

London Borough of Barking and Dagenham

Children and Adolescent Mental Health Integrated Needs Assessment



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1. Executive Summary

Introduction

In order to more effectively meet the needs of children and young people, the London Borough of Barking and Dagenham (LBD) wants to:

- understand the mental health needs of the child and young person's living in the borough,
- understand the services that respond to these needs currently,
- understand the gaps in current provision,
- build a model of response to the identified needs based on robust evidence

National policy sets out the direction of travel to meet the mental health needs of children and young people in England. Service transformation is key. Throughout the different national policy there is an emphasis on prevention and promotion, earlier intervention and timely access to specialist services, with intervention and support being evidence-based and focused on achieving measurable outcomes. There is a need to demonstrate accountability and transparency and measurability alongside developing the appropriate workforce. Future in Mind (2015) sets out numerous recommendations, which have been re-iterated by the Five Year Forward View for Mental Health (2016). There are many wider policies affecting children and young people's mental health as their mental health is multi-faceted and involves their family, their education and their social relationships.

The local strategic direction for Barking and Dagenham reflects these national policies, with an emphasis on early help, resilience-building, better support for the most vulnerable children, and service transformation, which are being addressed through the Local Transformation Plan (LTP) for Children and Young People's Mental Health. This will become part of the local Sustainability and Transformation Plan as that is developed. The LTP sets out the work to be done locally on: building resilience and promoting prevention; developing a wellbeing hub; maximising the use of digital resources and guided self-support; better support for children, young people and families with mild/emerging behaviour difficulties; better support for looked after children and those leaving care; and a new service model for eating disorders.

Commissioning

Commissioners of services may be within the CCG, the local authority, NHS England and schools. This can lead to fragmented commissioning with gaps and overlaps occurring. LBD have started to address this fragmentation this through appointing a joint CAMHS commissioner across the CCG and LA.

Overview

Good mental health is more than the absence of mental illness; it is a positive sense of well-being. This includes the ability to play, learn, enjoy friendships and relationships, as well as deal with the difficulties experienced during childhood,

adolescence and early adulthood.¹ This means that all parts of the system that work around the child and family have a part to play in promoting their mental health and supporting them when they are experiencing difficulties.

Particular development phases have specific issues in relation to children and young people's mental health. Particularly key are infancy and adolescence.

This needs assessment looked at the mental health needs of the children and young people of Barking and Dagenham from the perspective of epidemiological information, stakeholders (staff and service users) and comparative in other areas of England.

Epidemiology and prevalence findings for Barking and Dagenham

There is little published data about prevalence of mental health disorders in children and young people in Barking and Dagenham, and there appears to be limited service activity data available for public health analysis. This presents a barrier to describing the relationship between likely need and provision, however, the borough's demographic profile suggests that high levels of common mental illness would be expected. There was a need to use publicly available health data collected for Barking and Dagenham from a range of sources. In order to verify this data, statistical neighbours were then used to compare findings. LBBDD prevalence rates are largely similar to their statistical neighbour, which indicates that the data can be taken as reliable.

Between 10.4% (n=6796) and 11% (n=7188), of children and young people (aged under 19) in Barking and Dagenham are estimated to currently have a diagnosable mental health problem. This rate is higher than the national average of 9.3%. Rates of autism, ADHD, learning disability and pupils with behavioural, emotional and social support needs are lower than national rates. Rates of eating disorders are higher than the national average. Rates of admission to acute hospitals for mental ill health, substance misuse and self-harm are lower than the national average (2013)

By 2020 At least 8,044 children and young people in Barking and Dagenham are predicted to have a mental health problem requiring Child and Adolescent Mental Health Services (CAMHS). This is an 18.3% increase on 2013 numbers.

Some groups of children and young people are more at risk of experiencing mental health problems, these include those living in poverty, Looked After Children, those in contact with the criminal justice system, those with a learning disability, children whose parents have their own mental health problems, and children living in situations of domestic violence.

The Index of Multiple Deprivation indicates that LBBDD falls into the top 7% of most deprived boroughs in England. The link between social advantage and the risk of developing a mental health problem is strongly documented in literature, which also explains the high rate of mental health disorders in LBBDD. The statistics indicate that the LBBDD population scored very highly on the key risk factors for child mental illness, including the number of lone parents, number of homeless families, number of unemployed persons of economically active age, children <16 living in poverty and <18s pregnancies, to name a few. Barking and Dagenham has a disproportionately high number of first time offenders.

¹ NPC (2008) Heads up. Mental Health of Children and Young People.

At any one time, 14,150 children and young people may need support for their mental health in Barking and Dagenham. Across the tiers of services, this is 8870 children and young people requiring support from tier 1, 4140 at tier 2, 1095 at tier 3 and 45 at tier 4.

Benchmarking

The latest available cost and outcome data for CAMHS is 2011/12. When compared to other areas with similar programme budgets Barking and Dagenham outcomes for A&E attendances for self-harm, hospital admissions for self-harm, and hospital admissions for alcohol specific conditions are better than other areas.

When compared to other areas with similar programme budgets Barking and Dagenham outcomes for number of first entrants into the youth justice system, number of hospital admissions for substance misuse is poorer than other areas.

When compared to other areas with similar programme budgets Barking and Dagenham outcomes for admission rates for mental health problems is similar between areas.

Mapping local services

The services available to children and young people in Barking and Dagenham were mapped across four tiers:

- Tier 1 prevention and resilience building activities which are typically picked up by schools and colleges, paediatricians, health professionals and 3rd sector services.
- Tier 2 services available within school, children's centres (via PMHWs up to the 31st March 2016), drop in centres and 3rd sector services.
- An integrated Tier 2/3 CAMHS service provided by North East London Foundation Trust (NELFT), including a Crisis Response team (sitting between tier 3 and tier 4)
- A Tier 4 inpatient service (Brookside CAMHS Tier 4 and Willow High Dependency Unit) commissioned by NHS England. Due to unavailability of local beds, some young people from Barking and Dagenham go to in-patient units in different parts of the country. As of May 2016 no children and adolescents are being transferred from Barking and Dagenham to Brookside. This is as a result of building issues with the unit which are to be resolved.

Many universally accessed services in Barking and Dagenham report that they are involved in mental health promotion in some way. This can be through providing opportunities to discuss mental health concerns, or by ensuring that children and young people have someone to talk to 'in general'². Professionals working at tier 1 also indicated a range of emotional and practical support provided to support low level mental health needs including one-to-one work, home visits, reminders to attend appointments, consultation with CAMHS, counselling and referrals to other agencies. In schools it included pastoral support, mentoring support, groups, signposting, and support for parents. There is a plethora of promotion, prevention and interventions occurring in schools, including counselling, PHSE, anti-bullying approaches, amongst many more.

² Facilitated staff workshops held in October 2015

Tier 2, or targeted services, are most likely to be involved in the provision of early intervention, or working with those children and young people who have specific risk factors for higher rates of mental health problems. Barking and Dagenham has a well-embedded weekly Multi Agency Panel (MAP) which manages referrals to early intervention services which anyone can refer to. It also provides advice and consultation, including whether a child should be referred for CAMHS intervention.

Tier 3, or specialist CAMHS - referrals to community CAMHS average 103 per month and 94 are accepted. 59 new first appointments on average are conducted per month. About 340 children and young people are seen per quarter. Children and young people are seen, on average, for 7.85 appointments. 76% of those discharged from the service did so on clinical advice. There is an all-age eating disorder service.

Barking and Dagenham has tier 4 services, that is, a crisis response team (not 24 hours) and in-patient care within the borough. However, beds are commissioned nationally and sometimes children and young people have to go out of the borough to access in-patient care as local beds are full.

Stakeholder views

Families indicated:

- Accessing services can be daunting
- Some families are not aware of the services available to them
- Some professionals are not aware either
- Families appreciate consistent relationships with professionals who know them well
- Children and families like to understand what is happening, what is expected of them and to be involved in the decisions about what happens next.
- Families want a flexible approach to when and where services are provided.

Feedback from staff indicated the following needs and gaps:

- Staff in universal services are working with high levels of complex mental health needs and disorders and a third estimate that 30% of the children and young people that they work with have mental health problems
- Most staff know how and where to refer to specialist CAMHS, but a small majority do not think that the route to CAMHS is easy to navigate
- There is a need for more information from CAMHS on how to refer, when to refer, what work they are doing with children and young people who are accessing the services, and what these staff need to do once the child or young person is discharged from CAMHS via a step-down meeting
- A clear and simple pathway is needed across all services, which is consistently applied and communicated, and that includes self-referral, choice for the family, and electronic methods of communication
- There is a significant amount of resilience-building activity occurring, but this is not co-ordinated.
- There are gaps around promotion of mental health, but lots of ideas for delivering more mental health promotion work.
- Knowledge of current services and what support is available is limited

- There is a perceived lack of self-help materials
- A minority of staff felt that the interventions on offer in CAMHS met the needs of children and young people
- A large majority felt that there were not enough services to support children and young people in the borough

Options for the future

A blended model of the Thrive Model, incorporating resilience-building, has been recommended as the operating model for Barking and Dagenham.

14 recommendations have been made, under the following headings:

1. Key recommendations from Future in Mind
2. LTP Delivery
3. Resilience Building
4. Early Years
5. Age 5-12
6. Schools
7. Adolescents
8. GPs
9. Specialist Services
10. Transition
11. Partnership Working
12. Participation and Active Involvement
13. Workforce Development and Capacity Building
14. Cultural Competence

Child and Adolescent Emotional Wellbeing and Mental Health Needs Assessment

2 Introduction

2.1 Why was this needs assessment undertaken?

In order to more effectively meet the needs of children and young people, the London Borough of Barking and Dagenham (LBBD) wants to;

- understand the mental health needs of the child and young person's living in the borough,
- understand the services that respond to these needs currently,
- understand the gaps in current provision,
- build a model of response to the identified needs based on robust evidence.

3 Background information

3.1 Current national policy

In 2011, the government published a cross-government strategy for mental health, *No Health Without Mental Health*, which recognised mental health as 'everybody's business'. It set out six objectives:

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

In 2013, the *Children and Young People's Outcomes Forum: Mental Health Sub-Group*³ set out the key outcome measures mapped against the six objectives on the Mental Health Strategy⁴ above:

Objective 1: **More children and young people will have good mental health:**

- More children and young people of all ages and backgrounds will have better well-being and good mental health; and
- Fewer children and young people will develop mental health problems by starting well, developing well, learning well, working and living well.

³ Children and Young People's Health Outcomes Forum (2012) Report of the Children and Young People's Health Outcomes Forum – Mental Health Sub-Group

⁴ HM Government (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.

Objective 2: More children and young people with mental health problems will recover:

- More children and young people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable place to live as they reach adulthood.

Objective 3: More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health:

- Fewer children and young people with mental health problems will be at risk of premature morbidity and mortality in adult life. There will be improvements in the mental health and wellbeing of children and young people with serious physical illness and long-term conditions.

Objective 4: More children and young people will have a positive experience of care and support:

- Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give children and young people and their families the greatest choice and control over their own lives and a positive experience of care. Where in-patient care is required this should be in an age-appropriate setting and in the least restrictive environment

Objective 5: Fewer children and young people will suffer avoidable harm:

- Children and young people and their families should have confidence that care is safe and of the highest quality.

Objective 6: Fewer children and young people and families will experience stigma and discrimination:

- Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to children and young people with mental health problems will decrease.

The governmental policy document, *Achieving Better Access to Mental Health Services by 2020* (DH, 2014⁵), promotes parity between mental health and physical health services. It recognises the significant burden of mental ill health on the economy as well as the current imbalance in comparative budget allocation. This results in very different experiences of access and treatment for those experiencing mental health problems. The vision for 2020 promotes:

- ▶ Mental Health having equal footing with physical health
- ▶ Equivalent level of access to timely, evidence-based, clinically effective, recovery focused, safe and personalised care
- ▶ Physical needs of people with mental health conditions to be assessed routinely alongside their psychological needs and vice versa
- ▶ New standards, new payment and new commissioning regimes will drive a richer set of **data** - the maternity and children's dataset will provide picture of provision from next year.

⁵ DH (2014) *Achieving Better Access to Mental Health Services by 2020*. Department of Health.

The most recent reports specifically on mental health have been *Future in Mind: promotion, protecting and improving our children and young people's mental health and well-being* (2015) (FiM⁶) and the *Five Year Forward View for Mental Health* (2016) (FYFVMH⁷). Alongside other evidence, the findings from FiM will be referred to throughout this report, as will the findings from the FYFVMH.

Future in Mind (FiM) (2015) is structured around five key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

FiM describes the implications of transforming children and young people's mental health services for different staff and organisations, which can be summarised as:

Professionals working with children and young people in any setting

- skills and knowledge to deal with mental health needs, by providing or signposting
- understand the importance of their role

Health providers

- work collaboratively to deliver best possible care to improve outcomes
- using evidence based approaches and taking full account of the views of children, young people and their families/carers

Education providers

- whole school approaches to promotion and resilience
- early years settings, schools and colleges should have easy access to advice and referral routes

Voluntary and Community Sector

- provide support and expert advice
- greater use made of the VCS in local service design and commissioning

Children's Social Care

- commissioner and provider
- specialist knowledge of needs of many vulnerable children, young people and families
- social work teams need clear routes of referral and access to consultation and advice

Local Authority and Health Commissioners

- work together to ensure access to range of evidence-based services/interventions, across sectors with emphasis on early support
- feel confident that they have skills, information and support to make commissioning decisions, engaging with children and young people and families/carers

Health and Well-Being Boards

- JSNAs and Health and Wellbeing Strategy address needs effectively and comprehensively

⁶ DH & NHSE (2015) *Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being*. Gateway ref no 02939

⁷ Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health*.

Overall, FiM expects that the recommendations made will be delivered through Local Transformation Plans (LTPs) for children and young people's mental health, clear governance and co-commissioning arrangements. The LTPs should include the following key elements:

1. **Transparency:** A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing. A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.
2. **Service transformation:** A requirement for all partners, commissioners and providers, to sign up to a series of agreed principles covering:
 - the range and choice of treatments and interventions available;
 - collaborative practice with children, young people and families and involving schools;
 - the use of evidence-based interventions;
 - regular feedback of outcome monitoring to children, young people and families and in supervision.
3. **Monitoring improvement:** Development of a shared action plan and a commitment to review, monitor and track improvements towards the Government's aspirations set out in *Future in Mind*, including children and young people having timely access to effective support when they need it.

The Local Transformation Plan for Barking and Dagenham, which has been agreed and signed up to locally, is outlined in Section 3.2 below.

The Five Year Forward View for Mental Health (FYFVMH) from *The Mental Health Taskforce (2016)*⁸ calls for £1billion extra investment in mental health and outlines priority action for the NHS by 2020/21 as:

- A 7 day NHS – right care, right time, right quality – people facing crisis should have access to mental health care 7 days a week
- An integrated mental health physical health approach. By 2020/21 at least 30,000 more women each year should be supported to access evidence-based specialist mental health care during the perinatal period.
- Promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens – children and young people being the key group for this. Waiting times for children and young people should be substantially reduced, and significant inequalities in access should be addressed and support should be offered while people are waiting for care. By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it.

FYFVMH makes children and young people the priority group for mental health promotion and prevention. Commissioners are urged to place greater emphasis on prevention, early intervention and evidence-based care. Public Health England are asked to develop a national Prevention Concordat programme to support all Health

⁸ Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health*.

and Wellbeing Boards, to put in place updated JSNAs and joint prevention plans, no later than 2017.

Overall, the FYFVMH, in relation to children and young people, urges that the recommendations in FiM are acted upon and that the LTPs are refreshed and integrated into the new Sustainability and Transformation Plans (STPs).

The *NHS Mandate* sets the strategic direction for the NHS, for April 2016- March 2017⁹ as well as outlining expectations to 2020. The Mandate has several objectives, with some specific direction for child and adolescent mental health services (CAMHS). A new 'Ofsted-style' CCG framework for 2016-17 includes metrics to measure progress on priorities set out in the mandate:

OBJECTIVE 1: Improve local and national health outcomes through more effective commissioning.

OBJECTIVE 2: To help create the safest, highest quality health and care service.

OBJECTIVE 3: To balance the NHS budget and improve efficiency and productivity.

OBJECTIVE 4: To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

OBJECTIVE 5: To maintain and improve performance against core standards.

OBJECTIVE 6: To improve out-of-hospital care

- 1) Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018.
- 2) Agree and implement a plan to improve crisis care for all ages, including investing in places of safety to reduce the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and support them to live full, healthy and independent lives.

OBJECTIVE 7: To support research, innovation and growth.

The *Mental Health Crisis Care Concordat* is a national agreement between services and agencies involved in the care and support of people in crisis, setting out how organisations will work together to make sure that people get the help that they need when they are having a mental health crisis. The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to emergency crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in a crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

⁹ DH (2016) The Government's Mandate to NHS England for 2016-17.

The Care Act 2014, which consolidates all social care law into a single framework, became operational on 1 April 2015, and set out a new focus and direction for social care, with a focus on prevention, wellbeing and personalisation. The elements of wellbeing and prevention require a specific response of a locally agreed approach to promoting wellbeing and developing prevention¹⁰. The Care Act places the individual at the centre and the starting point for judging their wellbeing and taking responsibility, using their strengths and personal resources, to maintain wellbeing. The act outlines three core elements to prevention: prevent, reduce and delay.

The Children and Families Act set out changes to be implemented by local authorities from September 2014¹¹ and introduced a new single assessment process and an Education, Health and Care (EHC) Plan to support children, young people and their families from birth to 25 years. EHCs replace 'statement of education needs'. The Act also expects health services and local authorities to jointly commission and plan services for children, young people and families, and that there is integration between the NHS and local authorities in the delivery of care and support services. Local authorities need to publish a local offer. The local offer for Barking and Dagenham can be found here:

<https://www.lbbd.gov.uk/residents/children-young-people-and-families/local-offer/>

3.2 Local strategic direction

The Barking and Dagenham Children and Maternity Group (CMG) agreed 7 key themes for its work in 2015, sharing this with the Children's Trust and aligning it with the Children & Young People's Plan, the Health & Well-Being strategy and Joint Strategic Needs Analysis recommendations. These themes are:

- Improving Health outcomes for children with Special Educational Needs & Disabilities
- Integrated Early years (to include Maternity, Breastfeeding, early years development, HV transition, Immunisations. Currently separate priorities for Children's health and Maternity board)
- Improving Health outcomes for Looked After Children, Care Leavers and Youth Offenders
- Childhood Obesity
- Children's Mental Health and Wellbeing
- Teenage pregnancy and Sexual Health
- Urgent care (with particular reference to reducing paediatric attendances at A&E)

Barking and Dagenham's vision for Early Help¹² is:

"That the Council, with its partners, will work in a holistic way, to provide families – including those with additional and complex needs - with the interventions required to build resilience and help them thrive. Those interventions will be co-ordinated and sequenced in a way that maximises resources and minimises duplication, communicating with children and families in a clear and co-ordinated manner."

¹⁰ Joint Health and Wellbeing Strategy 2015 to 2018. Barking and Dagenham CCG and LBBDD.

¹¹ IBID

¹² Barking and Dagenham Website (Bardag-lscb.co.uk)

More specific to mental health, the CYP mental health LTP¹³ for Barking and Dagenham has as its vision:

“we want all children in Barking and Dagenham to enjoy emotional well-being and mental health...and that (they) are empowered to be resilient and able to cope with the challenges of everyday life...envisage that mental health to be seen as everybody’s business and that people within a child’s sphere of influence understand their role to prevent and promote good mental health.”

The LTP for children’s mental health has been agreed in Barking and Dagenham. It identified five themes for investment in addition to the specific investment in eating disorders. These themes are:

1. Building resilience and promoting prevention
2. Developing a well-being hub
3. Maximising use of digital resources and guided self-support
4. Better support for children, young people and families with mild/emerging behaviour difficulties
5. Better support for looked after children and those leaving care

These will be delivered through:

- Improvements in early intervention to include building support for emotional needs (as distinct from mental health needs), targeting investment in lower level and earlier help (including counselling and cognitive behavioural therapy) and collaborative commissioning with schools to support whole school resilience building
- Redesign services to remove the traditional tiers of CAMHS and have a single point of access for referrals, while exploring options for a dedicated service for Looked after Children (LAC) and outreach support.
- Redesign of services will include improved monitoring of outcomes delivered and targets regarding timely access
- Investment in skills and training of parents, children themselves, schools staff and staff in universal services, including a GP hotline, the development of mental health champions and a campaign to support improved understanding that ‘Mental Health is Everyone’s Business’
- Utilise new technologies to better support services
- Joint working between agencies and co-location of workers, with a single point of access into services and integrated electronic records
- Health promotion, prevention and early intervention through effective outreach into schools, primary care with targeted input to ‘hard to reach groups’
- Children’s self-help and self-management

¹³ Barking and Dagenham Children’s and Young People’s Mental Health Transformation Plan (October 2015)

- Technological solutions to include a digital directory of services and digital platforms for assessing outcomes and for use in clinical applications
- Outcomes monitoring that considers outcomes across the whole pathway and goals compatible with the new CAMHS Payment by Results and introduction of personal budgets

It is important to note that the LTPs are about service transformation and not filling gaps created through the de-commissioning of services.

CCGs are also working with partners in the development of the Borough Mental Health Crisis Concordat plan¹⁴. An action plan for a wider partnership is now in place. Partners include Barking and Dagenham CCG, Havering and Redbridge CCGs, North East London Foundation Trust (NELFT), London Borough of Barking and Dagenham (LBBD), London Borough of Havering, London Borough of Redbridge, London Ambulance Service and the Metropolitan Police. This plan will drive and deliver local improvements to crisis care, the specific parts relating to children and young people are:

- Extend the hospital based and CAMHS based support for children and young people at high risk
- Outreach services through CAMHS reviewed and developed to ensure Children and Young People identified as high risk are supported to remain out of Emergency Departments

3.3 Commissioner roles and responsibilities

Commissioning is the process for deciding how to use the total resource available for children, young people and parents and carers. The goal is to improve outcomes in the most efficient, effective, equitable and sustainable way. FiM (2015) acknowledges that commissioning might be a barrier to better models of care being successful, as commissioning is fragmented, with money sitting in different budgets and in different parts of the system. To address this, FiM expects that Local Authority and Health commissioners:

- work together to ensure access to a range of evidence-based services/interventions
- ensure provision is available across sectors with an emphasis on early support
- to feel confident that they have skills, information and support to make good commissioning decisions
- to engage with children and young people and families/carers routinely as part of the commissioning role

3.3.1 CCG as Commissioners

The Clinical Commissioning Group (CCG) commissions¹⁵ acute hospital care, community health services, rehabilitative care, urgent and emergency care, mental health services and, jointly with the Local Authority, learning disability services.

¹⁴ NHS Barking and Dagenham CCG (2015) Action plan to enable delivery of shared goals of the Mental Health Crisis care Concordat

¹⁵ NHS/DH (2012) equity and Excellence: Liberating the NHS.

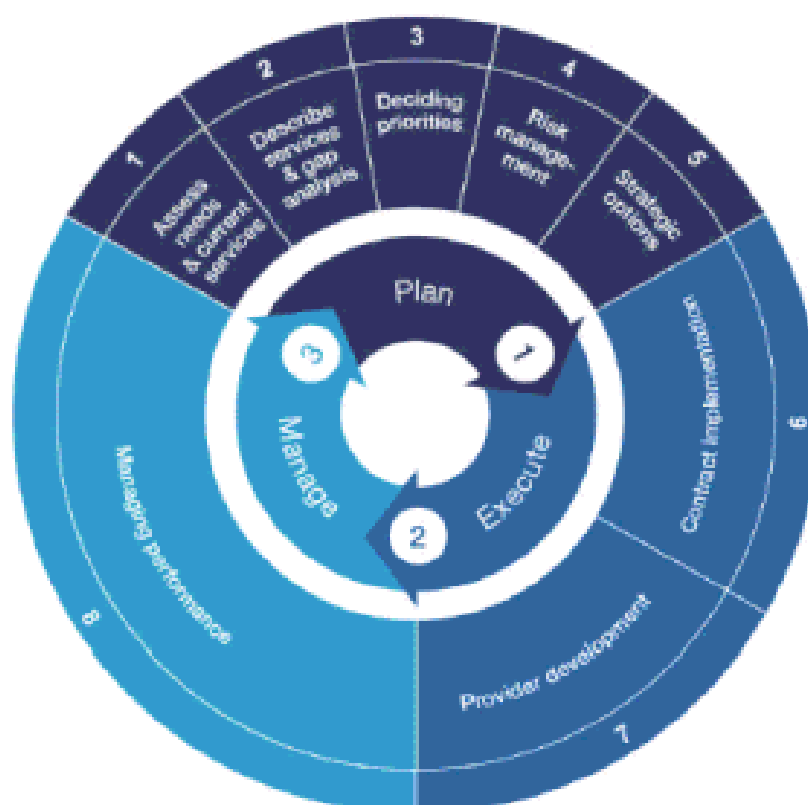
Barking and Dagenham CCG, in 2015, was given delegated commissioning responsibility for primary care from 2015/16 onwards.

The approach to commissioning health services across outer north east London is set out in the diagram below¹⁶ and described here:

1. Assess needs: through a systematic process, understanding of the health and health care needs of the resident population.
2. Describe services and gap analysis: reviewing the services currently provided and based on needs, defining the gaps (or over provision).
3. Deciding priorities: given a list of desirable actions, using available evidence of cost effectiveness and based on robust and defensible ethical framework, prioritise areas for purchase.
4. Risk management: understanding the key health and health care risks facing the system and deciding on a strategy to manage it.
5. Strategic options: bring together all the available information into a single strategic commissioning plan that outlines how the core objectives will be delivered
6. Contract implementation: put those strategic plans into action through contracting.
7. Provider development: (including care pathway redesign and demand management): support provider improvements or introduce new providers to deliver the services required (including setting up demand management systems and designing new care pathways). This includes supporting providers in decommissioning of services where appropriate.
8. Managing provider performance: monitor and manage the performance of providers against their contracts, especially against KPIs

Figure

1



¹⁶Barking and Dagenham CCG, in 2015, was given delegated commissioning responsibility for primary care from 2015/16 onwards.
<http://www.barkingdagenham.nhs.uk/>

The 2015/16 planning guidance reaffirms the expectation of the commitment to deliver the Five Year Forward View. For CCGs there is the expectation that spending on mental health services in 2015/16 is to increase in real terms by at least as much as the CCG allocation increase. There are new access and waiting time standards in mental health that are focused on:

- Early Intervention in Psychosis (EIP),
- Increasing Access to Psychological Therapies (IAPT) for adults,
- Community eating disorder services for children and young people,
- The planning of effective liaison psychiatry services.

There is also the expectation that CCGs work with local government partners to set local levels of ambition to reduce health inequalities and improvement in outcomes for health and wellbeing by focusing on prevention.

