there has been a year on year improvement), low educational attainments has a knock on effect in terms of obtaining a job which leads to a cycle of poor adult mental health.
- There is a recognition that increasing birth rate within the city may contribute towards an increasing number of children particularly within the deprived wards of Nottingham which in turn is a risk factor to emotional and mental health issues.
- The recognition that Nottingham City is an Early Intervention City and if successful with the Big Lottery Big StepsChange Big Difference this could impact on changing the way families work together by the provision of universal approach to improve families across the city.
- Domestic violence is a significant issue within the City.

7.2 Needs of children and young people

Emotional and Mental Health Conditions Issues

Self-harm

- Increasing referralsto tier 2 and tier 3 CAMHS for children and young people who are self-harming
- An increasing number of presentations to the Emergency Department (ED) at Queens Medical Centre by children and young people who are self-harming.
- An overall increase in the complexity of cases presenting both to ED and CAMHS.
- A significant number of children in Nottingham City are exposed to domestic violence either as part of their family life or within their own relationships.
- School nurses are seeing an increasing number of children and young people who are experiencing emotional and mental health problems.
- School nurses are seeing an increasing number of children who are self-harming. Due to waiting time into be seen within tier 2, school nurses are holding and 'counselling' children who may be at significant risk to themselves.
- Some stakeholders stated that Schools needs to take greater responsibility for raising awareness of self-harm. This will hopefully be ameliorated by the development of the Kooth counselling services being placed within the City schools and the SHARP team self-harm specialist team within tier 2.
- The age of children and young people presenting to services with regards to self-harm is lowering to age 7.
- There are a significant number of children in Nottingham who are witnessing/experiencing domestic violence with an estimated 3 children in every classroom. Research states that children who experience DV have a 4 fold increased risk of experiencing mental and emotional health issues. Therefore there are a substantial number of children in Nottingham who may be experiencing/witnessing DV however their emotional and mental health needs are not being catered for.
- A number of high profile suicides of young people in the city where previous self-harm was a prominent feature.

Behavioural Issues/ ASD/ADHD

- A significant number of referrals to CAMHS are related to behaviour which is taking up significant time and resources. It is anticipated that the new emotional health and wellbeing

pathway commissioned by the NHS Nottingham CCG will help to divert these referrals away from CAMHS, if appropriate.

- A significant number of referrals from GPs to community paediatricians for behaviour and suspected ASD/ADSD. However there is a view that there is limited resources within community paediatricians to cope with the sheer number of referrals being made on a weekly basis (again this should be alleviated with the development of the Emotional Wellbeing Pathway) and that community paediatricians do not have a wide source of opportunities to refer onto to support parents, therefore pharmacological treatment is used as a first line of treatment rather than parenting and psychological support.
- Stakeholders expressed care of children with behavioural issues should be multidisciplinary and focused on the child's needs rather than medical diagnosis
- A recognition that many of the referrals coming through to both community paediatricians and CAMHS tier2 are caused by attachment issues. Therefore work should be focused on parenting programmes.

Early Intervention

- Stakeholders felt that there needs to be a greater emphasis on early intervention, identifying emotional and mental health problems early in order to 'break the cycle'.
- It is also recognised that resilience needs to be systematically promoted within the school setting starting within primary schools.
- Some stakeholders felt there is a perceived gap around teaching young people to work through and manage issues themselves.
- There needs to be more emotional and mental health training and support provided to universal services due to sheer numbers of children and young people accessing these services.
- Schools needs to take on a greater role in promoting emotional health and wellbeing as well identifying children who are at risk of emotional and mental health problems.

7.3 Issues related to the provision of CAMHS Services

Overall stakeholders recognised there are blockages at every tier of CAMHS and there is no step up step down approach within Nottingham City which allows children to move up and down the tiers of CAMHS depending on their level of need. It is also recognised by stakeholders the children and

young people are not at the heart of the service in terms of the development and care and this needs to be developed further.

