Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People 2014

Version 2

Version Number	Revision date	Summary of Changes	Change By	Changes accepted
1.0	10.07.14	First draft following discussion with PT	SM	
1.1	01.08.14	Amendments from NP	SM	
1.2	28.08.14	References added	SM	
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Approval Process			
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1.   Introduction

Improved emotional health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include:

- improved physical health and life expectancy
- better educational achievement
- increased skills
- reduced health risk behaviours such as smoking and alcohol misuse,
- reduced risk of suicide
- improved employment rates and productivity
- reduced anti-social behaviour and criminality
- higher levels of social interaction and participation

Source - various including Annual Report of the Chief Medical Officer 2012

The emotional health and wellbeing of children and young people is nurtured primarily at home, however everyone delivering children and young people's services (particularly early years and schools) has a role in improving outcomes and reducing inequalities. This includes supporting the public to make healthier, informed choices to improve emotional health and wellbeing and to improve access to services where and when they are needed.

This Analysis of Need has been produced to inform Rotherham's Emotional Wellbeing and Mental Health Strategy for Children and Young People.

2.   National Guidance

This Strategy is informed by a wide range of current guidance the most relevant of which is detailed below.

2.1   National CAMHS Review – 2008

The review made a number of recommendations as follows.

2.2.1. All parents, carers, children and young people throughout the country should have:

- a more positive understanding of mental health and psychological well-being as a result of national media activity
- up-to-date information, in a range of formats, about mental health and psychological well-being and what services are available locally to help them
- good telephone and web-based help and advice
- confidence that staff in the services they use every day:
  - understand child development and mental health
  - actively promote strong mental health and psychological well-being
  - use language that they understand
  - take them seriously

- o can identify needs early
- o can help their child and can draw on support from others to make sure needs are addressed.

2.1.2   Children and young people who need more specialised support, and their parents and carers, should have:

- a high-quality and purposeful assessment, which informs a clear plan of action and which includes, at the appropriate time, arrangements for support when more specialised input is no longer needed
- a lead person to be their main point of contact, making sure other sources of help play their part, and co-ordinating that support
- clearly signposted routes to specialist help and timely access to this, with help available during any wait
- clear information about what to do if things don't go according to plan.

2.1.3   Children and young people and their families who are vulnerable (such as children in care, children with disabilities and children with behavioural, emotional and social difficulties) should be confident that, in addition to the above:

- their mental health needs will be
- assessed alongside all their other needs,
- no matter where the need is initially identified
- an individualised package of care will be available to them so that their personal
- circumstances, and the particular settings in which they receive their primary support
- appropriately influence the care and support they receive

For those experiencing complex, severe and ongoing needs, these packages of care will be commissioned by the Children's Trust and delivered, where possible, in the local area. Effective regional and national commissioning will occur for provision to meet rare needs.

2.1.4.   Young adults who are approaching 18 years of age and who are being supported by CAMHS should, along with their parents and carers:

- know well in advance what the arrangements will be for transfer to adult services of any type, following a planning meeting at least six months before their 18th birthday
- be able to access services that are based on best evidence of what works for young adults, and which have been informed by their views
- have a lead person who makes sure that the transition between services goes smoothly
- know what to do if things are not going according to plan

- have confidence that services will focus on need, rather than age, and will be flexible.

2.2.1. National Service Framework (NSF) for Children, Young People and Maternity Services.

Standard 9 of the NSF specifically deals with '*The Mental Health and Psychological Well-being of Children and Young People*'. This proposed three elements of a 'Vision' as follows:

2.2.1	An improvement in the mental health of all children and young people.
2.2.2	That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.
2.2.3	That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

It also outlined the following standard:

> '*All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families*.'

2.3   National Institute for Health & Care Excellence (NICE)

Various NICE clinical guidance deals with areas of relevance to child and adolescent mental health services provision. An up to date list of guidance is included in Appendix 3.

2.4   No Health without Mental Health (Centre for Mental Health et al. 2012)

The guidance contains the following priorities:

2.4.1	More children and young people will have good mental health.
2.4.2	More children and young people with mental health problems will recover.
2.4.3	More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health.
2.4.4	More children and young people will have a positive experience of care and support.
2.4.5	Fewer children and young people will suffer avoidable harm.
2.4.6	Fewer children and young people and families will experience stigma and discrimination.

2.5   Children & Young People's Health Outcomes Strategy (Lewis & Lenehan, 2007)

The Public Health Group of the Children and Young People's Health Outcomes Forum focused on developing suggestions and recommendations for how the new health system could improve the life chances of children and young people by promoting good health and acting early where problems are developing.

Highlighted within the document are the views of children and young people in relation to health promotion and illness prevention. They found children and young people generally:

- understand that peer pressure and advertising can work against healthy choices;
- need better information and advice about healthy lifestyles;
- believe that too many public health campaigns are aimed at adults;
- connect being healthy with 'things to do' in their area and access to public transport and sports facilities;
- want involvement in the design, development and evaluation of child friendly campaigns and services;
- recognise and value the role of the school in encouraging healthy behaviour;
- recognise there is a place for social media and want a trusted internet source of accurate health information.

For further information visit:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216854/CYP-Public-Health.pdf

2.6   Everyone Counts – Planning for Patients 2014-15 to 2018-19

This planning guidance specifically outlines the need for Parity of Esteem between physical and mental health. It specifically states:

> '*We are absolutely committed to moving towards parity of esteem, making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems'.*

The guidance specifically calls for commissioners to be clear about the resources they are allocating to mental health to achieve parity of esteem and that there is specific identification and support for young people with mental health problems. They should also be clear on plans to reduce the 20 year gap in life expectancy for people with severe mental illness.

2.7   Closing the Gap: Priorities for Essential Change in Mental Health (Department of Health, 2014)

Closing the Gap supports the measures in the national mental health strategy '*No Health without Mental Health*', the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through the following 25 priorities for action.

2.7.1	High quality mental health services with an emphasis on recovery and meeting local need.
2.7.2	An information revolution around mental health.
2.7.3	Waiting time limits for mental health services.
2.7.4	Tackling inequalities in access.
2.7.5	Increasing the uptake of psychological therapies for children and young people.
2.7.6	Extend access to psychological therapies for children and young people.
2.7.7	The most effective services will get the most funding.
2.7.8	More choice.
2.7.9	Reduce all restrictive practices and end the use of high risk restraint.
2.7.10	Friends and family test.
2.7.11	Poor quality services identified sooner and action taken.
2.7.12	Better support and involvement for carers.
2.7.13	Better integration of mental and physical health.
2.7.14	Front-line services respond more effectively to self-harm.
2.7.15	No one in mental health crisis should be refused a service.
2.7.16	Better support for postnatal depression.
2.7.17	Schools supported to identify mental health problems sooner.
2.7.18	End the cliff-edge of lost support at age-18.
2.7.19	People with mental health problems will live healthier and longer lives.
2.7.20	More people will live in homes that support recovery.
2.7.21	A national liaison and diversion service.
2.7.22	Enhanced support to victims of crime.
2.7.23	Support employers to help more people with mental health problems stay in or enter employment.
2.7.24	New approaches to help people with mental health problems move into work and support them when unable to work.
2.7.25	Stamping out discrimination.

2.8 Children and Families Bill 2013

The Government is transforming the system for children and young people with special educational needs and disability (SEND), including those who are disabled, so that services consistently support the best outcomes for them. The Bill will extend the SEND system from birth to 25 years, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met. It takes forward the reform programme set out in '*Support and Aspiration: A new approach to special educational needs and disability* progress and next steps' (Department for Education, 2012) by:

- Replacing statements and learning difficulty assessments with new birth to 25 years Education, Health and Care Plans, extending rights and protections to young people in further education and training and offering families personal budgets so that they have more control over the support they need.
- Improving cooperation between all the services that support children and their families and particularly requiring local authorities and health authorities to work together.
- Requiring local authorities to involve children, young people and parents in reviewing and developing provision for those with special educational needs and to publish a 'local offer' of support.