3.3.2 Local Authority as commissioners

Local Authorities, under the NHS architecture outlined by the government in 2012¹⁷, now lead on local health improvement and prevention activity, otherwise known as public health, as well as leading on the production of Joint Strategic Needs Assessments (JSNA). The Local Authority also now commissions the Healthy Child Programme delivered by health visiting and school nursing services.

There is a requirement through the Children and Families Act that health services and local authorities jointly commission and plan services for children, young people and families. Barking and Dagenham have established a joint CCG/LBBD commissioning post for children, and have joint governance for both organisations through the Health and Wellbeing Board (HWB).

3.3.3 NHS England (NHSE) as commissioner

NHSE is expected to commission primary care medical/GP services, other family health services such as dentistry and community pharmacies, national and regional specialised services, maternity services and prison health services. In relation to CAMHS, this means that NHSE commission Tier 4/very specialised services for the whole of England. They also commission some perinatal and mother & baby units.

3.3.4 Schools as commissioners

In recent years, schools have become significant commissioners in their own right, with increasing autonomy over resources and budgets. The Academy programme driven by national government will further support this trend. It is critical that schools are supported to work together and are engaged as equal partners to avoid fragmentation and duplication in the system. Due to the current financial climate, pressure on the public purse and new reforms, it is important that schools are able to clearly demonstrate need for goods and services that are commissioned¹⁸.

¹⁷ NHS/DH (2012) Equity and Excellence: Liberating the NHS

¹⁸ Hertfordshire (2015) School Commissioning Guide: an information guide for the commissioning and procurement of goods and services for schools

http://www.thegrid.org.uk/info/office/commissioning/documents/school_commissioning_guide_oct15.pdf

4. Definitions of mental health

Good mental health is more than the absence of mental illness; it is a positive sense of well-being. This includes the ability to play, learn, enjoy friendships and relationships, as well as deal with the difficulties experienced during childhood, adolescence and early adulthood.¹⁹

The NPC (2008) distinguish between mental health problems, mental health disorders and mental illness, in line with most CAMHS services:

Mental health problems – a range of milder symptoms, such as feeling unusually sad, worried or angry. They affect 20-30% of children and young people and although debilitating at times, they will not be diagnosed for specialist treatment.

Mental health disorders – affect about 10% of children and young people and fit diagnostic criteria. This is when behaviour or feelings are seriously outside the normal range and cause significant suffering, impairing day-to-day life.

Mental illness - affecting 1-2% of children and young people – being more common in young people than young children. These are severe forms of psychiatric disorder, particularly of the kind also found in adulthood, for example, depressive disorder, schizophrenia and obsessive disorders.

Diagnoses alone do not indicate the severity of a condition, so they are often described as 'mild', 'moderate' or 'severe'. Diagnostic labels provide a rough guide to understanding and treating a child's problems, but are often not the only reason for a particular feeling or behaviour as children also experience a whole range of family and social pressures and historical influences, which may also contribute to a child or young person's mental health problem. Children and young people want to be treated as individuals rather than as a diagnosis, and sometimes find diagnosis to be stigmatising.

One of the greatest concerns relating children with mental disorders is the rate of self-harm. In the 2004 prevalence survey (ONS, 2004²⁰), the rate of self-harm in 5–10 year olds was 0.8% in those with no disorder, rising to 6.2% in those with an anxiety disorder and 7.5% among the group of children with hyperkinetic disorder, conduct disorder or one of the less common disorders. The prevalence increased dramatically in adolescence with rates of 1.2% in those with no disorder, rising to 9.4% in those with an anxiety disorder and 18.8% in those with depression. In addition, the survey suggests that mental health problems are more common in boys (13%) than in girls (9%). These figures reinforce the need for a timely diagnosis of mental health problems.

¹ NPC (2008) Heads up. Mental Health of Children and Young People.

²⁰ Office for National Statistics: The mental health of children and adolescents in Great Britain. London: Office for National Statistics, 2004.

4.1 Specific development phases

There is very little strong evidence of the prevalence of mental health problems in 0-3 year olds, but it is estimated that 10% could have mental health problems. Marmot (2010)²¹ suggests that every child should be given the best start in life in order to reduce future social and health inequalities, reflecting the view that the origins of much adult disease are in the very early years (Davies et al, 2012²²). Davies *et al* also cite a number of longitudinal studies that have shown that securely attached children function better across a number of domains, including emotional, social and behavioural adjustment. The majority of children are securely attached, but up to 40% are insecurely attached: 25% have avoidant attachment patterns, and 15% (rising to 25% in disadvantaged cohorts) who have disorganised or resistant attachment (Moullin et al, 2014²³). These children are most at risk of behavioural problems, poor literacy, leaving school without further education, employment or training. They are at higher risk of externalising problems characterised by aggression, defiance and hyperactivity; poorer language development, weaker skills with their working memory and cognitive flexibility. Positive pro-active parenting (e.g. parenting that involves praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence and is protective against later disruptive behaviour and substance misuse.

Breast-feeding has been linked to positive emotional, health and cognitive outcomes for children. The national average for breast-feeding at initiation is 73.9% and in Barking and Dagenham is 73.7%. At 6-8 weeks the national average is 47.2% and in Barking and Dagenham it is one in four²⁴. The Joint Health and Wellbeing Strategy recognise the importance of breastfeeding to health and wellbeing and has adopted this as a priority area within the JSNA, particularly targeting White British mothers who are culturally less likely to breast-feed than residents who are black or from an ethnic minority group.

Adolescents have experienced the least improvement in health status of any age group in the UK in the last 50 years (Davies et al, 2012²⁵) but the brain development in early adolescence and through the early 20s brings with it great potential for building lifelong resilience and wellbeing. It also brings with it significant risks as it is also a window of vulnerability - choices made at this age heavily determine future life chances. Key protective factors at this age include a sense of belonging, strong peer support and a sense of community gained from schools and neighbourhoods.

²¹ Marmot (2010) Fair Society Healthy Lives <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

²² Davies et al (2012) Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays

²³ Moullin, S., Waldfoegel, J., Washbrook, E. (2014) Baby Bonds: Parenting, attachment and a secure base for children

²⁴ Barking and Dagenham HWB (July 2014) Breastfeeding Pathway Review. <http://moderngov.barking-dagenham.gov.uk/documents/s81406/6%20-%20Breastfeeding%20Pathway%20-%20report.pdf>

²⁵ Davies et al (2012) Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays

5. Methodology for the needs assessment

There are three main approaches to a health needs assessment, which were used to develop this needs assessment:

Approach	Method within this approach
<p>Epidemiological – prevalence and incidence data; the services available</p>	<p>Data from several different sources was used to identify prevalence and incidence data, and extrapolated to Barking and Dagenham*.</p> <p>Enquiries were made to organisations by email, telephone and attending meetings to identify services available locally and to request data on usage, demand, capacity, mental health presentations etc.*.</p>
<p>Stakeholder evaluation – structured collection of the knowledge and views of stakeholders; recognition of the importance of information and knowledge available from those involved in local services, including service users.</p>	<p>Two facilitated workshops for staff in CYP's services were held. About 20 people attended the workshops, held in October 2015*.</p> <p>An online survey for staff in CYP's services was developed and analysed. The survey ran from 1st October 2015 to 5th January 2016. 40 staff completed the survey. The survey was promoted via the staff stakeholder workshops and the Children's and Maternity Group members. Respondents were from different services and tiers, including Education (teachers; inclusion managers; PSAs, SENCos; Headteachers; n=18); CAMHS (psychologists; mental health workers; therapists; workers from 'The Listening Zone' (TLZ); n=12); Local Authority Children's Services (social workers; early intervention workers; early help; n=6) and the Voluntary & Community Sector (VCS) (n=4). One person did not identify their organisation or role*.</p> <p>An online survey for parents/carers was developed and analysed. They were asked to describe why and how they were referred to the CAMH Service, their awareness of universal preventative services in the community, waiting times to see CAMHS workers, types of interventions received and discharge processes. Ten parents responded to the survey and one grandparent.</p> <p>Two interviewers spent a day in the CAMHS waiting room to interview users of the service. Semi-structured interviews with parents and children who currently use CAMHS, to map out their referral pathways, reasons for coming to CAMHS, type of service received and experience of using Crisis services. Three interviews were conducted.</p> <p>Two interviewers attended the Listen group (CAMHS participation group) to ask about their experience before seeing CAMHS, experience of universal preventative services when problems first arose, suggestions for crisis services and idiosyncratic issues that local young people who live with mental health problems face. 1 young person was present at the group*.</p>
<p>Comparative: contrasts with other areas where the information is available</p>	<p>A bench-marking exercise was undertaken comparing B&D with nearest neighbours and statistical neighbours.</p>

*separate reports available.

5.1 Data Limitations

There were several data limitations in the production of the needs assessment. This is not a purely local issue - for example, it has been found that for 67% of CAMHS in England there is little or no data available for how mental health funding is used at a local level²⁶.

Routine data collection is required to provide transparency about how local areas are addressing needs, including how they are responding to the community demographic profile (age, gender, ethnicity, disability and sexuality). The transformation envisaged by several policy/guidance documents will take a number of years to implement. Delivery of plans will require clear information and good quality data ranging from qualitative information on outcomes delivered, care pathways and quality of care provided through to, hard data on levels of spending, access, discharge etc. Without this data, it will be very challenging to accurately assess the impact of any organisational change. A separate report, outlining potential data collection requirements has been produced.

5.2 Data used

Due to the limited nature of local data, several other data sources were used to inform the needs assessment. These are set out in the table below alongside the rationale for usage and the limitations of each:

Table 1

Data item	Reference	Reason for use	Limitations
PHE profiling tools/ prevalence estimates	http://www.phoutcomes.info/	Prevalence rates for mental health, risk factors associated with mental health, benchmarking	Data is often from two or three years ago, no data available for 0-18s, only for 5-16s and 16-24s.
ChiMat	http://www.chimat.org.uk/	Prevalence rates for mental health, risk factors associated with mental health, benchmarking	Estimates rely on data obtained from PHE
JSNA	LBBD (2015) Joint Strategic Needs Assessment. Health and Wellbeing Board.	To compare PHE figures to some local data. Also used it for establishing profile of local children	Not much mental health data available from local sources.
DfE SEN statistics	Department for Education special educational needs statistics (2016)	To estimate the prevalence of ASD; behavioural, emotional and social support needs; communication needs and SEN statements	Difficult to compare to PHE statistics because the breakdown of data is different. Also some disorders are categorised differently.
B-CAMHS	Office for National Statistics: The mental health of children and adolescents in Great Britain. London: Office for National Statistics, 2004	To estimate national prevalence rates	Categories are very general and do not allow much comparison with more detailed data in PHE and ChiMat

²⁶ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

Youth Justice statistics	MoJ and Youth Justice Board for England and Wales (2016) Youth Justice Annual Statistics. London: Stationery office	To estimate no. of young offenders who commit violence against a person and sexual offences	No estimate of offenders <15
LBBB Public Health Intelligence Office	Correspondence	To estimate no. of UASC	Does not compare the number to other parts of the country or national average
Psychiatric Morbidity among Young offenders survey	ONS (1997) Psychiatric Morbidity among Young Offenders in England and Wales. London: DH	To estimate prevalence of MH problems in young offenders	Data is from 1997
ONS mid-year estimates	Office for National Statistics mid-year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014).	To estimate number of service users per tier and to compare to PHE and other estimates	Figures are estimates of users at any one time and do not take into account differing volumes of referral
Population estimates	ONS (2011) Sub-national population estimates	To estimate population projections until 2020	The data is from 2011. It doesn't take into account changes in population trends over time
Census data	Census (2011) Barking and Dagenham Ward Level Analysis https://www.lbbd.gov.uk/wp-content/uploads/2014/09/2011-Census-Borough-Analysis.pdf	To estimate the number of lone parent households and unemployed persons of economically active age with children	Data is from 2011
Census data	Census (2011) Sub-national population estimates. UK:ONS	Population projections	Data is from 2011, but that specific gender breakdown was wanted.
Barking and Dagenham Gypsy and Traveller population report	Barking and Dagenham Council-London and Gypsy Traveller Unit (2006) Report on Gypsies and Travellers NHS (2013) Commissioning Support and Implementing Best Practice Factsheet: Perinatal Mental Health Problems	To estimate the size of Gypsy and Traveller population	Data is outdated and does not cover all sub-categories of Gypsy/Roma population
Rate of looked after children who meet criteria for mental health disorder	ONS (2002) The mental health of young people looked after by local authorities in England. London: DH	In absence of LBBB data we used national prevalence	Does not take into account local user profile, needs etc.
Rate of looked after children who meet criteria for emotional and behavioural difficulties	[1] Sempik, J (2008). Mental Health of Looked After Children in the UK: Summary. Centre for Child and Family Research	In absence of LBBB data national prevalence was used	Does not take into account local user profile, needs etc.
Adult Psychiatric Morbidity Survey	McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. Adult psychiatric morbidity in England, 2007. Results of a household survey. Leeds: The Health & Social Care Information Centre, 2009.	To estimate mental health disorders for 16-18 year olds, where B&D data was not available	Data is from 2007. Only represents national estimates

6. The Local context

6.1 Children and Young People's Population in LBBD

According to the LBBD Joint Strategic Needs Assessment (2015)²⁷, there are currently 65,345 children and adolescents <19 years living in LBBD.

6.2 Estimated population growth

Up until 2008, Barking and Dagenham's population growth rate was below the London average. Since 2008 however, the Barking and Dagenham population has increased at an average rate of 2.5% a year, compared to an average rate of 1.6% for the whole of London. Census data shows that between 2001 and 2011 the population of LBBD grew by 12.2% - this has particularly been in the age group 0-19. This is significantly higher than the England and Wales average of 7.1%. It is also higher than the London average of 11.6%. This indicates that the population in LBBD is on the rise, which will need to be addressed by the commissioning and through the transformation of local services, including CAMHS (ONS, 2015). Below are the projected figures for children and adolescents until 2020.

Table 2

Males	2012	2020	Difference %	Females	2012	2020	Difference %
0-4	9,682	11,650	20.3%	0-4	9,382	11,030	17.6%
5-9	8,038	10,302	28.2%	5-9	7,376	9,903	34.3%
10-14	6,458	8,354	29.4%	10-14	6,363	8,198	28.8%
15-19	6,710	6,824	1.7%	15-19	6,294	6,617	5.1%

The figure above suggests that by 2020, the male child population <18 years of age in LBBD will increase by approximately 11.4% and the female population of the same age- by 12% (extrapolated from the table). This represents an increase of approximately 7,600 children in LBBD.

7. Expected numbers, distribution and pattern of mental health need in LBBD (Epidemiology)

By 2020 at least 8,044 children in Barking and Dagenham are predicted to have a mental health problem requiring CAMH services. Estimates are based on extrapolating from national population data but do not include social factors which may increase vulnerability.

²⁷ LBBD (2015) Joint Strategic Needs Assessment. Health and Wellbeing Board.

7.1 Estimated Prevalence

Mental health problems in children and adolescents are common and account for a significant proportion of ill health issues in this age group (Murphy and Fonagy, 2012²⁸). Mental ill health in children causes distress and can have wide-ranging effects, including impacts on educational attainment, and social relationships, as well as physical health. Public Health England data (2013²⁹) suggests that in the age group between 5-16 years, the prevalence of mental health disorders is close to 1 in 10. This figure has been relatively stable over the past 15 years (see Office for National Statistics, 2004³⁰). There has been less research on the profile and rates of problems in the under-5s. One study showed that the prevalence of problems for 3-year-old children was similar to the 5-16 year-olds, and was in the region of 10% (Stallard, 1993³¹).

7.2 Comparative prevalence of mental health disorders in LBB

Of the 65,345 children and adolescents <19 years currently living in LBB, it is estimated by the JSNA that 4,500 children and adolescents in Barking and Dagenham have a diagnosable mental health problem (6.8%). This is considerably lower than the Public Health England figures for Barking and Dagenham, which suggest 10.4% (n=6796). The PHE figure, used in the comparison tables below, is likely to be more accurate because it takes into account all known risk factors.

Looking at the conditions with the highest prevalence rate in LBB (emotional disorders, conduct disorders and hyperkinetic disorders), it can be concluded, by using data from ChiMat and Public Health England, that LBB rates are significantly higher than the national average. This again indicates that the figure of 6.8% may be considerably under-estimated.

The table below shows data collated from national data sources³² in December 2015. We recognise that data sets are updated regularly, up-to-date data will be needed for accurate monitoring see Appendix 1.

The prevalence of mental health disorders in children and adolescents in Barking and Dagenham is significantly higher than the national averages. As the local population increases the number of cases of mental illness will increase.

Prevalence of emotional disorders, conduct disorders, hyperkinetic disorders, speech and language disorders as well as suspected eating disorders are all significantly higher in LBB compared to national averages. Notably, the rate of children with autism spectrum disorder, learning disability and behavioural, emotional and support needs are all significantly lower than the national average. There is a local perception that the rate of autism is high, contrary to the figures – local figures have been examined and do support the lower rate. This perception may warrant further investigation. The rate of special education needs and rate of SEN statements are all similar to national figures.

²⁸ Murphy M. & Fonagy, P. (2012) Mental health problems in children and young people. In Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays.

²⁹ Public Health England Observatories. Retrieved from <http://www.phoutcomes.info/>

³⁰ Office for National Statistics: The mental health of children and adolescents in Great Britain. London: Office for National Statistics, 2004

³¹ Stallard P: The behaviour of 3-year-old children: Prevalence and parental perception of problem behaviour: a research note. *J Child Psychol Psychiatry* 1993, 34: 413- 421

Table 3. Comparison of LBBB with national data figures³² mental health disorders - collated December 2015

Benchmark Value (England) (2011, 2013, 2014/15)

Indicator	LBBB (%)	England (%)	Ranking of LBBB compared to England average
Prevalence of any MH disorder: % population aged 5-16	10.4	9.3	Significantly higher: above 75 th percentile
Estimated prevalence of emotional disorders: % population aged 5-16	3.9	3.6	Significantly higher: above 75 th percentile
Estimated prevalence of conduct disorders: % population aged 5-16	6.5	5.6	Significantly higher: above 75 th percentile
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	1.8	1.5	Significantly higher: above 75 th percentile
Pupils with autism spectrum disorder: % of pupils with this disorder ³³	0.7	1.4	Significantly lower than the national average: on 25 th percentile
Pupils with Learning Disability: % of pupils with Learning Disability	2.26	2.87	Significantly lower than the national average: on 25 th percentile
Pupils with behavioural, emotional, and social support needs: % of pupils with behavioural, emotional, and social support needs ³⁴	1.1	2.2	Significantly lower than the national average: on 25 th percentile
Pupils with speech, language, or communication needs: % of pupils with these needs ³⁵	2.3	2.2	Similar to national average
Pupils with special educational needs (SEN): % of all school age children with SEN	18.1	17.9	Similar to national average

³² The figures in this table were obtained from and cross-referenced between Public Health England (<http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>), Child and Maternal Health Observatory (<http://www.chimat.org.uk/>) and LBBB Joint Strategic Needs Assessment (<http://www.barkinganddagenhamjsna.org.uk/Pages/jsnashome.aspx>)

³³ Department for Education (2016) special educational needs statistics – January. UK: DfE




³⁴ IBID

³⁵ IBID

Pupils with a SEN statement or EHC plans: % of all school age pupils ³⁶	2.3	2.79	Similar to national average
Number of young people in substance misuse treatment (<18)	302 (0.5%)	N/A	N/A
Prevalence of potential eating disorders among young people: % of 16-24 year olds	4.9	2.7 ³⁷	Significantly higher: above 75 th percentile
Prevalence of ADHD among young people: estimated % of 16-24 year olds	5.2	13.8 ³⁸	Significantly lower than the national average: on 25 th percentile

Hospital admissions due to mental ill health, substance misuse and self-harm were examined. Notably, Barking and Dagenham rates of hospital admissions for 2013 were significantly lower than the national average for the same year. All the figures are calculated from Hospital Episode Statistics. All the figures refer to hospital inpatient admissions not A&E episodes.

Table 4. Comparison of LBBD with national data figures ³⁹ admissions data collated December 2015

-  Within range of national average
-  Statistically better than national average
-  Statistically worse than national average

Red Line- Benchmark Value (England) (2011, 2013, 2014/15)

Indicator	LBBD (n)	England (n)
Child admissions for mental health: rate per 100,000 aged 0-17	66	87.2
Hospital admissions as a result of self-harm (10-24 years)	264.1	352.3
Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18	26.6	42.7

³⁶ IBID

³⁷ HSCIC (2012) Provisional monthly topic of interest: Eating disorders

³⁸ Adult Psychiatric Morbidity in England - 2007, Results of a household survey

³⁹ Amalgamated from Public Health England records

YP hospital admissions due to substance misuse: rate per 100,000 aged 15-24

79.7

81.3

The figures in Table 2 suggest that just over 11% of children in LBBD have one of the listed mental health disorders or substance misuse.

These are very conservative estimates, which control for high rates of co-morbidity in children. Public Health England figures indicate that approximately 60% of children's mental health problems are co-morbid.

Disorders which are typically not recorded for LBBD were also examined, and in order to do this, we extrapolated from the national figures obtained through ONS (2004) survey (data only available for <16s) and the Adult Psychiatric Morbidity survey (in order to examine figures for 16-18 year-olds) conducted by HSCIC in 2007. The table in the previous section indicates that the prevalence of mental health disorders in LBBD is on average 12% higher than the national average, and this has been taken into account when calculating the numbers in the table below.

Table 5. Estimated prevalence of MH problems in LBBD

MH disorders	National prevalence	Estimated no of 5-15-year-olds in LBBD (National prevalence increased by 12%)	National prevalence	Estimated no of 16-18 year-olds in LBBD (Nat. prevalence increased by 12%)
	For 5-15 year-olds(%) ⁴⁰		For 16-18 year-olds (%) ⁴¹	
Anxiety	3.3	1,195	2.5	356
Depression	0.9	323	0.9	127
Psychosis	N/A	N/A	0.2	38
PTSD	0.2	97	4.7	673
Diagnosable personality disorder ⁴²	N/A	N/A	1.9	267

⁴⁰ Office for National Statistics (2004): The mental health of children and adolescents in Great Britain. London: Office for National Statistics.

⁴¹ McManus S, Meltzer S, Brugha T, Bebbington P, Jenkins R. (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Leeds: The Health & Social Care Information Centre.

⁴² Adult Psychiatry Morbidity Survey uses this figure to predict the likely number of young people who will move to adult services and receive official diagnosis

The figures suggest that out of the 10-11% of children in LBBD who may have a mental health problem, as many as 7% of those aged 5 -18 years could have a more severe mental health disorder (single or co-morbid). This further supports the view that the figure of 11% is likely to be closer to the true estimate of prevalence based on 2015 population.

If we extrapolate national prevalence figures for boys (13%) and girls (9%), based on the population growth predicted in section 2.2, a very conservative prediction is that by 2020 at least 4,827 boys and 3,217 girls will have a mental health problem and may require CAMH service (8,044 children in total). This figure does not take into account any of the social factors which could increase vulnerability.

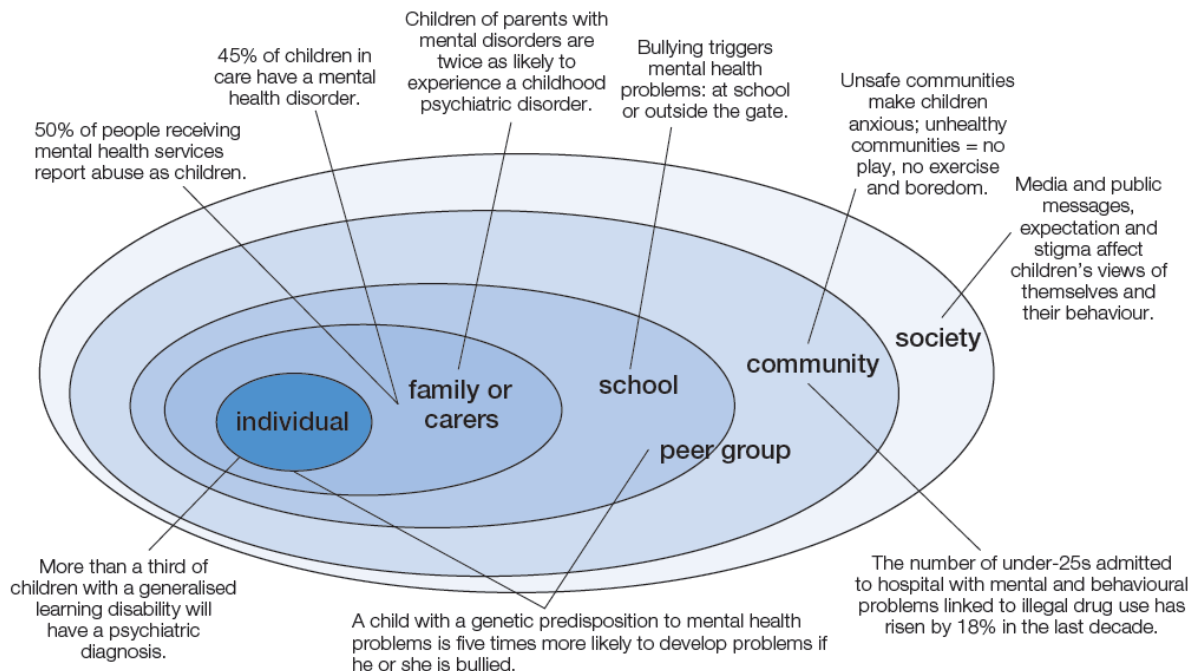
7.3 Risk and vulnerability factors

The causes of mental health problems are complex and there are a range of interrelating risks and triggers that will influence a child's development and mental health. These include:

- genetic factors
- individual risks such as having a learning difficulty
- the family environment
- problems at school (a child with a genetic predisposition to mental health problems is five times more likely to develop these problems if he or she is bullied⁴³); the community environment; and wider social influences.

NPC's (2008)⁴⁴ diagram illustrates the risk factors associated with child mental health problems, the influences on the child and gives examples of the risk they may face:

Figure 2



⁴³ Personal communication with Geraldine Strathdee, Director of Clinical Services at Oxleas NHS trust (3rd June 2008). Cited in: NPC (2008) Heads Up.

⁴⁴ NPC (2008) Heads Up. Mental health of children and young people. A guide for donors and charities. www.philanthropycapital.org

In the 2004 survey (ONS), the prevalence of mental disorder was higher in children and young people living in:

- lone-parent families (16%) compared with two-parent families (8%)
- families where a parent has no educational qualifications (17%) compared with those who had a degree-level qualification (4%)
- families with neither parent working (20%) compared with those in which both parents worked (8%)
- areas classed as 'hard pressed' (15%) compared with areas classed as 'wealthy achievers' or 'urban prosperity' (6% and 7% respectively)
- families where a parent has significant personal difficulties. Parental mental illness is known to be associated with a higher rate of mental health problems in children and young people, as is parental substance misuse and parental criminality (Royal College of Psychiatrists, 2012).