Universal Services (tier 1)

- The numbers of pupils seen by school nurses for emotional and mental health problems are increasing (557 from April until October 2013).
- There is still a need for tier 1 services to be trained in dealing with young people self-harming (despite the new services coming on line). In particular there needs to be recognition by schools and school governors that self-harm is a public health challenge.
- GPs are referring to community paediatricians rather than into CAMHS services due to being 'bounced' around the existing CAMHS provision.

Tier 2 Services

- Neither universal services nor community paediatricians currently receive any feedback from the CAMHS services with regards to the children and young people they refer into the SPA.
- There is a lack of knowledge within clinical children's services of the skills and competences of the tier 2 work force.
- The community paediatricians currently do not receive feedback from the SPA on the care plan and outcomes of the children/ young people they have referred.
- There is a lack of knowledge from referrers into the CAMHS service on the outcome of referral through the SPA process.
- A number of referrals made into the SPA (tier 2) by the community paediatrician have been 'bounced back' to them instead of being placed within tier 2.
- After examining the data, in each of the 3 localities there is the same number of CAMHS tr 2 workers. However there are more referrals and more need in terms of the risk factors in North Locality than in the Central Locality. Therefore there is an Inequity of service provision which may be causing longer waiting times for children and young people to be seen
- It was reported that there are increasing waiting times for children to be seen in tier 2 after a referral has been made into the SPA due to the numbers of referrals being made into CAMHS. In some cases children and Young people are waiting up to 8 weeks to be seen initially within CAMHs after a referral has been made. However this issue is now being dealt with, with the introduction of the CAPA model within tier 2.
- There appears to be reduced capacity within tier 2 due to an increase in the number of referrals.

Tier 3 Services

- The Head to Head service are not filling all their numbers of planned sessions for Nottingham City. However the cases that they are working with are extremely complex and taking up significant time.
- There is a significant waiting time for tier 3 services.
- Tier 3 services including the special self-harm team work office hours Monday to Friday, which does not cater to the demand for the service as the majority of ED presentations which would warrant a special tier 3 intervention are at an evening or weekend.
- The self-harm team are only able to see a small proportion (2 assessments per professional per day) of those young people who are admitted to a paediatric bed in QMC for self-harm due to the sheer number of admissions. This is causing an increase in bed stays within the paediatric wards for the young people until the young people can be assessed and having a knock on effect and increasing pressure in paediatric care.

Looked After Children

- The CAMHS Looked after Children team has seen an increase in the number of referrals which is a reflection of the increasing number of children and young people entering into care.
- There is currently no monitoring system to assess the emotional and mental health of all children who are in care. The SDQ questionnaire is only used for children who have been referred into the team to assess their emotional and mental health.

Tier 4 Services

- There is recognition locally and nationally that there are a limited number of inpatient beds within tier 4 (12 beds locally for all children and young people who live in Nottinghamshire and Derbyshire).
- There are issues that local children and young people have been placed out of area due to impatient capacity.
- In patient unit at Thorneywood is mainly occupied by long term stay patients. There is currently no step up step down pathway for children and young people who no longer require inpatient care but require intensive support.

Secondary Care- QMC

- There are an increasing number of children who are presenting and admitted to ED at QMC with emotional and mental health issues.
- Children and Young People who present to ED with self-harm on a Friday afternoon or over the weekend are not assessed by the CAMHS self-harm service until a Monday morning. The consequence of this is that children and young people have to stay over the weekend in a paediatric bed which again causes pressures on paediatric care.
- If a young person is admitted to QMC over the weekend, it will not be the specialist self-harm team that undertakes the assessment, a Registrar Psychiatrist or a Consultant Psychiatrist will undertake the assessment using a different risk assessment tool from the self-harm team and will only assess and not refer onto appropriate CAMHS services.

