JSNA Children and Young People: Emotional Wellbeing and Mental Health

Kate Wilcox

Strategy & Policy Development Officer

(Family Support & CYP IAPT Lead)

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Contents

Executive Summary

- It is estimated that 1 in 10 children will have a clinically diagnosed mental health disorder at any one point during childhood with 50% of mental health disorders emerging before the age of 14 and 75% before the age of 25.
- There is a paucity of national and local data about children's mental health. The most recent national prevalence survey was in 2004; a new survey has now been commissioned by the government and the findings will be available in 2018.
- There is also a new, national Mental Health Services Data Set but specialist CAMHS in North Somerset will not have a compatible IT system through which it can submit data until its integration with Bristol and South Gloucester (BNSSG) in 2017-2018.
- Public Health England publishes mental health data via CHIMAT. However, a significant amount of the CHIMAT data necessarily applies the 2004 national prevalence data to the North Somerset 2014 population figures. The data contained in this chapter should therefore be treated with caution.
- Children's mental health is a government priority but, while the government has provided some additional investment in children's mental health, budget cuts in other services have resulted in local reductions in funding and some of this additional government funding has been used to help with the wider financial challenges of the North Somerset CCG. Currently 6% of CCG funding is spent on children's mental health.
- In 2012-2013, £20.15 per head was spent on children's mental health in North Somerset; the average in the South West was £43.09, and in England £58.84.
- We know that North Somerset has a higher than average (England and regional averages) in the number of:
    - children and young people admitted to hospital due to self harm
    - children and young people with a conduct disorder (estimated through proxy measures)
    - children and young people in care who are in the 'borderline' or 'cause for concern' mental health categories (as measured by the Strengths and Difficulties Questionnaire)
- The number of Care Leavers who are not in employment or training (NEET) due to mental health issues is around one quarter
- There are some significant gaps in our knowledge, for example, we do not know how many children are being treated for anxiety and depression in North Somerset. Specialist CAMHS does not currently disaggregate these data and there is no centralised data hub for comprehensive CAMHS (all services supporting children's mental health). This also applies to the outcomes of treatment.

- However, we do know that from 2009-2015, North Somerset has had a significantly higher prevalence of adult depression than both Bristol and South Gloucestershire (BNSSG).
- Mental health is 'everyone's business' with specialist CAMHS focusing on children and young people with severe and enduring mental health disorders; other services are supporting with children at an earlier stage of need but there is no clear picture of whether this is happening consistently in North Somerset although it is known that there are many examples of good practice.
- Specialist CAMHS only accepted 54.3% of all referrals last year, suggesting that its threshold is not widely understood by other agencies and/or there are insufficient early help services for children's mental health (with some of these being reduced); and/or professionals in non-specialist services do not feel confident working with mental health.
- Specialist training has been commissioned and/or delivered by Public Health, the Learning and Development team, VLS, CAMHS and the Resource Service. A multi-agency training audit is planned which should result in an integrated training plan for all relevant staff.
- North Somerset has a committed, multi-agency Future in Mind: Children's Emotional Wellbeing and Mental Health Strategy Group which has designed the North Somerset Local Transformation Plan and is implementing its priorities. The Future in Mind group will also consider the findings of the JSNA chapter.
- Children's Social Care and the Vulnerable Learners' Service have released staff to train in therapeutic support via CYP IAPT; the first cohort is now offering some early intervention therapy, including in the Resource Service which is designing a more robust mental health service to meet the needs of Children Looked After or Adopted and their families.
- The majority of secondary schools have part-time counsellors and it is planned to strengthen the links between specialist CAMHS and schools, with a nominated lead in each school.
- CAMHS has appointed a full time participation worker who is training young people to be involved in all aspects of the CAMHS service from recruitment and interviewing to commissioning. Children and young people who attend CAMHS as service users are encouraged to give ongoing feedback, working in partnership with therapists to set their own goals and reviewing their progress in achieving them

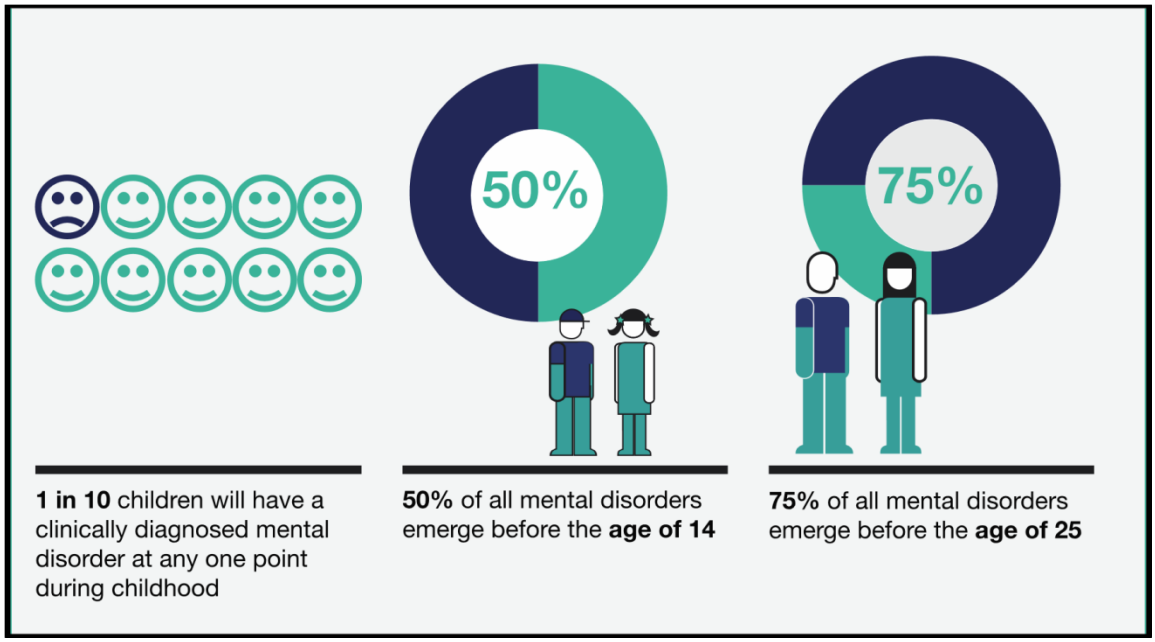
Section 1

Introduction

> Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison[1].

Mental health problems in children and young people cause distress and can have wide-ranging effects, including impacts on educational attainment and social relationships. There are also known associations between mental health problems in childhood and adolescence and poorer physical health, as well as the possibility of developing at-risk health behaviours.

Childhood can have a profound effect on our adult lives. Many mental health conditions in adulthood show their first signs in childhood and, if left untreated, can develop into conditions which need regular care.[2]



Some risk factors make children more vulnerable to poor mental health, including social disadvantage. In the most recent Indices of Multiple Deprivation (IMD, July 2015), there were areas in North Somerset which fell within the most deprived 1% nationally, and the least deprived 1% nationally. This resulted in North Somerset

[1] (Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf)

[2] Public Health England (2015) Measuring mental wellbeing in children and young people, page 7 http://www.yhpho.org.uk/resource/view.aspx?RID=213417

having the 7th largest inequality gap in the country. 7% of North Somerset's 0-15 year olds (n=2416) live in the most deprived areas, all of which are in the South and Central Wards of Weston.[3]

While there is no consistent correlation between prevalence rates of adult depression and poverty, there is a significantly higher level of depression in one GP Practice in a geographical area in North Somerset that falls within the 1% most deprived areas in England. Of the eight local GP surgeries with a highter prevalence rate of adult patients with depression than the North Somerset average, five are in Weston but two are in Clevedon and one is in Nailsea.[4] From 2009-2015, North Somerset has had a significantly higher prevalence of adult depression than both Bristol and South Gloucestershire, even though Bristol has higher levels of poverty.

Data

The most recent national prevalence survey on children's mental health was undertaken in 2004[5]. Much of the current published data focusing on children's mental health rely on these out-of-date prevalence data applying them to the known population. However we know that the prevalence of many forms of mental health has increased, for example, self harm (only mentioned twice in the 2004 survey report). The published data should therefore be treated with caution.

Currently there is also a limited range of local data relating to health services pending the implementation of the new CAMHS' Mental health Services Data Set (MHSDS) when specialist CAMHS is recommissioned in 2017 and integrated with Bristol (B) and South Gloucester (SG) Children's Services (BNSSG). The MHSDS will capture the conditions, activity and evidence based interventions to allow benchmarking, in-depth analysis and evaluation of commissioned care and to ensure measurable progress and improved outcomes are achieved. The government has also commissioned a prevalence survey due to report in 2018.

This JSNA chapter has been produced using data from the Office of National Statistics (ONS), the National Child and Maternal Health Intelligence Network (CHIMAT), the Department for Education, other national websites, and local data from North Somerset's Children's Social Care; the Vulnerable Learners' Service (VLS); and specialist CAMHS (Child and Adolescent Mental Health Services).

CHIMAT has provided estimates of the number of children in North Somerset with a mental health issue based on the 2004 national prevalence rates and 2014 North

[3] http://www.n-somerset.gov.uk/community/partnerships/Documents/JSNA/Overall%20findings/population%20chapter%20(pdf).pdf

[4] GP profiles: http://fingertips.phe.org.uk/profile/general-practice/data#mod,6,pyr,2015,pat,19,par,E38000125,are,-,sid1,2000005,ind1,-,sid2,-,ind2,-

[5] Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004. A survey carried out by the ONS on behalf of the Department of Health and the Scottish Executive.*
Basingstoke: Palgrave Macmillan. http://www.esds.ac.uk/doc/5269/mrdoc/pdf/5269technicalreport.pdf

Somerset population estimates (in 2013, there were were 46,500 children[6] in North Somerset aged between 0 and 19, 22.6% of the total population):

Estimated number of children and young people in North Somerset with a mental health issue			
	Aged 5-10	**Aged 11-16**	**Aged 5-16**
Boys Girls	1000	1445	**2445**
Boys	675	815	**1490**
Girls	325	635	**960**

Please note that the numbers in the age group 5-10 years and 11-16 years do not add up to those in the 5-16 age group as the rates are different within each age group.

These prevalence rates are further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders (descriptions taken from the 2004 national survey):

Estimated prevalence in 5-16 year old children in North Somerset by disorder	**Estimated number of children and young people (CYP)**
Conduct	1450
Emotional (including anxiety, depression)	955
Hyperkinetic (including ADHD)	405
Less common issues (including eating disorders)	350
Autistic spectrum (including Asperger syndrome)	260

Please note that the numbers in this table do not add up to the numbers in the previous table because some children have more than one issue.

Funding

Future in Mind[7], the report of the government's Children and Young People's Mental Health Taskforce, sets out the national ambition for the improvement of children's mental health services.

While, on the one hand, North Somerset has received additional government funding to transform children and young people's mental health services, on the other, cuts to health, education, social care and other public services has led to reductions in specialist CAMHS funding from the local authority, and reductions to wider CAMHS

[6] Unless specified in this document, 'children' will include children, young people and, where relevant, their parents, carers and wider family

[7] *Future in Mind* (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

funding from schools and public health. The Clinical Commissioning Group (CCG) currently spends 6% of its budget on children's mental health services.

A requirement of the additional government funding was the design of a Local Transformation Plan (LTP) to detail how the money would be invested to improve local mental health services for children and young people. This funding was ring-fenced in 2015-16 but only a proportion was spent within the short time allowed between the assurance of the Transformation Plan by NHS England and the release of funds. The funding has not been ring-fenced in 2016-17 and some of the funding has been used to help with the wider financial challenges of the North Somerset CCG.

This Transformation Plan will need revising in the light of the reduction in planned investment.

However, North Somerset has benefited from training and funding attached to CYP IAPT (Children and Young People's Improving Access to Psychological Therapies). Since 2014, staff in specialist CAMHS and in the local authority have been trained in evidence-based therapies (Cognitive Behavioural Therapy (CBT), Systemic Family Practice and Parenting), in Supervision, and in Leadership. This has led to a transformation of specialist CAMHS and the local authority is in the process of embedding this learning and providing a service in wider CAMHS to allow earlier help to be offered to children, young people and their families.