These changes will clearly impact on the future direction of emotional wellbeing and mental health services for children in Rotherham in a number of key areas:

- Extending the age range to 25 years, which may mean that transition to adult services from children's mental health services becomes even more important.
- Requiring a joint 'Health & Care' plan and the associated co-operation between health and social care services necessary to achieve that.
- Requiring the offering of personal budgets to families.
- Requiring the involvement of children, young people and their families in reviewing and developing service provision and the publication of a 'Local Offer'.

3.   Local Guidance

3.1   Rotherham Health and Wellbeing Board

There are six identified high level priorities for the Health and Wellbeing Board (HWBB):

3.1.1   Prevention and Early Intervention - Rotherham people will get help early to stay healthy and increase their independence.

3.1.2   Expectations and Aspirations - All Rotherham people will have high aspirations for their health and wellbeing and expect good quality. services in their community, tailored to their personal circumstances

3.1.3   Dependence to Independence - Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.

3.1.4   Healthy Lifestyles - People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

3.1.5   Long-term Conditions - Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

3.1.6   Poverty - Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

All these are across the Life Course Framework adapted from the Marmot Life Course.

3.2   Rotherham Director of Public Health's Annual Report

The Director of Public Health's Annual Report (2013-14) recommends the development of a Rotherham Mental Health Strategy which will outline local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems in Rotherham. This strategy will have a lifespan focus and therefore will support the vision of this Emotional Wellbeing & Mental Health Strategy for Children & Young People 2014-19 in supporting good mental health in children, young people and families.

3.3   Children's Plan

RCCG has some key areas of work relating to Children's and Maternity services. These are:

- Implementation of the SEND reforms resulting from the new Children's Act 2014.
- A review of the community midwifery service looking at issues such as choice, accessibility and continuity.
- Production of a Rotherham Maternity Services Strategy and service specification.
- A South Yorkshire and Bassetlaw review of children's continuing care service.
- Continuation of the Care Closer to Home workstream looking at pathways of care for children.
- A review of children's therapy services.

4.   Tiered Approach to Services

A wide range of services play an important role in the promotion and support of children and young people's emotional health and wellbeing. They work together to deliver a four tier model of Child and Adolescent Mental Health Services (CAMHS) as outlined in *Together We Stand* (Health Advisory Service, 1995). This model is illustrated in Figure 2.
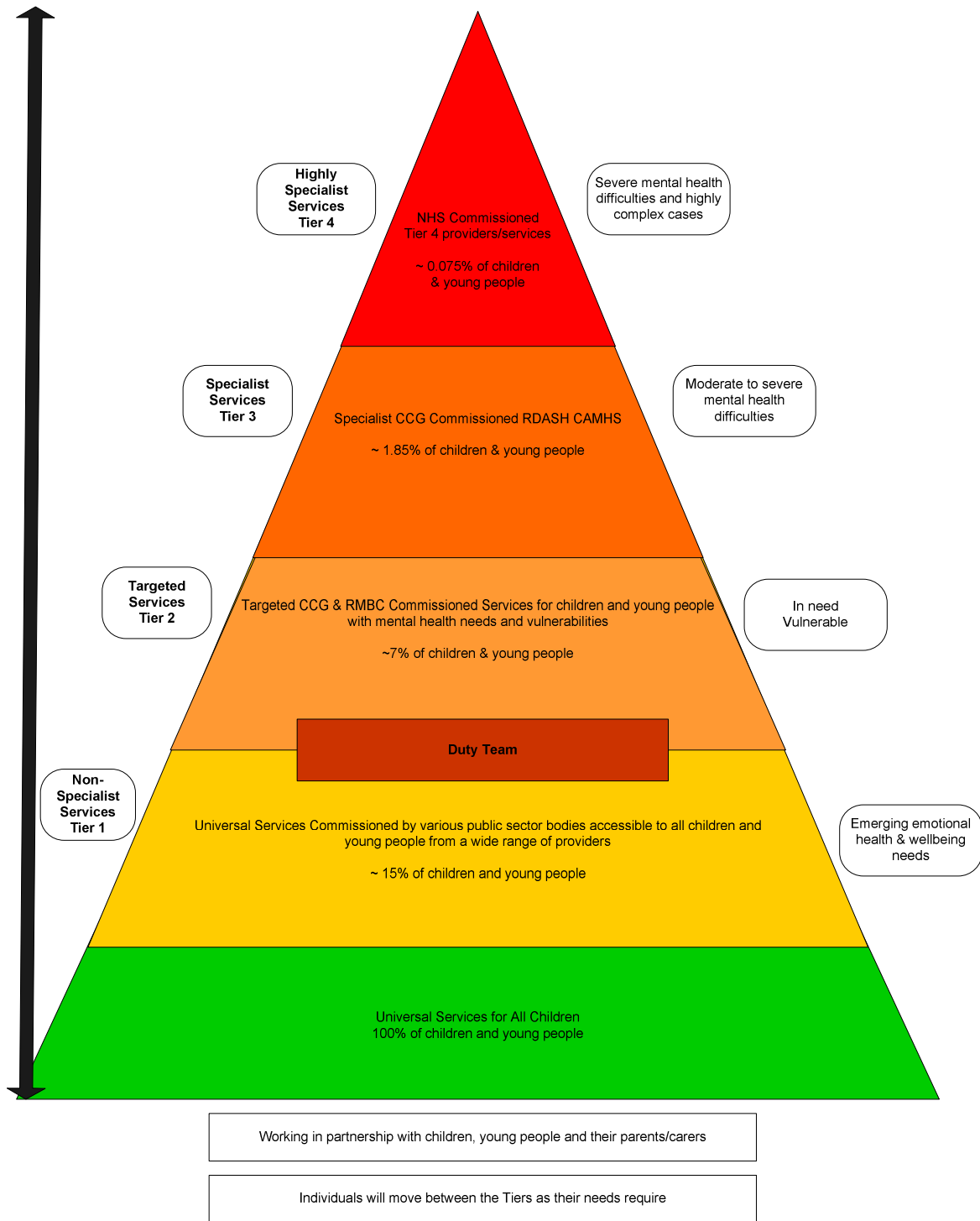
The following is a definition of child and adolescent mental health services:

Child and Adolescent Mental Health Services is commonly used as a broad concept that embraces all those services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. As well as specialist services, this definition also includes universal services whose primary function is not mental health care, such as GPs and schools, and explicitly acknowledges that supporting children and young people with mental health problems is not the responsibility of specialist services alone

Source – http://www.everychildmatters.gov.uk/health/CAMHS/

Figure 2

Comprehensive Child & Adolescent Mental Health Services in Rotherham (CAMHS)

Highly Specialist Services Tier 4

NHS Commissioned Tier 4 providers/services

~ 0.075% of children & young people

Severe mental health difficulties and highly complex cases

Specialist Services Tier 3

Specialist CCG Commissioned RDASH CAMHS

~ 1.85% of children & young people

Moderate to severe mental health difficulties

Targeted Services Tier 2

Targeted CCG & RMBC Commissioned Services for children and young people with mental health needs and vulnerabilities

~7% of children & young people

In need Vulnerable

Duty Team

Non-Specialist Services Tier 1

Universal Services Commissioned by various public sector bodies accessible to all children and young people from a wide range of providers

~ 15% of children and young people

Emerging emotional health & wellbeing needs

Universal Services for All Children
100% of children and young people

Working in partnership with children, young people and their parents/carers

Individuals will move between the Tiers as their needs require

Kurtz Z, 1996.

NB Figures and percentages in each Tier are estimates based on national prevalence numbers

Table 1 shows the different levels of the tiered approach, together with information on the types of service to be found at each level.