Transition to Adult Services

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

7.4 Commissioning of CAMHS

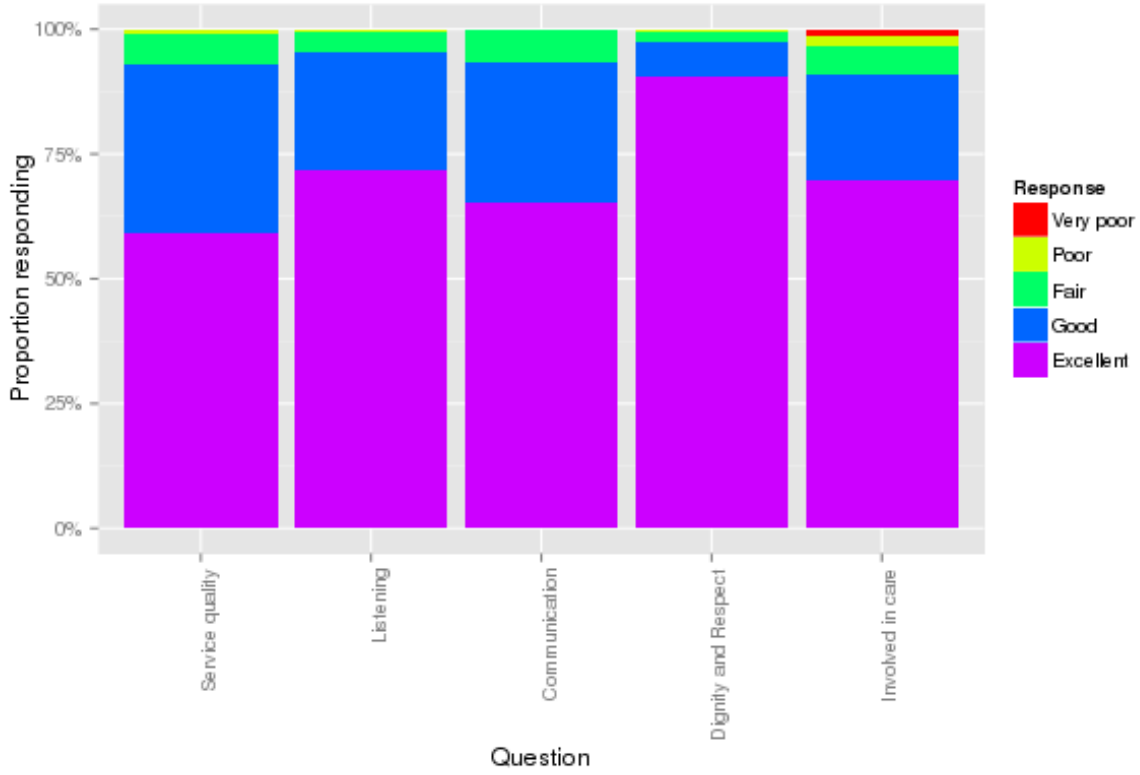
- Each tier of CAMHS is commissioned by different organisations, which has led to fragmentation of the service (tier 2, CCG/Local Authority; tier 3, CCG; tier 4, NHS England). Therefore this is causing difficulties in commissioning services across the life course.
- Data that is currently fed back to commissioners concentrate on the process rather than the outcomes.
- There are several different data systems which each commissioned CAMHS service use. None of these data systems talk to each other which mean that notes cannot follow the child or young person when they enter the CAMHS system be it through ED or a referral from CAMHS tier 2 into tier 3 (Tier 2 CAMHS system data is different to tier 3 CAMHS data system). This means that sometimes a child or Young Person, parent or carer has to repeat their story every time they meet a new professional within CAMHS and in addition children passing through the tiers often rely on professionals tacit knowledge.