The North Somerset Clinical Commissioning Group (CCG) also provided an additional £145,000 in 2015-2016 from Parity of Esteem[8] funding to reduce CAMHS waiting times and increase assessment capacity through the introduction of the Choice and Partnership Approach (CAPA) in March 2015

Organisation	Description	2014-2015	2015-2016	2016-2017
North Somerset CCG	CAMHS and Learning Disability	£1,474,000	£1,542,000	£1,542,000 ↔
	Parity of Esteem	£0	£145,000	£145,000 ↔
North Somerset Council (NSC)	CAMHS Funded Support	£159,666	£89,000 ↓	£40,000 ↓
Strategic Schools Forum (SSF)	Parenting Groups	£97,671	£72,000 ↓	£12,000 ↓
North Somerset Council Public Health	YOS mental health support	£50,000	£50,000 ↔	£25,000 ↓
	NSC Health Visiting	£2,663,000	£3,031,000↑	£2,841,000 ↓

[8] Parity of esteem means valuing mental health equally with physical health

	NSC School Nursing	£566,000	£584,000 ↑	£539,000 ↓
North Somerset CCG: CAMHS Transformation Funding	Additional CAMHS Transformation Plan Spend	£0	(£300,197)↑ £162,585	(£336,000*)↔ £156,000 **↓
	Additional Eating Disorders funding	£0	(£119,930) ↑ (% included in the £162,585 above)	(£119,930)*↔ (% included in the £156,000 above)
	Additional Perinatal Mental Health Funding	£0	£0	£40,000↑

*** allocated**

**** additional CCG investment**

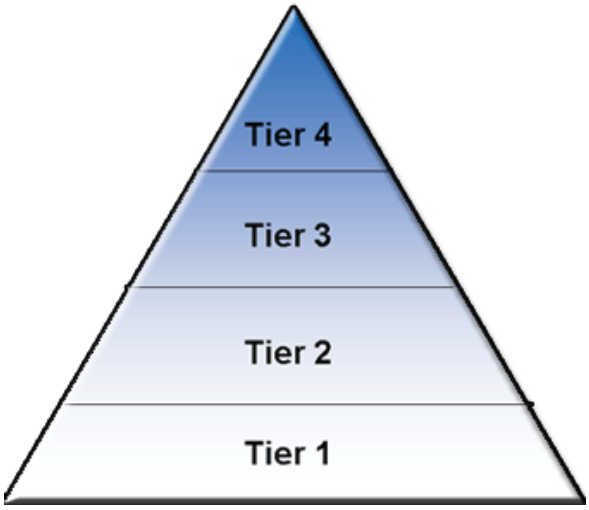
CAMHS programme budget per head

	Programme budget per head (2011/12)	Programme budget per head (2012/13)
North Somerset	**£ 15.75**	**£ 20.15**
South West	**£ 52.54**	**£ 43.09**
England	**£ 59.35**	**£ 58.84**

Source: Department of Health/Office for National Statistics

CAMHS Tiers

Mental health is 'everyone's business'. Comprehensive or wider CAMHS comprises all agencies who work with children and young people while specialist CAMHS works with children and their families where there is a severe and enduring mental health problem. Traditionally, Comprehensive CAMHS has been conceptualised in a tiered model:



Tier 1 mental health services: universal provision, non-specialist primary care workers working with all children for example, GPs, midwives, health visitors, schools, school nursing, public health and the voluntary sector.

Tier 2 mental health services: early intervention, targeted provision, specialised primary mental health workers for example, school counsellors; VLS which includes Educational Psychologists and the Anti-Bullying Lead; evidence based parenting programmes; the adult mental health worker attached to a Children's Centre and the young person's mental health worker attached to the Youth Offending Service; CYP IAPT.

Tier 3 mental health services specialist provision: for example, specialist CAMHS which includes the Children's Learning Disabilities Team (CLDT) and operates from Weston-super-Mare (Drove Road) and Clevedon (the Barn) offering a range of assessment and treatments to those children and young people with severe and enduring mental health needs. The multidisciplinary team includes specialist mental health practitioners from: psychology, psychiatry, nursing, family therapy, and creative therapies.

Tier 4 mental health services highly specialist provision: for example, the Riverside unit, a 9 bed generic unit run by Bristol Community Children's Health Partnership providing inpatient and day service currently commissioned by NHS England.

A 1996 study estimated the number of children and young people experiencing mental health problems appropriate for a response from CAMHS at Tiers 1, 2, 3 and 4 (Kurtz, 1996). The table shows these estimates for the population of North Somerset aged 17 and under, based on 2010 data:

Tier 1 (15%)	6466
Tier 2 (7%)	3017
Tier 3 (1.85%)	797
Tier 4 (0.075%)	32

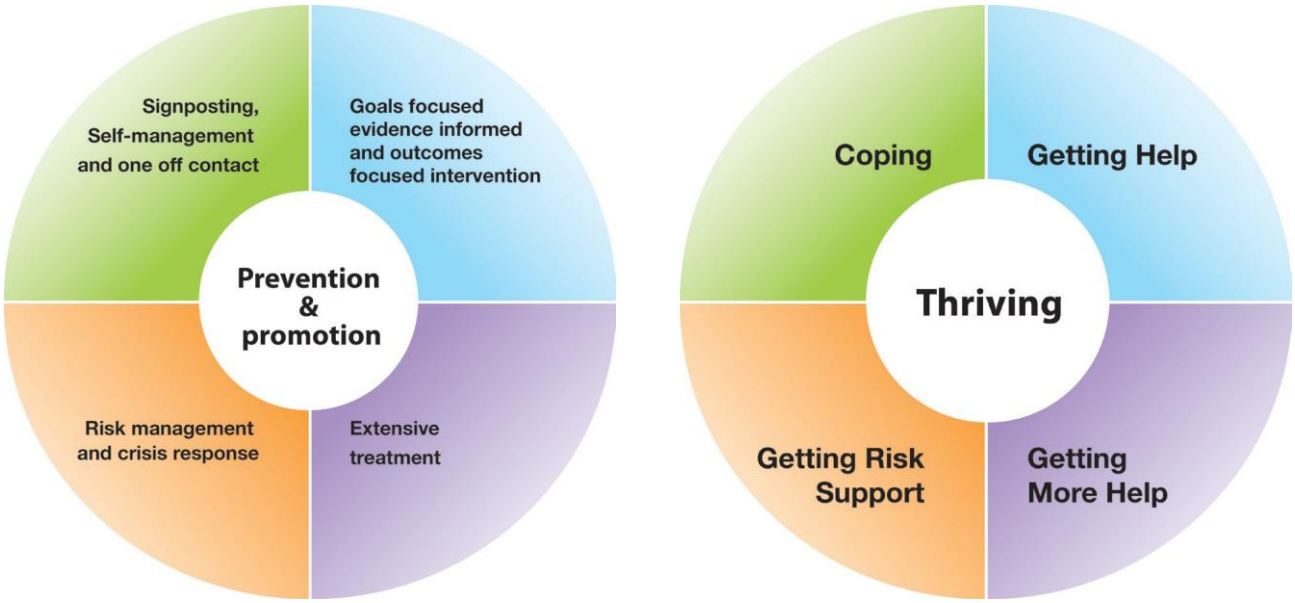
(CHIMAT Youth Justice)

Although the four tier model helps to differentiate between services and the support available to children and young people, there are potential difficulties:

- The development of divisions between services
- Unnecessary waits between the various tiers
- Children and young people having to repeat their stories several times to different professionals
- A lack of clarity about thresholds

Alternative models: Thrive

Future in Mind supports the development of 'a system without tiers', moving towards a 'seamless pathway of care and support' where the changing mental health needs of children are addressed flexibly rather than children having to fit into a rigid system of services. The individual child and family working collaboratively with professionals would decide on what would work best for him or her at any given point. The authors highlight the potential of *Thrive*, a conceptual framework designed by the Anna Freud Centre and the Tavistock: 'Rather than an escalator model of increasing severity or complexity, we suggest a framework that seeks to identify somewhat resource-homogenous groups…who share a conceptual framework as to their current needs and choices.' [9] The *Thrive* authors make a distinction between the language used in education (the promotion of wellbeing); health (treating illness); and social care (managing risk), and show how they can be integrated into a whole system's approach.



[9] http://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf

Coping: Signposting, self-management and one-off contact

There is anecdotal evidence of good mental health practice in many universal service in North Somerset but this work is not coordinated nor is there a central repository of data, making an analysis of its scope and its effectiveness impossible. Feedback from schools and other non-specialist mental health agencies does highlight the importance of workforce development (see below) and the provision of quality information for children, young people, parents/carers and staff.

A recent sample of schools in a mental health audit showed that the majority of secondary schools have part-time school counsellors, and learning mentors, parent support advisers (PSAs) and other staff in primaries and secondaries use counselling skills to meet the needs of children and young people and their families. Access to quality information and a directory of agencies with clear referral criteria was an identified need. The increase in mental health difficulties was noted by all schools interviewed. Several secondary schools have been trained in the specialist CAMHS referral pathway and are allowed to make direct referrals to CAMHS. However, primary schools are not able to make direct referrals and this was seen as a gap in the system, precluding reciprocal information sharing to the potential detriment of the child and family.

Parents and carers have asked for more information about children's mental health and how they can support their children in being resilient and looking after their mental health. Transformation Plan funding was used in 2015-2016 to provide all secondary schools, Weston College, the Resource Service and public libraries with a set of 'Reading Well' books which focus on different mental health issues. Each of the non-fiction and fiction books contains a list of national and local mental health organisations and helplines.

The North Somerset Online Directory (NSOD) is also being updated to include local and national mental health organisations[10]. In addition, members of the CAMHS young people's participation group (see Section 2) are designing a website page signposting young people and their parents to online sources of help and kite marked apps.

Workforce development

A multi-agency workforce mental health audit is being undertaken to identify gaps in training and to design a training plan so that all staff feel confident in working with children and young people's emotional wellbeing and mental health. Children often disclose their worries to a non-specialist member of staff and it's important that staff and parents feel confident working with children and young people's emotional wellbeing and mental health.

[10] http://nsod.n-somerset.gov.uk/kb5/northsomerset/directory/home.page The North Somerset Online Directory includes the Local Offer: information for children and young people with special educational needs and/or a disability.

Mental health issues

In this chapter, each of the most common mental health conditions has a section of its own:

- Perinatal
- Neurodevelopmental disorders: autistic spectrum condition; attention deficit hyperactivity disorder
- Eating disorders
- Self harm (and suicide)
- Anxiety and depression
- Conduct disorders
- Parenting
- Psychosis

There is also a section on one of our priority groups of children and young people: children looked after. As corporate parents we recognise the additional trauma that can be experienced as a result of neglect and/or abuse and separation from birth families and we are committed to give our children looked after the best support available, from health promotion and prevention to intensive interventions when there is a clinical need.

While early help is the responsibility of all children's services, severe and enduring mental health is the remit of specialist CAMHS.

Referrals to Specialist CAMHS 2014-2015

Activity 2014-2015	**Numbers of children and young people**
Referrals received	961
Referrals accepted	522* (54.32%)
Waiting times:	
0-6 weeks	139
7-12 weeks	73
13-18 weeks	28
19-25 weeks	73
26-52 weeks	105

***** 104 (19.92%) of the 522 failed to respond to opt-in letters meaning that 418 (43/5%) accessed the service.

To reduce waiting times, the Choice and Partnership Approach (CAPA) was introduced in March 2015. CAPA is a system to manage demand that also promotes collaborative practice and shared decision-making with children, young people and families. The focus of the first, longer 'choice' appointment in CAPA is to get an

understanding of what a young person and family want to change, deciding together on the goals of the intervention, and sharing ideas about the possible choices that may lead to reaching the goals.

While many young people will go on to generic therapy, certain groups will be referred for a full, specialist assessment within CAMHS, for example, with the Eating Disorders Team or the Virtual Team for Children Looked After.

