West Sussex Mental Health Needs Assessment (Children and Young People)

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Report by the
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Preface

The emotional wellbeing and mental health of young people is a critical determinant of their future quality of life. Half of those with lifetime mental health problems experience their first symptoms before the age of 14 and early intervention can make a significant different in helping them to fulfil their potential. The national mental health strategy 'Closing the gap: priorities for essential change in mental health ' published in January 2014 makes it clear that, across the country, services are not currently meeting the needs of young people, and it identifies priorities for action. The recommendations in this report are made within that framework as well as information gathered locally.

Comprehensive needs assessments like this one tend to focus on what's not working rather than what is. It's important to keep in mind the context of a highly complex range of specialist, targeted and universal services, each of which will have strengths and weaknesses, working within a health and social care system that is undergoing significant change. During this research we have been impressed by the desire of people in all parts of the system to make services work better for young people and their families. We have heard about their frustration where something isn't working well and they haven't been able to change it themselves: this has nearly always been due to a failure of the system and not the individual. We have also heard about services and professionals who are highly valued and have had a huge impact on the wellbeing of young people and their families,

Our recommendations inevitably highlight problems but they are intended to be constructive. Progress will be quicker where there is an evidence base to underpin the development of an effective and cost effective service model, it will necessarily be slower where innovation is needed and risks have to be locally identified and managed. We expect that in most cases improvements will be incremental, with their impact being understood across the system before the next step is taken, in order to ensure continuity of care, stability in services and patient safety.

This comprehensive needs assessment provides a huge amount of data and information, and we are very grateful for the time and commitment of all the people who have helped us to prepare it. Children and young people, their families and health professionals have all provided their own perspectives on what's working well in current services in West Sussex, and what needs to improve. One thing that has clearly emerged is the determination on all sides to make the changes needed, building on the many examples of good practice locally.

Five issues need to be addressed as a priority:

1. **The need for single commissioner**

   Overall, services are fragmented and poorly understood by those not working in them (including professionals working for other providers or in primary care). Some services are valued and well received, but there are also significant gaps. Services are dispersed across the public, private

and voluntary sectors, with different funding models, all serving different age groups, geographical areas and client groups. Our intention in undertaking this needs assessment was to describe this landscape – or at least the publicly funded parts of it – but that has proved almost impossible because currently nobody has an overview of the whole system and both national and local data sources are inadequate. There is some professional agreement that a single commissioner of services should be identified with the aim of bringing coherence to the care pathway and its integration or alignment with other services for children and families.

2. **Urgent referrals into specialist services**

The system for urgent referrals by GPs into specialist services is not working. It is unclear from the data provided to us why this is, particularly as the acceptance rate, which is an indicator of an effective system, is much higher in East Sussex. Factors may include lack of capacity in specialist services, need for referral training for GPs and/or gaps in services. Primary and secondary care professionals should undertake a retrospective review of referrals to establish what the issues are and, as these patients are high risk, an audit for on-going monitoring. Consideration should be given to joint audit with East Sussex to provide a quality benchmark.

3. **The care pathway for young people with behavioural problems**

Many health professionals, service users and families expressed strong concerns about what happened to young people who had been referred to Tier 3 services but were not accepted for treatment. We were told this may particularly apply to young people with behavioural problems, ADHD or ASD, and it was thought to be due to insufficient capacity and training in Tier 1 and 2 services. Families and some professionals reported that this had resulted in lengthy and unacceptable delays in treatment. We recognise that the families we spoke to in this exercise may have been more likely to be those who eventually needed specialist services than those who did not, and we are aware that for many young people, their behavioural issues are resolved successfully in Tier 1 and 2 services. This needs assessment was not able to identify the scale of this problem, the characteristics and symptoms of the young people affected, or establish what happens to them, because of a lack of data of sufficient quality. This raises three issues. Firstly, appropriate alternative support should always be identified for young people who don't meet the criteria for the service they've been referred to: currently there is little evidence to show this is happening. Secondly, it's extremely important we understand why referrals are not being accepted so that any necessary changes can be made to the care pathway. Routine data flows must be established to track all referrals (including behavioural problems) which should allow regular audits and also provide aggregated information to inform planning. Thirdly, it may be unrealistic to expect referrers from a range of agencies to have sufficient understanding of the increasingly complex landscape of services. Many asked for a single point of access followed by triage especially for non-urgent referrals, as a way of reducing delays in treatment and the number of unnecessary specialist assessments which are not a good use of resources.

4. **Shared decision making**

Health professionals often have to balance the risks of early treatment with taking time for assessment. Early intervention can provide early resolution but there is a risk it will lead to

inappropriate labelling of young people and overtreatment, or it can mask symptoms and cause delays in making the correct diagnosis. Waiting means there is a risk of the condition deteriorating but can reduce the risk of side effects related to unnecessary interventions. Families understandably want a quick resolution and said they don't always understand the reasons for delays. Shared decision making between professionals, patients and their families is clearly the goal. All providers should ensure that all professionals are trained in this approach and routinely seek feedback to ensure families and patients feel empowered.

5. **Communications and engagement**

   Improved access to information is an issue that was raised repeatedly by families, young people and GPs. Basic information about progress through the system is sometimes not being shared. This should be reviewed as part of the care pathway with families and patients co-designing points at which information is shared routinely. Providers should ensure that patients and families all have a named contact who they can phone or email. The use of social media should be explored, for example live chat, patient forums and targeted websites with links to other safe web resources.

We hope that this needs assessment will be used to underpin the development of improved services for young people and their families in West Sussex, and that, for these five issues, commissioners and providers will be held to account for making significant progress over the next 12 months.

Catherine Scott

Head of Public Health, West Sussex County Council

May 2014

Quotes from the consultation with young people:

"The services need to be advertised more so that more people know where go for help if they feel embarrassed telling someone that they know."

"I just want somewhere where I can go and be me and not get bullied for it."

"They have all helped a lot with support, and they are always there to help if it's needed."

"I'd trust my mum with everything, but I'd feel awkward to talk to my dad about personal subjects."

"CAMHS used to assume I had all these things wrong with me, but it turned out that it wasn't me; it was my environment. Being in care is the best thing that ever happened to me because now I don't have any of these problems."

"YMCA was good because I was talking to a complete stranger so I didn't have to worry about what they thought of me."

"It's important to feel like there's someone there for you, who will never leave."

"I speak to family; always there to listen. I think that is very important to have people to talk to no matter what age you are."

"I would never talk to my teachers about drinking, or taking drugs, or having sex… because I know that my parents would find out and that would be the worst!"

"A bad social worker is one who rarely comes to see you, or when you ask for something to be done, it isn't done, or they let you down; A good social worker is someone who is there for you and doesn't let you down."

"Since year seven, they've been saying 'If you don't do well in school, you won't do well in life'. If someone had just told me when I was younger that it's not all about doing well at school, or having lots of friends, then it would have helped me a lot."

Quotes from the consultation with parents/carers of young people involved with CAMHS:

"Listen to parents more. Parents know their children more than anyone and know when something isn't right. Listen to them and don't ignore them and hope it will go away.'

"It's constant fighting and you are asking where you can find information out, you just have to find it out yourself, really, because it's really difficult"

'Therapeutic Parenting - made a real difference in the way we parent both our adopted children. It gave us lots of strategies to use and plenty to think about. The therapists were fantastic.'

"They say 'it's all early intervention', but then they're all 'wait and see, wait and see'. They think it's just immature behaviour; it takes ages to get an assessment done. They need to make 'early intervention' earlier."

"I think the one word to sum it up is 'frustration'."

"Help us help our children."

"I would like to think that all people could get as good a service as we received, and from such an experienced psychologist who knew just how to get my daughter to change her thought processes in such a positive way."

"Provide the right services to support all young people. Where do parents turn when told supporting a disorder is not within the remit? We have felt utter despair and isolation in obtaining care support and understanding for our daughter and it continues."

"No one talks to anyone else. I have had to arrange meetings myself in order to get people together."

Quotes from the consultation with Professionals:

"If we get in earlier then potentially the trajectory is much, much reduced in terms of the challenges that the children present."

"Not sure anyone realises how much teams are running on empty and morale is very low, even from amazingly skilled and thoughtful professionals."

"Some of the best work that I've done, we've joint-worked things together, worked side by side and it worked well then."

"No one understands the role of CAMHS any more, what they do accept and what they do not and the reasons for this."

"I often feel that young people's emotional health gets neglected due to fact that they may not have a formal MH diagnosis and therefore often don't meet the threshold for a service from CAMHS."

"I find it frustrating that despite the law stating we should act in the best interests of the child, confidentiality within the health profession appears to over-ride this."

"I feel that better communication with the families to help manage their expectations of what CAMHS can actually do would be helpful. Knowing what the service isn't just as much as what it is, is important for families to understand."

"Stuck in the middle without enough information to help with stressed and angry people asking us to do something."

"It feels as if young people need to fit in to service provision rather than service provision being designed to meet their needs."

"It still feels like CAMHS can still be difficult for people to access and sometimes it seems that there are young people that get missed as a result."

"It's like put all these hoops in the way, all these hurdles in the way and if you might finally get to the end or you get to that stage where you think, 'It's got to be CAMHS,' and they think, 'Well, actually no, it doesn't meet our criteria.'"

"There are some very good, excellent bits of service, but it's not offering a coherent package across the county. Some families get brilliant, or what we think of as fantastic, and you see the difference it makes, and other families don't."

"Many referrals are returned, suggesting we use other services which do not exist, leaving parents and children without the support that they need."

1 EXECUTIVE SUMMARY

This is a summary of the key findings of a needs assessment of the emotional and mental wellbeing needs of children and young people in West Sussex.

1.1 Introduction

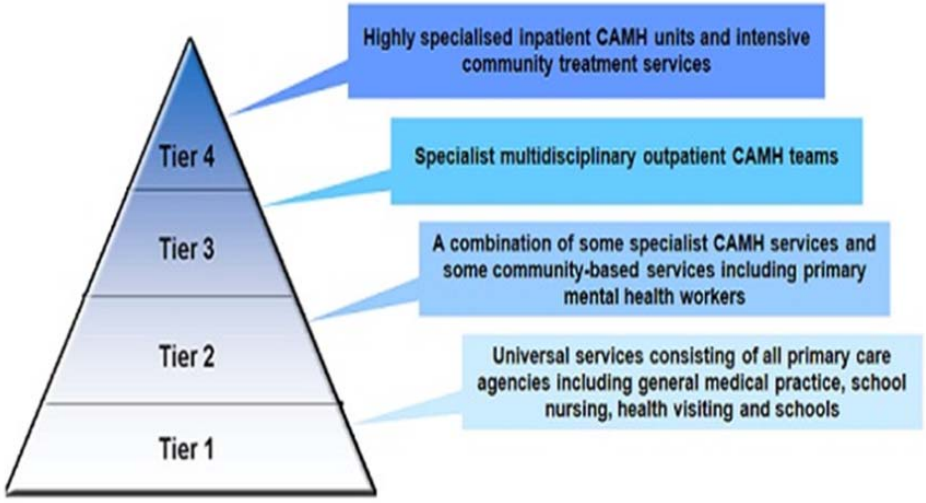
The West Sussex Joint Strategic Needs Assessment (JSNA) is an on-going process by which the health and wellbeing needs of the local population are identified. It involves a range of work, including data analysis, surveys and in-depth needs assessments. This needs assessment looks at the emotional wellbeing and mental health of children and young people in West Sussex; in the main people aged 0-18 years of age, in some instances up to 25 years.

The information collated aims to answer some basic questions:-

- *What are the characteristics of the population aged 0-24 years in West Sussex?*
- *What are the risk factors and protective factors affecting the mental health and emotional wellbeing of the population?*
- *What are the mental health, emotional and behavioural conditions and needs requiring commissioned services?*
- *What services are currently provided to meet those needs?*
- *How well are services currently provided to meet those needs? What gaps/barriers, if any, need to be addressed?*

While a range of data have been collated, at the heart of this work are the experiences and views of children and young people, parents, carers and professionals. The needs assessment was conducted by researchers in the Public Health, Health and Social Care Commissioning Directorate, with consultation fieldwork undertaken between October 2013 and December 2013.

Tiers of Services and Need



Note :

Services in mental health are often described in terms of "tiers", where services become more specialised the further up the tier, from universal wellbeing services at Tier 1 to highly specialist outpatient teams and inpatient provision at Tier 4.

A number of findings and recommendations are also termed in relation to tiers of service and needs.

1.2 Key Findings

1.3 POPULATION CHARACTERISTICS AND PREVALENCE OF MENTAL HEALTH PROBLEMS

- It is estimated[1] that one in ten children aged between 5 and 16 years has a mental health problem which translates to approximately 10,900 children in West Sussex. The child population is projected to increase across West Sussex, with the number of 0-15 year olds projected to increase by over 10% by 2021, this should be built into service planning and commissioning.

- Prevalence of problems differs by age and gender. Overall 10% of 5-16 year olds were found to have a mental health disorder; 7.7% of 5-10 year olds and 11.5% of 11-15 year olds, with boys estimated to have higher prevalence than girls overall.

- The most common mental disorders amongst the young are anxiety, depression, eating disorders, conduct disorders, attention deficit hyperactivity disorder (ADHD) and self-harm. The most common issue for boys are conduct disorders while for girls they are emotional disorders.

- There are known risk factors for poor mental health in childhood, including poverty, poor housing, and identifiable vulnerable groups, including children looked after, children with a learning disability, young offenders, children affected by domestic violence, substance misuse or poor mental health. Many children and young people will have multiple risk factors and have a number of mental health problems.

1.4 SERVICE ACTIVITY AND DATA

- In relation to Tier 3 provision, approximately 300-400 referrals are made every month to CAMHS (SPFT) and, at any one time, there is a caseload of approximately 3,000 children in West Sussex. Most referrals are made by GPs.

- Overall 61% of referrals (July 2013 - November 2013 period) were accepted by Sussex Partnership NHS Foundation Trust (SPFT). Detailed data are not available to Commissioners to examine, at population level, which groups of children are *not* being accepted.

- A low percentage (less than 10%) of urgent GP referrals were found to meet the SPFT criteria over the period July 2013 to January 2014; this is in stark contrast to East Sussex, where during the same period *all* urgent GP referrals met the criteria. Overall in relation to the data provided, activity in West Sussex appears more volatile than elsewhere in Sussex, with fluctuations of activity levels from one month to another.

[1] Green H, McGinnity A, Meltzer H, Ford T, Goodman R. Mental Health of Children and Young people in Great Britain 2004. Office for National Statistics on behalf of the Department of Health and Scottish Executive. Crown Copyright 2005

- There were also differences within West Sussex, referrals from Crawley were less likely to be seen face-to-face and a lower percentage of service users had a valid outcome measure; and only 1 referral of 112 made by GPs in the Coastal CCG area was found to meet the SPFT criteria for a 4 hour response.

- Performance data did not identify waiting time (referral to assessment and then treatment) as an issue, although this was a clear concern expressed during the consultation. The quality and scope of performance data should be reviewed, across all Tiers and services, to understand what is happening across the system.

1.5 FINDINGS FROM THE CONSULTATION WITH YOUNG PEOPLE, FAMILIES AND PROFESSIONALS

- Young people's wellbeing is closely related to the quality of interpersonal relationships they build; those with less close relationships tend to suffer more than those with friends, family or others in whom they can confide.

- Some children and young people do not feel comfortable accessing support or advice in schools as they suspect that any serious issue will be reported back to their parents.

- Parents and young people had mixed experiences of services.
  - There were individual psychiatrists/psychologists who were viewed as caring, approachable and understanding; there were comments about staff being willing to visit and assess outside the office, taking the time to explain why behaviours happen.

  The following services, from across all tiers, were particularly well received by those consulted:-
  - Child Development Centres,
  - Short Break provision,
  - Leapfrog,
  - therapeutic parenting courses run by CAMHS LAAC,
  - Worth Emotional Support Service,
  - Youth Services including at Glynn Owen,
  - The Anxiety group.

- The needs assessment also identified areas needing improvement:-
  - *Tier 1* services and capacity in the community are perceived by some people to have been reduced and access to professional training and advice is needed if prevention strategies are to be effective.
  - *Tier 2* services are perceived to have been reduced and are more focused on individual cases than on much needed training and consultation support for other professionals.
  - *Tier 3* services are perceived, by some, as being professionally isolated from other support service networks and communication with other networks should be integral to service delivery in the future.
  - Young people in *Tier 4* inpatient facilities said they did not feel that they had anyone with whom to raise any concerns they might have.

- There were some issues around communication, continuity and the level of care for young people making the transition to Adult Mental Health Services, and a view that the age of transition could be more flexible, up to age 25 in some cases.

- Staff turnover is perceived to be high in many areas, leaving gaps in experience, training and knowledge of existing networks and pathways. A contributing factor to this may be pressure of work which impacts on staff morale.

- Current intervention strategies are believed to fall short of required support and are perceived to function as gatekeeping techniques, rather than as preventative support.

- Eligibility criteria for different services or support are not clear to service users and are believed to be too rigid and not flexible enough to meet needs. Service users tend to deteriorate past internally defined benchmarks before being able to access further support.

- Referral processes require constructive and cooperative development from both referring and receiving professionals to develop a streamlined and effective methodology.

- Many parents suggested that earlier guidance and intervention could have had considerable benefits for their child (including looked after and adopted children) and alleviated distress for both the child and family. Parents do not seem to routinely access parenting programmes or support groups, although there is evidence that these are effective and valued.

- Clinical Commissioning Groups, District and Borough Wellbeing teams, CAMHS commissioners and service providers need to work collaboratively to develop and maintain an effective and thorough map of available services. This would allow oversight of the impact of changes in one service on another and enable all workers to navigate the systems in place and signpost or refer accordingly.

- There is no single commissioner with overall responsibility and until recently there has been no dedicated commissioning function for Tier 2 and Tier 3 commissioning.

- Leadership is required to develop a change in culture, to take a holistic view of young people's wellbeing and enable effective prevention strategies. This would include all aspects of health and wellbeing, from diet to environment to emotional wellbeing; be they at school, in the community or at home.

- The West Sussex "CAMHS" brand has generally been considered to be poor. This is believed by some tier 3 workers to be counterproductive, as reputations do not necessarily reflect recent service improvements. Widespread advertisement and communication of future changes will be essential to re-establishing trust in the service.

1.6 GAPS IN PROVISION

- Consultation identified gaps in provision / unmet need, of note:
  - Specialist provision for children under 5 years.
  - A "transition service" – and the need for some CAMHS to extend to the age of 25. Some people expressed concern that CAMHS starts "turning off" at 17.
  - Increased family therapy.
  - Earlier guidance and intervention (including for LAAC) and provision of parenting and support groups.
  - Post diagnosis service for autism / autism support within schools.
  - Direct referral route when families choose not to engage with other routes (for example where family does not go to their GP).
  - Well-staffed Helpline (staff with good knowledge of services and processes).
  - Awareness of peer mentoring / support
  - Overall concern that in relation to behavioural issues, not clear who provides what and what tier 3 should be doing.
  - Branding of services unappealing to young people (liked terms such as "Time to Talk")

1.7 GAPS IN KNOWLEDGE

- The lack of any detailed information on who is, and who isn't, accessing services, even where referred, means that medium to long term planning and commissioning are poorly informed.

- Little evidence is available relating to outcomes, data provided by services are process dominated.

- There was little evidence of how transition from childhood to adulthood was working, and how transition planning is developed as part of the commissioning process.

- Although information on services, at different Tiers, was obtained; service information is fragmented and not easily accessed.

- The needs assessment has included the issue of promotion of good mental health and earlier intervention and prevention. It is recognised that more could be done.

- The needs assessment did not examine system-wide spend and resourcing, existing service mapping and expenditure.

2 RECOMMENDATIONS

2.1 LEADERSHIP, GOVERNANCE AND ACCOUNTABILITY

Leadership across the system is generally perceived to be weak and accountability poor. It is important for children, families and professionals "on the ground" that commitments made at a senior level to improving services are demonstrated by actions, including funding levels, recruitment to key posts and transparency. Parents described the impact of changes in lower level services (for example youth services), and they thought a combination of changes were adversely affecting specific groups of children, including children with autism, and children with lower level mental health problems. Parents felt that the *combined* impact of individual changes is not understood by decision-makers.

RECOMMENDATION(S) :

1) Existing structures should be reviewed and strengthened to ensure cross-service representation, reflecting services from birth to young adulthood and linking to wider strategic groups.

2) Commissioning structures should be reviewed to ensure there is strategic oversight of the whole care pathway for young people including integration with other services for children and families.

3) As a matter of urgency there needs to be clinical leadership on the commissioning side, with clinical leads covering all parts of the county.

4) People consulted, and notably young people, highlighted the need to reduce the stigma often attached to mental health problems. Some parents and professionals suggested that leadership through schools and other universal services could help to address this issue.

2.2 ENGAGEMENT OF CHILDREN, YOUNG PEOPLE AND PARENTS / CARERS IN DESIGN, DELIVERY AND DEVELOPMENT OF SERVICES

There are some pilot projects which have been developed as part of better engagement, but engagement does not appear to be embedded into practice.

RECOMMENDATION(S):

5) Improve and sustain engagement with children, families and also wider community and voluntary support. This should be required of providers and demonstrated to commissioners.

6) For older children, explore adopting the '*You're Welcome*'[2] quality standard for delivering young person-friendly services.

[2] Department of Health. You're Welcome: quality criteria for young people friendly health services. (DH May 2011)

2.3 EXPERIENCE OF EXISTING CAMHS SERVICES (ALL TIERS)

The Tier 2 / Tier 3 interface persists as a key problem in the system.
GPs are extremely frustrated when trying to access support for their patients, and CAMHS staff are frustrated by inappropriate referrals. Tier 2 services are very poorly defined, and even when established, it is perceived the work tends to "migrate" to Tier 3.

RECOMMENDATION(S):

7) Service re-design at all/any Tiers should tackle the issue of equity across West Sussex. Access and experience of services, at present, is inconsistent.

8) Clear referral criteria, service provision, standards and where appropriate, pathways, will support greater consistency. Staff training is important to ensure these are widely understood.

9) Tier 2 provision needs to be mapped and monitored.

10) Part of the role of Primary Mental Health Workers (PMHWs) is to provide support, advice and training to universal services and staff. It was reported that with increasing caseloads this function was being reduced. This should be reviewed.

11) A number of professionals, including, but not only, GPs, are requesting a single point of access to Tier 2 and Tier 3 provision. Commissioners should review how this could operate and should incorporate ease of access (for referrers) to information on the progress of any referrals made.

12) Priority should be given to reviewing out-of-hours provision. It is clear that the urgent GP referral process is not working in West Sussex as the vast majority of referrals from GPs do not meet the criteria, in stark contrast to the situation in East Sussex. Commissioners should also review the out-of-hours helpline.

13) There is a lack of any detailed information on who is, and who isn't accessing services; this means that longer term population planning and commissioning poorly informed, for example who is being signposted from Tier 3 provision having been considered not to meet service criteria. Commissioners need to specify improved process *and outcome* information to be supplied by providers.

14) Providers should ensure that young people have awareness of and good access to advocacy, to raise any concerns they might have.

15) Some young people cited concerns relating to support whilst on temporary leave or after discharge from inpatient facilities. This should be reviewed.

16) There needs to be better engagement between Adult Mental Health services and services for children and young people, as part of transition services but also services where the parent/carer is the focus, including substance misuse services. The Worth Emotional Support Service was well received and could inform other services.

17) Commissioners should build on services *perceived* to be working well, including Child Development Centres (CDCs), parenting programmes, self-help and mentoring schemes and children and young peoples' planning forums.

2.4 ACCOMMODATION AND VENUES

The environment where some services are delivered is considered unsuitable, as expressed by adolescents**.** CAMHS (Tier 3) provision is considered by some people to be very "static" and within an office environment.

18) The environment in which services are provided should be reviewed and informed by engagement with children and young people.

2.5 KNOWLEDGE MANAGEMENT (COMMUNICATION AND INFORMATION)

There is a lack of consistent and coherent knowledge management practice, and investment in underpinning data and information to commission and de-commission services. Children and young people seeking information, as well as service providers and commissioners need access to quality, reliable information.

Considerable confusion exists, notably expressed by parents, about processes, procedures and information even after diagnosis. Young people interviewed were not always aware of available services.

For professionals, communication about young people "in the system" is considered poor, and information about the range of community and voluntary sector support is not easily accessed. For commissioners, there is limited data, both in terms of input and outcomes, to inform planning.

RECOMMENDATION(S):

19) Develop an approach to knowledge that manages it as an *asset* to improve planning and performance. Focus on connecting people, processes and technology within and across services and commissioners. Within this, address the desire for *greater use of online resources* and social media expressed by young people and families.

20) Commissioners need to specify improved process *and outcome* information to be supplied by providers.

21) Review, *with* parents and young people, the quality and clarity of information provided, of note:-
- A basic service directory, for parents and for young people themselves.
- Information about the Special Educational Needs (SEN) progress and changes to it.
- In relation to CAMHS, information on service standards, procedures and access
- Post diagnosis information.

22) Information should also consider the "branding of services"; some existing branding found to be unappealing to young people; some young people stated a preference for terms like "Time to Talk".

2.6 WORKFORCE

Concerns were expressed by some professionals about low morale amongst the CAMHS workforce and the increasing pressures it is under with a lack of time for reflective learning and professional support. The community and voluntary sector reported concerns at the lack of *continuity* of staff.

RECOMMENDATION(S) :

23) As part of provider reporting, commissioners should monitor staffing levels, turnover and caseload levels.

2.7 UNMET NEEDS/GAPS IN PROVISION

A range of specific service gaps and at risk groups were identified during the consultation. Some services exist but are considered by some to be insufficient.