7.5 Views of Service users

7.5.1 User feedback from CAMHS Services

Service user and carer feedback from July 2012 – March 2013 for tiers 3 and 4 CAMHS was supplied by Nottinghamshire Healthcare Trust. In this time 298 responses were received however friend and family scores are not included as the number of responses within the reporting periods does not meet the requires threshold. Figure 36 shows the overall responses to a series of questions about patient/carer experiences. Most questions about care received high proportions of 'excellent' or 'good' only one question with regards to Involved in care receive a 'poor' or 'very poor' response.

FIGURE 32: SERVICE USER FEEDBACK, NOTTINGHAMSHIRE HEALTH CARE TRUST JULY 2012 – MARCH 2013



Source: Nottinghamshire Healthcare Trust, 2013

Figure 32 show service user feedback to the question "if you could improve just one thing about the care you received and what would it be?" and what was the best thing about the care you received?" The main themes coming out of the feedback was improved waiting times and more staff. Positives aspects of care related to listening skills of the staff, having someone to talk to and care from the staff.

8 Recommendations

8.1 Early Intervention –Breaking the cycle and taking a life course approach

Antenatal

- There is still more work which needs to take place within universal services to actively promote attachment theory (Conception to age 2 - the age of opportunity | WAVE Trust) to all women who are pregnant. This should be incorporated into all antenatal appointments. *This recommendation will be fed into the midwifery review and be incorporated into NHS Nottingham City CCG new midwifery specification.*
- Antenatal and perinatal health needs to focus more on emotional and mental health of mothers with the development of specialist mental health midwives to support mothers with post natal depression . This is due to the link between antenatal anxiety at 32 weeks and the link to behavioural and emotional problems in children. *This recommendation will be fed into NHS Nottingham City CCG midwifery review.*
- Develop universal programmes which address how to parent effectively as part of antenatal care for example based on the Family Partnership programme in the USA. This recommendation will be fed into the Nottingham City Emotional, Mental Health and Wellbeing pathway which is in development.

Early Years

- Utilise the school readiness check at age 4 to undertake an emotional and mental wellbeing check of the child and pass on any information to the school and school health.

School Aged Children

- Provide guidelines to schools on how to effectively use the pupil premium for quality emotional and mental health support for pupils.
- Systematically deliver evidence based interventions (SEAL programme) within all schools with Nottingham.

Parents/Family

- Systematic support should be provided to families with children and young people who are experiencing domestic violence at all risk levels as assessed by DART. There needs to be recognition the impact of DV on children's emotional and mental health.
- Ensure all services are linked into Nottingham City Council's Family Support Strategy.
- All adult mental health services should have a Key Performance Indicator to support the emotional and mental health needs of children particularly when parents are diagnosed with a mental health condition.
- All children's services to consider parental mental health, substance misuse and domestic violence as a factor affecting child emotional and mental health and to signpost/refer to appropriate services.

Training

- All primary care (GPs, school nurses and health visitors) and schools (all teachers) should have comprehensive training in the skills and knowledge required to recognise children and families who may be experiencing emotional and mental health issues.
- A comprehensive self-harm training programme should be developed and delivered to all GPs, schools (both primary and secondary including teachers) and school nurses.
- Roll out the Public Health England Tool Kit for emotional health in schools.

Children and adolescent mental health services and proposed pathways

- Utilise tier 2/3 service usage data to deliver a multi-disciplinary and skilled community CAMHS pathway provision where the child and young person is at the centre of delivery. This includes appropriate venues for meeting families and children and young people, suitable waiting times to the point of invention and length of intervention time.
- Ensure that the CAMHS pathway systematically supports universal services after the point of referral.