Barking and Dagenham:

- has the highest percentage of lone parent households in England and Wales at 14.3%. This is much higher than in other parts of London and England as a whole.
- is in the top 7% of most deprived boroughs in England (IMD, 2015). This means that children from this area are three times more likely to suffer from mental health problems than those living in more affluent boroughs.

7.4 Particular groups at higher risk of mental health problems

Children and young people who have experienced severe adversity such as abuse and neglect are at a particularly high risk of developing a mental health problem, as are looked after children and young people in contact with the criminal justice system.

National prevalence rates suggest that 45% of children who are Looked After meet criteria for a mental health disorder (ONS, 2002)⁴⁵, and 75% have emotional and behavioural difficulties (Sempik, 2008)⁴⁶. Extrapolating to predict local need indicates that 240 looked after children will have a mental health disorder and a total of 390 will have associated difficulties in 2015/16.

A study by Beck in 2006 in an inner-London local authority used the Strengths and Difficulties questionnaire to compare the mental health of looked after children who move placement frequently. The study found that young people who had moved placement three or more times in the previous year were three times more likely to have a 'probable' psychiatric diagnosis. They were also significantly more likely to report deliberate self-harm in the last six months compared to those who had moved placement less frequently

The emotional and behavioural health of children looked after is locally and nationally assessed through the completion of the Strengths and Difficulties Questionnaire (SDQ) for each looked after child from parents or carers collected by social workers. It is used with children aged between 4 and 16 who have been in care for at least 12 months. The SDQ is a short behavioural screening

⁴⁵ ONS (2002) The mental health of young people looked after by local authorities in England. London: DH

⁴⁶ Sempik, J (2008). Mental Health of Looked After Children in the UK: Summary. Centre for Child and Family Research

questionnaire. It has five sections that cover details of emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also positive behaviour. Good performance is a low SDQ score.⁴⁷

In 2014/15, for Barking and Dagenham:

- 183 scores were submitted for eligible Looked after Children (total 235) giving a good coverage rate of 78% (compared to the national rate of 68%).
- the average SDQ of LAC was 14.7 compared to 14.9 in 2013/14 (a Total Difficulties Score on the SDQ of 14-16 is a score of 'borderline'). This is slightly higher than national figures and those of comparable areas.
- the average SDQ LAC score has reduced significantly from a high average of 18.6 (an 'abnormal' score) in 2009/10.⁴⁸ This is closing the gap in relation to national and statistical neighbours,
- Scores relating to local children placed out of the borough are not known.
- Extrapolating from national research (ONS, 1997)⁴⁹ would indicate that 12,350 young people involved in the criminal justice system living locally could be diagnosed with a mental health problem in 2015/16.

Findings from the analysis of local data have shaped the development of the LPT.

Research suggests that just over 10% of White children have a mental disorder. Children of Black ethnic origin also have a fairly high rate of mental disorders (9%), followed by Pakistani/Bangladeshi group (8%) (ONS, 2004). The data on LBBB population indicates that 85% of children living in LBBB fall into these three ethnic groups.

There is a lack of evidence linking physical disability to mental health conditions, but children with a long-term illness are twice as likely as their peers to experience emotional or conduct disorder problems.

Learning disability is strongly associated with mental health problems in children and young people. Children and young people with learning disabilities are 3 to 4 times more likely to have behavioural problems and 40% will have a diagnosable mental health disorder. For those with severe learning difficulties, the rate is 3 to 4 that of the general population. Those with learning disabilities living in deprived, urban areas are at particular risk of mental health problems⁵⁰.

Children's whose parents have a mental health problem are at risk of developing mental health problems themselves. It has been suggested that up to 25% of these children aged 5-15 years will develop their own mental health problems. It is estimated that 9-10% of women and 6% of men will be a parent with a mental health problem (non-elderly adults), most having depression/anxiety and a small proportion any kind of psychotic disorder⁵¹. Some research also suggests that

⁴⁷ Barking and Dagenham JSNA 2015

⁴⁸ LBBB (2015) Joint Strategic Needs Assessment. Health and Wellbeing Board.

⁴⁹ Office for National Statistics (2004): The mental health of children and adolescents in Great Britain. London: Office for National Statistics.

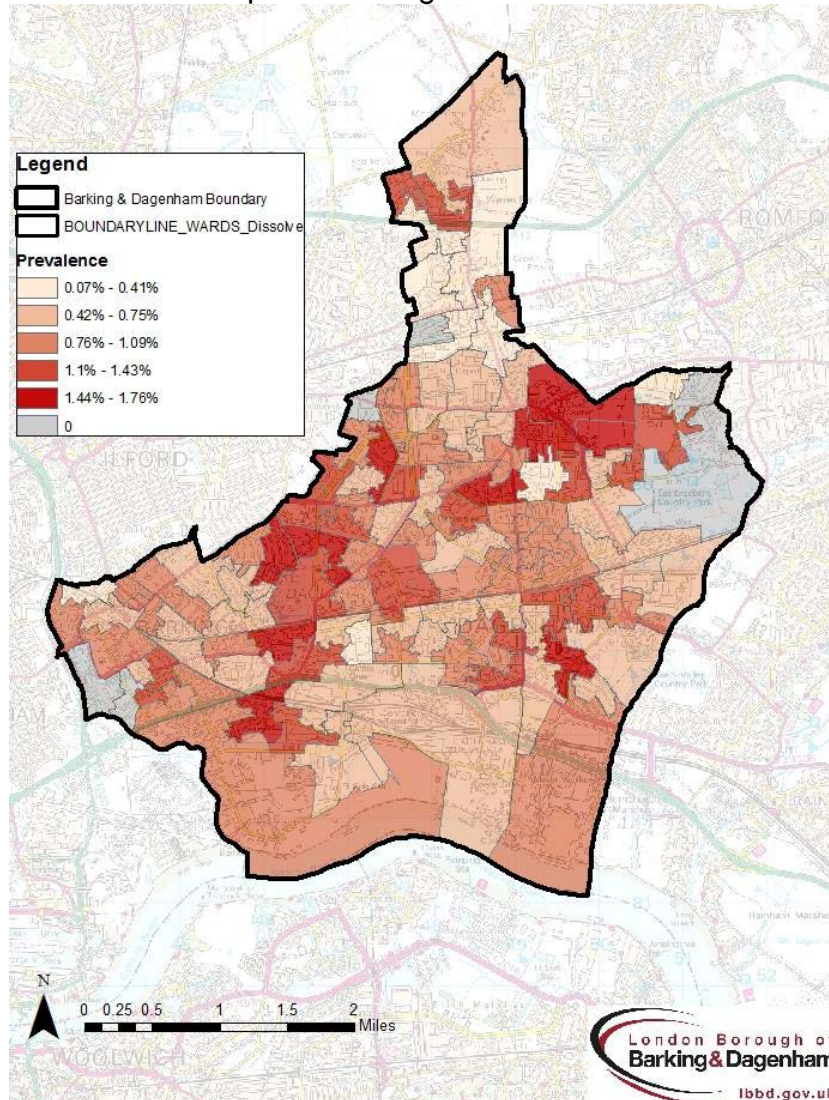
⁵⁰ TCRU (2007) *Young London Matters: The emotional well-being and mental health of young Londoners: A focused review of evidence*. Thomas Coram Research Unit, University of London. <http://tinyurl.com/947vxek>

⁵¹ Chimat. Key risk factors indicating harm or poorer developmental outcomes in children <http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=48&geoTypeld> [accessed 21.03.16]

younger mothers are more likely to have mental health problems than older mothers.

There are likely to be 200 children in 2015/16 in Barking and Dagenham living with a parent dealing with a mental health problem. The prevalence of mental illness in those aged 18+ is shown on the map below (2014⁵²). In areas where there are higher numbers of adults with mental illness it is possible to surmise that a proportion of these will be parents living with children.

Figure 3



The research identified a number of barriers to identifying and recording children who are affected by a parent's mental health problems, and made a number of recommendations to address the problems, including the importance of building trust and of working collaboratively with other agencies.

Domestic violence also impacts on the mental health of parents and children. Domestic violence often begins in pregnancy⁵³ and evidence suggests having

⁵² *Health Analytics, Extracted from HSCIC-QOF, 2013-14*

⁵³ Lewis, G. and Drife, J. (2004) *Why mothers die 2000-2002: the sixth report on confidential enquiries into maternal deaths in the United Kingdom (CEMACH)*.

experienced partner violence during pregnancy results in a three-fold increase in the odds of high levels of depressive symptoms in the postnatal period⁵⁴.

⁵⁴ Howard, L., Oram, S., Galley, H., Trevillion, K., and Feder, G. (2013) Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLOS Medicine*. 10(5). Available at: www.ncbi.nlm.nih.gov/pubmed/23723741

In addition to the obvious increased risk of physical injury from any attack, the child is potentially at further risk of emotional harm due to witnessing or involvement in the abuse. Moreover the quality or consistency of parenting capacity is likely to be affected by the abuse especially if it is over a sustained period. 1.8% of children in England live in households where there is known high risk of domestic violence⁵⁵. This equates to 1,176 children in Barking and Dagenham.

Figures below indicate that the LBBB population scored very highly on key risk factors for child mental illness.

Table 6. Comparison figures of risk factors for LBBB⁵⁶ collated December 2015

Benchmark Value (England) (2011, 2013, 2014/15)

Indicator	LBBB	England
Lone parents: % of households that have lone parents with dependent children	14.4%	7.1%
Relationship breakup: % of adults whose current marital status is separated or divorced	12.8%	11.6%
Children <16 in poverty: % of dependent children under 16	30.8%	19.2%
Under 18 pregnancy: rate of conceptions per 1,000 females aged 15-17	40.1	24.3
Looked after children: Rates per 10,000 children <18 years	80	60
Unemployed persons of economically active age with children	7.3%	6%
GCSEs achieved (5 A*-C inc. English and maths)	58.2%	56.8%
Juvenile first time offenders-annual number	525	417
Number of young offenders 15-18 formally in the Youth Justice System (rate per 1,000 persons)	19.9	15.7
Serious youth crime (sexual offences)-% of offences ⁵⁷	1.5%	2%
Serious youth crime (violence against a person)- % of offences ⁵⁸	23.7%	23.6%

⁵⁵ Laming, H. (2009) The protection of children in England: a progress report. London: The Stationery Office.

⁵⁶ The figures have been obtained from: 2011 Census Barking and Dagenham Ward Level Analysis; Public Health England; Child and Maternal Health Observatory; LBBB Joint Strategic Needs Assessment; 2006 Youth Survey; NHS Commissioning Support and Implementing Best Practice Factsheet: Perinatal Mental Health Problems; and London Gypsy and Traveller Unit.

⁵⁷ Youth Justice Annual Statistics

⁵⁸ Youth Justice Annual Statistics

% of children with disability	19.4%	5.4%
Homeless households headed by a YP aged 16-24 (rate per 1,000 households)	2.86	0.64
Family homelessness (headed by adult)- (rate per 1,000 households)	8.8	1.7
Gypsy and traveller children (% of children population)	36 (0.05%)	0.03%
Perinatal mental ill health (% of population)	8%	4%
Children Providing Considerable Care: % of children <15 providing 20+ hrs unpaid care per week	0.27%	0.21%
Primary school fixed period exclusions: % of pupils	0.88%	1.02%
Secondary school fixed period exclusions: % of pupils	2.4%	6.6%
Domestic abuse: incidence rate per 1,000 population ⁵⁹	18.6	18.8
Children in need: rate of children in need during the year, per 10,000 aged <18	878	679
Free school meals (% uptake among all primary school pupils)	19.1 %	15.6%
Free school meals (% uptake among all secondary school pupils)	21.8%	13.9%
Domestic abuse: incident rate per 1,000 population (>16)	18.6	18.8
Unaccompanied asylum seeker children LAC Section 20	28(1.4%) ⁶⁰	1,945

The estimates calculated by the Office of National Statistics (sourced from the local CCG which holds aggregate figures for all GP surgeries in LBB) seem to be in line with the prediction based on the PHE figures. Below is an estimate of children and young people in LBB for 2014 who may need support and intervention for their mental health. The figures are estimates of users at any one time. They are not dependent on the volume of referrals.

Table 7

	Tier 1	Tier 2	Tier 3	Tier 4	Total
Barking and Dagenham	8,870	4,140	1,095	45	14,150

⁵⁹ For those aged 16 and over

⁶⁰ Obtained from LBB public Health Intelligence Office-correspondence for 2014/15

8. Benchmarking

8.1 Costs

We were able to compare the cost of CAMH services across North East London (NEL). The services include services provided to Barking and Dagenham residents. Benchmarking data is from the provider NELFT. NELFT takes part in national CAMHS benchmarking. The benchmarked costs are in Figures 4 to 10.

In 2012 -13 Tier 1-3 and Tier 4 CAMHS services in NEL were in the highest 25% of costs across the UK by 2014-15 the cost of both services had decreased in comparison to other providers and were close to the average cost of CAMHS services in England. .

In 2012 -13 the total cost of Tier 1-3 services for NEL were higher than the England average; the total cost of providing Tier 4 services was lower than the England average (when the cost of secure provision was excluded).

NELFT did not take part in the 2013-14 benchmarking exercise

In 2014-15 the total cost of Tier 1-3 services for NEL were lower than the England average cost; the total cost of providing Tier 4 service cost was higher than the England average (when the cost of secure provision was excluded).

Figure 4 Total costs of service for tiers 1-3 per 100,000 registered population (including costs and overheads), 2012/13

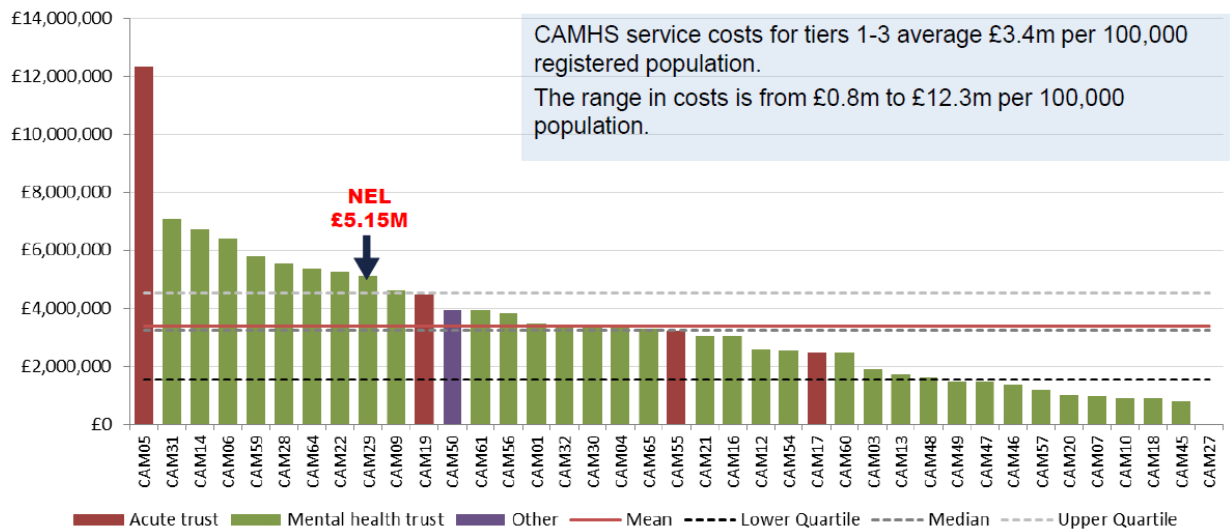


Figure 5 Total costs of service for tiers 1-3 per 100,000 registered population (including costs and overheads), 2014/15

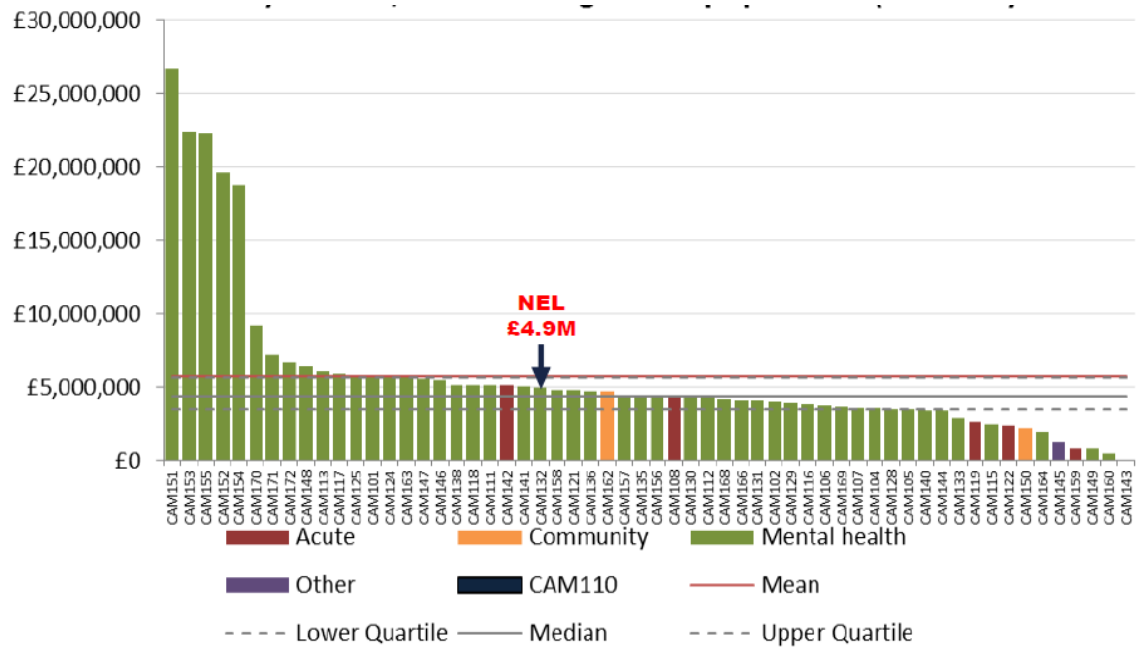


Figure 6 CAMHS benchmarking comparisons Tier 1-3: Finance, NEL & England, 2012-13

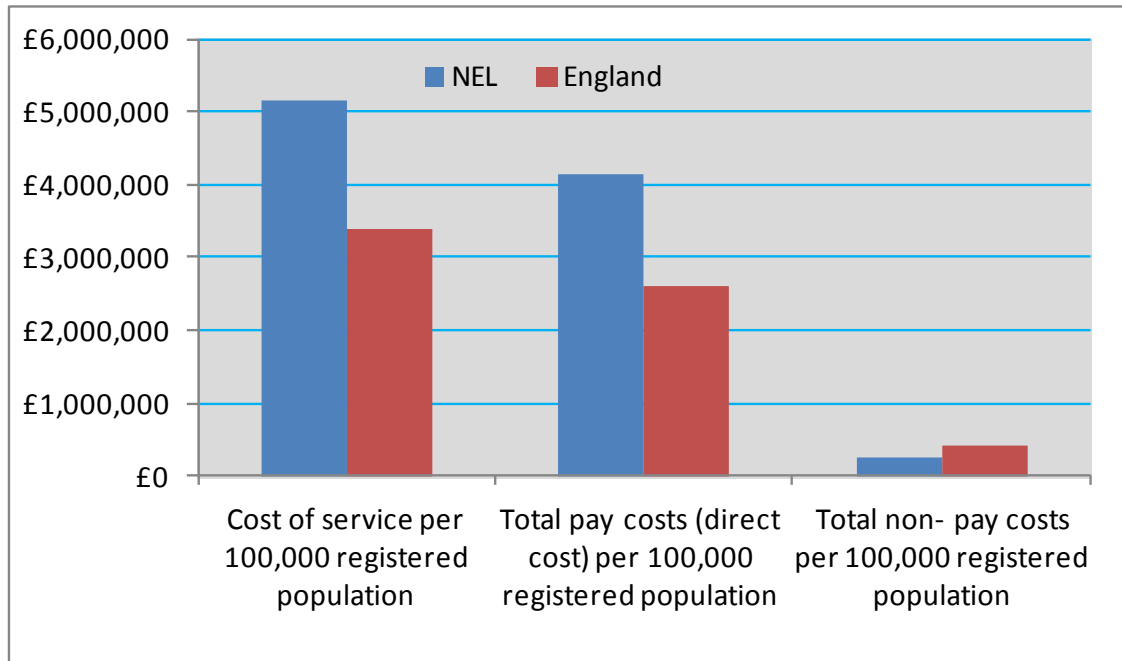


Figure 7 CAMHS benchmarking comparisons: Finance, NEL & England, 2014-15

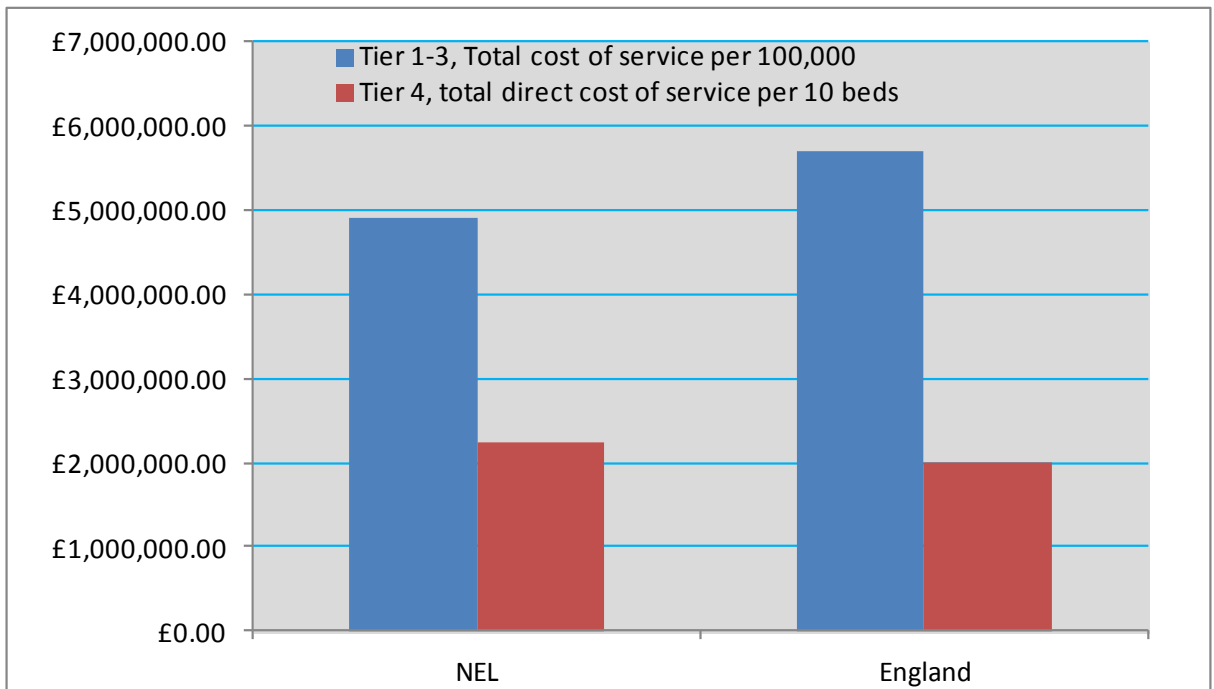


Figure 8 Total costs of service for Tier 4 per 10 beds excluding secure provision (including corporate costs and overheads), 2012/13

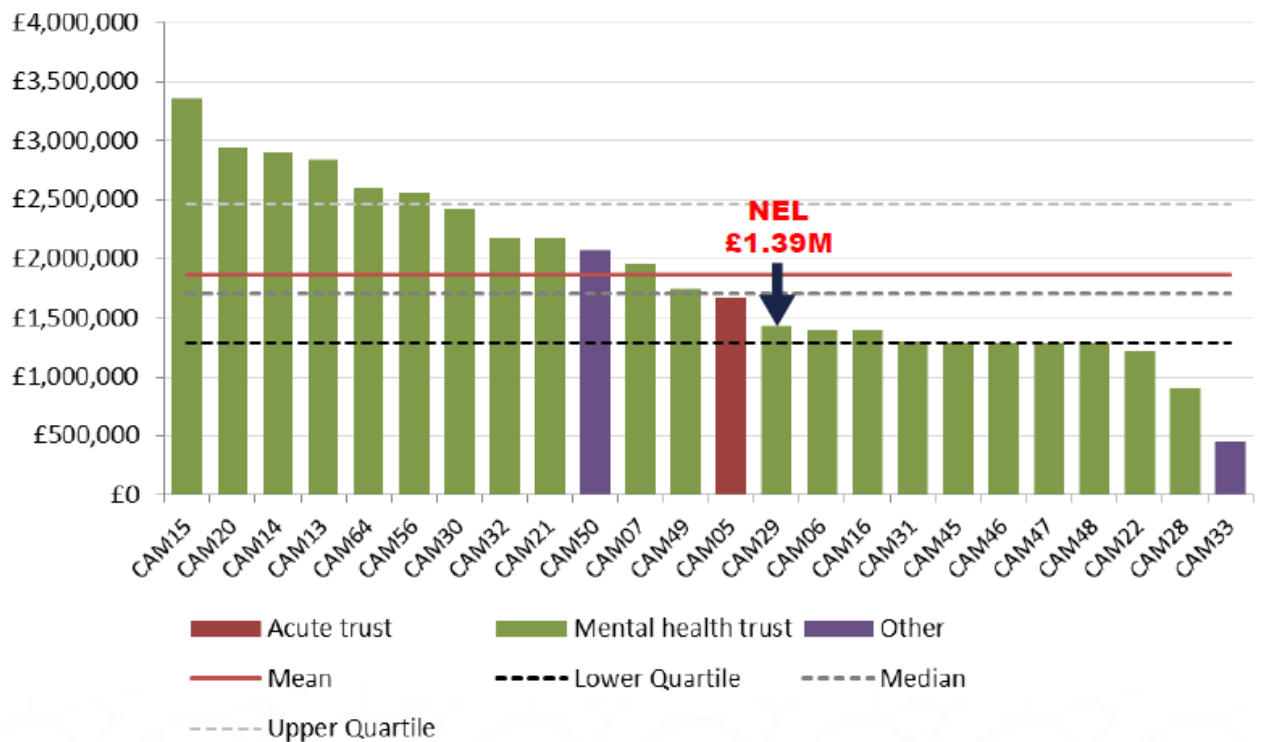


Figure 9 Total costs of service (including corporate costs and overheads) for tier 4 per 10 beds, 2014/15