RECOMMENDATION(S) :

24) Services for these issues, and groups, should be considered in service re-design:-

- Specialist Provision for children under 5.
- *Transition* service – and the need for some CAMHS to extend to the age of 25. Some people expressed concern that CAMHS starts "turning off" at 17.
- Family therapy.
- Post diagnosis service for autism / autism support within schools.
- Direct referral route when families refuse to engage with other routes (for example where family does not go to GP).
- Well-staffed Helpline (staff with good knowledge of services and processes).
- Peer mentoring / support
- Overall concern that in relation to behavioural issues, not clear on who provides what and what Tier 3 should be doing.
- Further consideration of ways to promote good mental health, earlier intervention and prevention.

Specific groups / issues

- *Lesbian, Gay, Bisexual and Transgender (LGBT)* – some young people expressed concern on how the issue of homosexuality was being dealt with "separately" in some school-based sexual education; identifying these young people as "something other than the norm".
- *Black and Minority Ethnic (BME)* language was noted as a barrier by some young people.
- *Children Looked After (CLA)* – from other areas – Children placed by other local authorities in West Sussex were often not linked into events and services locally which may be helpful to them and there were still concerns about these children accessing local specialist support
- Complex/multiple needs -/ Autism
- A number of comments were made about basic support and networking reducing – e.g. youth provision – tier 1/ tier 2 provision which had acted to provide some lower level support and valued by parents and young people.

- Some facilities (e.g. playground facilities) at special schools were considered to be unsuitable for some of those who also had a physical disability and restricted these children from being physically active (to “get rid of some energy and frustration through physical exercise”)
- Support for siblings was identified as an unmet need.

3 INTRODUCTION

The West Sussex Joint Needs Assessment is an on-going process by which the health and wellbeing needs of the local population are examined. This needs assessment looks at emotional wellbeing and mental health of children and young people; people aged 0-18 years of age, in some instances up to 25 years, in West Sussex and Clinical Commissioning Group (CCG) populations.

This report examines the current level of children and young people's functional mental health need in the county; including prevalence estimates of mental health illnesses, and risk and protective factors, it also outlines the range of services available and explores how well services are meeting the needs. While a range of data have been collated, at the heart of this report are the experiences and views of children and young people, carers, parents and professionals.

3.1 When conducted

The needs assessment was conducted "in house" by officers in the Public Health, Health and Social Care Commissioning Directorate, with consultation fieldwork undertaken between October 2013 and December 2013.

3.2 Previous Needs Assessment

This needs assessment updates some of the work undertaken in 2009 and detailed in *"Children and Adolescent Mental Health Needs Service Needs Assessment drafted by Jo-Anne Alner, Consultant in Public Health, West Sussex PCT.*

This report also uses the information on prevalence and summarised research on risk factors provided by the Child and Maternal Health Intelligence Network (CHIMAT).

3.3 The Aims of this Needs Assessment

The information collated aims to answer some basic questions:-

- *What are the characteristics of the population aged 0-24 years in West Sussex?*
- *What are the risk factors and protective factors affecting the mental health and emotional wellbeing of the population?*
- *What are the mental health, emotional and behavioural conditions and needs requiring commissioned services?*
- *What services are currently provided to meet those needs?*
- *How well are services currently provided to meet those needs? What gaps/barriers, if any, need to be addressed?*

NOTE: Following discussion with commissioners, it was decided that this needs assessment would concentrate on Tiers 2, 3 and 4. Further work on resilience and Tier 1 services and support will be undertaken at a later date.

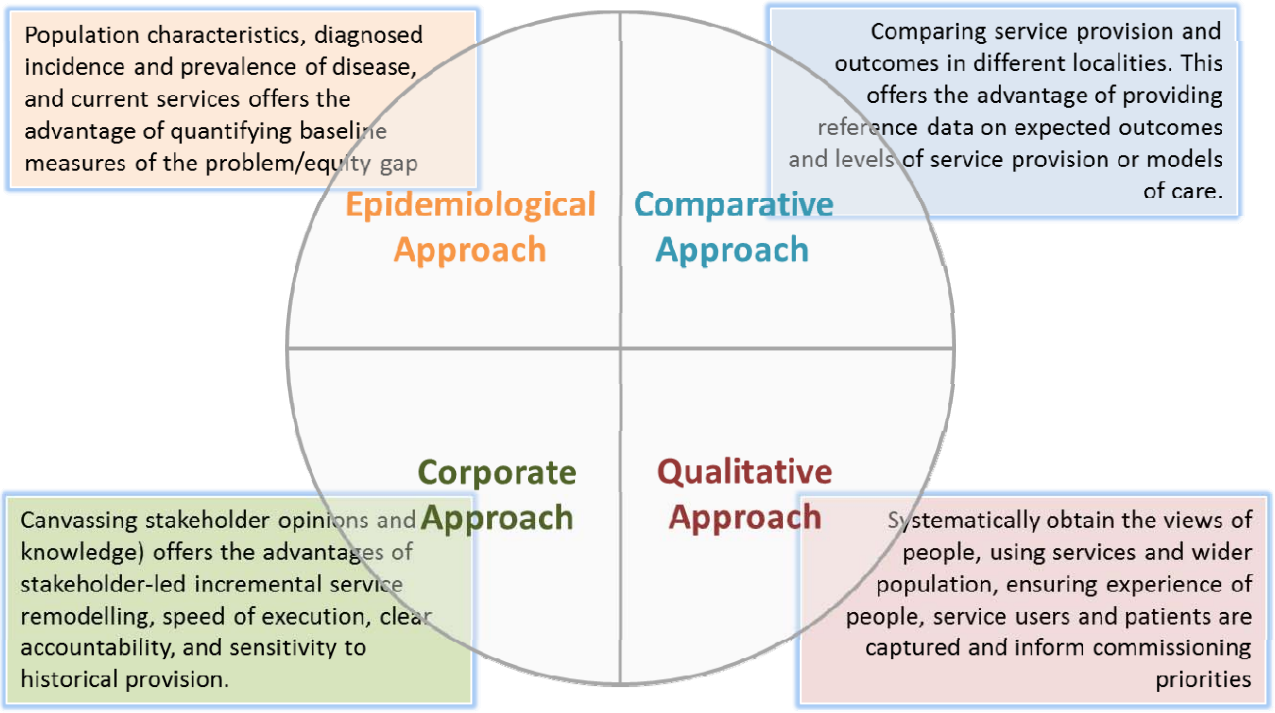
The term CAMHS refers to all services and support, at all Tiers, not just one provider or Tier. Provision is outlined in section 9 of this report (Services/Provision in West Sussex).

4 METHODOLOGY

This needs asessment uses a mixture of methods, these are described in the diagram below.
The first two parts of the needs assessment collate the background data on the characteristics of the local population and the prevalence of disease (epidemiological approach); and information comparing local provision and outcomes (comparative approach). The following parts canvass the view of local stakeholders and those using services and the wider population.

Given the paucity of comparative information, this needs assessment was primarily qualitative. The corporate work will, in part, be taken forward by commissioners.

Figure 1 Methodology



4.1 Defining Mental Health and Wellbeing

Mental Health - The World Health Organisation (WHO) defines mental health as *"a state of well-being in which every individual realises 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."*

Alongside the WHO's definition of overall health as *" a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity";* this means it is not just important to consider how to support people with mental health problems or disorders, but also how to promote and sustain good mental health in a population. This also highlights the intertwining of physical and mental wellbeing.

Aligned to WHO descriptions, the national mental health strategy *No Health without Mental Health*: - *"Good or positive mental health is more than the absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and for their communities.".*

Mental health problem - This is an overarching term used to refer to a wide range of diagnosable mental illnesses and disorders, including common mental health problems of low severity and long lasting severe problems.

Mental illness - This is generally used to describe more serious mental health problems which may require specialist services, ranging from depression and anxiety (often referred to as common mental problems) to less common problems such as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness).

Mental Disorder – This is often used to cover a broad range of illnesses, learning disability, personality disorder and substance misuse problems. Under the 2003 Mental Health Act mental disorder was defined as *'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind*' and was divided into a number of classifications. The 2007 Mental Health Act amended to a more general statement and removed specific classifications.

Wellbeing - The concept of "*wellbeing*" has gained a wider public airing following the decision to embark on a national measurement programme developed by the Office for National Statistics (ONS), introduced in 2011. At a personal level wellbeing is *"a positive physical, social and mental state"* at a population, or national level, a range of indicators are being included, individual wellbeing but also the quality of the environment, equality, sustainability and the economy**.**

4.2 Introduction

It is estimated[3] that one in ten children aged between 5 and 16 years has a mental health problem, using this estimate this translates to approx. 10,900 children in West Sussex.

Having a mental health problem in childhood increases the likelihood of having a mental health problem in adulthood. Half of those with lifetime mental health problems first experience symptoms by the age of 14[4]. It is clear that risk factors and certain exposures during the formative stages of life have a direct impact on wellbeing later on in life.

The link between mental health problems in childhood and adulthood has also been captured in the government's '*No Health without Mental Health'* report. The report focusses on promoting good mental health and intervening early, particularly in childhood and teenage years to prevent mental health illnesses from developing and mitigating its effect.

The report sets out six objectives to improve mental health outcomes for individuals of all ages. For children and young people, the main aims of the strategy are:-

1. Improve the mental health and wellbeing of all children and young people and keep them well
2. Improve outcomes for children and young people with mental health problems through high quality services that are equally accessible by all.

In 2012, the Children and Young People's Health Outcomes Strategy established a forum tasked with finding out health outcomes that matter most for children and young people.

A subgroup report on mental health aligns with the Mental Health Strategy. Table 1 overleaf outlines the key points of the report.

[3] Green, H., McGinnity, A., Meltzer, H., et al. (2005). Mental health of children and young people in Great Britain 2004

[4] Kim-cohen J,Ccaspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. Archives of General Psychiatry 60: 709–717; Kessler R, Berglund P,Ddemler o et al. (2005) lifetime prevalence and age-of-onset distributions of dsM-Iv disorders in the national comorbidity survey Replication. Archives of General Psychiatry 62: 593–602

Table 1 Key Points from the Children and Young People's Health Outcomes Forum – Mental Health Subgroup

Outcomes	Priorities
More people with good mental health	Emphasis on a good start to life and effective parenting as key factors for good wellbeing and mental health as well as builds resilience to adversity in later life. Recommendations include:- • Development of School Readiness Assessment • Survey to measure child wellbeing during the primary to secondary school transfer • Role of schools and colleges:- whole school approach to support pupil wellbeing, addressing bullying and ensuring staff are able to recognise signs of mental ill-health and how it effects attendance and attainment.
More people with mental health problems will recover and more people will receive positive experience of care and support	Proposes to monitor referral rates by *problem type* and *demographic profiles* of children and young people referred into services. Involvement of children and young people in shared decision making in the development of care plans and service design, delivery and evaluation
More people with mental health problems will have good physical health	Children and young people with mental health problems have access to health promotion initiatives. Appropriate monitoring of children and young people on ADHD and anti-psychotic medication and the need for long term monitoring of use of ADHD medication.
Fewer people will suffer avoidable harm	Suggestion to monitor rates of admissions to age inappropriate environments including those in secure settings. Indicators addressing suicide rates and hospital statistics on self-harm have been included in Public Health Outcomes Framework (PHOF).
Fewer people will experience stigma and discrimination	Proposal to survey children and young people's wellbeing including measures of stigma and discrimination experienced by children and young people with mental health problem and including the issue of bullying.

4.3 Health and Social Care Outcome Framework

The three outcomes frameworks:-NHS Outcomes Framework (NHSOF), Public Health Outcomes Framework (PHOF) and the Adult Social Care Outcomes Framework (ASCOF) were established to provide a focus for quality improvements across the system. A further framework was developed to provide information about the quality of health services commissioned by CCGs, this is referred to as the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS).

Each framework has a number of outcome indicators which are organised into themes or domains. The table below highlights the relevant indicators on mental health for children and young people.

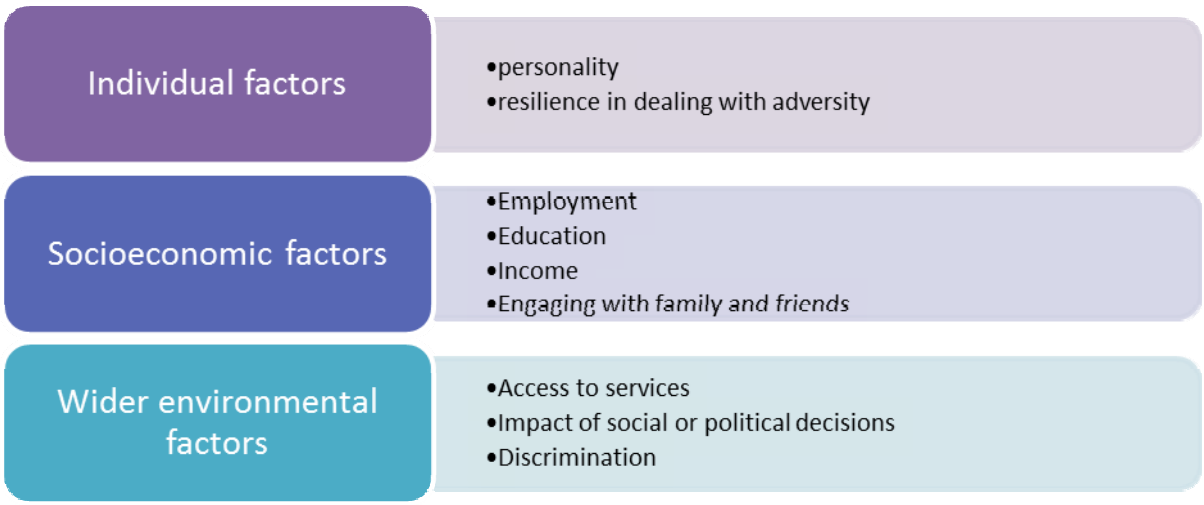
Table 2 Indicators from the frameworks relating to wellbeing and mental health of children and young people

Domain	Ref	Outcome
Public Health Outcomes Framework (PHOF)		
2.Health Improvement	2.05	**Child Development at 2 – 2 ½ years** *(under development)*
	2.08	**Emotional Wellbeing of looked after children** *Average difficulties score for all looked after children aged 4-16 who have been in care for at least 12 months on 31st March* *Data is collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted to the Department for Education through the SSDA903 data return. A higher score indicates greater difficulties.*
	2.10	**Self-harm** *Hospital admissions as a result of self-harm*
NHS Outcomes Framework (NHSOF)		
4.Ensuring that people have a positive experience of care	4.8	**Improving children and young people's experience of healthcare** *(under development)*
5.Treating and caring for people in a safe environment and protect them from harm	5.6	**Delivering safe care to children in acute settings** *Incidence of harm to children due to 'failure to monitor'*

4.4 Determinants of Mental Health and Wellbeing

Mental wellbeing is influenced by a combination of factors, broadly these are divided into individual attributes, socioeconomic factors and wider environmental factors.

Figure 2 Determinants of Mental Health and Wellbeing



Within each, there are some issues which can add to risk and ones which act to increase resilience.

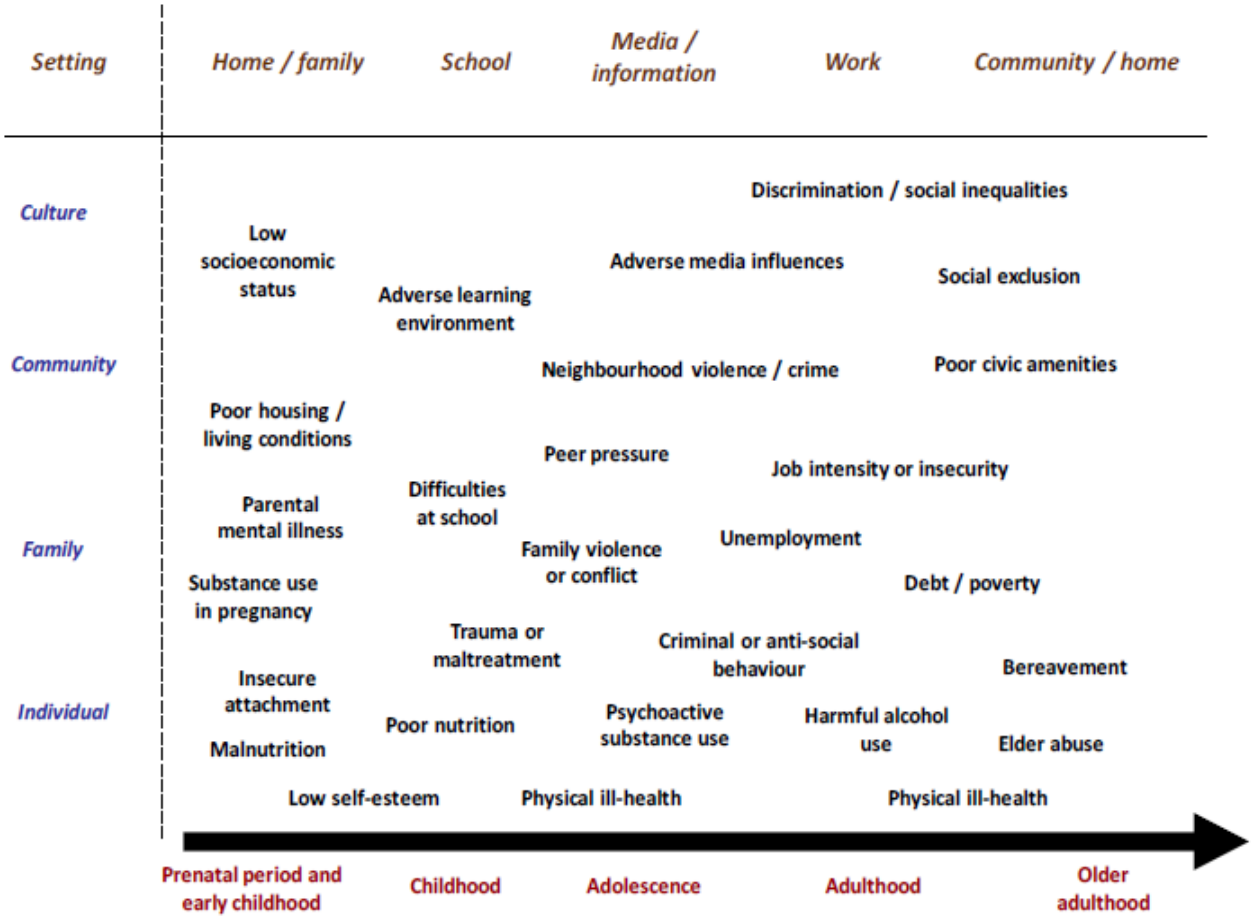
Table 3 Risk Factors and Resilience
(taken from Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors WHO 2012)

Level	***Adverse factors***		***Protective factors***
Individual attributes	Low self-esteem	⇔	Self-esteem, confidence
	Cognitive/emotional immaturity	⇔	Ability to solve problems & manage stress or adversity
	Difficulties in communicating	⇔	Communication skills
	Medical illness, substance use	⇔	Physical health, fitness
Social Circumstances	Loneliness, bereavement	⇔	Social support of family & friends
	Neglect, family conflict	⇔	Good parenting / family interaction
	Exposure to violence/abuse	⇔	Physical security and safety
	Low income and poverty	⇔	Economic security
	Difficulties or failure at school	⇔	Scholastic achievement
	Work stress, unemployment	⇔	Satisfaction and success at work
Environmental Factors	Poor access to basic services	⇔	Equality of access to basic services
	Injustice and discrimination	⇔	Social justice, tolerance, integration
	Social and gender inequalities	⇔	Social and gender equality
	Exposure to war or disaster	⇔	Physical security and safety

Exposures during the formative stage of childhood have an impact on mental wellbeing in later life highlighting how mental health risk factors interact over time and age. The WHO report into vulnerabilities and risk factors to mental health considers the life-course approach on the importance of risks presenting at different life stages impacting on wellbeing in later life.

Circumstances at home and school influence child development and emotional wellbeing. Supportive families, housing conditions, access to material things, connectedness to school, social interaction with friends and a positive learning experience are protective factors. Exposure to events including abuse and parental loss can have long-term implications. Exposure to different risks change over a life course.

Figure 3 Schematic overview of risks to mental health over the life course
(Source: Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors WHO 2012)



4.5 Information And Recommendations From Recent Health Needs Assessments In West Sussex

There have been a number of health needs assessments and local research which have included mental health issues, these are summarised below.

Note : Full copies of these reports are available on the West Sussex JSNA website.

4.5.1 CHILDREN AND ADOLESCENT MENTAL HEALTH (CAMHS) NEEDS ASSESSMENT (2009)

The last children and young people emotional wellbeing assessment was carried out in 2009.
The key findings from 2009 were:-

Tier 1

- Professionals lack the knowledge, skills, training or interest to address mental health problems and these issues are addressed effectively when professionals are motivated and skilled to do so. GPs are unsure of the referral pathway and services available.
- Children and Family centres (which were being developed when the report was written) needs to carry out outreach services to target families that need support
- Increasing number of schools keen to provide more specialist support to address problems.

Tier 2

- Clear gaps in services leading to other services/professionals picking up Tier 2 level work such as school nurses and health visitors. Other gaps in services addressing all mental health and developmental disorders at this level and services at Tier 1 and 3 are not commissioned to address these needs.

Tier 3

- Lack of diagnosis and outcome data available for providing information and analysis of whether services are meeting needs
- CAMHS specialist services are meeting the 18 week target although waiting lists into it is considered a major issue for Tier 1 practitioners.

Tier 4

- At the time that this report was being written, provision of specialist service within West Sussex for eating disorders was being considered.

2009 CAMHS Needs Assessment - Recommendations

- Provide good universal services.
- Promote maternal mental health.
- Parenting skills in infancy and early childhood.
- Specific mental health disorder interventions – ensuring NICE guidelines for identifying and addressing specific mental health disorders are implemented.
- Professionals in touch with children and young people need to recognise and act upon the contribution they make to supporting their mental health needs
- Better collection of data on children at risk, collection of key information on all children and young people aged 0-19 years and information sharing protocols.
- Services to help children, young people and parents by listening to their needs, knowing what is available and directing them in the right direction.

4.5.2 THORNEY ISLAND HEALTH AND WELLBEING NEEDS ASSESSMENT (2012)

Report on the health and wellbeing of families of personnel stationed at Thorney Island, West Sussex. Prevalence of mental health problems within military families is thought to be higher than the general population. Parental deployment can lead to feelings of fearfulness and increased behavioural problems and emotional problems.

Recommendation: Services need to build emotional resilience and respond to mental health problems of children throughout deployment and beyond.

4.5.3 VULNERABLE AND LOOKED AFTER CHILDREN NEEDS ASSESSMENT (2009)

Issues identified in relation to CAMHS service

- Interviews with professionals within specialist CAMHS services recognise that the service is highly valued. However, waiting times and lack of resources are significant problems. In addition, they mentioned that those with lower level mental health problems are not able to access services.
- Focus groups with young people revealed that they did not think that professionals picked up on mental health problems

Emotional and psychological wellbeing

- Preventative work around emotional and psychological wellbeing was neglected in the past, although more is being done now
- Lack of access to psychological support was considered to be one of the most significant barriers in meeting the needs of vulnerable children.
- ***Recommendation:*** Investment in psychological support services and reviewing the care pathway especially CAMHS.

Perceptions of young people in care

- Young people are affected by stigma around receiving support such as mental health services

4.5.4 HEALTH AND SOCIAL CARE NEEDS OF GYPSIES AND TRAVELLERS (2010)

This report assesses the health and social care needs of Gypsies and travellers in West Sussex. As interviews were carried out with adults, more information relating to mental health related to adult mental health. However, parental mental health does impact on the rest of the family.

Mental health problems were identified as being widespread in the community, including anxiety, depression, paranoia and panic attacks. Living arrangements, accommodation and pressures of travelling have been cited as some of the main reasons for poorer mental health.

Other issues that were raised include poverty, financial difficulties, racism, discrimination and social isolation. Among children, the main issues faced are bullying and racism.

Awareness of mental health services was through word of mouth or referral from GPs. However, fear of mental illnesses or mental health services prevents more people from seeking support and treatment.

4.5.5 LIFESTYLES OF 14-15 YEAR OLDS IN WEST SUSSEX 2010, PUBLIC HEALTH RESEARCH UNIT

This survey, carried out in 2010, examined the attitudes and lifestyles of young people aged 14-15 (Year 10) in West Sussex. A total of 1,700 children responded to the survey.

Approximately 19% of pupils said they were bullied at school during the previous past year. A significant proportion of pupils were bullied weekly (33%) while 18% said they were bullied every day. Bullying clearly impacted on emotional wellbeing with higher percentage of victims of bullying having low self-esteem, feelings of being regularly stressed and depressed compared to pupils who are neither perpetrators nor victims.