- Identify resources to develop a new CAMHS pathway in light of the increased number of referrals and improve partnership working with adult mental health services
- Undertake a whole CAMHS workforce review to ensure there are the right skills and competences in relation to working with children and young people who are experiencing emotional and mental health problems.Develop a skills and competences quality standard for all CAMHS workforce.
- Develop a multi-agency assessment process with a single point of access which is inclusive of all appropriate referrers into the CAMHS service.
- Support the workforce and service users to smooth transition of patients between tiers and transition to adult services to minimise duplication of assessments.
- All young people who are admitted to QMC over the weekend with self-harm should have the standardised self-harm risk assessment tool undertaken as done by the specialist tier 3 self-harm team.
- Develop an appropriate pathway for children and young people who attend emergency department (ED) for self-harm.
- Track systematically the number of referrals into CAMHS for challenging behaviour to identify if there is a reduction of referrals as a direct result of the development of the emotional, mental health and wellbeing pathway
- To ensure all referrers into CAMHS are provided with feedback on what intervention has been undertaken with the child and outcome of that intervention.
- The new CAMHS pathway needs to be communicated effectively across all universal services by the provision of comprehensive training, these needs to include explicit knowledge of interventions undertaken by the CAMHS workforce with the child/young person.
- Provide a responsive CAMHS service which works into the evenings and weekends to minimise the number of admissions to QMC by young people and the need for inpatient beds.

Waiting times

- All referrals should work towards a standardised waiting times and all interventions should be standardised to ensure children and young people are at the heart of the service.

CAMHS specific services

- All looked after children (LAC) undertake a strengths and difficulties questionnaire SDQ) every 6 months as part of their LAC review. This will ensure that all LAC will be monitored for changes in their emotional and mental health state and subsequently be referred into the CAMHS looked after children team to appropriate interventions

Improving local data on children and young people's mental health

- Develop a core dataset to be reviewed at the CAMHS Executive, taking account of the development of a national CAMHS minimum dataset and the use of outcome measures such as The health of the nation outcomes scale for children and adolescents (HoNOSCA), for more information please go to http://www.liv.ac.uk/honosca/faq.htm.
- A systematic change needs to be implemented across the CAMHS which focuses on the outcome of the child/young person rather than the process. Investigate the possibility of a newly commissioned data system or that existing data systems talk to each other to ensure a smooth referral or transition between tiers of CAMHS children and young people.

9 References

1. **Greeb, H. McGinnity, A., Meltzer., Ford, T. & Gooddman, R.** *Mental health of children and Young people in Great Britain.* London : s.n., 2004.

2. **Department of Health.** *Department of Health 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: a cross-Government mental health outcomes .* 2011.

3. **Cavenagh, S. & Chadwick, K.** Health Needs Assessment: A Practical Guide. *www.nice.org.uk.* [Online] 2005. [Cited: 11 September 2013.] www.nice.org.uk.

4. **Office for National Statistics.** *Mental health of children and young people in Great Britain, 2004. .* London : HMSO, 2004.

5. **Gardner, F. & Shaw, D.** Behavioural Problems of infancy and Preschool Children (0-5). *Rutter's Child and Adolecents Psychiatry.* 2008.

6. *. Common emotional and behavioural disorders in preschool children. Presentation, nosology and epidemiology.* **Egger, H. , & Anngold, A.** 44 945-960, s.l. : Journal of Child Psychology and Psychiatry, 2006.

7. *Infant need mental health checks.* **Foundation, . M. H.**

8. **MInds, Young.** Young Minds . [Online] 1 October 2013. www.youngminds.com.

9. *A Time trends in adolescent mental health. 45.* **Collishaw, S. Maughan, B., Goodman, R & Pickes, A.** 1360-62, s.l. : Journal of child psychology and psychiatry, and allied disciplines, 2004, Vol. 45.

10. **Foundation, Ann Hagell –Nuffield.** *Time trends in adolescent well-being: Update 2009.* London : Nuffield Foundation, 2009.

11. **Mental Health Foundation.** *Truth Hurts: Report of the National Inquiry into self-harm among young people .* London : Mental Health Foundation, 2006.

12. **Young MInds: Cello Group.** *Talking Self Harm.* London : Cello Group, 2012.