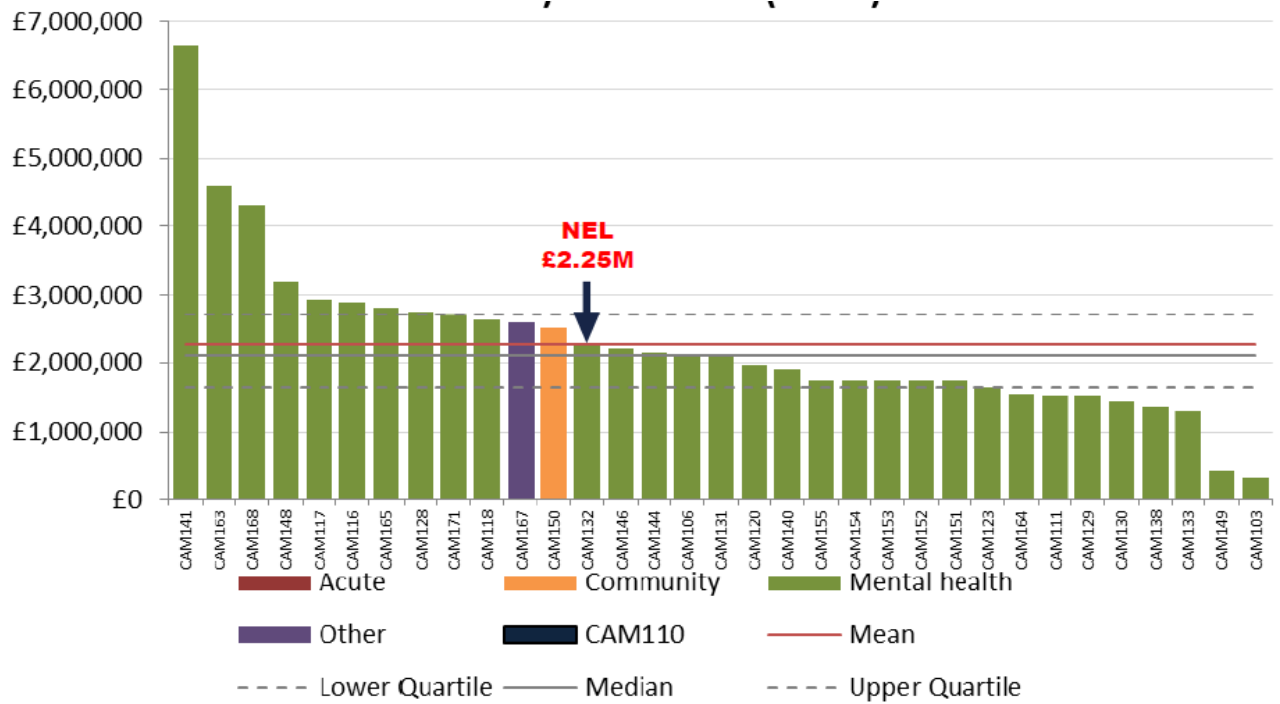
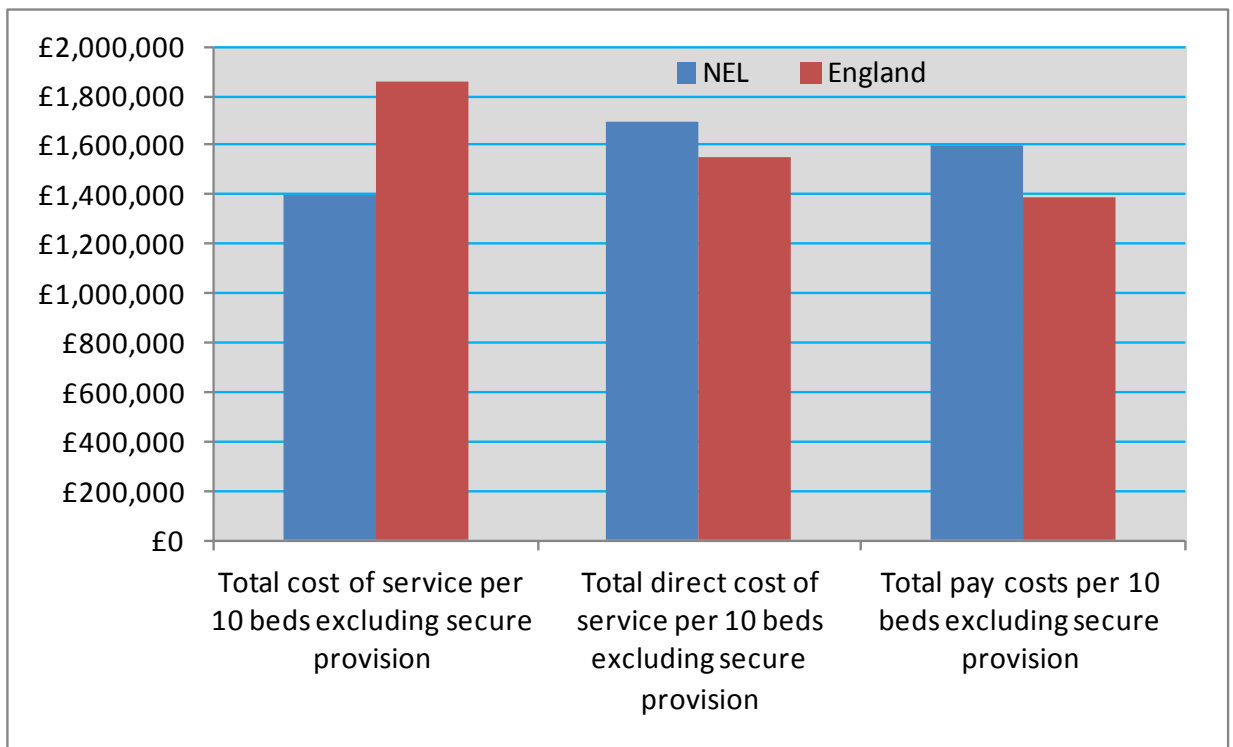


Figure 10 CAMHS benchmarking comparisons Tier 4: Finance, NEL & England, 2012-13



8.2 Spend and outcome

The latest available cost and outcome data for CAMHs is from 2011/12. More recent local commissioning budget data has been provided locally for 2015/16.

The benchmarking data is provided anonymously, however partners have access to more detailed data dependent on need.

Programme budgeting per head of population and first entrants into the youth justice system per 100,000 population 2011/12

Compared to other areas the programme budgeting cost is average but the outcome poorer than in local authorities that are spending the same amount or less (Attachment 1, Figure1)

Programme budgeting per head of population and aged 0-18 compared to A&E attendances for self harm per 100,000 population 2011/12

Compared to other areas the programme budgeting cost is average and the outcomes are better than local authorities that are spending the same amount (Attachment 1, Figure2)

Programme budgeting per head of population and aged 0-18 compared to 0-18 hospital admissions for self harm per 10,000 population 2011/12

Compared to other areas the programme budgeting cost is average and the outcomes are better than local authorities that are spending the same amount (Attachment 1, Figure3)

Programme budgeting per head of population and aged 0-18 compared to 0-18 hospital admissions for alcohol specific conditions per 100,000 population 2011/12

Compared to other areas the programme budgeting cost is average and the outcomes are better than local authorities that are spending the same amount (Attachment 1, Figure 5)

Programme budgeting per head of population and aged 0-18 compared to 0-18 hospital admissions for substance misuse per 100,000 population 2011/12

Compared to other areas the programme budgeting cost is average but the outcome poorer than in local authorities that are spending the same amount or less. (Attachment 1, Figure 5)

Programme budgeting per head of population and aged 0-18 compared to hospital admission rate for mental health problems per 100,000 population aged 0-17 years 2011/12

Compared to other areas the programme budgeting cost is average and the outcome comparable with other local authorities that are spending the same amount or less. (Attachment 1, Figure 6)

8.3 Benchmarking local performance

This strand of the needs assessment was impacted due to the lack of local data. As a result there was a need to use publicly available health data collected for Barking and Dagenham from a range of sources. To a limited extent the predicted rates for Barking and Dagenham has been verified by statistical neighbours who have completed local needs assessments based on their local data. Lewisham, Greenwich and Nottingham were found to be suitable statistical neighbours for this study.

Table 8. LBBD's statistical neighbours: Collated December 2015

	Benchmark Value (England) (2011, 2013, 2014/15)			
	LBBD	Lewisham	Greenwich	Nottingham
Estimated prevalence of any mental health disorder: % of population aged 5-15	10.3%	9.4%	9.6%	10.6%
Estimated prevalence of any emotional disorder: % of population aged 5-15	3.9%	3.6%	3.7%	4.1%
Estimated prevalence of any conduct disorder: % of population aged 5-15	6.5%	5.8%	5.9%	6.6%
Estimated prevalence of hyperkinetic disorder: % of population aged 5-15	1.8%	1.6%	1.6%	1.8%
Prevalence of potential eating disorders among young people: estimated number of 16-24 year olds	2998	4,381	4,192	9,055
Pupils with special educational needs (SEN): % of all school age children with SEN	18.1%	18.9%	21.5%	19.6%
Pupils with a SEN statement: % of all school age pupils with a statement	2.26%	2.71%	2.9%	1.53%
Pupils with autism spectrum disorder: % of pupils with this disorder	0.77%	2.21%	1.34%	1.35%
Pupils with Learning Disability: % of pupils with Learning Disability	2.26%	2.11%	2.27%	1.54%

Pupils with behavioural, emotional, and social support needs: % of pupils with behavioural, emotional, and social support needs	1.48%	1.88%	1.75%	1.61%
Pupils with speech, language, or communication needs: % of pupils with these needs	2.86%	3.07%	4.13%	0.81%
Number of young people in substance misuse treatment (<18)	302	200	140	N/A
Prevalence of ADHD among young people: estimated number of 16-24 year olds	3,165	4,515	4,438	9,509

It can be seen from the table above that Barking and Dagenham has a high rate of young people in substance misuse treatment.

The table below illustrates rates of hospitalisations for a variety of mental health issues. As can be seen, the rates of admissions are fairly consistent between LBBB and the statistical neighbours. Interestingly, all of the admission rates in LBBB are lower than the national averages, and the statistical neighbours are also in line with this trend.

Table 9. LBBB's statistical neighbours collated December 2015

	LBBB	Lewisham	Greenwich	Nottingham
Child admissions for mental health: rate per 100,000 aged 0-17	66.0	118.7	81.6	100.2
Young people hospital admissions for self-harm: rate per 100,000 aged 10-24	264.1	220.8	233.3	365
Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18	26.6	24.1	20.6	29.9
YP hospital admissions due to substance misuse: rate per 100,000 aged 15-24	79.7	96.1	92.2	62.1

8.3 Summary of the Epidemiological Needs Assessment

If all of the estimated figures on mental health problems from the tables and charts above are amalgamated, the prevalence rate is approximately 10-11%, or 6,534 – 7188, children at any one time, taking into account all risk factors. This is approximately 2,000 more children than the JSNA predicts. If young offenders are included the number may exceed 10,000 children.

LBBB prevalence rates are largely similar to its statistical neighbours. In some instances, LBBB performed better than the rest. The only figure which is higher for LBBB than its statistical neighbours is the number of young people in substance misuse treatment. The LBBB rate is the highest in London.

9. Existing service provision

The Barking and Dagenham LTP outlines an ambition to move away from ‘tiered services’ in line with FiM. Currently, the mental health services available for children and young people in Barking and Dagenham are currently built around the four tiers:

- Tier 1 prevention and resilience building activities which are typically picked up by schools and colleges, paediatricians, health professionals and 3rd sector services.
- Tier 2 services available within school, children’s centres (via PMHWs up to the 31st March 2016), drop in centres and 3rd sector services.
- An integrated Tier 2/3 CAMHS service provided by NELFT, including a Crisis Response team
- A Tier 4 inpatient service (Brookside CAMHS Tier 4 and Willow High Dependency Unit) commissioned by NHS England. Due to unavailability of local beds, some young people from Barking and Dagenham go to in-patient units in different parts of the country

It is worth noting that there are often overlaps between tier 1 and tier 2 services, and different views of which tier services should be in. For the purpose of this report, services are mapped as ‘tier 1’ if they are non-mental-health services.

Also worth noting is that CYP IAPT is currently under development in Barking and Dagenham, as part of a national programme that aims to transform CAMHS services, tiers 1-3. Unlike IAPT for adults, it does not form a standalone service, rather it is a service transformation project of existing services. Barking and Dagenham is part of the London and the South East learning collaborative (NHS England 2014)⁶¹.

⁶¹ Barking and Dagenham JSNA 2015

This section will highlight the findings from the mapping of services, the current evidence base for each service, and feedback from the engagement work. Where data relating to mental health need has been provided, this is included with the service that it relates to. The mapping of services is based on information that was given and then 'snowball' or 'chain referral' where people detail other possible respondents. More detailed summaries linked to these aspects are available on demand.

10. Tier 1

As can be seen from the list above, tier 1 or universal services primarily focus on prevention, promotion and resilience building.

Many universally accessed services in Barking and Dagenham report that they are involved in mental health promotion in some way. This can be through providing opportunities to discuss mental health concerns, or by ensuring that children and young people have someone to talk to 'in general'⁶². Professionals working at tier 1 also indicated a range of emotional and practical support provided to support low level mental health needs including one-to-one work, home visits, reminders to attend appointments, consultation with CAMHS, counselling and referrals to other agencies. In schools it included pastoral support, mentoring support, groups, signposting, and support for parents. More detail is provided below:

11. Key Tier 1 Services available locally

11.1 Health Visitors

Health Visitors (HVs) deliver the Healthy Child Programme 0-5 years, in partnership with other health and social care colleagues⁶³. They offer support, guidance and programmes of health promotion to all families from pregnancy and birth to primary school and beyond. They are based in 7 health centres across Barking and Dagenham.

Health Visitors offer support and interventions on a range of issues impacting on early parenting including breast-feeding and post-natal depression in mothers. They are well placed to identify developmental delay or emerging behavioural and emotional difficulties in children, including attachment difficulties. Standardised points of intervention are nationally prescribed. The HVs in Barking and Dagenham have standard times that they would expect to meet families, when the child is 10-14 days old, 6-8 weeks old, 8 month-1 year old, between 2-2 ½ years old⁶⁴.

There is a pilot Health Visitor in A&E in a project led by NELFT.

Referrals for extra support to those prescribed nationally are accepted from GP practices, accident and emergency departments, walk in centres, social care services, children's centres and other NHS trusts.

⁶² Facilitated staff workshops held in October 2015

⁶³ NHS England (2013) Securing Excellent in Commissioning for Health Child Programme 0-5 years 2013-2015.

⁶⁴ NELFT Health Visiting Team, Barking and Dagenham team, leaflet.

The service is commissioned by the local Public Health team. The Health Visitor service was transferred from health to LBBD in October 2015 with the intention that this would lead to an integrated early years services from conception to age 5.

11.2 Children's Centres

There are eight Children's Centres in Barking and Dagenham⁶⁵. Provision is highly rated with centres assessed as outstanding or good by Ofsted.

Children's Centres in Barking and Dagenham offer a range of early intervention services such as support for parents and carers, help getting jobs and training, health services, day-care and activities for babies and toddlers. Each centre offers different services, but this may include: childcare, early education, antenatal classes, baby clinics, support with breastfeeding, support with parenting, speech and language advice sessions, services for children with special needs and disabilities.

There are several parenting programmes available in the borough, including:

- Incredible Years Basic
- Incredible Years Basic (for parents of disabled children)
- Incredible Years Babies
- Strengthening Families, Strengthening Communities
- Strengthening Families, Strengthening Communities 10-14 years
- Domestic Violence Treatment Programme (for children and their mothers who have been exposed to domestic abuse)

11.3 GPs

There are 39 GP Practices listed in Barking and Dagenham. The JSNA states that there is very little known about the degree to which local general practices are involved in diagnosis and care of children and young people with mental health problems in the borough.

In Future in Mind (2015) (FiM), young people emphasised the difficulties many of them had faced in discussing their problems with their GP. Many GPs across the country have improved accessibility to young people by using the 'You're Welcome' standards and self-audit, even though they are not primary care specific. FiM suggested that the use of You're Welcome should be encouraged amongst GP practices in order for young people to access a less stigmatising environment than a mental health clinic to discuss their mental health concerns.

FiM also suggests that GPs should be enabled, through commissioning approaches, to offer social prescribing, where activities such as sport are used as a way to improve wellbeing. FiM proposes that there should be a dedicated, named

⁶⁵ Joint Health and Wellbeing Strategy 2015 to 2018. Barking and Dagenham CCG

contact in targeted or specialist mental health services for each GP practice, who would provide timely advice on the management or referral of cases, including consultation, co-working or liaison.

11.4 Schools

The important and valuable role that teachers, teaching assistants, Parent Support Advisors (PSAs), learning mentors and school nurses etc. have in promotion and prevention of mental health cannot be overstated. Section 3 of the 2012 JSNA reported on the strong growth in the 5-19 years population being seen in rising primary school pupil numbers, and although there is not access to specific usage data, there are Tier 1 preventative services operating out of many schools. LBBD operates a devolved model of school preventative services, with the responsibility to determine what form these in-school preventative services take being largely left to the schools.

- **School Nurses and Health Advisors:** School nurses are specialist public health nurses who deliver public health interventions to school-aged children and young people, and provide the Health Child Programme (5-19 years). This programme offers school aged children a schedule of health and development reviews, screening tests, immunisations and health promotion, as well as tailored support for children and families and expects that every child is offered a health review which includes attention to their mental and emotional wellbeing. There are four clinics (Thames View; Church Elm; Five Elms & Trinity) that provide school nurses into the borough schools.
- **Personal, Social and Health Education (PSHE)** LBBD have developed a bespoke PSHE curriculum for its children and young people from Key Stage 1 to key Stage 4. This was developed by working with 4 schools and Public Health and is used by a significant number of schools in the Barking and Dagenham area. PHSE is a non-statutory teaching subject, but there is a commitment from schools in Barking and Dagenham to delivering it, and support from the Local Authority to do so. The LTP outlines the intention to better support schools to deliver PHSE Resilience guidance.
- **Health & Personal Development Advisor for Education, Youth and Childcare** leads on the Healthy Schools programme and support for PSHE in the Local Authority and provides support for co-ordinators and teachers both centrally and in schools, and signposts to quality resources and services. There is a comprehensive programme of training events and networks, some of which have focused on emotional health and well-being and teaching about mental health, including a conference for schools which was facilitated by Young Minds in 2014 and is running a PSHE conference (including workshops on Mental Health and further discussions of the PSHE teaching resources for mental health).
- **Healthy Schools** can help children lead a healthy lifestyle directly – emotional health and well-being is one of the elements of the healthy schools programme. There is guidance for schools on developing emotional health and well-being, although this was published in 2007⁶⁶.

⁶⁶ Guidance for Schools on Developing Emotional Health and Well-Being DCSF, November 2007.
<http://www.healthyschoolslondon.org.uk/sites/default/files/EHWPB.pdf>

52 schools (i.e. 94.5%) in the Barking and Dagenham area are signed up to the **Healthy Schools London** programme, with 2 schools having achieved a gold award (of only 11 in the London area), 18 achieving silver and 30 achieving bronze.

- **Education Inclusion Team** provide an opportunity to discuss emotional health at home and school. They encourage community support, deal openly with issues, they provide coping strategies and ways of seeing issues in perspective, and signpost as required. The EIT also:
 - Provides advice and support for schools working with children and young people with social emotional needs.
 - Raises awareness and understanding of emotional well-being and mental health for staff and children through training and networks. Opportunities are given to share practice and discuss work in schools carried out to prevent bullying.
 - Supports schools to ensure they have in place effective policies for well-being and anti-bullying.

11.5 Youth centres

Three youth centres offer a range of free activities and facilities for young people aged 11 to 19 (11 to 25 for those with a disability). The three centres are:

- The Vibe
- Gascoigne
- Sue Bramley

11.6 Big White Wall

This service supports young people aged 16 years and over and is commissioned for Barking and Dagenham by Public Health, funded from May 2013 to September 2016. Big White Wall (BWW) is a safe 24/7 online community of people aged 16 years + who are anxious, down, or not coping, who support and help each other anonymously by sharing what's troubling them, guided by trained professionals.

BWW offers treatment at steps 1 – 3 of the NICE stepped pathway, although in Barking and Dagenham it is commissioned to provide only steps 1 and 2:

- Step 1 is a 24/7 anonymous Support Network providing self-help tools and resources with trained counsellors online at all times.
- Step 2 is a range of online Guided Support courses for managing depression and anxiety, plus a range of other behavioural topics including problem solving, managing negative thinking, using activity to raise mood etc. BWW have recently launched three new healthy lifestyles courses for Stopping Smoking, Reducing Drinking and Healthy Eating.

Residents in Barking and Dagenham can access the above services via self-referral simply by entering their postcode on BWW.

BWW is an anonymous service so there isn't data on individual users (although they do collect the same adult IAPT measures if users are referred for a step 2 treatment). About one quarter of members in Barking and Dagenham are aged 16-24, which is a higher majority than the overall BWW membership. This is probably due to the close work that BWW have done to promote the service by Barking and Dagenham IAPT service and the Listening Zone.

11.7 The Voluntary Sector

Barking & Dagenham Council for Voluntary Services identified the following voluntary services that potentially deal with CYP's mental health in the Barking and Dagenham area:

- AB-Phab Youth Club
- DABD – provision of: support with activities and family outings; personal care support for children aged 5-18; buddy club (run jointly with Ab Phab Youth Club); short breaks for CYP with disabilities
- Health Psychology Management Organisation Services - offering a range of psychological and social well-being strategies, mental and physical health training services, one to one and group counselling, using different therapeutic techniques. They aim to identify and support marginalised and disadvantaged adults, children and young people with long term mental and physical health conditions, with varying disabilities within different community settings and different educational needs with an outcome of improving quality of life, hence improve employability status.
- Osborne Partnership – focus on education and skills for those who are disadvantaged – particularly those with learning or physical disabilities, or mental health issues, through training courses, guidance, and support; day outings and various arts courses are run by the partnership. They aim to help people to take part in society and to realise where they need support. Based in Barking and Dagenham.
- Studio 3 Arts – The aim of Studio 3 Arts is to create art that is local and accessible. They run a venue for artists, individuals, and communities to use in North East London, aiming for socially engaged, co-created artistic practice; Studio 3 is the lead organisation for Creative Barking and Dagenham.
- Sycamore Trust – work specifically with those who have autism or learning disabilities. They have a Young Peoples service with a few youth clubs, football and multi-sports projects, and a voluntary befriending project. There are also services directed at adults, including an 18-25 service, parenting programmes, and an autism hub which works with local health services and education services to provide better access for those on the autism spectrum. Aside from this is the family service – this also provides support for parents and families, as well as activities.
- Wellgate Community Farm – runs training courses in farming and conservation – for 14 to 19 year olds.
- Youth League International – info@youthleagueuk.org – youth and community service which aims to help young people under 25 with the transition from school to higher education and the working world, and to relieve poverty, sickness, and stress, particularly those of African or ethnic minority backgrounds, but not exclusively. Programmes include voluntary youth leadership project, health promotion, and training and employment projects.
- Rethink Community Services – aims to provide help and necessary tools for those with severe mental health issues to thrive in both workplace and social environments. They work in partnership with local mental health services, usually on a one to one basis, with a key worker assigned to those in need, or a small group of people with similar needs working together.

- Peer 2 Peer Education – deliver educational programmes, mostly to 7 to 13 year olds, covering a variety of issues including development of personal confidence, sex and STIs, LGBT awareness, peer pressure, and forced marriage. These are often delivered in schools as part of the PSHE programme.
- Green Shoe Arts – work with Local Authorities to deliver what the community wants in Barking and Dagenham, through a youth programme and an adult one. Youth services include leadership programmes, theatre, dance, and art classes. Adult services are more aimed at those with a disadvantage, for example a mental health issue, a disability, or social deprivation. The programmes aimed at adults are also largely arts based, with an emphasis on developing confidence and social skills.
- Arc Theatre – work particularly with young people, aiming to get them involved in theatre through workshops and interactive theatre, and deal with community issues such as racism, community cohesion, and inclusion. They have a ‘Raised Voices’ female-leadership group which formed to provide peer mentoring and awareness-raising on issues like FGM, domestic violence and child sexual exploitation and have produced a DVD on the same (funded by the Paul Hamlyn Foundation): <https://vimeo.com/119445133>
- HTW Counselling Service – delivers help to those within Barking and Dagenham who are dealing with issues such as bereavement, domestic violence, anger problems, and the effects of child abuse.
- Positive Change Consultancy CIC –work in Barking and Dagenham, delivering training, development, and coaching programmes to people and organisations in the community. Particularly target issues such as self-confidence, motivation, and communication within the community.
- Make a Difference at Sandie’s – charity based in East London, delivering counselling services and psychotherapy.

11.8 Tier 1 – Staff engagement

The two staff stakeholder groups identified that a significant amount of resilience-building that occurs in Barking and Dagenham is achieved through the promotion and prevention activities alongside working with families and providing coping strategies.

A majority of almost 80% of respondents to the staff survey indicated more can be done to promote children and young people’s mental health. Ideas included:

- reducing waiting times for those referred,
- schools promoting mental health and reducing stigma,
- use of TV, radio
- youth centres
- better access to parenting groups for those with children who have emotional or mental health issues,
- more therapeutic services,
- training in schools for both teachers and students,
- having mental health champions in schools,
- support groups led by the children themselves.

Almost 83% of survey respondents stated that there are opportunities to develop resilience for the children that they work with. Describing the activities of their own organisations they reported as follows:

Education professionals:

- the PHSE curriculum
- small group interventions such as Circle of Friends, social skills groups, nurture groups,
- anti-bullying activities,
- transitions groups,
- SEAL activities
- a positive whole school ethos buddying systems
- counselling pastoral support
- mentoring support groups,
- signposting and support for parents.

Views expressed:

- Acknowledgement of the volume of work going on in schools.
- Knowledge of available support was limited
- Thresholds to CAMHS was seen as high with situations becoming very complex before they are seen.
- Need for earlier intervention
- People working in universal services could do more direct intervention such as Health Visitors, School Nurses, teachers, learning mentors.
- There is a low recognition by GPs of mental health problems in children and young people
- The levels of mental health needs are directly affected by the very stressful situations children live in and parents capacity to help.
- A decrease in service provision and pressure from school work were seen as contributory factors.

Ideas expressed on what would be helpful:

- Need to have CAMHS staff in schools
- Need for more counselling.
- Attendance by CAMHS at planning and review meetings to share information would be helpful
- Clear 'step-down' process for children and young people who have been discharged from targeted or specialist services
- Creating a health 'passport' for the user that outlines what has been provided and what is needed to ensure mental health is stabilised and what extra services are needed
- Training in mental health for professionals that demystifies and builds confidence
- More preparation on what to say and do after episodes of self-harm
- Training to help children, young people and their families better understand their own mental health and how it impacts the family, possibly delivered via schools.

- Advice from CAMHS (without referral)
- what to say/do in
- guidance on how to refer and what problems to refer to CAMHS;
- training for management in how to maintain and support staff who are feeling anxious about the mental health of the children and young people that they are working with;
- training on risk assessment, opportunities to shadow a mental health worker. more information needed for parents surrounding mental health, how to spot warning signs and where to go
- a rolling programme travelling around schools in the area educating both teachers and pupils on mental health needs, issues, and where to get help.
- A phone app would be helpful to young people providing high quality and accurate advice and information

Levels of Need: workers described the following range of issues that they were working with:

- ASD
- ADHD
- self-harm &, suicidal thoughts
- anxiety and depression
- hearing voices
- eating disorders,
- post- traumatic stress
- fabricated illness
- attachment difficulties
- anger issues; aggression
- behaviour disorders
- bereavement and grief.

Capacity & Confidence:

- 67% of survey respondents who were not CAMHS professionals agreed or strongly agreed that they feel confident in recognising emerging mental health problems in children and young people.
- 19% disagreed or strongly disagreed with this statement (14% were neutral).
- In relation to lower level mental health problems the survey showed that more people are confident (57%) than not (19%) in managing these.
- 24% of respondents felt they did have the capacity to deal with low level mental health issues
- 33% felt that they did not have the capacity to deal with low level mental health problems.
- 38% of people would always refer or recommend referral to CAMHS for children and young people with emerging mental health needs. 33% would not, and 28% were neutral /did not know
- 81% felt the mental health needs of the children and young people they are working with are high or very high (19%).

- 19% of people said they '*regularly managed children and young people with mental health problems without having to refer or seek referral to Child and Adolescent Mental Health Services (CAMHS)*' - 33% disagreed/strongly disagreed with the majority of respondents either being non-committal by saying neither agree nor disagree (38%) or did not know (9.5%) (47.6%).
- 36% of respondents estimated that 30% of children and young people have mental health problems.

Access to Self Help:

Only 5% of respondents agreed that there was sufficient self-help and information to support low level mental health problems'.

11.9 Service User Feedback

- The lack of things to do for young people in Barking and Dagenham was identified as a barrier to self-help. There are some fitness-related activities with some gyms promoting cheap membership for young people. CAMHS can also refer through the Fit 4 life campaign. However a strict attendance policy often results in failed access.
- Isolation and apathy among young people is perceived to be a significant issue in the borough. Young people identified two locally authority run youth clubs in the borough with provision available from other organisations.
- A majority (73%) of respondents (parents/carers) said they are unaware of anything being done in B&D to prevent mental ill health.
- 2 out of the 11 respondents were aware of any services to build resilience (National Citizenship scheme, Sycamore Trust)
- 50% were unaware of any information available when mental health problems arise.
- Young people identified a gap in services before CAMHS. The interviewees stated that when young people first begin worrying there is nowhere for them to turn until the issues become very serious or get to crisis point.
- New technology was seen as having the potential to build resilience and promote positive mental health. An app called *Power Up* was mentioned positively.
- The 'Listen Up' participation group reported finding it very difficult to recruit young people. 'Listen Up' are reported to be unsure how to go about getting new people involved. A lack of funding was seen as a contributory factor. All participation work is delivered by the participants and the professionals/clinicians on a voluntary basis.

In relation to counselling support a number of issues were identified:

- Poor communication between counselling services in schools and CAMHS
- Variable support available and lack of agreed standards (as a direct result of individualised commissioning arrangements)
- Lack of privacy in some cases
- Issue of stigma
- Lack of preparation before accessing counselling (knowing what to expect).

12. Targeted services/Tier 2 services

Targeted services are services delivered to particular groups of children at risk of experiencing mental health problems, for example Looked After Children (LAC) or children with learning disabilities. There also is some limited evidence (Centre for Mental Health, 2015⁶⁷) to suggest that working with the child and parent on specific risk factors for depression, such as bereavement, may make a difference to some outcomes, including depression and internalising symptoms.

Targeted services are most likely to be involved in the provision of early intervention. Early intervention⁶⁸ seeks to avoid young people falling into crisis and reduces the need for expensive and longer term interventions. One of APYH's ten reasons to invest in young people's mental health⁶⁹ is that mental health issues are often diagnosed at this age, and half of all psychiatric disorders start by age 14, three quarters by age 24. It is estimated that 60-70% of children and young people who experience clinically significant difficulties have not received appropriate interventions at a sufficiently early age⁷⁰.

12.1 Support for specific risk factors

There are many services that are set up to deal with specific issues, many of these issues are risk factors in terms of developing mental health problems:

There is a specific work programme around preventative work on child sexual exploitation, and a service for those subject to sexual exploitation or involved in sex work (Open Doors).

Subwise and **Substance Misuse Workers** work with young people and parents with substance misuse problems, which may be occurring in the presence of mental health problems, or be the cause of mental health problems. Subwise is an outreach drug and alcohol support service which offers support to young people up to the age of 19 years old who are using drugs or alcohol or who are affected by parents' or carers' substance misuse. The service offers a wide range of services from confidential advice and information, assessment of an individual's specific needs; one-to-one sessions and group work; appointments at a convenient location; drop-in at local centres in the borough and a gateway to other services. Subwise also work in close partnership with a variety of other services such as sexual health, housing, life skills, education and employment.

Housing is important for mental health and some housing agencies have recognised this, for example, the Housing Access and Referral Team (HART) which provides housing related support for vulnerable adults to prevent them becoming homeless and to help them live independently. HART helps anyone who needs additional support to cope with the demands of living independently, including teenage parents, people with mental health problems, and those leaving care.

⁶⁷ Centre for Mental Health (2015) Investing in children's mental health.

⁶⁸ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

⁶⁹ AYPH (2015) Ten Reasons to invest in young people's mental health
[<http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/08/Ten-reasons-to-invest-in-young-peoples-health.pdf>]

⁷⁰ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

London Streetlink connects rough sleepers with local support and services. South Anglia Housing – The Vineries - provides accommodation (32 spaces) for young single homeless people aged 16-25, including those leaving care. There are also 6 flats for mothers and babies. It is possible to surmise that they are actively supporting very vulnerable young people.

Referrals are accepted from Barking and Dagenham Homeless Persons Unit and Social Services.

12.2 Early Intervention Service

In 2013, MALTs were renamed Multi-Agency Panels (MAPs), recognising the central role of the weekly multi-agency panel meetings. Multi-Agency Locality Teams (MALTs) were established in 2009, largely funded through the Direct Support Grant (DSG). MALTs aimed to provide integrated and targeted locality-focused support for children, young people and families. MALTs became part of the Early Intervention (EI) strand of Targeted Services in June 2011, and a triage system was introduced in August 2011 creating a clear pathway into the MALTs.

Weekly MAPs manage referrals from MASH and step down from social care cases are discussed and a decision is made as to what work needs to be carried out and by who.

The MAP has three virtual, multi-agency teams: East-South; North-Central; West-South; which consist of:

- The MAP chair
- Early Intervention Workers
- A primary mental health worker (now decommissioned)
- A youth worker
- A 14-19 careers advice service personal adviser
- A health visitor or school nurse
- The MAP support officer

Targeted Early Intervention Workers hold cases that are referred via the Multi Agency Panels. Workers aim to tackle the needs of vulnerable children young people and their families to prevent the escalation of need or in situations when risk in families is reducing but families require ongoing support to sustain change. These can be children, young people and families where there was previous social worker involvement that are 'stepped down', of cases where despite social care thresholds not being met, support is required to prevent escalation.

Referrals can also be made to the Early Intervention Service via the targeted referrals in-box and must include either a pre-CAF, CAF or other agency form of assessment.

The Early Help and early intervention services working locally were identified in the staff workshops as offering direct work, assessments, referrals, and promoting IAPT. The LBB Early Intervention Children's Services were identified as responsible for identifying mental health needs through caseloads and referring onto specialist services, as well as offering targeted work and family support. Early help is used as an umbrella term and is available across services.

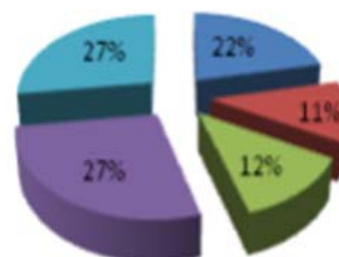
Exclusions: None. Urgent/emergency risk issues

12.3 Use of CAF/FCAF⁷¹

Barking and Dagenham have been implementing the use of CAF as its primary Early Help assessment tool since 2008. Piloting of the framework and establishing a local Continuum of Needs and Services thresholds model saw borough-wide implementation start in 2010. In the 4 years since then, there has been an average of 73 CAFs initiated every month leading to a current total figure of 4326 as of the end of March 2014. This figure now represents a mix of CAF assessments on individual children and family wide assessments since the launch of Family CAF in 2012/13.

Figure 11 CAF/FCAF setting breakdown (2010-Mar 2014)

Setting	CAFs completed
Children's Centres	933
Community Voluntary Sector	493
Health	537
LA teams	1187
Schools	1176
Total	4326



12.4 Schools Counselling Service

The School Counselling Service operates out of all of high schools and primary schools in the Barking and Dagenham area. Counsellors also offer advice to school staff who have concerns about a child or young person's well-being. LBBDD operates a devolved model of school preventative services, with the responsibility to determine what form these in-school preventative services take being largely left to the schools.

Referrals: from the school or CAMHS.

12.5 Children's Social Care

Children's Social Care work with the most vulnerable children, young people and their families. Social Work teams work with mental health services, given many of the children have significant emotional and behavioural difficulties which arise from their often abusive and traumatic early histories. Teams are frequently working with a combination of risk factors including the 'toxic trio' in relation to parenting (mental illness, domestic abuse, alcohol/substance misuse). Specific teams identified through the mapping exercise included:

Leaving Care Team, offer a monthly drop-in service providing mental health support and education. There are quarterly sessions that involve other agencies such as Terence Higgins, Subwize, LAC nurses etc.

Look Ahead Care and Support Ltd is a residential care service for people with learning disabilities operating across five supported living schemes. The service provides care and support to residents encouraging supportive networks and

⁷¹ Barking and Dagenham Early Help Strategy 2014 - 2014

reducing stigma. Residents are helped to manage day to day issues including sleep hygiene, anger management etc.

12.6 Community Medical Service

The Community Medical Paediatric Service in Barking and Dagenham works with children and young people where there are concerns about a child's health, development or educational progress. Their statutory work includes medical advice for Educational Health Care Plans (EHCP), health assessment of children in care and those subject to child protection concerns. Community Paediatrics Service operate outreach clinics in local health centres. Referrals will be accepted from professionals in health care, education and social services, the police and the voluntary sector.

The speech and language therapy (SALT) service for children in Barking and Dagenham although a specialist provider, does have a preventative role. SALT provides specialist assessment, diagnosis, treatment and management of communication and/or feeding and swallowing difficulties for children and young people from birth up to the age of 16 years (or up to 19th birthday for those with an Education Health Care Plan).

Working with Children's Centre staff the team delivers advice sessions and 'Play and Language' groups. This intervention seeks to identify emerging issues early and supports parents and professionals to support good communication skill and language development in young children.

Referrals

Referrals are accepted from parents/guardians and healthcare, education and social care professionals.

12.7 Baby FIP

With high rates of teenage pregnancy LBBD continues to prioritise this group of vulnerable parents. Locally a Baby Family Intervention Programme is now well established and provides support for vulnerable parents and their babies. The Family Nurse Partnership has been decommissioned.

12.8 Perinatal Parent and Infant Mental health service (PPIMHS)

Provided by NELFT, PPIMHS is a specialist psychiatric and psychological service. The service works with parents with children up until the age of three to address attachment difficulties to prevent complex mental health problems when the babies and toddlers become older. There is a clear pathway of support for both mild/moderate and moderate/severe emotional distress.⁷² There are three types of clinicians in the PPIMHS service: perinatal psychiatrists, perinatal community mental health practitioners; psychotherapist/psychologists. The psychiatric component of the service works with women with mental health problems during pregnancy and up to a year postnatally. It has integrated perinatal and parent infant services.

FiM tells us that there is a strong link between parental (particularly maternal) mental health and children's mental health, and that three quarters of the long-term cost of maternal perinatal depression and psychosis together relates to the adverse impact on the child rather than the mother.

⁷² Barking and Dagenham JSNA 2015

20% of women experience mental health problems during the perinatal period (pregnancy to one year after birth)⁷³. This has been shown to compromise the healthy cognitive, emotional and behavioural development of their children. The long-term cost to society is about £10,000 per birth in the UK⁷⁴, with 72% of this cost relating to adverse impacts on the child rather than the mother. There is a need for better detection and treatment of mental health problems in the perinatal period. FiM⁷⁵ suggest that strengthening early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour would enhance existing services. FiM also points out that every birthing unit should have access to a specialist perinatal mental health clinician by 2017.

The expectation that every birth unit should have access to a specialist perinatal mental health clinician and the work of the Institute for Health Visiting on updating the training given to HVs around mental health will help ensure that needs are addressed early.

12.9 The Sycamore Trust

Is a service which works at educating the community and empowering individuals affected by autism and/or learning difficulties. The service offers a range of services designed for young people including, youth clubs, football and multi sports projects and under 8s activities.

13. Tier 2 CAMHS

Currently **Tier 2** NHS CAMHS services are commissioned via a mental health block contract covering both adult and children and adolescent mental health services and provided by NELFT and are available to children from 5 years old.

Current Tier 2 services provided by NELFT include:

i) The Primary Mental Health Team:

This small team (2 workers) is commissioned by the Local Authority (Public Health) and are funded (£150k) are funded to March 2016 by Public Health.

The team provides brief intervention (max 12 sessions) working with young people aged up to 18 and their families who are experiencing social, emotional, behavioural or mental health difficulties.⁷⁶ This team is a brief intervention service, usually 6-12 sessions, linking in with LBD staff and offering support to families and children accessing CAMHS service. The therapeutic services that offer include: behaviour management; solution focused therapy; psychodynamic therapy; CBT; anger management; anxiety, family work and groups.

ii) The Listening Zone (TLZ) CAMHS Tier 2

The Listening Zone is a young people's counselling service providing individual counselling to young people aged 14 to 22 who live or study in Barking and

⁷³ Centre for Mental Health (2015) Investing in children's mental health.

⁷⁴ Bauer A., Parsonage, M., Knapp, M., Lemmi, V. & Adelaja, B. (2014) The costs of perinatal mental health problems. London: Centre for Mental Health.

⁷⁵ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

⁷⁶ NELFT.NHS.UK

Dagenham. TLZ was a standalone service until recently when it became integrated with the NHS CAMH service.

The Listening Zone provides mental health counselling services, and other more generalised therapeutic interventions, consistent with Tier 2, for young people with low level emotional and mental health problems. Short term (1-4 sessions) or longer term counselling (1-12 months) is offered according to need.

The Listening Zone also provides a weekly drop-in session where a young person can speak to a counsellor without having made a prior appointment. They also provide a counselling service to primary and secondary schools in Barking and Dagenham. In 2014, 200 young people (14-21yrs) accessed the service.

Referrals

Young people can self-refer by phone, letter or by dropping into the service. They also take referrals from the full range of professionals, but always ask the young person to confirm that they want to be seen. Young people can request a preference to see a female/male, black/Asian counsellor, and the service describes itself as LGBT friendly.

Referral criteria: Aged 14 to 21 living or studying in Barking and Dagenham with moderate to severe emotional/mental health difficulties.

Service usage

The LBB Mental Health Needs Assessment Final Report (March 2015) reports that 200 young people between the ages of 14 and 21 accessed TLZ service during 2014.

iii) Mental Health Worker (x3)

This service offers brief intervention based therapy and support and includes one nurse (CPN) and two Approved Mental Health professionals. This function is currently being reviewed.

14. Key Tier 3 Services

14.1 CAMHS Tier 3

Currently Tier 2 and Tier 3 services are commissioned via a mental health block contract covering both adult and child and adolescent mental health services and provided by NELFT. They are available to children from 5 years old. Specialist services work with children and young people with complex, severe and/or persistent needs. Typically, Tier 3, or specialist services see children, young people and their families when there is a clear mental health problem, or when the problems have become severe and/or complex.

The NHS community-based CAMHS service in Barking and Dagenham provides assessment and treatment for young people up to the age of 18. The Barking and Dagenham CAMHS team is based in a local clinic and provides assessment and treatment to children and young people experiencing moderate to severe emotional and mental health difficulties in line with NICE guidelines.

The team also provides support and advice to the families and carers of the children and young people using the service. The positive role and inclusion of carers is essential for the best outcome for the child or young person.

The CAMHS team are a multi-disciplinary team (MDT) with clinicians from different professional backgrounds including psychiatrists, clinical psychologists, counselling psychologists, family therapists, child psychotherapists and nurses (CPNs and a Clinical Nurse Specialist). This clinical multi-disciplinary workforce is a total of 17.71⁷⁷ whole time equivalents.

Referrals

Referrals are accepted from anyone who has a 'professional' qualification, using the two-page referral form.

Referral Criteria: Age under 18 years and having experience of emotional or mental health difficulties.

Exclusions: Where the primary need is: specific learning disability assessment, emotional and/or behavioural problems as a response to family stress, legal reports, substance misuse.

All new referrals are screened by admin to ensure the form is completed correctly, then are screened by the Triage Manager, who will also undertake a telephone triage if appropriate. Some are streamed to Tier 3 after this initial assessment. Some Tier 3 referrals will go directly to Tier 3 without going through Triage (e.g. step-down care from Tier 4 or a patient referred from a paediatrician who has already assessed needs). Those going directly to Tier 3 may face a short waiting period, and it is understood they do not appear in Tier 3 waiting list data.⁷⁸

14.1.1 Service usage – Tier 3

During the 5 months for which there is available data, the number of referrals received averaged at 103 per month (although ranged from 130 to 82 during that time). Accepted referrals (referrals received minus referral not accepted) averaged at 94 per month (although ranged from 123 (July) to 69 (August)). This gives an indication of demand – in itself an indication of need – but it does not give a comprehensive picture of need.

Table 10 - Tier 3 Demand

Referrals	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Number of referrals Received	101	97	105	130	82
Number of referrals not accepted	7	11	5	7	13
% of referrals accepted	93.2%	94.5%	95.7%	95.1%	88.5%
% of referrals not accepted	6.8%	5.5%	4%	4.9%	11.5%
Number of repeat referrals (within the last 12 months)	18	9	15	30	17

⁷⁷ NELFT information 23/12/15

⁷⁸ LBBB Mental Health Needs Assessment Final Report (March 2015)

There is not data about the number of 1st appointments to indicate the capacity and subsequent ability of the provider to meet the current demands on the service. However, between Oct 2014 and March 2015 the provider reported on the number of 1st appointments conducted which showed an average of 59 1st appointments being conducted each month (ranging from 76 to 49).

Table 11 - Tier 3 Appointments and DNA Rates

Appointments & DNA Rates	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
1st Appointments	76	71	50	51	57	49
1st Appointment DNA	17	8	10	8	7	15
1st Appt DNA Rate (%)	18.3%	10.1%	16.7%	13.6%	10.9%	23.4%
Follow up Appointments	374	408	306	370	314	396
Follow up Appointment DNA	83	61	40	36	43	42
Follow Up Appt DNA Rate (%)	18.2%	13.0%	11.6%	8.9%	12.0%	9.6%
Total CAMHS 2 DNA rate (%)	18.2%	12.6%	12.3%	9.5%	11.9%	11.4%

The gap between the average of 94 referrals per month and the average of 59 1st appointments per month indicates that NELFT only have the capacity to engage in a 1st contact with ~62.8% of their referrals in a month. This suggests a potential waiting list building up for the CAMHS team. e.g. if CAMHS started the year with no waiting list and so had the capacity to see the 1st referral on the same day (1st January), by the 31st of December the wait time will have increased from 0 to 135 days (19.3 weeks) and would continue to increase year on year. Current monitoring information submitted to commissioners shows that children and young people are seen within the 18 week referral to intervention standard but the implications of this shortfall between accepts and 1st appointments perhaps warrants further examination.

The other indicator of delays in accessing the service (in the absence of actual wait times) is the level of DNA rate (an assumption that the longer people wait for a service, the less likely they are to turn up), which fluctuated between 23.4% and 10.1% during the measured months of October 2014 to March 2015 (averaging at 15.5% for 1st appointments).

The final potential impact of delays to accessing services is that the number of referrals drops as waits become so significant that individuals and professionals no longer see CAMHS as offering a timely solution, although local reporting data is that there is some intervention offered within 18 weeks. Whether this is a factor in Barking and Dagenham is conjecture without additional data, but this needs examining.

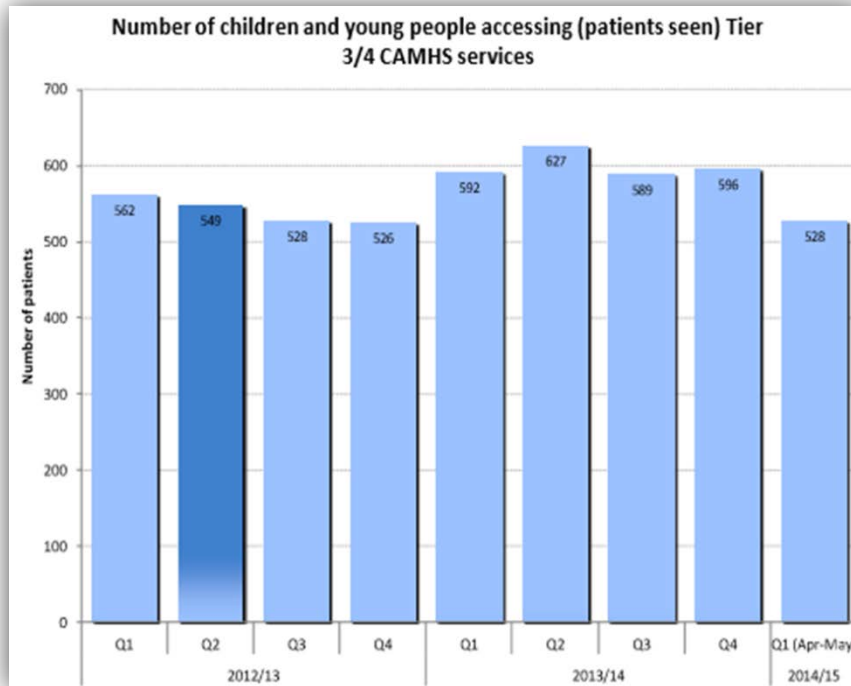
Based on the data provided to us by the CCG, the Key performance Indicators for the 2015-2016 financial year have changed to focus on *Routine referral to treatment waiting times for Tier 3 CAMHS* (99.1% reported for April – June 2015) and *Routine referral to treatment waiting times for BHR LAC placed in borough to Tier 3 CAMHS* (no data provided).⁷⁹

⁷⁹ Q1 B&D CAMHS only (for VM)

14.1.2 Demand on services

Data provided to CCGs from NELFT suggests that the average number of appointments conducted per child or young person ranged from 6.5 to 9.2 (reported quarterly) during FY2014/15.

Figure 11 Number of children and young people accessing Tier 3/4 CAMHS services



If it is assumed that ‘activity’ and ‘sessions’ are the same, then extrapolating this data shows that between 284 and 381 CYP were seen each quarter during FY2014/15.

Table 12

Tier 3 Throughput	Q1 (14/15)	Q2 (14/15)	Q3 (14/15)	Q4 (14/15)	Q1 (15/16)
Average number of sessions completed per child/family by Tier 3 CAMHS team	9.2	6.5	6.8	8.1	
Activity	2615	2410	2606	2644	2955
Number of CYP Seen	283.8	368.4	381.4	326.4	

14.1.3 Discharge Data

NELFT Tier 3 data shows that 76% of those that were discharged from the service (1631 discharged in FY2014/15 + 143 for Q1 FY2015/16) were discharged on professional advice. 8% discharged themselves, either against professional advice or by not attending, and just 1% were transferred to other health care services (including Tier 4 & adult mental health Services).

14.2 CAMHS Tier 3 also offer the following services/workers:

CDC: Child Development Centre

One post that covers both CDC and CAMHS Tier 3 this post offers support across the neurological and mental health pathway.

Child & Family Consultation Service

This offers psychological based therapy in line with NICE guidelines to children and their family who have mental health needs these included diagnostic pathways around ASD and ADHD.

Mental Health Specialists in Youth Offending Service

A nurse and clinical psychologist provide specialist input to the Local Authority Youth Offending Service.

14.3 Early Intervention Psychosis Service

An NHS provision providing early intervention supports to young people aged 14-35 years with psychosis.⁸⁰ Referrals can come from CAMHS, Access Team and GPs.

14.4 Eating Disorder Service

An eating disorders service (EDS) is based in Dagenham which offers specialist assessment and treatment to people aged 8 years and over. The service works with individuals and their families to support them in their recovery by providing psychological treatments (individual and group), dietetic input and nutritional support and medical and nursing.

Referrals

Referrals are accepted from GPs, community mental health teams, home treatment teams (HTTs), and the A&E liaison service.

Accept Criteria:

- aged eight and over with no upper age limit
- registered with a GP in Barking and Dagenham, Havering, Redbridge, or Waltham Forest
- people who are not registered with a GP but are ordinarily resident in the four localities above
- people meeting the criteria for the spectrum of eating disorders including anorexia nervosa, bulimia nervosa, binge eating disorder and eating disorders not otherwise specified

Exclusions: None

Test results required at referral:

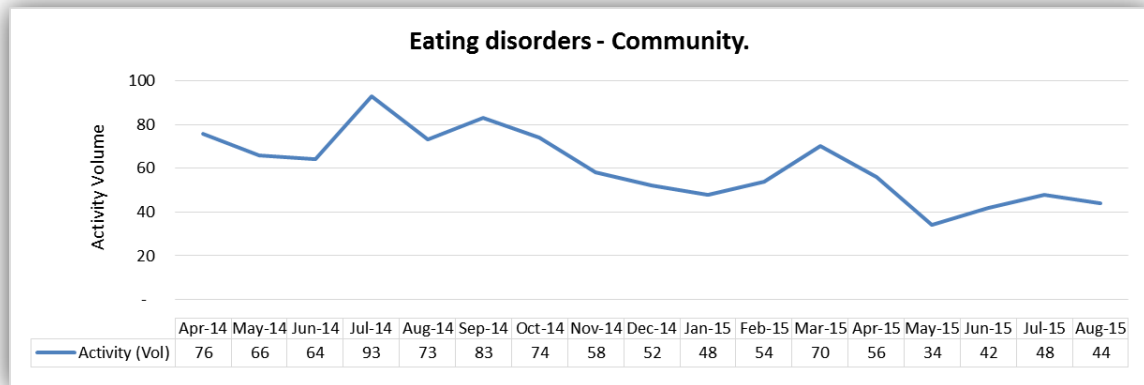
- current weight and height
- recent weight loss
- blood test – FBC, U&E, glucose sodium & potassium, TFT, LFT, calcium and phosphate

⁸⁰ Barking and Dagenham JSNA 2015

Service Usage

The following Eating Disorder Team activity data from the KPI data which is submitted to the CCG by NELFT shows the activity of this team trending downwards but without an accompanying narrative it is not possible to draw any clear conclusions. The data does not differentiate by age and therefore again conclusions regarding trends cannot be made.

Figure 13



14.5 Outcomes measurement

As part of being in CYP IAPT, community CAMHS are expected to use Routine Outcomes Measures (ROMs) with children, young people and their families, and to work towards this being with 90% of the total caseload. CAMHS in Barking and Dagenham are using the SDQ as their standard ROM and have a recently developed Standing Operating Practice document to embed this. CAMHS currently has two people identified as 'IAPT trainees'. Reported measures are in the table below:

Table 13

Measurement	Q1 (14/15)	Q2 (14/15)	Q3 (14/15)	Q4 (14/15)	Q1 (15/16)
Number (client total) of initial measures	104	67	85	58	60
%age (client total) of initial measures	33.1%	29.1%	31%	24.2%	
Number of follow up mental health	21	18	15	5	16
%age of follow up mental health	6.7%	7.8%	5.4%	2.1%	

These reported measures suggest that outcome measures are not taken consistently as it appears that between 24% and 33% of children and young people's mental health is measured upon entry to the service, and only between 8% and 2% receive any follow up mental health measurement.

If initial measures are taken during the 1st Appointment, then the reported percentage of initial measures taken in a quarter points to a different number of 1st appointments than is reported, or a different way of calculating the percentage of initial measures that were conducted.

Table 14

	Q1 (14/15)	Q2 (14/15)	Q3 (14/15)	Q4 (14/15)	Q1 (15/16)
1st Appointments			197	157	
Number (client total) of initial measures	104	67	85	58	60
%age (client total) of initial measures	33.1%	29.1%	31%	24.2%	
Calculated 1st Appointments (based on initial measures)	314	230	277	240	

14.6 Transition to adult mental health services

PHE & ayph (2014) state any transition point is a critical time for supporting a young person, and all local services should have arrangements in place to manage transitions, particularly for vulnerable groups. Both young people’s services and adult services need to have an understanding of the needs of this age group. Transitions are a ‘stress point’ and AYPH (2016) point to the number of transitions made by the 10-24 year old age-group, building resilience will help them cope with the transitions.

A pathway for transition from CAMHS to adult mental health services (AMHS) was signed off across NELFT in February 2016, although it had been live for 18 months previously for non-psychotic problems – mood, anxiety and personality disorder (MAP) and the neuro-development pathway. An adult psychiatrist has run joint clinics with paediatricians every 3 months since 2013. CAMHS can refer into the ‘access’ team in AMHS from the age of 17 ½. The new transition pathway includes psychosis as a ‘severe and enduring mental illness’.

A diagram of the transition pathway is in Appendix 2.

FiM⁸¹ states that services, in partnership, need co-ordinate the provision of mental health care for young adults. The Taskforce recommends flexibility around the age of transfer, where it is based on individual circumstances rather than absolute age. There is also the suggestion that more vulnerable young people, such as care leavers and those in contact with the criminal justice system may be especially vulnerable at time of transition. This flexibility might be worth considering in Barking and Dagenham.

14.7 Targeted (Tier 2) and Specialist Service (Tier 3) Stakeholder Feedback - Staff engagement

- 67% of respondents to the survey know how and where to refer to Specialist CAMHS.
- 43% of people stated that the route into CAMHS is easy to navigate,
- 57% do not think it is easy to navigate or don’t know (9%).
- *Specific comments included the following statements:*
 - *the referral process should be easier*
 - *access to all CAMHS staff should be easier*
 - *referral systems to CAMHS change and we are not always notified*
- 52% of respondents said they understood the configuration of services in Targeted (tier 2) and specialist (tier 3) CAMHS.

⁸¹ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people’s mental health and well-being. Gateway ref no 02939

- 24% of respondents felt that the interventions on offer meet the needs of the children and young people that they feel need to be referred.
- 38% felt that CAMHS did not meet the needs of the children and young people whom they referred.
- 24% of survey respondents felt that they had enough information from CAMHS,
- 48% felt that they do not get enough information from CAMHS.
- 3.45% of survey respondents felt that there are sufficient services in Barking and Dagenham to support children and young people with their mental health needs.
- A large majority (79%) felt there weren't enough services.

Stakeholders made the following suggestions or comments in relation to the development of a mental health/emotional well-being pathway of services:

- the pathway should be as clear and as simple as possible, with clear access points and transparent processes – preferably one across all services – to make the services child-focused. Any pathway would address the current gap identified for those young people accessing CAMHS who do not meet the criteria for Adult Mental Health Services (although they currently access other adult services via step-down and adult IAPT)
- self-referral was also seen as important
- a map/chart of services to be available outlining how services work, what types of issues services work with and where there is overlap.
- The use of electronic methods of communication to improve services
- contact details of support services should be available for those waiting to be seen
- workers at tiers 1 and 2 should be provided with more information on a child's discharge and information on what further work is recommended by those at T3.
- CAMHS should attend meetings to share information and communicate with the rest of the professional network.
- Workers could be helped to continue to support children and young people when they are discharged from CAMHS. Suggestions included a written report with targets. One idea was that CAMHS hold a 'step-down' meeting with the professional network which would provide an opportunity to talk face to face and to feedback to organisations that are working with the child.

Additional statements and views were expressed during the stakeholder engagement work:

- There is a perceived need in that there are times when patients are discharged from Tier 4 back into the community without any Tier 3 support in place
- *"The reduction of services is impacting on the support young people are receiving. We are advised students need school counselling which is not always available with the limited time available with the counsellor."*
- *"Support via CAMHS such as counselling is very limited. It is often difficult to get a referral accepted."*

- *“The service the school has received from CAMHS is inadequate. We often want to make Tier 3 referrals and we are nearly always told they do not meet threshold.”*
- *“Resources in B&D do not correspond to children's needs. There are not enough spaces to provide school counselling, family therapy and other psychological interventions. Schools do not get enough of Educational Psychologist assessments or speech and language therapy”.*
- *“there needs to be more choice available to young people around the type of treatment they receive Young people need to be more involved and informed about the care they receive. Practitioners need to be able to deliver treatments that are beneficial to the client and that are proven to be effective Routine outcome measures are really useful for both clients and practitioners to ensure the right type of care is offered but also that progress is being made”*
- *“Better funding and less procedural red-tape and recording would mean staff/services could provide a true best-practice experience and intervene earlier to prevent difficulties becoming chronic and entrenched. This would have positive wider outcomes on society as a whole saving money in what is an increasingly reactive society where resources are scarce, access to support is difficult and time limited (not always for the best reasons) and where young people feel unsupported and isolated. Not surprisingly in attempts to fit in and a desire to belong gangs, crime and substance misuse then tends to draw some in.”*

14.8 Tier 3: Stakeholder Feedback: Service User Engagement

Parents of service users were asked about their family experience of CAMHS. The feedback is from 11 survey respondents and 3 interview, and the findings were:

- 9.5% had finished CAMHS treatment and been discharged.
- 24% were regular users of outpatient CAMH Services 24% had received help from other services (child development team and community paediatrician).
- Generally respondents reported the issues were identified by parents. Concerns usually emerged 4-6 months before referral.
- There is some indications that earlier intervention may have averted a crisis with some parents reporting serious level concerns or crisis prior to referral.
- Length of wait varied between 2 weeks, to over 6 months.
- All children received individual counselling, with emphasis on coping strategies and easing the transition between key life stages. Of those interviewed two indicated they were happy with the treatment and had begun to see positive results. One interviewee noted that her child still felt 'stuck'. One child had had three different therapists within 2 months.

Improvements suggested by some of the parents included:

- Better links are needed between social care services and CAMHS services so that social workers can refer more smoothly.

- Schools should have more awareness of mental health and provide more information about the referral process.
- It would be helpful if CAMHS workers could explain the process to parents at the beginning. Having a plan in place would have helped with their child's anxiety.
- Venues such as GP, Children's Centres, and the internet would be good places to receive more information on child mental health issues.

15. Tier 4 services

Since April 2013, NHS England has been responsible for commissioning CAMHS Tier 4 services and clinical commissioning groups (CCGs) for CAMHS tiers 2 and 3, including the provision of effective early intervention services which can prevent problems escalating to the point where admission to hospital becomes necessary. In-patient care needs to be age-appropriate and as close to home as possible (FiM⁸²). Ideally the local commissioning should address provide a range of provision including pre-crisis, crisis, and step-down services.

The Mental Health Taskforce report (2016) talks about crisis care, saying people facing a crisis should have access to mental health care 7 days a week, 24 hours a day. The FYFVMH suggests that an equivalent model to the Crisis Resolution and Home Treatment Teams (CRHHTs) for adult care should be developed for children and young people. Some areas have a dedicated home treatment team for children and young people. The Crisis Care Concordat stated that there should be an out-of-hours mental health team. The government is expecting that the provision of an all-age liaison psychiatry services in A&E departments will mean that appropriate mental health care in A&E is more readily available.

15.1 Mapping of local services

i) INTERACT (Adolescent Outreach Team)

Provided by NELFT, INTERACT is a mental health community support service that works with young people aged between 12 and 18, following a crisis situation by providing a series of home visits in addition to any support already being received. Working collaboratively with local child and family consultation services, they provide additional community support for young people between the ages of 12 to 18 years. In addition INTERACT provide the Accident and Emergency/paediatric wards liaison service Monday to Friday 9am to 5pm for King George and Queens Hospitals. They also provide assessment and follow up support and or facilitating admission to Brookside⁸³ adolescent unit, or another unit in a different part of the country, if required.

Interact work alongside any organisations that are already helping young people to give extra support at times of increased difficulties. There are four main situations in which their services would get involved:

⁸² DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

⁸³ Since writing this needs assessment issues have arisen around Brookside, this is outside the scope of this work.

1. After a young person's admission on to a general hospital ward or a visit to A&E. Following an assessment the young person may receive support at home following discharge from the ward/A&E.
2. When a decision has been made by the community CAMHS team for a planned admission as either day patient or inpatient, INTERACT may provide short term support to bridge the gap between assessment and admission, or whilst waiting for a decision on funding from NHSE.
3. Following discharge from Brookside, or another in-patient unit, it may be necessary for a young person to receive additional support, for a set period of time, from INTERACT.
4. When the limitations of child and family consultation service mean that a young person would require extra support or be referred for admission to an inpatient unit. The INTERACT team may provide additional support for a period of time and admission may be avoided.

Referrals are accepted from the child and family consultation services (CFCS), eating disorders service (EDS), early intervention in psychosis (EIP) and staff in A&E wards of general hospitals. INTERACT does not accept referrals from GPs, social services, schools, or self-referrals.

ii) Brookside - child and adolescent inpatient unit ⁸⁴

Brookside is currently not available because of upgrading but will be available in future.

The Brookside unit is divided into three services onsite - there are two inpatient services (Willows and Reeds wards) and a day patient service (Waterfalls ward).

Brookside is a 24 hour service available nationally with 14 beds available.

Brookside supports young people and their families to return to the community with signposting to the appropriate community support after an acute episode of poor mental health. Brookside hosts an in-house school that supports young people with their education tailored to the needs of young people and supports a return to full time education. Brookside also supports families, carers and guardians of patients with support and advice during admission and recommendations post discharge⁸⁵.

Referrals

NELFT internal referrals are via the INTERACT team. All other referrals are via A&E services or Tier 3 CAMHS only.

Young people with mild to moderate learning disabilities can be referred to the unit as long as there is a co-morbid mental health problem.

iii) Willows high dependency unit (HDU)

The Willows high dependency unit (HDU) is a four bedded inpatient service that offers admission for young people between 12 to 18 years old who cannot be

⁸⁴ Since writing this needs assessment issues have arisen around Brookside, this is outside the scope of this work.

⁸⁵ Barking and Dagenham Children's and Young People's Mental Health Transformation Plan (October 2015)

treated in a more open environment. There are close links with the therapeutic programme offered on the Reeds unit at Brookside. The Willows shares the same staff team as the Reeds ward. The majority of young people are voluntarily admitted, but some young people are detained under the Mental Health Act. Parents and carers are involved in all aspects of the young person's treatment.

Willows High Dependency Unit providing a 24 hour service available nationally.

Referrals

This is a service available nationally. NELFT internal referrals are via INTERACT. All other referrals are via A&E services or Tier 3 CAMHS only.

15.2 Tier 4: Stakeholder Feedback

Three responses were gained from service users, some of whom had experienced crisis. From the responses gained it would seem that people are largely unaware of the Interact crisis service operating locally and have little or no knowledge on how to access it, nor do they know where else to turn when their child was experiencing a crisis.

16. Workforce Development

16.1 CYP IAPT training

As a member of the London and South East CYP IAPT Learning Collaborative, practitioners across the pathway have access to training in:

- Transformational Leadership
- Enhanced Evidence Based Practice
- Supervision of therapists
- Cognitive Behavioural Therapy
- Interpersonal Therapy
- Family Therapy
- Parenting for Conduct Disorder (aged 3-10)

NELFT currently (February 2016) has two CAMHS staff identified as 'IAPT trainees'.

16.2 Mental Health First Aid Training

During 2014/15, Public Health funded the training course 'Mental Health First Aid'. Over 1000 delegates from a range of professionals working in the Barking and Dagenham area attended. This training is no longer available.

From the limited information received it is not possible to accurately identify specific training needs of the workforce. However practitioners engaged in the workshops did identify the following issues/needs:

- How to work with specific mental health issues and gain awareness
- De-mystification of what to do or say in some situations, i.e. self-harm
- Risk assessment training
- Management training – in maintaining and supporting anxiety with their staff

- Teachers should be taught about child development in their initial training – parents need to know too.
- Early Intervention workers should also be aware of child development
- How to identify early warning signs of emerging mental health issues
- Training in how to measure the impact of the support and interventions offered

The 2015 mental health needs assessment⁸⁶ made 25 recommendations for improving mental health services. For CAMHS it identified '*Lack of peer support as a means of helping recovery and as additional capacity*' as an issue and made the following recommendation: *Commissioners across health and social care should agree to invest in the development and establishment of a peer support programme in mental health, seeking advice from areas where good practice is in place as necessary. The programme should have sufficient capacity to offer meaningful access to mental health service users across the borough, and provide funded coordination and appropriate training and development for those in peer support roles.* This identifies a further training need for the workforce to enable peer support to be put in place.

17. Stakeholder involvement and participation in developing mental health services

17.1 Service user and carer voice

PHE & ayph (2015) stress the importance of young people being involved in designing, commissioning and evaluating services. PHE & ayph⁸⁷ suggest the use of the Department of Health's 'You're Welcome' standards in order to encourage accessible, youth-friendly health services. Services are encouraged to deliver in accessible locations, consider greater use of social media and modern technology and ensure staff are skilled in confidentiality and communicating with young people.

Barking and Dagenham has a user group known as the 'Listen' group, but it is not well attended. The group is operated on a volunteer basis.

⁸⁶ Time to Change/Delta (2015) Mental Health Needs Assessment, 2nd March 2015.

⁸⁷ Public Health England and Association for Young People's Health (2014) Improving young people's health and wellbeing: a framework for public health.

18. Service demand

For every five children and adolescents seen currently we will see six children and adolescents in the future (2020). It is proposed that the Tier model is replaced by the Thrive Model (see recommendations). Based on the population and service information in this report demand for services would increase from 2013 to 2020. Below we show a DRAFT calculation of possible future demand in each section of the Thrive Model is

To be clear of actual future demand robust data collection for each section of the Thrive Model will be needed.

Table 15

Type of help	Demand based on 2013 data				2020			
	Total number of children needing CAMHS	Different type of needs (%)	Different type of needs (number)	Total number of contacts	Total number of children needing CAMHS	Different type of needs (%)	Different type of needs (number)	Total number of contacts
Coping cluster	6,800	32%	2176	16973	8044	32%	2574	20078 (+3,105) (18.3%)
Getting Help cluster		53%	3604	28111		53%	4263	33254 (+5143) (18.3%)
Getting More Help		15%	1020	7956		15%	1207	9411 (+1455) (18.3%)
Getting Risk Support		N/A	N/A	N/A		N/A	N/A	N/A

19. Discussion: gaps and needs identified

As mental health and emotional well-being work covers so many different facets of a child's life, it is impossible to put a figure to the number of children and young people who are accessing emotional wellbeing/mental health support at universal and targeted levels (tier 1 and tier 2), but there is an expectation that, in Barking and Dagenham, 14,050 at any one time will need support with their mental health from across the tiers, based on current figures. There are no specific mental health demand figures available locally apart from the number of referrals to specialist CAMHS, but the felt-needs of staff across all services are that they are dealing with increasingly complex problems with very little support or training from people who know more about mental health. Staff's perceptions from the survey indicates that they feel this need to be large percentage of the children and young people whom they are working with. This may be that those who feel they are working with mental health needs were more likely to have answered the survey or attend the workshops. Putting these elements in place would need a co-ordinated approach and for all commissioners to monitor what is being delivered, and to whom.

The calculations made in this report, which interrogated the data collated by, amongst others, Public Health England and Department for Education, suggest that the figure of children and young people with a diagnosable mental health problem is currently (2015/16) 6,500 children in Barking and Dagenham, which is close to 10.4%. Out of these nearly 7% (n=4574) will have a severe mental health problem, either as a single disorder or co-morbid. Thus, the conclusion is that the rate of mental health disorders in LBBDD is significantly higher than the national average of 9.3% of child population. The rates of emotional, conduct and hyperkinetic disorders, as well as potential eating disorders are all significantly higher than national averages.

The forecasted growth of LBBDD child population shows a sharp increase in population by 2020. This represents an increase of approximately 7,600 children in LBBDD. Extrapolating national mental health disorder prevalence figures for boys (13%) and girls (9%), a very conservative prediction is that at least 4,827 boys and 3,217 girls will have a mental health problem and may require CAMH service by 2020 (8,044 children in total). Service development and investment needs to take account of this increase in population need.

This figure does not take into account any of the social factors which could increase vulnerability. These could be summarised as:

- Poor attachment is seen as a root cause of challenging behaviour in both pre-school and primary school age children
- Large numbers of young people are experiencing distressing but common life events, such as parental separation/divorce, bullying, bereavement, domestic violence
- The emotional and psychological difficulties experienced by adults have a very significant adverse impact on children and young people and is seen as an underlying cause.
- Issues of anger and self-harm are recurrent themes in work with young people

This needs assessment involved and talked with stakeholders as they are key to understanding local needs. Families indicated:

- Accessing services can be daunting
- Some families are not aware of the services available to them
- Some professionals are not aware either
- Families appreciate consistent relationships with professionals who know them well
- Children and families like to understand what is happening, what is expected of them and to be involved in the decisions about what happens next.
- Families want a flexible approach to when and where services are provided.
- That they want help before crisis point, but don't often get this.

Feedback from staff indicated the following needs and gaps:

- Staff in universal services are working with high levels of complex mental health needs and disorders and a third estimate that 30% of the children and young people that they work with have mental health problems
- Most staff know how and where to refer to specialist CAMHS, but a small majority do not think that the route to CAMHS is easy to navigate
- There is a need for more information from CAMHS on how to refer, when to refer, what work they are doing with children and young people who are accessing the services, and what these staff need to do once the child or young person is discharged from CAMHS via a step-down meeting
- A clear and simple pathway is needed across all services, that includes self-referral, choice for the family, and electronic methods of communication which is consistently applied and communicated
- There is a significant amount of resilience-building activity occurring, but this is not co-ordinated.
- There are gaps around promotion of mental health, but lots of ideas for delivering more mental health promotion work.
- Knowledge of current services and what support is available is limited
- There is a perceived lack of self-help materials
- A minority of staff felt that the interventions on offer in CAMHS met the needs of children and young people
- A large majority felt that there were not enough services to support children and young people in the borough

Data analysis to inform the needs assessment has been difficult due to the paucity of local demand/service usage figures. However, FYFVMH (2016⁸⁸) states that the transformation envisaged for CAMHS and the wider emotional wellbeing pathways will need good data on current levels of spending, access,

⁸⁸ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

quality and outcomes, as well as clear information on best care pathways. This will take a number of years, stating that the collection of data on children and young people has been subject to delays and the data itself lacks clarity. There is no access to equalities data, showing breakdowns in access and outcomes across groups protected by the Equality Act 2010.

FYFVMH recommends collecting information that many providers are already collecting including: the NHS Benchmarking Collaborative; outcomes data collected by members of CORC; the CYP IAPT datasets and outcome measures; data collected for CAMHS currencies; and health and justice data as well as how funding is used. Without the data and information, it will be hard to assess the impact of organisational change, including those outlined in the LTP.

The FYFVMH⁸⁹ suggests that currently providers carry much of the risk and responsibility for improvements in quality and outcomes, with too little scrutiny from commissioning. Commissioners must remain responsible for meet the needs of their local population and must be held to account according to the FYFVMH⁹⁰ and recommend that the CYP Local Transformation Plans (LTPs) should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs). The STPs will cover all health and social care in the local geography and should include evidence about how local areas are ensuring a joined-up approach that is consistent with the existing statutory framework for children and young people. There is a need for more consistent outcome measurement in targeted and specialist services, so that children, young people, their parents/carers, the therapist and the service can identify what improvements are being made over time.

There is an ambition to move away from tiered services locally, but currently services are still arranged on this basis, so this report used the language of tiers. There are a plethora of tier 1 services, all offering prevention, promotion, resilience-building and support functions, but a majority think that there is more that should be done, and many had ideas about how to. There is a training need for staff around what works in mental health promotion, which needs to be evidence-based and identify which programmes are best suited to promotion.

The majority of workers also stated that there are currently opportunities to develop resilience. However, there does not appear to be a systematic programme of working with children and young people within and beyond schools on promotion and protection of mental health, which could also go some way to addressing the stigma that has been described by families and staff. There are many ways to enhance young people's resilience, not all of them will need more resources, but they will need development and monitoring. This needs leadership and HWB might be best placed to drive this development of integrated working.

There are many factors that increase the risk of developing mental health problems for children and young people. There is a high level of mental health needs amongst LAC and young offenders, and many of these young people may be placed out of area whilst still having mental health needs, as well as those who have physical health problems. There are likely to be 200 children and young people living with a parent with a mental health problem, increasing the child's risk of developing their own mental health issue. There is likely to be services specifically responding to these risk factors, indicating a need to work collaboratively amongst agencies, including adult mental health services.

⁸⁹ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

⁹⁰ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

There is also a proportionate response needed to addressing the on-going mental health needs of LAC, as demonstrated by SDQ scores. SDQs give some indication of this need and the completion rate for LAC (78%) needs to increase. The needs of LAC who are placed out of borough needs to be assessed and monitored in borough.

Barking and Dagenham already offer a pretty thorough Tier 2 support. There are however, several additions that could be made to strengthen this. This could save resources through integrating staff and streamlining service provision. It could also improve the uptake and retention rates for children and young people with ADHD/LD/ASD through timely diagnosis and intervention. The other suggestion is to offer a dedicated LAC service. The mental health of particularly vulnerable groups needs to be understood and met. First-time offenders whose number is disproportionately high in the borough, compared to national (and even London) average. FiM⁹¹ argues that there is a clear need for appropriate and bespoke care pathways for vulnerable children and young people to provide a social and clinical response to meeting their needs, based on the presenting needs of the child, not just a mental health diagnosis. The analysis suggests that across the system there is a lack of assertive outreach to those who may be more at risk/reluctant. Partners need to work together to develop a far stronger focus on resilience and protective factors in families so that all partners can have greater confidence about their contribution to improving children's outcomes.

It appears that children and young people may have been experiencing problems for a long time before they get referred to CAMHS, indicating that they would benefit from some kind of intervention earlier. Problems tended to have got to a crisis or severe point before referral, and disparity in waiting times appear to be an issue. The crisis service in Barking and Dagenham is not available 24 hours a day.

It appears from the survey and the staff workshops that workers in universal and targeted services understand that they do have a role on the CAMHS pathway and seem willing to undertake these roles, but feel that they need more capacity and support to do this. Only a quarter felt that they had the capacity to deal with mental health problems, and just over a quarter felt that they could fulfil their role on the CAMHS pathway, suggesting staff feeling overwhelmed by the need that are trying to respond to and manage. Staff would be better able to do this if there was provision of training in the mental health of children and young people, there was information available for self-help, and more information from CAMHS when children and young people are discharged. They are dealing with quite severe mental health issues, a risky situation if they do not feel supported in this work. In order for the pathway of services to work, workers at all parts of the system need to know about the other services and what children, young people and their families can expect from those services. Information about mental health, and referrals to CAMHS do not seem to be consistently known amongst staff and service users. The information about CAMHS needs to be on the internet, school bulletin boards, GP surgeries and other places young people might go, and needs to be reiterated constantly. The access to someone in the MAPs who knows about mental health and the mental health system is welcomed by many staff.

Turnover of staff has an impact on who knows what, so the 'marketing' of services needs to be current, on-going and sustained.

⁹¹ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

There is also an overwhelming majority of workers who feel that there are insufficient services to support children and young people. Even allowing for any bias that a question like this is likely to produce, it is a significant finding.

Tier 1 services want more information from CAMHS, at all stages of CAMHS work with children and young people – they want to know how and what to refer, what to do whilst the child is on the waiting list, what to do to complement the work that CAMHS is doing once they are in treatment, and what to do to help once the child has been discharged. Parents also want more information about where to turn when they are worried about their child's mental health as do young people. Young people and parents also wanted services to communicate with each other.

As is a general problem in England, transition to adult services can be hampered by poor coordination but this appears to be addressed locally through the transition protocol.

Findings indicate workforce development needs across the system, and workforce planning is needed in order to make the most of an integrated system. It is also worth noting that, although it is acknowledged as a very ambitious recommendation, the guidance from The Royal College of Psychiatrists⁹² for the number of tier 2 and 3 CAMHS clinicians for the age group 0-17 years would suggest 20 wte clinicians per 100,000 total population. For Barking and Dagenham, this figure would be 38.2 clinicians. This would need to include 4.6 psychiatrists, 9.6 PMHWs, 7.6 psychologists (3.8 in Tier 2 and 3.8 in tier 3), 9.2 nurses and 2.3 art therapists. There would also be 1.3 wte clinical psychologists for children and young people who have a learning disability and mental health problems. The current tier 2 and 3 staffing is below this guidance at 22.88 wte, based on information from NELFT (although in the LTP there are 29.96 clinical staff noted). Alongside this they recommend that a CAMHS clinician's key worker caseload should average 40 cases per WTE across the services, varying according to the other responsibilities of the clinician. A clinician seeing 40 new referrals per year has the capacity to offer evidence-based treatments. This needs assessment was unable to establish the current CAMHS caseloads but operational managers need to monitor this. The RCPsych also recognise that some commissioners may prefer to use existing capacity in a specific ways, such as seeing more than 40 new referrals per annum but limiting the number of treatment sessions available. If this is done, it needs to be recognised that some effective treatments cannot be provided.

Analysis suggests there are service gaps which should have priority in future commissioning:

1. There is a lack of co-ordinated effective prevention and early intervention available for children and young people with emerging emotional difficulties. This appears to be contributing to the escalation of need with growing numbers of referrals to high cost services such as specialist CAMHS or social care services.
2. Inconsistent responses to early parenting problems are increasing the number of children presenting with emotional and behavioural difficulties later in childhood. This has a significant impact on a range of outcomes including relationships and education. Underlying issues such as domestic violence, the quality of attachment in infancy are potential root causes which need to be better addressed to ensure the risks to children are managed.

⁹² RCPsych (2013) CR182. Building and sustaining specialist CAMHS to improve outcomes for children and young people. College Report.

3. Consistent, responsive and warm parenting is essential for children of all ages. Parents' role in providing a consistent home environment and the ability of parents to have a positive relationship with school are protective factors for children and have a significant impact on a range of outcomes. From the analysis it appears that services are not intervening positively to support parents in their behavioural management and care of children. As children grow and develop many parents lack confidence in their skills and abilities to tackle children's problematic behaviours. Early opportunities to affect change quickly may be lost.
4. Services are missing the signals of risk. This results in missed opportunities for families; needs escalate and families are 'funnelled' up tariff receiving more intrusive levels of intervention that are less likely to be successful. Risk factors such as domestic violence, poor parental mental health and/or parental abuse of substances are likely to compromise parenting capacity.
5. There appears to be a lack of a coherent response across the continuum of need with both families and staff unclear on what is available for what issues. A gap in professionals' skills and capacity to provide mental health support to young people is identified by practitioners, parents and young people themselves.
6. Many practitioners in universal and primary care services feel they lack both the skills and confidence to intervene effectively with those families who have children and young people who are experiencing escalating levels of distress, emotional and psychological pain. This is reported as a particular issue for teenagers. This picture is recognised by Department of Health's Task Force Report, *Future in Mind: Promoting and improving our children and young people's mental health and wellbeing*.

20. Design of future options

This section will look in detail at what needs to be in place in the future - using the evidence of what works in supporting and treating children and young people with mental health problems and an analysis of models to deliver a whole-system emotional wellbeing and mental health integrated service.

Service models appraisal

Within CAMHS, the four-tiered model has been used for over a decade to conceptualise the planning and delivery of mental health services. This is the model that currently operates in Barking and Dagenham. More recently, however, there has been a move towards the concept of universal, targeted and specialist services, as used across the children's services more widely. An emphasis has been placed on early intervention, the importance of which has been well-rehearsed in research. It is important to note that, whichever conceptual model is used, a child may be receiving services in one or more of these categories at any one time. They may be delivered by public, private or third sector providers, and they need to be evidence-based (see section 27).

FiM⁹³ states, based on evidence presented to the review, that there should be a move away from the tiered system of mental health, and there should be integrated service delivery – *right time, right place, right offer*. This can be achieved by enabling single points of access, and a one-stop shop service for the VCS. This is something that FiM suggests can be done now without additional funding, along with the named mental health contacts for primary care and schools, and the named individual in schools (see above). Integrated service delivery should ensure that no child or young person falls through the gaps between the tiers or different services, and there should be a seamless pathway of care and support with collaborative choices about what would work best for that individual at that point in time.

As part of Future in Mind exercise, many trusts have tried innovative approaches to problems which many CAMHS services across the country struggle with such as waiting times, crisis services, increased volume of referrals and the need to manage the resources more carefully. As part of this project, these solutions have been analysed, and we will present some key findings which could be beneficial for Barking and Dagenham.

In considering future design options, three different models were reviewed. These were:

- The Thrive Model
- Stepped Model of Care
- Hub Model of Care

20.1 The Thrive model

The Thrive Model (Timely, Helpful, Respectful, Innovative, Values-based, Efficient) is aligned to emerging thinking on payment systems, quality improvement and performance management⁹⁴. The model informed by young people's views, seeks to draw a clearer distinction between treatment and support. Rather than an escalator model of increasing severity or complexity, the model suggests 'resource-homogenous groups'⁹⁵ (although it is understood that there will be variations in needs within each group) who share a conceptual framework as to their current needs and choices. The model describes four clusters of young people with mental health issues and their families, including those who are supported to thrive through prevention and promotion activities delivered in the community. The model describes both input offered and a continuum of recovery using language informed by consultation with young people and parents with experience of service use.

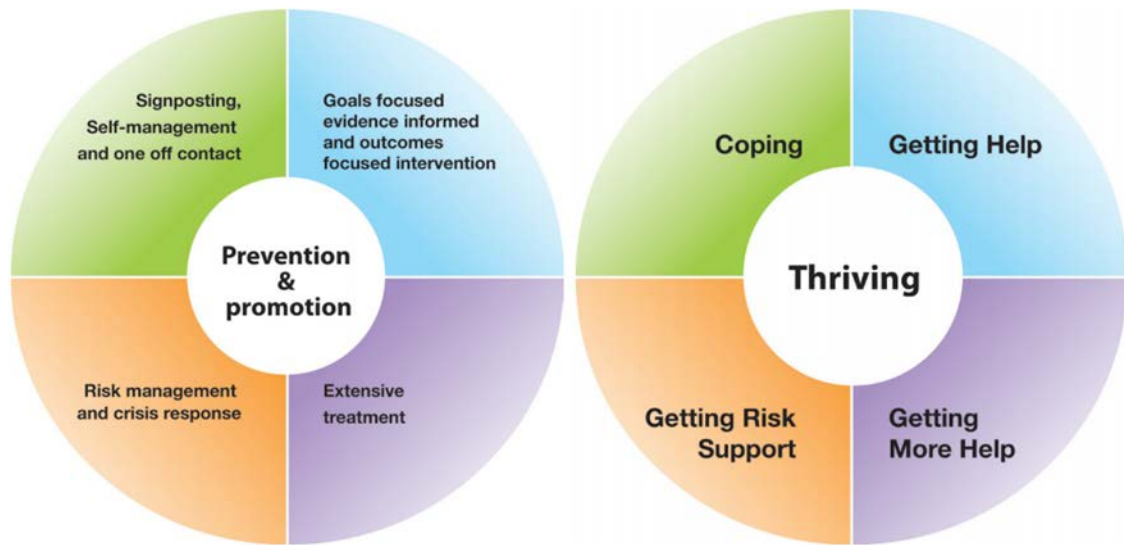
The THRIVE model below presents four clusters for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community. The image to the left describes the input that offered for each group; that to the right describes the state of being of people in that group - using language informed by consultation with young people and parents with experience of service use.

⁹³ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

⁹⁴ IBID

⁹⁵ IBID⁹⁶ British Psychological Society (2012) Consultation on Child and Adolescent Mental Health Services – A Service Model. London: BPS

Figure 14: Thrive model



- Cluster 1 – Coping

This segment refers to children, young people and their families who are adjusting to life circumstances, with mild or temporary difficulties, where intervention is self-help or comes from within their community. This group may also include those with chronic, fluctuating or ongoing severe difficulties. The THRIVE model of provision uses language of ‘wellness’ and advocates provision provided from within education or community settings, It is advised that input in this group should also involve some of the more experienced workforce, to be involved in the decision-making process about how best to help people in this group.

- Cluster 2 – Getting Help

Getting Help cluster ought to include children and young people with difficulties that fell within the remit of NICE guidance and where there are interventions that might help. These are children who would benefit from focused, evidence-based treatment, with clear aims, and criteria for assessing.

The THRIVE model of provision would suggest that, wherever possible, provision for this group should be provided with health as the lead provider. Health input in this group might draw on specialised workers in different treatments. The most radical element of this cluster is that the treatment would involve explicit agreement at the outset as to what a successful outcome would look like, how likely this was to occur by a specific date, and what would happen if this was not achieved in a reasonable timeframe.

- Cluster 3 – Getting More Help

Some conditions are likely to require prolonged or intensive treatment. In particular, young people with psychosis, eating disorders and emerging personality disorders are likely to require significant input potentially including inpatient care or extensive outpatient provision.

Health is seen as the lead provider, involving specialised health workers in different treatment as required.

- Cluster 4 – Getting Risk Support

There is limited evidence to support this cluster, and it is not possible to separate this group from the other groups with the THRIVE model, as any child or young person, at any time, may need risk support.

20.2 Stepped Care Model

A stepped-care model (SCM) is recommended by NICE.⁹⁶ In SCM, the least intensive intervention appropriate for a person is typically provided first with care tailored as needs change or escalate.

- Step 1 – Universal/prevention

Universal services should be designed or adapted to provide the best start in life for all children. These foundations of development help to ensure good outcomes in later life. The quality of provision at this first step is key to averting the need for other more intensive (and costly) services once problems have emerged.

- Step 2 – Targeted Intervention

This involves early detection and provision of preventative support to children and families in need. Intervention at this step is provided to children and young people who are experiencing:

- early developmental or behavioural difficulties
- mental health and or emotional difficulties;
- are engaging in risky behaviours

and where these are progressively impacting the child's, young person's and their family's functioning.

At this step structured approaches are provided to reduce the impact of mental health and emotional problems and prevent their escalation to more significant difficulties. Step 2 interventions may be provided by a range of services including primary mental health services, paediatric care services, child development services, infant mental health services, family support and social care services, LAC therapeutic services, community led mental health services, youth counselling and children's disability teams.

- Step 3 – Specialist Intervention

This involves specialist diagnostic assessment and the provision of psychological, systemic and/or pharmacology therapy. Intervention at this step is provided to children and young people who are experiencing moderate mental health and emotional difficulties which are having a significant impact on daily psychological /social/ educational functioning. Intervention at this step is normally provided through specialist / specific multidisciplinary teams. Step 3 interventions may be provided by a range of services including elective CAMHS teams, CAMHS eating disorder services, Specialist Autism services, CAMHS Addictions services, Safeguarding teams, family trauma services and behaviour support for Learning Disability services.

⁹⁶ British Psychological Society (2012) Consultation on Child and Adolescent Mental Health Services – A Service Model. London: BPS

- Step 4 – Crisis and intensive

This involves the provision of crisis resolution and intensive home/ residential/ or day care services designed to reduce and/or manage those children and young people who are at immediate risk or who need intensive therapeutic care. The primary objective of this intervention is to prevent admissions to acute hospital care. This service has already been piloted across several regions, and it has drastically reduced both the volume of referrals to Tier 4 service, as well as the pressure on Tier 3 service once the patients are discharged from Tier 4 service. This type of service is typically provided by CAMHS Crisis Intervention Teams or Intensive Day Support Services.

- Highly Specialist Inpatient/secure care

Care at this step is provided for those children and young people who are experiencing highly complex, enduring mental health and emotional difficulties which severely restrict daily psychological/social functioning. This level of service provision is usually commissioned at a regional or national level.

20.3 Hub Model

The Hub model tends to be used in Children’s Social Care Services. Pioneered by 4Children arising from work with Sure Start centres around the country⁹⁷. The model has service “Hubs” at the heart of a community offering advice, support and focused intervention. Different professionals deliver a range of services from the hubs (which can be real or virtual) such as advice, bringing together and coordinating services, from midwives and health visitors to childcare and support for young people, building early intervention in at the core, and including support for families with complex needs, safeguarding, child protection and social care.

In some areas the children centre programme has been extended to become a 0-19 Children & Family ‘hub arrangement’ delivering a mix of universal and targeted support to vulnerable families with additional needs.

In summary, the approach would:

- Extend all Sure Start Children’s Centres into local Children and Family Hubs
- Further embed these at the heart of their communities, bringing together local support and resources in a joined up way
- Continue with their existing strength of providing universal as well as targeted services, building Early Intervention and help at their core, as well as providing support for families with complex needs
- Support children as they grow up, from 0-19 years
- Be part of a wider overhaul of social care

⁹⁷ Children and Family Hub (2014) 4Children’s integrated model for effective children and family support. London:4Children

21. Evidence of what works for children and young people with mental health issues

In order to explore what works in services, whichever model is chosen, the following will look at what works with specific mental health disorders, and needs to be built into the relevant cluster/step/hub & spoke:

21.1 Promotion, Prevention

Prevention and promotion aim to focus on developing resilience and attachment. Prevention is about taking measures to stop a problem occurring in the first place. In the context of mental health, this could be an activity to avert the initial onset of a mental disorder, targeted at those at risk. The Mental Health Taskforce (2016⁹⁸) (FYFVMH) states that children and young people are the priority group for mental health promotion and prevention. Effective promotion involves ensuring that frontline practitioners can play their part in promoting mental health and bring support into the community settings to make it easy and less stigmatising to access.

Prevention and promotion is typically done at Tier 1 and involves close cooperation between a range of partners from statutory and voluntary sector services. FIM (2015) states that an integrated, partnership approach should be taken. A description of the tasks for relevant professionals are set out below:

- Promoting good mental wellbeing and resilience, by supporting children and young people and their families to **adopt and maintain behaviours** that support good mental health
- Preventing mental health problems from arising by **taking early action** with children, young people and parents who may be at **greater risk**
- Early identification of need, so that children and young people are **supported as soon as problems arise** to prevent more serious problems developing wherever possible.

The Department of Health/NHS England⁹⁹, ChiMat¹⁰⁰ and Public Health England¹⁰¹ evidence-base suggests the following approaches to good promotion practice:

- Promotion of mental health across Voluntary and Community Services (VCS)
- Development and training of frontline practitioners across multi-disciplines to raise awareness of mental health
- Development of online resources and applications such as a 'resilience app' to support emotional wellbeing promotion
- Developing local community campaigns with voluntary sector to raise the awareness of mental health
-

⁹⁸ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

⁹⁹ DH/NHS England (2015) Children and Young People's Mental Health and Wellbeing Taskforce

¹⁰⁰ ChiMat (2013) Better Mental Health Outcomes for Children and Young People. National CAMHS Support Service

¹⁰¹ DoH/Public Health England (2014) Promoting emotional wellbeing and positive mental health of children and young people. London: DoH

- Work with Public Health around implementation of the Healthy Child Programme (the public health programme that is a foundation for the universal health services for children and families)
- Whole school based approaches including the implementation of Mental Health and Behaviour in Schools¹⁰² advice and a Counselling in Schools strategy¹⁰³

In relation to prevention and support, the evidence base suggests the following:

- Development of a Hub that will offer a drop in service for children and young adults to discuss issues that are of concern to them
- Developing a graduated perinatal mental health provision to support & advise mothers pre and post birth including for those who would be deemed as 'worried but well' who would not otherwise receive any extra support
- A multi-disciplinary centre to deliver triage ensuring that children and young people access the right services, at the right time to meet their needs and avoid medicalisation of need unless required
- Development of a peer support programme that is led by children, young people and parents/carers with appropriate support
- Developing e-tools that support and aid self-help; providing good quality information on specific conditions that enable families to understand mental health and mental illness
- To develop a directory of services that support children and young people holistically ranging from education, recreational and social support available
- Implement 'HeadStart' project
- Implement 'Schools Link' project or similar
- Implement Virtual Schools for LAC
- Raising the profile of health visitors and school nurses' contribution to emotional wellbeing and mental health
- Developing guidance / tools for transition with clear role definition for Health visitors and school nurses to ensure clear transition pathways
- Actively engaging parents/carers in the prevention work

The Mental Health Taskforce (2016¹⁰⁴) expects that the savings and efficiencies generated by a strengthened approach to prevention and early intervention should be re-invested in mental health care, creating a challenge to the system to delineate these savings in order to re-invest them.

¹⁰² Department for Education (2015) Mental Health and behaviour in schools. London: DfE

¹⁰³ DfE (2015) Counselling in schools: a blueprint for the future

¹⁰⁴ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

21.2 Resilience building

The Association for Young People's Health (AYPH) (2016)¹⁰⁵ define resilience as:

"... the capacity to bounce back from adversity. Protective factors increase resilience, whereas risk factors increase vulnerability. Resilient individuals, families and communities are more able to deal with difficulties and adversities than those with less resilience."

AYPH (2016)¹⁰⁶ state that promoting resilience means supporting the development of good personal life skills, helping young people to sustain good relations and providing resources and intervention to ameliorate or prevent the effects of 'set-backs'. Other elements¹⁰⁷ that are important for building resilience are preparing young people to cope with adversities, by strengthening life skills, enhancing self-efficacy, nurturing their creativity and making sure external resources are available when they need to draw on them.

The Mental Health Taskforce report (2016)¹⁰⁸ suggests that peer mentoring is highly valued by young people, and should be developed as a core part of developing life skills and building effective networks of support. FiM¹⁰⁹ states that peer support schemes should be led and designed by children and young people, or by parents and carers. Professional support would help build capacity and manage any risk.

PHE and ayph (2014)¹¹⁰ identify six core principles that cut across all health topics for young people. They build on the concept of resilience, seeing relationships as pivotal. The diagram illustrates their resilience model:

Figure 15: Thrive model



¹⁰⁵ AYPH (2016) A public health approach to promoting young people's resilience. A guide to resources for policy makers, commissioners and service planners and providers. <http://www.youngpeopleshealth.org.uk/>

¹⁰⁶ AYPH (2016) A Public Health Approach to promoting young people's resilience.

¹⁰⁷ Public Health England and Association for Young People's Health (2014) Improving young people's health and wellbeing: a framework for public health.

¹⁰⁸ Mental Health Taskforce (2016) The Five Year Forward View for Mental Health.

¹⁰⁹ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people's mental health and well-being. Gateway ref no 02939

¹¹⁰ Public Health England and Association for Young People's Health (2014) Improving young people's health and wellbeing: a framework for public health.

[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399391/20150128_YP_HW_Framework_FINAL_WP__3_.pdf]

The central part of this model is relationships being key to achieving good outcomes in both the short and longer term for children and young people. The following interventions help build resilience and relationships:

- empowering young people in educational settings by giving them the skills they need to develop healthy relationships – for example, by providing opportunities within the curriculum to teach relationship skills (partly through personal, social, health and economic (PSHE) education, and sex and relationships education). Evidence shows that interventions taking a whole school approach to promoting resilience and improving emotional well-being have had a positive impact in relation to both physical health and mental wellbeing outcomes. The majority of programmes to promote positive mental health are within the context of PSHE¹¹¹. There is also evidence that, when implemented well, the Social and Emotional Learning Programme (SEL), has a positive effect on children’s social and emotional skills, behaviour and educational attainment¹¹².
- schools, colleges and higher education institutions’ health services have a critical part to play in building positive health settings and health messages
- promoting anti-bullying interventions to reduce short and long-term adverse consequences. Whole-school programmes with multiple components are also effective in helping reduce children being victimised by bullying, helping to improve emotional, physical and social health of those who are bullied as well as better school attendance and attainment which has a benefit: cost ratio of 14:1, based on the impact on future earnings of the victims¹¹³.
- providing an appropriate range of support for young people affected by violence, adverse childhood experiences and sexual exploitation
- recognising the important protective effects of having an adult that the young person trusts
- supporting parents and carers of young people with general parental advice as well as advice on specific issues
- educating peer and staff groups to reduce stigma about mental health and promote positive emotional wellbeing.

However, FiM¹¹⁴ found that many young people reported that school was not an environment in which they felt safe to open up about their mental health concerns, so making them feel safe is a key element of building resilience and helping them get early support.

FiM¹¹⁵ proposes that there should be a dedicated, named contact in targeted or specialist mental health services for each school. FiM also suggests that there

¹¹¹ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people’s mental health and well-being. Gateway ref no 02939

¹¹² Centre for Mental Health (2015) Investing in children’s mental health.

¹¹³ Centre for Mental Health (2015) Investing in children’s mental health.

¹¹⁴ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people’s mental health and well-being. Gateway ref no 02939

¹¹⁵ DH & NHSE (2015) Future in Mind: promoting, protecting and improving our children and young people’s mental health and well-being. Gateway ref no 02939

should be specific individual who is responsible for mental health in schools, to identify issues, discuss concerns and provide a link to expertise and support.

A joint training programme for named individuals in schools and mental health services will ensure shared understanding and support effective referrals and communications.

The next sections deal with the evidence of what works for specific mental health disorders:

21.3 Disturbances of conduct

When conduct disorders start below secondary school age, around half of affected children go onto to have very poor life chances, including an increased risk of adult mental illness¹¹⁶. These children could be considered a public health priority as they are, on average:

- 2 times as likely to leave school without qualifications
- 4 times more likely to become drug dependent
- 6 times more likely to die before the age of 30
- 8 times more likely to be placed on the child protection register
- 20 times more likely to end up in prison

It has been estimated that children with early conduct disorder are 10 times more costly to the public sector than other children by the age of 28, and two-thirds of this cost is related to crime. Therefore, only a small improvement in outcomes is needed to support a value for money case for intervention. There is also a case for early intervention, as the interventions for adolescents tend to be more complex and resource-intensive than those for younger children – although the interventions for adolescents still have a benefit: cost ratio of 13:1, so it is still worth intervening.

Most parents with a child who meets the diagnostic criteria for conduct disorder do seek advice from professionals (usually teachers and GPs) but only a quarter get the help that they need¹¹⁷ - this help-seeking is a prime opportunity to help these children and families).

The Centre for Mental Health (2015¹¹⁸) looked at various interventions for helping children and families with conduct disorders. They found that the Family Nurse Partnership (a preventative programme targeting risk factors and building strengths in first-time teenage parents) has a benefit: cost ratio of 2:1 with potential savings being higher the longer that children and parents are followed up. Barking and Dagenham has a high rate of teenage pregnancy compared with London and England so those savings are likely to be high. However, AYPH (2016)¹¹⁹ report that the FNP showed no significant effects for primary outcomes but did show some small positive effects on secondary outcomes, including child cognitive development, partner relationship quality and self-efficacy, all important elements of mental health.

¹¹⁷ Centre for Mental Health (2015) Investing in children's mental health.

¹¹⁸ Centre for Mental Health (2015) Investing in children's mental health.

¹¹⁹ AYPH (2016) A public health approach to promoting young people's resilience. A guide to resources for policy makers, commissioners and service planners and providers. <http://www.youngpeopleshealth.org.uk/>

FiM states that there is a strong evidence base of the benefits of evidence-based parenting programmes in intervening early for children with behavioural problems. The Centre for Mental Health (2015) also looked at group parenting programmes and individual parenting programmes to help with conduct disorder.

Group parenting programmes generate the biggest returns by focusing on children with the highest need, and also benefit parents and siblings. The more effectively that the programme is implemented, the better the outcomes, suggesting that staff need to receive high quality training. Poorly implemented programmes with unskilled staff have been noted to make children's outcomes worse. Individual parenting courses, such as Parent Child Interaction Therapy were found to be expensive but do demonstrate good results, having a benefit: cost ratio of 2:1, whereas group parenting interventions are 3:1 and include a social element for parents which can contribute to their wellbeing. Individual support does need to be on offer for those small numbers of parents who have children with more complex needs.

These programmes need to remain a priority for the local authority and better links developed with specialist services to work jointly on cases.

The table below is a summary of the types of interventions for conduct disorder and cost associated with this, from the Centre for Mental Health (2015).

Table 16

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

CAMHS Evidence-Based Practice Unit¹²⁰ reviewed the following interventions for disturbances of Conduct and issued recommendations:

Behaviour Therapies, Cognitive Behavioural Therapies (CBT) and Parent Training

- In parent training, on average two thirds of children under 10 years whose parents participate, show improvement. The effects of parent training programmes are detectable in long-term follow-ups of up to four years.

¹²⁰ CAMHS EBPU (2006) Drawing on the Evidence Advice for mental health professionals working with children and adolescents. London

- Media-based behavioural treatments using parent training tapes without significant therapist input and reports have only very moderate effects.
- Problem-solving skill training for children, in combination with parent training, is an effective intervention for conduct problems in children aged 8-12 years.
- Helping parents' deal with their own problem solving in relation to life stress, offered as an adjunct to parent training with problem solving skills training for the child, appears to improve both child and adult outcomes.
- Whilst mild conduct problems in children under 11 are ameliorated with the help of social cognitive intervention programs, social skills training and anger management skills training, there is no evidence for the use of these approaches on their own with more chronic and severe cases

21.4 Children who have committed offences

Multi-Modal Therapies

- Re-offending rates in adolescents who have committed crimes, are most likely to be reduced by multi-modal, behavioural and skills-orientated treatment programmes
- The strongest evidence is for multi-level, relatively intensive, community-based, highly structured and well integrated programmes focusing on changes which reduce opportunities for offending (e.g. family monitoring and supervision of the adolescent).
- Multi-systemic therapy involving multiple interventions delivered in a planned and integrated manner, chiefly by a single practitioner working intensively with a child and family is the most effective treatment for delinquent adolescents in reducing recidivism and improving individual and family functioning although its superiority to a fully comprehensive community mental health service such as ideally offered by CAMHS has not been unequivocally established.

Other Psycho-Social Approaches

- Therapeutic foster care has been shown to reduce the rate of recidivism, to increase placement stability in a hard to place population and to improve social skills

21.5 ADHD

Compared with their peers, children with ADHD are twice as likely to live in a home where neither parent is working; twice as likely to live with a lone parents; four times as likely to have recognised special educational needs, and are over twice as likely to have poor physical health¹²¹. ADHD is associated with increased risk of academic failure, dropping out of school, criminality and teenage pregnancy. Nearly all parents with children who have ADHD seek help, 70% of these consult a teacher, but only a minority receive treatment.

NICE recommend Social Skills Training and CBT for school-aged children with ADHD – these interventions were found had moderate beneficial effects on parent-rated ADHD symptoms but no beneficial effect on teacher-rated scales. NICE also recommend parent-training programmes for children with ADHD, such as the

¹²¹ Centre for Mental Health (2015) Investing in children's mental health.

Incredible Years programme. Medication should be used in severe cases of ADHD when psychological treatments are not working, and should be implemented by a qualified health professional with expertise in the area of ADHD. It needs to be prescribed as part of a comprehensive treatment programme such as multi-modal therapy which has a benefit: cost ratio of 2:1 for group programmes. The following table (Centre for Mental Health, 2015¹²²) summarises the interventions:

Table 17

Intervention	Age range targeted	Cost per child	Benefit: cost ratio
Group parent training (e.g. Incredible Years)	2-12	£1,211	1.4:1
Multi-modal therapy	School-age	£1,495	2:1

21.6 Anxiety

The Centre for Mental Health (2015¹²³) states anxiety is under-recognised in primary care and educational settings and often goes untreated, and frequently occurs alongside another mental health condition such as mood disorder and substance misuse. Staff in primary care, educational settings and substance misuse services should be trained in recognising and supporting people with anxiety problems.

Interventions for anxiety disorders¹²⁴ are Cognitive Behavioural Therapies which needs to be delivered by a trained therapist and involve both the parent and the child, or sometimes just with the parent with a much younger child, so that they can administer the interventions. A 31:1 benefit: cost ratio of an evidence-based group CBT has been found, mainly in the form of higher earnings for the person with anxiety and reduced healthcare costs. Group parent CBT had a benefit: cost ratio of 10:1, although is more cost-effective in terms of delivery than individual therapy. School based interventions such as the SEL have been shown to reduce anxiety in children. AYPH (2016¹²⁵)

The Centre for Mental Health (2015¹²⁶) has summarised the intervention and costs for anxiety in the table below:

Table 18

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

The CAMHS Evidence-Based Practice Unit reviewed the following interventions for Anxiety Disorders and issued recommendations:

¹²² Centre for Mental Health (2015) Investing in children's mental health.