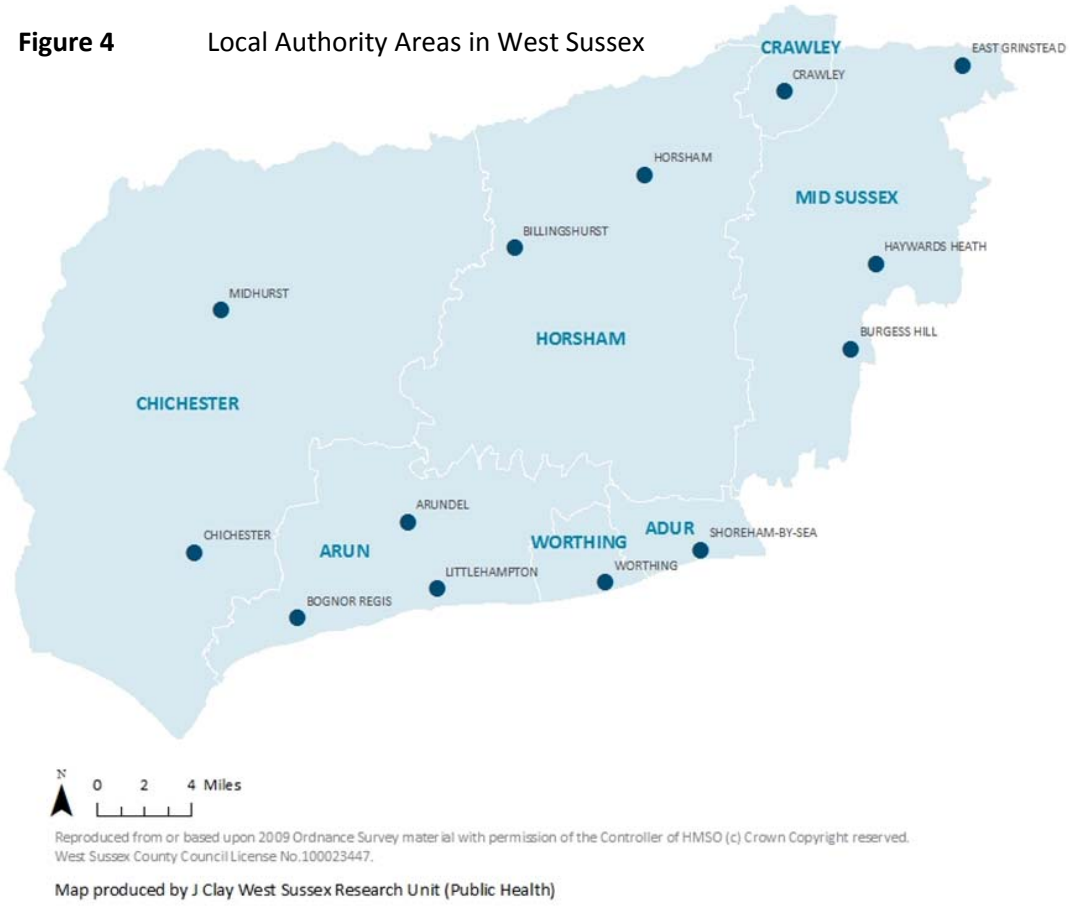
On emotional wellbeing, girls were twice as likely to report feeling stressed and depressed than boys (19.2% and 9.2%), which mirrors results found from other reports. Depression was strongly correlated with self-perceived health. Pupils from poorer backgrounds were more likely to report negative emotional wellbeing, which supports the association found between socioeconomic deprivation and poorer mental wellbeing.

Note this survey has recently (March 2014) been repeated, results for the 2013/14 surveys should be available by August 2014.

5 POPULATION CHARACTERISTICS AND PREVALENCE

West Sussex is a large county covering some 770 square miles, and comprises a coastal strip with a series of medium size coastal towns (Shoreham, Worthing, Littlehampton, Bognor), small to medium size towns in relatively rural areas (Petworth, Midhurst, Storrington, Burgess Hill, Arundel) and large town centres (Chichester, Crawley, Horsham, Haywards Heath). This needs assessment covers a geographical area containing seven Local Authorities (shown on Figure 1) and three Clinical Commissioning Groups, Figure 2 overleaf.

Figure 4 Local Authority Areas in West Sussex



Map produced by J Clay West Sussex Research Unit (Public Health)

Table 4 Population by Local Authority Areas 2011

Area	Total	Age Groups			
		0 - 15	16 - 64	65 & over	18 - 24
West Sussex	808,900	145,200	495,700	168,100	58,700
Adur	61,300	10,600	37,200	13,600	4,300
Arun	149,800	23,400	86,800	39,600	10,600
Chichester	114,000	18,600	67,300	28,100	9,100
Crawley	107,100	22,200	71,300	13,600	9,100
Horsham	131,500	24,500	81,100	25,900	8,500
Mid Sussex	140,200	27,100	87,500	25,600	9,300
Worthing	105,000	18,700	64,500	21,800	7,800

Source : ONS Mid-Year Estimates 2011

Figure 5 Clinical Commissioning Group Geographies in West Sussex

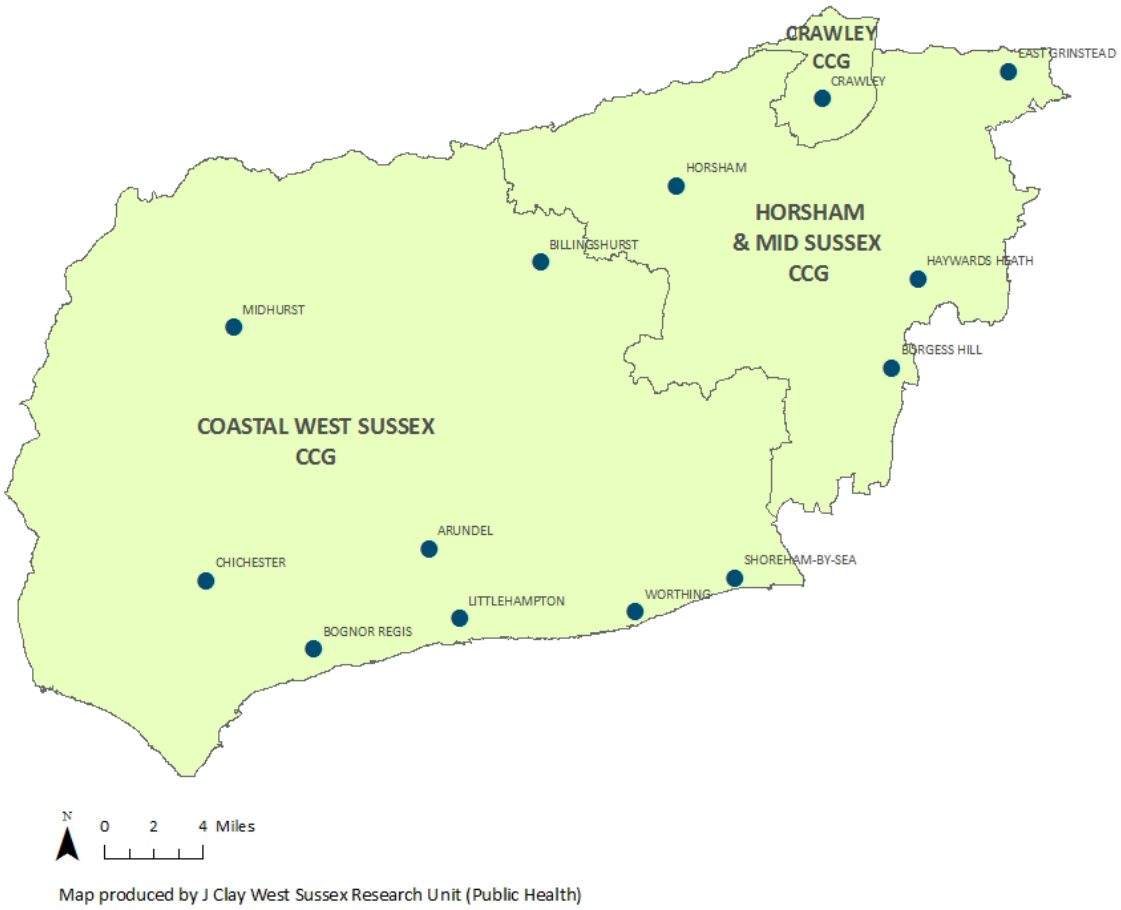


Table 5 Population (Resident and Registered Patients) by CCG Area

Resident Population	Total	% Population 0-15	Specific Age Groupings			
			0 - 15	16 - 64	65 & over	18 - 24
West Sussex	808,900	18.0%	145,200	495,700	168,100	58,700
Coastal CCG	480,030	16.6%	79,910	284,950	115,180	34,720
Crawley CCG	107,050	20.7%	22,190	71,300	13,560	9,250
Horsham & Mid Sussex CCG	221,830	19.3%	42,840	139,680	39,310	15,630
Registered PATIENT Population	Total	Total 0-15 Population	Specific Age Groupings			
			0 – 15	16 – 64	65 & over	18 - 24
Coastal CCG	490,935	16.3%	79,913	291,129	119,893	58,606
Crawley CCG	127,072	20.1%	25,506	84,730	16,836	18,012
Horsham & Mid Sussex CCG	227,203	18.6%	42,214	142,199	42,790	27,681

Source: *Resident* population – ONS MYE 2011, Registered *Patient* Population Exeter 2013

Table 6 Younger Age Groups Broken Down

	All Ages					
	Total Pop	0-4	5-9	10-14	15-19	20-24
Coastal West Sussex	480,030	25,500	23,920	25,200	26,420	24,150
Crawley	107,050	8,140	6,550	6,250	6,250	6,750
Horsham and Mid Sussex	221,830	13,030	12,940	14,120	13,720	10,140
Total	808,920	46,670	43,420	45,570	46,400	41,040

5.1 Projected Change in Population

NOTE: *The projections included in this report show projected population change to 2021. These are Sub National Population Projections (SNPP) produced by ONS in 2013. These are not constrained in relation to housing provision and will be revised when detailed Census 2011 is released in the autumn of 2013.*

Projections provided by ONS are currently available by local authority geographies. The figures below have been estimated at CCG level, using these ONS projections, by the West Sussex Public Health Research Unit.

All projections should be treated with caution and the current ONS projections will be revised in 2014 incorporating data from the 2011 Census.

5.1.1 Projected Population Change

Between 2011 and 2021, it is estimated that the population will increase by 10% in West Sussex. The 0-15 year old population is projected to increase by 13% which is higher than the 4.6% increase in the 16-64 population but lower than the 23% increase in the 65-84 year old population. This population increase should be factored into future service planning and commissioning.

Table 7 Projected population change 2011-2021

Age Group	2011 (MYE)	2021 Projection	% Projected Change
Total	808,920	891,840	10.3%
0-4	46,670	49,760	6.6%
5-9	43,420	54,060	24.5%
10-14	45,570	51,120	12.2%
15-19	46,400	44,440	-4.2%
20-24	41,040	37,630	-8.3%

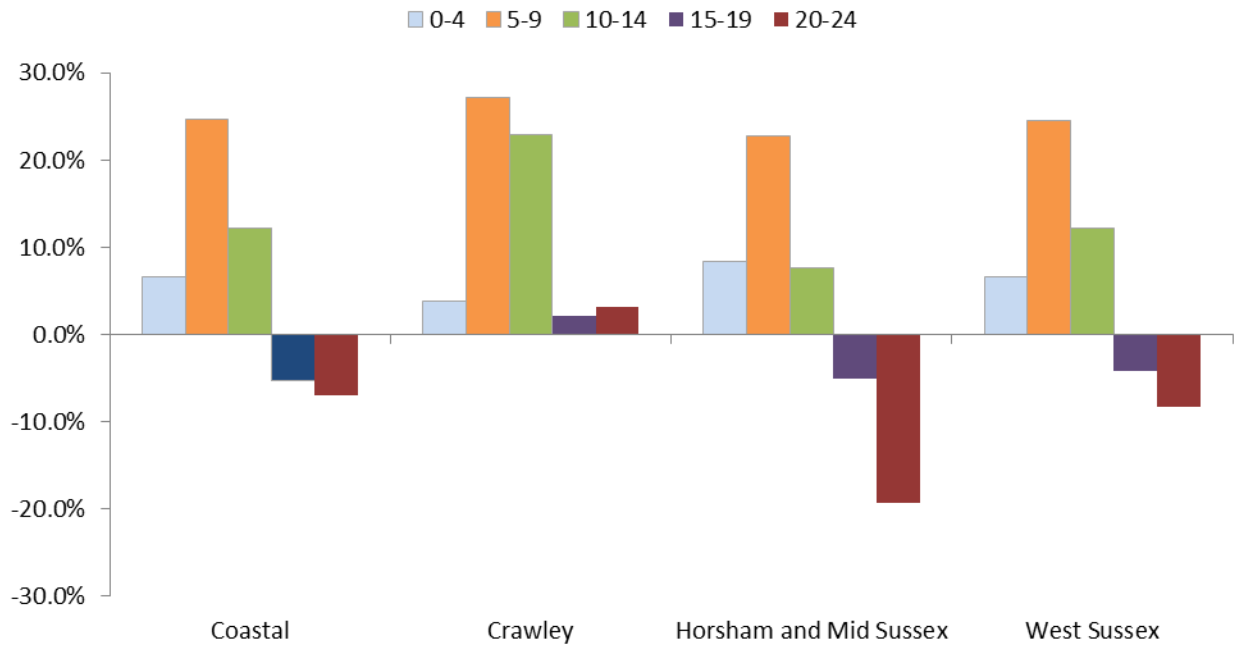
5.1.2 CCG Population Projections

Figure 7 shows the projected population change between 2011 and 2021 for all CCG localities and West Sussex between 0-24 years. Overall the 0-24 year old population is estimated to increase by 6.2% in West Sussex. *Again all projections , and notably those below county level, should be treated with caution.*

Population projections for CCG localities estimate that Crawley CCG will experience the highest increase, with a 11.4% increase, in the 0-24 year olds; Horsham and Mid Sussex CCG will experience the lowest increase at 3.8%

While the population in Crawley is expected to increase across all age groups, the remaining geographies show that the 15-24 year old population is expected to decrease. This is particularly apparent for Horsham and Mid Sussex CCG where the 20-24 year old population is estimated to decrease by 19.3%.

Figure 6 Projected Percentage Change 2011 – 2021 for CCG Localities and West Sussex



Source: West Sussex Public Health Research Unit

5.2 DEPRIVATION

Deprived areas have higher rates of poor mental health, higher admission rates to hospital and higher recorded prevalence of adult patients on the serious mental health register. In relation to children poverty is an adverse risk factor for poorer mental health.

There are two main sources of information relating to the *overall* level of deprivation experienced by people within specific areas or neighbourhoods, DCLG rankings (Indices of Deprivation 2010) and data collated from the decennial census.

The Indices of Deprivation is produced every 3-4 years and published by the DCLG; it ranks each small area of England and Wales in terms of deprivation and its findings are incorporated into many Government allocation formulae. The latest indices were published in 2010.

Using information from ID2010, West Sussex is a relatively affluent county however county level data masks considerable differences within areas and there are some very deprived neighbourhoods. In 2010 West Sussex ranked 130th out of 152 upper-tier authorities on the Indices of Deprivation; in 2007 West Sussex ranked 132nd. West Sussex may have become relatively more deprived although the change may not be significant. In relation to neighbouring authorities, West Sussex is relatively less deprived than East Sussex (ranked 90th) and Brighton and Hove (ranked 53rd); more deprived than Hampshire (ranked 141st) and Surrey (ranked 150th).

Table 8 Ranking of West Sussex Against neighbouring Upper Tier Authorities ID2010
(Ranking out of 326 LAs. The most deprived LA is ranked 1)

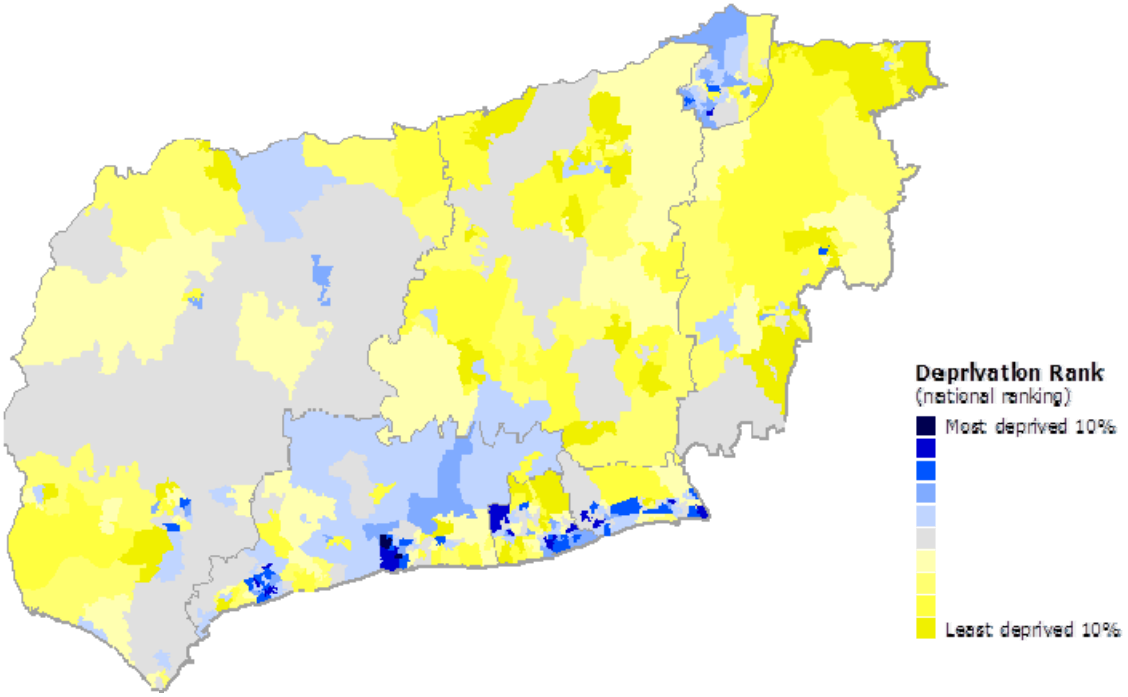
	Rank 2004	Rank 2007	Rank 2010
West Sussex	135	132	130
Brighton and Hove	62	59	53
East Sussex	103	95	90
Hampshire	142	141	141
Surrey	150	150	150

Source: DCLG

The most deprived lower-tier authority in West Sussex is Adur (ranked 145th out of 326 local authorities), the least deprived Mid Sussex (ranked 315th). In relation to "neighbourhood level" deprivation, West Sussex has three small areas (within River and Ham wards in Littlehampton) falling in the 10% most deprived areas in England. At *ward* level River and Ham wards are within the most deprived 10% in England, a further seven wards are within the most deprived 20% in England . Decline in coastal areas, such as Littlehampton, is in line with the wider national picture of coastal decline, for example areas such as Eastbourne and Hastings and coastal resorts in Kent becoming more deprived.

Figure 7 Overall Deprivation in West Sussex

- This maps shades small areas according to their relative deprivation ranking.
- The most deprived areas are shaded dark blue, and the least deprived shaded dark yellow.
- The darkest blue shading represents areas within the most deprived 10% in England.



In relation to Lower Super Output Areas the following were in the most 10% (dark blue shaded) and 20% deprived (light blue) of all LSOAs in England

Table 9 Most Deprived Neighbourhoods In West Sussex

LSOA	District	Ward	IMD National Overall Ranking (out of 32468)
E01031427	Arun	Ham	1,764
E01031456	Arun	River	2,616
E01031429	Arun	Ham	2,783
E01031454	Arun	River	3,270
E01031819	Worthing	Northbrook	3,650
E01031404	Arun	Bersted	3,704
E01031779	Worthing	Broadwater	3,753
E01031808	Worthing	Heene	3,812
E01031790	Worthing	Central	4,023
E01031436	Arun	Marine	4,120
E01031432	Arun	Hotham	4,507
E01031558	Crawley	Broadfield South	4,553
E01031450	Arun	Pevensey	5,018
E01031371	Adur	Southlands	5,399
E01031348	Adur	Eastbrook	5,627
E01031811	Worthing	Heene	5,952
E01031341	Adur	Churchill	6,047
E01031361	Adur	Peverel	6,274
E01031783	Worthing	Castle	6,437

5.2.1 DEPRIVATION INFORMATION FROM THE 2011 CENSUS

The 2011 census collected a wide variety of information which can, in combination, be used to identify some of the characteristics common to deprived households. Census data are available at smaller geographies than the ID2010, down to output areas level (covering approximately 100 households); this is useful in West Sussex as in some areas deprivation is concentrated in small neighbourhoods, where affluence and deprivation are "cheek by jowl".

The census examines four dimension of deprivation:-

- Employment *(deprivation identified where any member of a household not a full-time student is either unemployed or long-term sick).*
- Education *(deprivation identified where no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student)*
- Health and disability *(deprivation identified where any person in the household has general health 'bad or very bad' or has a long term health problem).*
- Household overcrowding *(deprivation identified when the household accommodation is either overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating.)*

Information is provided where households have none of the above, and where households "score" on one, two, three or score on all dimensions of deprivation.

The two maps below show areas which have households which have at least one measures of deprivation and the second map shows the percentage of households which have 3 or 4 measures of deprivation. Using the census 2011 groupings these represent the most deprived areas in the county.

Figure 8a
Households with At Least One Deprivation Measure Deprivation
Source: Census 2011

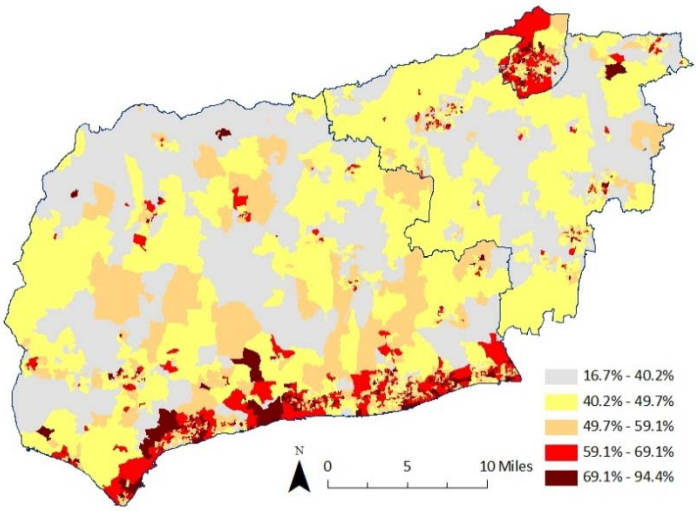
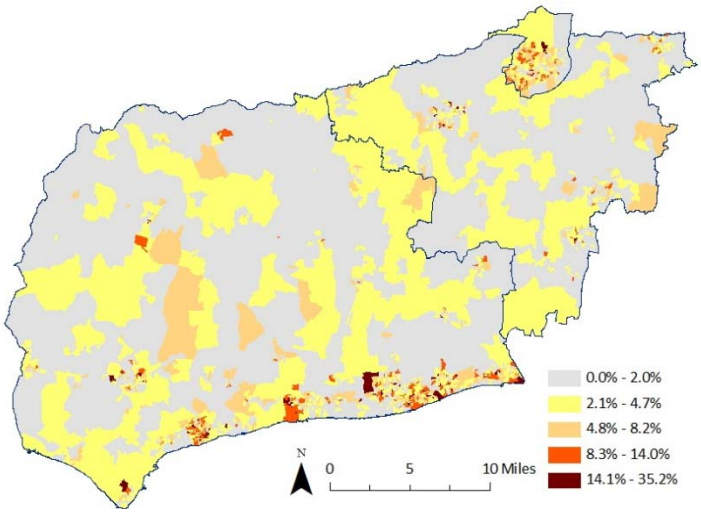


Figure 8b
Households with 3 or 4 Measures of Deprivation
Source: Census 2011



6 PREVALENCE ESTIMATES

In 2004 ONS conducted a national survey[5] of approx. 8,000 families in order to estimate the prevalence of mental disorders in children. This initial survey was then followed up three years later to determine the *persistence* of mental disorder. This study remains the largest study undertaken in the UK and is widely used as the source for prevalence assumptions. Unfortunately, there is a lack of *current* and r*egular* data on the prevalence of mental health disorders among children and young people, it is therefore hard to estimate where changes in prevalence have occurred.

Overall Key Points

- Prevalence of problems differs by age and gender. Overall 10% of 5-16 year olds were found to have a mental health disorder; 7.7% of 5-10 year olds and 11.5% of 11-15 year olds.
- Among boys, 10.4% of 5-10 year olds have a mental health disorder rising to 12.8% of boys aged 11-15 year olds. For girls, the rate increases from 5.9% at age 5-10 years to 9.7% at age 11-15 years.
- Overall the most common mental disorders amongst the young are anxiety, depression, eating disorders, conduct disorders, attention deficit hyperactivity disorder (ADHD) and self-harm. The most common issue for boys are conduct disorders while for girls they are emotional disorders.

Table 10 Percentage of Children with a Mental Health Disorder

	5-10 year olds			11-15 year olds			Total		
	Girls	Boys	All	Girls	Boys	All	Girls	Boys	**All**
Less common disorders	0.4%	2.2%	1.3%	1.1%	1.6%	1.4%	0.8%	1.9%	**1.3%**
Hyperkinetic disorders	0.4%	2.7%	1.6%	0.4%	2.4%	1.4%	0.5%	2.6%	**1.5%**
Emotional disorders	2.5%	2.2%	2.4%	6.1%	4.0%	5.0%	4.3%	3.1%	**3.7%**
Conduct disorders	2.8%	6.9%	4.9%	5.1%	8.1%	6.6%	3.9%	7.5%	**5.8%**
Any disorder	5.1%	10.2%	7.7%	10.3%	12.6%	11.5%	7.8%	11.4%	**9.6%**

Source: ONS 2004. *Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life*

Less common disorders include autistic spectrum, eating disorder
Hyperkinetic disorder include Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD)
Emotional disorders include: separation anxiety, specific/social phobia, generalised anxiety disorder and depression.
Conduct disorders include: oppositional defiant disorder, socialised and unsocialised conduct disorder

[5] Green H, McGinnity A, Meltzer H, Ford T, Goodman R. Mental Health of Children and Young people in Great Britain 2004. Office for National Statistics on behalf of the Department of Health and Scottish Executive. Crown Copyright 2005.