13. **Department of Children, Schools and Families.** *Children and young people in Mind: The final report of the National CAMHS Review .* London : s.n., 2008.

14. **Meltzer, Gatward,Corvin et al.** *The Mental Health of Young People Looked After by Local Authority in England.* London : TSO, 2003.

15. **Hatton, Emerson and.** *The Mental Health of Children and Adolescents with Learning Disabilities in Great Britain.* Lancaster : Institute of Health Research Lancaster University, (2007).

16. **Healthcare Commission.** *A Review of Healthcare in the Community for Young People who Offend.* London : Commissioning for Healthcare Audit and Inspection, 2006.

17. **Department of health.** *Promoting Mental Health for Children in Secrure Settihgs: A Framework for Commissioning Services. London. DH.* London : Department of Health, 2007.

18. **Shooter.** Children and adolescents who have chronic physical illness . . [book auth.] Williams and Kerfoot (eds). *Child and Adolescent Mental Health Services: Strategy, planning, delivery and evaluation.* Oxford : Oxford University Press, 2005.

19. **Ermisch.** *Does a 'Teen-Birth' have longer term impacts on the mother? Suggestive evidence from the British Household Survey.* Colchester : : Institute for Social and Economic Research., 2003.

20. *Sexual orientation and mental health in a birth cohort of young adults. .* **Fergusson D, Horwood JL, Ridder EM et al.** 35 971-81, s.l. : Psychological Medicine, 2005.

21. **Niven S, Stewart D.** *Resettlement outcomes on release from prison in 2003.* London : Home Office Research Findings: Home Office, 2005.

22. **Department of Health.** *Department of Health 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.* London : Department of Health, 2011.

23. **Friedli L, Parsonage M.** *Mental health promotion: building an economic case. Belfast: Northern Ireland.* Belfast : s.n., 2007.

24. **World Health Organisation.** World Health Organisation Social Cohesion for Mental Well-being among Adolescents. [Online] 2008. [Cited:] <http://www.euro.who.int/__data/assets/pdf_file/0005/84623/E91921.pdf>.

25. —. *Promoting Mental Health. CONCEPTS. EMERGING EVIDENCE. PRACTICE. .* s.l. : World Health Organisation, 2004.

26. **Department for Educarion.** *Conception to age 2- the age of opportunity.* Croydon : Wave Trust, 2013.

27. **Klaus, M. H., Kennell, J.H. Klaus, P.H.** *Bonding: Building the foundations of secure attachment and independance.* Harlow : Addison-Wesley Publishing Co, 1995.

28. *Support from the Start: effective programmes in pregnancy.* **Glover, V. Sutton, C.** 1, 8-17, s.l. : Journal of Children's Services, 2012, Vol. 7.

29. *Maternal antenatal anxiety and children's behaviour/emotional problems at 4 years.* **O'Connor, T. G. Heron, J. Golding, J.Beveridge, M. Glover, V.** 502-8, s.l. : British Journal of Psychiatry, 2002, Vol. 180.

30. *Early stress, translational research and prevention science network: fetal and neonatal experience on child and adolescent mental health.* **Talge, N.M. Neal, C. Glover, V.** 245-61, s.l. : Journal of Child Psychology and Psychiatry, 2007, Vol. 48.

31. **Natioanl Institute for Health and Clinical Excellence.** *Antenal and postnatal mental health: Cl9inical management and service guidance.* s.l. : NICE, 2007. CG45.

32. **National Institute for Health and Clinical Excellence.** *Antenatal Care: routine care for the healthy pregnant women.* s.l. : NICE, 2008. CG62.

33. **Seaman, P. Turner, K. Hill, M. Stafford, A. Walker, M.** *Parenting and Children's Resilience in Disadvantaged Communities.* London : Natioal Children's Bureau, 2006.