The introduction of CAPA has improved flow through the system by providing an initial session to children and young people who meet the threshold within 6 weeks. For some children and young people, this one session is sufficient. The average waiting list for those who choose to go on to treatment is now 14 weeks. It is hoped to reduce this further to meet the 18 week referral-to-treatment target for all children in 2016.[11]

[11] www.capa.co.uk

Perinatal[12] and Infant Mental Health

The mental health problems that pregnant women or new mothers can experience are the same as those that can affect people at other time, and they are often similar in nature. However, there are a number of reasons why mental health problems in pregnant women and new mothers are different and particularly important to address. These include the effect they can have on the foetus, baby wider family and mother's physical health and the fact that problems often are not disclosed, recognised or treated during this period. Additionally, there are some mental health problems from which women are at increased risk during this period, for example, women with a history of bipolar disorder are at increased risk of relapse in the postnatal period.

There is a well-established perinatal mental health pathway in North Somerset led by Specialist CAMHS and delivered by health visitors, midwives, Positive Step, children's centres and Adult Primary Mental Health Workers (APMHW) offering support and intervention to mothers, infants and their families alongside consultation and training to a range of health and care professionals. More recently a multi-agency strategy group has been established to work with the aim of an integrated Perinatal Mental Health Service aligned to the vision outlined in *Future in Mind* for 'enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.' A detailed plan will be prepared when the government provides more information about its objectives in meeting the mental health needs of mothers and infants, and the extent of any additional investment.

Numbers given below are estimates based on the number of women giving birth in North Somerset and national estimates of mental health conditions in the pregnancy and postnatal period. Some women will have more than one condition. Overall it is believed that 10%-20% of women are affected. In 2013, 2204 babies were born in NHS North Somerset.

[12] Perinatal is defined as conception to two years

North Somerset estimates of the numbers of women with mental health problems during pregnancy and the postnatal period 2013-2014	
Estimated number of women with postpartum psychosis[13]	5
Estimated number of women with chronic serious mental illness[14]	5
Estimated number of women with severe depressive illness	65
Estimated number of women with mild-moderate depressive illness and anxiety	220-325
Estimated number of women with PTSD[15]	65
Estimated number of women with adjustment disorders or distress[16]	325-650

Approximately 49 (75%) of the 65 women with severe depressive illness will not be under the care of mental health services when they become pregnant and many would not be considered to meet the threshold for adult mental health services but whose mental illness is significant in terms of the potential adverse impact on the developing baby or attachment/bonding[17].

Mother and Baby Unit

There is a four-bed Mother and Baby Unit commissioned by NHS England for the BNSSG, Bath & North East Somerset, Wiltshire region. The New Horizon Mother and Baby Centre offers a specialist inpatient service for women suffering from mental illness in the postnatal period, particularly when there are issues relating to attachment and when the mother's mental illness has an impact on her ability to care for her baby. After 36 weeks of pregnancy, admission may be offered to the unit if it is felt to be the best care option. The team also offers advice and liaison to professionals working with women in other settings in the perinatal period (pre-conception, antenatally and up to the baby's first birthday). The team includes psychiatrists, mental health nurses and nursery nurses, health care assistants and an occupational therapist. The New Horizon Mother and Baby Centre has strong links with maternity services, primary infant mental health specialists, health visitors and children and young people's services. It provides a 24/7 service and is available for emergency admission. Two women from North Somerset accessed New Horizons in 2015.

[13] Postpartum psychosis (or puerperal psychosis) is a severe episode of mental illness that begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They include high mood (mania), depression, confusion, hallucinations and delusions.

[14] Serious mental illness includes diagnoses which involve psychosis.

[15] Post-traumatic stress disorder (PTSD) is associated with experiencing a traumatic birth, stillbirth or the death of a baby

[16] Adjustment disorder is a state of mixed emotions such as depression and anxiety which occurs as a reaction to major life events

[17] Michael-Cox, K. (2016) Perinatal and infant mental health services in North Somerset: Statement of work

Ages and stages questionnaires (ASQs)

More data on pre-existing mental health conditions will become available with the implementation of the Mental Health Services Data Set (MHSDS) and the Maternity Services Data Set (MSDS). While it is not yet possible to estimate reliably how many babies and toddlers have poor social and emotional development or mental health, health visiting teams have started to use the evidence-based Ages & Stages Questionnaires (ASQ-3) as part of the Healthy Child Programme (HCP) reviews[18] to monitor child development outcomes at age 2 to 2½. This is a new indicator and will be published in the 2017 Public Health Outcomes data collection. Initially this will show the percentage of development reviews delivered but in the future achievement of child development milestones across a number of dimensions will be published. From October 2016, ASQ-SE (Social Emotional) will be collected and reported on nationally alongside ASQ-3. North Somerset has been piloting both measures since April 2015, with 849 ASQ-3s having been completed on children in this age range. There is no qualitative data yet.

The concept of an integrated review at age 2, bringing together the EYFS (Early Years Foundation Stage) progress check with the HCP health review is currently being explored jointly by the Department of Health and the Department for Education.

As mentioned above, when considering social and emotional development in babies, toddlers and young children, it is useful to understand the importance of attachment where parents and carers respond to their children's needs sensitively and consistently, enabling them to feel safe, secure and protected[19]. There are a number of identified risk factors which can lead to attachment problems: maternal mental illness; parental drug and alcohol use; domestic violence and abuse; and teenage parents.

Teenage parents

Pregnancy in under 18s can lead to poor health and social outcomes for both mother and child but, on an individual level, many teenagers will parent effectively and raise healthy children. In North Somerset the rate of teenage pregnancy has been falling over several years. In 2013 there were 66 conceptions in girls aged 15-17. There were 20 mothers aged under 18 who gave birth in 2013/2014 and 21 in 2014/2015 (0.9% of all mothers giving birth in North Somerset in both time periods). North Somerset has a similar teenage conception rate compared with the regional and England average.

[18] www.gov.uk/government/publications/measuring-child-development-at-age-2-to-25-years

[19] For a fuller explanation of attachment, see: Funivall, J. (2011) Attachment-informed practice with looked after children and young people. Institute for Research and Innovation in Social Sciences (IRISS) http://www.iriss.org.uk/sites/default/files/iriss_insight10.pdf

Factors identified by Children's Social Care

The prevalence in North Somerset of the other risk factors mentioned above can be estimated through the 1355 Single Assessments carried out by Children's Social Care in 2014-2015[20]. Shown below are the factors identified in these assessments:

Factors from Single Assessment from DfE Table SFR41, C3 for North Somerset, 2014-2015			
Total number of assessments in North Somerset: 1355			
	North Somerset: Number	North Somerset: Percentage	England: Average Percentage
Alcohol misuse	319	23.54%	17.8%
Drug Misuse	341	25.16%	17.7%
Domestic Abuse	790	58.30%	48.2%
Mental Health	684	50.48%	32.5%

It can be seen that the prevalence of these issues far exceeds the average percentage throughout England, and North Somerset has a higher level of substance misuse and domestic abuse in the whole of the south west, apart from Bristol.

[20] DfE (2015) SFR41 Characteristics of Children in Need, 2014 to 2015, Table C3

Self harm and suicide

Deliberate self-harm

Surveys and research suggest that between 6% and 20% of young people may have self-harmed. As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months.

Rates of self harm are significantly higher In North Somerset than in other areas of England and the South West. The following data were published in February 2016[21]:

CYP with long term conditions	England	South West	BANES	Bristol	Glos	North Somerset	Somerset	South Glos
Hospital admissions as a result of self-harm (10-24 years) 2013-14	412.1	516.8	541.3	528.1	566.9	604.6	589.8	413.5

Significantly worse than England

No significant difference to England

The rate of self harm in North Somerset is 'significantly worse than the England average in both the 2015 and the 2016 Child Health Profiles. In 2013-14, there were 195 admissions to hospital following self-harm and in 2014-15 there were 191 admissions.[22]

Self presentation at hospital

Children and young people aged under 16 who present at Weston General Hospital A&E with deliberate self harm are referred to Bristol Children's Hospital where an initial assessment is undertaken by the Central Intake Team (CIT), with a follow-up undertaken by North Somerset specialist CAMHS. Data for 2013-2015 are:

[21] CHIMAT (February 2016) file://nsc-gov/UserProfiles/Redir/kwilcox/Downloads/ChildHealthClinicalIndicatorSummary-SouthWest%20(1).pdf
Hospital admissions as a result of self-harm (10-24 years): Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2013/14

[22] CHIMAT North Somerset Child Health Profile, 2015 & 2016

Year	Number of North Somerset under-16s seen at Bristol for deliberate self harm
2013	54
2014	61
2015	55
2016 (January – March)	20
Total	335

In the first quarter of 2016, there were 20 young people aged under 16 who were referred to or presented at Bristol in an emergency, of whom 13 were known to North Somerset specialist CAMHS, with an additional 6 referred to specialist CAMHS after initial assessment. Repeat data are not available for North Somerset but, in 2013 throughout the whole of BNSSG, 23 young people presented twice, 3 young people three times, 2 young people four times, 1 young person 5 times and 1 young person 7 times. This service is co-funded by North Somerset CCG (£22,000 2015-16).

Young people aged 17+ are seen by the Mental Liaison Team at Weston General Hospital who undertake an assessment before deciding whether or not to refer to specialist CAMHS who sometimes take part in the initial assessment. From April 2015 to January 2016, there were 81 presentations in this age group.

Urgent, non-routine referrals which could include those young people seen in A&E are prioritised and given a 'choice' appointment (see p.4) to be seen by a specialist health worker in CAMHS. 34 young people were given an urgent 'choice' appointment during the seven month period November 2014-June 2015.

There were 13 North Somerset in-patient admissions to hospital, excluding young people with an eating disorder, during the sixteen month period August 2014 – November 2015. In February 2016, in answer to a question from Norman Lamb, Shadow Liberal Democrat Spokesperson for Health, asking how many times there were no tier four child and adolescent mental health services beds available, Alistair Burt, the Minister of State, Department of Health said that while there had been tier 4 CAMHS beds available in England as a whole since April 2015, there were 52 days when no beds had been available in the South West, the highest number in the whole country[23].

Section 136 assessments

Section 136 assessments are undertaken when the police detain young people under the Mental Health Act. There is a special suite at Southmead Hospital where the young people are assessed by a North Somerset psychiatrist during the daytime

[23] http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-02-01/25026/

or a BNSSG psychiatrist during the night-time. Five North Somerset young people were assessed under s136 during 2014-2015.

Suicide

Although suicide is rare and rates are decreasing nationally, it remains a significant cause of death of young people. The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%.

The most recent data from the Office for National Statistics (ONS) indicate that in 2005 there were 125 deaths of 15 to 19 year olds from suicide or undetermined injury in England and Wales[24]. This is a rate of 3.6 deaths per 100,000 population aged 15 to 19 years. In 2016, the suicide definition was revised by ONS to include deaths from intentional self-harm in children aged 10 to 14: in the UK 98 children aged 10-14 have killed themselves in the last decade, 2005-2014, 59 boys and 39 girls[25].

While the suicide rates for males has traditionally been higher, statistics from Weston General for the three year period 2013-2015 show that the percentage of females attempting suicide is higher in the under-25s age range than in any other age range:

Total number of A&E attendances for patients with reason for visit and diagnosis of attempted suicide 2013-2015[26]				
Age Groups	Male	Female	Unknown	Total
Under 25s	**37**	**87 (=70%)**		**124**
26-36	29	39 (= 57%)		68
37-45	30	21	1	52
46-65	51	34		85
66+	5	1		6
Total	152	182	1	335

The rate of attempted suicide has increased year on year although it is not possible to disaggregate the under-25s from the other age ranges:

Year	
2013	81
2014	120
2015	134
Total	335

[24] ONS Vital Statistics and 2005 Mid-Year Population Estimate in CHIMAT Youth Justice

[25] http://www.theguardian.com/society/2016/feb/04/female-suicide-rate-in-england-highest-for-a-decade-in-2014-figures-reveal

[26] information obtained from North Somerset Clinical Commissioning Group

From 2001-2014, 18 young people under 25 in North Somerset either intentionally killed themselves or died as a result of self harm[27]; eight of these young people were aged under 20 years old.

Transformation Plan funding in 2015-16 enabled three staff to be trained in the ASIST programme (Applied Suicide Intervention Skills Training); they will facilitate workshops for staff across all agencies in 2016-17.

[27] Public Health data (Nina Robery)

Behavioural Problems/Conduct Disorder: Data

> Children from low income families are at highest risk [of mental health problems], three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison[28].

Mental Health

The most prevalent mental health problem is conduct disorder, with an estimated 1450 children and young people aged between 5-16 with this diagnosis in North Somerset. Although it is not possible to confirm this figure, other data support the prevalence of conduct disorder in North Somerset.

Socio-economic context

The 2015 Indices of Deprivation showed that[29]:

- 25% of children aged between 0 and 15 live in the most deprived half of LSOAs[30] in North Somerset with 7% of all children (2,416) living in the LSOAs in the most deprived decile in North Somerset.
- North Somerset was the district with the 3rd highest inequality, as measured by the range between the most and least deprived LSOAs in the district.
- North Somerset had 5/135 LSOAs within the most deprived 5% in England, all within South or Central wards of Weston-super-Mare; two of these on the Bournville Estate were within the most deprived 1% nationally.
- 21.5% of secondary school pupils (n=2,364) and 18.5% of primary school pupils (n=2,980) are eligible for the Deprivation Pupil Premium[31]

Exclusion from education

State-funded secondary schools				
	Fixed term exclusions		Permanent exclusions	
	2012/13	2013/14	2012/13	2013/14
North Somerset	4.6%	5.09%	0.18%	0.23%
South West	5.6%	5.9%	0.10%	0.12%
England	6.8%	6.62%	0.12%	0.13%

Source: Department for Education[32]

[28] (Five Year Forward View https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf)

[29] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 Local data compiled by North Somerset Business Intelligence Service, Briefing Note, November 2015

[30] Lower Layer Super Output Area. There are 135 LSOAs in North Somerset, each with a population of approximately 1500.

[31] DfE (2015) Pupil premium final allocations 2015-2016 by local area and region in England

[32] DfE (2015) SFR27 2015 Local Authority Tables, Tables 19 & 20

here is a rise in the percentage of Fixed Term Exclusions (FTEs) in the South West but a comparatively higher trend in North Somerset in both FTEs and Permanent Exclusions (PEx).The number of FTEs in all state-funded schools (primary, secondary and special) in 2013/14 was 680; the number of PEx was 30.

In 2014/15 the number of Permanent Exclusions in North Somerset 'increased from 4 pupils to 12 pupils in primary schools and from 35 to 42 pupils in secondary schools'[33] (suggesting a revision of the 2013/14 DfE figures).

In 2013/14, the reason for the majority of FTEs in North Somerset state-funded primary, state-funded secondary and special schools was 'persistent disruptive behaviour' (n=154, 23%) but 351 (51%) were for verbal or physical abuse, 61% of those (n=213) against an adult[34].

Nationally and locally, the percentage of FTEs and PEx is much higher for students with Special Educational Needs (SEN) but North Somerset percentages for SEN students in each category are lower than the average in England.[35,36] Nationally, pupils with SEN were more likely to be excluded due to physical assault against an adult in 2013/14 compared to those without SEN.

Youth Justice

In 2013, 101 children entered the youth justice system in North Somerset for the first time which equates to 543.9 per 100,000 10-17 year olds compared with 440.2 per 100,000 in the South West and 440.9 in England. This gives a significantly higher rate than the England average for young people receiving their 'first reprimand, warning or conviction'[37]. Offending behaviour is often linked with 'conduct disorder'[38].

Children Looked After

It has been known for some time that North Somerset has a higher percentage of children in care than its comparator authorities.

While data are not complete for the number of family, adoption and placement breakdowns due to behaviour, an analysis of 45 Children Looked After under s20 (voluntary accommodation) in the Social Impact Bond outline business case indicated that 'among children, anti-social behaviour is the most prevalent issue (51%)'. For further information about Children Looked After, please see the separate section on Children Looked After, mental health.

[33] Noticeboard, Issue 10, 17 November 2015, p4
[34] DfE (2015) SFR27 2015 Local Authority Tables, Table 24
[35] DfE (2016) SEN Absence and exclusions: Local authority tables (2013-14)
[36] DfE (2016) Absence and exclusions: special analysis for pupils with special educational needs (SEN)
[37] CHIMAT, Child Health Profile, June 2015
[38] NICE (2013) Antisocial behaviour and conduct disorders in children and young people: recognition and management https://www.nice.org.uk/guidance/cg158

These data suggest that children and young people's behaviour is a more serious problem in North Somerset compared with other local authorities in the south west and in England. It is an issue that affects all services (Education, Health, Social Care, Youth Justice) and suggests the need for a systemic response.

Parenting

Research shows consistently that work with parents/carers is essential to address conduct disorder/behavioural problems. Systematic reviews of interventions to prevent conduct disorder, anxiety and depression before adulthood have shown that programmes targeting at-risk children that use parent training or child social skills training are the most effective[39]. Evidence-based parenting programmes are the first treatment of choice for conduct disorders in under-12s in the NICE Clinical Guidelines.[40]

Conduct disorder is the most common childhood mental disorder, for which parenting support interventions are recommended as first-line treatment[41]. A number of studies have shown that effective parenting interventions and school-based programmes can result in significant lifetime savings. It is estimated that parenting interventions for parents who have children with conduct disorder cost about £1,200 per child. They have been shown to produce savings of around £8,000 for each child over a 25-year period (14% of the savings are in the NHS, 5% in the education system and 17% in the criminal justice system).[42]

Children who experience negative parenting[43], poor-quality relationships and other adversity in early life are at particular risk of a number of poor outcomes later on, including mental health problems. Good parent–child or carer–child relationships promote emotional, social and cognitive development, emotional resilience and healthy lifestyles. They are also associated with increased resilience against a range of difficulties, including mental illness.

Parenting groups

There are a number of well-validated, evidence-based parent support programmes delivered in North Somerset. Some of these are generic, for example Incredible Years and Strengthening Families, Strengthening Communities, while others are issue specific, for example, My Kids and Me (for mothers who have experienced domestic abuse). Some are targeted at the most vulnerable parents, for example, Mellow Mums, Mellow Dads and Mellow Babies.

Parenting programmes are also offered in some schools, while trained foster carers and the Resource Service have delivered the Family Links programme to foster carers. There are also separate programmes offered to parents of children with a

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39 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf No health without mental health

40 *Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management Clinical guidelines CG158* Issued: March 2013. http://publications.nice.org.uk/antisocialbehaviour-and-conduct-disorders-in-children-and-young-people-recognition-intervention-cg158

41 Please see the separate section in this JSNA chapter on 'Conduct disorder' and its manifestation in different guises in Social Care, Health, Education and Youth Justice. 'Conduct disorder' is often a sign of emotional distress but can go unrecognised.

42 Ibid

43 Please see references to Attachment in the Perinatal mental health; and Children looked after sections.

learning disability. There are parenting groups at all levels of need. The levels of need used in the matrix below correspond to the thresholds used in children's social care.

Parenting Groups:	**Age: 0 – 4s**	**Age: 4-11s**	**Age: 11-16s**
Tiers 3+	**Mellow Bumps** **Mellow Babies** **Mellow Mums/Dads** (NSC)	**Moving Forward** (Addaction/NSC) **My Kids and Me** (Alliance/Chapter 1)	**Moving Forward** (Addaction/NSC) **My Kids and Me** (Alliance/Chapter 1)
Tiers 2B+	**Incredible Years (IY)** (NSC/CAMHS)	**Incredible Years (IY)** (NSC/CAMHS)	**Strengthening Families, Strengthening Communities (SFSC)** (NSC)
Tiers 1 & 2A	**Antenatal PEEP** (NSC) **Baby PEEP** (NSC) **ParentWISE** (Lighthouse)	**Family Links** **(**Schools) **ParentWISE** (Lighthouse)	**Family Links** (Schools) **ParentWISE** (Lighthouse)

NSC = North Somerset Council

From January 2014 to April 2016, there were 521 referrals to parenting groups offered by North Somerset Council excluding PEEP (Parenting Early Education Partnership). 54% of those referrals originated from a health practitioner. The Strategic Schools Forum has supported these groups for the past eight years but there will be an 83% cut in their funding in 2016-2017 leading to a reduction in the number of groups and in the number of referrals accepted from agencies external to North Somerset Council.

No health without mental health recommends that children's services should offer 'evidence-based parenting interventions to families with children at risk of conduct disorder and those experiencing conduct problems,' adding that 'effective parenting support also needs to include the development of effective referral routes and awareness raising, for example with local GPs, maternity services, health visitors and other services working with young families,' something that is now in danger of fragmenting due to this reduction in funding. [44]

44 Department of Health et al (2012) *No Health Without Mental Health: Implementation framework* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

Autism Spectrum Conditions - Enhancing Nurture and Development (ASCEND)

While currently there is a wide range of evidence-based parenting groups available in North Somerset, there was a gap in the provision to parents and carers whose child had a diagnosis of autism or Asperger syndrome or was being assessed. ASCEND is a dedicated parenting group for parent/carers of children with a diagnosis of autism facilitated by CAMHS, the Disabled Children's Team and the Vulnerable Learners' Service. In 2015-2016, Transformation Plan funding enabled three workshops to be offered to staff across all settings to introduce them to the psycho-educational part of the ASCEND programme. The more advanced part of the programme will be co-facilitated by experienced staff from CAMHS, the Disabled Children's Team and the Vulnerable Learners' Service, providing a multi-agency, holistic approach.

Year	Number of parents offered group	Waiting list
2014	9	
2015	19	
2016	13	66
Total	41	

Another identified need is support for families where the child or young person is aggressive towards family members. Again, the Transformation Plan funding enabled 40 North Somerset staff, across all agencies, to be trained in the Non-Violent Resistance (NVR) programme. Practitioners are starting to use these strategies and will be evaluating their impact.

Neurodevelopmental disorders

Hyperkinetic disorders (ADHD)

Attention Deficit Hyperactivity Disorder is a behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. Although these symptoms tend to cluster together, some children and young people are predominantly hyperactive and impulsive, whereas others are primarily inattentive. It can affect educational attainment, peer relationships, self-esteem and can contribute to youth offending.[45]

CAMHS follows the National Institute for Health and Care Excellence (NICE) guidelines and uses a stepped approach to ADHD. Assessments always include a school observation. The parents of children who do not receive a diagnosis are supported in their parenting through the use of North Somerset's *Busy Wiggly Children* book. A parenting group is the usual first step in treatment for those with a diagnosis, followed by a consultation with school and, finally, medication. Prescribing is shared with some GP practices but all reviews are held at CAMHS. Schools are always informed of a diagnosis of ADHD and offered support. An annual parents' meeting is well-attended, with topics chosen by parents.

Children and young people who are open to Community Paediatricians have ADHD with no complicating factors. There is a monthly multi-agency strategy meeting to discuss children and young people affected by ADHD

One third of children and young people diagnosed with ADHD grow out of their symptoms, while a third may continue to experience significant symptoms until their mid-twenties (which fits with developments in neuroscience evidencing the maturation of the decision making parts of the brain at about 25).

Estimated number of children with hyperkinetic disorders by age group and sex

Based on local population figures and prevalence data from 2004, CHIMAT has estimated the number of children aged between 5 - 16 years with hyperkinetic disorders[46]:

	Children aged 5-10 (2014)	Children aged 11-16 (2014)	Boys aged 5-10 (2014)	Boys aged 11-16 (2014)	Girls aged 5-10 (2014)	Girls aged 11-16 (2014)
North Somerset	215	180	185	150	30	35

[45] *Key Data on Adolescence, 2013.*

[46] Local authority mid year resident population estimates for 2014 from Office for National Statistics; CCG population estimates aggregated from GP registered populations (Oct 2014);Green, H. et al (2004).

Actual numbers of children with hyperkinetic disorders open to children`s health services in February 2016:

	Children aged 5-10 (2016)	Children aged 11-16 (2016)	Boys aged 5-10 (2016)	Boys aged 11-16 (2016)	Girls aged 5-10 (2016)	Girls aged 11-16 (2016)
North Somerset CAMHS	3	53	3	43	0	10
North Somerset Community Paediatricians	55	108	44	100	11	8

It can be seen that, compared to the CHIMAT estimate, there are fewer children in the 5-10 range but the numbers in the 11-16 range are very similar, except for the number of girls. It suggests that children with ADHD are not being identified at an early age and/or schools are providing early help.

In addition, in February 2016, there were 12 young people (10 boys and 2 girls) aged 17-18 with a diagnosis of ADHD open to CAMHS and, a further 9 young people aged 17-18 with ADHD open to Community Paediatricians. There were also 6 children waiting for an ADHD assessment at CAMHS, and 59 children waiting for an ADHD assessment by a Community Paediatrician.

Neurodevelopmental Disorders: Autistic Spectrum Condition

The essential features of a diagnosis of autism are behavioural: a persistent impairment in reciprocal social interaction and social communication and restricted / repetitive patterns of behaviour, interests or activities. Symptoms vary greatly depending on the severity of the autistic condition, developmental level and chronological age and the presence or absence of associated conditions (such as intellectual disability or anxiety), hence the notion of a ‘spectrum’. In classic autism the child is slow to develop language (no single words by age 2, no phrase speech by age 3), and usually has additional intellectual impairment (that is, an IQ in the below average range). In contrast, in Asperger’s syndrome, there is no history of delayed language development and IQ is within the average range (that is above 70). Statistically autism affects more males than females.

Autism is a lifelong condition. As the defining characteristics of autistic spectrum disorders are impairments of social interaction, adolescence can be a particularly challenging life stage as the majority of young people become more focused on their peer groups.

Current research indicates about 1:100 people are on the autism spectrum[47] although more than this will show some traits or have other social communication needs.

The CHIMAT table below shows the estimated numbers of children aged 5-10 with autistic spectrum disorders, if the prevalence rates found by Baird and by Baron-Cohen are applied to the population of NHS North Somerset[48]

Estimated number of children aged 5-10[49]				
	Autism in children aged 9-10 years (2014)	Other ASDs in children aged 9-10 years (2014)	Total of ASDs in children aged 9-10 years (2014)	Autism-spectrum conditions disorders in children aged 5-9 years (2014)
NHS North Somerset	20	40	60	200

The estimated total for children aged 5-10 years is 260. There were 29,308 pupils enrolled in North Somerset mainstream schools in January 2015; this would approximate to 340-460 children of all ages on the autistic spectrum in North Somerset schools using the 1:116 or 157:10,000 ratios.

In the 2015 DfE Tables for Special Educational Needs[50], the total number of children and young people in North Somerset with Autistic Spectrum Disorder identified as the 'Primary Need' was given as 197. There may be other children with another primary need who are also on the autistic spectrum.

	Total number SEN	**Autistic spectrum disorder**	**ASD as % of total SEN**	**cf England average**
Primary schools	1671	73	4.4%	6.5%
Secondary schools	1128	63	5.6%	8.3%
Special schools	263	61	23.2%	24%
Total	3062	197		

[47] The NHS Information Centre, Community and Mental Health Team, Brugha, T. et al (2012).*Estimating the prevalence of autism spectrum conditions in adults: extending the 2007 Adult Psychiatric Morbidity Survey*. Leeds: NHS Information Centre for Health and Social Care quoted on the National Autistic Society website: http://www.autism.org.uk/About/What-is/Myths-facts-stats

[48] Baird et al (2006) estimated the rate of prevalence of autism in 9 to 10 year olds as 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000.
A survey by Baron-Cohen et al (2009) of autism-spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ratio of known to unknown cases is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases.

[49] Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004)

[50] DfE (2015) Special Educational Needs in England, January 2015. Local authority tables. SFR25/2015

When comparing the percentage of North Somerset children in primary and secondary schools with ASD with the average percentage of children in England, it appears that there are fewer children in North Somerset with ASD or fewer identified children in mainstream education.

In January 2016, on the North Somerset Education database (ONE), there were 333 children and young people identified with ASD. The year ranges are:

- 107 in Reception to Year 6
- 123 in Year 6 to Year 11
- 48 in Year 12 & Year 13
- 55 Year 14+, the majority at Weston College

Compared with the Baron-Cohen and Baird estimates above, the numbers of primary aged children with ASD still seem low.

Of the 333, 55 had a start date of 2015. It can be seen that there is a spike in numbers at transition points, especially on entry to secondary school:

Primary School Year	Number of children	Secondary School Year +	Number of young people
Reception	4	Year 7	19
Year 1	1	Year 8	1
Year 2	2	Year 9	1
Year 3	1	Year 10	4
		Year 11	2
Year 4	5		
Year 5	0	Year 12	2
Year 6	5	Year 13	2
		Year 14+	6

Social Communication and Autism Multi-Professional Pathway (SCAMP)

In North Somerset, the Social Communication and Autism Multi-professional Pathway (SCAMP), is the recognised pathway for a diagnosis of autism or other complex social communication needs for children and young people (2-18 years old). The team comprises: community paediatricians; community paediatric nurses; CAMHS; Vulnerable Learners' Service (VLS); and a speech and language therapist (SLT).

Currently there is no medical test to diagnose autism and other needs may look similar to autism, for example, someone with attachment difficulties can show behaviour that mimics autistic behaviour. Other children may have other needs in

addition to autism, for example, learning difficulties or Attention Deficit Hyperactivity Disorder (ADHD). The National Autistic Society (NAS) speculates that 42-54% of autistic people may have learning disabilities making up a third of all people with learning disabilities (defined as having an IQ less than 70)[51]. NAS suggests that females may be under-diagnosed but that it likely that males outnumber females by about 5:1. SCAMP signposts to other services to address needs other than autism and the Local Offer gives information about a range of local and national support and activities for families who have a child diagnosed with autism[52].

SCAMP data 2014-2016[53]

	2014	2015	2016 (first quarter)
New referrals	60	118	52
Male	53	92	36
Female	7	26	9
0-5 year olds	7	23	13
6-11 year olds	32	52	21
12-16 year olds	17	36	10
17-18 year olds	4	7	1
Accepted	58 (97%)	106 (89%)	24 with 22 awaiting panel
Not accepted			3
More information needed			3

From the 230 referrals received during 2014-2016, 59 families have had a final diagnosis feedback meeting and from these, 46 have been diagnosed with ASD and 5 have been found not to have ASD.

[51] http://www.autism.org.uk/About/What-is/Myths-facts-stats
[52] http://nsod.n-somerset.gov.uk/
[53] Please note that these data are an estimate taken from a manual count of paper records

Eating Disorders

Eating disorders include anorexia nervosa, bulimia nervosa and eating disorders not otherwise-specified (EDNOS). North Somerset set up a community based eating disorders service in 2005 which sits within specialist CAMHS and provides assessment, treatment and care for children and young people in North Somerset with complex eating disorders. The team works closely with Weston General Hospital and supports acute admissions to hospital where indicated (Bristol Children's Hospital for under-16s and Weston General for 16-18 year olds). A comprehensive transition protocol is in place to ensure continuity of care into the Adult Eating Disorders Service (Avon and Wiltshire Mental Health Partnership NHS Trust Specialised Treatment for Eating Disorders (STEPS). The STEPs service interfaces with five CAMHS community teams and one in-patient unit (Riverside) and there is a minimum of a six months lead-in time before transferring from CAMHS to adult services.

The CAMHS Eating Disorders Team has developed a model of outpatient treatment based on family-based intervention.[54] Clinicians are trained in Maudsley Multi Family Group Therapy, CYP IAPT Systemic Family Practice (Eating Disorders), Enhanced CBT,[55] Interpersonal Psychotherapy[56] to treat the eating disorder, and any co-morbid difficulties including anxiety and depression. The team has had an average of 18 – 28 referrals per year for the last 5 years.

Eating Disorders	2007	2008	2009	Total
New referrals	18	32	20	70 (mean = 23)
Diagnosed with Eating Disorder	12	16	9	37 (mean = 12)
Referred on to adult services	0	1	0	1
Inpatient admissions during year	2	2	1	5
Total number of Eating Disorder cases worked in year (new cases plus open cases at year start)	28	34	28	90 (mean = 30)

[54] Lock, J., Le Grange, D., Agras, W.S., & Dare, C. (2001). Treatment manual for Anorexia Nervosa; A Family-Based Approach. New York: The Guildford Press.

[55] Fairburn, C. (1995). Overcoming Binge Eating. New York, London: The Guildford Press.

[56] Mufson, L., Noreau, D., Weissman, M.M., & Klerman, G.L. (1993). Interpersonal psychotherapy for depressed adolescents. New York, London: The Guildford press.

Once a referral is received in specialist CAMHS, it is triaged and if any indication of an eating disorder or eating issue is noted, the referral is passed straight to the specialist eating disorders team. Young people and their families are offered an assessment within two weeks of referral for routine referrals and within one week for urgent referrals. Referrals from Specialist CAMHS clinicians, when an eating disorder is suspected in their Choice or Partnership sessions, are made directly, via internal referral, to the Eating Disorders Team, who will offer assessment which involves a generic mental health assessment and a specific eating disorders assessment. If indicated, treatment begins at the assessment and as a minimum young people and their families are seen weekly for treatment.

As part of the transformation of CAMHS and the anticipated joint commissioning of children's community health services across North Somerset, Bristol and South Gloucestershire in 2017, a cross area eating disorder service is being developed. There is additional government funding for eating disorders which should be invested to develop the service[57]. It is hoped that the number of acute bed nights required will be reduced when the new service is in place, increasing access to community support.

[57] In December 2014 the government announced £150m over five years to improve care for those with eating disorders. A new Access and Waiting Time Standard for Children and Young People with Eating Disorders has been devised which states that National Institute for Health and Care Excellence (NICE)-concordant treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases. In the case of emergencies, the eating disorder service should be contacted to provide support within 24 hours. This will be rolled out with the aim of 95 per cent of cases meeting this standard by 2020

Psychosis

Psychosis is a generic psychiatric term to describe a mental state that often involves a loss of contact with reality. Psychosis is most likely to occur in young adults and is quite a common problem, affecting around 3% of the younger adult population. Schizophrenia accounts for 24.5% of all psychiatric admissions in young people aged 10–18 years

The current thinking is that we all develop a level of vulnerability throughout early life. A combination of biological, environmental and social factors shape this vulnerability, and each factor will have a different amount of influence in each individual. The vulnerability determines how much stress an individual can cope with. Once the stress levels in a person's life breach that safe level, the symptoms described above may be triggered, and the individual may have a psychotic episode.

Most people who have a psychotic episode go on to make a full recovery and lead a normal life. Psychosis is often characterised by some or all of the following: confused thinking; false beliefs/delusional ideas; hallucinations; changed feeling and/or behaviour.

The rise in incidence increases most from age 15 onwards. North Somerset Early Intervention in Psychosis Team is a service for people who are experiencing the onset of psychosis. The service offers psychosocial interventions for the first three years after onset of psychosis, including cognitive behavioural therapy and family work for psychosis. The service is available to those aged 14+, who live in North Somerset. Its opening hours are Monday to Friday, 9am to 5pm. It offers a more intensive therapeutic service than traditional community services. The service is currently in the process of significant service development in line with new NICE guidelines. This includes a move to an ageless service (no upper age limit), referral to assessment target of 2 weeks and treatment with NICE compliant packages of care.

In North Somerset, about 24 people will have their first episode of psychosis each year.[58] New data suggests this is more likely to be 20 cases each year.

North Somerset data for the period: January 2014 – April 2016

Number of referrals for 14-18 year olds: 44 referrals

Number of referrals for 18 + year olds: 102

Somerset and Avon Rape and Sexual Assault Service (SARSAS)

SARSAS is a specialist support service for people in Bath and North East Somerset, Bristol, North Somerset, Somerset, or South Gloucestershire, who have

58 Avon and Wiltshire Mental Health Partnership NHS Trust (2009) *North Somerset Early Intervention for Psychosis Service.* Leaflet

experienced any form of historic sexual violence. Historic in this context means more than one year ago. SARSAS offers a confidential helpline, regular support sessions, counselling, and email support to individuals aged 13+. As a recent NSPCC paper has highlighted, experiencing abuse can have 'a major impact on the developing child and is linked to long term chronic problems into adulthood…exposure to childhood adversity such as abuse increases the risk of developing mental illness.'[59]

Support provided during April 2014-June 2016 in North Somerset: 13-17 year olds			Helpline & Email Service April 2014-2016
BS20	2	13%	
BS21	1	7%	
BS22	1	7%	
BS23	1	7%	
BS24	4	27%	
BS25	2	13%	
BS29	1	7%	
BS48	0	0%	
BS49	3	20%	
Total	15	100%	10

Support provided during April 2014-June 2016 in North Somerset: 18-24 year olds			Helpline & Email Service April 2014-2016
BS20	1	4%	
BS21	2	7%	
BS22	6	22%	
BS23	14	52%	
BS24	3	11%	
BS25	0	0%	
BS29	0	0%	
BS48	1	4%	
BS49	0	0%	
Total	27	100%	23

[59] NSPCC (2016) Transforming mental health services for children who have experienced abuse: a review of local transformation plans. https://www.nspcc.org.uk/globalassets/documents/research-reports/transforming-mental-health-services-children-experienced-abuse.pdf

Vulnerable Children

Young Minds highlights discrete groups of children and young people where there is a higher risk of mental health problems: children in care; disabled children; young offenders; young carers; BAME (Black, Asian and Minority Ethnic); LGBT (Lesbian, Gay, Bisexual, and Transgender).[60] There is currently limited data about these groups in North Somerset, apart from children looked after.

Children Looked After

The cross Government Mental Health Strategy, *No Health without Mental Health*, identified looked after children as one of the particularly vulnerable groups at risk of developing mental health problems. Under Section 10 of the Children Act 2004, local authorities have a duty to co-operate to promote well-being among children.

The emotional wellbeing and mental health of all children looked after aged between 4 and 16 who have been in care for at least 12 months is measured through the use of the Strengths and Difficulties Questionnaire (SDQ)[61]. The average total difficulties score, as assessed by their carer, is collected by local authorities and a single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted to the Department for Education (DfE) through the SSDA903 data return each year.

North Somerset has consistently had a higher rate of children in care than neighbouring authorities and the England average:

Looked After Children: rate per 10,000 population		
Geographical area	**Young people, aged 10-15 (2013)**	**Young people, Aged 16+ (2013)**
North Somerset	69.6	113.7
South West	60.8	102.8
England	67.8	105.8

In North Somerset, at the end of March 2015, there were 115 children and young people who had been in care for at least twelve months and were eligible to have their carers' SDQ scores submitted to the DfE.

Local data show that 69 carers of these remaining 115 completed an SDQ, a return rate of 60% compared with 72% in England overall (nb the DfE tables show a return

[60] http://www.youngminds.org.uk/about/whats_the_problem/mental_health_statistics

[61] SDQ = Strengths & Difficulties Questionnaire (Goodman, 2001) The SDQ assesses emotional and conduct problems, hyperactivity/inattention and peer problems (which can all be summed to provide a 'total difficulties' score), as well as prosocial behaviour. It offers versions for caregivers/teachers or for self-report (for young people aged 11 and above).

rate of 59%) ie 46 (40%) were coded SDQ2 which means the carer 'refused to complete'.

SDQs are coded, with those scoring under 14 falling in the 'normal' range, those scoring between 14-16 falling in the 'borderline' range and those scoring 17 or above falling into the 'cause for concern' range.

The DfE figures below show comparison with the England average over 3 years.

	2013 % (cf England%)	2014 %	2015 %	2015 number
Percentage return of all eligible cyp (cf England)	69% (71%)	64% (68%)	59% (72%)	69/115
Normal range	39% (50%)	37% (50%)	41% (50%)	28
Borderline range	20% (13%)	17% (13%)	19% (13%)	13
Cause for concern	41% (37%)	45% (37%)	41% (37%)	28
Average score	15 (14)	15.7 (13.9)	15 (13.9)	

Children and young people looked after with a learning disability (CYPLD)

Local data shows that from the 115 eligible children looked after there were 21 children and young people with a learning disability (18%).

17/21 carers of a child with a learning disability completed an SDQ. This is a much higher rate of return: 81% of carers compared with 59% overall. A higher percentage of children and young people with a learning disability had scores in the 'cause for concern' range (53% cf 41%) and 'borderline concern' (23.5% cf 13%).

	2015 CYPLD % of all North Somerset SDQ returns	2015 CYPLD number	2015 CYPLD % of North Somerset CYPLD returns only
	25%	17/69	81% (17/21)
Normal range	14%	4	23.5%
Borderline range	31%	4	23.5%
Cause for concern	32%	9	53%

Specialist CAMHS prioritises children looked after who meet their threshold. There is a dedicated Children Looked After virtual team in specialist CAMHS who undertake an holistic assessment.

NB some of these children and young people may have been placed in North Somerset by other local authorities ie they may not all be children looked after by North Somerset.

Children Looked After: Attachment and Transitions

Furnivall and others write about the importance of attachment-informed practice with children and young people looked after (and adopted):

'The experience of a prolonged insecure attachment, whatever the cause, has long been suspected of producing 'invisible damage'. New methods of measurement in neuropsychology and neurobiology have been able to quantify this damage in terms of brain growth and activity. In short, we now know that parental rejection, abuse and neglect not only cause grievous developmental harm, but also grievous bodily harm.' Cameron and Maginn 2008[62]

Understanding the importance of attachment can inform the planning and management of transitions for children and adults. Every time a child moves from one living situation to another it involves separation from a caregiver and the likely disruption of an attachment. Changing teachers or schools can also disrupt relationships that have particular meaning for children. Sufficient thought and respect must be given to the meaning and importance of relationships when change is planned. Children need to create a coherent autobiography for themselves to develop their identity and sense of self. If they experience a series of placements with little or no connection between them this is hard to achieve. Whenever possible children should remain in the same placement unless there are strong reasons to move them. When a move is inevitable special relationships should be recognised and supported for as long as they remain important to the child. It is important to

[62] Funivall, J. (2011) Attachment-informed practice with looked after children and young people. Institute for Research and Innovation in Social Sciences (IRISS)
http://www.iriss.org.uk/sites/default/files/iriss_insight10.pdf page 12

recognise the impact on staff, carers and other children of a child moving placement, whether this is in a planned way or as a result of disruption. Immediate placement of another child in the same foster home or residential unit should be avoided where possible. All transitions, including those of staff leaving a home, should be marked and, where appropriate, they should be celebrated. The particular importance of the transition from care into independent living cannot be over-estimated and policies should support the continuation of relationships between young people and those who have been caring for them. Ideally, they should continue to be a secure base and safe haven for those young people who have left their care.[63]

While all foster carers and adopters in North Somerset are offered attachment training, and due care is given to helping children looked after form a coherent narrative about their past, a clear strategy is needed to address the relatively high SDQ scores, and to ensure that children looked after have their individual needs met while in care and when moving towards independent living.

Care Leavers

Young people in care have often had difficult lives and have to start living independently much earlier than their peers. Of children in care, 62% are there because of abuse or neglect. This can have a significant and lasting impact on their mental health and emotional well-being. Only half of children in care have emotional health and behaviour that is considered in the 'normal' range and this has changed little in recent years.

Every year around 10,000 16- to 18-year-olds leave foster or residential care in England. Local authorities must support care leavers until they are 21 years old (or 25 if they are in education or training). On leaving care, some young people return home to their families but many start to live independent lives.

From DfE interviews with care leavers and other surveys of young people, ongoing mental health and emotional well-being are important issues. Some young people felt past trauma had affected their ability to form relationships. Others felt they had not been prepared emotionally to live alone and struggled to cope with loneliness and not being with family and friends. Often they did not have anyone to speak to in the evenings, weekends or Christmas if no one from their local authority was available

There is a significant gap between the educational and employment achievements of care leavers and other young people. In England in 2013-14, 41% of 19-year-old care leavers were Not in Education, Employment or Training (NEET) compared with 15% for all 19-year-olds. This is the highest proportion since 2001-02. In addition, 6% of care leavers were in higher education compared with one-third of all 19-year-olds

Until 2013 there was no separate Ofsted judgement on whether local authorities' support for care leavers met expected standards. From 2013, under a new inspection framework, Ofsted has rated local authority support for care leavers

[63] Furnivall (2011) ibid

against the Department for Education's standards for the first time. Ofsted inspections of care leaver services have found that two-thirds require improvement or are inadequate. So far, Ofsted has reported on care leaver services in 59 local authorities. By end-June 2015, only 34% of local authority services were judged 'good', with just one judged to be 'outstanding'.

The Department for Education introduced its Staying Put policy in 2014 to help care leavers stay in foster homes longer, although it is too early to assess its impact. Research and evidence highlight that where children in care are given longer to become independent like their peers, this improves their outcomes. Staying Put offers care leavers approaching 18 the security of knowing they can stay with foster carers until they are 21, if they both wish. The DfE only collects data for Care Leavers aged between 19 and 21 meaning longer term outcomes are not easily identified.

DfE analysis shows there is minimal correlation between local authorities' reported spending on care leavers and the quantity and quality of their services. Although there are examples of good local practice, it is not developed or shared well enough nationally. Two examples of good practice are New Belongings, funded in part by the Department for Education, and the National Leaving Care Benchmarking Forum run by the charity Catch22. However, not all local authorities are involved: 30 participated in New Belongings and 78 in the Benchmarking Forum. North Somerset was a Phase 2 local authority in New Belongings which aimed to raise expectations, aspirations and outcomes for Care Leavers. The project finished in April 2016. [64,65]

The Work Capability Assessment (WCA) is the test designed and used by the Department for Work and Pensions (DWP) in the United Kingdom to determine whether disabled welfare claimants or those suffering from long-term illnesses are entitled to the main out-of-work sickness benefit: Employment and Support Allowance (ESA). The WCA aims to sort sickness benefit claimants into three groups: fit for work; unfit for work but fit for pre-employment training; or fit for neither work nor training.

The most recent data (2016) shows that there are a significant number of North Somerset Care Leavers who are NEET and have been assessed as not being fit to work due to mental health issues (n=33, approximately 25%). They are currently eligible for the Disability Living Allowance (which is being replaced by the Personal Independence Payment (PIP) for those aged 16+). Children and Adolescent Mental Health Services (CAMHS) provide services to young people up to their 18th birthday. When care leavers move from children's to adult services they may not reach the diagnostic threshold for access to adult services.

The 2014-2015 data for North Somerset Care Leavers is below, with the England average, where applicable, in brackets:

NEET categories: Illness/disability; Other reasons; Pregnancy or Parenting.

[64] National Audit Office/DfE (2015) *Care leavers' transition to adulthood*
[65] http://www.newbelongings.org.uk/new-belongings

North Somerset Care Leavers, 2014-2015[66]			
	19 year olds	**20 year olds**	**21 year olds**
Number	45	35	30
In Education, Employment or Training (EET)	North Somerset* = 20 National average** = 24	North Somerset = 15 National average = 17	North Somerset = 15 National average = 13
Not in Education, Employment or Training (NEET)*	North Somerset* = 10 National average** = 12	*Illness/disability:* North Somerset* = 5 National average** = 4 *Other reasons:* North Somerset* = 10 National average** = 9	x
Accommodation with parents or relatives	North Somerset* = 10 National average** = 6	North Somerset* = 5 National average* = 4	x
Independent accommodation	North Somerset* = 20 National average** = 14	North Somerset* = 15 National average** = 14	North Somerset* = 15 National average** = 13
Suitable accommodation	North Somerset = 84% National average = 83%	North Somerset = 82% National average = 82%	North Somerset = 79% National average = 77%
Local authority does not have information	x	x	x

** Number of care leavers reported in each category. Please note actual totals may be higher where it includes sub-categories with numbers of <5 which have been supressed for confidentiality.*

*** Projected number of care leavers in each category if the national average percentage is applied to the North Somerset population.*

Children and Adolescent Mental Health Services (CAMHS) provide services to young people until their 18th birthday. When care leavers move from children's to adult services they may not reach the diagnostic threshold for access to adult services.

[66] Department for Education, 2016. SFR 34 2014-2015 https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015 These data refer to young people who were looked after for a total of at least 13 weeks after their 14th birthday including some time after their 16th birthday.

Transition

Transition can be defined as the purposeful, planned movement of young adults with ongoing mental health issues from specialist CAMHS to adult mental health organisations.

Young people transferred from children's health services to adult services: April 2015 – April 2016		
Referring service		
CAMHS	Adult mental health	7
CAMHS	Adult learning disabilities	4
CAMHS	Adult ADHD	6
Community Paediatrics	Adult ADHD	4
Total		21

Positive Step

Positive Step offers support for people with common mental health problems through self help materials, psycho-educational courses and one to one support. It works in partnership with GPs and colleagues in primary care and is made up of a range of professionals with a wide variety of skills and training.

Positive Step recommends that 16-17 year olds initially speak to their GPs and their schools/colleges but it also allows direct access.

Positive Step delivers various talks at 6th form colleges/schools in the North Somerset area to raise awareness of help for those still in education who are struggling with common issues, for example self-esteem and low mood. A Positive Step Wellness Advisor works at Weston College one day per week.

	2013-14	2014-15	2015-16
16-17 year olds entering Positive Step	52	79	173
18-25 year olds entering Positive Step	557	715	976
Total	**609**	**794**	**1149**

Section Two

National Policies[67]

The Chief Medical Officer made mental health the subject of her annual report in Autumn 2014[68]. This was followed by a critical House of Commons Select Committee report in October 2014[69], which concluded:

> There are serious and deeply ingrained problems with the commissioning and provision of Child Health Services. These run through the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people".[70]

Earlier in 2014, NHS England commissioned a review of inpatient services. The review raised serious concerns about inadequacy of provision in inpatient settings, but also in community services which had led to further pressure on beds.

Future in Mind

A children's mental health taskforce was established to tackle these issues. Its report, *Future in Mind*, was published in March 2015 and contained a series of recommendations for changes in the way services are commissioned and provided, such as tackling stigma, introducing access standards and moving away from a 'tiered' system[71].

Future in Mind was accompanied by the announcement of £1.25bn investment over five years (£250m per year) in the last budget before the 2015 general election. With previously announced investment in eating disorder care, this is a total of £1.4bn additional investment by 2020.

Progress since Future in Mind

In 2015/16 only £143m of the proposed £250m funding was allocated but the government has reiterated that the total amount over the next five years will still reach £1.25bn[72]. This funding has not been ring-fenced and from 2016/17 it has been part of the CCG's baseline allocation. This means it will compete with other CCG priorities.

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[67] Much of the information for this section is taken from: **Frith, E. (2016)** *CentreForum Commission on children and young people's mental health: State of the nation.* http://centreforum.org/publications/children-young-peoples-mental-health-state-nation/

[68] Annual Report of the Chief Medical Officer 2013 https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health

[69] House of Commons Select Committee inquiry into child and adolescent mental health 2014 http://www.publications.parliament.uk/ pa/cm201415/cmselect/cmhealth/342/34202.htm

[70] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/1036/103605.htm

[71] CAMHS services have historically been structured across four tiers, with the first being preventative, non-specialist support and tier four meaning inpatient services

[72] Alastair Burt MP, Mental Health Minister, House of Commons Hansard 3 Dec 2015, column 606

In order to gain access to this investment at a local level, each area was asked to produce and publish a Local Transformation Plan. These plans were assured by NHS England in the process of allocating funding to local areas. Going forward, these plans will be included in each area's five year strategy for health and assurance of progress will be mainstreamed into the wider annual assurance process for local health commissioners.

Other changes since *Future in Mind* include:

- a new section of the *NHS Choices* website on youth mental health, which includes advice and self-help apps for young people looking for support
- a government backed national anti-stigma campaign for teenagers and parents, launched in November 2015
- with the Health and Social Care Information Centre, the Department of Health is commissioning the first national survey of children and young people's mental health since 2004. The final results are expected in 2018
- the launch of MindEd, the free, online educational resource on children and young people's mental health for all adults working with or caring for children.[73]
- Department of Health (DH) and the Department for Education (DfE) have published new statutory guidance on *Promoting the health and well-being of looked-after children*[74].
- a House of Commons inquiry into the mental health needs of children looked after[75]

In February 2016 NHS England published a *Five Year Forward View for Mental Health in England*[76]. This adopted a 'life course' approach to mental health, covering care for new families, through the early years, school, adulthood and older age. On child and adolescent care, it endorsed the direction of travel outlined in *Future in Mind* and recommended additional measures including:

Future in Mind and the *Five Year Forward View* have set out a clear pathway for the transformation of child and adolescent mental health services at a local level. There is, however, real uncertainty as to whether the additional funding will result in sufficient, genuine extra investment.

Education policy

The Department for Education has also taken a number of actions to improve mental health support in schools. New guidance has been produced for school counselling

[73] www.minded.org.uk

[74] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

[75] http://www.publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/481.pdf

[76] The Five Year Forward View for Mental Health, NHS England, 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

services[77]. Updated guidance has been published on mental health and behaviour[78], and on children with physical and mental health conditions[79].

The Department for Education is investing £3m with NHS England to pilot joint training for designated leads in CAMHS services and schools (unfortunately North Somerset was unsuccessful in its bid to become one of the pilots sites); £5m in 'character education' including peer mentoring; and nearly £5m for grants for organisations that work with vulnerable children and young people, such as funding for a comprehensive directory of all mental health services for schools.

In March 2016, the Department launched a call for evidence to gather views on what support could be offered to encourage peer mentoring in schools[80].

In spite of pressure to introduce mandatory mental health education as part of PSHE, following a consultation 2013, the Department of Education confirmed in February 2016 that it would remain optional. Instead, to improve teaching about mental health the department funded the PSHE Association to produce guidance and lesson plans to support teachers to deliver age-appropriate lessons on mental health in PSHE education[81]. The Department has also commissioned a survey to provide nationally representative estimates of what provision schools and colleges offer for mental health and character education[82].

The recent Carter Review of Initial Teacher Training (ITT)[83] recommended that in future, training should provide new teachers with a grounding in child and adolescent development, including emotional and social development, which will underpin their understanding of issues like mental health. The Department for Education has established an independent group of experts to build a better shared understanding of what elements good ITT courses include and to develop a framework of core ITT content. The group will consider the Carter Review recommendations on emotional and social development[84]. In advance of further formal training support, the

[77] Counselling in schools: a blueprint for the future Departmental advice for school leaders and counsellors, Department for Education, updated February 2016
https://www.gov.uk/government/publications/counselling-in-schools
[78] Mental health and behaviour in schools, Department for Education, updated March 2016
https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2
[79] Supporting pupils at school with medical conditions, Department for Education, December 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484418/supporting-pupils-at-school-with-medical-conditions.pdf
[80] Children and young people's mental health: peer support, Department for Education, February 2016 https://consult.education.gov.uk/ children-and-young-people2019s-mental-health-team/peer-support-for-children-and-young-people-s-menta/consult_view
[81] https://www.pshe-association.org.uk/curriculum-and-resources/resources/guidance-preparing-teach-about-mental-health-and
[82] House of Commons Written Answer, March 2016 http://www.theyworkforyou.com/wrans/?id=2016-03-16.31291.h&s=Mental+Health+Services+Young+People#g31291.r0
[83]Carter Review of Initial Teacher Training (ITT), Sir Andrew Carter OBE, Department for Education, January 2015
[84] Government response to Youth Select Committee, para 37:
http://www.byc.org.uk/media/279518/ysc_report_response_cleared.pdf January 2016

Department of Health funded MindEd website[85] is an invaluable resource for all families and professionals, including those in the education sector, on young people's mental health care.

Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)

In recognition of the prevalence of children and young people's mental health issues, the government established the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) to transform CAMH services through the provision of evidence based therapies and supervision; routine outcomes monitoring to measure the effect of treatment and to gain feedback from children and families; and collaborative working with children and families through participation in all aspects of the service from recruitment of staff to development and commissioning of services. The *Future in Mind* report is based on CYP IAPT principles and evidence of effective practice.

In North Somerset, local authority staff have been trained alongside specialist CAMHS staff in Cognitive Behavioural Therapy (Anxiety and Depression); Systemic Family Practice (Self Harm; Depressions; Conduct Disorder) and Parenting (in recognition that the evidence shows the importance of parenting in the long term protection of children's mental health).[86] Specialist CAMHS staff have also trained in Systemic Family Practice (Eating Disorders). Following their training the CYP IAPT practitioners will offer evidence based therapies in early help settings as well as in specialist CAMHS, providing an additional resource.

Participation

As part of the re-commissioning process, there has been a recent consultation with children, young people and families through *Your Healthy Future*[87] and, as part of the CYP IAPT programme and the new Transformation Plan monies, a participation worker has been employed by specialist CAMHS to ensure that the voices of the child, young person and parents inform all of our decision making. Participation activity includes children and young people who use specialist CAMHS and also those who choose not to use specialist CAMHS but meet the threshold and may need an alternative, innovative type of provision. The latter cohort may include identified vulnerable groups such as children looked after; young offenders; and children with special educational needs and disabilities (SEND).

[85] https://www.minded.org.uk/
[86] Public Health England (2015) Measuring mental wellbeing in children and young people
[87] https://www.yourhealthyfuture.org/

NICE (National Institute for Health and Care and Excellence)

Clinical guidelines recommend how healthcare professionals should care for people with specific conditions.

They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management.

These guidelines are also important for health service managers and commissioners of NHS services.

Public health guidelines

Guidelines on public health topics make recommendations on local interventions that can help prevent disease or improve health.

The guidance may focus on a particular topic (such as smoking), a particular population (such as schoolchildren) or a particular setting (such as the workplace).

Quality standards

NICE quality standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE. They are developed independently by NICE, in collaboration with health and social care professionals, their partners and service users.

Quality standards cover a broad range of topics (healthcare, social care and public health) and are relevant to a variety of different audiences, which will vary across the topics. Audiences will include commissioners of health, public health and social care; staff working in primary care and local authorities; social care provider organisations; public health staff; people working in hospitals; people working in the community and the users of services and their carers.

Clinical Guidelines

http://www.nice.org.uk/guidance/cg9 Eating disorders (2004)

http://www.nice.org.uk/guidance/cg16 Self harm: the short term physical and psychological management and secondary prevention of self harm in primary and secondary care (2004)

https://www.nice.org.uk/guidance/cg26 PTSD (2005)

https://www.nice.org.uk/guidance/cg28 Depression in children: identification and management in primary, community and secondary care (2005)

http://www.nice.org.uk/guidance/cg31 Obsessive Compulsive Disorder (2005)

https://www.nice.org.uk/guidance/cg72 ADHD (2008, updated 2016)

http://www.nice.org.uk/guidance/cg78 Borderline personality disorder (2009)

http://www.nice.org.uk/guidance/cg120 Psychosis with coexisting substance misuse (2011)

https://www.nice.org.uk/guidance/cg123 Common mental health disorders (2011)

http://www.nice.org.uk/guidance/cg128 Autism diagnosis in children and young people (2011)

https://www.nice.org.uk/guidance/cg133 Self harm: longer term management (2011)

http://www.nice.org.uk/guidance/cg155 Psychosis and schizophrenia in children and young people (2013)

http://www.nice.org.uk/guidance/cg158 Antisocial behaviour and conduct disorders (2013)

http://www.nice.org.uk/guidance/cg159 Social anxiety disorder: recognition, assessment and treatment (2013)

www.nice.org.uk/guidance/cg170 Autism: management and support of children and young people on the autistic spectrum (2013)

http://www.nice.org.uk/guidance/cg185 Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (2014)

http://www.nice.org.uk/guidance/cg192 Antenatal and postnatal mental health (2014 rev.2015)

http://www.nice.org.uk/guidance/ng11 Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015)

http://www.nice.org.uk/guidance/ng26 Children's attachment: attachments in children and young people who are adopted from care, in care or at high risk of going into care (2016)

http://www.nice.org.uk/guidance/ng43 Transition from children's to adults' services for young people using health or social care services (2016)

Quality Standards

https://www.nice.org.uk/guidance/qs31 Looked After Children (2013)

https://www.nice.org.uk/guidance/qs34 Self harm (2013)

https://www.nice.org.uk/guidance/ qs39 ADHD (2013)

https://www.nice.org.uk/guidance/qs48 Depression in children and young people (2013)

https://www.nice.org.uk/guidance/qs51 Autism (2013)

http://www.nice.org.uk/guidance/qs53 Anxiety disorders (2014)

https://www.nice.org.uk/guidance/qs59 ASB and conduct disorders (2014)

https://www.nice.org.uk/guidance/qs102 Bipolar disorder, psychosis and schizophrenia in children and young people (2015)

https://www.nice.org.uk/guidance/qs115 Antenatal and postnatal mental health (2016)

https://www.nice.org.uk/guidance/qs116 Domestic violence and abuse (2016)

Public Health

https://www.nice.org.uk/guidance/ph4 Interventions to reduce substance misuse among vulnerable young people (2007)

https://www.nice.org.uk/guidance/ph12 Social and emotional wellbeing in primary education (2008)

https://www.nice.org.uk/guidance/ph20 Social and emotional wellbeing in secondary education (2009)

http://www.nice.org.uk/guidance/ph28 Looked After Children and young people (2010)

https://www.nice.org.uk/guidance/ph40 Social and emotional wellbeing: early years (2012)

https://www.nice.org.uk/guidance/ph50 Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014)

Advice

www.nice.org.uk/advice/esuom88 Attention deficit hyperactivity disorder in children and young people: clonidine (ESUOM8) (2013)

www.nice.org.uk/advice/esnm19 Attention deficit hyperactivity disorder in children and young people: lisdexamfetamine dimesylate (ESNM19) (2013)

https://publications.nice.org.uk/lgb12 Social and emotional wellbeing for children and young people (2013)

Department for Education

https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2 Mental health and behaviour in schools (2015)

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NICE guidance: indices

https://www.nice.org.uk/guidance

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
APMHW	Adult Primary Mental Health Worker
ASCEND	Autism Spectrum Conditions Enhancing Nurture and Development
ASIST	Applied Suicide Intervention Skills Training
ASQ-3	Ages and Stages Questionnaire
ASQ-SE	Ages and Stages Questionnaire: Social and Emotional
BNSSG	Bristol, North Somerset & South Gloucestershire
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach (a system to manage demand and capacity)
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHIMAT	National Child and Maternal Health Intelligence Network
CIT	Central Intake Team (Bristol)
CLA	Children Looked After
CLDT	Children's Learning Disabilities Team
CONSULT	North Somerset multi-agency consultation service for foster carers
CYP IAPT	Children and Young People's Improving Access to Psychological Therapies
DfE	Department for Education
DWP	Department for Work and Pensions
EDNOS	Eating Disorder Not Otherwise Specified
ESA	Employment and Support Allowance
EYFS	Early Years Foundation Stage
FTE	Fixed Term Exclusion
HCP	Healthy Child Programme
IMD	Index of Multiple Deprivation
ITT	Initial Teacher Training
JSNA	Joint Strategic Needs Assessment
LD	Learning Disability
LSOA	Lower Super Output Layer
LTP	Local Transformation Plan
MHSDS	Mental Health Services Data Set
MSDS	Maternity Services Dataset
NAS	National Autistic Society
NEET	Not in Education, Employment or Training
NICE	National Institute for Health and Care Excellence
NSC	North Somerset Council
NSOD	North Somerset Online Directory
NVR	Non-Violent Resistance
ONS	Office for National Statistics
PEEP	Parenting Early Education Partnership
PEx	Permanent Exclusion
PIP	Personal Independence Payment
PSA	Parent Support Adviser
SEND	Special Educational Needs and Disability

SCAMP	Social Communication and Autism Multi-Professional Pathway
SDQ	Strength and Difficulties Questionnaire
SSF	Strategic Schools Forum
STEPS	Specialised Treatment for Eating Disorders
VLS	Vulnerable Learners' Service
WCA	Work Capability Assessment
YOS	Youth Offending Service

Weston Area Health NHS
NHS Trust

Specialist Community Children's Services

Referral Guidelines for the
Child and Adolescent Mental Health Services (CAMHS) and Learning Disabilities (LD)

INTRODUCTION

Specialist CAMHS/Learning Disabilities provides evidence-based services for children and adolescents suffering from severe and complex mental health issues which have a significant impact on the child's development and causes distress to the child and/or carers. Services are provided in clinics, schools, early years settings and in families' homes. CAMHS staff often work as part of a multi-agency team and also provide consultation and training to staff from other agencies who work with children.

DEFINITIONS

SEVERE AND ENDURING MENTAL HEALTH PROBLEMS

Severity
Specialist CAMHS will accept referrals of children and young people whose symptoms or distress and degree of social and/or functional impairment are severe and where there is likelihood that the child or young person has a severe mental health disorder.
Duration
Usually, the duration of these difficulties should be *not less than three months*.
For severe / life-threatening conditions (see below) and for other conditions where there is severe impairment of functioning, the referral should be made immediately and discussed with a senior member of the CAMHS team. .
Case Complexity
Specialist CAMHS will accept referrals where there is a high level of case complexity.
This might include, for example, multiple risk factors, complex family problems, child protection concerns.
Please note that any child protection concerns should already have been reported to the statutory agencies prior to referral.
Timing of the Involvement of Specialist CAMHS Services
Despite the apparent intensity or severity of a problem when it is first identified, an important issue for the child/young person and family is the ***timing*** of the involvement of specialist CAMHS services. This should be discussed carefully with the parent(s) and the child/young person because they are best placed to know when they are ready to engage with services which might lead to a programme of treatment that will require their involvement.

SEVERE LEARNING DISABILITIES

Individuals with severe disabilities typically have IQ scores in the 20-35 range. (World Health Organisation), may exhibit a wide range of characteristics, which may include:

- Significant delay in reaching developmental milestones
- Serious speech or communication problems
- A severe degree of apathy in relation to the environment
- Difficulty in basic physical mobility
- Inability to remember basic skills
- Inability to generalise skills from one situation to another
- Dependence on others to satisfy basic needs, e.g., feeding, toileting
- Inability to live without support throughout life
- A variety of medical conditions may accompany severe or profound disabilities, such as epilepsy, hydrocephalus and scoliosis.

We do not routinely assess I.Q scores within our team.
'Learning disability' does not include all those who have a 'learning difficulty' (e.g. Dyslexia)". (Valuing People, DOH, 2001).

AGE RANGE AND ACCESS

1. Children aged 0-18 years **with consent from the person with parental responsibility** (Children between 13 years and 16 years (if Gillick competent) can give their own consent but should be accompanied by a caregiver to the first appointment)
2. Children up to the age of 19 in special circumstances (ADHD, ASD, Complex disability, Special Educational Needs).
3. Children who are resident in North Somerset

4. Children registered with a North Somerset GP, even if children are attending a school in another county
5. Children who attend a Special School in North Somerset
6. Children 'Looked After' by North Somerset Council, where practically possible

7. Children 'Looked After' by other Local Authorities but placed in N. Somerset, where medical follow up by local CAMHS/LD is impractical. Information about the Local Authority who has responsibility for the child will need to be included in the referral, otherwise it will not be accepted. An extra-contractual referral agreement may be required.
8. There are joint adult mental health (AMHS)/CAMHS referral pathways for young people aged 16/17 years who have more serious psychiatric disorder. A referral into either service will be the point of access for obtaining the most appropriate service provision including possible joint AMHS/CAMHS care.

EXAMPLES OF PROBLEMS

- Aggression/conduct problems which significantly impacts on everyday functioning.
- Parent/carer/relationship problems with complex and severe behavioural difficulties in the child.
- Depression and mood disorder.
- Attempted suicide and deliberate self harm that poses a risk to safety which significantly restricts every day functioning.
- Anxiety and obsessive compulsive disorder which significantly impacts on everyday functioning.
- Eating disorder
- Hyperactivity and attention deficit disorders which significantly impairs daily functioning.
- Post traumatic stress disorder

- Psychoses
- Consequences of sexual, physical or emotional abuse following initial therapeutic treatment via social services
- Complicated bereavement and loss
- Complex sleeping, eating, toileting or behaviour problems accompanied by a severe learning disability.

STATUTORY WORK

This includes medical advice for Statements of Special Educational Need (SEN).

HOW TO REFER

Complete the Single Point of Entry form and send to the address on the form and attach any supporting information which would be of help.

There is always someone available for advice if you are not sure what is appropriate.

CONSENT

It is expected that informed consent for the referral has been obtained from someone with legal parental responsibility for the child or young person. Young people aged 16 and above can consent to a referral in their own right. Some young people under 16 may consent to a referral and request that their parents are not informed. In this case it is expected that the referrer has decided that he young person has Gillick competency and has considered the risks and benefits of not informing the parents or carers of the referral.

WHO CAN REFER

Referrals to the CAMHS Service are accepted from: - Health (GP's, paediatricians, health visitors, school nurses), social workers, educational psychologists, education welfare officers, Youth Offending Team, Head teachers of Special Schools. SENCos at secondary schools who have had attended training on referral to CAMHS

HOW TO DECIDE WHAT IS NOT AN APPROPRIATE REFERRAL

- Learning disability as the primary problem without mental health issues
- Reaction to external life crises that is likely to resolve with time or with general counseling or advice from other agencies. (e.g. bereavement, divorce)
- School related problems or educational difficulties where the dynamics are primarily in the school or where the intervention is more appropriately carried out by the education service.
- Substance abuse unless there is a significant associated mental health problem
- Mild and Moderate Learning Disability
- See definition of Severe Learning disability above.

Cases that do not meet the referral criteria may be returned to the referrer. It is also possible that mild to moderate cases may be passed to Primary Mental Health workers for possible consultation, joint working and advice about management.

WHAT WORK NEEDS TO BE DONE BEFORE MAKING A REFERRAL

Direct assessment
The child or young person needs to have been seen in person and assessed by the referrer prior to making a referral to the service.
Intervention by frontline staff
It is an essential requirement before a referral can be accepted into specialist CAMHS that attempts have been made by frontline staff (e.g. primary health care staff, school staff, school health nurse, CYPS staff) to resolve the child / young person's difficulties or problems before making a referral. Many children/young people can be helped in this way and, generally, it is better if the problems can be resolved without the need to identify the child/young person with mental health services though we are always happy to consult / advise as necessary.
Likelihood of Attendance
If the referrer knows that a family has found it difficult to attend for CAMHS appointments in the past, the referrer will be asked to consider how they can help the family to engage with CAMHS this time before making the referral. We will also need to know from you, the referrer, what we can do to try to ensure the family's engagement.
CYPS Assessments
For referrals from CYPS, a social work Initial or Core Assessment, or a Common Assessment Framework (CAF) assessment needs to have been completed before referral to CAMHS**.**

ETHNICITY MONITORING

Please note that we have a legal requirement to monitor ethnicity as defined by the child or young person themselves or by a parent with legal parental responsibility in the case of a young child. This means that the ethnicity section on the referral form must be completed please.

WHAT WILL HAPPEN NEXT?

- All referrals will be acknowledged to the referrer/parents/carers/GP within 7 working days
- Referrals will be reviewed by the relevant team in CAMHS who will contact the referrer if further information is required or if the referral does not fulfil the referral criteria.
- Parents/carers/young people will receive a letter giving them information on how to book an initial appointment.