6.1 MENTAL HEALTH DISORDERS - SUMMARY

Group	Estimate	Description
Conduct disorders	6% of children aged 5–15	Conduct disorders - severe and persistent disobedience and defiance. Typical behaviour includes - unusually frequent and severe temper tantrums, - excessive levels of fighting and bullying, - cruelty to others or animals, - running away from home and criminal behaviour.
Emotional/ anxiety disorders	4% of children aged 5–15	Include anxieties, phobias and depression. Symptoms of depression include sadness, loss of interest in activities, changes in appetite, sleep disturbance and tiredness, difficulty concentrating, feelings of guilt and worthlessness, and suicidal thoughts. Anxieties and phobias are related to fear, which can either be generalised or specific to a situation or object—for example, school or separation from a parent.
Hyperkinetic disorders	1.5% of children aged 5–15	Hyperkinetic disorders prevent children from learning and playing as they should. They make children very overactive and restless, and can damage their relationships with other children and adults. Common symptoms include a short attention span, restlessness, being easily distracted, and constant fidgeting. Attention-deficit hyperactivity disorder (ADHD) and attention-deficit disorder (ADD) are also commonly-used terms for less severe hyperkinetic disorders.
Developmental disorders	1% of children aged 5–15	Developmental disorders include autistic spectrum disorders and associated learning disabilities that typically affect a child's ability to communicate, learn, or interact with others. They usually affect children from an early age and persist into adulthood.
Eating disorders	1–2% of young women; 0.1% of young men	Including anorexia nervosa, bulimia nervosa and binge eating and restrictive eating.
Psychotic disorders	0.2% of 16–25	Psychotic disorders cover a range of conditions where a person suffers from symptoms such as delusions and hallucinations. Schizophrenia can involve episodes during which reality is perceived differently Do not usually emerge until late adolescence.
Self-harm	6.7% of young people	Self-harm is not strictly a disorder in itself, but often the symptom of an underlying mental health problem. It is the way that some young people deal with psychological distress. It can include cutting, burning or poisoning oneself, and taking overdoses. Young people aged 11–24 are many times more likely to self-harm than any other age group.

Reproduced from *Heads Up: Mental health of children and young people* Paul Hamlyn Foundation 2008

6.1.1 CO-MORBIDITY

Some children and young people will have more than one mental health problem (co-morbidity). The ONS study in 2004 found that 1 in 5 children with a mental health disorder had disorders in more than one category. Co-morbidity can make assessment, diagnosis and treatment more complex. In relation to children seen by a CAHMS service, the Royal College of Psychiatrists 2010 handbook cites Audit Commission findings that found 95% of children attending CAMHS have more than one diagnosis.

6.2 APPLYING PREVALENCE ASSUMPTIONS TO LOCAL POPULATION

The table below shows the prevalence of some of the most common mental health disorders as well as the prevalence of having any mental health disorder.

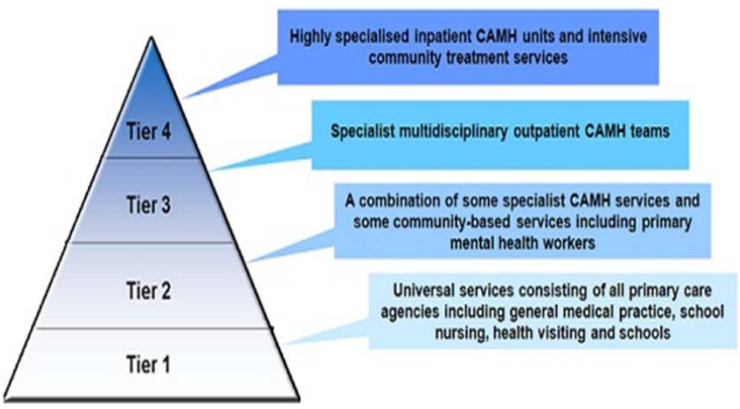
Table 11 Estimate of the Number of Children (5-16 years) with a Mental Health Disorder

	Population 5-16 years	Any disorder	Conduct disorders	Emotional disorders	Hyperkinetic disorders	Less common disorders
Coastal West Sussex	59,690	5,730	3,460	2,210	900	780
Crawley	15,300	1,470	890	570	230	200
Horsham & Mid Sussex	32,550	3,120	1,890	1,200	490	420
Total (West Sussex)	107,550	10,320	6,240	3,980	1,610	1,400

6.3 PREVALENCE BY SERVICE "TIER"

Services mental health are often described in terms of "tiers" , where services become more specialised the further up the tier, from emotional wellbeing services at Tier 1 to highly specialist outpatient teams and inpatient provision at Tier 4. Prevalence estimates based on findings published in "Treating Children Well" (Kurtz, 1996) are shown below against each of the tiers, prevalence and estimates based on population aged 17 years or under. These provide an estimate of young people who, may at any one time, need a service response or support.

Figure 9 **Service Tiers**



Prevalence Assumption	Children in West Sussex
0.075%	90
1.85%	2,220
7%	8,420
15%	18,040

6.4 EVIDENCE FROM SURVEYS OF CHILDREN AND YOUNG PEOPLE IN WEST SUSSEX

Tellus was a national survey that gathers the views of children and young people in year 6, 8 and 10 about their lives, school and their local area. The last survey *Tellus* 4 was released in March 2010; the survey has now been discontinued.

Results from the 2010 survey found:

- The majority of children and young people say they feel happy with life and have someone to talk to.
- Boys were more likely to report feeling happy with life than girls (72% v's 62%). However, 72% of girls were more likely to talk to friends when they were worried compared to 59% of boys.
- Children and young people with a disability were less likely to report that they were happy, and less likely to have friends or friends they could talk too when they were worried.
- Bullying is a problem experienced by half of the children who participated in the survey and about a quarter worry about being bullied.
- School is the main place where bullying occurs with 46% of children and young people being bullied in school and a further 21% said this happened when they were not in school.
- Children and young people who are disabled and from White other ethnic backgrounds reported higher percentages of being bullied in school recently.

6.5 ADDITIONAL NOTES ON SPECIFIC DISORDERS

6.5.1 EATING DISORDERS

The most common eating disorders are anorexia, bulimia and "eating disorders not otherwise specified" (EDNOS), these tend to start during adolescence. It is estimated that for those with eating disorders, 10% have anorexia, 40% have bulimia and the remaining fall under the EDNOS category. It is more common in women although the incidence is increasing among boys and men. Around 1 in 250 teenage girls and 1 in 2,000 teenage boys have anorexia. Although bulimia is more common, anorexia is the main reason for hospital admissions.

Eating disorders are complex and there may be multiple factors which lead some people to develop a disorder, but some common traits have been identified including low self-esteem, lack of social skills, and a tendency to be a perfectionist Women aged 15 to 25 are more at risk but anyone can develop a disorder.

A small number of studies have been undertaken to identified the prevalence of disorders in the UK.

In relation to adults, the Adult Psychiatric Morbidity Survey (APMS) 2007 introduced, for the first time, screening questions relating to eating disorders. The screening tool (called SCOFF tool) was supplemented with an additional question, for those scoring 2 or more on the impact of behaviour on social participation.

The SCOFF screening questions, amended for use on APMS 2007:

In the last year

1. Have you lost more than one stone in a three month period? Yes/No
2. Have you made yourself be sick because you felt uncomfortably full? Yes/No
3. Did you worry you had lost control over how much you eat? Yes/No
4. Did you believe yourself to be fat when others said you were too thin? Yes/No
5. Would you say that food dominated your life? Yes/No

Supplementary question – (asked of respondents scoring two or more on the SCOFF): 'Did your feelings about food interfere with your ability to work, meet personal responsibilities and/or enjoy a social life?'

Saying yes to two or more questions represented a positive screen for eating disorder and indicated that that clinical assessment for eating disorder is warranted.

APMS 2007 found that:-

- 6.4% of adults screened positive for a *possible* eating disorder in the past year and the proportion who screened positive and also responded yes to the supplementary question was 1.6%.
- Eating disorders more likely in women than men (9.2%in women compared with 3.5% in men, with young women 20 times more likely than older women.
- Ethnicity and household income were *not* significantly associated with a positive screening.

6.5.2 SUICIDE and SELF HARM

Suicide - The Mental Health Foundation report[6] that in relation to young people bullying, family turmoil, mental health problems, unemployment and a family history of suicide act to increase the risk of suicide. The majority of suicides at, all ages, are male, and one in three young people who commit suicide were found to have been drinking at the time of their death.

Self-harm –An estimated one in fifteen young people are estimated to have self harmed at one time[7]. For most people, self-harm is a mechanism used to cope with a situations including social issues (bullying, difficult relationships with family and friends), trauma (physical or sexual abuse) or as a way of dealing with a mental health condition such as depression. Self-harm is more common in teenage girls and in people aged 11-25 years (Association for Young People's Health 2013).

As it is often carried out discreetly, it is difficult to identify and treat people who are self-harming. For this same reason, it is difficult to find a reliable source on the prevalence of self-harming in young people. Rates are known to be higher for those in the youth justice system. In relation to unintentional and deliberate injuries West Sussex has a high hospital admission rate for people aged

[6] Mental Health Foundation Retrieved December 14, 2013, from http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/suicide/

[7] Camelot Foundation and Mental Health Foundation (2006) Truth Hurts: Report of the National Inquiry into Self-harm among Young People.

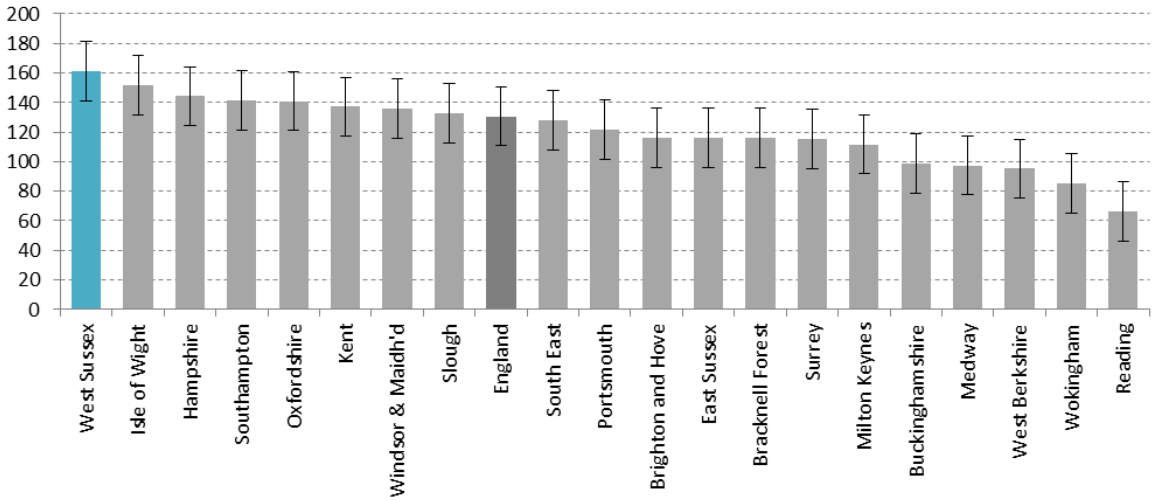
15-24 years, in 2012/13 there were approximately 1,400 admissions. The rate has been falling in recent years.

Table 12 Crude rate of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years), per 10,000 resident population 2012/13

	West Sussex Rate	*Lower CI*	*Upper CI*	England
2010/11	168.6	*166.1*	*177.5*	154.2
2011/12	164.9	*156.5*	*173.6*	144.7
2012/13	161.0	*152.7*	*169.7*	130.7

Source: PHE PHOF Outcomes (http://www.phoutcomes.info)

Figure 10 Crude rate of hospital admissions (2012/13) South East Upper Tier Authorities



6.5.3 AUTISM

A range of conditions are grouped under the term autism and these are broadly outlined on the table below *(adapted from ICD-10, Diagnostic Statistical Manual IV and the National Autistic Society website)*

Autistic Disorder (also known as Classic Autism or Kanner‟s Autism)	Autistic Disorder is considered to be at the severe end of the Autistic Spectrum. It is characterised by the presence of the "triad of impairments", which include impairments in: (1) social interaction abilities; (2) communication abilities; (3) presence of repetitive, stereotyped behaviours. Onset is before the age of 3 years. The presentation of the disorder is different across individuals depending on their developmental level and chronological age.
Asperger Syndrome (AS)	Asperger Syndrome is also characterised by the presence of the triad of impairments, however there is no delay in the development of language and IQ is in the average to above average range (IQ≥70). Difficulties in motor skills and coordination are often present.
Pervasive Developmental Disorder- Not Otherwise Specified (Also referred to as "Atypical Autism- ICD-10)	This diagnosis is given if the criteria for another autistic disorder is not met (i.e. one of the triad of impairments may not be present or it is difficult to determine whether onset was before age 3).
High Functioning Autism (HFA)	High Functioning Autism is not currently recognised by either the ICD-10 or the DSM-IV, but is nevertheless referred to in the literature. Those with High Functioning Autism also present with the triad of impairments and language delay in childhood, but are found to have IQ levels in the normal range (IQ≥70). Adults with HFA present similarly to those with Asperger Syndrome.

In terms of a prevalence assumption on the number of young people in West Sussex with autism:

- There is no single source or register and setting one up would be difficult to maintain.
- Not all people will have been diagnosed and some people may have been "mis-diagnosed".
- There are also inconsistencies in how agencies record autism.
- There may be enduring problems of childhood mis-diagnosis or some people only being diagnosed in adulthood. There is some evidence of poor identification of adults with autism compared with children. A GP practice audit in Brighton and Hove in 2010 found that prevalence amongst patients under 18 was approx. 1-2% but was around 0.1% for patients aged 18+.

Even where a diagnosis has been made, it is important to note that different conditions are likely to be diagnosed at different ages, and there are some common mis-diagnoses.

- Frith (2009) found that, in relation to autism, average age of diagnosis was within primary schools years (often by age of 6).
- Atwood (1997) found Asperger's syndrome diagnosis not until secondary school (by 14 years) or early adulthood.
- Many adults do not receive a diagnosis or maybe mis-diagnosed including as depression or a personality disorder or as psychosis or schizophrenia.

In relation to autism three recurring risk factors are identified:-

- *Male* – more men than women likely to have autism,
- *Learning disability* – although the evidence is complex, approx. 20-30% of people with a diagnosed learning disability are thought to have autism,
- *Epilepsy* – strong evidence on prevalence of Autism and epilepsy.

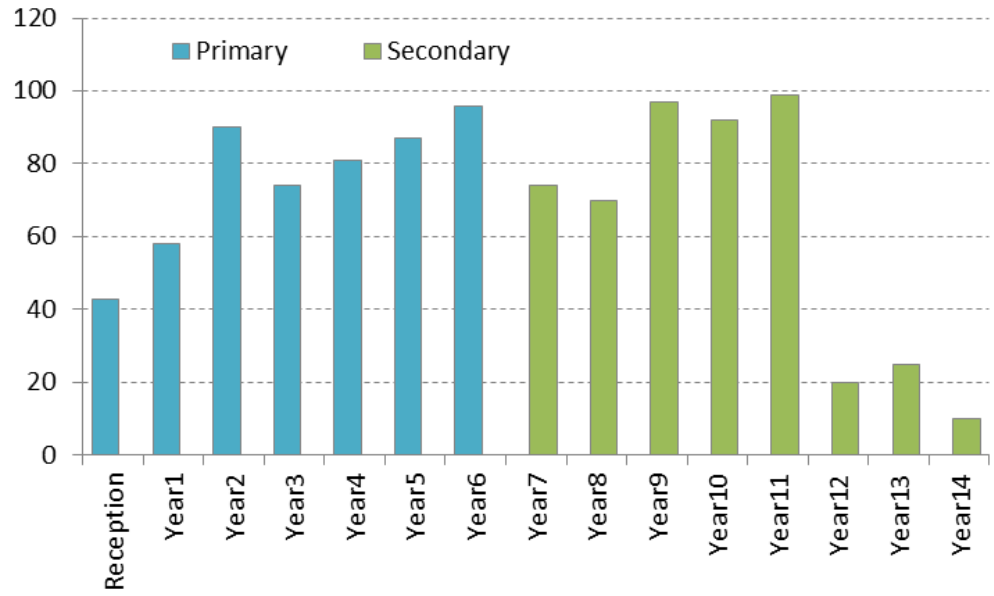
Recorded prevalence of autism in children and young people in West Sussex

Two key sources of recorded prevalence have been explored, school SEN data and Connexions data. *It should be noted that there will be children with autism not identified in schools or via Connexions and some children may be mis-diagnosed.*

Children with Special Education Needs Identified as Having Autism

Using information from the 2011 School Census approximately 1,000 children and young people in West Sussex were identified as having ASC. Over 85% are boys.

Figure 11 SEN / Autism



Source : SEN Data WSCC – data relates to 2011. *This data relates to children in state maintained schools with a home postcode within West Sussex.*

Connexions Data (date provided November 2012) – data relate to Young People Aged 14 -19

300 young people with autism (aged 14-17 years) and 175 young people with Asperger's (aged 14-17 years) were known to Connexions. This provides an idea of the number of young people who may need support during transition from childhood into young adulthood.

Table 13 Young People with Autism and Asperger's identified by Connexions

Autism

Gender	Age				
	14 years	15 years	16 years	17 years	Total
Female	4	13	15	11	43
Male	63	57	75	60	255
Total	67	70	90	71	298

Asperger's

Gender	Age				
	14 years	15 years	16 years	17 years	Total
Female	3	8	6	8	25
Male	26	34	46	44	150
Total	29	42	52	52	175

Source: WSCC

6.6 ADULT / TRANSITION AGE GROUPS

The 2004 ONS study used in the prevalence estimates above related to children aged 5-16 years. For young adults (16 to 24 years) table 14 below shows how many 16 to 24 year olds would be expected to have a disorder if nationally researched prevalence rates were applied to the population of West Sussex.

Table 14 Prevalence of Common Mental Disorders for people aged 16-24 years in West Sussex and CCGs

	West Sussex		CCG		
			Coastal	Crawley	Horsham & Mid Sussex
MEN	**%**	**Count**	**Count**	**Count**	**Count**
Mixed anxiety & depressive disorder	8.2	3,260	1,890	480	900
Generalised anxiety disorder	1.9	760	440	110	210
Depressive episode	1.5	600	350	90	170
All phobias	0.3	120	70	20	30
Obsessive compulsive disorder	1.6	640	370	90	180
Panic disorder	1.4	560	320	80	150
Any CMD	13	5,170	2,990	750	1,430
WOMEN					
Mixed anxiety & depressive disorder	12.3	4,710	2,740	730	1,240
Generalised anxiety disorder	5.3	2,030	1,180	310	540
Depressive episode	2.9	1,110	650	170	290
All phobias	2.7	1,030	600	160	270
Obsessive compulsive disorder	3.0	1,150	670	180	300
Panic disorder	0.8	310	180	50	80
Any CMD	22.2	8,500	4,950	1,310	2,240
ALL					
Mixed anxiety & depressive disorder	10.2	7,950	4,620	1,200	2,150
Generalised anxiety disorder	3.6	2,800	1,630	420	760
Depressive episode	2.2	1,710	1,000	260	460
All phobias	1.5	1,170	680	180	320
Obsessive compulsive disorder	2.3	1,790	1,040	270	490
Panic disorder	1.1	860	500	130	230
Any CMD	17.5	13,630	7,930	2,070	3,690

6.7 RISK GROUPS

In relation to mental health disorders there are a number of groups in the child population that have been identified as being at a higher risk of developing a disorder. These are summarised in the table below.

Table 15 Mental Health Disorders - Vulnerable Groups

	Estimated Proportion with mental health disorder
Total child population (5–15)	10%
Children in care	45%
Generalised learning disability	33-50%
Homeless young people (16–21)	60%
Young offenders (15–20)	40-95% (various studies)
Children with a parent who has a mental health problem	20%
Refugee children	40%
Children who have witnessed domestic violence	45%

Reproduced from *Heads Up: Mental health of children and young people* Paul Hamlyn Foundation 2008

In terms of family characteristics the 2004 ONS report collected information about family/parental background and family structure, identifying increased risk:-

- Children from single parent families higher risk compared to those in in two parent families
- Higher risk identified with low parental, and notably maternal qualifications
- Families where the interviewed parent had no educational qualifications
- Families living in poverty
- Workless households.

6.8 NUMBERS OF CHILDREN AT RISK OF DEVELOPING MENTAL HEALTH PROBLEMS

The section above focused upon those children and adolescents with mental health *disorders*, in relation to "lower level" mental health *problems* research has identified a number of risk groups, including children with disabilities, including learning disabilities, young carers, children who move frequently circumstances at home (being a young carer) , children looked after, children with parents who have mental health and/or substance misuse problems, children from deprived backgrounds. Risk does not mean that all children from these will develop a problem, but they are at a greater *risk* of doing so.

6.8.1 Children with a learning disability

About 36% of children and young people with a learning disability have a mental health problem, which is much higher than the rate for the general population *(Emerson and Hatton, 2007).* The risk factors that contribute towards this include communication difficulties, physical illness to external factors such as discrimination and family breakdown.

Table 16a Estimated total number of children with a learning disability
(Reproduced from CHIMAT)

	Children aged 5-9 yrs with a learning disability (2012)	Children aged 10-14 yrs with a learning disability (2012)	Children aged 15-19 yrs with a learning disability (2012)
West Sussex	440	1,015	1,235

Source: Office for National Statistics MYE for 2012 Emerson E. at al (2004).

Table 16b Estimated total number of children with learning disabilities with mental health problems
(Reproduced from CHIMAT)

	Children aged 5-9 yrs with a learning disability with mental health problems (2012)	Children aged 10-14 yrs with a learning disability with mental health problems (2012)	Children aged 15-19 yrs with a learning disability with mental health problems (2012)
West Sussex	175	410	495

Source: Office for National Statistics MYE 2012 The Foundation for People with Learning Disabilities (2002).

6.8.2 Children with physical health problems/disabilities

People with a serious physical illness are more likely to see a mental health provider for mental health services. The relationship between physical and mental wellbeing is complex, for example having a physical illness can affect relationships, impacts how a person socialises with others and can result in sudden changes to lifestyles and routines.

- Population level health

Population level information is provided by the census. Overall there are 33,750 people who stated that their general health was “bad” or “very bad” in West Sussex. Among 0 - 15 year olds, 0.5% reported being in bad health compared to 1% of 16-24 year olds.

Table 17 Residents reporting being in bad or very bad health (all age groups and 0-24 year olds)

	All Ages	%	0-15	% 0-15	16-24	% 16-24
Coastal CCG	22,300	4.8%	440	0.5%	440	1.0%
Crawley CCG	4,550	4.3%	120	0.5%	110	1.0%
Horsham and Mid Sussex CCG	6,850	3.2%	190	0.4%	170	0.9%
West Sussex	33,750	4.3%	740	0.5%	700	1.0%

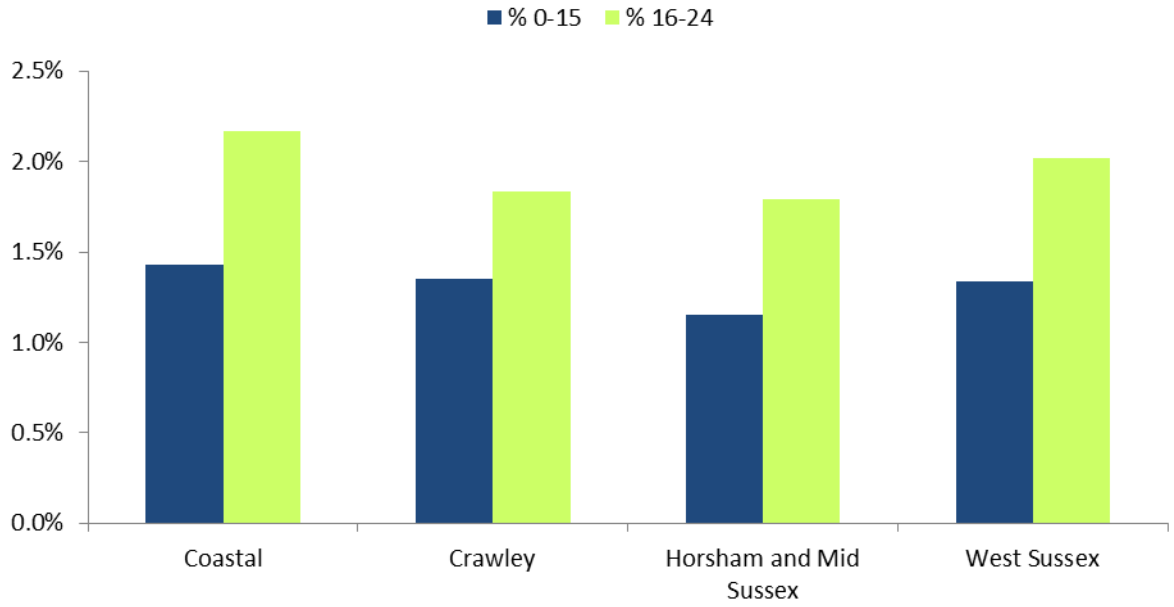
Source: 2011 Census

6.8.3 Day-to-Day Activities Limited

The Census also includes a question on whether day-to-day activities are limited as a measure of disability or long term condition. In West Sussex, 7.5% of residents stated that their day-to-day activities are limited a lot.

The proportion of children and young people who have a long term condition in West Sussex is low with 1.6% children stating their day-to-day activities were limited a lot. This was higher among the 16-24 year olds.

Figure 12 Percentage of people aged 0-15 and 16-24 whose day-to-day activities are "limited a lot".



6.8.4 Children on a Child Protection Plan

The impact of abuse in children has long-term effects and is a risk factor for mental disorders in adulthood. Research has found that 50% of people receiving mental health services report being abused as children. In 2010 a briefing by the NSPCC[8] reported that child physical abuse is associated with a wide range of debilitating emotional and behavioural problems that may persist into adulthood and generalize to future relationships, including parent-child relationships. It has been linked to aggressive behaviour, emotional and behavioural problems, and educational difficulties in children.

In West Sussex (during 2012/13) approximately 550 children were subject (at some point during that period) to a child protection plan, in the main with the initial reason of emotional abuse or neglect.

6.8.5 Children Looked After

Children looked-after are more likely to experience mental health problems (Ford, T. et al, 2007). It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder.

It is estimated that 60% of looked after children have emotional or mental health problems (Department of Children, Schools and Families 2009) with conduct disorders were the most common problem diagnosed, followed by emotional disorders.

[8] Lazenbatt, A The impact of abuse and neglect on the health and mental health of children and young people (2010) NSPCC Reader in Childhood Studies, Queen's University Belfast

In addition, children looked after have a higher rate of teenage pregnancies, substance misuse, school dis-engagement and offending behaviour.

There are approximately 700 children looked after in West Sussex.

Table 18 Children Looked After at 31 March

	2009	2010	2011	2012	2013
West Sussex	745	785	745	670	670

Source: DfE

In addition to children for whom West Sussex is the responsible authority, there are children who are placed within West Sussex but remain the responsibility of another local authority.

Data for 31st March 2013 shows that in total over 900 children looked after had their placement in West Sussex, this included 380 children placed by external LAs.

Table 19 Children Looked After at 31 March (including external LA placements)

	Children who are the responsibility of the local authority				Local authority of placement for children[5]		
	All children looked after at 31 March 2013	Placed within LA boundary	Placed outside LA boundary	Area of placement unknown*	All children placed within LA boundary	Children placed internally within LA boundary	External children placed within LA boundary
West Sussex	670	545	90	35	925	545	380

**Placement is not known or not collected (not collected where child placed for adoption).*

6.8.6 Teenage mothers

There are higher rates of depressive illness, as well as stress and feelings of isolation amongst younger mothers. Young mothers are at a higher risk of poorer mental health for 3 years after the birth and three times more likely to experience postnatal depression, with approximately 40% of young mothers affected.[9]

- In West Sussex annually approximately 400 – 500 births are to teenage mothers.

The teenage conception rate in West Sussex is lower than the national rate and has decreased from 31.3 to 27 between 2007-2009 and 2009-2011 (Public Health Research Unit, 2013). The majority of teenage mothers were between the ages of 18-19 years, lone parents, live in deprived areas and were not engaged in education or employment. These factors increase the risk of poorer mental

[9] Liao, T.F. (2003) Mental Health, Teenage Motherhood, and Age at First Birth among British Women in the 1990s, in Working papers of the Institute for Social and Economic Research. University of Essex: Colchester.

wellbeing together with concerns over motherhood such as feeling overwhelmed, difficulties in coping and bonding with the child.

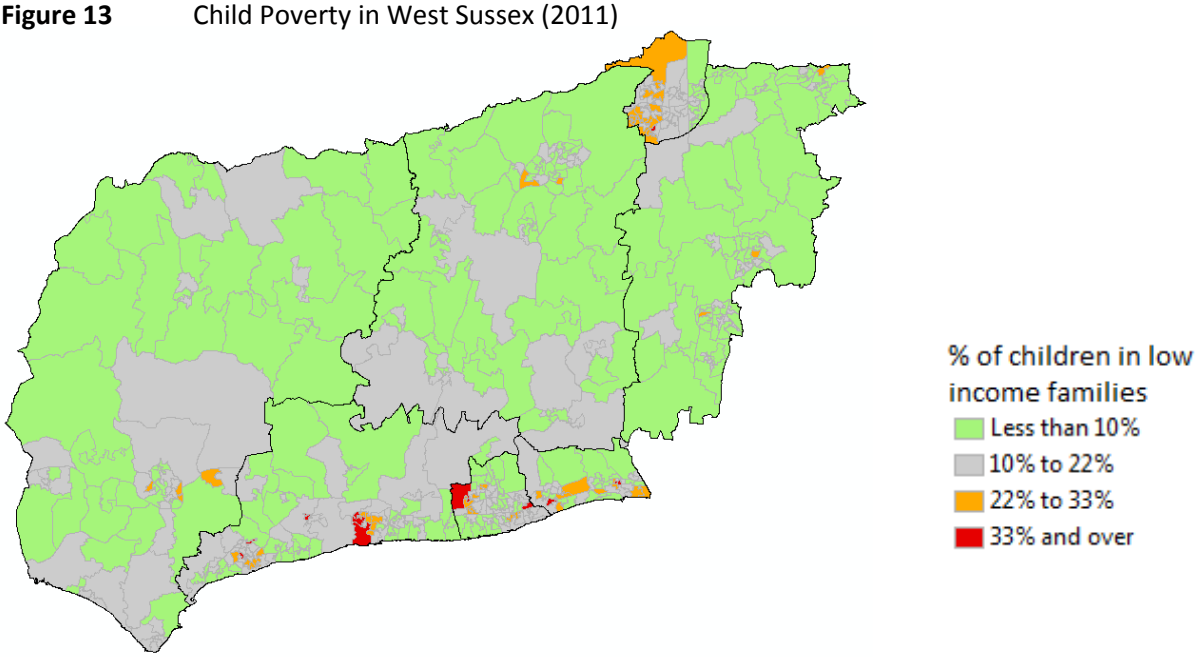
6.8.7 Child Poverty

The social gradient of mental health in children is strong. Socio-economic disadvantage mediates through parenting and environmental factors to influence mental problems in children. This includes increased parental conflict, limited access to material items or opportunities either through the family or neighbourhood as well as higher levels of parental mental health problems.

In West Sussex, 13% of all children (approximately 23,000 children) and 13.5% of children under 16 years old were estimated to be in relative poverty.

Child poverty is highest in Crawley (18.4%) and lowest in Mid Sussex (8.1%). At ward level there were large variations in child poverty rates with Ham (Arun) having the highest rate (33.1%) while East Grinstead Imberhorne had the lowest rate (1.9%).

Figure 13 Child Poverty in West Sussex (2011)



6.8.8 Children in Workless Households

There are 19,100 children aged 0-15 years living in workless households in West Sussex, representing 19.6% of children within that age range. Crawley CCG had the higher proportion of children in workless households with 19.3% while Horsham and Mid Sussex CCG had the lowest proportion at 7.8%.

6.8.9 Children of Black and Minority Ethnic Backgrounds

The ONS survey (2004) found that rates of mental health problems were higher in some ethnic minority groups (black groups) and lower in some others (including Indian, Asian and Bangladeshi). Ethnicity should be seen in a wider context, and is often part of a complex set of inter-relating risk factors, for example children from BME backgrounds are more likely to live in poverty or workless

households, also risk factors for poorer mental health and BME groups are more likely to experience racism, racial harassment or racist bullying.

Table 20a BME population by Local Authorities in West Sussex (%)

Area	0-4	5-9	10-14	15-19	20-24
Adur	10.4%	9.4%	7.8%	9.8%	7.9%
Arun	12.5%	8.7%	7.9%	7.9%	12.6%
Chichester	9.4%	6.8%	6.1%	7.4%	9.8%
Crawley	37.8%	34.0%	27.5%	26.5%	30.0%
Horsham	10.4%	9.2%	9.8%	10.4%	7.8%
Mid Sussex	12.5%	10.2%	9.8%	10.3%	9.0%
Worthing	15.4%	13.3%	10.8%	10.2%	11.4%
West Sussex	16.4%	13.3%	11.4%	11.6%	13.3%

Table 20b BME Population (Numbers)

	Age 0 to 4	Age 5 to 7	Age 8 to 9	Age 10 to 14	Age 15	Age 16 to 17	Age 18 to 19
Adur	275	150	85	180	60	105	90
Arun	420	190	130	330	45	145	140
Chichester	345	145	100	215	55	115	145
Crawley	2,520	1,200	670	1,475	310	585	530
Horsham	515	270	195	610	125	335	170
Mid Sussex	720	345	215	555	130	255	175
Worthing	775	410	200	485	90	180	180
West Sussex	5,575	2,710	1,595	3,850	815	1,725	1,430

6.8.10 Young carers

The Longitudinal Study of Young People in England (LSYPE) finds that young carers are:-

- 1.5 times more likely to have a disability or long-term condition
- 1.5 times more likely to be from a black, Asian or minority ethnic group
- Twice as likely not to speak English as their first language

Carers are also more likely to live in workless or lower income household as well as with an adult who has a disability. These factors also contribute towards increased stress and poorer mental wellbeing experienced by the carer.

6.8.11 LGBT

Bullying and discrimination are major issues faced by gay, lesbian and bisexual young people. The Stonewall School Report estimates that more than 55% of young people aged between 11 and 19 have experienced bullying in school (Stonewall School Report, 2012).

The effects of bullying can lead to mental health disorders with surveys finding that 35% - 40% of young people are likely to be depressed (Life in Scotland for LGBT Young People: Health Report, 2013). In more serious cases, one in four have attempted or thought about taking their own life while more than half of gay young men have self-harmed.

6.8.12 Young Offenders

There are high levels of mental health problems among young offenders. Research shows that rates of mental health disorders are three times higher for those within the criminal justice system than for the general population. Approximately 95% of young people in detention have a mental health problem and 80% have more than one (Lader et al, 2000). This higher rate is attributed to erratic parenting, aspects of offending that leads to mental health problem and interaction with the justice system that increases anxiety and depression (The Mental Health Needs of Young Offenders, 2002).

A recent report of the health and wellbeing needs of young offenders in West Sussex found that out of 114 young offenders (as of October 2013), 1 in 5 have had a formal mental health diagnosis (Youth Offending Report, October 2013). These include ADHD, Bipolar disorder, conduct disorder, early trauma and attachment disorder. Over 47% have had some contact or referral into mental health services while 21% were assessed as having self-harmed. Circumstances within their living arrangement and family background contribute towards poorer wellbeing. The predominant issues include living in a deprived household, living with other offenders, family members in criminality, experience of abuse and experience of bereavement.

6.8.13 Lone Parent Households

Children from lone parent families are at higher risk of mental health problems. There were 18,700 lone parent households in West Sussex, which represents 5.4% of all households. Crawley had the highest percentage of lone parent households (7.7%) while Chichester, Horsham and Mid Sussex had the lowest percentage (4.5%, 4.6% and 4.6% respectively).

6.8.14 Young People Not in Employment, Education or Training (NEETS)

NEETs are defined as young people aged 16-24 years old not in education, employment or training. Being out of work can lead to low self-esteem, reduced confidence, stress and depression. The link between mental health and NEETs can also be considered bi-directional as people with mental health issues are more likely to become NEETs.

A recent report published by the University and College Union (UCU) found that a third of NEETs have suffered from depression while 15% have a mental health problem (NEETs Survey, UCU, 2013). Social isolation is an issue as 37% of NEETs rarely leave the home and 40% feel they have no part in society.

6.8.15 Bullying

Around 70% of young people have been bullied at one time and one million children are bullied each week. Bullying can take many forms from name calling, teasing, spreading lies to more serious things such as kicking and intimidation. With more children using computer, mobile phones and social media, cyberbullying is becoming an increasingly ‘popular’ way of bullying.

Children who are bullied are likely to have poorer mental wellbeing and may develop mental problems. They may experience depression, anxiety, feelings of sadness and loneliness as well as lost in interest of activities that they normally enjoy. These issues may persist into adulthood.

7 SUMMARY OF CONSULTATIONS

A range of consultations – focus groups, interviews and online surveys - was carried out between October and mid December 2013. This section *summarises* the consultation work.

7.1 Aims of the Consultation

One aim of the work was to obtain views about CAMH services from professionals working within mental health services or accessing them on behalf of children and young people. It was also hoped to capture the views of some children and young people using services as well as their parents. In order to include consideration of wider emotional wellbeing we also consulted a small number of children and young people who were not necessarily involved with mental health services.

7.2 Consultation Questions

The questions used in the targeted focus groups/interviews were similar whether they were addressed to professionals, children and young people or parents.

We asked people:-

- to think about first experiences of services and how parents' and young people's worries and concerns were dealt with;
- how referral processes worked;
- what services were provided and what difference they made;
- what happened if further help was required;
- how did professionals work together;
- and more generally what worked well, what could have been improved, or what was missing.

The online surveys mirrored the approach of seeking the views of professionals, children and young people and parents. Some questions were similar to those asked in the focus groups but there was more opportunity to ask a broader range of additional questions.

The survey, focus groups and interviews were carried out in parallel. Ideally, it would have been helpful to run the online surveys prior to the focus groups and interview discussions so that the analysis from the surveys could have informed the more detailed discussions. However, the timescale for the work did not allow this to happen.

7.3 Numbers

19 focus groups: 8 with young people, 5 with parents and 6 with professionals.

2 focus groups were offered to social work case managers via their senior managers but the managers decided to encourage their staff to complete the online survey for professionals.

6 interviews: 2 with parents, 4 with professionals

Online surveys produced responses from: 67 children and young people, 137 parents whose children had had some involvement with CAMHS or were waiting for their services, and 334 professionals from a range of sectors. Public Health staff took the opportunity to attend the Youth Voice Network Conference organised in Worthing by the West Sussex Youth Council, in order to encourage young people to complete the online survey.

The following pages provide quotes from those taking part in the research within summaries for each element: the children and young people, the parents and the professionals.

7.4 Findings From Across The Consultation

Note: There were some very positive comments and experiences of services in all tiers, including individual psychiatrists/psychologists who were viewed as caring, approachable and understanding; there were comments about staff being willing to visit and assess outside the office, taking the time to explain why behaviours happen.

- Young people's wellbeing is closely related to the quality of interpersonal relationships they build; those with less close relationships tend to suffer more than those with friends, family or others in which they can confide.

- *Tier 1* services and capacity in the community are perceived to have been reduced and access to professional training and advice is needed if prevention strategies are to be effective.
- *Tier 2* services are perceived to have been reduced and are more focused on individual cases than on much needed training and consultation support for other professionals.
- *Tier 3* services are perceived to have become professionally isolated from other support networks; communication with other networks should be central to service delivery in the future.
- *Tier 4* services provide essential care for young people at high risk; however some young people felt that they had nobody with whom to raise concerns.

- Staff turnover is perceived to be high in many areas, leaving gaps in experience, training and knowledge of existing networks and pathways.

- Current intervention strategies are believed to fall short of required support and are perceived to function as gatekeeping techniques, rather than as preventative support.

- Internally defined criteria for different levels of support are not clear to service users and are believed to be too rigid. Service users tend to deteriorate past internally defined benchmarks before being able to access further support.

- Referral processes require constructive and cooperative development from both referring and receiving professionals to develop a streamlined and effective methodology.

- Clinical Commissioning Groups, District and Borough Wellbeing teams, CAMHS commissioners and service providers need to work collaboratively to develop and maintain an effective and thorough map of available services. This would allow oversight of the impact of changes in one service on another and enable all workers to navigate the systems in place and signpost or refer accordingly.

- The West Sussex CAMHS brand has been generally considered to be poor, which is believed by some tier 3 workers to be counterproductive, as reputations do not necessarily reflect recent service improvements. Widespread advertisement and communication of future changes will be essential to re-establishing trust in the service.

7.5 Consultation with young people:

"The services need to be advertised more so that more people know where go for help if they feel embarrassed telling someone that they know."

"I just want somewhere where I can go and be me and not get bullied for it."

"They have all helped a lot with support, and they are always there to help if it's needed."

"I'd trust my mum with everything, but I'd feel awkward to talk to my dad about personal subjects."

"CAMHS used to assume I had all these things wrong with me, but it turned out that it wasn't me; it was my environment. Being in care is the best thing that ever happened to me because now I don't have any of these problems."

"YMCA was good because I was talking to a complete stranger so I didn't have to worry about what they thought of me."

"It's important to feel like there's someone there for you, who will never leave."

"I speak to family; always there to listen. I think that is very important to have people to talk to no matter what age you are."

"I would never talk to my teachers about drinking, or taking drugs, or having sex… because I know that my parents would find out and that would be the worst!"

"A bad social worker is one who rarely comes to see you, or when you ask for something to be done, it isn't done, or they let you down; A good social worker is someone who is there for you and doesn't let you down."

"Since year seven, they've been saying 'If you don't do well in school, you won't do well in life'. If someone had just told me when I was younger that it's not all about doing well at school, or having lots of friends, then it would have helped me a lot."

7.6 EXECUTIVE SUMMARY OF CONSULTATION WITH YOUNG PEOPLE

1. *Method and response to consultation.* To inform the Children's Emotional Wellbeing and Mental Health Needs Assessment, consultations were held with young people across the county. Eight focus groups were held with young people in the community, young people in residential and foster care and current users of CAMHS. In addition, an online survey was developed to capture a wide range of young people's views and opinions. The findings of these two methods of research are summarised in this section of the wider Needs Assessment.

   Other sections of the Needs Assessment report on the consultations with a range of professionals and with the parents of service users.

2. The main areas of focus, where young people were concerned or worried, were: stress and pressures to succeed; peer support and the effects of not having close friends; bullying and the effects this has on wellbeing.

   Children and young people reported the levels to which they felt comfortable confiding in parents. Over one third of surveyed young people said they would not talk to their parents about sensitive or high-risk issues, such as sex and sexuality, self-harm, bullying and eating disorders. An equal number said that there was nothing they would not tell their parents. In discussion groups, the effects of having someone in which to confide, be that parents or friends, were seen as the central factors in being able to deal with emotional problems.

   This is especially apparent with children in foster or residential care, who spoke about the essential need to build long term emotional connections with new families and friends. It was also a priority for those with long term emotional issues, mental disorders or learning difficulties, as they found it harder to establish and maintain close relationships.

   It was widely agreed that public understanding of mental health and mental disorders/disabilities is lacking and those with a condition experience prejudice in the wider community and can be made to feel ashamed of their condition or disability.

3. Many young people believed that information and advice should primarily be provided in person, relying on text only for initial signposting of how and when to access this support. Surveyed young people found that speaking to friends, families and professionals had been most likely to help and books, blogs and forums had been least likely to help. Young people suggested that school assemblies and PSHE lessons could be used to promote mental health awareness and available services.

   Many of those who could not access the support they needed felt that they either deteriorated or had to learn to internalise their problems.

   There were frequent references to concerns over the training and capabilities of the Tier 1 and 2 support workers. Effectiveness here was found to be inconsistent. This was highlighted in multiple contexts.

4. Those who had low self-esteem or feelings of depression highly valued weekly support groups or social clubs. Youth Services were also greatly valued by those who had used them, with 95% of surveyed users saying that it had helped their wellbeing. The benefit they bring, of being able to make new friends and build relationships, was recognised by many of the discussion groups. Community based drop in clinics were discussed as a way to allow young people to access support at short notice.

   When asked what was good about support services they had used, most answers referred to being able to talk to someone, that the staff were understanding and informative or that it gave them motivation or confidence. When asked what could have been better, most referred to waiting times, that they wanted more information and alternative services, that communication was poor or that the service did not meet their expectations.

   Many past CAMHS users believed that acceptance criteria assess how the child is now, rather than how they will be in the future if they don't get the help they are seeking. This creates resentment as children feel they have to wait to deteriorate before accessing the service they believed they needed all along.

   Some past CAMHS users, especially those with eating disorders, said that acceptance criteria are set far too high for specialist intervention, to the point where the child's health must be at significant risk in order to access specialist support. Some children in care are referred to CAMHS by their school by default, even if the child insists that they feel fine. This example of potentially inappropriate referrals is discussed in the professionals' consultation.

5. Some young people do not feel comfortable accessing support or advice in schools as they are aware that any serious issues may have to be reported back to their parents. As a result there are some schools where young people believe there is no one they can confide in and high risk issues may be underreported. Where pastoral support is available from those in non-teaching roles, some young people said that they felt more comfortable confiding in them.

   Commissioning a CAMHS worker to work in a school, for one day a week, was said by a staff member in one school to allow them to streamline the referrals they made and access CAMHS directly. More generally, mental health provision in schools is inconsistent and depends largely on the priorities and capacities of the individual school.

7.7 Consultation with parents/carers of young people involved with CAMHS:

"Listen to parents more. Parents know their children more than anyone and know when something isn't right. Listen to them and don't ignore them and hope it will go away.'

"It's constant fighting and you are asking where you can find information out, you just have to find it out yourself, really, because it's really difficult"

'Therapeutic Parenting - made a real difference in the way we parent both our adopted children. It gave us lots of strategies to use and plenty to think about. The therapists were fantastic.'

"They say 'it's all early intervention', but then they're all 'wait and see, wait and see'. They think it's just immature behaviour; it takes ages to get an assessment done. They need to make 'early intervention' earlier."

"I think the one word to sum it up is 'frustration'."

"Help us help our children."

"I would like to think that all people could get as good a service as we received, and from such an experienced psychologist who knew just how to get my daughter to change her thought processes in such a positive way."

"Provide the right services to support all young people. Where do parents turn when told supporting a disorder is not within the remit? We have felt utter despair and isolation in obtaining care support and understanding for our daughter and it continues."

"No one talks to anyone else. I have had to arrange meetings myself in order to get people together."

7.8 EXECUTIVE SUMMARY OF CONSULTATION WITH PARENTS

1. *Method and response to consultation.* To inform the Children's Emotional Wellbeing and Mental Health Needs Assessment, consultations were held with parents across the county. Five focus groups were held with parents: the Autism Sussex parents group, a CAMHS group, adoptive parents, foster carers and parents whose children had received counselling help through the Worth Emotional Support Service (WESS).

   An online survey was also developed to capture the views and opinions of parents whose children had had some involvement with CAMHS. The findings of these two methods of research are summarised in this section of the wider Needs Assessment.

   Other sections of the Needs Assessment report on the consultations with children and young people and with a range of professionals.

2. Parents described the stress and frustration of trying to get help for their children, in some cases over many years.

   Significant variation in referral waiting times to see a CAMHS worker was noted. However this was compounded by parents perceiving the wait to be from the time they identified their child's needs for specialist help to actually accessing the service.

   Many parents feel they are not listened to and professionals, in some cases, can appear disrespectful.

3. Many parents are unaware of CAMHS and so rely on professionals in contact with their child to identify the need for a referral and to support them through the process. Parents expressed concern that not all professionals have knowledge and expertise of mental health issues and resources. In schools it can be unclear which member of staff has responsibility.

   Parents find it more difficult to get advice if their child is home schooled or not in school.

   Foster and adoptive parents in WSCC can be referred to CAMHS LAAC by social workers. Those who foster or adopt through agencies or other local authorities are not linked to CAMHS LAAC or to support groups and sources of information. In general, they access support in the same way as other parents through their child's school or GP. This can be problematic.

   Foster parents have a social worker to help them navigate services and to support them. It is possible that other parents of children with mental health difficulties could benefit from this level of support.

   Many parents found the CAMHS referral process to be confusing; with some reporting that they needed to be proactive and persistent in order to find the most effective route. In addition, they felt that communication whilst waiting was often poor. Timely information and guidance would have helped to allay their concerns and to manage their expectations.

   In order to access services parents felt that they needed a clear diagnosis.

In some cases after a service has been accessed further help can be obtained, but most responses painted a negative picture of parents' ability to get further help.

4. Many parents were convinced that earlier guidance and intervention could have had considerable benefits for their child and alleviated the distress for both the child and family. They do not seem to routinely access parenting programmes or support groups, although there is evidence that these are effective and valued. Parents in focus groups rarely mentioned any targeted school provision for their children, for example, to support or improve social and emotional skills, raise self-esteem or to prevent exclusion. (Some were aware of services for vulnerable children in schools: educational psychologists, school nurses, counselling and the virtual school for children looked after.) It was felt that currently there has to be a crisis before an appropriate service is considered.

5. There is confusion about what services are available. Useful information often travels via word-of-mouth and the main sources of information are key individuals. Parents wanted a clear pathway and information on who to contact if they have concerns about their child and what they can expect. They want to understand why their child is having difficulties and to obtain practical advice about what to do to help. They are also aware of the importance of services to support them as individuals, such as counselling and support groups.

   There is a need for better web-based local information for parents and for young people. However, it is important to be aware that parents can sometimes feel overwhelmed by too much internet information and require support to access what they need. There was agreement in one focus group about the usefulness of Facebook since it was accessible at any time and provided a way for parents to support and learn from each other as well as to find out what help is available to them.

   Across the groups and survey findings the CAMHS helpline and website was rarely mentioned. Telephone advice is useful for some and it was felt that it should be available for teenagers.

   Some parents did not receive advice while waiting for the CAMHS services and others received advice that they did not find helpful.

6. Parents suggest that some professionals need further training to be able to support their children. The parents often recognise that their child is experiencing difficulties at an early age and find health visitors, teachers and GPs do not always have sufficient knowledge and skills to offer advice. Unskilled and unqualified teaching assistants may be given a lead role with vulnerable children and young people. Some adoptive parents were concerned that teachers generalise from very limited personal experience and would like an expert on adoption available to each school.

   Some parents found that professionals welcomed advice. Attention was drawn to parents who passed on their learning from a CAMHS intervention and this was appreciated by school staff. Similarly, some experienced foster carers would like to contribute to training new foster carers.

7. Despite the issues with referral processes and communications many parents reported a good service once they manage to access CAMHS. Some were very positive about the service, feeling it was the first time they and their child had received the help they needed.

   Parents who were disappointed with the service included those whose children only received medication or short term support, those with ADHD, teenagers and those in transition to adult services. Also foster carers were concerned that they could not access help for children who had not yet 'settled' in their placement, though they often needed help in the early stages of the placement.

8. Interagency communication is perceived to be poor, with parents often having to re-tell their story, and feeling as though they are being passed from one agency/service to another. When agencies are unable to help they do not all routinely signpost parents to another service.

   Parents suggested that Schools and Health Services do not work well together. There is on-going confusion about the interface and pathways between Special Education Needs processes and mental health provision. From the parent's perspective not all schools are taking responsibility for supporting young people with mental health or emotional difficulties.

   Parents said that, from their experience, the Common Assessment Framework (CAF) and the team around the child approach did not appear to be embedded.

9. Parents perceive current services to be insufficient in number/range, not to be child-centred, and with systems and processes that are unnecessarily bureaucratic and a barrier to access.

   They noted that some primary schools offer support and that the transition to secondary school was problematic for some children.

   Parents were concerned about the impact of having a child with mental health difficulties on the whole family. They highlighted that service providers need to be aware that children who find it difficult to socialise may need support to access universal services (clubs, leisure activities etc.) which increases demands on parents and siblings if parents accompany them.

   Services were seen to be thinly spread and parents identified a range of provision that they felt was needed both within CAMHS and in general:

   - Early intervention, Tiers 1 and 2 services for children and parents
   - Parenting programmes easily accessed at early stage of difficulty
   - Information including the use of social media
   - Services for children with behaviours issues/conduct disorders and their parents
   - Activities for the whole family to benefit siblings
   - Advice while waiting for assessment at CAMHS
   - Telephone counselling and advice for parents and young people
   - Parenting support programmes
   - Services for teenagers and for transition to adult services
   - Services for children and young people with autism and their parents
   - Specialist services for children who are also physically disabled
   - One stop shop for advice and information places for advice

10. Possible further research identified by this project:

- Investigating the needs of fathers/what sort of services they would find most helpful.
- Mapping of tier1 and tier 2 services
- Investigating the extent to which evidenced based Early Intervention programmes are being accessed across the county as well as their impact and benefits
- Mapping what activities and groups are offered in schools for vulnerable children and young people (Identifying any issues relating to the change of school status to academies and the decline in central support services).
- Exploring in more depth the needs of:
  - Teenagers and of those in transition to adult services.
  - Those with autism and mental health difficulties
  - Those with behavioural and mental health difficulties (including attachment)
  - BME groups
  - Adopted children

7.9 Consultation with professionals:

"If we get in earlier then potentially the trajectory is much, much reduced in terms of the challenges that the children present."

"Not sure anyone realises how much teams are running on empty and morale is very low, even from amazingly skilled and thoughtful professionals."

"Some of the best work that I've done, we've joint-worked things together, worked side by side and it worked well then."

"No one understands the role of CAMHS any more, what they do accept and what they do not and the reasons for this."

"I often feel that young people's emotional health gets neglected due to fact that they may not have a formal MH diagnosis and therefore often don't meet the threshold for a service from CAMHS."

"I find it frustrating that despite the law stating we should act in the best interests of the child, confidentiality within the health profession appears to over-ride this."

"I feel that better communication with the families to help manage their expectations of what CAMHS can actually do would be helpful. Knowing what the service isn't just as much as what it is, is important for families to understand."

"Stuck in the middle without enough information to help with stressed & angry people asking us to do something."

"It feels as if young people need to fit in to service provision rather than service provision being designed to meet their needs."

"It still feels like CAMHS can still be difficult for people to access and sometimes it seems that there are young people that get missed as a result."

"It's like put all these hoops in the way, all these hurdles in the way and if you might finally get to the end or you get to that stage where you think, 'It's got to be CAMHS,' and they think, 'Well, actually no, it doesn't meet our criteria.'"

"There are some very good, excellent bits of service, but it's not offering a coherent package across the county. Some families get brilliant, or what we think of as fantastic, and you see the difference it makes, and other families don't."

"Many referrals are returned, suggesting we use other services which do not exist, leaving parents and children without the support that they need."

7.10 EXECUTIVE SUMMARY OF CONSULTATION WITH PROFESSIONALS

1. *Method and response to consultation.* To inform the Children's Emotional Wellbeing and Mental Health Needs Assessment consultations were held with professionals across the county. Six focus groups were held with professionals from Chichester CAMHS, Horsham CAMHS, Worthing CAMHS, Looked after and Adopted Children Staff, Primary Mental Health Workers (PMHWs) and Social Workers (Targeted Team). Interviews took place with: an individual PMHW, a school counsellor and paired interviews with representatives of HomeStart-Chichester and the adjacent Children and Family Centre Manager and separately with CAMHS Commissioners.

   In addition, an online survey was developed to capture the views of professionals from a broad range of organisations working with children and young people across West Sussex within Social Care, Education, Health, Youth Services and Commissioning. The findings from these two methods of research are summarised in this section.

   Across the research process the Joint Strategic Needs Assessment was welcomed. Professionals welcomed the opportunity to air their views on CAMHS and they articulated a wish for the findings from this consultation to be shared with them and to be acted on.

   Because of the timeframe for this study and the breadth of findings, we have, in the main, combined the perspectives of different professionals in relation to the broad themes identified. On occasion the views of particular professional groups have been analysed separately, e.g. GPs, and there could be merit in exploring these different perspectives further.

2. The referral process and problems experienced during the referral process were a dominant and recurring theme highlighted by professionals (including CAMHS professionals) in the focus groups, interviews and the survey.

   The main issues discussed were: knowledge and understanding of eligibility criteria and how to meet them, the quality of referrals, communication between professionals and with families during the referral process, waiting times for decisions and appointments when referrals are accepted, support, training, and signposting to other services, the support and advice provided to families and young people.

   There was considerable consistency across all professionals about the nature and extent of these issues. However, there were differing interpretations about responsibilities, e.g. in relation to: signposting alternative or interim support, communicating with parents and communication between professionals.

   The bulk of referrals were made by professionals from Social Care, Youth, Health and Education Services with the latter two groups most likely to find the referral process unsatisfactory or highly unsatisfactory, when asked in the survey.

   GPs had the highest proportion of surveyed professionals dissatisfied with the referral process. They were particularly concerned about communication and feedback from CAMHS, the high threshold for accessing the service and they found referral forms unwieldy and unsuited to their 10 minute consultation model. Whilst CAMHS staff were sympathetic to the constraints of GP

working practices they felt that GP referrals were often made without sufficient consideration or understanding, with the result that they were of poor quality. Both parties appear to think the other is responsible for signposting, which indicates that neither is taking responsibility, wholly.

Overall, social workers were more satisfied with the process than GPs, although they shared many of their concerns. They also felt that there was occasional tension or disagreement with CAMHS over labelling the 'problem' or 'need' of a client.

Gaps in knowledge and understanding of the referral process were felt by many to be in large part due to a shortage of training, support and access to informed individuals. This also applied to knowledge of services and how to obtain them. Professionals who had a trusted contact with CAMHS staff (often a PMHW) argued that the opportunity for swift, flexible, informal dialogue and advice was invaluable. They especially valued the opportunity to understand better when and how to refer, scope out what support there is and to be signposted towards it. Whilst acknowledging other professionals' needs, some CAMHS staff stated that they can be reduced to fire-fighting and no longer have the resources for effective preventative work, training, consultation and signposting. This appeared to have had an impact on morale.

The provision of over-arching information and support via a contact point, with good understanding of current service provision, some ability to track and record individual cases as well as to monitor CAMHS journeys, would be welcomed.

When professionals were asked for their views about how children and families find the referral process, 41% felt that the time from referral to receiving a service was 'not usually' or 'never' acceptable. 34% of professionals thought the support put in place for families and young people between referral and service provision was 'not usually' or 'never' acceptable most of the time. In addition, there was a feeling that recording the time from referral to receiving a diagnosis/support does not adequately capture the length of time it can take for support to be offered nor the number of unsuccessful attempts a family or young person may have made to get help. It is also possible that some children may be slipping through the net and that these children's experiences are not being recorded.

Professionals suggested that families find it easier to access support when problems re-occur rather than during their first referral, 45% felt that it was easy for families to access support 'always' or 'most of the time' when problems re-occurred. It is difficult to compare parents' own views as over half of them did not answer the question in their survey. However, in general, they appeared to have a less optimistic view than professionals.

3. Early intervention provision was thought by some to be inadequate and there was a recurring emphasis on both its efficacy and the need for more. Early intervention was discussed in its widest sense to include not only early CAMHS help but also help within a universal context in relation to: low level work with teenagers on stress, self-esteem, sex education and body image and on emerging challenging behaviours with the aim of reducing the potential life-long impact. The aim of all interventions would be to: prevent issues escalating, stop young people becoming isolated, support them so that they struggle less at school and so that the impact and distress of emotional and MH issues on young people, their families and those around them are lessened.

Professionals recognised that schools have a very important role in early intervention. It was widely agreed that there is a need for more schools to raise the profile of mental health by supporting young people in articulating and discussing their concerns, removing stigma and providing support. Similarly, professionals identified a broader need to support and build parents' behaviour management skills pre-school and to help them reduce their children's anxiety levels, depression and inability to work and learn.

It was suggested that access to services should focus on the level of distress a child or young person presents rather than their specific age. Another specific concern raised was for earlier access to support for attachment issues, especially for LAAC.

The Early Intervention Service received praise and the role of alternative providers was recognised as an essential part of early intervention.

4. There was a general consensus on the need to raise awareness of the different sorts of services offered by CAMHS and how professionals and users can access them. Few felt adequately aware of what the full range of services available were, what they offered or who could access them.

Professionals felt that staying up to date with the ever-changing array of services/approaches available and their differing remits requires time, effort and resources. Safeguarding training was the most commonly noted form of continuous professional development (CPD) highlighted by surveyed professionals, 148 (44%). More generally, training was most often provided by colleagues, 99 (30%). 161 (48%) professionals indicated that they would like further training to help them support children and young people. They suggested that this should include training to: recognise the signs of different mental health conditions, ascertain which CAMHS service is most appropriate, to make better referrals, to help support and develop Tier 1 and 2 provision in order to alleviate pressure on Tier 3 services. Professionals also articulated the view that education and training about mental health should be a key requirement for all staff working with children and young people.

Professionals extended the above requirement for better understanding and education about emotional wellbeing and mental health issues to include young people and their families. This would be especially helpful for those accessing interim support if not eligible for Tier 3 referral and for understanding and managing conditions.

More generally, whilst it was thought to be improving, professionals felt that more should be done to de-stigmatise mental health, raise its profile and improve awareness of, and access to supporting resources. There was some optimism for the future in that current government priorities and policy suggest a commitment to improving the understanding of mental health and recognition of the importance of addressing mental health issues.

148 (44%) had received CPD training on safeguarding. Training was most often provided by colleagues, 99 (30%). 161 (48%) professionals indicated that they would like further training to help them support children and young people.

5. Professionals identified a range of concerns in relation to young people's perceptions of and potential engagement with CAMHS. The name 'CAMHS', in itself was not always understood and viewed as off-putting to some potential service users.

Comments were made that young people can be reluctant to engage with CAMHS and did not always see the service as friendly or approachable, with some young people fearing it. Others identified insufficient inclusion in consultations where young people's views of service provision and their voice in decision making were not always perceived to be marked enough. It was suggested that CAMHS should be doing more to reach out and proactively engage with young people.

Professionals argued that young people and families will often look online for information or support. Current online services were thought to be fragmented, poorly presented, hard to find and inconsistent. Suggestions for improving online provision included: simple remote counselling and 'apps' that might provide support with specific issues, videos of professionals and young people talking about their conditions and treatment.

6. The shared view, across the research, was that there is insufficient provision at all tier levels to provide adequate support to children, young people and families. Children's mental health services were regarded by many professionals as piecemeal, fragmented and inconsistent and there was a perceived insufficiency of equity of access across the county. CAMHS was thought by many to be overwhelmed, to be engaging with the 'tip of the iceberg' and only accessible to young people with very severe needs.

   There was also felt to be insufficient overall knowledge of mental health provision and incomplete mapping of CAMHS services more generally.

   Consistently across the research responses to referrals, time taken to diagnosis and access to appointments and CAMHS services were all believed to take too long.

   There were a number of resource/capacity issues also highlighted with potential impact on the quality of care, access to services, number and quality of referrals. - *These issues were raised with varying degrees of consensus from the professionals consultation.*

   - Some Tier 3 workers said they were struggling to find time for all their appointments.
   - The number of PMHW's, school nurses, education psychologists and non-teaching pastoral staff in schools is thought by some professionals to have reduced and schools were thought to be lacking in adequate CAMHS provision.
   - The commissioned services for those with learning disability or autism were felt to be insufficient.
   - Some professionals said that children exhibiting extreme behaviours struggled to receive a response or diagnosis.
   - There were a range of areas where some concerns were raised regarding insufficient provision of care. These included provision for behavioural problems, eating disorders, anxiety and severe anxiety, substance misuse, emotional mental health issues, self-harmers, bullying, depression and school avoidance; young people involved in domestic abuse or with parents with drug and alcohol issues; the number of in-patient beds and

facilities for young people in crisis (a national problem); support for young people during the transition from primary to secondary school.

- Accessing timely specialist support out of hours (including weekends) was raised as a concern, including support for some young people with severe mental health problems.

7. Throughout the research a dominant theme was the need for all professionals to work together more effectively and for someone to be responsible for reviewing the whole picture including the impact of changes in one service on another. The desire was to improve co-working practices and develop thorough, systematic and collaborative approaches to meeting the needs of young people, and for any changes following the Needs Assessment to be coherent and co-ordinated with other child and young person focused services.

Professionals wanted to create a more holistic approach to mental health and wellbeing. They stressed that the broader familial context and needs should be assessed and addressed and the importance of diet, nutrition and physical health to emotional wellbeing, especially anxiety and depression be considered. Holistic care plans for vulnerable children, positive partnership working and the value of working in a reflective, specialist team with a focus on psychological formulation were all thought to be useful approaches.

Professionals across the research commented on the important role of schools in relation to emotional wellbeing and mental health. There was concern that signposting, commissioning and provision of Tier 1 and 2 CAMHS provision within schools was increasingly fragmented as a result of changing structures and funding arrangements (free schools, academies, etc.). Within this context GPs currently have a role in making referrals to CAMHS in collaboration with schools. The development of improved training and communication between GPs, schools and other professionals could have a beneficial effect.

Transitioning to adult mental health services was broadly felt to be working satisfactorily when accessed. There was a view that more flexibility over the age of transition could be allowed. Some young people were not thought to be mature enough to move to adult services and the feeling was that CAMHS could offer support to some young people up to age 25.

Occasional concern focussed around an increasing culture of early medication of young people by GPs without them being seen by either a PMHW or consultant.

The impact on children of growing up with parents who have their own unaddressed mental health issues and whose only current provision is medication managed by the GP was not felt to be wholly satisfactory.

Some CAMHS staff hoped that they would continue to be co-located as they believed that this offered opportunities for multi-practitioner working, skill-sharing and supportive reflective practice.

8 ACTIVITY AND PERFORMANCE DATA – TIERS 3 AND 4

8.1 Information from Sussex Partnership Foundation Trust

Detailed activity information is provided to commissioners every month. Information for the period July 2013 to November 2013 (where available to January 2014) is shown below. This has been shown by CCG area activity, West Sussex overall and, for comparison, East Sussex and Brighton and Hove data combined.

8.2 Referrals

There are approximately 300 to 430 new referrals (external referrals) each month to SPFT. There are a variety of referral sources, including schools, health visitors, carers, social services; the majority of referrals come from GPs. It should be noted that young people can self-refer.

Table 21 External Referrals to SPFT July 2013 to November 2013
Source : SPFT Commissioners Report

All Referrals to SPFT	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	5 month period July to Nov 2013
Coastal CCG	241	184	247	263	239	1,174
Crawley CCG	59	44	45	60	57	265
Horsham and Mid Sussex CCG	103	68	94	106	108	479
West Sussex	403	296	386	429	404	1,918
GP Referrals to SPFT	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	5 month period July to Nov 2013
Coastal CCG	156	104	173	200	169	802
Crawley CCG	44	29	30	44	38	185
Horsham and Mid Sussex CCG	81	55	87	89	92	404
West Sussex	281	188	290	333	299	1,391
GP referrals as % of all referrals	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	5 month period July to Nov 2013
Coastal CCG	64.7%	56.5%	70.0%	76.0%	70.7%	68.3%
Crawley CCG	74.6%	65.9%	66.7%	73.3%	66.7%	69.8%
Horsham and Mid Sussex CCG	78.6%	80.9%	92.6%	84.0%	85.2%	84.3%
West Sussex	69.7%	63.5%	75.1%	77.6%	74.0%	72.5%

Table 21a Referrals Accepted and Referrals Not Accepted (Signposted)

Data on referrals are split into those accepted and those not accepted. It should be noted that during the consultation phase the term "inappropriate referral" was used. From data provided by the Trust it is clear that systems are in place to signpost on "not accepted" referrals to the appropriate services.

		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	5 month July to Nov 2013
Coastal CCG	GP Referrals Accepted	102	61	125	80	101	469
	GP Referrals Not Accepted (Signposted)	54	43	48	120	68	333
	All Referrals Accepted	158	98	174	121	151	702
	All Referrals Not Accepted (Signposted)	83	86	73	142	88	472
Crawley CCG	GP Referrals Accepted	20	13	18	28	26	105
	GP Referrals Not Accepted (Signposted)	24	16	12	16	12	80
	All Referrals Accepted	30	21	23	39	40	153
	All Referrals Not Accepted (Signposted)	29	23	22	21	17	112
Horsham and Mid Sussex CCG	GP Referrals Accepted	49	24	65	60	64	262
	GP Referrals Not Accepted (Signposted)	32	31	22	29	28	142
	All Referrals Accepted	65	27	69	74	75	310
	All Referrals Not Accepted (Signposted)	38	41	25	32	33	169
West Sussex Overall	GP Referrals Accepted	171	98	208	168	191	836
	GP Referrals Not Accepted (Signposted)	110	90	82	165	108	555
	All Referrals Accepted	253	146	266	234	266	1,165
	All Referrals Not Accepted (Signposted)	150	150	120	195	138	753
ESx and Brighton & Hove Combined	GP Referrals Accepted	237	108	163	238	256	1,002
	GP Referrals Not Accepted (Signposted)	88	75	83	97	73	416
	All Referrals Accepted	374	175	273	363	376	1,606
	All Referrals Not Accepted (Signposted)	156	128	126	152	120	682

SPFT note that "The majority of unaccepted referrals are signposted to more appropriate emotional wellbeing services better able to meet the needs of young people with a lower level of need."

% of Referrals Accepted – Overall 61% of referrals (during July 13- Nov 13 period) were accepted by SPFT. This is 10% lower than the level accepted in the rest of Sussex. Crawley has the lowest level of referrals accepted at 57.7%. This lower level may indicate a lack of services at Tier 2 and/or a poorer understanding of services available.

Figure 14 Percentage of Referrals Accepted West Sussex Compared to Rest of Sussex

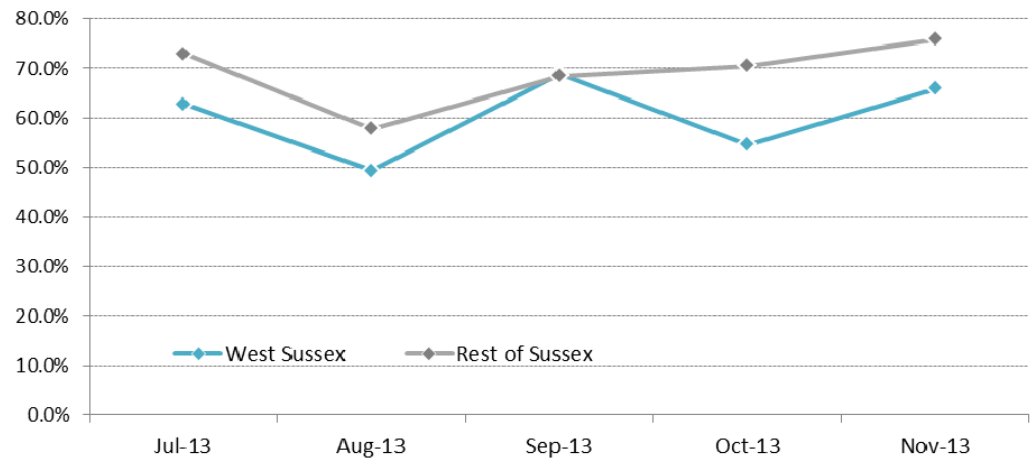


Table 22 Percentage of Referrals and Percentage of GP Referrals Accepted

% of All Referrals Accepted	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	5 month period July to Nov 2013
Coastal CCG	65.6%	53.3%	70.4%	46.0%	63.2%	59.8%
Crawley CCG	50.8%	47.7%	51.1%	65.0%	70.2%	57.7%
Horsham and Mid Sussex CCG	63.1%	39.7%	73.4%	69.8%	69.4%	64.7%
West Sussex	62.8%	49.3%	68.9%	54.5%	65.8%	60.7%
Rest of Sussex	70.6%	57.8%	68.4%	70.5%	75.8%	69.6%
% of GP Referrals Accepted	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	5 month period July to Nov 2013
Coastal CCG	65.4%	58.7%	72.3%	40.0%	59.8%	58.5%
Crawley CCG	45.5%	44.8%	60.0%	63.6%	68.4%	56.8%
Horsham and Mid Sussex CCG	60.5%	43.6%	74.7%	67.4%	69.6%	64.9%
West Sussex	60.9%	52.1%	71.7%	50.5%	63.9%	60.1%
Rest of Sussex	72.9%	59.0%	66.3%	71.0%	77.8%	70.7%

Urgent GP Referrals

Source : SPFT Commissioners Report

In relation to referrals made between July 2013 and January 2014, it is apparent that only 1 of 113 referrals from GPs in Coastal West Sussex CCG met the definition while all 88 referrals made by GPs in East Sussex met the definition. SPFT state that referrals not meeting the definition are managed and seen via the Choice system. Given the high level of "inappropriate" referrals this system warrants more investigation.

SPFT Note

All Urgent GP referrals, received by the Trust, are carefully screened by clinicians, to ensure they are responded to in the most appropriate way.

The 4 hour response

Where, in the view of the clinician, the patient is presenting an immediate risk to themselves or others; an immediate response is required. The response that the Trust makes must be adequate to address the level of risk described above. This could be either assessment, or other actions, to ensure the safety of the patient and others appropriate to the particular circumstances. This may not necessarily mean meeting the patient face-to-face. This could be achieved through discussion with the GP or patient. The clinical responsibility is to ensure that the GP's request has been responded to and the patient is safe. Patients who do not meet the above definition are seen through the Choice system. The Urgent Help Service (UHS) deals with patients who require to be seen within 4 hours (for urgent referrals) or 24 hours (for routine referrals).

Target

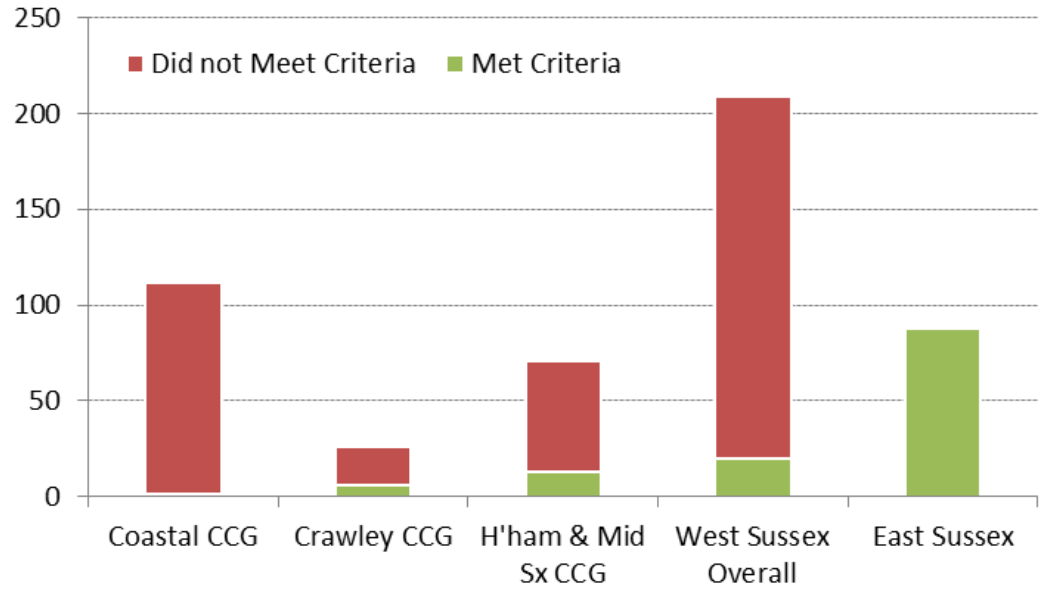
The target is 95% of all urgent GP referrals that meet the definition must be responded to within 4 hours.

Table 23 Urgent GP Referrals

		Jul-13	Aug-13	Sep-13*	Oct-13	Nov-13	Dec-13	Jan-14	July to Jan 2014
Coastal CCG	Referrals	23	11	11	17	23	9	18	112
	Meeting the "4 hour definition"	0	0	0	0	0	0	1	1
	% Meeting Definition	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	0.9%
Crawley CCG	Referrals	5	0	0	4	7	6	4	26
	Meeting the "4 hour definition"	0	0	0	2	2	1	1	6
	% Meeting Definition	0.0%			50.0%	28.6%	16.7%	25.0%	23.1%
Horsham and Mid Sussex CCG	Referrals	5	0	0	4	28	10	24	71
	Meeting the "4 hour definition"	0	0	0	1	5	3	4	13
	% Meeting Definition	0.0%			25.0%	17.9%	30.0%	16.7%	18.3%
West Sussex Overall	Referrals	33	11	11	25	58	25	46	209
	Meeting the "4 hour definition"	0	0	0	3	7	4	6	20
	% Meeting Definition	0.0%	0.0%	0.0%	12.0%	12.1%	16.0%	13.0%	9.6%
ESussex CCGs	Referrals	7	18	18	11	9	11	14	88
	Meeting the "4 hour definition"	7	18	18	11	9	11	14	88
	% Meeting Definition	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Data caveat: data provided in the Commissioners report for this measure in September 2013 are identical to data provided for August 2013.

Figure 15 Urgent GP Referrals / Meeting 4 Hour definition



8.3 Caseloads

Source : SPFT Commissioner Reports

In any one month approximately 3,000 children and young people in West Sussex are open cases at SPFT.

Table 24 Caseloads

		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Coastal CCG	Cases open at end of month	1,783	1,768	1,798	1,700	1,720
	Cases closed during month	326	170	184	275	216
Crawley CCG	Cases open at end of month	447	456	456	457	481
	Cases closed during month	77	38	42	55	37
Horsham and Mid Sussex CCG	Cases open at end of month	708	687	711	719	759
	Cases closed during month	131	88	64	96	74
West Sussex Overall	Cases open at end of month	2,938	2,911	2,965	2,876	2,960
	Cases closed during month	534	296	290	426	327
Sussex (excluding WSx)	Cases open at end of month	2,783	2,658	2,736	2,835	2,927
	Cases closed during month	672	434	350	443	406

Table 25 Appointments Offered

		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Coastal CCG	New Contacts offered	125	97	119	127	130
	Follow-up Contacts offered	1,702	1,112	1,584	1,760	1,504
Crawley CCG	New Contacts offered	33	17	14	15	24
	Follow-up Contacts offered	398	225	243	247	213
Horsham and Mid Sussex CCG	New Contacts offered	54	41	40	47	49
	Follow-up Contacts offered	675	459	615	588	466
West Sussex Overall	New Contacts offered	212	155	173	189	203
	Follow-up Contacts offered	2,775	1,796	2,442	2,595	2,183
Sussex (excluding WSx)	New Contacts offered	311	229	200	272	281
	Follow-up Contacts offered	3,218	2,244	2,964	3,217	3,084

8.4 Appointments Cancelled / Not Attended

Source : SPFT Commissioner Reports

Did Not Attend (DNA) Rate

SPT Note : Indicator shows the number of clients who were offered appointments. Of these a certain number did not attend their confirmed appointments or failed to respond when offered the appointment.

Target

The indicative target is that the DNA rate should not exceed 10% of all appointments offered.

There is a consistently low DNA rate, remaining well below the 10% target threshold.

Table 26a Did Not Attends (DNA) – First Contact

		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Coastal CCG	DNAs - New Contacts	13	5	0	0	0
	DNAs - Follow-up Contacts	75	66	73	95	64
Crawley CCG	DNAs - New Contacts	1	0	0	0	0
	DNAs - Follow-up Contacts	12	17	11	6	11
Horsham and Mid Sussex CCG	DNAs - New Contacts	0	1	0	0	0
	DNAs - Follow-up Contacts	31	34	25	26	26
West Sussex Overall	DNAs - New Contacts	14	6	0	0	0
	DNAs - Follow-up Contacts	118	117	109	127	101
Sussex (excluding WSx)	DNAs - New Contacts	6	5	0	0	0
	DNAs - Follow-up Contacts	246	179	189	208	194

Table 26b Did Not Attends (DNA) – Follow Up Appointments

		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Coastal CCG	% of DNAs - New Contacts	10.4%	5.2%	0.0%	0.0%	0.0%
	% of DNAs - Follow-up Contacts	4.4%	5.9%	4.6%	5.4%	4.3%
Crawley CCG	% of DNAs - New Contacts	3.0%	0.0%	0.0%	0.0%	0.0%
	% of DNAs - Follow-up Contacts	3.0%	7.6%	4.5%	2.4%	5.2%
Horsham and Mid Sussex CCG	% of DNAs - New Contacts	0.0%	2.4%	0.0%	0.0%	0.0%
	% of DNAs - Follow-up Contacts	4.6%	7.4%	4.1%	4.4%	5.6%
West Sussex Overall	% of DNAs - New Contacts	6.6%	3.9%	0.0%	0.0%	0.0%
	% of DNAs - Follow-up Contacts	4.3%	6.5%	4.5%	4.9%	4.6%
Sussex (excluding WSx)	% of DNAs - New Contacts	1.9%	2.2%	0.0%	0.0%	0.0%
	% of DNAs - Follow-up Contacts	7.6%	8.0%	6.4%	6.5%	6.3%

8.5 Type of Contacts

Source : SPFT Commissioner Reports

SPT Note: *Data relate to the number of clients who had an appointment recorded either as a Face-to-Face (F2F) contact, in the community or in an outpatient setting, or non-Face-to-Face (non-F2F) contact, such as either telephone or other/indirect/proxy.*

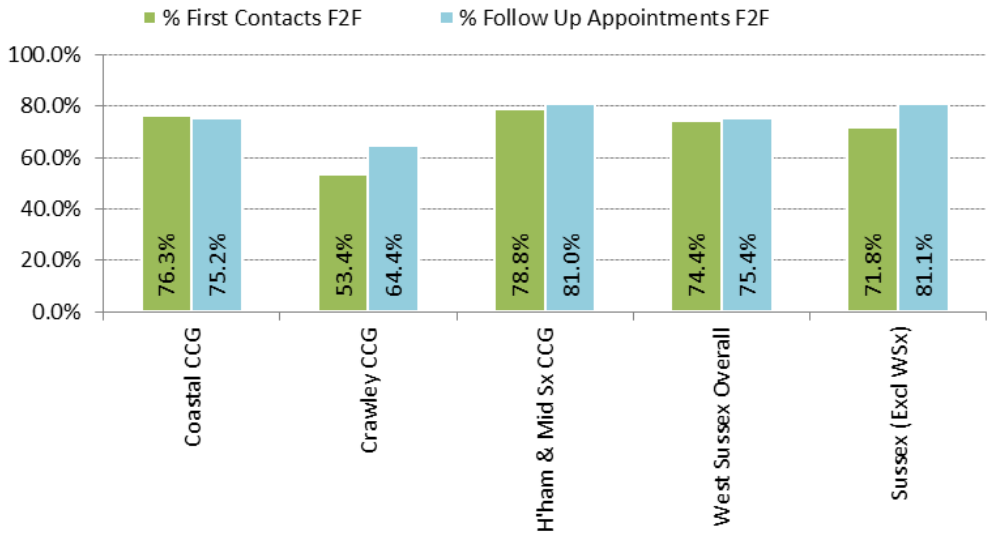
Of note there are fewer contacts in Crawley that are face to face (either at first contact or follow up) than elsewhere in West Sussex.

Table 27 Type of Contact

FIRST CONTACT		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Jul - Nov 2013
Coastal CCG	Face to Face	94	78	87	97	100	456
	Non Face to Face	31	19	32	30	30	142
Crawley CCG	Face to Face	24	10	5	7	9	55
	Non Face to Face	9	7	9	8	15	48
Horsham and Mid Sussex CCG	Face to Face	38	34	34	40	36	182
	Non Face to Face	16	7	6	7	13	49
West Sussex Overall	Face to Face	156	122	126	144	145	693
	Non Face to Face	56	33	47	45	58	239
Sussex (excluding WSx)	Face to Face	202	174	147	207	199	929
	Non Face to Face	109	55	53	65	82	364
FOLLOW UP		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Jul - Nov 2013
Coastal CCG	Face to Face	1,305	870	1,070	1,364	1,155	5,764
	Non Face to Face	397	242	514	396	349	1,898
Crawley CCG	Face to Face	274	159	133	150	138	854
	Non Face to Face	124	66	110	97	75	472
Horsham and Mid Sussex CCG	Face to Face	522	379	498	492	380	2,271
	Non Face to Face	153	80	117	96	86	532
West Sussex Overall	Face to Face	2,101	1,408	1,701	2,006	1,673	8,889
	Non Face to Face	674	388	741	589	510	2,902
Sussex (excluding WSx)	Face to Face	2,625	1,761	2,343	2,703	2,509	11,941
	Non Face to Face	593	483	621	514	575	2,786

Figure 16 **% of Contacts Face to Face (Pooled data July to November 2013)**

Source : SPFT Commissioner Reports



8.6 Waiting Times

The Trust measures two waiting periods – waiting for an assessment and waiting time to treatment. There are contractual targets set against each, the Trust consistently meets target times for assessment and treatment.

Routine Assessment within 4 weeks – measured as the number of referrals meeting the 4 week target for assessment. The contractual target is that at least 95% of assessments are carried out within 4 weeks.
Routine treatment within 18 weeks – measured as the number of patients waiting less than 18 weeks from referral to treatment. The second contact following referral is taken to represent treatment. The contractual target is that at least 95% are treated within 18 weeks of first referral.

Table 28 Waiting Time to Assessment and Waiting Times to Treatment

Waiting Times to **Assessment**		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Coastal CCG	0 - 4 weeks	88	72	72	110	88
	5 - 13 weeks	0	0	0	0	0
	14 - 18 weeks	0	0	0	0	0
	19 - 25 weeks	0	0	0	0	0
	26 weeks +	0	0	0	0	0
Crawley CCG	0 - 4 weeks	18	14	14	12	21
	5 - 13 weeks	0	0	0	0	0
	14 - 18 weeks	0	0	0	0	0
	19 - 25 weeks	0	0	0	0	0
	26 weeks +	0	0	0	0	0
Horsham and Mid Sussex CCG	0 - 4 weeks	58	29	29	41	44
	5 - 13 weeks	0	0	0	0	0
	14 - 18 weeks	0	0	0	0	0
	19 - 25 weeks	0	0	0	0	0
	26 weeks +	0	0	0	0	0
Waiting Times to **Treatment**		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Coastal CCG	0 - 4 weeks	76	64	64	98	83
	5 - 13 weeks	11	3	3	7	7
	14 - 18 weeks	3	2	2	0	0
	19 - 25 weeks	0	0	0	0	0
	26 weeks +	0	0	0	0	0
Crawley CCG	0 - 4 weeks	13	10	10	11	13
	5 - 13 weeks	3	2	2	0	1
	14 - 18 weeks	0	0	0	0	2
	19 - 25 weeks	0	0	0	0	0
	26 weeks +	0	0	0	0	0
Horsham and Mid Sussex CCG	0 - 4 weeks	48	22	22	38	32
	5 - 13 weeks	9	4	4	2	8
	14 - 18 weeks	0	0	0	0	0
	19 - 25 weeks	0	0	0	0	0
	26 weeks +	0	0	0	0	0

Data caveat: data provided in the Commissioners report for this measure in September 2013 are identical to data provided for August 2013.

8.7 Outcome Measures - Use of the Strengths and Difficulty Questionnaire (SDQ)

Source : SPFT Commissioner Reports

SPT Note: *Within CAMHS, the main Outcome Measure is the Strength and Difficulty Questionnaire (SDQ). This is a brief screening questionnaire covering 3—16 year olds. It is based on 25 attributes on five different scales:*

- *emotional symptoms,*
- *conduct problems,*
- *hyperactivity or inattention,*
- *peer relationship, and*
- *pro-social behaviour*

Different versions of the questionnaire are available for parents and teachers, and for older children (11+) themselves.

Performance Measurement

This is the percentage of service users referred to teams who have been given the questionnaire. The caseload is defined as the number of open referrals with a contact within the last seven months.

Target

75% of all CAMHS service users should be assessed using SDQ.

The use of this from the information provided appears below the 75% set, and lower in the Crawley CCG area, although care should be taken in the snapshot interpretation, as the period in which the tool is used will differ for individual children and young people.

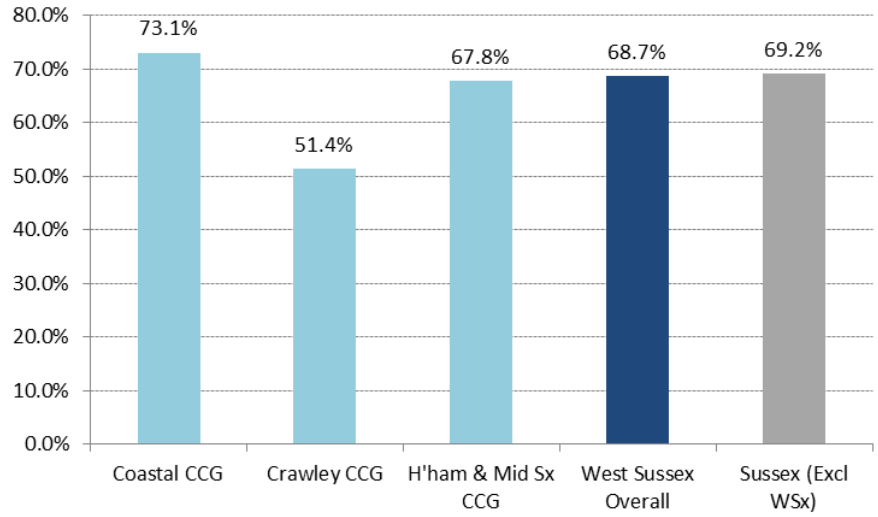
Table 29 Number of Service Users with a Valid Outcome Measure

% with a valid Outcome		Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Jul - Nov 2013
Coastal CCG	Service Users	1,078	1,040	1,040	1,043	1,025	5,226
	With a Valid Outcome	787	769	769	755	739	3,819
Crawley CCG	Service Users	258	245	245	220	225	1,193
	With a Valid Outcome	138	131	131	112	101	613
Horsham and Mid Sussex CCG	Service Users	469	453	453	427	433	2,235
	With a Valid Outcome	318	310	310	292	285	1,515
West Sussex Overall	Service Users	1,805	1,738	1,738	1,690	1,683	8,654
	With a Valid Outcome	1,243	1,210	1,210	1,159	1,125	5,947
Sussex (excluding WSx)	Service Users	2,145	2,114	2,114	2,181	2,212	10,766
	With a Valid Outcome	1,427	1,459	1,459	1,537	1,574	7,456

Data caveat: data provided in the Commissioners report for this measure in September 2013 are identical to data provided for August 2013.

Figure 17 % of Service Users with a Valid Outcome measure (Pooled Data July 2013 to Nov 2013)

Source: SPFT Commissioner Reports



8.8 Caseload Background (Snapshot data November 2013)

Source: SPFT Commissioner Reports

Table 30 Gender of Service Users (Nov 2013)

November 2013 data	Female	Male	TOTAL
Coastal CCG	861	1,075	1,936
Crawley CCG	208	310	518
H'ham & Mid Sx CCG	422	411	833
West Sussex Overall	1,491	1,796	3,287

Figure 18 Gender of Service Users by CCG area

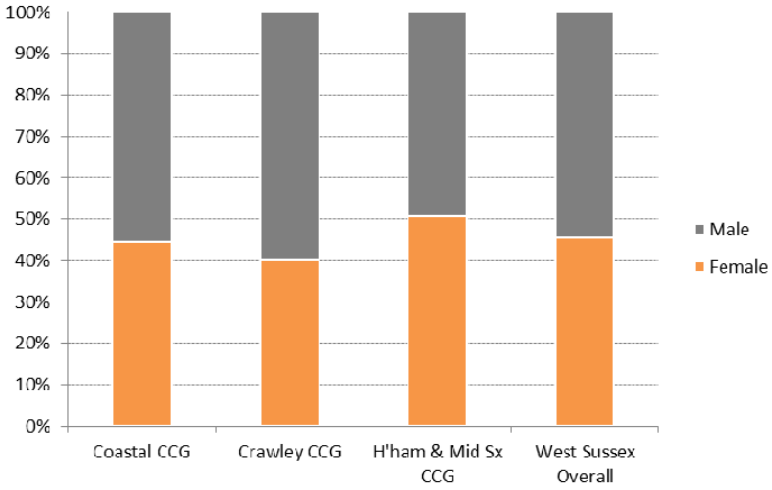


Table 31 Age of Service Users (November 2013)

The information shows that the majority of young people are aged between 11-15 years but people over 16 and also over 18 are supported and treated by the Trust.

CCG	0 - 3 years	4 - 10 years	11 - 15 years	16 - 17 years	18+ years	TOTAL
Coastal West	2	365	907	589	73	1,936
Crawley	0	96	244	144	34	518
Horsham & Mid-Sussex	1	145	389	236	62	833
West Sussex	3	606	1,540	969	169	3,287
Sussex (Excl WSx)	8	760	1,680	716	169	3,333
CCG	0 - 3 years	4 - 10 years	11 - 15 years	16 - 17 years	18+ years	TOTAL
Coastal West	0.1%	18.9%	46.8%	30.4%	3.8%	100.0%
Crawley	0.0%	18.5%	47.1%	27.8%	6.6%	100.0%
Horsham & Mid-Sussex	0.1%	17.4%	46.7%	28.3%	7.4%	100.0%
West Sussex	0.1%	18.4%	46.9%	29.5%	5.1%	100.0%
Sussex (Excl WSx)	0.2%	22.8%	50.4%	21.5%	5.1%	100.0%

Figure 19 Age of Service Users

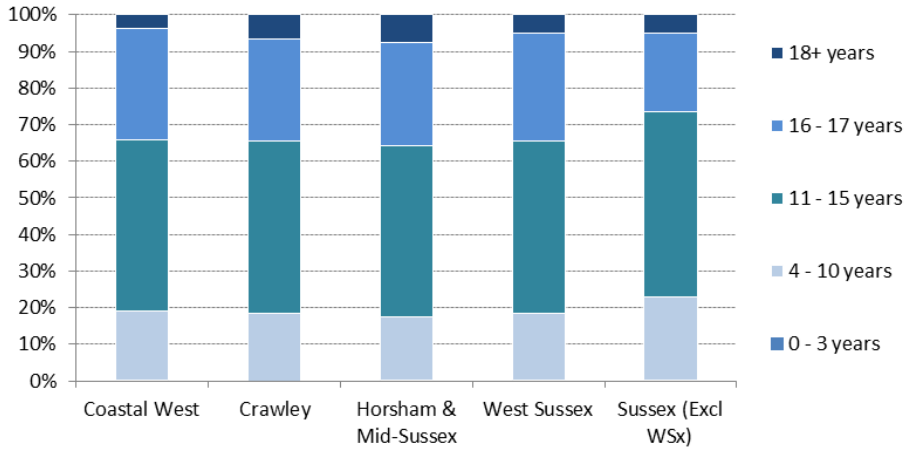


Table 32 Ethnic Background (Snapshot data November 2013)

	Coastal CCG	Crawley CCG	Horsham and Mid Sussex	West Sussex Overall	Sussex (Exc WSx)
White British	1,731	423	726	2,880	2,907
White Other (including White Irish)	49	33	25	107	66
Asian	5	4	9	18	14
Black	11	4	3	18	23
Mixed	25	21	13	59	70
Other	15	7	4	26	18
Not known	100	26	53	179	235
Total	1,936	518	833	3,287	3,333
% (of known from BME background)	5.7%	14.0%	6.9%	7.3%	6.2%

8.9 HOSPITAL ADMISSIONS OF CHILDREN OR YOUNG PEOPLE

The information below relates to children and young people who visited or were admitted into hospital due to a mental health problem. Between 2010 and 2012, there were 1,487 admissions to hospitals, 375 admissions for 0-16 year olds and 1,112 admissions for 17-24 year olds.

Caveats:

- There were 247 admissions due to alcohol and drug misuse, these have not been included in the analysis below; because there is a lack of clarity if admissions for these young people were a result of having a mental health condition or due to independent cases of substance misuse.

- Totals for the tables below may be less due to incomplete recordings.

Table 33 Mental health-related hospital admissions by local authorities in West Sussex

Area	0-16	17-24	Total
Adur	33	85	118
Arun	74	254	328
Chichester	80	106	186
Crawley	20	81	101
Horsham	19	110	129
Mid Sussex	34	110	144
Worthing	23	137	160
Total	283	883	1,166

Source: HES data analysed by West Sussex Public Health Research Unit.

*74 admissions were not included due to null recording of local authority where young people resided

Table 34 Admissions by CCG localities in West Sussex

CCG	0-16	17-24	Total
Crawley	21	87	108
Coastal	214	600	814
Horsham and Mid Sussex	44	216	260
Total	279	903	1,182

8.9.1 Admissions by mental health condition

Among 0-16 year olds, psychological developmental disorders were the most common condition while mood disorders were the most common among 17-24 year olds.

Table 35 Most common mental health conditions for 0-16 and 17-24 year olds.

Source : HES

0-16	**Total**
Behavioural or emotional disorders	69
Mood disorders	23
Neurotic disorders	28
Psychological developmental disorders	146
Total	266
17-24	**Total**
Adult personality & behavioural disorders	140
Behavioural syndromes	54
Learning Disability	107
Mood disorders	181
Neurotic disorders	99
Rehabilitation	119
Schizophrenia and delusional disorders	116
Total	816

The table below shows the hospitals where young people have been admitted. For people aged 0-16 years, South Downs Health Trust received the most number of admissions between 2010 and 2012. For those aged 17-24, Sussex Partnership Trust received the most admissions. It should be noted that these could be repeat admissions where an individuals could have been admitted more than once for the same condition.

Table 36 Hospitals where those aged 0-16 years of age received treatment and by condition

Source : HES

	RDR	RTP	RX2	RXH	RYR	Total
0 – 16 Years	111	12	54	31	41	249
17 – 24 Years	30	13	597	40	211	889

RDR – South Downs Health NHS Trust
RTP – Surrey and Sussex Partnership Trust
RX2 – Sussex Partnership Trust
RXH – Brighton and Sussex University Hospitals NHS Trust
RYR – Western Sussex Hospitals

9 SERVICES / PROVISION IN WEST SUSSEX

Current mapped service delivery in West Sussex

Note this section includes services provided in March 2014

This section provides an overview of the current range of CAMH services in West Sussex.

In 1995, the NHS Advisory Service published a review of CAMHS in which a four-tiered framework for CAMHS was introduced. The 4 tier framework has since been used as the basis for developing and planning children and young people's mental health services.

The tiered system is one of organisational structure that supports such a method of service delivery, each CAMHS professional having the potential to work at, or with, more than one tier.

A brief description of each tier of the framework is given below:

> ***Tier 1***: Services include universal ones provided by health visitors, school nurses, early years staff, school staff) who identify and support the parents of children and other relevant staff in contact with children who are showing early signs of emotional and behavioural problems. This can also include GPs. They can offer general advice and support but are not necessarily mental health specialists. These services are designed to promote good emotional and mental health, to identify problems early and refer to more specialist services where appropriate.
>
> ***Tier 2:*** Services offered by specialists working in community and primary care settings to provide assessment and intervention from a single mental health professional. This includes primary mental health workers, psychologists and counsellors. They also offer consultation to families, assessment and training to Tier 1.
>
> ***Tier 3:*** These are services which are usually multi-disciplinary teams working in a community mental health clinic or child psychiatry outpatient service, to provide a specialised service for children and young people with more severe, complex and persistent disorders. They include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.
>
> ***Tier 4:*** These are tertiary level services for children and young people with the most serious problems, comprise highly specialised outreach teams, day units and in-patient units, including secure forensic adolescent units, eating disorders units and other specialist teams.

Tier 1

Tier 1 has an additional Peer Mentoring programme commissioned by Public Health West Sussex which is the Solihull Parenting Model. A number of other individual interventions exist that are commissioned by individual schools which have, in part, replaced what was the healthy schools programme and built on the good practice that exists.

The Public Health commissioning plan for 2013/14 is focused on influencing the wider system through the delivery of training for the following frontline staff in early years and school settings to support prevention and early intervention programmes:

- Early years services: Children and Family Centres staff, Family Outreach Workers, Community Nursery Nurses, Health Visitors, Parenting Group/Facilitators, Mothers and Toddlers Groups, Midwifery Teams – Linked with Think Family, Family Support Interventions, Looked after Children Services, GP's
- School age group services: including school nurses, Family Link workers for schools, Teaching Assistants, Pastoral Leads, Parent Support Workers, Primary and secondary education teaching staff, Special Education Needs Staff, Youth Offending Team, Youth Services, Voluntary Sector, etc.

The public health commissioning plan further builds on existing evidence based approaches for early intervention by promoting emotional wellbeing and building resilience within children and young people. It references the Public Health Outcomes Framework, Improving Children and Young People's Health Outcomes[10] as well as local need. The plan aims to achieve the following outcomes:

- Developing workforce competencies which enable parents and their children secure higher levels of attachment and emotional wellbeing.
- Improving practitioner skills and practice in building resilience within children and young people
- Reducing the negative impact of parental mental illness on children and families/carers.
- Increasing the proportion of children assessed as ready for school.
- Developing workforce and carer competencies in identifying and supporting children and families/carers with emotional needs and seeking the appropriate help when required.
- Ensuring that women who experience postnatal depression receive support from universal services
- Improving the self-esteem and confidence of children and young people leading to positive attitudes and healthier lifestyle choices.
- Ensuring that parents who experience emotional and relationship difficulties receive skills and support in parenting, behaviour management and problem-solving
- Ensuring that parents and their children have improved communication skills and an increased capacity to reflect
- Reducing absenteeism from school, antisocial and conduct-related behaviour, and the proportion of young people entering the criminal justice system.

Early intervention approaches commissioned to promote emotional wellbeing and resilience in children and young people in West Sussex include:

1. **Solihull Approach** – is an evidenced based model which meets NICE and DH guidance for promoting emotional wellbeing in early years and in children and young people. It promotes a model which combines the theories of attachment, reciprocity and containment in behaviour management and child development. It emphasises the importance of secure attachment and emotional communication between child and parent/carer during the early years of the child's

[10] Improving Children and Young People's Health Outcomes: a system wide response. February 2013. www.dh.gov.uk/publications

life as the building blocks for emotional health, self-assurance and confidence. These building blocks provide the protective factors for the child's emotional and mental health and overall child development throughout adulthood[11].

2. **Peer Mentoring** – a method used within schools to train older pupils to support their younger peers through a variety of mechanisms such as mentor-mentee relationships and ad hoc and group support. Peer Mentoring in schools has been shown to be effective in building emotional resilience and alleviating the negative impacts of bullying[12],[13].
3. **Primary Mental Health Worker Training Programme** (see PMHW section)

Tier 2

These services are commissioned by the West Sussex County Council on behalf of the three Clinical Commissioning Groups and West Sussex County Council.

Primary Mental Health Workers (PMHW)

This service is delivered by Sussex Partnership NHS Trust (SPFT). PMHW's are a group of qualified specialist professionals attached to Child and Adolescent Mental Health Service (CAMHS) locality teams and working within Primary Care. PMHW's provide an early intervention and prevention provision to young people with mild to moderate mental health difficulties. The provision is delivered through consultation and training to professionals in Primary Care on a range of young peoples' mental health and emotional wellbeing issues and direct clinical work with young people and their families/carers. This is a clinical assessment and early intervention focused provision and in addition PMHW train other professionals on a wide range of young people's mental health and emotional wellbeing issues.