34. **Gardner, F.E.M.** Positive interaction between mothers and children with conduct disorders: is there training for harmony as well as fighting. *Journal of Adnormal Child Psychology.* 15, 1987, Vols. 283-93.

35. **Sutton, C.Utting, D. Farrington, D.** *Support from the start- worknig qith young children and their families to reduce the risk of crime and anti social behaviour.* London : DfES, 2004.

36. **National Institute for Health and Clinical Excellence.** *Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management.* s.l. : NICE, 2013. CG158.

37. **National Institure for Health and Clinical Excellence.** *Attention deficit hyperactivity disorder: Diagnosis and managementof ADHD in children, young people and adults.* s.l. : NICE, 2012. CG72.

38. **National Institute for Health and Clinical Excellence.** *Social and Emotional Wellbeing: early years.* s.l. : NICE, 2012. PH40.

39. **Wear, K.** Promoting mental health and preventing mental health problems through school settings. *Public Mental Health Today.* A Handbook, 2010, Vols. 135-146.

40. **National Institute of Health and Clinical Excellence.** *Social and emotional wellbeing in primary education.* s.l. : NICE, 2008. PH12.

41. **National Institute for Health and Clinical Excellence.** *Social and emotional wellbeing in secondary education.* s.l. : NICE, 2009. PH20.

42. **Department for Education.** *Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011.* London : s.n., 2011.

43. **Jarrett, M & Mitchell, J.** *Targeted Mental Health in Schools (TaMHS) NOttinghamshire.* s.l. : Local Evaluation, 2011.

44. **National Institute for Health and Clinical Excellence.** *Interventions to reduce sustance misuse among vulnerable young people.* s.l. : NICE, 2007. PH4.

45. —. *School-based interventions on alcohol.* s.l. : NICE, 2007. PH7.

46. **Massie, L.** *Right Time, Right Place:Leanring from the Children's National Service Framework development initiatives for psychological well-being and mental health, 2005-2007.* 2007.

47. Joint Commissioning Panel for Mental Health GUidance for Commissioners of mentla health services for young people making the transition from chil and adolescent to adult services. [Online] 2012.

48. **Child and Maternal Health Observatory Child health Profiles.** CHiMat. [Online] [Cited: 10 Octiber 2013.] http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES.

49. **Home Office.** *Home Office Domestic Violence and abuse.* London : s.n., 2013.

50. **NSPCC.** *Child abuse and neglect in the UK today.* s.l. : NSPCC, 2011.

51. **Wolfe, D A. Zak, L. Wilson, S. & Jaffe, P.** Child witnesses to violence between parents: critical issues in behaviour and social adjustment. *Journal of adnormal child psychology.* 1986, Vol. 14, 95-104.

52. **Parrott, L. Jacobs, G. & Roberts, D.** Stress and resillience factors in parents with mental health problems and their children. 2008.

53. **Singleton, N. Bumpstead, R. O'Brain, M. Lee, A. Meltzer, H.** *Psychiatric morbibity among adults in living in provate households.* London : s.n., 2000.

54. **National Institute for Health and Clinical Excellencw.** *Looked-after children and young people.* s.l. : NICE Public Health Guidance 28, 2010.

55. **Mektzer, Gatward & Corbin.** *The Mental Health if Young Poeple Looked After by Local Authorities in England.* London : s.n., 2003.

56. **Office for National Statistics.** *Providing unpaid care may have an adverse affect on young carers' general health.* s.l. : Office for National Statistics, 2011.

57. **CHiMAT.** CHiMAt Needs Assessment. *CHiMAT.* [Online] 13 November 2013. http://www.chimat.org.uk/resource/view.aspx?RID=101746&REGION=101631.

58. Department of Communities and Local Government. [Online] 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236920/Table_784.xls.

59. Homeless Watch. [Online] 2013. http://www.hlg.org.uk/images/stories/Homeless_Watch_Files/2013_Paperwork/Notts_Homeless_Watch_2012_final_report.pdf. .