Table 1

Tier	Description	Professionals providing the service include but are not limited to	Function/Service
4	Essential tertiary level services such as day services, highly specialised out-patient teams and in-patient units	Services provided by professionals, usually on the basis of a multi-disciplinary team approach • Child and adolescent psychiatrists • Clinical child psychologists • Nurses (community or inpatient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists Family Therapists	• Child and adolescent inpatient units • Secure forensic units • Eating disorder units • Specialist teams (e.g. for sexual abuse) • Specialist teams for neuro–psychiatric problems
3	Specialised services for more severe, complex or persistent disorders such as depression & eating disorders		Services offered by multi-disciplinary teams: • Assessment and treatment • Assessment for referral to T4 • Contributions to the services, consultation and training at T1 and T2
2	Services provided by professionals with training in mental health	Services provided by professionals, usually on a 1:1 basis • RDaSH CAMHS workers eg social workers, therapists, nurses, doctors, psychologists • IYSS Youth Start • Rotherham & Barnsley Mind • Education psychologists	Child and adolescent mental health services professionals should be able to offer: • Training and consultation to other professionals (who might be in T1) • Consultation to professionals and families • Outreach • Assessment • Therapeutic interventions
1	Services provided by a wide range of commissioned and non-commissioned providers	Services provided by professionals, usually on a 1:1 basis • GPs • Midwives • Health visitors • School nurses • Social workers • Teachers & pastoral support • Integrated Youth Support workers • Education psychologists • Paediatricians • Voluntary services	Child and adolescent mental health services at this level are provided by professionals working in universal services who are in a position to: • Identify mental health problems earlier in their development • Offer general advice • Pursue opportunities for mental health promotion and prevention

5.   The Needs of Young People in Rotherham

5.1   Self Reported Emotional Health & Wellbeing

In October 2008 the Department for Children, Schools and Families (DCSF) commissioned the National Foundation for Educational Research (NFER) to develop and deliver the Tellus4 survey. The purpose of this national survey was to gather children and young people's views on their life, their school and their local area. Findings from the survey were used to inform policy development and to measure progress and performance at both a local and national level. The survey represents the views of 253,755 children and young people in school years 6, 8 and 10 in 3,699 schools. Table 2 shows the results from Rotherham compared to England as a whole.

The Rotherham Secondary School Lifestyle Survey is conducted with years 7 and 10. The results from the 2013 survey on how young people think and feel showed the results in Table 3. Responses from both year 7 and year 10 pupils to the questions shown in Table 3 were almost identical.

Table 2   Self Reported Emotional Wellbeing & Mental Health Needs

	Rotherham %	England %	Comparison
Enjoyed good relationships with family and friends	56.4	56.0	√
Children and young people using alcohol	20.0	15.0	X
Children and young people using drugs	2.0	4.0	√
Children and young people smoking	4.0	4.0	=
Reported being bullied	10.5	9.6	X
Consider school deals 'not very well or badly' with bullying	29.0	26.0	X

Source: Respondents from the Tellus4 Survey (2009) sample of school children from years 6, 8 & 10

Key   √ means that Rotherham is better than the national position
         X means that Rotherham is worse than the national position
         = means that Rotherham is equivalent to the national position

Table 3   Rotherham Secondary School Lifestyle Survey

|	2012 %	2013 %	Comparison
Feel good about family and home life	64	62	X
Feel good about friendships	77	74	X
Feel good about the way they look	44	37	X
Feel good about school work	57	44	X

Source: Rotherham Secondary School Lifestyle Surveys 2012 & 2013

Key   X means that the position has worsened from 2012 to 2103

Pupils were then asked about who they felt they would mainly discuss their problems with. The results are shown at Figure 3.

The majority of year 7 and year 10 pupils would speak to either an adult at home (54% of year 7 and 34% of year 10) or a friend (30% and 48% respectively). Around 9% of both year 7 and 10 pupils would talk to their brother or sister about their problems. Only 3% of both year groups would mainly talk to a teacher and only 1% of pupils would approach a youth worker, learning mentor, school nurse or other adult at school about their problems.

Figure 3   CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM – REPORT OF THE PUBLIC HEALTH AND PREVENTION SUB-GROUP
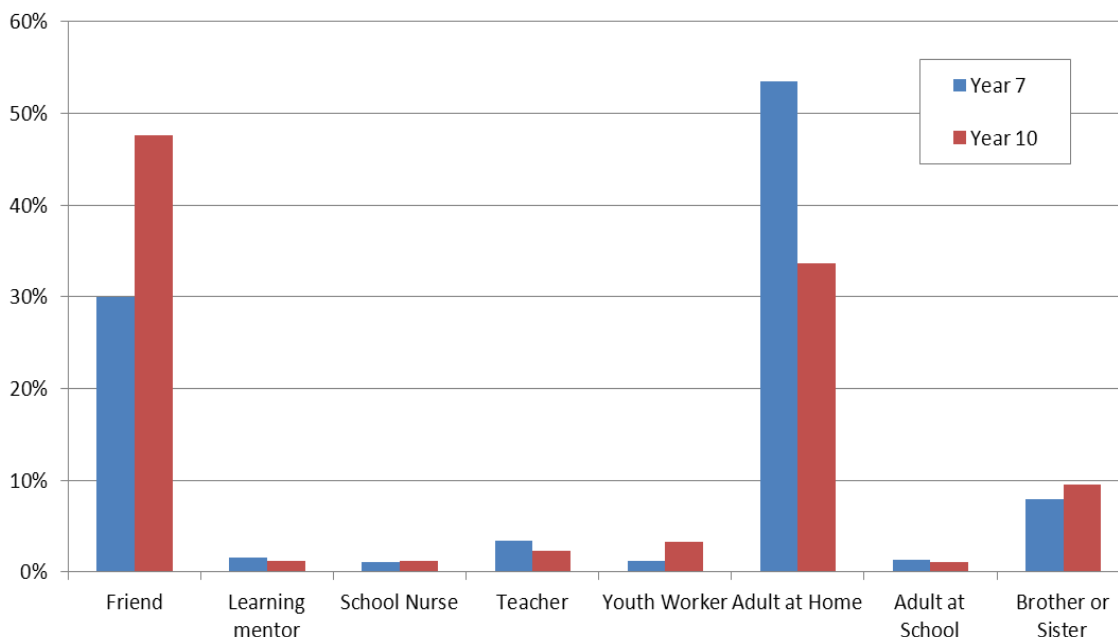
Females in both year groups were more likely to mainly speak to a friend about their problems and males in both year groups were more likely to speak to an adult at home.

Poor mental health for adults, children and young people is associated with poverty, social position, poor housing, other disabilities and trauma such as living in households where there is domestic abuse. Table 4.1, 4.2 and 4.3 highlight some of the measures which would indicate that children and young people who are more at risk of having poorer mental health, showing how Rotherham compares to England as a whole.

Key to Tables

Key √ means that Rotherham is better than the national position
     X means that Rotherham is worse than the national position
     = means that Rotherham is equivalent to the national position

Table 4.1 Wider Determinants of Health / Risk Factors

	Period	Rotherham	England	Comparison
Children living in poverty (all dependent children under 20 years)	2011	22.3%	20.1%	X
Children living in poverty (under 16 years)	2011	2.3%	20.6%	X
16-18 year olds not in employment, education or training	2012	7.4%	5.8%	X
First time entrants to the Youth Justice System (10-17 years) (per 100,000)	2012	435	537	√
Family homelessness (per 1,000 households)	2011/12	0.5	1.7	√
Children in care (per 10,000 under 18years)	2012	68	59	X
Emotional wellbeing of looked after children (4-16 years) (score)	2011/12	15.3	13.8	Not tested

Source: Public Health England

Table 4.2 Health Improvement

	Period	Rotherham	England	Comparison
Excess weight in children (overweight/obese) (4-5 years)	2012/13	22.2	22.2	=
Excess weight in children (overweight/obese) (10-11 years)	2012/13	35.2	33.3	X
Participation in at least 3 hours of sport/PE (5-18 years)	2009/10	48.1	55.1	X
Hospital admissions due to alcohol specific conditions (0-17 years) (per 100,000)	2008-11	42.9	55.8	√
Hospital admissions due to substance misuse (15-24 years) (DSR per 100,000)	2009-12	70.1	69.4	=
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years) (per 100,000)	2012/13	102.3	103.8	=
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years) (per 100,000)	2012/13	117.9	130.7	√

Source: Public Health England

Table 4.3 Levels of Mental Health & Illness

	Period	Rotherham	England	Comparison
Hospital admissions for mental health conditions (0-17 years) (per 100,000)	2011/12	53.5	91.3	√
Hospital admissions as a result of self-harm (0-17 years) (per 100,000)	2011/12	83.8	115.5	√

Source: Public Health England

5.2   Estimated Emotional Health & Wellbeing Prevalence in Rotherham

The cost of poor mental health to the individual child and young person cannot be under-estimated. We know that there are also significant financial costs. For mental health disorders the annual short term costs of emotional, conduct and hyperkinetic disorders among children aged 5-15 years in the UK are estimated to be £1.58billion and the long term costs £2.35billion (Annual Report of the Chief Medical Officer, 2012: *Our Children Deserve Better: Prevention Pays).*

In addition with 75% of adult mental health problems occurring before the age of 18 it is imperative that the burden of disease is monitored regularly (Dunedin Multi-Disciplinary Health & Development Research Unit http://dunedinstudy.otago.ac.nz cited in the Annual Report of the Chief Medical Officer, 2012: *Our Children Deserve Better: Prevention Pays).*

If children and young people do not receive early intervention and adequate treatment for their mental health problems there is a higher likelihood that they will have poorer academic achievements, face higher unemployment, premature morbidity and long term physical and mental health problems (Goodman et al cited in the Annual Report of the Chief Medical Officer, 2012*).*

At any one time, between 10% and 20% of children will have a diagnosable mental health problem severe enough to require child and adolescent mental health services intervention at Tier 1 to 4. Around 10% of children and young people have similar, but more severe, complex or persistent difficulties, these are referred to as "mental health disorders□. The prevalence of mental health disorders has been established by detailed studies, notably the *Mental Health of Children and Young People in Great Britain* (Green et al, 2004) published by the Office for National Statistics (ONS) which built on the work of a previous study in 1999.

5.2.1   Estimates for Rotherham

The prevalence of mental health disorders varies significantly according to a range of socio-economic and demographic factors. Based on the socio-demographic profile of Rotherham summarised in 5 ACORN Categories (CACI 2012), the prevalence of mental health disorders in Rotherham is estimated to be 14% above the UK average. This results from the higher levels of deprivation in Rotherham which is reflected in the higher proportion of children in the ACORN Category "hard pressed" families.

According to the Interim 2011-based population projection for 2013, there are currently 62,300 children and young people living in Rotherham aged 0 -19. Table 5 shows the profile of Rotherham's 0-19 population by age.

Table 5   Rotherham's 0-19 Population

0-4	5-9	10-14	15-19	Total
16,300	15,400	14,900	15,700	62,300

Data from the 2013 annual school census (PLASC) shows that 84.3% of Rotherham's school age population are from a white British background and 15.7% from a black and minority ethnic (BME) background. National prevalence rates show that white and black

groups have the highest rates of mental health disorder whilst Indians have the lowest rate. However, higher levels of deprivation affecting most BME communities in Rotherham mean that their incidence of mental health disorders is likely to be higher that suggested by their ethnicity alone.

Table 6 illustrates the findings of the ONS study 2004 and gives the percentage estimates of disorders within the population. From this, using our population data, the prevalence of mental health disorders across Rotherham's Children and Young People have been estimated.

It is possible to estimate the prevalence of mental health disorders for Rotherham based on national prevalence rates (ONS 2004) for children aged 5-16, adjusted based on prevalence by ACORN Category to take account of socio-economic factors. This assumes that there will be a similar prevalence for 0-19 as for 5-16, which is reasonable given that rates increase with age. It can safely be assumed that children aged 0-4 will have rates below average and young people aged 17-19 will have rates above average, which will largely cancel each other out.

Table 6   **Estimates of Mental Health Disorders in Rotherham Based on National Prevalence Rates**

	5-10		11-16		All
	Boys	**Girls**	**Boys**	**Girls**	**5-16**
Total Number of Children	9,426	8,935	9,270	9,074	36,705
Emotional Disorders	2.2% 240	2.5% 250	4.0% 420	6.1% 630	3.7% 1,540
Conduct Disorders	6.9% 740	2.8% 290	8.1% 860	5.1% 530	5.8% 2,420
Hyperkinetic Disorders	2.7% 290	0.4% 40	2.4% 250	0.4% 40	1.5% 620
Autistic Spectrum Disorder	1.9% 200	0.1% 10	1.0% 110	0.5% 50	0.9% 370
Rare Disorders	0.3% 30	0.3% 30	0.6% 60	0.6% 60	0.4% 180
All Disorders	**10.2%** **960**	**5.1%** **460**	**12.6%** **1,170**	**10.3%** **930**	**9.6%** **3,520**

In Rotherham, there are an estimated 6,800 children and young people aged 0-19 with a diagnosable mental health disorder, 2,600 with an emotional disorder (anxiety and depression), 4,100 with a conduct disorder (eg oppositional defiant disorder), 1,100 with a hyperkinetic disorder, 640 with Autistic Spectrum Disorder and 280 with a rare disorder.

A notable feature of the estimates is the higher incidence of mental health disorders amongst boys, particularly conduct, hyperkinetic and autistic spectrum disorders. The highest rate affecting any sub-group is for conduct disorders which affect 13.7% of boys aged 11-16 from "hard pressed" backgrounds.

5.2.2 Estimates by Child and Adolescent Mental Health Services Tier

A research study by Z Kurtz in 1996 for the Mental Health Foundation entitled *"Treating Children Well"* reported the prevalence of mental health problems appropriate to a response from each child and adolescent mental health services Tier. Estimates of the level of need in Rotherham are shown at Table 7.

Table 7   **Estimated numbers of children & young people aged 0-18 in Rotherham with mental health problems appropriate to a response from child and adolescent mental health services (2013 estimate)**

CAMHS	Summary of Services	Prevalence	Number
Tier 1	Primary Care	15%	8,916
Tier 2	Specialist & community based	7%	4,161
Tier 3	Specialist	1.85%	1,100
Tier 4	Highly specialist	0.075%	45

The 15% of children and young people estimated to have mental health problems appropriate for Tier 1 is higher than the 9.6% estimated to have mental health disorders in the ONS 2004 study. This probably reflects the difficulty in estimating lower levels of need where services are not just responding to known disorders, but also providing wider advice and preventative activity. The implication is that around 5% of children and young people are at risk of developing a mental health condition and would benefit from Tier 1 services, but do not have a diagnosable disorder.

5.2.3 Disability Living Allowance

In Rotherham, 2,490 children and young people aged 0-17 are entitled to Disability Living Allowance (DLA). Of these 488 children are entitled to DLA because of a mental health condition (20%), of which 389 are boys and are 99 girls. This reflects the significant gender differences observed in the prevalence data.

Only about 8% of children and young people with a mental health condition claim DLA as a result, which suggests that only the more severe and complex cases are likely to be eligible. The main mental health conditions for which DLA is claimed by people under 18 are hyperkinetic and behavioural disorders. There are very few cases where emotional disorders result in entitlement to DLA. It should be noted that some children claiming DLA because of a physical disability will also have a secondary mental health condition.

5.2.4 Special Educational Needs

A total of 4,332 children in Rotherham schools have a Special Educational Need (SEN) classified as either statemented or School Action Plus. Of these 829 children have behavioural, emotional or social difficulty and 784 have Autistic Spectrum Disorder (ASD). The numbers of children and young people aged 5-16 predicted to have these conditions is 3,960 and 370 respectively. This indicates that far more Rotherham children have ASD than national prevalence rates would suggest, possibly because ASD diagnosis rates have increased since the 2004 ONS study. About 46% of children (5-16) expected to have mental health disorders are not statemented or subject to School Action Plus.

5.2.5 <u>Bullying & Feelings of Safety</u>

The 2013 Secondary School Lifestyle Survey showed that 38% of Rotherham year 7 and year 10 pupils had been bullied, the same as in 2012. Table 8 shows the prevalence of bullying by type.

Table 8   Types of Bullying in Rotherham

Verbal	90%
Being Ignored	22%
Physical Bullying	21%
Cyber Bullying	22%

29% of year 10 pupils said that they were victims of cyber bullying compared with 19% of year 7 pupils. The results show that the main reasons why pupils are bullied are their weight and the way they look (the same as the 2012 survey). A high percentage of year 7 pupils also said that they were bullied for another reason.

Table 9 shows the number of young people who reported bullying and how many received help and support as a result.

Table 9   Bullied Young People

	2012 %	2013 %	Change %
Bullying Reported	44	28	-16
Received Help & Support	43	26	-17

43% of pupils that took part in the survey had witnessed bullying of others (similar to last year). 5% said that they had been involved in bullying someone else in the last four weeks.

Children and young people were also asked where the felt safe with the results shown at Table 10. Home was felt to be the safest place with 90% of pupils always feeling safe there. Year 7 pupils tend to feel less safe than year 10 pupils which suggests that confidence increases with age.

Table 10   Safe Places

Place	2012 %	2013 %	Change %
School	56	51	-5
Travelling to and from school	34	28	-6
On local buses & trains	21	18	-3
Waiting for local transport	17	14	-3
In local communities	29	27	-2
Rotherham Town Centre	14	12	-2

5.2.6 Suicide & Suicide Prevention

In a 2007 survey of young adults, 6.2% of 16–24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. ((McManus S, et al. 2009).Suicide is the leading cause of death in young people. The Office of National Statistics shows that that numbers of suicides (including undetermined deaths) amongst 16-24 have been on the increase since 2007. We know from research that suicide is rarely the result of a one off factor or factor and that for young people the following increases the risk:

- having an existing mental health problems or behavioural disorders
- misuse substances
- family breakdown
- loss of a family member of friend
- social isolation
- abuse, neglect
- mental health problems or suicide in the family

The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person. In addition young people are not a homogenous group and some of the vulnerable groups listed in 3.3 are at higher risk of suicide, for example looked after children, young offenders and LGBT young people.

There is a growing concern regarding the use of the internet promote suicide and suicide methods and the use of social media in the aftermath of a young person taking their own life. This has been identified as a priority for further research at a national level (Department of Health. Mental Health, Disability and Equality Division 2014).

For young people the protective factors are:

- being loved and feeling secure
- living in a stable home environment
- parental employment
- good parenting
- good parental mental health
- activities and interests
- positive peer relationships
- emotional resilience and positive thinking
- sense of humour.

In Rotherham we are working to improve the support we provide to children who are bereaved as a result of suicide. Research shows that the bereavement due to suicide provokes stronger and longer lasting feelings amongst children and young people (Trickey, 2012). In Rotherham we have introduced a pathway into services/support for children and young person bereaved by suicide this will also act as an alert schools and health professionals.

To date work on suicide prevention includes:

- The development of the Rotherham Community Response plan- Rotherham Multi-agency Guidance for Preventing and Responding to Behaviours which may Indicate Potential Suicide or Self-Harm Clusters, July 2013.
- Rotherham's first suicide prevention conference on 3rd April 2014 to share best practice in relation to suicide prevention and support mangers and frontline staff to understand their role in preventing suicide.
- Launch of the CARE about suicide guidelines for frontline works and the general public
- Provision of information to schools and colleges on suicide prevention including the resource from Samaritans, 'Help when we needed it most'
- Youth Mental Health First Aid Training and roll out of Applied Suicide Intervention Skills Training.

Suicide prevention is not the responsibility of just one sector and requires a multiagency response. Action on suicide prevention for young people needs to include schools, colleges, providers and commissioners of services, police, local media, voluntary sector services, parents, carers and young people themselves.

5.2.7   Self Harm

Self-harm, as defined in the National Institute of Clinical Excellence guidelines (2004), is an:

> *".. an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same." (NICE, 2004)*

Essentially self-harm is any behaviour where the intent is to cause harm to oneself, this includes self-poisoning or self-injury There is sometimes an assumption that self-harm is an attempt at suicide. While an individual episode of self-harm might be an attempt to end life, acts of self-harm are not always connected to attempted suicide. People may harm themselves as a way of coping with overwhelming situations or feelings. For some people, self-harm may actually be a way of preventing suicide. However we do know that people who self-harm are more at risk of suicide than those who do not self-harm.

The estimates for self-harm amongst young people vary and indeed some may be an underestimate because many young people do not disclose that they are self-harming, treating themselves at home and never coming to the attention of services. However, one survey estimates that 1 in 10 young people self-harms at some point in their teenage years (Hawton et al. 2013).

Young people may self-harm for a variety of reasons and these include:

- being bullied at school
- not getting on with parents
- stress and worry around academic performance and examinations
- parental divorce

- bereavement
- unwanted pregnancy
- experience of abuse in earlier childhood (whether sexual, physical, and/or emotional)
- difficulties associated with sexuality
- problems to do with race, culture or religion
- low self-esteem
- feelings of being rejected in their lives

(Brophy, 2006)

In Rotherham the Youth Cabinet are currently looking at this issue and working with providers and commissioners to look at how awareness can be raised and services improved for young people in Rotherham (please refer to 3.5.3).

Rotherham Suicide Prevention and Self Harm Group are looking at developing guidelines for all staff working with children and young people who self-harm.

5.3   Vulnerable Groups

National evidence has identified that there are a number of groups who are considered to be more at risk of developing emotional health problems than others. Children living with Adverse Childhood Experiences (ACE) generally have poorer health outcomes when compared to children with no ACE. The following are examples of ACE:

- low-income households
- families where parents are unemployed
- families where parents have low educational attainment
- looked after by the local authority
- disabilities (including learning disabilities
- black and other ethnic minority groups
- lesbian, gay, bisexual or transgender (LGBT)
- in the criminal justice system
- a parent with a mental health problem
- misusing substances
- refugees or asylum seekers
- gypsy and traveller communities
- being abused
- young carers
- young people accessing pupil referral units
- teenage parents
- non-standard intake to schools, i.e. children and young people who move schools during the academic year

Further information on prevalence rates for these groups is available in Joint Strategic Needs Assessment available at http://www.rotherham.gov.uk/jsna/

Compared to children and young people with no ACE, those with four or more are at greater risk as Table11 shows.

Table 11   Increased Risks for Young People with 4+ ACE

Type of Risk	Increase in Risk
Smoking	3.96 times more likely
Drinking	3.72 times more likely
Incarceration	8.83 times more likely
Obesity	3.02 times more likely

Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. J Public Health (Oxf). 2013 'Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population.' Cited in 2012, Annual Report of the Chief Medical Officer 2012: 2012 Our Children Deserve Better: Prevention Pays .

In addition, children and young people with four or more ACE are more likely to have:

- poor educational outcomes/poor unemployment opportunities
- low mental wellbeing and life satisfaction
- had more recent inpatient hospital care and chronic conditions
- been pregnant unintentionally before age 18

There are targeted resources in Rotherham for some of the ACE groups, for example there are dedicated services for young people misusing substances, young carers, youth offenders and a dedicated LGBT group. In terms of emotional health and wellbeing these services operate at mental health Tier 1 whilst providing a level of counselling and emotional support through assessment and 1:1 working, but do not undertake specific programmes relating to mental health. These services tend to have received training through Rotherham and Barnsley Mind regarding bullying and self-harm and also Mental Health First Aid Training and refer on to IYSS Youth Start and RDaSH CAMHS for mental health interventions.

The Looked After and Adopted Children Children's (LAAC) Support and Therapeutic Team provide a dedicated emotional health and wellbeing service for LAAC, giving emotional, mental health and wellbeing advice and support, as well as providing training, advice and support to foster carers and adoptive parents. The service operates at mental health Tier 2 and provides direct therapeutic work with young people including theraplay, art therapy and family and psychological interventions.

Further equality impact analysis is needed to ensure that children and young people from other vulnerable groups have access to emotional health provision.

5.3.1 The Rowan Centre

As noted above, children and young people accessing pupil referral units (PRU)are at increased risk of developing emotional health problems.

The Rown Centre is a PRU providing KS3 and KS4 education to students unable to attend mainstream school on health grounds (both mental and physical) and school age mothers/pregnant schoolgirls. Education and support is offered to students who have additional needs. The centre provides a small, calm and nurturing setting and works in partnership with parents, carers, schools and a range of agencies including CAMHS.

The Centre offers a range of guidance and support under Tier 1 as well as Thrive assessment and emotional support action plans.

5.4   Parental Wellbeing

'What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.'
(The Marmot Review, 2010)

We know that there are certain risk and protective factors observed within families which determine both the physical, mental, emotional and social development of an infant. Such protective factors include:

- authoritative parenting combined with warmth
- an affectionate bond of attachment being built between the child and the primary caregiver from infancy
- having parents who are educated and in employment
- living in warm, dry homes
- family harmony
- the primary caregiver having psychological resources including self-esteem

Risk factors would include:

- poor attachment
- inconsistent and critical parenting
- poor parental/carer mental health
- family instability, conflict or violence
- marital disharmony/divorce
- large family size/rapid successive births
- absence of father
- very low level of parental education
- drug and alcohol misuse
- primary care givers having learning difficulties

Pregnancy and the first five years of life are one of the most important stages within the life cycle (Shribman, S. and Billigham, K. 2009). Maternal mental health is so important to the development of the mother/child bond that within 10–14 days of birth women should be asked appropriate and sensitive questions to identify depression or other significant mental health problems, such as those recommended by the NICE guidelines on antenatal and postnatal mental health. The Chief Medical Officer's report 2012 recommends that services should ensure that where parents have a mental illness both services and interventions are available which take account of their needs and role as a parent.

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Medical Officer's report 2012 recommends that services should ensure that where parents have a mental illness both services and interventions are available which take account of their needs and role as a parent.

5.4.2 Improving Maternal Mental Health

Maternal Mental Health problems affect 1 in 8 women and are a leading cause of maternal mortality. Psychiatric disorders contribute to 12% of all maternal deaths.

In April 2011 NHS Rotherham implemented a Maternal Mental Health Referral Pathway. This was introduced for three key reasons:

   I.   NICE guidance (Antenatal and Postnatal Mental Health, Clinical Guidance 45) suggests 1 in 8 women will suffer a maternal mental health problems antenatally or postnatally – this equates to more than 500 women per year in Rotherham with young babies and between 500 and 700 pregnant women who currently have no or only a poorly co-ordinated service to support their Mental health.
   II. Suicide is the leading indirect cause of death for women up to a year after childbirth (Lewis, 2007) Rotherham has had 2 maternal suicides in the last ten years.
   III. Maternal mental ill health can produce adverse outcomes for babies and other children, with consequent long-term impacts, particularly for the child's development. There is robust evidence that babies of parents with mental disorder are more likely to suffer from attachment disorders, also cognitive development deficits and increased likelihood of child psychiatric illness. (NSF For Children, Young People and Maternity Services – Standard 11, 2004)

The pathway is multi-agency and was developed to cover mild, moderate and severe maternal mental health issues. It was agreed by all partners including The Rotherham Foundation Trust FT and RDaSH. Training in the pathway was provided to Midwives during March of 2011 as detailed in section 4.1.2.1 below.

5.4.3 Targeted Early Help Services, including Family Nurse Partnership

RMBC offers a range of Early Help services to families according to how their needs are assessed. If a family's needs are deemed to require statutory intervention, a Child's Assessment will be completed by Social Care teams and an appropriate response will be led by Social Care, with regular statutory reviews.

If a family's needs do not require a statutory intervention an alternative assessment will be completed; wherever a multi-agency response is required, this will be the Family Common Assessment Framework (FCAF). The Family CAF captures a families strengths and difficulties under the categories of alcohol, substance misuse, mental health and emotional wellbeing, work and money, adult skills and learning, exploitation, housing, social isolation and engagement with local services, parenting and basic care skills, family relationships, domestic incidents, anti-social behaviour and crime.

A coordinated response will be formulated which may draw from a number of different services. Children's Centres specialise in responding to the needs of families where there is a child who is 0-5 years old, each school will have an individual offer for children who are

5-18 years old, and the Integrated Youth Support Service will provide a specialist response to children who are 10-18 years old.

In addition to these there are some specialist services in place, including the Targeted Family Support (TFS) Team, who will provide high quality whole family support in line with Rotherham's Early Help Strategy. The team use multi-agency methodology to support families with vulnerable and complex needs across the borough, working to the principles of the Family CAF model.

The work undertaken by the TFS Team is evidenced based, with solution focused interventions and plans used. The intervention is time limited to a maximum of 12 months. All referrals completed to the TFS Team must evidence there are prevalent issues with family relationships; mental health and special educational needs within either the parent/carer or child/children. To be eligible for service provision from TFS, parents/carers or the child must live within the Rotherham Learning Community reach area and the referred child or young person must be between 5 and 13 years of age.

The Family Nurse Partnership programme is licensed by the Department of Health and is an evidence based programme that can positively change the life-course of the clients and their children. Family nurses receive specialist training to work with first time pregnant teenagers up to the age of nineteen years with an intensive home visiting programme offered from early ante-natal until the child is two years of age when the child and mother graduate from the programme to Universal Health Visiting Services.

The family nurses work with the young people to encourage good maternal mental and physical health, raise aspirations, improve economic self-sufficiency and promote strong attachment and positive parenting.

A targeted response is also available through the Families for Change work, which identifies a specific cohort of families according to criteria set out in the Troubled Families Financial Framework, published by the Department of Communities and Local Government (2012). The criteria that trigger inclusion in this cohort are poor school attendance, anti-social behaviour or youth crime and adult worklessness. At least two criteria must be met, alongside a local filter of poor parental mental health, adult misuse of drugs or alcohol and domestic abuse. The response to families in this cohort will also be coordinated using the Family CAF. If a specific need is identified, families will be able to access targeted family intervention services, delivered by a range of providers at various levels of intensity. A family intervention approach will ensure that each family has a dedicated worker who leads a coordinated response for the whole family and provides hands-on interventions (including practical tasks) within the family home. The most intensive family intervention service in Rotherham is delivered by the Family Recovery Programme, an in-house service with eight outreach workers.

Families for Change is also piloting family mediation, which focuses on a restorative approach to repairing family communications, and Multi-Systemic Therapy. During the pilot period there will be places for ten families to access Multi-Systemic Therapy. Multi-Systemic Therapy is for families with a young person between the ages of 11 and 17 who is at risk of going into care due to serious anti-social behaviour and / or juvenile offending. MST is an intensive way of working with families and works to support parents/carers and other family members to develop and sustain strategies to improve their child's behaviour at

home, in school and out in the community. MST is delivered over a period of three to six months using a variety of techniques based upon holistic assessment of the child's ecology. Interventions ay focus upon cognitive and or behavioural change, communication skills, parenting skills, family relations, peer relations, school performance and social networks.

5.5   Voice of Children and Young People

The information below details some of the work undertaken by child and adolescent mental health services and partners to ensure that young people have a voice within the service.

5.5.1   RDaSH Consultation with Children and Young People

RDaSH CAMHS has taken an innovative approach to facilitate participation and to maximise the engagement and experience of children and young people within services with the role of Peer Support Workers (PSW). These are people with a lived experience of mental health difficulties who are employed primarily to help navigate the transition process from children and young people's mental health to adult mental health or wider services such as college.

A key element of the PSW role is to support and maximise participation and they work closely with the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) project manager on this agenda. The PSWs have agreed a slogan to underpin our participation agenda '*Your Service, Your Say, Your Way';* designed an associated poster campaign to recruit children, young people and families to engage in service planning and consultation; supported a young person to design a poster to advertise self-referral in our services; and led various consultation events in local colleges and schools which have informed service development.

The RDaSH CAMHS teams commenced self-referral in September 2013 and a feedback audit tool has been developed which will be used to invite feedback from those young people who have accessed the service via self-referral since September 2013 and on an on-going basis to inform service planning and delivery.

The PSWs have devised a project plan for participation underpinned by the '*Ladder of Participation*' (Hart 1992) which will be presented for approval. RDaSH recognises the need to further develop direct consultation and service evaluation with young people and aspire to have a participation strategy that is written by young people.

Two young people have recently been on the interview panel for RDaSH CAMHS clinicians appointed to attend the CYP-IAPT Systemic Family Practice Pathway. An Interview panel training session in April is being advertised for people aged 13 – 19 years.

The CYP-IAPT project manager has supported the PSWs to begin using a sessional feedback measure to capture the young person's on-going experience of working with a PSW. RDaSH CAMHS plan to collate this information to understand how young people's involvement in differing interventions impact on both their experiences and their outcomes.

5.5.2 Youth Start

Youth Start interventions with young people take a client informed approach and each young person is instrumental in designing their own package of individual support.

Young people were recently involved in interviewing for a new counsellor within the service via a young person's interview panel.

5.5.3 Youth Cabinet Manifesto for Self-Harm 2014-15

For 2014-15 Rotherham Youth Cabinet has as a manifesto aim around the issue of self-harm. The Youth Cabinet is examining how services provide support and advice to young people around issues of self-harm. This work is being supported by a small number of Rotherham Councillors who sit on the Council's Scrutiny Committees and Officers from the IYSS, Scrutiny and Public Health.

As part of its evidence gathering, the Youth Cabinet have spoken with their peers in schools and colleges across Rotherham to collect views from a wide range of young people. This evidence has formed the basis of their work and has been used in meetings with representatives of provider agencies, schools/colleges and Council services to discuss current provision and to identify ways in which services to young people can be improved. From this the Youth Cabinet have identified a number of priority areas which they discussed with decision makers, school leaders and commissioners of services with a view to incorporation into service design and delivery.

On completion of this work, the Youth Cabinet will take their report to Cabinet, following which the recommendations will be circulated to partner organisations for action. The initial themes emerging from this work include:

- Consistent, concise and simple messages for ALL organisations
- Clear, consistent referral routes for ALL organisations
- Involve young people to develop user-friendly information/media messages (including new technology/social media)
- Ensure that young people are involved in service design e.g. commissioning of school nurses
- Ensure that advice to young people is available through drop-ins, one-to-one sessions as well as web-based materials
- Improve and standardise the provision of information on self-harm to all schools
- Establish better links between schools and colleges and share best practice (for example work around peer support and strategies to address stress and exam pressure)
- Examine ways in which access to school nurses can be improved
- Availability of resources/training/support for schools, colleges, amongst parents, young people etc.

5.5.4 Chief Medical Officer's Report 2012

The report by the Chief Medical Officer captured the voice of children and young people. The following were recommendations specific to mental health services:

- Managing the transition from children's to adult services has been consistently identified as a problem for young people, in particular for some vulnerable groups such as those with long-term disabilities and mental health problems
- Mental health to be taken as seriously as physical health
- Stigma was highlighted as a key issue for young people with mental health problems, mainly as a barrier to their accessing services and support
- More health promotion campaigns and teaching in schools to counter the stigma associated with mental illness
- Children and young people who use mental health services want a confidential, accessible mental health service, when and where needed and for services to be age appropriate, with flexible opening hours at times that suited them. Preferred referral methods include self-referral and drop-in services available through the internet, mobile phones, text or email.
- Many young people want access to counselling services within their school
- Young people want more support at first presentation, quicker access to help during an emergency, and better out-of-hours and crisis services, with inpatient units that are easier to access.
- Staff who are approachable, available and skilled in engaging and listening to young people. Children and young people valued continuity, confidentiality and support, particularly at transition.
- For young people using mental health services, lack of adequate information is a repeatedly highlighted problem

There were other recommendations from children and young people within this report which relate to the role of schools, school nursing and GPs.

5.6 Voice of Parents and Carers

As part of regular capture of service evaluation, the RDaSH CAMHS service invites parents and carers to complete 'Experience of Service' (ESQ) questionnaires which are collated on a quarterly basis. In the 3 month period of October to December 2013 the feedback shown at Table 12 was received from 25 parents/ carers.

Parents and young people can complete ESQ's at any time throughout the journey in RDaSH CAMHS; forms are available for completion anonymously and posted into a box within the reception area at Kimberworth Place. Parents and young people seen within community settings are also offered questionnaires which can be returned to service anonymously too.

The Parent Carers Forum has been invited to and attended some of the CYP-IAPT steering group for the partnership, which includes Rotherham.

RDaSH CAMHS are equally aware of the need to engage with parents and carers and have agreed that a series of open days across the localities will be hosted with one of the aims being to ask children, young people and parents how they would like to work with the service. Activities on offer during these days include a design a letter competition and the PSWs will host 'stress bucket sessions' where both young people and parents can gain skills.

GIFT is a participation service commissioned by the National CYP-IAPT team and have contacted the Rotherham Parent Carers Forum directly to ask how they would like to be involved in local service delivery. GIFT have asked for our permission to publish our 'Guide to Routine Outcome Measures for Young People and Families' as an example of good practice with the MyAPT's audience of child and adolescent mental health services professionals.

Healthwatch Rotherham are working with parents to gather their experiences of using RDaSH CAMHS to gain insight into the perceived culture of the service. The report will be provided to RDaSH in the summer of 2014 for their comments and feedback prior to the report being provided to parents.

Table 12

Parent/ Carer	Certainly	Partly True	Not True	Don't Know
I feel that the people who have seen my child listened to me	19	5	1	0
It was easy to talk to the people who have seen my child	20	3	2	0
I was treated well by people who have seen my child	21	2	2	0
My views and worries were taken seriously	17	6	1	1
I feel the people here know how to help me	16	6	3	0
I have been given enough explanation about the help available here	15	6	3	1
I feel that the people who have seen my child are working together to help me	14	9	1	1
The facilities here are comfortable (e.g. waiting area)	24	0	0	1
My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)	10	11	4	0
It is quite easy to get to the place where I have my appointments	19	3	3	0
If a friend needed this sort of help, I would suggest to them to come here	19	5	0	1
Overall, the help I received here is good	19	5	1	0

6.   Forthcoming Challenges & Risks

A number of challenges and risks will impact on the CAMHS strategy in the coming years. These include:

- Potentially further reducing budgets, both in Health and Social Care.
- Implementation of the new SEND agenda.
- Future integration of Health and Social care provision.
- The introduction of a different payment system for Mental Health Services.

Appendix 1

Glossary of Terms

ACE	Adverse Childhood Experiences
ASD	Autistic Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black & Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDC	Child Development Centre
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies
CYPS	Children and Young People's Services
DCSF	Department for Children, Schools & Families
DLA	Disability Living Allowance
EHWB	Emotional Health & Wellbeing
EHWBB	Emotional Health & Wellbeing Board
FT	Foundation Trust
GIFT	Great Involvement, Future Thinking
GPs	General Practitioners
IYSS	Integrated Youth Support Service
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LAAC	Looked After & Adopted Children
LGBT	Lesbian, Gay, Bisexual & Transgender
NFER	National Foundation for Educational Research
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NSF	National Service Framework
ONS	Office of National Statistics
PICU	Psychiatric Intensive Care Unit
PSW	Personal Support Worker
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster & South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SEN	Special Education Needs
TaMHS	Targeted Mental Health in Schools
TRFT	The Rotherham Foundation Trust

Appendix 2

References

Brophy, M. (2006) *Truth hurts - Report of the National Inquiry into Self-harm among Young People*, London: Mental Health Foundation & Camelot Foundation. http://www.mentalhealth.org.uk/content/assets/PDF/publications/truth_hurts.pdf

CACI (2012) *ACORN* http://acorn.caci.co.uk/

Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point (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

Davies, S.C. (2013) *Annual report of the Chief Medical Officer 2012: our children deserve better: prevention pays,* London: Department of Health. https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

Department for Children, Schools and Families (2010) *Tellus4 national report.* https://www.gov.uk/government/publications/tellus4-national-report

Department for Education (2012) *Support and aspiration: a new approach to special educational needs and disability - progress and next steps*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/180836/DFE-00046-2012.pdf

Department of Health (2011) *No health without mental health: a cross-government mental health outcomes strategy for people of all age*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health (2012a) *Maternal mental health pathway*. https://www.gov.uk/government/publications/maternal-mental-health-pathway

Department of Health (2012b) *Preventing suicide in England: A cross-government outcomes strategy to save lives.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

Department of Health (2014) *Closing the gap: priorities for essential change in mental health.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Department of Health: Mental Health, Disability and Equality Division (2014). *Preventing suicide in England: One year on first annual report on the cross-government outcomes strategy to save lives.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278119/Annual_Report_FINAL_revised.pdf

Digital First http://digital.innovation.nhs.uk/pg/dashboard

Goodman, A., Joyce, R., Smith, J.P. (2011) *The long shadow cast by childhood physical and mental health problems on adult life*. Proc Natl Acad Sci, 108(15), pp. 6032-6037.

Green, H., McGinnity, A., Meltzer, H., Ford, T. (2005) *Mental health of children and young people in Great Britain, 2004,* Palgrave Macmillan http://www.hscic.gov.uk/pubs/mentalhealth04

Hart, R. (1992) *Children's participation from tokenism to citizenship,* Florence: UNICEF Innocenti Research Centre. http://www.unicef-irc.org/publications/pdf/childrens_participation.pdf

Hawton, K., and Rodham, K., and Evans, E., Samaritans; University of Oxford. Centre for Suicide Research (2003) *Youth and self harm: perspectives. A report,* Oxford, Samaritans.

Health Advisory Service (1995) *Together we stand.*

Kurtz, Z. (1996) *Treating children well: A guide to using the evidence base in commissioning and managing mental health services for children and young people,* London: Mental Health Foundation.

Lewis, G (ed.) (2007) *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer- 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom,* London: CEMACH. http://www.oaa-anaes.ac.uk/assets/_managed/editor/File/Reports/2003-2005_saving_mothers_full_report.pdf

Lewis, I. & Lenehan, C. (2012*) Children and young people's health outcomes strategy: Report of the Children and Young People's Health Outcomes Forum.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216852/CYP-report.pdf

The Marmot Review Team (2010) *Fair society, healthy lives (The Marmot Review).* http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

McManus, S., Meltzer, S., Brugha, T., Bebbington, P., Jenkins, R. (2009) *Adult psychiatric morbidity in England, 2007*, Leeds: The NHS Information Centre for health and social care. http://www.hscic.gov.uk/pubs/psychiatricmorbidity07

National Institute for Clinical Excellence (2004) *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* http://www.nice.org.uk/guidance/CG16

National Institute for Health and Care Excellence (2014) *Antenatal and postnatal mental health.* http://www.nice.org.uk/guidance/indevelopment/GID-CGWave0598

NHS England (2013) *Everyone counts – planning for patients 2014-15 to 2018-19.* http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

NHS England (2014) *Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report.* http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf

NHS Rotherham (2011) *Maternal Mental Health Referral Pathway*.

NHS Rotherham & Rotherham Metropolitan Borough Council (2012) *Rotherham borough joint health and wellbeing strategy* http://www.rotherham.gov.uk/info/200048/health_and_wellbeing/812/health_and_wellbeing_board/5

Radford, J. (2013) *Rotherham Director of Public Health annual report (2013-14)*, Rotherham: Rotherham Metropolitan Borough Council.

Rotherham Clinical Commissioning Group (2013a) *Top Tips for children and young people's emotional wellbeing issues.*

Rotherham Clinical Commissioning Group (2013b) *Your life, your health. Annual commissioning plan 2013/14.* http://www.rotherhamccg.nhs.uk/Downloads/Publications/RCCG%20Annual%20Commissioning%20Plan%202013%2014.pdf

Rotherham Health and Wellbeing Board (2014) *Rotherham joint strategic needs assessment.*
http://www.rotherham.gov.uk/jsna/

Rotherham Metropolitan Borough Council & NHS Rotherham (2012) *Rotherham Borough joint health and wellbeing strategy 2012-15.*
http://www.rotherham.gov.uk/downloads/file/1163/rotherham_borough_joint_health_and_wellbeing_strategy_2012-15[1].pdf

Rotherham Metropolitan Borough Council (2013a) *The Rotherham secondary school lifestyle survey.*
http://moderngov.rotherham.gov.uk/documents/s90949/Final%20Lifestyle%20Survey%202013%20Borough%20Wide%20Report.pdf

Rotherham Metropolitan Borough Council (2013b) *Youth Cabinet Manifesto 2013 -14.*
https://public.rgfl.org/youthcabinet/Documents/Rotherham%20Youth%20Cabinet%20Manifesto%202013-14.pdf

Rotherham Metropolitan Borough Council (2014a) *CARE about suicide.*
http://www.cypfconsortium.org.uk/UserFiles/File/CARE_about_suicide_guidelines.pdf

Rotherham Metropolitan Borough Council (2014b) *Children and young people's commissioning strategy 2013-2016.*
http://www.rotherham.gov.uk/info/200017/children_and_family_care/779/see_how_we_plan_and_pay_for_childrens_services

Rotherham Metropolitan Borough Council (2014c) *Rotherham safeguarding children and families procedures manual: Chapter 2.1.4 Families for Change (FfC).*
http://rotherhamcsyp.proceduresonline.com/chapters/p_fam_f_chan.html

Rotherham Parent Carer's Forum. *Guide to routine outcome measures for young people and families.*

Rotherham Safeguarding Children Board (2013) *Rotherham Local Safeguarding Children Board manual: Chapter 6.3. Rotherham community response plan- rotherham multi-agency guidance for preventing and responding to behaviours which may indicate potential suicide or self harm clusters.*
http://rotherhamscb.proceduresonline.com/chapters/g_multi_age_prev_self_harm.html

Rotherham Safeguarding Children Board. *Family common assessment framework (FCAF).*
http://www.rotherham.gov.uk/safeguarding/caf

Shribman, S. and Billigham, K. (2009) *Healthy Child Programme: Pregnancy and the first five years.* London: Department of Health.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Trickey, D. (2012). *Young people bereaved by suicide: what hinders and what helps*. Saunderton: Child Bereavement UK
http://www.childbereavement.org.uk/Portals/0/Support%20and%20Information/Information%20Sheets/Young%20People%20Bereaved%20By%20Suicide.pdf

Appendix 3

NICE guidance

The National Institute for Health and Care Excellence has produced evidence based clinical guidance for England and Wales on a number of topics with relevance to CAMHS practice.

The following list is correct as of September 2013.

Eating disorders (CG9)
Self-harm (CG16)
Anxiety (CG22)
Violence (CG25)
Post-traumatic stress disorder (PTSD) (CG26)
Depression in children and young people (CG28)
Obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
Bipolar disorder (CG38)
Antenatal and postnatal mental health (CG45)
Drug misuse: psychosocial interventions (CG51)
Chronic fatigue syndrome/myalgic encephalomyelitis (CG53)
Attention-deficit hyperactivity disorder (ADHD) (CG72)
Antisocial personality disorder (CG77)
Borderline personality disorder (BPD) (CG78)
Schizophrenia (update) (CG82)
When to suspect child maltreatment (CG89)
Depression with a chronic physical health problem (CG91)
Nocturnal enuresis – the management of bedwetting in children and young people (CG111)
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (CG113)
Alcohol dependence and harmful alcohol use (CG115)
Psychosis with coexisting substance misuse (CG120)
Autism in children and young people (CG128)
Self-harm (longer-term management) (CG133)
Conduct disorders in children and young people (CG158)
Social anxiety disorder (CG159)
Four commonly used methods to increase physical activity (PH2)
Interventions to reduce substance misuse among vulnerable young people (PH4)
School-based interventions on alcohol (PH7)
Physical activity and the environment (PH8)
Maternal and child nutrition (PH11)
Social and emotional well-being in primary education (PH12)
Social and emotional well-being in secondary education (PH20)
School-based interventions to prevent smoking (PH23)
Alcohol-use disorders: preventing harmful drinking (PH24)
Health and well-being of looked after children and young people (QS31)
Insomnia – newer hypnotic drugs (TA77)
Attention-deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) (TA98)
Structural neuroimaging in first-episode psychosis (TA136)
Domestic violence and abuse – identification and prevention (in progress)