Aims of the PHMW service delivery are to:

- To facilitate appropriate access to specialist children and young peoples' services through consultation and to signpost to other relevant provision according to level and nature of the child or families/carers needs. This is by promoting integrated working between Head Teachers, General Practitioners, Educational Welfare Officers, Family Link Workers, School Nurses, Educational Psychologists, Special Educational Needs Co-ordinators, Learning Mentors, Pastoral Care Workers, Counsellors, Health Visitors, Social and Caring Services, Connexions and other professionals in the workforce.

- To enhance access to specialist children's and young people's health services where clinically appropriate.

- To support and strengthen primary care provision through building capacity and capability within primary care in relation to early identification, prevention and intervention with children's emotional health needs

[11] Solihull.approach@heartofengland.nhs.uk. www.solihullapproachparenting.com

[12] A Review of Evidence of Peer Mentoring in Schools. MBF, 2010-2011. www.mandbf.org/wp-content/uploads/2011/10/Peer_Mentoring_in_Schools1.pdf

[13] Promoting the emotional health of children and young people. Guidance for Children's Trust Partnership including how to deliver N1 50. Department of children, schools and families. 2010. www.teachernet.gov.uk/publications

- To build the capacity and capability in Primary Care to meet the mental health and emotional needs of children and young people, by offering a mixed model of consultation, direct clinical intervention and training in order to promote confidence and skills in working with children, young people and their families/carers with emotional problems.

- Enhance accessibility and equity for children, young people and families/carers especially those who would not ordinarily engage with mental health service e.g. asylum seekers, young offenders.

- There are 8 PMHW posts across West Sussex, the equivalent of 6.5 WTE posts, 1 of these posts is a support worker and part of another post is as a development lead for the PMHW service. PMHW report to Child and Adolescent Mental Health Service locality team leaders and the Child and Adolescent Mental Health Service service manager.

- Each NHS Band 7 PMHW has an allocated geographical area within the three CAMHS localities of the North, South and Chichester areas. Within their area, the PMHW is a named consultation contact for professionals. This provides an opportunity through consultation to explore concerns relating to the complex needs of children and young people who have mental health or emotional issues and to provide information, advice and supervision. The Band 6 PMHW work directly to a Band 7 who supervises their consultation work.

- PMHW are contactable directly by mobile phone between working hours Monday to Friday. Consultation is provided via telephone or face to face, PMHW also provide opportunities for regular agreed consultation sessions to a range of professionals and agencies.

Asylum Seekers Service

This is a county wide project. The 0.6 PMHW offers consultation and direct work with asylum seekers and is closely linked to the Local Authority Young People Asylum Seekers team and the various establishments where young people are placed on arrival in the UK. A significant number of young people have experienced trauma and this worker assesses and considers their needs, liaising with local CAMHS were appropriate.

Direct Clinical Interventions

PMHW provide direct interventions to young people and there families/carers where there is a clear mild to moderate mental health difficulties, for these children and young people there are 6-8 sessions of PMHW intervention is provided, drawing from a range of therapeutic modalities. Sessions are typically offered in the young person's own home or local community setting. PMHW input is considered beyond the expertise of Primary care professionals/agencies but does not warrant intervention at tier 3. The Band 6 PMHW's work is supervised by a Band 7 practitioner. PMHW sit within the locality CAMHS teams and requests for direct work are via the CAMHS single referral access point or integrated services via the children and young peoples' planning forums.

Training delivery to primary care professionals

PMHW have six core training packages they provide to primary care professionals on subjects such

as: self harm, mental health awareness, bereavement, divorce and separation the impact on young people

The Schools PMHW projects

There are also two schools PMHW projects. One PMHW post is funded by Chichester schools (FACCS) 1.0 PMHW (term time) and also the Horsham Schools Project 0.4WTE PMHW (term time) the roles include consultation training and assessment/direct work.

Schools Project PMHW Role

- Consultation work with all identified schools and associated professionals such as School Nurses, Family Link Workers, Inclusion Support Teams, Family Services, Integrated Services.
- Training/education of school staff with respect to children's mental health and emotional wellbeing – whole school and through joint working.
- Direct work with children/young people and their families/carers both at school and at home, to include mental health assessments when appropriate and specialist interventions. This can take the format of work with individuals or groups.
- To ensure safeguarding of children through risk assessment and multi-agency working.
- To provide advice and support to parents in an accessible environment, and signpost to other agencies if and when appropriate.
- To liaise with Tier 3 CAMHS if specialist assessment is deemed necessary and for consultation.

Consultation

Consultation continues to be offered by telephone and face to face contact as well as through networking and multi-agency working. This continues to ensure effective working relationships with school staff and other professionals.

Assessment

All children who are seen for direct work have a mental health assessment which also involves appointments with parents following their consent/permission for involvement. All of these children will have health notes. Specific outcome measures continue to be researched for use within this role. These will be standardised as far as possible to ensure Impact of evidence is clearly recorded from both a clinical perspective and also from school staff, other professionals and parents in the format of evaluation forms and continued use of the strengths and difficulties questionnaire.

Links to Tier 3 CAMHS

Links to tier 3 CAMHS ensure an effective way of supporting both parents and school staff with concerns about children/young people. Joint working with Tier 3 ensures effective and appropriate input from services at all levels

Youth Offending Team and CAMHS

There is a PMHW 0.5 FTE working to deliver the mental health element of Health's statutory duty to the YOT to provide specialist assessment, intervention and consultation to children and young people. This post supports young people who have been convicted of an offence, are subject to YOT intervention and have mental health needs.

Sussex Central YMCA Counselling Service

The YMCA delivers Counselling services commissioned by the WSCC Joint Commissioning Unit. An eight session model is delivered to 13-25 year olds in Find it Out Centres located in Burgess Hill, Crawley, Horsham, Lancing and at the Place in Worthing. Last year 196 young people were referred through and the service is delivered by twelve honorary counsellors who are supervised and line managed by paid staff. The service is funded until March 2014. The referral pathway is predominately self, Youth Service, CAMHS, school/FE College and GP. Funding has been agreed to roll out this service to Bognor and Chichester in April 2014. Evaluation of the service last year evidenced self-harm, bullying and suicidal thoughts as main presenting issues. YMCA Counselling Project in Henfield - 3 hours counselling provided through YMCA at GP surgery in Henfield (This contract ends in March 2014). YMCA also run a counselling project for young people in Adur and Worthing providing services to the community.

Mind The Gap

Mind the Gap is delivered by an Emotional Well Being Practitioner based in Crawley that was originally jointly funded as a new project for 9 months by CAMHS /SPFT. Sussex Central YMCA Housing, continuation of funding has been agreed. The worker is located within Crawley Foyer Supported Housing Project with the 16 -25 year old residents and provides a link between and staff with GP/ CAMHS /Youth Service/Social Services/Schools & Colleges. The project offers one to one support, group work, learning and engagement, activities, online counselling, staff consultation, parent/carer liaison and is flexible to engage hard to reach young people wherever possible. The worker is currently leading the agency on Trauma-informed approaches to supporting young people and has just recruited 2 young people to voluntarily assist with the project.

Know Your Goals

Know Your Goals is described as a partnership between CAMHS /SPFT, Sussex Central YMCA, Crawley Borough Council Well-Being team and Freedom Leisure. This is an innovative evidence-based project, piloted by Tottenham Hotspur, and brings together football coaches with emotional well-being practitioners to offer 6 week courses for male and female 16-25 year olds. Know Your Goals was launched in February 2014 at K2 in Crawley, the model has been written with the intention of being able to replicate it across the county.

Emotional Wellbeing Pathfinder Project

The Worthing **Emotional Well Being Pathfinder** Project is based in Worthing, and is managed through a multi-agency steering group. It is run as a GP referral project and based within the Youth Service Information Shop. A detailed evaluation has been developed. This project will be jointly funded with Think Family and will be rolled out to Crawley from April 2014.

Early Intervention Project

Led by Sussex Partnership Foundation Trust, it provides mental health services for 16-25 year olds within Crawley. Early intervention Project was established in 2012 to help young people, aged 16 to 25 years, with mental health concerns who reside in Crawley West Sussex. The staff are aware that most mental health problems first develop in these years, and early intervention and prompt access to support is crucial. The Team consists of multi-disciplinary practitioners drawn from CAMHS, Early Intervention Services and Adult Mental Health Services. All practitioners work collaboratively with

Young People and their support networks. Targeted Youth Support, Education, Employment, Housing, Health and Leisure.

This project work across community settings and have a base at the Crawley Find it Out Shop on a Thursday and Friday.

Find It Out West Sussex Youth Service, 37 Queens Square, Crawley, West Sussex, RH10 1HA

Website: www.yourspacewestsussex.co.uk/advice_and_info/organisations/connexions_centres/connexions_centre_-_crawley.aspx

Young People's Homelessness Prevention Team
This is a service commissioned by West Sussex County Council for 16–17year olds, led on behalf of WSCC but not commissioned by Public Health/Joint Commissioning Unit. They work in partnership with housing support and other agencies, specifically for 16 and 17 year olds who are benefiting from targeted interventions and support, designed to help them maintain existing accommodation and relationships, or secure suitable alternative arrangements.

Quick access interim accommodation is available across the County and up to 8 bed spaces are available in each of the Foyers. Bed spaces are available in Crawley Foyer, Horsham Y, Chichester Foyer and Worthing Foyer. These bed spaces will be shared across the boundaries of the Districts and Boroughs as not all areas have a Foyer. The average length of stay in quick access interim accommodation is between 14 and 21 days. Stays of longer than 28 days are only available if there are exceptional circumstances.

Referral of young people to the quick access accommodation in the Foyers is undertaken primarily by the Young Persons Worker following a joint assessment. The outcome of preventing homelessness is a significant reduction in the costs of temporary accommodation and long term dependency associated with young people becoming looked after.
Website:
http://www.yourspacewestsussex.co.uk/advice_and_info/housing_for_young_people/housing/16_and_17_year_olds.aspx

Your Space Counselling Service
This is a counselling service for schools in West Sussex which was based in a school in Sompting previously and is now commissioned and delivered through WSCC, Youth Service. There are 1.5 WTE managing the service and 19 therapists. Services offered are play therapy and counselling for children and a school-based counselling service. Schools can opt to purchase services from Your Space.
Website:
http://www.yourspacewestsussex.co.uk/advice_and_info/organisations-1/organisations/finditout_centres/online_chat_and_support_facili.aspx

Social Communication Services

Social Communication Services (Sussex) is a voluntary sector service offering support / social mentoring to individuals with Asperger's Syndrome, Autism (ASC) and other Social Communication Difficulties. SCS provide outcome based, personalised assistance to any individual who has a long or short term difficulty in perceiving, transmitting or understanding social information, interaction or communication and the impact this has on their lives and the society around them. Social mentors are available to provide flexible 1:1 support for customers as well as services for families/carers. Social Mentors wide skill and knowledge base enables them to work according to the customers' needs in many different settings.

The diverse support this service provides includes:

- Developing independence skills
- Life skills coaching
- Social communication skill mentoring
- Positive behavioural management
- Building confidence and self esteem
- Social Inclusion
- Understanding Asperger's/Autism and other social communication difficulties
- Parental support and bespoke training adapted to personal circumstances.
- Assistance with employment / college
- Life transition work
- Self-management competencies
- Management of obsession and special interests.
- Carer and personal assistant advice and support

Website: http://www.socialcommunication.co.uk/

Brighton and Hove Advocacy Project

The Young People's Advocacy service work with young people who experience mental health difficulties or distress. The service has bases at Chalkhill and in Worthing (Worthing MIND) although on occasion home visits may be required. Outreach visits take place in a variety of appropriate locations in the local community.

Two part time advocates ensure that the service is promoted and accessible and is linked into all the relevant local networks. Advocates engage with clients through a range of methods including face to face meetings, group meetings, telephone support, letters, email and texts. From 2012-13, the service is reported to have worked with 98 clients with a further 16 receiving an introduction to the service. Access to the service is predominantly through referrals from professionals, with some referrals also from nearest relatives, and some self-referrals.

The predominant presenting issues that were elicited from service users and relatives for the service during 2012/13 included: Access to Services (voluntary, social services and primary care in particular), issues relating to mental health conditions, care and treatment, education issues such as Special Educational Needs (SEN), out of school learning and exclusion, legal support and housing issues.

Worthing Behavioural Service pilot

This is a Worthing based project for young people who are aged 12 – 18 years old and focuses on behaviour pathways for the following:

- Children and young people with severe learning disabilities.
- Children and young people with a diagnosis of ASC and/or ADHD.
- Children and young people with similar behaviour difficulties that are
- Persistent and on-going

The group aims to:

- To develop an integrated multi-agency behaviour support pathway for disabled children and young people and those with additional needs.
- To provide a forum for advice to commissioners and service providers.
- To receive feedback and information from families/carers about services and gaps in support.
- To inform the development of courses, workshops and information sessions for parents.

Lifestyle Weight Management Programme

Tier 2 weight management services for children in West Sussex are described as being:

- Multi-component
- Community based
- Are a Local Authority responsibility
- Should reflect best practice – see *Developing a specification for lifestyle weight management services: Best practice guidance for tier 2 services* (Dept. of Health 2013) and NICE Public Health Guidance 47
- Are a behaviour change service
- Need to include the whole family/parents
- Are for children aged 5yrs

Tier 3

Sussex Partnership NHS Foundation Trust

The Child and Adolescent Mental Health Service (CAMHS) / Children and Young People Services (ChYPS) Services

The Child and Adolescent Mental Health Service (CAMHS), is a specialist service which provides assessment and treatment of children and young people up to their 18th birthday who are experiencing significant mental health difficulties. The service is commissioned to bring about improvement in the mental health and wellbeing of children, young people and their families/carers, by working with the individual, family and wider multi agency network. CAMHS is a multi–disciplinary service, comprised of psychiatrists, psychologists, social workers, specialist nurses and a range of therapists who work closely together in order to improve emotional wellbeing, mental health and resilience for children, young people and their families/carers.

They offer children, young people and their families/carers a range of evidence based therapeutic interventions including, client centred, psychodynamic and systemic therapies, risk management,

problem solving, parental and family support, group therapies, cognitive behaviour therapy (CBT), pharmacology.

The service prioritises children and young people on mental health need and will see those at most risk within 4 hours, with a maximum wait of 4 weeks for those with more routine mental health needs. There is an 'Urgent Help Service' that provides intensive support for the most complex children and young people (See Tier 4). Priorities for response are; those who are considered a risk to self or others; Looked after Children, young people at risk of offending, substance misuse and developmental disorders. Locally based community CAMHS services are delivered through three teams across West Sussex:

Tier 3 service locations:

CAMHS Service	Area
North CAMHS	New Park House, North Street, Horsham RH12 1RJ
	Chalkhill Hospital, Lewes Road, Haywards Heath RH16 4EX
Worthing CAMHS	Children's Centre, Worthing Hospital Lyndhurst Road, Worthing BN11 2DH
Chichester CAMHS	John Grenville House, Stockbridge Road, Chichester PO19 8QJ
LAAC	Carters Lane House, Brunswick Road, Shoreham BN43 5WA
Assessment & Treatment Service (ATS)	New Park House, North Street, Horsham RH12 1RJ

Therapy

There are a number of therapeutic approaches reported to be practised by the Social Workers across the CAMHS teams. These range from individual work using an eclectic mix of Social Work skills and theories e.g. client centred, psychodynamic, systemic and systems theory, risk management, problem solving, parental support etc, to a number of group therapies. The group therapies include IAPT (Cognitive Behavioural Therapy), Family therapy (F/T), Brief Solution Focussed therapy (BSFT) and Emotional Wellbeing Clinics (EWB).

71 of the 187 cases (38%) are being worked therapeutically by Social Workers as described. Social Workers undertake around 17 sessions a week of group therapies. Sessions are approximately 3.5-4 hours in duration giving a total of 52 - 68 hours of group work a week (17 – 22% of the total of 301 hours per week worked by SW's).

Early Intervention Service

The Early Intervention Service is a community based service for young people aged 14 to 35 years, who are experiencing a first episode of psychosis. Early Intervention means getting help for any problems when they start, before they develop into a more serious illness - the earlier someone gets help, the more quickly support can be put in place to help their recovery.

The services offers one to one talking therapies, such as counselling and cognitive behavioural therapy (CBT), which may help young people to explore thoughts and feelings that can affect their behaviour and to develop ways of coping with those experiences.

Practical help is also offered with housing, benefits and finances, daily living skills support for people in getting back to work, studies and other social and leisure activities and also work with friends and families/carers.

EIP may use low doses of medication to help reduce the frequency, intensity and distress associated with unusual experiences occurring in psychosis. If the service assesses that medication might be appropriate, then there will be an opportunity to discuss options with a Doctor and the Pharmacist from the team. The service believes that it is important for the person accessing the service and others involved to have the right information to make choices about their care.

Five teams across Sussex are made up of professionals from a range of backgrounds, in order to offer a variety of perspectives and tailor the service to individual needs; i.e. Doctors, Nurses, Social Workers, Occupational Therapists, Psychologists, Pharmacists and Community Support Workers, Peer Support Workers & Employment Specialists

Assessment & Treatment Service (ATS)

The service works with children and young people who are/or have displayed worrying or harmful sexual behaviours. The team is available to offer consultation and direct work by working closely with the young person, their family or carer and the professionals who are involved with the case.

Looked After and Adopted Children Team (LAAC)

The CAMHS LAAC Team is a multidisciplinary team based in Worthing and providing a CAMHS input to Looked After and Adopted Children in West Sussex. The team consists of clinical staff: - art therapist, occupational therapist, primary mental health worker, psychologists, social work/play therapist, and systemic family therapist. A steering group of Senior Managers from Health and
Children and Young People's services provides the strategic overview for the service, sets priorities and implements policy and service development.

Complex Behaviour Support Service
The Child and Adolescent Mental Health Service/Child Disability Service (CAMHS /CDS) Complex Behaviour Support Team specialises in working with young people with moderate/severe learning disabilities and behaviours which can be described as presenting a challenge to their families/carers and carers. The team provides two ways of working; network consultations and direct case work.

West Sussex Urgent Help Team for young people
An acute community service that supports young people in crisis (Crisis Resolution Home Treatment, CRHT). They aim to support and work with other CAMHS teams, such as the community teams and to focus on home treatment. They are a multi-disciplinary team covering East and West Sussex and Brighton and Hove. There is a team leader in each area and a central hub for consultation.

Referral process
Assessments are undertaken within a demand and capacity model which is across Tier 2 and Tier 3. This is known as the Choice and Partnership Approach (CAPA) and was introduced across CAMHS in 2013. Choice is the initial assessment and Partnership is working together with the young person and if appropriate family/carer to formulate the care plan if further intervention is required following the Choice appointment. The CAPA model is multi-disciplinary and makes positive use of the skill mix, knowledge and experience of the multi-disciplinary team.

Duty system tier 2/3
There is a CAMHS duty system operating daily from Monday-Friday, 9-5. This provides a rapid response to any queries regarding mental health and risk for young people who may present at their GP's, local hospitals or paediatric wards.

There is also a consultation line that is staffed from 9-5, Monday-Friday. This provides advice and guidance regarding possible referrals or general concerns about young people and their mental health.
www.sussexpartnership.nhs.uk/services/childrenandyoungpeople

Crawley and Worthing Pilot Project – GP Referral Pathway Pilots
Locally and nationally the majority of young people suffering from depression and or anxiety often get no treatment. As a result of local concern raised by GPs in 2012 a new GP referral pathway was trialled in Worthing during 2013 and is about to be rolled out in Crawley (March 2014), with a view to possibly rolling out county wide in the future.

The Youth Service, in conjunction with Sussex Partnership Foundation Trust, Sussex Central YMCA and West Sussex Integrated Services Team, have successfully provided the seamless pathway. The aim of the GP referral pathway:

- To engage and support young people (aged 12-18 years) with emerging mental health difficulties by providing early intervention for their long term mental health needs.

This pathway has provided a youth friendly environment to the world of mental health, responding to calls from young people for many years whenever they have been consulted.

Targeted services

Social Worker provision

The majority of funding for targeted services goes into this area and is delivered through a Social Work team which consists of; 8 FTE social workers who are West Sussex County Council employees seconded to Sussex Partnership NHS Foundation Trust. In terms of staffing;

The Social Workers in CAMHS are currently seconded to Sussex Partnership Foundation Trust (SPFT) under a schedule of the CAMHS contract until May 2013 when the contract was due for review. There are 8.18FTE (301 hours social work posts and a Professional Lead (Service Manager) post of 0.86 FTE (32 hours). There are ten Social Workers occupying these posts and one Professional Lead.[14]

Tier 4

Funded and commissioned by NHS England

Sussex Partnership NHS Foundation Trust

Chalkhill Hospital
Lewes Road
Haywards Heath
RH16 4EX

Chalkhill Young Persons Inpatient Unit

Chalkhill is described within their marketing materials as a contemporary non-institutional building for vulnerable group of young people [aged 5 – 18] who suffer from a wide range of mental health conditions. The building has the facility for 16 adolescent beds (across Sussex and nationally under NHS commissioning arrangements) with access 24 hours a day seven days a week. Within the service there is also a de-escalation area, adolescent day places, together with education, therapy and the crisis resolution and home treatment team base. These services are described as being part of a comprehensive stepped model of care to support young people with acute mental health problems from East Sussex, West Sussex and Brighton and Hove.

There is a comprehensive Education programme delivered through an onsite school and this recently received an 'outstanding' rating from OFSTED.

The main aim with inpatient admissions is to keep the stay as a short as possible and the emphasis is on ensuring that the treatment follows the child back to the community so that the treatment programme matches the needs of the child and the family and carers. The service works with all of the agencies which can play a part in children's lives, for example education, social services and where appropriate the police and substance misuse services. Young people seen within services present with a range of problems; early onset psychoses, depression, and eating disorders.

[14] Extracted from a social work report dated January 2013

Day Service
Chalkhill also provides a day care programme for adolescent young people, which is commissioned by CCG'S across West Sussex, East Sussex, and Brighton & Hove.

Urgent Help Service (UHS)
The crisis resolution and home treatment team (urgent help service) acts as the gateway into the service. It aims to add to existing packages of care for children and young people with acute mental health needs in an intensive way by providing 3-5 contacts per week over a time limited period of 4-8 weeks in order to maximise the coping resources of the child or young person and their support networks. The service operates 0900-2000 weekdays with a weekend service, 1000 to 1800, in order to meet crisis and home treatment needs during this period.

The service operates locally based home treatment services in East Sussex, West Sussex, and Brighton & Hove. The model is designed to support Care Co-ordination at a Tier 3 level and multi-agency working in a team around the child approach.

It is expected that the care coordinator in the locality CAMHS will broker in home treatment team services. Therapy and medical interventions where appropriate will continue to be provided from that locality service. This is in order to maximise the team around the child approach, and provide a continuity of care. Resources at Chalkhill are focussed on assuring robust positive risk management and consistency of formulation across the caseload. Long term therapeutic interventions (i.e. beyond 4-8 weeks) will for the most part remain the province of the referring team.
The primary purpose of the CRHT Service is to provide an intensive home treatment service to children and young people who are presenting with acute mental health needs or emotional disturbance to a degree where the levels of risk they pose indicate an inpatient admission may be necessary. This will enable young people where possible to be supported to remain at home and reduce the need for an inpatient admission and ensure appropriate and a timely access to and discharge from the inpatient service.

In addition, the service responds to mental health crises of children and young people out of normal office hours as well as undertaking a gate-keeping role for admission to the CAMHS Tier 4 Day and Inpatient Adolescent unit.

Family Eating Disorders Team (FEDS)
Sussex Partnership NHS Foundation Trust
Chalkhill Hospital
Lewes Road
Haywards Heath
RH16 4EX

Service Objectives

The primary objective of the CAMHS Family Eating Disorder Service for West Sussex is to provide an early intervention, intensive home treatment service which puts young people at the centre. The primary aims are; to keep them in their home environment thus increasing positive outcomes and

reducing need for inpatient care, to ensure appropriate and timely access to and discharge from, the inpatient service when necessary. In addition the service undertakes a facilitating role, in partnership with UHS, for admission to Chalkhill, the CAMHS Tier 4 Day and Inpatient Adolescent unit.

It is expected that the care coordinator in the locality CAMHS will access services from the team and that therapy and medical interventions, where appropriate, will continue to be provided from that locality service, in order to maximise the team around the child approach. Where there are acute co-morbid MH issues FEDS will work in conjunction with T3 locality CAMHS and UHS to facilitate care plans.

Service provision

The service delivers an intensive home treatment package which include consultation and joint working with Tier 3 clinicians. An individual diet plan is formulated and supported with regular weight and height monitoring. Family/Individual work includes, support around mealtimes that may be intensive initially, but will decrease in frequency as the family feel more confident in their own management skills in that situation. Young people will have a primary diagnosis of anorexia nervosa. But Consultation can be sought for EDNOS. This is the mental health service delivery as they work closely with the GP who delivers the general medical aspect of care.

Referral criteria

Anorexia Nervosa with rapid onset and/or rapid weight loss.
Newly presenting and/or untreated Anorexia Nervosa
Where little or no improvement is made following intervention within tier 3 MDT

Access

Via referrals from Tier 3 CAMHS Community teams (using CPA + gateway screening tool) following a multi-disciplinary assessment.

APPENDICES

Appendix 1: NICE Guidelines (adapted from CHIMAT resource)

Appendix 1 NICE Guidelines (adapted from CHIMAT resource)

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

NICE Public Health Guidance

PH12	Social and emotional wellbeing in primary education	Sept 2009
PH20	Social and emotional wellbeing in secondary education (PH20)	March 2008