¹²³ Centre for Mental Health (2015) Investing in children's mental health.

¹²⁴ Centre for Mental Health (2015) Investing in children's mental health.

¹²⁵ AYPH (2016) A public health approach to promoting young people's resilience. A guide to resources for policy makers, commissioners and service planners and providers. <http://www.youngpeopleshealth.org.uk/>

¹²⁶ Centre for Mental Health (2015) Investing in children's mental health.

Behaviour Therapies and Cognitive Behavioural Therapies

- Overall, for over half the children treated in RCTs, the anxiety disorder remits with CBT.
- There is evidence that generalised anxiety can be effectively treated using cognitive behavioural therapy.
- For children under 11 with specific phobias, in vivo exposure is particularly beneficial (in contrast to more cognitive techniques) and the support of parents has a positive effect. However, it appears that various forms of brief therapeutic input (cognitive behavioural therapy, supportive psychotherapy) may only accelerate spontaneous improvement that might occur in this age group.
- Flooding, via rapid return to school, can be successful in managing school refusal but may not be more effective than 'educational support' (this involves information about the nature and treatment of anxiety disorders, together with therapeutic listening and clarification).
- Individual case studies suggest that the inclusion of behavioural prescriptions, in addition to non-prescriptive anxiety management techniques, facilitates greater and more rapid improvement.
- Cognitive behavioural therapy for childhood anxiety disorders can be successfully delivered in a group, or family, as well as in an individual format, and it may be especially helpful if parents are included, for children under 11 and where there is high parental anxiety.

21.7 Depressive disorders

The Centre for Mental Health (2015¹²⁷) states that children with depression are much more likely to be from a disadvantaged background and have parents with poor physical and mental health. More than 95% of major depressive episodes in young people arise in those with long-term psychosocial difficulties such as parental divorce, domestic violence, abuse and school difficulties. 30% of depression in children and young people continues into adulthood. As with other disorders, most parents seek advice about their children, but only about a quarter have contact with mental health services. Those who parents are first seeking help from need to understand and recognise depression in children and young people.

The Centre for Mental Health (2015¹²⁸) state that the evidence for CBT for depressed adolescents suggests that CBT may be effective in reducing major depressive symptoms, and improving global functioning. Benefit: cost ratio of a group-setting for CBT is 32:1 and for individual CBT is 2:1. The summary is in the table below:

Table 19

Intervention	Age range targeted	Cost per child	Benefit: cost ratio
Group cognitive behavioural therapy	12 – 18	£229	32:1
Individual cognitive behavioural therapy	12 – 18	£2,061	2:1

¹²⁷ Centre for Mental Health (2015) Investing in children's mental health.

¹²⁸ Centre for Mental Health (2015) Investing in children's mental health.

The CAMHS Evidence-Based Practice Unit also reviewed the following interventions for Depressive Disorders (Major Depressive Disorder and Dysthymic Disorder) and issued recommendations:

Behaviour Therapies and Cognitive Behavioural Therapies

- Overall evidence for the effectiveness of individual CBT is inconclusive. CBT may speed up the recovery compared with no treatment and may reduce the length of the depressive episode compared with other treatments
- Given the high rate of remission in control groups, initial psychological treatment (either CBT, family therapy or IPT) for up to three months should be offered as the first line of treatment.
- If psychological treatment does not produce improvement in symptoms by six weeks, anti-depressant medication should be offered for adolescents (and cautiously considered for younger children) in combination with longer term psychological treatment using either CBT, psychotherapy or family therapy.

Other Psychosocial Approaches for depression

- Interpersonal Psychotherapy (IPT) is effective in reducing depressive symptoms although evidence in achieving remission is inconclusive. In direct comparison with CBT there was no difference in outcome between the two treatments.

21.8 Post Traumatic Stress Disorder

The CAMHS Evidence-Based Practice Unit reviewed the following interventions PTSD and issued recommendations:

Behavioural Therapies and Cognitive Behavioural Therapies

- Debriefing should not be offered routinely immediately following a trauma
- Children and young people with PTSD, including those who have experienced traumatic events other than sexual abuse, should be offered a course of trauma-focused cognitive behaviour therapy adapted appropriately to suit their age, circumstances and level of development.
- Trauma-focused cognitive behavioural therapy should be offered to older children with severe symptoms of PTSD in the first month after the traumatic event.
- Drug treatments should not be routinely prescribed for children and young people with PTSD.

Eye Movement Desensitisation and Reprocessing (EMDR) EMDR

- Two studies indicate Eye Movement Desensitisation and Reprocessing (EMDR) is effective, but further studies are required

21.9 Psychosis

Psychosis that occurs in adolescence leads to greater impairment than onset in adulthood, poorer educational and employment outcomes along with poor physical and reduced life expectancy. Early Intervention in Psychosis approaches have been found to be effective in preventing full psychosis and reducing relapse. These services include CBT for psychosis (CBTp), medication and intensive work with

workers¹²⁹. They also include interventions to help people stay in, or get into, education or work. New standards for Early Intervention in Psychosis services have recently been published and CCGs are expected to comply with this standard in 2016/17 – that 50% of people experiencing first episode of psychosis will be in treatment within 2 weeks, and that they should receive NICE approved package of care¹³⁰.

21.10 Autistic Spectrum Disorders (ASD)

Two-thirds of all children with ASD also have another type of mental health condition and half have an intellectual disability. Therefore they are likely to be in touch with other services, all of whom need to know how the ASD may affect them, and how to best support them. In terms of interventions, the quality of evidence is generally low, and there is no evidence of cost-effectiveness¹³¹. What evidence there is focuses mainly on social functioning, and there is some emerging evidence that positive outcomes can be gained from interventions that focus on developing social skills and social communication. This includes speech and language therapists working with the carer/parent and child, and peer-mediated play sessions between a child with ASD and a typically-developing peer.

21.11 Self-harm

Certain groups of young people are at more risk of self-harm or suicide, including lesbian, gay, bisexual, transgender and questioning young people (PHE & ayph, 2015), indicating that mental health specialists should work alongside those delivering services to this vulnerable group as well as the provision of training and consultation to those staff.

Self-harm is a predictor of suicide – 0.5-1% of those admitted to hospital for self-harm committing suicide in the subsequent year¹³². It is also strongly associated with depression, anxiety, psychosis and alcohol misuse. The Centre for Mental Health (2015¹³³) on reviewing the evidence for interventions in self-harm found that the paucity of evidence meant that they could not recommend any specific treatment. However¹³⁴:

- Clinical consensus suggests that all children who self-harm should be assessed by a professional with specialist child mental health training.
- There is evidence that approaches focusing on prevention of further suicide attempts may not be effective in the presence of co-morbid depression.
- Brief intervention (problem solving) with families of adolescents following a suicide attempt can improve adolescents' feelings of depression and suicidality, enhance positive maternal attitudes towards treatment and reduce subsequent use of residential and foster care
- For young people who have self-harmed several times, consideration should be given to the addition of group psychotherapy

¹²⁹ Knapp, M., Andrew, A., McDaid, D., Lemmi, V., McCrone P., Park, A., Parsonage, M., Boardman, J. & Shepherd G. (2014) Investing in recovery: making the business case for effective interventions for people with schizophrenia and psychosis. London: Rethink Mental Illness.

¹³⁰ NHS England (2015) Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16. Gateway ref: 02932

¹³¹ Centre for Mental Health (2015) Investing in children's mental health.

¹³² Centre for Mental Health (2015) Investing in children's mental health.

¹³³ Centre for Mental Health (2015) Investing in children's mental health.

¹³⁴ CAMHS EBPU (2006) Drawing on the Evidence Advice for mental health professionals working with children and adolescents. London

21.12 Eating Disorders

Eating disorders reach the threshold for a mental health diagnosis when they become severe and persistent. Only 1 in 10 young people with eating disorders received treatment and only 35% of these get treatment at a specialised facility for eating disorders. This suggests that most of the work with eating disorders needs to be done as early as possible to prevent it becoming persistent and severe, and that it will tend to be the people that know them who will have to support them to recover from their eating problems. Those people with eating disorders are five times the standardised mortality ratio of the population average. The average duration of an eating disorder is 6 years. Evidence for the effectiveness of interventions is limited. The most promising approach seems to be Family Therapy, in particular, the Maudsley Family Therapy approach. For bulimia and non-specific eating disorder, adapted versions of CBT are also recommended by NICE.

Behaviour Therapies

- Operant conditioning used in hospital settings has been shown to be effective in short-term weight gain.

Systemic Family Therapies

- Family therapy (behavioural/structural) is an effective treatment for anorexia nervosa in young people, and is more effective than individual therapy where the illness is not chronic. However, there is insufficient evidence to determine whether conjoint (i.e., patient and parents meet together) or separated forms of family therapy (i.e., therapist meets patient and parents separately) are more effective.

Psychodynamic Therapy and CBT

- Individual psychodynamic therapy shows benefit in those with late-onset anorexia and may contribute to the prevention of relapse after discharge from hospital treatment
- Older adolescents with bulimia nervosa may be treated with CBT adapted as needed to suit their age and level of development.

Multi-Modal Treatments for eating disorders

- There is clinical consensus that multifaceted treatment programmes (including individual psychotherapy, behaviour therapy and family therapy) may be the most effective approach to anorexia but they have been insufficiently researched for any firm conclusions to be drawn.

There is a new (2015) Access and Waiting Time Standard for Children and Young People with an Eating Disorder¹³⁵ outlines the needs for evidence-based, high quality care and support and the need for a dedicated eating disorder service. The sooner someone starts an evidence-based NICE concordat treatment, the better the outcome. Training for staff who work in dedicated ED services will be commissioned nationally. An amended NICE guideline on eating disorders is due to be published in 2017 and will consider:

¹³⁵ NHSE (2015) Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide (July 2015)

- The efficacy of day care versus inpatient care. Some evidence has emerged to suggest that day care may be equally as effective for young people with anorexia nervosa as inpatient care but associated with lower cost.
- The role of family interventions in the treatment of eating disorders. Evidence has emerged that may enable more specific recommendations to be made relating to more formalised family therapy. Family interventions are likely to remain a core component of treatment required for eating disorders in children and young people.
- The efficacy of CBT and enhanced CBT (CBT-E) in the treatment of anorexia nervosa, bulimia nervosa and related adolescent presentations.
- The use of guided self-help for some presentations of bulimia nervosa. Most work in this area has been conducted with adults and, to some extent, older adolescents.

The role of pharmacological treatments. No evidence has emerged to suggest changes to recommendations regarding the use of pharmacological treatments. In children and young people, these are unlikely to be recommended as first-line interventions for managing eating disorders.

22. Recommendations

Recommendation 1

- 22.1 The Thrive model is suggested by Future in Mind, and has already been identified in the local LTP as the basis for design of future services. However, the findings of the needs assessment identify the need for an increased emphasis on ‘prevention and promotion’. Additionally, the inclusion of concepts that give prominence to resilience building could be considered in order to reflect the feedback from stakeholders consulted to date. This blended model is illustrated in the diagram below. In implementing this model, the evidence-base for interventions outlined in Section 20 should be used

Figure 16: Thrive model



22.2 Within this revised model for Barking and Dagenham, the centrality of relationships for children and young people is given emphasis as this builds resilience. To establish a local culture that prioritises resilience, AYPH (2016), suggests that partnerships should:

- Drive local leadership and accountability through Health and Wellbeing Boards, School Forums, Lead Members, Children and Young People's Partnership Boards. Agreed joint priorities and responsibilities with other partners
- Champion evidence based commissioning and use levers and incentives to influence LA/CCG practice
- Explore innovative co-commissioning and co-design of provision with other agencies

- Develop resources on adolescent development, risk and resilience and tailor them to different audiences who have regular contact with young people including parents and carers/foster carers, teachers, social care professionals, school nurses and GPs
- Develop the knowledge and skills of adults working with children and young people to enable them to recognise signs of stress
- Foster partnerships and relationships with key stakeholders; linking schools with out of school clubs; linking local health services with local schools; linking GPs up with voluntary sector provision.

Key recommendations from Future in Mind

There are several expectations outlined in FiM which are relevant to this needs assessment and are formulated into overall recommendations below. Other, more specific recommendations that are specifically relevant for local issues are outlined in the following sections. FiM expects that the recommendations it made will be delivered through Local Transformation Plans (LTPs) for children and young people's mental health and Barking and Dagenham have identified which FiM recommendations it is prioritising in the LTP.

The Local Transformation Plan (LTP) for children and young people's mental health in Barking and Dagenham was written on 16th October 2015 and identified the following themes and investment:

- Theme 1: Building resilience and promoting prevention. Investment 2015/16 £50,000 for i) resilience training and ii) CYP IAPT compliance and training.
- Theme 2: Developing a wellbeing hub. Investment 2015/16 £120,000 for three band 6 CAMHS workers.
- Theme 3: Maximising use of digital resources and guided self-support. Investment 2015/16 £28,739 for pilot of self-support.
- Theme 4: Better support for children, young people and families with behaviour difficulties. Investment of £40,000 for 2015/16 for a Band 6 CAMHS worker.
- Theme 5: Better supporting looked after children and those leaving care. Investment of £40,000 in 2015/16 for a Band 7 CAMHS worker.
- Eating Disorder Access and Waiting time standard – investment of £111,358 staffing to meet the standard (80% staffing, 20% non-staffing)

Local areas are also urged to develop plans to track progress on the following issues:

- Transparency on the levels of current investment and information on the range of provision available to meet local need.
- Timely access to effective support with routine feedback of outcomes achieved by children and young people.
- Co-production and collaborative practice with children, young people and families
- Active engagement with schools;
- The use of evidence-based interventions

The needs assessment was undertaken in a time period before the impact of the LTP could be felt/ measured, hence the following recommendations being made even if the LTP is addressing them.

Recommendation 2

LTP delivery

In order to help deliver on these and taking account of the 5 LTP themes in Barking and Dagenham the following recommendations are made:

- 22.3 The emphasis on prevention and early intervention described in the FiM is recognised in the Barking and Dagenham LTP. This indicates a local shared commitment for emerging issues to be tackled quickly and not passed around the system. Joint investment with commitment to the alignment and pooling of resources now needs to be progressed. Additionally providers should be supported to:
- ensure a clearer focus on those who are likely to be at future risk
 - provide greater join up across current service boundaries to simplify access for families and do what works best for them
 - develop innovative and creative ways to fully exploit the available resources to meeting children's outcomes and manage increasing levels of demand
- 22.4 Commissioners and operational service managers should identify and agree the key data sets that are required as a minimum to ensure a service that is outcomes based and good value for residents. A list of suggested data for service monitoring and future needs assessments is enclosed in Appendix One of the needs assessment.
- 22.5 Commissioners and providers should ensure that performance and business information is more consistently aligned to outcomes (rather than outputs or process such as waiting times) for children and families. All services must develop and maintain systems which can routinely and robustly collect relevant data including information on outcomes delivered.
- 22.6 All services commissioned across the partnership should be able to describe how the activities that take place contribute to a positive change in outcomes for children and their families. Services should not continue to be commissioned if they cannot demonstrate impact.
- 22.7 Public Health should consider the development of school health profiles or similar which provide information on local needs.
- 22.8 To develop improved transparency in relation to commissioning and decommissioning decisions consideration should be given to how best to strengthen governance and better involve parents and young people in local decision making forum.
- 22.9 Services should be informed by a clear evidence base and the involvement of users in design delivery and evaluation.
- 22.10 Adoption of a 'no wrong door' or a 'single point of access' service approach including links with MASH.
- 22.11 Investment should be put into prevention, promotion and early intervention evidence-based services as outlined in the LTP. Expected outcomes should be evident in the commissioning plan, as should monitoring arrangements that ensure

collection of data around how many children and young people from different ages, geographical areas and vulnerable groups are actually accessing these services, and the training and supervision that staff receive.

- 22.12 The HWB to aspire to ensuring that money saved through prevention is re-invested in mental health care, by evaluating all prevention activities to identify what is generating the savings in terms of reducing the burden of mental ill-health. A clear statement of strategic intent to focus on preventative measures to align thinking about preventative approaches, with a target for prevention spending to focus efforts on shifting to more prevention spending year on year once a baseline has been established.

Recommendation 3

Resilience Building

- 22.13 Models of peer support are examined by providers and commissioners, alongside children and young people, with an intention to implement these in Barking and Dagenham.

Recommendation 4

Early Years

- 22.14 The transfer of commissioning of 0-5 public health services to local government provides an opportunity for Health and Wellbeing Boards to create a stronger focus on mental health in the early years. The HWB for Barking and Dagenham should have a joint partnership strategy to develop this focus
- 22.15 Ensure the children centre programme has a strong focus on pre-birth to age 2 years as the most significant stage of a child's early development. Commissioners should consider the emerging evidence from the 0-2 early intervention pilots (FiM) with a view to implementing locally what is found to work most effectively and efficiently.
- 22.16 Strengthen provision for children with developmental delay/additional needs.
- 22.17 Promote the value of the early education entitlement across the borough (given the significance of early learning on achieving improved outcomes for children and helping build a good foundation)
- 22.18 Develop and adopt a 'Healthy Early Years' programme across the borough aimed at local early years settings in parallel with the Healthy Schools programme.
- 22.19 Services should actively build community capacity (including the use of volunteers and mentors) to ensure sustainability of provision, in facilitating parental support groups, or parent led provision linked to Children Centres.
- 22.20 Services should prioritise areas of deprivation, and ensure a strong focus on:
- Parent child relationships, including dealing with domestic violence.
 - Promotion of the home environment and learning through play to promote children's intellectual, physical social, emotional and behavioural development and skills
 - Promotion of language and communications skill development

- 22.21 Consider if any specialists (either in-house or procured) could be embedded within community based arrangements to promote good attachment and early identification of emerging difficulties for this age group.
- 22.22 Barking and Dagenham needs to ensure that all Health Visitors are given access to the IfHV training.
- 22.23 The work on encouraging and supporting breast-feeding in Barking and Dagenham is continued with the aim to increase the percentage of breast-feeding at initiation and particularly the continuation of breast-feeding to 6 weeks after birth.

Recommendation 5

Age 5-12

- 22.24 Develop an approach with schools that builds their capacity and their knowledge and understanding of what works to inform their commissioning approach.
- 22.25 Evidenced informed interventions from providers able to ensure good fidelity to parenting models adopted and are successful in improving parenting capacity and family stability.
- 22.26 Advice and support from mental health workers is routinely available to support and enhance early intervention services locally.
- 22.27 Development of parent to parent peer support to help sustain change, build capacity and prevent relapse
- 22.28 Develop a pathway of care for those with emerging behavioural difficulties (in LTP).
Schools

Recommendation 6

Schools

Build on the current PSHE work to promote mental health and wellbeing.

A named individual to take lead on mental health is identified in every school. This is planned to happen from September 2016

A named mental health worker from CAMHS is named as a contact for each school.

A joint training programme is established between school staff and mental health staff for the professional groups named above. The programme could be agreed through the MDT meeting which is incorporate health and education staff.

Recommendation 7

Adolescents

- 22.29 Develop an outcomes framework for this age group to ensure an evidence-informed approach is adopted across all providers working with this age group. Once agreed,

this framework must be used in any operational commissioning and procurement activity to ensure the outcomes required are delivered.

- 22.30 Secure sufficient and appropriate mental health outreach (and knowledge) to engage young people from particularly vulnerable groups including those with special educational needs, those on the fringes of youth crime or those who are in care or are leaving care to ensure they get the help they need to address their needs and make a good transition to adulthood.

This may include extending the existing opportunities for peer support approaches to build skills knowledge and confidence in young people to support each other.

- 22.31 Consideration should be given to the commissioning of primary mental health workers seconded from the NHS who can be embedded within Local Authority services to share expertise and ensure mental health needs are addressed effectively.
- 22.32 Consider opportunities to further develop multi-disciplinary teams in working with children in care and those leaving care. To improve the support offered to this vulnerable group approaches are needed which recognise the significant impact on children's emotional health and wellbeing (and longer term outcomes) of experiences such as poverty, homelessness, parental mental ill health, parental drug & alcohol abuse and domestic violence.
- 22.33 No further commissioning for improvement of emotional wellbeing should proceed without the full and active involvement of young people.

There should be robust evaluation of the current counselling provision to inform any future decisions.

Recommendation 8

General Practice

- 22.34 There is a named mental health worker for each GP practice, providing ease of access to advice and consultation.
- 22.35 It may be worth further investigating why the referral practice (identified by parents) differs between GPs and how a consistent level of completion of the referral form could be secured.
- 22.36 The idea of GP social prescribing is explored with local providers of sports amenities, libraries and youth groups, with agreement reached to facilitate this.
- 22.37 The use of You're Welcome, or similar, standards should be encouraged amongst GP practices in order to make their practices young-people friendly for young people to access a less stigmatising environment than a mental health clinic to discuss their mental health concerns.

Recommendation 9

Specialist services

- 22.38 Parenting programmes for families of a child with behavioural problems, conduct disorder and ADHD should be on offer, and delivered by appropriately trained and skilled staff.
- 22.39 Waiting lists for specialist CAMHS need to be monitored, and any impact of earlier intervention on waiting lists noted.
- 22.40 Local CCG commissioners should work with NHSE commissioners to ensure that better decisions can be made about in-patient care for children and young people and to improve outcomes for who in-patient care cannot be avoided.
- 22.41 Use of the NHSE 'Passport' <https://www.england.nhs.uk/mentalhealth/cyp/iapt/> might be one way to achieve communication between services, and is focused on what the service user wants to share.
- 22.42 A feasibility study into the need for and possible implementation of a 24 hour crisis service should be undertaken, and outcomes of this discussed with NHSE. An examination of the need of crisis services outside of its current operating hours should be undertaken to ensure the needs of children and young people are being met as they arise.
- 22.43 Children's commissioners should work with their adult colleagues to ensure that the needs of children and young people are considered when new crisis services are planned and implemented. Clear monitoring should be in place to identify the demand by children and young people and the response they receive.
- 22.44 Examine the downward trend of activity in the all age eating disorders service to identify if this is for children and young people, in order to inform the eating disorders service transformation outlined in the LTP.

Recommendation 10

Transition

Local strategic planning on transition should ensure that the needs of more vulnerable young people are taken into account:

- 22.45 Consideration is given to the impact of having flexibility in the age of transfer to adult mental health services, which would be based on need rather than age through work with colleagues in adult commissioning and provision.
- 22.46 Children's commissioners should continue to work with colleagues in adult mental health commissioning to ensure that children and young people are taken fully into account for the all-age early intervention psychosis standards.

Recommendation 11

Partnership working

- 22.47 CCG and LBBDD commissioners and providers across health, education, social care and youth justice need to work together to develop appropriate and bespoke evidence-based care pathways for vulnerable children. (FiM).
- 22.48 Access to good quality self-help and other information in the management of lower level mental health problems would be a cost-effective way of providing earlier

support for families. There is an intention in the LTP to develop digital resources and guided self-support.

Recommendation 12

Participation and Active involvement

22.49 Development of a shared strategy with action plan which ensures the active participation and involvement of children, young people and their parents and carers in the development, evaluation of services including the commissioning and decommissioning of services. A clear governance structure (preferably partnership) should provide robust oversight and challenge.

Recommendation 13

Workforce development and capacity building

22.50 An annual graduated programme to address the training needs of the universal and targeted workforce should be developed. This should include issues identified through this assessment such as:

- understanding common mental health problems
- child development
- using evidence-based approaches to promotion and prevention
- the needs of children with special educational needs
- managing risk
- understand resilience and protective factors in families and the significance of relationships and positive self-esteem for children/young people
- peer mentoring for young people
- appropriate therapeutic interventions which promote good mental health and build resilience in young people.

22.51 Proactive consultation and support provided by specialists which is easy to access would further build capacity across the workforce.

22.52 Commissioners need to ensure that the people delivering parenting groups are trained through contractual arrangements with providers – particularly taking advantage of the courses set up via the CYP IAPT project.

22.53 An audit of the current targeted and specialist workforce, their numbers and their skills and confidence in the following evidence-based practice interventions for mental health issues in children and young people to enable a workforce strategy relating to mental health to be developed:

- Assessment of clinical need
- Assessment of risk
- Evidence-based group parenting programmes
- One to one parenting programmes to meet the needs of those with more complex needs
- Family therapy
- Aggression replacement therapy
- Multi-systemic therapy
- Social skills training

- Cognitive Behavioural Therapy (CBT), group and individual
- Interpersonal Psychotherapy
- Medication prescribing and monitoring
- CBT for psychosis (CBTp)
- Problem solving

Recommendation 14

Cultural Competence

22.54 Given the demographic make-up identified of Barking and Dagenham, it important that all providers are delivering culturally appropriate services and that staff are competent. Consideration should be given to the use of an assessment tool to help assure commissioners.

Appendix One- Data Collection

Suggested data to inform service monitoring and future needs assessments, with the reasons:

Data Item	What it would be helpful for:
Services & pathways (PMHW, Schools CAMHS, Voluntary Sector, Tier 2/3 CAMHS, Tier 4 CAMHS)	Identification of current services and their roles in prevention/promotion, identification, early intervention and treatment of mental health problems, and any agreed pathways through services.
Outcome measures and data captured (PMHW, Schools CAMHS, Voluntary Sector, Tier 2/3 CAMHS, Tier 4 CAMHS)	<p>Collection and analysis of data on local services, recovery rate, transitions and workforce development.</p> <p>Report on the available data and economic analysis, with recommendations for commissioners to maximise the opportunity to improve mental health outcomes</p>
Capacity and demand data (PMHW, Schools CAMHS, Voluntary Sector, Tier 4 CAMHS)	<p>Benchmarking of local data, including usage data.</p> <p>Collection and analysis of data on local services, recovery rate, transitions and workforce development.</p> <p>Report on the available data and economic analysis, with recommendations for commissioners to maximise the opportunity to improve mental health outcomes</p>
Anonymised copy of collated 'Schools risk register'	Collection of LBBB data from various stakeholders on presentations and risk/vulnerability factors
Key data on each school's population vulnerability factors	Collection of LBBB data from various stakeholders on presentations and risk/vulnerability factors
Individual Service costs	Report on the available data and economic analysis, with recommendations for commissioners to maximise the opportunity to improve mental health outcomes
Tier 2 & 3 CAMHS Capacity and Demand data	<p>Key to the review of demand on current services and their ability to meet demand. Matching actual presentation data with prevalence:</p> <p>Benchmarking of local data, including usage data.</p> <p>Collection and analysis of data on local services, recovery rate, transitions and workforce development.</p> <p>Report on the available data and economic analysis, with recommendations for commissioners to maximise the opportunity to improve mental health outcomes</p>
Local Authority Spend on CAMHS	Report on the available data and economic analysis, with recommendations for commissioners to maximise the opportunity to improve mental health outcomes

Appendix 2 – Diagram of the Transition Pathway for Barking and Dagenham between CAMHS and AMHS