60. **Vostanis, P. Grattan, E. & Cumella, S.** Mental health problems of homless children and families. *BMJ.* 1998, Vol. 316, 899-902.

61. **Parry, G. et al.** Health status of Gypsies and Travellers in England. *Journal of epidemiology and community health.* 61 , 2007, 198-204.

62. **Goward, P. Repper, J., Appleton,L. & Hagan, T.** Identifying and meeting the mental health needs of Gypsies and Travellers. *Journal of Mental Health.* 15, 2006, 315-327.

63. **A, H. Bright Futures.** *The mental health of young offenders.* London : s.n., 2002.

64. **Department of Health.** *Promoting Mental Health for Children in Secure Settings.* London : Department of Health, 2007.

65. **Vermeiren, R., De Clippele, A. Deboutte, D.** A description servey of Flemish delinquent adolescents. *Journal of adolescence.* 23, 2000, 277-85.

66. **Department for Education.** Department for Education. [Online] 2010. [Cited: 21 October 2013.] http://www.education.gov.uk/schools/pupilsupport/sen.

67. **Emerson, E. & Hatton, C.** Mental health of children and adolescents with intellectual disabilities in Britain. *The British journal of psychiatry.* 2007, 191, 493–9.

68. **Parry-Landon, N.** Playfeild Institute. [Online] 2008. <http://www.playfieldinstitute.co.uk/information/pdfs/publications/general/Three_years_on_Survey_of_the_development_and_emotional_well_being_of_children_and_young_people.pdf>.

69. *Mental health and special educational needs: exploring a complex relationship.* **Rose, R., Howley, M., Fergusson, A. & Jament, J.** 2009. 36, 3–8 (.

70. **Rose, R., Howley, M., Fergusson, A. & Jament, J.** Mental health and special educational needs: exploring a complex relationship. *Britis Journal of Special Education.* 2009, Vol. 36, 3-8.

71. **Health and Social Care Information Centre.** *Smoking, drinking and drug use among young people in England in 2011.* London : s.n., 2012.

72. **Royal College of Psychiatrists.** Royal College of Psychiatrists. [Online] 2013. http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/cannabis.aspx.

73. **Department of Education and Skills.** *Every Child Matters.* London : The Stationary Office, 2003.

74. **Department of Health, Teenage Pregnancy Unit.** *Teenage pregnancy research programme research briefing. Long-term conseqences of Teenage births for Parents and their Children.* London : Department of Health, 2004.

75. **Rossman.** Time heals all: How much and for whom? *Journal of Emotional Abuse.* 2000, 2 31-50.

76. **Kashani, J. H., & Allan, W,D.** *The impact of family violence on children and adolescents.* Thousand Oaks : Sage Publications, 1998.

77. **Silverman, J. G., Raj, A., Mucci, L. A. and Hathaway, J. E.** Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behaviour, pregnancy, and suicidality. *Jounral of American Medical Association.* 286(5), pp572–579. .

78. **Roscoe, B. and Callahan, J. E.**) Adolescents' self-reporting of violence in families and dating . *Adolescents.* 1985, 20, pp546–553.

79. **Ministry of Justice.** *Compendium of reoffending statistics cited in Social Justice Transforming Lives.* 2010.

80. **Collishaw, S. et al.** Resilience to adult psychopathology following childhood maltreatment: evidence from a community sampl. *Child Abuse and Neglect.* 2007, 31, 211–29.

81. **Kurtz, Z.** *Services for the mental health of children and young people in England. Assessment iof needs and unmet need.* London : s.n., 1996.

82. *Health Needs Assessment Work Book.* **J Hooper, P Longworth.** 2002, Health Development Agency.

83. **HM Government.** HM Government No Health Without Mental Health. A cross Government mental health outcomes strategy for people of all ages. [Online] 2012. [Cited: 10 Septemver 2013.] . At https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf.