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East Sussex
County Council

East Sussex Child and Adolescent Mental Health Services (CAMHS)

Needs Assessment

Amendment and Update to ASD information 2016

East Sussex Public Health Department

Contents

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Date: June 2014
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Executive Summary

INTRODUCTION

This report provides an updated assessment of the characteristics and needs, and the likely numbers (prevalence) of children and young people vulnerable to mental health problems within the county. It maps the array of services currently offered to children, young people and their parents and carers to address these needs. The focus is all tiers of service from universal provision to Tier 4 specialist provision, looking in depth particularly at targeted and specialist CAMHS and the interfaces between services. Specific areas of inquiry included the following: an overview of the epidemiological need in East Sussex, service provision across comprehensive CAMHS, and a particular focus on a range of groups of children and young people thought to be vulnerable or at 'high risk' of mental health problems. The needs assessment has been developed to inform joint commissioning arrangements.

WHAT IS CAMHS?

Child and adolescent mental health services are defined as[1]: ***'any service provision whose aim is to meet the mental health and emotional wellbeing of children and young people. A distinction can be drawn between CAMHS in its broadest sense… (such as education or primary care services,) and "specialist CAMHS"…. In neither the broader nor the narrower usage does the term "CAMHS" imply any one particular form of service organisation'***

CAMHS deliver services in line with a four-tier strategic framework[2]:

- **Tier 1 Universal services**: early identification and prevention (GPs, HVs, teachers).
- **Tier 2 Targeted services/provision**: Provision for those with specific identified needs and/or are considered to be vulnerable. This involves low intensity of intervention and can be delivered through the universal settings but with provision aimed at identified groups. Specialist mental health workers may input.
- **Tier 3 (Specialist CAMHS)**: Multi-disciplinary team, child psychiatry out patient, specialized mental health working.
- **Tier 4 (Specialist CAMHS)**: Highly specialised services such as in-patient units or intensive outreach services for those with the most severe problems.

THE NATIONAL PICTURE

In the UK it has been estimated that 11% of boys and 8% of girls aged 5 to 15 have a clinically significant mental health problem, with 50% of lifetime cases of diagnosable mental illness beginning by age 14. Of those diagnosed with a mental disorder, 1 in 5 (1.9% of all children) have more than one category of mental disorder (co-morbidity). Nationally evidence indicates that self harm and eating disorders in particular are on the rise.

While any child can experience mental health problems, life events and circumstances mean that some children and young people are more vulnerable than others. There is a growing evidence base for the relative risks of different factors and their proportionality. Key risk factors include) living at the lowest income level, homelessness, being a young offender and being a looked after child. Children and young people with a mental health issue are also more likely to be absent or excluded from school, not be in education, employment or training (NEET), and be at increased risk of self harm or suicide.

THE LOCAL PICTURE

In East Sussex, 22% of the population is under 19, compared to South East (24%) and England (24%), with the local 0-19 population declining slightly faster than nationally and regionally since 2003. The number of 0-19 year olds is expected to decrease by 4% (5,000 young people) by 2027 however there is variation between different age groups.

Extrapolation from national prevalence ratios indicates an estimated prevalence of diagnosable mental disorders in East Sussex of 13,400 children and young people. This breaks down into: 2,000 5-16 year olds with Conduct Disorder, 300 with Hyperkinetic Disorder, 2,150 with Emotional Disorder, 1,100 with Co-morbid Disorder, 4,450 2-5 year olds with some form of mental health disorder and 3,400 16-19 year olds with Neurotic Disorder.

It is important to note that there are a much larger number of children and young people who have mental health or psychological problems, which may be less clearly defined. There are an estimated 25,000 children and young people needing support across all four tiers of CAMHS:

- Universal Services: 15,700
- Tier 2 Services: 7,330
- Tier 3 Specialist Services: 1,940
- Tier 4 Specialist Services: 80

There are indications of increased risk of mental health issues in the younger population:

- Approximately one third of households in East Sussex have less than 60% average income (approx. 3x more likely to have mental health issues)
- The county has highest rates of exclusion and absence amongst statistical neighbours (approx. 17x more likely for those with mental health issues) but rates are decreasing
- The rate of young people who are NEET is similar to nationally but there has been a 4% rise in those with emotional or behavioural difficulties (approx. a third of NEET young people have mental health issues)
- A consistent increase in hospital admission for self-harm
- A greater prevalence of emotional and physical bullying than nationally
- And a two third increase of self-reported unhappiness in 14-15 year olds.

There are fewer low birth weight babies than nationally or regionally, lower rates of youth offending, and a falling number of Looked After Children, with the exception of under 1's, all of which are known risk factors for mental health issues. There are other cohorts known to be at increased risk of mental health issues and for whom there is little local information on their emotional and mental health needs. For example, young care-leavers, LGBT young people, homeless young people and Black and Minority Ethnic young people.

UNIVERSAL AND TARGETED SERVICES IN EAST SUSSEX

Treatment of mental health problems and disorders occur in a range of settings including: primary care, community mental health clinics, paediatric clinics, schools and youth services and voluntary services. Evidence suggests that some of these services have seen an increase in numbers using their service in recent years. For example, the Flexible Learning Educational Support Service (FLESS) has received a third more referrals over the last year and the anti-bullying service a 132% increase in contacts. There are also indications of increased service use particularly for issues of emotional wellbeing, with noticeable rises in Primary Mental Health Worker consultations regarding depression and low mood, over half the caseload of the Targeted Youth Service (TYS) relating to initial referrals for emotional wellbeing, a quarter of the Youth Offending Service caseload having emotional or mental health issues, a growing trend within the service, and there has been a year on year increase in families using the

multidisciplinary autism support groups. This increasing prevalence of behavioural and emotional problems does not appear to be supported by an increase in targeted provision for this level of need.

In addition to indicating growing need amongst universal (tier 1) and targeted (tier 2) services, a number of assets have also been highlighted. For example, the THRIVE early help offer has increased targeted preventative family support and reduced referrals to child social care; since the inception of Targeted Youth Support the number of Children In Need open to social care youth support teams has decreased by 13%; the whole family approach of services such as Keyworkers and the SWIFT service provides holistic, contextualised support which improves the resilience of both the young person and their family; East Sussex anti-bullying services are being used to inform the development of national tools; and 12 schools and services in East Sussex have achieved Autism Accreditation, a mark of national excellence.

SPECIALIST CAMH SERVICES

There are three multi-disciplinary Tier 3 locality teams: Hastings and Rother, Eastbourne & Hailsham and Ouse Valley & High Weald. There are also smaller teams working with targeted groups: Looked after children mental health services (LACMHS); Learning disability and family intensive support service (CAMHSLD/FISS); Psychologists within the Youth Offending Team (YOT). The total spend on Child and Adolescent Mental Health services in East Sussex is £5,410,529. The vast majority (89%) referrals to specialist CAMHS come from GPs in 2012/13. Both LACMHS and the Community Eating Disorder service have seen a rise in referrals, despite an overall decrease in looked after children in East Sussex. There are higher referrals to Tier 4 services than national estimates suggest, and the national shortage of beds is reflected locally. There is a low rate of hospital admission for child mental health issues, although there has been a 68% increase in admissions for self harm over the last decade. The most common presenting primary diagnoses for specialist CAMHS in East Sussex are hyperkinetic disorders, emotional disorders, conduct disorders and eating disorders.

SERVICE USER VOICE

Service users and their families are positive about specialist CAMHS in the main but want more involvement in care decisions. The role of the keyworker is particularly highly regarded for the in-depth knowledge of the child and their needs, and as single point of contact for parents and services, creating more efficient communication and less duplication. The clinic rooms could be improved by being warmer and brighter, with more age appropriate facilities.

Children and their families feel isolated due to the difficult nature of mental health problems, and find peer support and socialisation opportunities particularly important, as well as the need for increased awareness and prioritisation of emotional and mental health in schools. The school nursing service is valued by parents and carers but they feel there needs to be increased resource and emphasis on emotional and mental health within the service.

Young people and their families want improved transition to adult services and note a lack of support to bridge the gap between child and adult support services. The notion of transition “buddies”, young adult mentors who have been through transition and can support those currently going through have been suggested as a potential improvement to the pathway.

PROVIDER VOICE

The consultation highlighted a lack of understanding and confusion of the strategic framework for organising and managing CAMHS both now and in the future. Work already undertaken to

develop multi-agency partnership working was recognised, but there is a strong belief that there are still improvements to be made to these working methods in wider services, including a stronger consultation and advice role to be provided by Specialist services. Providers and GPs particularly value the co-location of specialist mental health workers and the role of a single care co-ordinator. A second fundamental element of East Sussex's approach to developing and delivering CAMHS in provider/GP opinion is the investment in early identification, prevention and intervention, and in Tier 2 services in particular to deliver mental health support before a state of crisis is reached, and to address the rising numbers of young people presenting with lower level/behavioural needs.

The practicalities of a structured and sustainable development of a skill base and support system was also a strong theme of the consultation, with capacity for emotional and mental health support needing to be built across all services, both in knowledge and skills and in provision. Twilight training is very highly valued but more in-depth courses are required to support the rising complexity of behavioural needs, particularly for school staff and nurses, and for staff in Tier 2 services. School nurses are perceived to be under-resourced with links between education and CAMHS needing to be strengthened to enable earlier intervention and prevention of escalation of mental health issues. Information sharing between specialist CAMHS and wider services is felt to have deteriorated and a more structured, sustainable and timely system of multi-agency communication needed. The CAMHS consultation line is seen as essential but provision does not meet demand and longer consultation hours are wanted.

A strong message from providers is that there is large unmet need for those not meeting the criteria for Tier 3 CAMHS support, such as children and young people with high functioning ASD, ADHD, anxiety, or self-harm. These issues are increasing and lower level tier one and two support is felt to be highly insufficient to meet need. Providers feel better utilisation could be made of services such as school nurses and the community and voluntary sector. A holistic system of support is needed to address the whole spectrum of needs. This would ideally incorporate a broader embedding of the whole family approach across all systems to support parents to develop coping mechanisms, and strengthen the young person's support system.

The final theme of the consultation was accessibility of mental health support. Providers are unclear about the overall structure of the CAMHS system and routes of access. There is a lack of understanding, transparency and communication around CAMHS eligibility criteria generally, and specifically in relation to the differing criteria between adult and child services. This makes continuity of care difficult. Referral criteria and pathways for all services working with young people with mental health issues need to be collated and made widely available.

ALL TIER CAMH SERVICE DESIGN AND DELIVERY

Inconsistency of data collection across services and the constantly changing needs of the local population have made it difficult to identify current prevalence of mental health issues in children and young people. Therefore, national estimates have been used to estimate local prevalence to enhance the available local information. The needs assessment has also highlighted that improvements are needed in promoting understanding and acceptance of emotional and mental health issues within the wider community. Consultation with providers and GPs in particular indicated widespread confusion of thresholds and referral criteria across all mental health services and a lack of effective communication between specialist mental health services and Tier 1 and 2 services. Services are working particularly well to meet need where there is good access to mental health specialists, structured multi-agency joint working, and where there is a focus on outcomes.

RECOMMENDATIONS

The following recommendations are based on the evidence within this needs assessment.

1. **The strategic vision for CAMH services in East Sussex needs to be clarified. In order to meet the mental health needs of children and young people now and into the future, a holistic CAMH service requires effective multi-agency working, an emphasis on early intervention and further development of the whole family approach.**

2. **Strengthen provision of universal services to reflect the increasing volumes and complexity of low level emotional, behavioural and mental health needs within the general population.**
   - Early recognition of emotional and mental health issues
   - Developing parenting skills and promoting whole family resilience
   - Building capacity within the universal workforce.
   - Mental health and wellbeing promotion for the whole population

3. **Ensure the workforce has the knowledge and skills to meet the emotional and mental health needs of children and young people across all tiers.**
   - **TIER 1** - Provide more training to promote early recognition and appropriate referral
     - Build capacity through new partnership working with the voluntary sector
   - **TIER 2** - Provide a consultation and advice role to lower Tier providers, specifically specialist advice and support to schools
     - More co-location of mental health specialists into wider services to create a more holistic model of provision and foster greater links to Tier 3 CAMHS
   - **TIER 3** - Extend the opening hours of the CAMHS consultation line
     - Provide a consultation and advice role to lower Tier providers
   - **TIER 4** - The further development of multi-agency, multi-disciplinary pathways
     - Pathways and protocols in place
     - Access to website information provided by services

4. **Develop a multi-disciplinary framework enabling a common set of data to be collected about individuals accessing all tiers of mental health services which can be regularly reviewed to better align provision to changing service trends and populations at risk. To include:**
   - Implementation of a multi-disciplinary framework for CAMHS across all agencies
   - Development of clearer pathways
   - Clarity around thresholds/eligibility criteria

5. **Improve transition from children's to adult services.**
   - Development of clearer pathways
   - Clarity around thresholds/eligibility criteria
   - Better alignment of ways of working to bridge the cultural gap between being supported as a young person and being supported as an adult.

6. **Further work is required to fully understand and better meet the emotional and mental health needs of service users.**
   - Young people accessing Tier 1 and 2 services regarding their experiences.
   - Specific high risk groups of mental health issues for whom there is currently little local information about their emotional or mental health needs: Care leavers, LGBT young people, BME young people and Homeless young people

1. Introduction and Background

> ***"By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does."***
> No Health Without Mental Health: A cross-government strategy (2011)

Definition of Child and Adolescent Mental Health Services (CAMHS)

The Department of Health tasked the External Working Group (EWG) for Mental Health and Psychological Wellbeing of the Children's NSF5 to propose a uniform definition of CAMHS. They define it as:

> ***'any service provision whose aim is to meet the mental health and emotional wellbeing of children and young people. A distinction can be drawn between CAMHS in its broadest sense…(such as education or primary care services,) and "specialist CAMHS"…. In neither the broader nor the narrower usage does the term "CAMHS" imply any one particular form of service organisation'***

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework which is now widely accepted as the basis for planning, commissioning and delivering services.

CAMHS should cover the provision of services and interventions ranging from health promotion and primary prevention, through to very specialist care, as outlined in the four tier strategic framework adopted in the Children's National Service Framework:

Table 1: The Four Tiers of CAMHS

TIER 1 CAMHS	Provided by professionals whose main role is not in mental health, such as GPs, health visitors, paediatricians, social workers, teachers, youth workers and juvenile justice workers
TIER 2 CAMHS	Provided by specialist trained mental health professionals, working primarily on their own, rather than in a team, but potentially providing specialist input to multiagency teams. Tier 2 provides for young people with a variety of mental health problems that have not responded to Tier 1 interventions and also consists of practitioners and services from specialist CAMHS that provide initial contacts and assessments of children and young people and their families.
TIER 3 CAMHS	More specialised services provided by Multidisciplinary Teams (MDTs) or by teams assembled for a specific purpose based on the complexity and severity of needs or particular combinations of co-morbidity found on specialist assessment.
TIER 4 CAMHS	Highly specialised services in residential, day patient or outpatient settings for children and adolescents with severe and/or complex problems requiring a combination or intensity of interventions that cannot be provided by Tier 3 CAMHS. Tier 4 services are usually commissioned on a sub-regional, regional or supraregional basis. They include day care and residential facilities provided by sectors other than the NHS such as residential schools, and very specialised residential social care settings including specialised therapeutic foster care.

Source: DH NSFC. Child and Adolescent Mental Health, 2010

While most children with mental health problems will be seen at Tiers 1 and 2, it is important to note that neither services nor people fall neatly into tiers, for example, many practitioners work in both Tier 2 and Tier 3 services. Similarly, a child or young person may not move through the tiers as their condition is recognised as more complex, as some will require services from a number of the tiers at the same time. The model is not intended as a template that must be applied rigidly, but rather as a conceptual framework for ensuring that a comprehensive range of services is commissioned and available to meet all the mental health needs of children and young people in an area, with clear referral routes between tiers.

METHODOLOGY

The agreed objectives of this needs assessment were to provide an overview of:

- The epidemiological need in East Sussex;
- Service provision in East Sussex;
- Provider views regarding current provision;
- GP views regarding current provision.

This includes analyses of the available local evidence, combined with nationally published statistics and research materials. The needs assessment looks at East Sussex intelligence on prevalence, trends and provision. Information from a number of agencies and organisations has helped build a picture of this population and provided the evidence to identify current and future levels of need.

As agreed in the scoping process for this needs assessment, it does not include service funding information or any new consultation or engagement with service users/families. The needs assessment will has the following structure:

- **Chapter 1** introduces CAMHS and the national context of child mental health issues.
- **Chapter 2** looks at the national policy context and national policy levers before describing the local policy context and approach to support for child and adolescent mental health problems, and giving an overview of the best national evidence for the delivery of CAMHS services.
- **Chapter 3** – looks at the mental health of children and young people in East Sussex including epidemiology of the local population and population projections, estimated prevalence of key mental health disorders, estimated number of children at each Tier of CAMHS support and national evidence of estimated cost of child mental health.
- **Chapter 4** – Looks at national evidence of risk factors and groups most vulnerable to mental health issues. Local data on these cohorts is summarised where available and an overview of the impact of mental health issues on children and young people given.
- **Chapter 5** – Looks at Service Provision in East Sussex by Tier. Due to the broad nature of CAMHS provision and agreed scope for this needs assessment, more detail is attributed to the services provided in Tiers 3 and 4. Within Tiers 2 to 4 a service overview is outlined for each service and where available service data is analysed to give an overview of service use.
- **Chapter 6** – looks at views of CAMHS in East Sussex. The views of users, families and carers were obtained from a consultation exercise conducted as part of the re-procurement of school nursing and through routine feedback to specialist CAMHS. The views of providers and GPs were elicited as part of needs assessment through a postal questionnaire, face-to-face interview, telephone interview or email questionnaire.
- **Chapter 7** - The conclusions section outlines the key findings of the needs assessment from which the recommendations of the needs assessment have been drawn.

CONTEXT

Mental health has been defined as: "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[3] Emotional wellbeing has been defined as: "A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment."[4] It is increasingly used alongside mental health, and is often favoured by schools and others whose main contribution is around prevention and health promotion.[5]

According to a study carried out for the Office for National Statistics[6] which is the best available evidence to date:

- 1 in 10 children aged five to fifteen has a clinically significant mental health problem (for boys the rate is 11% and for girls, 8%)
- 5.8% have clinically significant conduct disorders
- 3.7% have clinically significant emotional disorders
- 1.5% have clinically significant hyperkinetic disorders
- 1 in 5 children diagnosed with a mental disorder (1.9% of all children) are diagnosed with more than one category of mental disorder (co-morbidity), making assessment, diagnosis and treatment more complex.

Evidence suggests some groups may be particularly vulnerable to mental health issues:

- Young people who are NEET (not in employment, education or training) are more likely to experience mental health problems than those in education, employment or training.[7]
- Young people with debt, homelessness and benefit problems are more likely to report mental health problems (31%, compared to 9% not reporting mental health problems). [8]
- 62% of young people reporting homelessness also report mental health problems[11]
- 15% of children at the lowest income levels are reported to experience mental health problems compared to 5% at the highest income levels.[9]
- Prevalence increases with age: from 8% of 5-10 year olds to 12% for 11-16 year olds. [12]
- Children and young people with mental health problems are 17 times more likely to be excluded from school and only 55% remain in full time education past the age of 15. Those aged 16-18 are twice as likely to have no qualifications.[10]
- 50% of lifetime cases of diagnosable mental illness begin by age 14. [12]

In addition to all the prevalence data within this document, it should be noted that a greater number of children will have mental health problems that are less severe and more likely to be short-lived, but may nonetheless affect their psychological well-being.

Since April 2013 Clinical Commissioning Groups (CCGs) and East Sussex County Council (ECC) have been responsible for planning, designing and commissioning local health and well-being services on behalf of the East Sussex population. In 2013 East Sussex County Council in partnership with health commissioned a CAMHS Needs Assessment (JSNA) to replace the previous needs assessment completed in 2008. The JSNA will support East Sussex to commission integrated emotional well-being and mental services to address the inequalities in current provision for children and young people. **It should be read in conjunction with the East Sussex 2014 comprehensive needs assessment for children and young people with special educational needs (SEN) or disabilities: HTTP://WWW.EASTSUSSEXJSNA.ORG.UK/JSNASITEASPX/MEDIA/JSNA-MEDIA/DOCUMENTS/COMPREHENSIVENEEDSASSESSMENT/FINAL-SEND-JSNA-JAN-2014.PDF**

2. Policy Context

This chapter of the needs assessment looks at the national and local policy context of child and adolescent mental health support and provision and gives an overview of the best national evidence for the delivery of CAMHS services.

2.1 NATIONAL POLICY CONTEXT

Improving the mental health and emotional wellbeing of children and young people has been high on the national policy agenda over the last decade, and there has been a wealth of policy and guidance, to support this aim, Including:

National Service Framework (NSF) for Children, Young People and Maternity Services. Child and Adolescent Mental Health (CAMHS)[11] National service framework sets clear standards for promoting health and wellbeing of children and young people and providing high quality services which meet their needs. It was developed in partnership with health professionals, patients, carers, health service managers, voluntary agencies and other experts. Standard 9 of the NSF states that: *"All children and young people from birth to their eighteenth birthday, who have mental health problems and disorders, should have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support for them and their families."*

Children and young people in mind.[12] In 2008 CAMHS services were the subject of a national review which reported "significant progress" since 2004, "positive trends" in CAMHS mapping and "numerous examples of approaches that are making a real difference to children and young people of all ages." However issues remained in terms of:

- Access to appropriate support for many vulnerable children and young people;
- Unhelpful service thresholds preventing holistic, flexible and responsive support;
- Inequalities in the level and type of support offered between and within regions;
- Difficulties in the dissemination and understanding of the research evidence about risk and protective factors, and what effective interventions are.

No Health without Mental Health[13] The government's mental health outcomes strategy, published in 2011, outlines six mental health objectives:

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

A major focus is to expand the Improving Access to Psychological Therapies IAPT programme to children and young people[14], an expansion formally launched in October 2011.

No Health without Mental Health: Implementation Framework[15] This framework sets out what local organisations can do to implement No Health without Mental Health, and improve mental health outcomes in their area. It also outlines what work is underway nationally to support this, and how progress will be measured.

Preventing suicide in England: A cross-government outcomes strategy to save lives[16] The 2012 strategy sets out key areas for action; states government department contribution; and brings together knowledge about groups at higher risk, effective interventions and resources to support local action in order to reduce the suicide rate and improve support for those affected by suicide. The strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of society.

Making mental health services more effective and accessible[17] In March 2013 the Government published its policy on making mental health services more effective and accessible. To achieve this, the policy outlines:

- The prioritisation of mental health for NHS England and Public Health England
- Making mental health a new national measure of wellbeing
- Investment in psychological therapies, tackling mental health stigma/discrimination
- Changing the ways in which mental health services are measured as successful
- By 2014, developing a new online guidance and training service on child mental health for teachers, police, health professionals and others working with children.
- Health and Wellbeing Boards duty to reduce health inequalities, (incl. mental health)

Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services[18] The Joint Commissioning Panel for Mental Health (JCP-MH) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, bringing together those with an interest in commissioning for mental health and learning disabilities. The JCP-MH 2013 guidance for commissioners is evidence based best practice to help people to understand what good quality transition services between CAMHS and Adult mental health services look like.

2.2 NATIONAL POLICY LEVERS

NHS Outcomes Framework for 2013/14: This introduces a stronger emphasis on mental health, including a measure relating to psychological therapies to ensure the framework takes into account recovery from common mental health problems (depression and anxiety) as well as the treatment of more severe mental illness. However, the key indicators for mental illness do not include data on children.

Public Health Outcomes Framework for 2013: This includes the following outcomes: Emotional well-being of looked after children; Self-harm (Placeholder); Suicide rate.

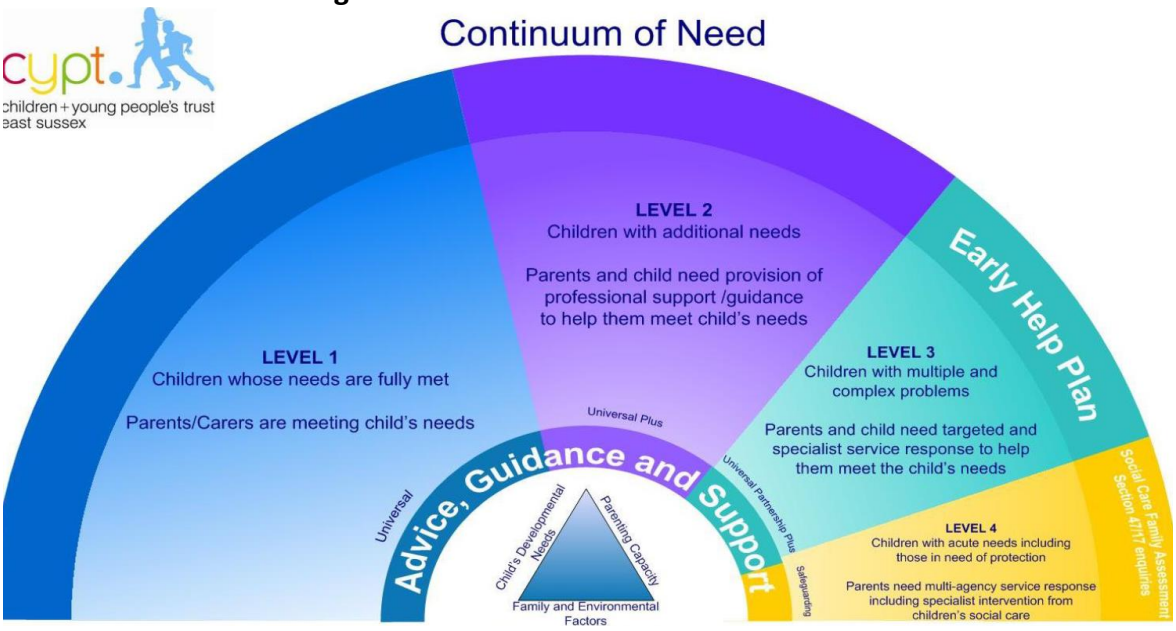
2.3 LOCAL POLICY CONTEXT

The Children and Young People Plan is the overarching strategy of the Children and Young People's Trust for East Sussex. Key outcome priorities to reduce inequalities include: better maternal health; effective and coordinated early intervention; early identification of children with special educational needs (SEN); high quality, specialist mental health services able to both directly address the needs of children and young people with acute and/or complex needs and to support the broader workforce in responding to lower level emotional and mental health needs; more children leading healthy lives, and timely assessments/advice for those in family court proceedings and with fostering/adoption requirements.[19] Key elements of achieving these objectives are the National Care Programme Approach, the East Sussex THRIVE programme and its focus on early intervention, and the holistic Team Around the Family (TAF) approach. A central tool to assessing the needs of children and young people in East Sussex is the Continuum of Need.

2.3.1 East Sussex Continuum of Need

The East Sussex Continuum of Need tools are designed to help with professional discussions. The continuum concept was launched in April 2012 and is made up of two parts: a windscreen tool showing levels of need and the relationship between them (figure 6) and an indicator tool outlining a set of possible descriptors for each level. The continuum is broken down into four levels of need with each level indicating escalating level of need across a wide range of key indicators relating to an individual child young person or their family. Most children and young people are at **Level 1** most of the time meaning that they don't have any additional needs, or their needs are fully met. If they have **Level 2** needs, then extra support can usually be provided by those that already know them (for example school, college, or pre-school, NHS community services such as Health Visiting, or youth activities they attend). For children and young people with **Level 3** needs, targeted Early Help services are provided and **Level 4** describes needs that require Children's Social Care involvement in order to ensure that children are protected from harm. https://czone.eastsussex.gov.uk/continuum. The four levels of the Continuum of need are not aligned to the four Tiers of CAMHS outlined earlier.

Figure 6: East Sussex Continuum of Need



Source: ESCC CYPT

2.3.2 Care Programme Approach (CPA)

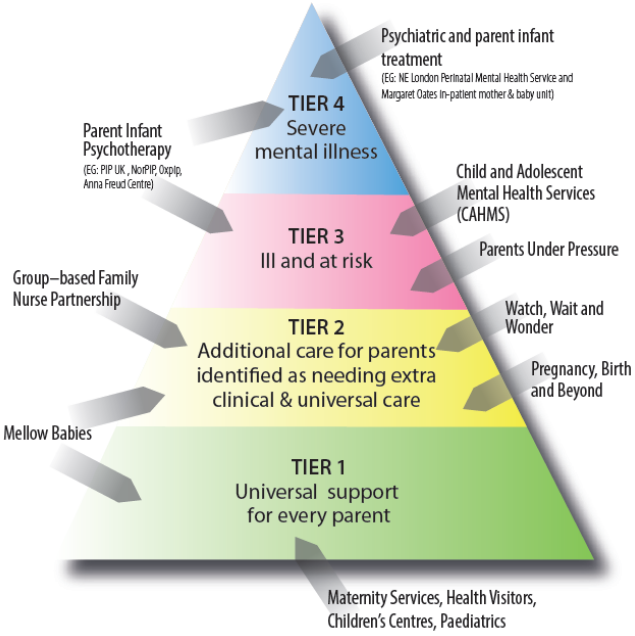
The CPA was introduced by the Department of Health in 1991 as a framework for community care of mentally ill people which requires health and local authorities to ensure the health and social needs of the mentally ill are addressed in a co-ordinated way, and that service users and their carers are involved in all elements of the process. It is applicable to all service users in receipt of secondary mental health services and involves: systematic arrangements to assess needs and risks of people accepted by specialist mental health services; a multi-disciplinary team of GPs, service users and their carers developing a Care Plan which identifies health and social care needs and interventions to meet those needs; nomination of a Care Co-ordinator who will keep in close contact with the service user to implement the Care Plan and monitor its progress; and regular review of progress and delivery of the care plan with the service user.

2.3.3 Early Intervention

Early intervention is 'an intervention which takes place prior to the onset of any difficulties for the individual, in order to prevent, or at least mitigate them and enable the individual to reach

their full health potential'. Interventions can be directed at whole communities, or at individual families and communities at risk.[20] NICE guidance states that services should adopt a life-course approach recognising that disadvantage before birth can have lifelong effects on health and wellbeing, and the social and emotional wellbeing of vulnerable children should be the key focus of both universal and targeted services.[21] National evidence suggests the bond between a baby and care giver affects a baby's emotional and social development,[22] with support for parent's mental health critical across 4 Tiers of provision (Figure 7). Identifying need early is critical to preventing abuse and neglect and improving a baby's emotional and mental wellbeing. To do this a partnership of relevant services must be in place and this requires high quality training in infant mental health and attachment so the health and early year's workforce understands parent-infant relationships and can identify difficulties early.[23]

Figure 7: Tiered Approach to parent-infant services



Source: Chief Medical Officer, Cross Party Manifesto

2.3.3.1 THRIVE: The Early Help Offer in East Sussex

The THRIVE programme in East Sussex is a strategic transformation approach to Early Help that aims to reduce children's safeguarding needs in the county as well as the demand for high cost statutory social care services and referrals, child protection plans and looked after children (LAC). This is achieved by investing in early help services, targeting services towards the most vulnerable families, for example through Family Keyworking, and helping to build resilience and coping strategies so that families can stay together and enjoy better outcomes where it is safe to do so. Where it is not, intervention is instigated as early as possible so as to secure good permanent alternatives for children. Compared to statistical neighbours and South East local authorities, overall rate of referrals, Child protection plans and assessments in East Sussex are high, although the inception of THRIVE has meant significant reductions in each of these.[24] For example, the first year of THRIVE saw a 21% increase in the number of families offered a targeted preventative family support service, a 45% reduction in referrals to child social care and 100 fewer children and young people with Child Protection Plans.[25]

Early help is provided by a number of different agencies and through many settings and services. Some of these services have both a universal and targeted aspect – for example

Health Visiting – and some respond to specific needs at a certain level – for example school behaviour and attendance services. Alongside several more specialist services, ESCC provides or commissions a core offer of holistic, flexible early help services that focus on supporting children, young people and their families, details of which are outlined in more detail in chapter 5 of the report.

2.3.3.2 Team around the family (TAF)

Where a multi-agency response is required, the Team around the family (TAF) is a partnership process which brings together relevant practitioners to work with families with children predominantly under the age of five, to plan co-ordinated, holistic support from agencies to address problems via a written support plan clarifying each team member's responsibilities. TAF includes: Health Visitors; Children's Centre Keyworkers; Midwives; School Nurses and Nursery Nurses. The team decide what level of support is appropriate using the Continuum of Need. In 2012/13, the TAF process was piloted in the Bexhill area prior to being rolled out across the county and by September 2013 each of the nine early year's clusters had TAF meetings in place.

2.4 EVIDENCE OF WHAT WORKS

What Good Looks Like **(2011)**[26] considers the available opportunities to improve local commissioning and delivery systems, to achieve better outcomes for children and young people's emotional wellbeing and mental health. The document reviews the whole system, from prevention through to specialist services and recommends good practice to include:

- **Joint commissioning -** Joint commissioning of a mix of provision (a whole system approach to EWMH), and treating specialist CAMHS as one component of the system, interdependent with others. Ensure specialist CAMH service is responsive and supportive of the broader system, providing a clear service offer, yet remaining flexible to changes
- **Strong partnership commissioning -** Strong partnership commissioning with a good joint plan or strategy to guide the commissioning activity now and in the future as the commissioning architecture changes
- **Performance dashboard** - to inform partnership commissioning and service improvements, including:
    - a. CAMHS activity data, such as analysis of referral routes and presenting issues (did not attend (DNA), etc.) to establish access issues and the need for more preventative or 'upstream' service improvements.
    - b. One-off audits, e.g. on safeguarding issues.
    - c. Service user experience, e.g. feedback, outcomes
- **Understanding of Evidence-based, practical approaches -** a good understanding by all staff of approaches to strengthen resilience and promote mental health (MH), particularly in deprived areas and with high risk groups, and staff who are able to easily access a range of training on mental health. Staff resilience is supported, particularly when working with complex, vulnerable families.
- **A range of 'doors' to mental health services -** Access to mental health services to include Common Assessment, Targeted Mental Health in Schools (TaMHS), and Primary Mental Health staff. This is supplemented by easy access to advice, direct from specialist CAMHS. For example, a telephone number for brief guidance from clinicians, to be accessed by GPs, teachers, etc. A Single Point of Access is helpful to improve the co-ordination of pathways. However, this should not be the only point of access.
- **Primary Mental Health Service -** should be easily accessible and consistently provided across the local area, ideally provided by the specialist CAMHS provider and part of the broader CAMHS team, but based out in the community e.g. schools, integrated teams. This

is an extremely effective way of increasing access to mental health services, whilst also increasing skills of the broader workforce. In the future, this service could be jointly commissioned by schools and GPs.

- **Joint pathway development -** for example Autistic Spectrum Disorder or Attention Deficit and Hyperactivity Disorder, is driven through children's trusts/partnerships, integrating educational and clinical approaches and resource allocation to provide streamlined services. Pathways are easily communicated and widely disseminated, including school/GP roles.
- **Service User Participation -** commissioners and senior leads are informed through case studies, user voice, participation and advocacy workers, parents, complaints, and direct contact with service users.
- **Identification of need and approaches to meet needs within schools -** Schools are guided through the range of approaches to strengthening emotional wellbeing and resilience, and CAMHS referral data is analysed to identify schools/areas which may need more support. The best, most cost-effective elements from local TaMHS projects are rolled out in schools
- **Formalisation of relationships/networks -** Specialist CAMHS has highly developed relationships/networks, which enable case-level discussion and co-ordinated planning with key services, such as educational psychology, behaviour support, learning disability services, and paediatricians. This can be formalised so it is not dependent on individuals, and co-location of staff/services also helps.
- **Information on services is communicated coherently** - to CYP, parents and professionals in a variety of media.
- **Children Centres have access to specialist MH guidance and advice -** (e.g. a CAMHS clinician or an Adult Mental Health (AMHS) community mental health worker), to support early years intervention.
- **Guidance from Peri-natal mental health services -** that goes beyond direct provision to mothers who meet clinical criteria, but also offers consultation and guidance to midwives, children's centre staff, and health visitors.

In addition to this, a 2008-11 national evaluation of targeted mental health in schools[27] prioritised primary school mental health work (particularly for behavioural problems) to maximise impact before issues are entrenched. This included further use of evidence based self-help materials for younger ages to ensure no negative impact. For older children (secondary school) improved interagency working, relationships and referral routes between schools and CAMHS are recommended to address behavioural problems. Further review of national evidence[28] recommends school based interventions promoting mental health through teaching skills of positive mental health, balancing universal and targeted approaches, early age intervention and embedding a multi-modal whole school approach over time.

3. MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE IN EAST SUSSEX

Young people's emotional health and wellbeing is important, both for the impact that it has on their present quality of life, and also for the implications it has for their future social and emotional development, academic experience and achievement. Chapter 3 begins to set out the picture of emotional and mental health of children and young people in East Sussex by looking at: demographics of the local population, population projections, estimated prevalence of key mental health disorders, estimated number of children at each Tier of CAMHS support and national evidence of estimated cost of child mental health.

There are 116,691 children (0-19 years) in East Sussex making up 22% of the total population: 5.3% 0-4 years; 5.3% 5-9 years; 5.5% 10-14 years and 5.9% 15-19 years. Wealden has the highest number of children across all age bands (151,029), and Hastings has the lowest number (90,345), followed by Rother (91,088). The Hastings population has the highest percentage of under 5's (6.3%) of all districts and boroughs (Table 2)

Table 2: Population estimates for children and young people aged 0-19, mid 2012

		0-4		5-9		10-14		15-19	
	All Ages	n	%	n	%	n	%	n	%
England	53,493,729	3,393,356	6.3%	3,083,582	5.8%	3,007,871	5.6%	3,286,306	6.1%
South East Region	8,724,737	545,710	6.3%	507,365	5.8%	502,658	5.8%	536,186	6.1%
East Sussex County	531,201	28,141	5.3%	27,906	5.3%	29,430	5.5%	31,214	5.9%
Eastbourne	100,049	5,515	5.5%	5,041	5.0%	5,273	5.3%	6,027	6.0%
Hastings	90,345	5,656	6.3%	4,937	5.5%	5,028	5.6%	5,652	6.3%
Lewes	98,690	5,225	5.3%	5,408	5.5%	5,455	5.5%	5,606	5.7%
Rother	91,088	4,092	4.5%	4,213	4.6%	4,812	5.3%	5,227	5.7%
Wealden	151,029	7,653	5.1%	8,307	5.5%	8,862	5.9%	8,702	5.8%

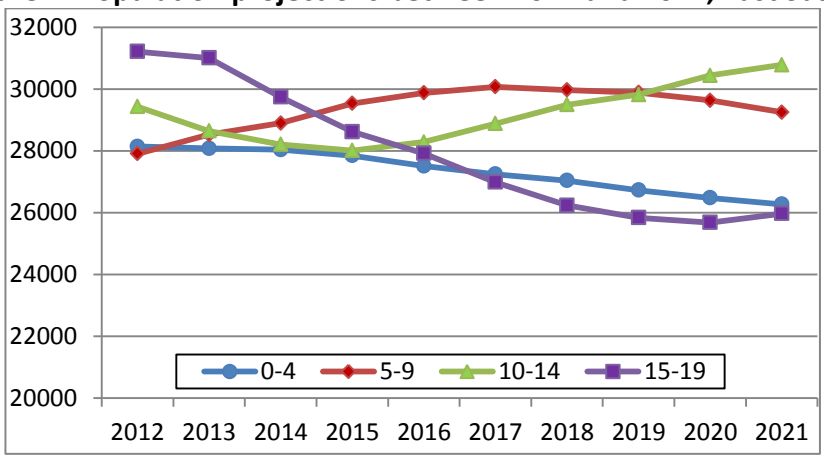
Source: Mid 2012 resident population estimates, Office for National Statistics

3.1 POPULATION PROJECTIONS

Population projections from 2012-2021 (Figure 1) predict a 4% decrease in the number of children across the county with the largest decrease in Lewes (6%), followed by Eastbourne (5%), Hastings (3%), Rother (3%) and Wealden (3%). However, across the county the number of children is projected to decrease in some age bands but increases in others:

- 0-4 year olds – predicted 7% **decrease**; largest in Eastbourne (15%) and Lewes (11%)
- 5-9 year olds – predicted 5% **increase**; largest in Hastings (9%) and Rother (13%)
- 10-14 year olds – predicted 5% **increase**; largest in Lewes (6%)
- 15-19 year olds – predicted 17% **decrease**; largest in Rother (26%) and Hastings (21%) and lowest in Eastbourne (10%).

Figure 1: Population projections between 2012 and 2021, East Sussex



Source: 2012 Policy based (Dwelling-led) Demographic Projections (2012-2027), ESCC

3.2 CHILDREN IN LOW INCOME FAMILIES

Families with low incomes are more likely to live in deprived neighbourhoods with poorer housing, higher rates of crime, poorer air quality, lack of green spaces for children to play and more risks to safety from traffic, all of which impact on health, including mental health.[29] Around one in five (18.1%) children in East Sussex is living in a low income family: The highest percentage in Hastings (29%), followed by Eastbourne (20.6%); and the lowest percentage in Wealden (10.3%) (Table 3). 2010 analysis showed almost a six-fold difference in the number of children living in low income families in urban areas (21.6%; n=14,055) compared to rural areas (10.5%; n=2,420).

Table 3: Number and % of children in low-income families, East Sussex 2011

	Number	%
England	2,026,465	20.6%
East Sussex	15,960	18.1%
Eastbourne	3,440	20.6%
Hastings	4,865	29.0%
Lewes	2,480	15.3%
Rother	2,600	19.0%
Wealden	2,575	10.3%

Source: HMRC

Of the 326 local and unitary authorities in England in 2010, Hastings ranked 40th most deprived, Eastbourne 99th, Rother 149th, Lewes 199th, and Wealden 274th.[30] These rankings are reflected in those of local clinical commissioning groups.[31] In these areas, income deprivation varies greatly by ward, from 46% in Central St Leonards, to 3% in Crowborough St Johns.[32]

3.3 EXPECTED PREVALENCE OF MENTAL HEALTH ISSUES

There is relatively little known about prevalence of mental health disorders in pre-school children. National evidence indicates an average rate of any mental health disorder to be 19.6% in children aged 2-5 years[33] which equates to: approximately 4,460 children aged 2 to 5 years in East Sussex with a mental health disorder: 1,460 in Eastbourne, Hailsham and Seaford CCG; 1,355 in High Weald Lewes Havens CCG and 1,470 in Hastings and Rother CCG area.[34]

National prevalence ratios have been applied to the local population to estimate the number of children and young people aged 5+ affected by mental disorders. It is important to note that the numbers estimated here are for mental disorders – that is diagnosable conditions. There are of course a much larger number of children and young people who have mental health or psychological problems, which may be less clearly defined. Also, the greatest numbers will be seen in the area with the greatest concentration of children, namely Wealden, although rates may be higher in other areas. The key mental health disorders affecting children and young people are:

- **hyperkinetic disorders** (characterised by hyperactivity, impulsiveness, inattention);
- **conduct disorders (**characterised by temper outbursts, arguing, disobedience, telling lies, fighting, bullying, cruelty, criminal behaviour);
- **emotional disorders** (depression, separation anxiety, specific phobias, social phobia, and generalised anxiety).

National research suggest that half of all lifetime cases of psychiatric disorders start by age 14 and three quarters by age 24. Around 13% of boys and 10% of girls aged 11-15 have mental health problems with conduct problems the most common issue for boys and emotional difficulties for girls. National research[35,36] has estimated prevalence of these disorders among children and adolescents. Table 4 presents the estimated prevalence of these disorders and from this extrapolates the estimated number in East Sussex.

Table 4: Estimated prevalence of Mental Health disorders: 5-15 year olds, England & Wales

	Boys		Girls		Estimated Prevalence	Estimated number in East Sussex
	5-10	11-15	5-10	11-15		
Conduct Disorder	3.75%	4.8%	1.75%	2.1%		2,000
Hyperkinetic Disorder	1.0%	0.4%	0.1%	0.1%		260
Emotional Disorder	2.2%	3.5%	2.8%	5.2%		2,150
Co-Morbid Disorder	2.1%	2.9%	0.6%	1.3%		1,100
Any Neurotic Disorder:	8.6		19.2		13.31	3,710
• Mixed Anxiety and depressive disorder	5.1		12.4		8.32	2,150
• Generalised Anxiety Disorder	1.6		1.1		1.36	330
• Depressive Episode	0.9		2.7		1.68	440
• All Phobias	0.6		2.1		1.27	330
• Obsessive Compulsive Disorder	0.9		0.9		0.89	330
• Panic Disorder	0.5		0.6		0.54	130

3.3.1 Stress and Anxiety

New national evidence indicates that hospital admissions for stress are highest amongst all ages are highest for the 15 to 19 year old female population. Levels of anxiety increase with age, with the exception of females aged 15 to 19 years who have the highest anxiety levels of all those aged under 65 years.[37] Between Dec 2011-Nov 2012 and Dec 2012-Nov 2013 there has been a rise in admissions for anxiety or stress in East Sussex but there is no data available on admissions for different age groups.

3.3.2 Autism Spectrum Disorder (ASD)

The term autism describes a lifelong disorder where there are: "qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours".[38] ASD is a collective term that includes: Autism; atypical autism; and Asperger's syndrome. Recent studies have shown that

nearly three quarters of people with autism also meet diagnostic criteria for at least one other (often unrecognised) psychiatric disorder that is further impairing their psychosocial functioning, with Intellectual disability (IQ below 70) occurring in around half of all young people with autism.[39] Prevalence estimates for autism spectrum conditions have shown a steady increase over the past four decades[40] from estimates for classic autism prevalence at 4 per 10,000 in 1978, to recent estimates of autism spectrum conditions (including classic autism) affecting approximately 1.16% of the population.[41] These increases have been attributed to: improved recognition and detection; changes in study methodology; an increase in available diagnostic services; increased awareness among professionals and parents; growing acceptance that autism can coexist with a range of other conditions; and a widening of diagnostic criteria.[42]

The British Association for Child and Community Health (BACCH) has created a calculator of expected service demands for certain clinical conditions including ASD based on a local areas child population and birth rate.[43] According to the calculator, the prevalence of ASD amongst children in the UK is 1.57%[44] (including previously undiagnosed cases). In total within the 0-19 year population of East Sussex we would expect approximately 1,840 children and young people to have Autism Spectrum Disorder, with an incidence (expected new cases) of 80 per year. The tool also calculates that there would be 240 expected appointments with community child health services for ASD each year.

Using 2014 mid-year population estimates and registered births in East Sussex (which includes calculations for children moving into and out of the county), Table 5 shows the estimated prevalence and incidence of ASD in East Sussex with the greatest expected incidence in Wealden based on 0-19 population size. Estimates of future prevalence have been calculated using the latest East Sussex County Council (ESCC) (dwelling-led) population projections, and CCG projections. CCG projections suggest a slightly higher total prevalence for East Sussex than ESCC projections because the former is based on ward level data aggregated into CCG area, while the latter is based on district level data. These figures are only a broad estimate of the prevalence and incidence of ASD, and they indicate a projected fall in actual numbers of 0-19 year olds with ASD over the next five years.

Table 5: Estimated prevalence of Autistic Spectrum Disorder, 0-19 year olds in East Sussex

	Estimated Prevalence of ASD (1.57%)	Estimated incidence of ASD (new cases per year)	Expected community child health appointments per year	Estimated future prevalence in 2021
East Sussex	**1,840**	**80**	**240**	**1,785**
Eastbourne	350	15	50	335
Hastings	340	15	50	325
Lewes	340	15	40	340
Rother	280	10	35	265
Wealden	530	20	65	525
EHS CCG	615	30	90	620
H&R CCG	620	30	85	615
HWLH CCG	610	25	70	580

Source: BACCH Prospectus Calculator Tool, accessed 2016

It is estimated that between 40% and 67% of autistic children may have a learning disability[45,46] equating to between approximately 740 and 1,230 children and young people in

East Sussex with autism who have a learning disability. However, the National Autistic Society states that it's not possible give an accurate estimate because some very able people with ASD may never come to the attention of services as having special needs because they have learned strategies to overcome any difficulties with communication and social interaction, while others may be able intellectually, but need support because the degree of social interaction impairment hampers their chances of achieving independence.[47] It is also estimated that approximately a third of children with a learning disability also have autism.[48] Estimated prevalence for learning disability is 2.6% of pupils[49] which equates to 1,680[50] 5-19 year olds with a learning disability in East Sussex, approximately 570 of whom may have autism.

The rate of Autistic Spectrum Disorder in East Sussex was consistently above national and regional rates until 2011 but over the last three years has been statistically similar to both nationally and regionally (Table 6). In 2014 the ASD rate for children in 2012 children in East Sussex was 11.3 per 1,000 pupils known to schools.[51] This identifies how many children with autism have been recognised, diagnosed and recorded as having ASD by schools.

Table 6: Children per 1,000 with ASD known to schools 2008-2014

	England Average	South East	East Sussex
2008	5.84	6.70	7.62
2009	6.30	7.10	8.20
2010	6.90	7.90	9.30
2011	7.60	8.60	9.80
2012	8.17	9.30	9.84
2013	9.1	10.0	9.6
2014	10.8	11.7	11.3

Source: Public Health England August 2016

3.3.3 Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit (Hyperactivity) Disorder is a condition in children who have three main kinds of problems: overactive behaviour (hyperactivity), impulsive behaviour, and difficulty in paying attention. ADHD is similar to hyperkinetic disorder and in the UK it is estimated that approximately 3-9% of school aged children have ADHD. Approximately one fifth of cases have a co-morbid mood or developmental disorder and approximately a quarter have anxiety disorder or compulsive disorder.[52] Of the 63,800 children in East Sussex attending a state maintained school, this equates to between 1,900 and 5,700 young people have ADHD, between 400 and 1,100 of whom may have a comorbid or developmental disorder and between 500 and 1,400 an anxiety or compulsive disorder.

3.4 ESTIMATED NUMBER OF CAMHS AT EACH TIER

Approximate numbers of young people who may experience mental health problems needing a response from CAMHS at Tiers 1, 2, 3 and 4 have been extrapolated from Kurtz (1996)[53]:

Table 7: Estimated number of young people at each CAMHS Tier

	Tier 1 (15%)	Tier 2 (7%)	Tier 3 (1.85%)	Tier 4 (0.075%)
East Sussex	15,700	7,330	1,940	80

These estimates should be interpreted with caution because, while they are the best available, they are nearly 20 years old and needs could have changed significantly in this time.

3.5 THE COST OF MENTAL HEALTH SERVICES – NATIONAL ESTIMATES

The King's Fund[54] estimated approximate spend on CAMH services (excluding those for 0-4 year olds) by combining population projections for England with prevalence of specific conditions targeted by mainstream services and where there was a reasonable evidence base recording intervention effectiveness. They estimated that in 2007 there was a spend of £0.14 billion (out of £22.5 billion in direct costs of mental health) on CAMHS, and projecting to 2026, that there would be a spend of £0.24 billion (out of a total projected spend of £47.48 billion). Whilst a small part of the overall mental health expenditure, these are significant sums and costs and cost effectiveness is an increasingly important part of the CAMHS commissioning landscape. Recently the cumulative costs of mental health problems and disorders in the UK have been quantified, suggesting mental health costs between £11,000 and £59,000 per child affected. The table below is reproduced from supporting material for the policy *No Health Without Mental Health.*[55]

Table 8: Costs of different mental disorders across the life course

Mental illness during childhood	UK costs (£11,030 to £59,130 annually per child)
Conduct disorder	Lifetime costs of a one year cohort of children with conduct disorder (6% of the child population) have been estimated at £5.2 billion. Cost of crime attributable to adults who had conduct problems in childhood is estimated at £60 billion a year in England and Wales, of which £22.5 billion a year is attributable to conduct disorder and £37.5 billion a year to sub-threshold conduct disorder.
Depression	Total annual costs of depression in England in 2007 were £7.5 billion, of which health service costs comprised £1.7 billion and lost earnings £5.8 billion. This does not include informal care or other public service costs. It has been estimated that lower productivity accounts for a further £1.7 – £2.8 billion and human costs for another £9.9 – £12.4 billion, bringing the total annual cost of depression to £20.2 – 23.8 billion a year.
Anxiety	Health service costs of anxiety disorders in 2007 were £1.2 billion. The addition of lost employment brings the total costs to £8.9 billion.
Medically Unexplained Symptoms (MUS)	Annual NHS cost of MUS in England amount to £3.1 billion (2008/9) with a further £5.2 billion in lost productivity and £9.3 billion reduced quality of life.
Schizophrenia	Total costs of schizophrenia were approximately £6.7 billion per year in England in 2004–05. Cost of treatment and care was £2 billion, annual costs of welfare benefits were £570 million and the cost to families of informal care and private expenditure amounted to £615 million. Costs of lost productivity due to unemployment, absence from work and premature mortality were £3.4 billion.

Source: Original Department of Health, table adapted from David Sayers et al 2013

SECTION SUMMARY

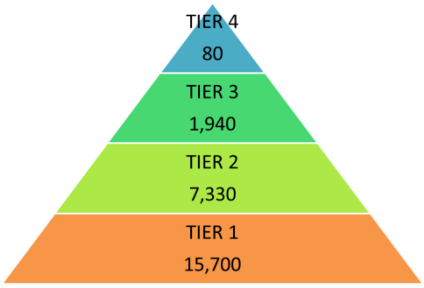
National research defines mental health as "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[56] In the UK it has been estimated that 11% of boys and 8% of girls aged 5 to 15 have a clinically significant **mental health problem,** with 50% of **lifetime cases** of diagnosable mental illness beginning by age 14. Of those diagnosed with a mental disorder, 1 in 5 (1.9% of all children) have more than one category of mental disorder **(co-morbidity**).

In East Sussex, 22% of the population is under 19, compared to South East (24%) and England (24%), with the local 0-19 population declining slightly faster than nationally and regionally since 2003. The number of 0-19 year olds in East Sussex is expected to decrease by 4% (5,000 young people) by 2027 however there is variation between different age groups.

National estimates suggest in East Sussex there could be:

	Boys 5-10	Boys 11-15	Girls 5-10	Girls 11-15	Estimated number in East Sussex
Conduct Disorder	3.75%	4.8%	1.75%	2.1%	2,000
Hyperkinetic Disorder	1.0%	0.4%	0.1%	0.1%	300
Emotional Disorder	2.2%	3.5%	2.8%	5.2%	2,150
Co-Morbid Disorder	2.1%	2.9%	0.6%	1.3%	1,100
Those aged 2-5 years with a mental health disorder (of those described above)					4,450
Neurotic Disorders (16-19 year olds)					3,400

Based on national estimates the approximate number of young people at each CAMHS Tier would be:



4. Who is most at risk?

While any child can experience mental health problems, life events and circumstances mean that some children and young people are more vulnerable than others. There is a growing evidence base for the relative risks of different factors and their proportionality:[57, 58]

4.1 EVIDENCE OF RISK

Table 9: Risk Factors and high risk groups for developing mental health problems

Risk Group	Degree of Risk	East Sussex Facts and Figures.
Use of alcohol, tobacco or drugs during pregnancy*	Increased risk of a wide range of poor outcomes including long-term neurological and cognitive-emotional development problems[59]	An estimated 4.5%, or 250 births in East Sussex are to women who misuse substances (alcohol and other drugs).[60] The NHS spends up to £23.5 million a year to treat infants (0-12 months) whose mother smoked during pregnancy.[61] In 2012/13 18% of women were smoking at 10-12 weeks of pregnancy; 16% at delivery. Rates are highest in the most deprived quintile.[62]
Maternal stress during pregnancy*	Increased risk of child behavioural problems[63] Impaired cognitive and language development[64]	Depression and anxiety are the most common mental health problems in pregnancy affecting 10-15% of women[65], equating to approximately 550-800 women in East Sussex.
Low birth weight*	Associated with increased risk of common mental disorder[66] 4-5 fold increased risk in onset of emotional/conduct disorder in childhood[67]	In 2011 5.5% of births (296) were low weight births, lower than national (7%) and regional (6.3%) levels.[68]
Poor maternal mental health*	In the UK a quarter of all babies have a parent affected by domestic violence, mental health or drug and alcohol problems, with mental health problems affecting an estimated 144,000 babies.[69]	Based on national estimates, of the 5,450 live births in East Sussex in 2012, an estimated 330 experienced depression two months post-natally, 380 at 6 months and 1,200 at 12 months.[70]
Unemployed parent	2-3 fold increased risk of emotional/ conduct disorder in childhood[71,72]	In 2011 there were 7,491 households in East Sussex with dependent children and no adult in employment.[73]
Poor parenting skills	4-5 fold increased risk of conduct disorder in childhood[74]	
Parents with no qualifications	4.25 fold increased risk of mental health problem in children[75]	In 2011 there were 7,924 households in East Sussex with dependent children and with parents with no qualifications.[76]
Deprivation – children in families with lower income levels	3 fold increased risk of mental health problems between highest and lowest socioeconomic groups (15% vs 5%)[77]	In 2010 in East Sussex, 32% of households had less than 60% median income[78] In 2011, 16,000 children were living in low income families (18.1%), with the highest numbers in Hastings (29%) and Eastbourne (20.6%).[79]
Four or more adverse childhood experiences (ACEs)[80]	12.2 fold increased rate in attempted suicide as an adult 10.3 fold increased risk of injecting drug use 7.4 fold increased risk of alcoholism 4.6 fold increased risk of depression in past year 2.2 fold increased risk of smoking	15% of females and 9% of males experience four or more ACEs
Child abuse (physical, emotional and/or sexual abuse and/or neglect)[81]	15.5 fold increased risk of minor depression as a child 8.9 fold increased risk of suicidal ideation 8.1 fold increased risk of anxiety 7.8 fold increased risk of recurrent depression as adult 9.9 fold increased risk of adult PTSD 5.5 fold increased risk of substance misuse/ dependence	Based on national estimates, 16,700 0-17 year olds may have experienced serious maltreatment by parents.[82]
Children who are bullied		Children and young people in East Sussex report a greater prevalence of emotional (66%) and physical bullying (43%) than nationally (52% and 29%)[83], with the most commonly reported reasons for bullying being "appearance" (45%) and "how you act or your personality" (40%).[84] According to the 2013 Safer Schools Survey, prejudiced based bullying (e.g. bullying due to race, religion, sexual

Risk Group	Degree of Risk	East Sussex Facts and Figures.
		orientation, physical appearance, special educational needs or disability) has increased by nearly a fifth since 2012.
Adolescent dating violence (physical or sexual abuse by a dating partner)	8.6 fold increased risk of suicidality[85]	Based on national estimates, 1,050 (8.9%) females and 150 (1.2%) males aged 16-19 may have been sexually assaulted in 2012.[86]
High level use of cannabis in adolescence	6.7–6.9 fold increased risk of developing schizophrenia[87]	Based on national estimates, 2,750 11-15 year olds may have used cannabis in 2012.[88] In 2012 over a third of 14-15 year old pupils (37%) reported being offered drugs and 17% said they had used Cannabis. There appears to be greater use of Cannabis in Hastings.[89]
Children with a Learning Disability	- 6.5 fold increased risk of mental health problems[90] - increased risk of developing psychological problems[91] - 2 fold increased risk of experiencing anxiety disorders - 6 fold increased risk of experiencing conduct disorders.[92] - 1.25 times more likely to try an illicit substance.[93]	According to national evidence, 2.6% of pupils have learning disabilities. In East Sussex this would mean approximately: • 280 aged 5-9 years, • 670 aged 10-14 years, • 840 aged 15-19 years.[94] East Sussex has a significantly lower prevalence of moderate learning disabilities (14.9 per 1,000) and severe learning difficulties (2.7 per 1,000) than both England (19.7 and 3.7 respectively) and the South East (16.5 and 3.2 respectively). However, the rate of young people with moderate Learning Difficulties is rising out of proportion to regionally/nationally.
Children with Special Educational Needs (SEN)	3 fold increase in conduct disorder[95]	The most frequent mental health issues in children with SEN include: conduct disorder, depression and suicide, ADHD, obsessive compulsive disorder and schizophrenia. In 2012 there were 13,900 pupils in East Sussex with SEN provision.[96]
Children with physical illness	- 2 fold increased risk of emotional/ conduct disorders over a 3 year period[97]	Based on national evidence, about 5-6,000 0-17 year olds in East Sussex may be in "fair/poor" health.[98]
Homeless young people	- 8 fold increased risk of mental health problems if living in hostels and B&B accommodation[99] - Evidence suggests 67% of 16-25 year olds sleeping rough in London had mental health problems.	According to national estimates, approximately 26 16-24 year olds sleeping rough in East Sussex, 18 with mental health issues.[100]
Young Black or Minority Ethnic people (BME)	- Increased prevalence of mental disorder among young black people (14% compared to 11.5% average); lower prevalence among young Indian people (approx. 3%).[101]	90% of 0-19 year olds in East Sussex are White British, ranging from 86% in Eastbourne to 93% in Wealden, and 10.6% of school children are from a minority ethnic group.[102] Eastbourne has the greatest proportion of White Non-British (5%), Mixed Ethnicity (4%) and Asian young people (4%) while Hastings has the greatest proportion of Black African young people (2%).
Young Lesbian, gay, bi-sexual or transsexual people (LGBT)	- 7 fold increased risk of suicide attempts in young lesbians - 18 fold increased risk of suicide attempts in young gay men[103]	According to nation estimates, there were around 3,400 LGBT 11-19 year olds in East Sussex in 2012: - over 1,700 likely experienced bullying[104] - 850 are likely depressed[105] - Over 1,700 likely have mental health issues[106] - 1,350 likely considered suicide (2x as many girls as boys).[107] In 2013 East Sussex significantly improved its position in the Stonewall Education Equality Index which benchmarks performance of different councils in preventing and tackling homophobic bullying in schools. However, there is little local data specifically on young LGBT people.
Young offenders	- 18 fold increased risk of suicide for men in custody age 15 – 17[108] - 40 fold increased risk of suicide in women in custody age < 25[109] - 4 fold increased risk of anxiety/ depression[110]	Nationally, 40% of young offenders have a diagnosable mental health disorder which is often undetected.[111] The rate of people in the youth justice system in East Sussex is currently lower than regional and national rates for all age groups

Risk Group	Degree of Risk	East Sussex Facts and Figures.
	- 3 fold increased risk of mental disorders	except 15 year olds. In 2012, 201 children entered the youth justice system for the first time.[112] Of the 281 young people open to the Youth Offending Team in 2012/13, 78 had emotional and mental health issues impacting on their offending
Looked After Children	- 5 fold increased risk of any childhood mental disorder[113] - 6/7 fold increased risk of conduct disorder - 4/5 fold increased risk of suicide attempt as an adult[114]	Nationally, an estimated 45% of LAC have a mental health disorder.[115] As at January 2014, there were 576 LAC in East Sussex: National evidence suggests among 5-9 year olds: • 52 may have mental health disorder • 45 may have a conduct disorder • 14 may have an emotional disorder • 14 may have a hyperkinetic disorder And among 10-15 year olds: • 110 may have mental health disorder • 90 may have a conduct disorder • 27 may have an emotional disorder • 16 may have a hyperkinetic disorder[116]

*More information can be found in the 2013 East Sussex Maternity and Paediatric Needs Assessment.

4.2 IMPACT OF EMOTIONAL AND MENTAL HEALTH ISSUES IN EAST SUSSEX

Mental wellbeing is associated with a range of outcomes. For instance, poor mental wellbeing among children and young people is associated with higher rates of crime, truancy or poor school attendance, use of alcohol, tobacco or cannabis, self-harm and suicide.[117] Mental health problems during childhood and adolescence are also associated with a wide range of adverse outcomes in later life, including higher rates of adult mental health problems, poor educational outcomes, unemployment, low earnings, teenage parenthood, marital problems and criminal activity.[118] They also impact on physical health and social functioning, and have serious repercussions on the life of the family and the community.

4.2.1 Absence and Exclusion

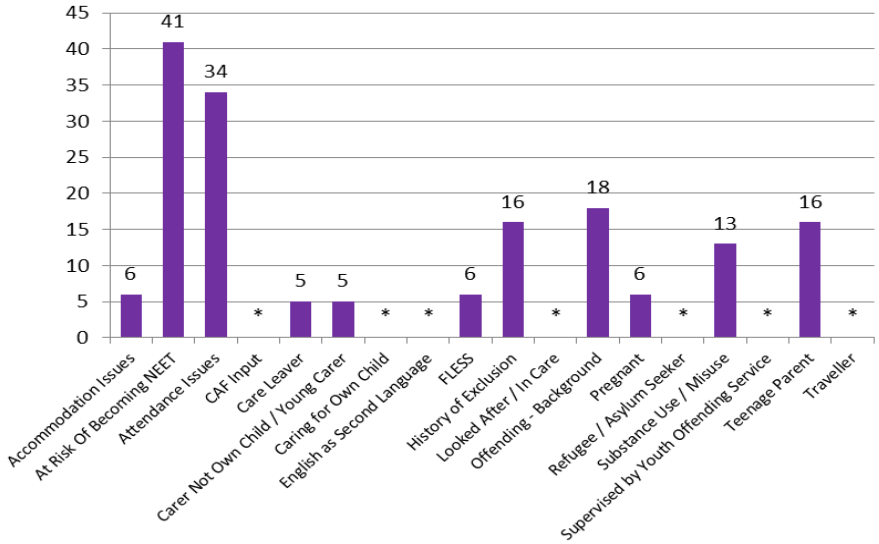
The overall local absence rate decreased from 5.8% in 2010/11 to 5.1% in 2011/12, continuing a downward trend. However, absence levels are substantially higher for pupils with profound and multiple learning disabilities (PMLD) and behavioural, emotional and social difficulties (BESD). Children who have BESD have behavioural or social needs affecting their ability to learn. In Comparison to statistical neighbours, pupils in East Sussex have the highest persistent absence and total absence, 0.3% above the national average for primary and 0.9% for secondary schools. East Sussex is also the poorest performing in relation to permanent exclusions from school.[119] A local 2012 scrutiny of school exclusions suggests much exclusion could be avoided if high excluding schools took responsibility for managing a wider range of behaviours, and while schools made adequate provision for pupils with physical disabilities, there is no comparable level of provision for pupils with behaviour related difficulties.[43]

4.2.2 Not In Education, Employment Or Training (NEET)

National research shows a positive association between being NEET and having poor mental health.[120] A 2013 UK survey of 1,000 NEET 16-24 year olds[121] found a third suffered from depression, 15 per cent had a mental health problem and 8% had self harmed. East Sussex has a similar percentage of 16-18 year olds who are NEET (5.9%) as nationally (6.2%).[122] In 2013 over 40% of young people with Special educational needs who are NEET had BESD, and 13% SpLD, representing an annual 4% increase in BESD and a 1.8% increase in SpLD. However, without longer trend data it is difficult to assess the significance of this increase. As of January

2014, 88 young people in Years 12 to 14 in East Sussex were recorded as being NEET and having emotional and mental health needs: 29% in year 12, 27% in year 13 and 36% in year 14. Of these 88 young people, a third (38%) had attendance issues and a fifth (21%) an offending background (Figure 4).[123]

Figure 4: Yr12-14 – Young people recorded as having 'Mental and Emotional Health' needs and currently NEET - By Individual Circumstances



Note: * numbers lower than 5 have been suppressed.

Source: Standards & Learning Effectiveness Service

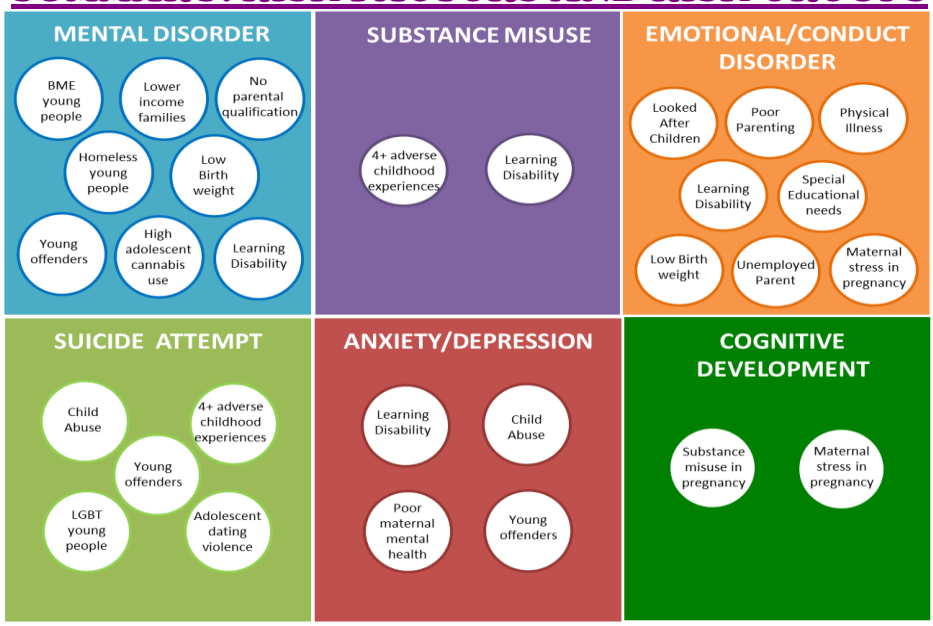
4.2.3 Self-harm and suicide

National research[124] suggests that young men aged 15-19 years are more likely than young women to commit suicide. However, while suicide rates for young men have fallen from 17.6 in 2001 to 13.3 per 100,000 in 2011, there has been little change for young women at approximately 2.5 per 100,000.[125] Self-harming and substance abuse are much more common in children and young people with mental health disorders – with ten per cent of 15-16 year olds having self-harmed. [126] Nationally there has been a 68% increase in the number of 10-24 year olds admitted to hospital due to self-harm over the last ten years.[127] However, in 2012-13 rates in East Sussex decreased to 287 per 100,000 compared to 346 nationally.[128] Levels of self-harm are higher among young women than men (4 times higher in 10 to 14 year olds and 3.5 times higher in 15 to 18 year olds) with self-poisoning the most common method. Research suggests young South Asian women have a raised risk of self-harm.[129] In 2010 there were 121 deaths of 10-19 year olds from intentional self-harm or undetermined intent in England and Wales: 1.8 deaths per 100,000. This would equate to an estimated one death from intentional self-harm or undetermined intent per year locally.[130] The rate of young people under 18 in East Sussex who are admitted to hospital as a result of self-harm fell between 2006 and 2012 and rates of admission are similar to the England average.[131]

4.2.4 Eating Disorders

Eating disorders tend to start in the mid-teens and it is estimated that around 1 in 250 females and 1 in 2,000 males will experience anorexia nervosa, usually as an adolescent or young adult. Around five times this number will suffer from bulimia nervosa.[132] However, like self-harm, eating disorders may be underestimated as many will not seek help. Young people aged 10 to 19 years account for more than half of hospital admissions for eating disorders.[133] The largest number of admissions to hospital for eating disorders is among young women aged 15 years.[134]

SUMMARY: RISK FACTORS AND RISK GROUPS



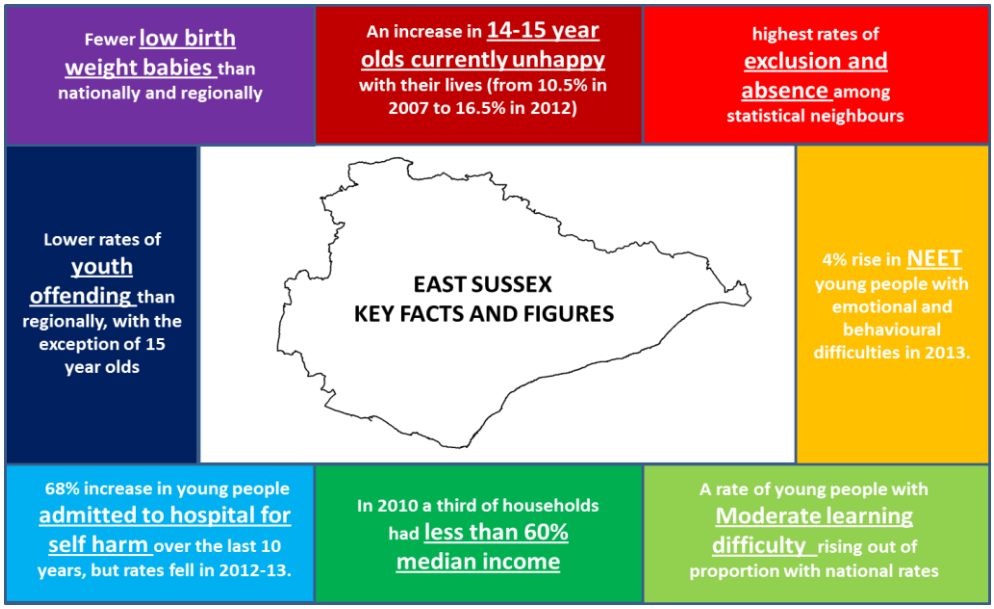
National evidence indicates that:

- Levels of **self harm** are 4 times higher for female 10-14 year olds than males
- Young people aged 10-19 account for over half of hospital admissions for **eating disorders**.
- Hospital admissions for **stress** are highest for 15-19 years olds of all age groups in England.

Young people who experience mental health problems are more likely to be:

- **NEET** (not in employment, education or training);
- At the **lowest income levels** (15% compared to 5% at highest income levels);
- **Excluded** (17 times more likely than those without mental health problems);
- **Homeless** (Two thirds of homeless young people report mental health problems);
- **Young Offenders** (about 40% Of young offenders have a mental health disorder);
- **Looked after Children** (LAC) (About 45% of LAC have a mental health disorder).

SUMMARY: LOCAL FACTS AND FIGURES



5. Service Provision in East Sussex

5.1 CAMHS IN EAST SUSSEX

Joint commissioning arrangements for services that work in partnership with specialist CAMHS provision have been in place for some time across the NHS and the Local Authority. Joint commissioning intentions are agreed annually and closer integration of all services contributing to the improvement of children and young people's emotional health and well-being has been the vision for the future. Each of the following service areas described are a part of the whole system designed to meet the needs of the children and young people and to respond to new priorities as outlined in the joint commissioning strategy.

CAMHS in it's broadest sense is any service provision whose aim is to meet the mental health and emotional wellbeing of children and young people. Within the scope of this needs assessment it has not been possible to look at all provision in detail and so a brief overview of Tier 1 and 2 services is provided, with Tier 3 and 4 (specialist) services looked at in more depth. Service data may be incomplete in some areas but has been provided where it has been made available.

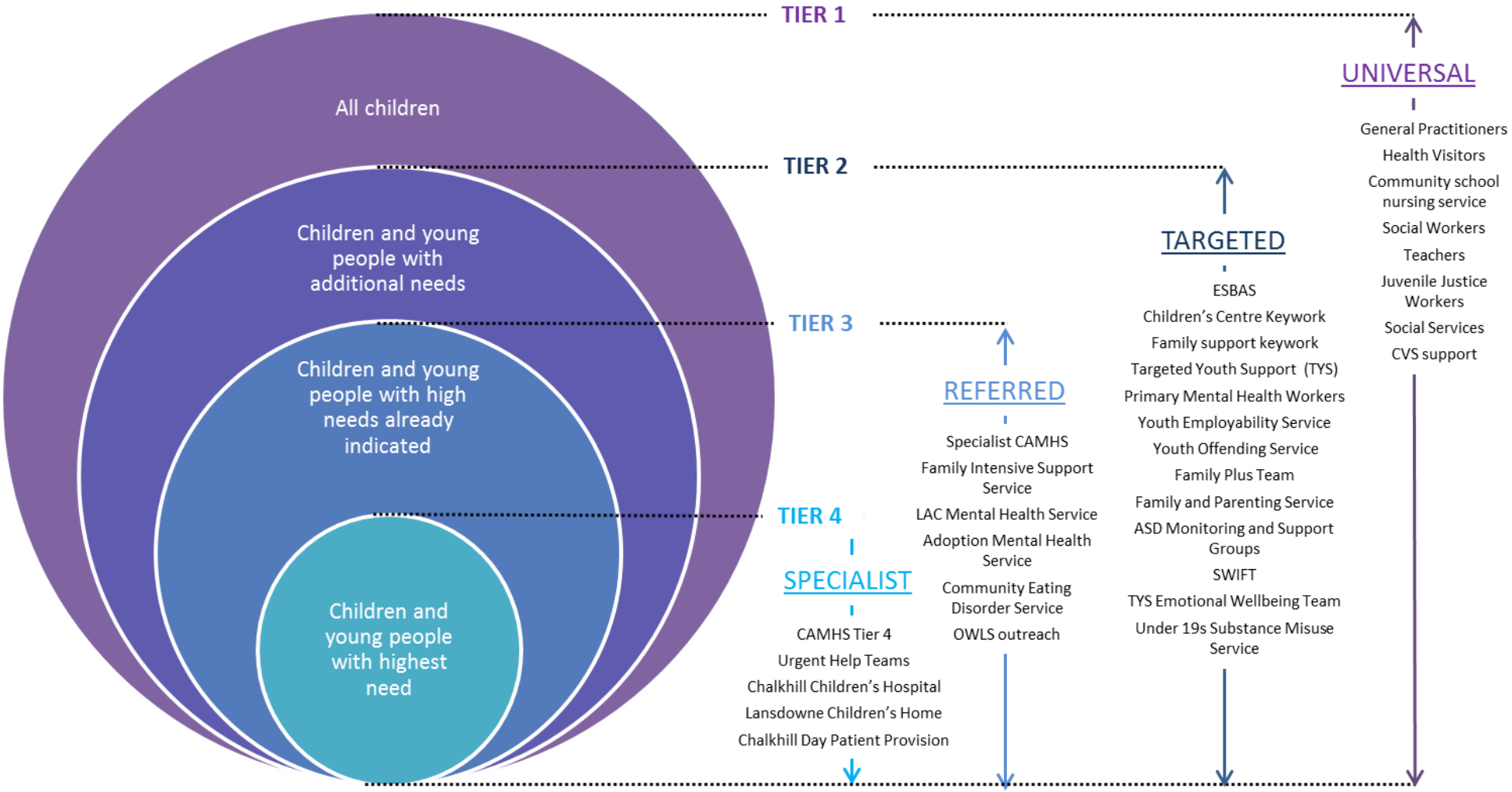
As outlined in Section 1 (Table 1), there are 4 Tiers of services to support the mental health and wellbeing of children and young people:
Tier 1 Universal services, early identification and prevention (GPs, health visitors, teachers, youth workers)
Tier 2 Targeted services/provision: Provision for children and young people who have specific identified needs and/or are considered to be vulnerable. This involves low intensity of intervention and can be delivered through the universal settings but with provision aimed at specific identified groups. Specialist mental health workers may input here.
Tier 3 (Specialist CAMHS) Multi-disciplinary team, child psychiatry out patient, specialized mental health working
Tier 4 (Specialist CAMHS) Highly specialised services such as in-patient units or intensive outreach services for those with the most severe problems

More recently CAMHS care pathways have been developed across the tiers, incorporating a concept of emotional health and wellbeing as well as mental health. Such pathways allow for a continuum of care that is commissioned across several organisations and takes into consideration the role of universal, targeted and specialist services and the multi-agency nature of service provision for children, young people and their families.[135] Figure 8 outlines the services in East Sussex at each CAMHS Tier.

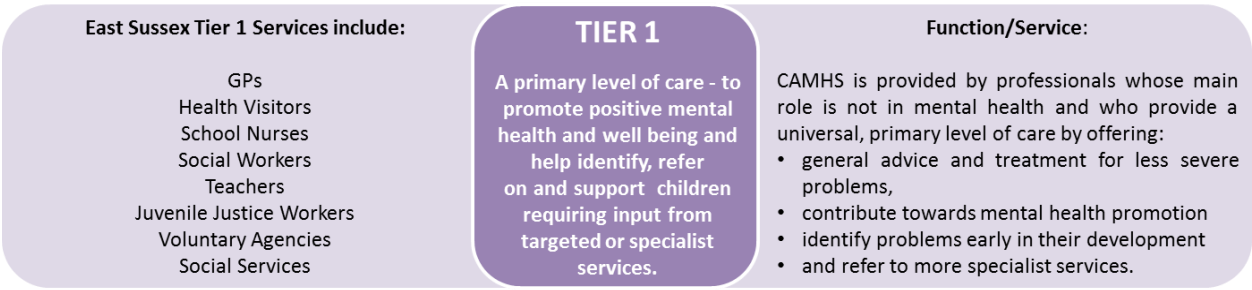
National evidence of effectiveness of CAMHS services (2010) calculates on a scale of 1 to 4, with higher scores showing higher service satisfaction (1: no aspects or service or strategic plans in place, 2: protocols and plans in place but services yet to be put in place, 3: protocols and plans in place but only partially implemented; 4: protocols and plans in place and fully implemented). East Sussex scored 4/4 for all levels of provision equating to a total score of 16 compared to 14.8 in the South East and 15.2 nationally.[136]

Care pathways are currently in place in East Sussex for: Eating Disorders, Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Depression and Anxiety.

Figure 8: Key CAMHS Services in East Sussex by Tier



5.2 MENTAL HEALTH CARE AT TIER 1 LEVEL (UNIVERSAL PROVISION)

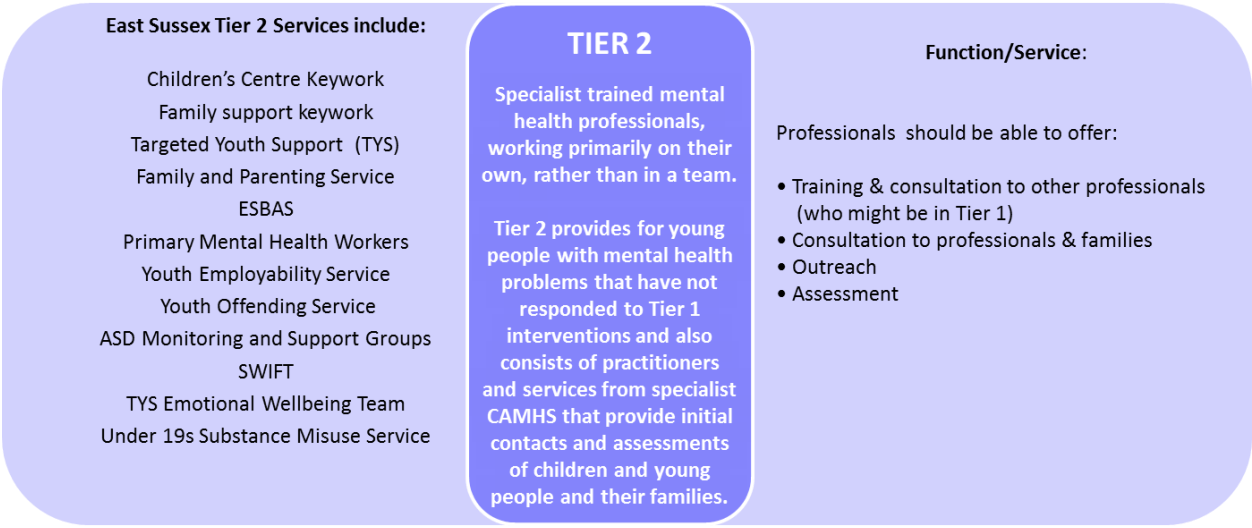


Universal mental health care at this level is provided by practitioners who are not mental health specialists; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.[137] Universal services contribute to identification and nurturing of core protective factors for mental wellbeing: enhancing control; increasing resilience and community assets; facilitating participation and promoting inclusion.[138]

Within early years parenting style and attachment have been identified as key factors in building a foundation for good mental health, with the quality of home and pre-school learning environments associated with greater self-regulation and improved educational outcomes. Within adolescence, key factors to positive mental health and wellbeing include attachment to school, family and community, positive peer influence, opportunities to success and social capital.[139]

It is beyond the scope of this needs assessment to look at Universal services in detail but information from the school nursing service suggests a significant need for support for emotional and mental health issues within the school environment, with 370 children and young people with emotional and mental health issues seen by the school nurse service between October and December 2013, 50 of whom were then referred on to Specialist CAMHS.[140]

5.3 TIER 2 CAMHS SUPPORT

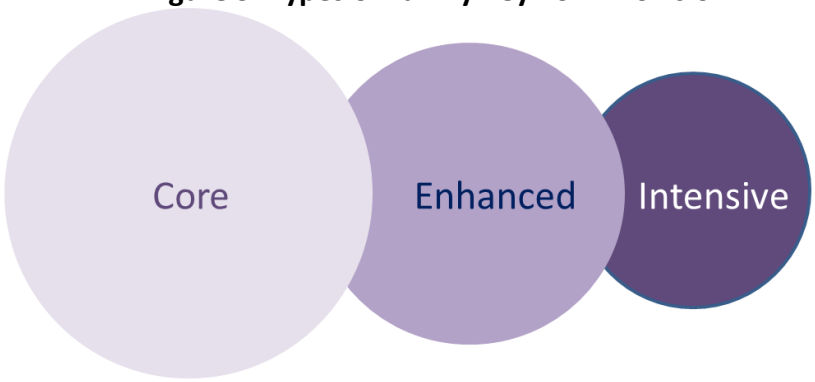


Practitioners at this level tend to be those providing emotional and mental health support in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services), including primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.[141]

5.3.1 Targeted Early Help Services

Targeted Early Help services are aimed specifically at helping families with children and young people whose needs are at Level 3 on the Continuum of Need to prevent families needing social care services and to keep families together where possible. Early Help Services provide proactive whole family keywork and focus on outcomes, motivating families to make changes to improve their lives, and children's safety and wellbeing. Targeted support is also provided by family keyworkers in specialist services, for example Probation, Sussex Police, the Traveller Education Team, and in some schools, and by School Nurses and Family Support Health Practitioners. There are three types of family keywork provision: core, enhanced and intensive (Figure 9):

Figure 9: Types of Family Keywork Provision



Core Keywork provision:
- Three or fewer planned contacts per week including at least one face-to-face
- General support for parenting and family wellbeing
- Signposting to specialist advice or interventions
- Safeguarding risk at Level 3 and occasionally at the upper end of Level 2

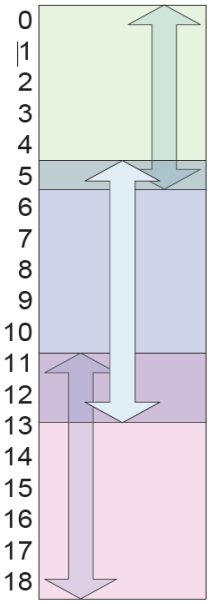
Enhanced Keywork provision:
- Three or more planned contacts per week including at least one face-to-face
- General support for parenting and family wellbeing
- Some specialist intervention delivered by the Keywork service e.g. parenting courses
- Safeguarding risk at Level 3 and occasionally at Level 4 in line with Joint Working Guidance

Intensive Keywork provision:
- Three or more planned contacts per week including at least two face-to-face
- General support for parenting and family wellbeing
- Variety of specialist and therapeutic interventions delivered by the Keywork service
- Safeguarding risk at higher end of Level 3 / Level 4 in line with Joint Working guidance

Source: Adapted from ESCC Guide to FKW provision

Family Keywork is part of THRIVE and is a top priority for the East Sussex Strategic Partnership. Alongside this, the Government's 3-year Troubled Families programme offers Attachment Fees and Payment-by-Results for local authorities that can turn around families in which members are involved in crime and anti-social behaviour, are unemployed and/or missing education. In East Sussex this funding is used to embed Family Keywork in local services.[142] There are three main services in East Sussex (Figure 10):

Figure 10: Early Help Services in East Sussex by age group



The **Children's Centre Keywork and Health Visiting** services work closely through the Good Start programme to agree what support is needed where families have children aged **0-5**. The Children's Centre Keywork service used to be called the Family Outreach Service.

Family Support Keywork services are provided across the county to work with schools and academies to provide coordinated support for families with children aged **5-13**. They are based on the previous Parent Support Advisor, COPES and Inclusive Learning Tutor services.

The **Targeted Youth Support** service provides help where there are children aged **11-19** and works closely with secondary schools, academies, and colleges. This service was created in 2011 by bringing together a range of smaller teams.

Source: ESCC Guide to Early Help

5.3.2 Children's Centre Keywork

Service overview: Children's Centres offer all families with children under five a range of services, information and support in their local community, including: home visiting; family drop-ins; parenting support; information on health needs; life skills training courses and help finding specialist groups and services. The Children's Centre Keywork service operates in a number of settings across the age range (including home visiting) to support families who have at least one child under 5 to overcome difficulties and make a positive change for the future. Keyworkers work across East Sussex and can offer practical help with a wide range of issues including: parenting; debt management; domestic abuse; depression and alcohol misuse. There are 31 Centres in East Sussex.[143] The purpose of children's centres was recently redefined by the Government in order to emphasise more clearly their role in addressing inequalities in health and education outcomes and providing "early help" of the kind designed to prevent the need for social care intervention. The East Sussex centres provide a range of open access services together with a targeted one to one family support service.

5.3.3 Family Support Keywork Service (FSKS)

Service overview: Family Support Keywork in East Sussex aims to improve outcomes for families with children aged 5-13 years identified as at risk of requiring repeated interventions or sanctions. It aims to provide earlier, coordinated and more effective support to whole families whilst reducing the long-term costs to local services. Family Keyworkers work in partnership with the family for up to 18 months, identifying strengths and issues, agreeing priorities for change and offering both support and challenge.

5.3.4 Targeted Youth Support (TYS)

Service overview: Targeted Youth Support (TYS) began in November 2011 as an integration of the Youth Development Service, Under-19 Substance Misuse, Teenage Pregnancy Services, the Connexions personal adviser service and preventative elements of the Youth Offending Service. The primary aim of the service is to deliver interventions to young people aged 11-19 years to support them to: live successfully within their families, participate in education, prevent antisocial and offending behaviour, and to promote health and well-being. Without an assessment and planned intervention these young people would be more likely to: be excluded from school; engage in criminal behaviour; become accommodated by the local authority, or have poor physical and mental wellbeing. Targeted Youth Support works one to one with young people in a range of settings to offer a continuum of support recognising escalating need. The service has clear pathways to specialist services and is co-located with statutory social care Youth Support Teams.[144] If referrals are accepted into the service, Social Workers work as keyworkers with other agencies to develop a plan to support the family.

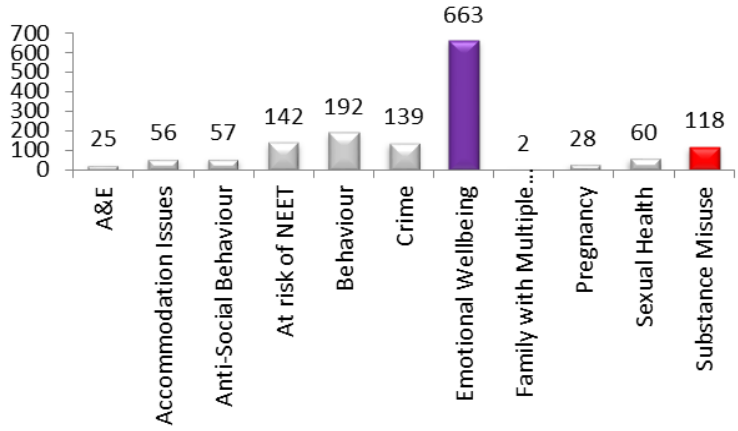
Targeted Youth Service (2012/2013) Service data:

Accepted referrals	Emotional Wellbeing (EWB) as primary issue	% EWB referrals referred on	Origin of EWB referrals				
			Eastbourne	Hastings	Rother	Lewes	Wealden
1,480 (90%)	663 (45%) (Figure 11)	12%	41%	18%	18%	15%	17%

Approximately 60% of emotional wellbeing referrals were for 14 and 16 year olds and females were nearly twice as likely to be referred as males.[145] Initial assessment of the issues is provided by the referrer so an assessment is completed by TYS after 12 weeks to reassess

primary needs. In the first two quarters of 2013/14, 54% (372) of 694 accepted referrals related to emotional wellbeing indicating a potential rise in referrals for emotional wellbeing issues. There were also 118 substance misuse referrals to the TYS in 2012/13, just over half (54%) of which were for males.

Figure 11: Accepted referrals to Targeted Youth Service 2012/13



Source: Targeted Youth support, February 2014

A 2012 review of the TYS service found that, since the inception of TYS the number of children in need open to Social Care Youth Support Teams (YST) has decreased by 13%.[146]

5.3.4.1 Emotional Wellbeing Team (EWBT)

Service overview: The Emotional Wellbeing Team is part of the TYS service to support those not accessing CAMHS (with a presentation other than mental health, for example low school attendance or substance misuse issues) as well as working to engage those refusing to access CAMHS. The EWBT assesses to see if a child needs CAMHS or early help services and assists access to these services. Referrals are mainly through the four locality teams of TYS but are also taken from other agencies, such as schools (via locality teams) and young people leaving CAMHS if help is needed with community support. The EWBT includes a CAMHS nurse.

5.3.4.2 Under 19s Substance Misuse Service

Service overview: The under 19s substance misuse service has been running for 12 years and is a TYS specialist team providing one to one support to young people who have concerns about alcohol or drug use. Whilst initially seen by a substance misuse worker, young people can be referred on to a range of other multi-disciplinary staff in the team including psychiatrists, psychologists and GPs. Young people can access the service directly or through their school or youth centre and can access joint appointments (if there is need to see multiple services).

Under 19 Substance Misuse Service (2012/13) data:
In 2012/13, three quarters of the 76 young people assessed by YOT as having a substance misuse issue affecting their offending were under the care of the Under 19 substance misuse service.

5.3.5 Families and Parenting Service

Service overview: The Families and Parenting Service provides intensive, persistent support to reduce poverty, antisocial behaviour, offending and domestic abuse; to improve family and parenting relationships; address low school attendance; unemployment; physical and mental

health problems; tenancy issues and substance misuse. The service is driven by a model of early intervention, and intensive whole family, coordinated support and works with children subject to, or post child protection plan in families with multiple complex needs who need intensive support in order to make and sustain positive changes. Primarily the service works with referrals from Hastings, St Leonards and Eastbourne but referrals are received from other agencies if there are concerns about the long term outcomes for the family and/or children.

5.3.6 The Education Support, Behaviour and Attendance Service (ESBAS)

Service overview: ESBAS is an integrated specialist support service (created in September 2011 following service restructures), for schools, children and families across Key Stage 1 and 4 providing a number of interventions: improving attendance; Improving behaviour; Improving emotional well-being and mental health; Reducing bullying; and providing for children who are unable to attend school. The ESBAS comprehensive outcomes-based accountability model focuses on judging service efficacy against outcomes for children/young people, schools and families by reviewing the impact of interventions on an ongoing basis.[147] Services delivered under ESBAS include: Anti-bullying; Children missing from education (e.g. safeguarding); Behaviour and Attendance Service; E-Learning Service; Flexible Learning Educational Support Service (FLESS); and the Legal Intervention Service. These are described in more detail below.

ESBAS Service data Sept 2012 to Sept 2013:

Number of children supported	Number of children given small group work or 1:1 support	% reporting ESBAS changed things for the better		
		Young people	Parents/Carers	Schools
4,280 (34% increase on 2011/12)	1,310 (28% increase on 2011/12)	62%	72%	52%

Feedback is positive about the range of support and interventions offered by ESBAS, but there is an identified need for: increased communication with parents/carers; and the introduction of strategies in schools for more sustained behaviour change. As part on the ongoing monitoring of the outcome based accountability framework across ESBAS, each service area was asked to review and refine their individual performance measures and outcome indicators in August 2012.[148]

5.3.6.1 Flexible learning educational support service (FLESS)

Service overview: FLESS is a team of teachers and teaching assistants who support schools in providing education for children who are ill, offering: attendance at all personal education plan (PEP) meetings in schools; teaching and support in small groups for children who are ill at locations around the county or at home; teaching and support in hospital children's wards; online learning and initial help in reintegrating children back into school after periods of absence due to ill health.

Flexible Learning Educational Support Service (Sept 2012 to Sept 2013) service data:

Number of children referred to FLESS	Number of Elective Home Education families accessing FLESS	%		
		Accessing E-Learning	Back into mainstream education	Offered 25 hours education a week
224 (32% increase on 2011/12)	374	73%	54%	100%

5.3.6.2 Anti-bullying service

Service overview: The core aims of the anti-bullying service are to provide strategic direction to the Local Authority by ensuring effective and consistent anti-bullying approaches are developed; to work with individual children and their families to respond directly to incidents of bullying behaviour; and to provide the Local Authority with safeguarding advice regarding cases of bullying.[149] The East Sussex Anti-Bullying Team achieves this by ensuring whole school anti-bullying approaches are embedded, and providing professional development for school staff and targeted support for vulnerable children and their families. These resources are being used to inform the development of training resources which are being rolled out nationally to all Achievement for All schools. [150] The Anti-bullying service prices their service to primary and secondary schools in "units" that can be used to "buy" interventions.[151]

Anti-Bullying Service (Sept 2012 to Sept 2013) service data:

Number of children in contact with the service	Number attending anti-bullying workshop	Number who took part in peer support training	Number receiving small group work or 1:1 support
2,400 (132% increase on 2011/12)	2,250	92	56 – 72% of which reached a positive outcome

In the academic year 2012/13, 342 professionals and parent/carers took part in anti-bullying training, representing a 122% increase compared to 2011/12. Approximately 90% reported anti-bullying training to be excellent or good.[152]

5.3.6.3 The Behaviour and Attendance Service

Service overview: The Behaviour and Attendance Service supports children, schools and families for attendance and behaviour related issues including reintegration support for children transferring schools following permanent exclusion, legal support to schools in relation to permanent exclusion, and support to area Behaviour and Attendance partnerships.

Behaviour and Attendance Service (Sept 2012 to Sept 2013) service data:

Number of children referred to ESBAS	Number at risk of permanent exclusion	Number with protracted poor attendance
944	208	736

Of those permanently excluded, 63 were reintegrated into mainstream education, 40% higher than 2011/12. Overall, 97% of children were reintegrated into mainstream school with no further permanent exclusion within 12 months and 71% of children met their attendance target by end of intervention, a 9% increase on 2011/12.[153]

5.3.7 Primary Mental Health Workers (PMHWs)

Service overview: A dedicated and discrete Primary Mental Health Work team (4.5wte) works within locality CAMHS teams to ensure a coherent pathway between universal services and Tier 3. Twilight Training is also provided by CAMHS Primary Mental Health Workers throughout the academic year with a rolling programme of sessions providing information and strategies on issues relating to the emotional and mental health of children and young people.

Service data: The Primary Mental Health Workers began working on a different way of recording their contacts in January 2013 to provide as much useful information about the

consultations to Tier 2 as possible. This involved splitting presenting problems into the following categories:

- **Category 1**-Anxiety, trauma and Habit behaviours
- **Category 2**-Health
- **Category 3**-Developmental
- **Category 4**-Family and Behaviour Difficulties
- **Category 5**-Self Harm
- **Category 6**-Depression/Low Mood
- **Category 7**-Emerging Mental Health issues

Between January 2013 and December 2013 the greatest presenting problems that primary mental health workers were consulted on were anxiety, trauma and habit behaviours and family and behavioural difficulties (Table 10), accounting for between 75% and 80% of the quarterly cases consulted on. Over this period there was a noticeable rise in the number of consultations for children and young people with depression/low mood (category 6).

Table 10: PMHW cases consulted on Jan 2013 to Dec 2013 by presenting problem

Presenting Problem	Jan to Mar 2013	April to June 2013	July to Sept 2013	Oct to Dec 2013
Category 1-Anxiety, trauma and Habit behaviours	67	47	45	71
Category 2-Health	*	*	*	6
Category 3-Developmental	17	5	4	10
Category 4-Family and Behaviour Difficulties	51	60	74	61
Category 5-Self Harm	10	12	14	12
Category 6-Depression/Low Mood	5	6	11	17
Category 7-Emerging Mental Health issues	*	*	*	*
TOTAL PROBLEMS	**152**	**132**	**149**	**177**

* numbers under 5 have been removed

Source: East Sussex PMHW quarterly reports

There has been a 23% rise in consultations with specialist services (from 52 between January and March 2013 to 64 between October and December 2013), and a 76% rise in consultations with schools (from 38 between January and March 2013 to 67 between October and December 2013. Consultation with advice services for parents has decreased by 50% from 54 to 27 over the same period.[154] Between January 2013 and December 2013 an average of 51 young people used the primary mental health worker service per quarter. Over half of those using the service are male.

In relation to the training provided by PMHWs, during the 2013 calendar year:

- 27 Twilight training sessions were delivered to 614 professionals
- 9 CAMHS workshops were delivered to 117 professionals
- 6 bespoke training sessions were delivered to 44 professionals[155]

5.3.8 Youth Employability Service (YES)

Service overview: YES East Sussex is a new targeted information, advice and guidance (IAG) service for 16-18 year olds who are NEET or at risk of becoming NEET which provides 1:1, group work and community outreach services. Commissioned by East Sussex County Council and delivered by Medway Youth Trust the service went live on 1st October 2013 and is collocated within the Youth Offending Team and the Leaving Care Team. YES also works with

young people towards the end of Year 11 to support transition to post 16 learning or employment with training. The service proactively engages young people as well as accepting referrals from agencies, parents and young people and incorporates a reengagement project. A 2 day a week drop-in service and rural outreach programme is being established.[156]

Youth employability service (January 2014) service data:

Number 16-18 year olds in receipt of service	In education/ employment/ training	NEET	Unknown
275	154 (56%)	88 (32%) - 35 (40%) on ES youth employability service	33 (12%)

5.3.9 Youth Offending Service

Service overview: There is one Youth Offending Team (YOT) in East Sussex which is organised into three service teams, covering Eastbourne, Lewes and Wealden, Hastings and Rother and a separate countywide Prevention Team. Made up of staff recruited from the Police, Probation, Children's Services, Health and the voluntary sector and two psychologists, the YOT works mainly with children and young people aged 10-17 who have offended and received a final warning from the police or who have been sentenced by the court to a community or custodial penalty. The YOT aims to prevent offending by children and young people aged between 10 and 17 through its youth crime prevention programmes that target young people at risk of offending. The two psychologists within the youth offending team (YOT) provide accessible support for young people with emotional or mental health issues within youth offending services by: supporting the caseworker if a young person refuses to see them; offering peer support; attending home visits; psychological assessments and screening those entering the service for risk of mental health issues.

Youth offending service (2012/13) service data:

Number 'open' to YOS	Scored 3 or 4 for emotional & mental health (very likely to be linked to reoffending)	Receiving intervention	% receiving intervention in contact with psychologist
291	78 (28%)	106 (38%)	48 (45%)

A 2012 service review of the Youth Offending Service (YOS) identified a reduction in overall YOS caseload but an increasingly complex and high risk cohort in youth justice services. The client group that the Youth Offending Service worked with in 2011/12 had committed more previous offences that on average in previous years.[157]

5.3.10 Autism Spectrum Disorder (ASD) Monitoring and Support Groups

Service overview: Multi-disciplinary ASD Monitoring and Support Groups form part of the Inclusion Support Services in the County and comprise of two groups, one for the East of the county and one for the West. The groups provide professional and parent training, peer awareness in schools, a two-yearly conference for parents/carers of children with ASD was held on managing behaviour and a variety of short breaks including activity mornings, school trips and after school clubs. There has been a year on year increase of families registered with the groups from 660 in 2012 to 790 in 2013 (+19%).

Autistic spectrum disorder (2012) service data:

Assessments	Autism	ASD	No autism
108	32 (30%)	18 (17%)	58 (54%)

Autism Accreditation is an internationally recognised mark of excellent practice in the field of autism and is recognition that a school or setting meets a set of standards that ensure good autism practice and policy is embedded in every aspect of the work of that school or setting. Currently 12 schools and services in East Sussex have achieved Autism Accreditation.

5.3.11 SWIFT Specialist Family Services (Tier 2/3)

Service overview: The SWIFT service, a joint commissioned Adult Health and Children's service, provides a multi-disciplinary specialist family focused substance misuse and/or mental health assessment and intervention response for local families involved in the Child protection process. From the 1st April 2012 the service commenced pre-proceedings assessment and intervention and specialist family assessments to the court arena. The service now comprises a multi-disciplinary group of professionals whose areas of expertise include the following parental presentations; Mental Health; Drug and Alcohol Misuse; Learning Disability; Domestic Violence; and Sexual Risk. As well as addressing parental risk factors, this service also informs the best care plan outcomes for the child both pre and in-court-proceedings; provides practical family support to increase parental capacity; consults on children's social care case planning; and contributes to children's social care case planning and risk management meetings. An initial brief assessment is offered aimed at identifying current substance/alcohol misuse and dual diagnosis need, any immediate risks to children and the formulation of appropriate treatment plans (tier 2 and 3). SWIFT are also able to provide intensive family support services provided by a Family Support Worker (FSW) to identified families. The FSW role assists families with developing parenting skills and strategies.[158]

SWIFT (April – December 2013) service data:

Work commissioned by CAMHS	New interventions	External assessments		Internal assessments: child and adolescent psychiatry	In wider SWIFT caseload - Support for MH issues
		child and adolescent psychiatry	psychology		
56 families	28	36	13	5	92 families a quarter

A 2012 local needs assessment found SWIFT has supported service users to make significant reductions to illicit substance misuse, has maintained at least 80% of children with their birth parents, and that service users reported improved psychological health and increased quality of life.[159] In 2013 nearly three times the number of families received family keywork services in quarter 3 compared to quarter 1, but intervention timescales decreased over this period by approximately 40% from 240 days in quarter 1 to 137 days in quarter 3.

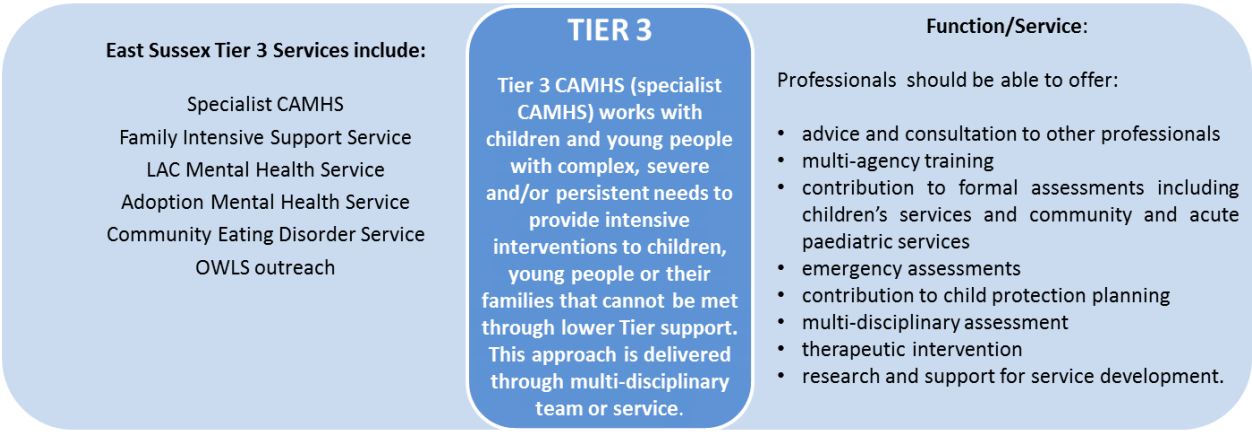
5.3.12 Transition

Service overview: East Sussex has a multi-agency transition strategy aimed at providing a holistic, people centred service to improve outcomes, prepare for adult independence, ensure the best quality of life and support young people to reach their maximum potential. Part of this is to provide a clear protocol between CAMHS and Adult Mental Health, including: a specialist CAMHS adolescent service for all young people with mental health issues up until their 18th birthday; internal transition protocol from CAMHS to Working Age Mental Health Services (WAMHS). In addition to this CAMHS is expected to:

- **Contribute to** the multi-agency transition planning process for those presenting with a range of needs including mental health; joint planning and commissioning of services if appropriate; training opportunities and the monitoring and evaluation process.
- **Provide** consultation to the transition service, young people and parents/carers; information to young people and their parents/carers
- **Ensure** views of young people and their carers are included when planning individual Transition; and young people and parents/carers participation in service planning.

The protocols will incorporate improved Adult mental health services such as Recovery Community Mental Health Teams, and relevant specialist services e.g. Early Intervention in Psychosis (a service for young people aged 16 to 25 years) and Eating Disorder Services as well as a commitment to continued partnership working across the statutory and voluntary agencies and with parents/carers and young people.[160]

5.4 TIER 3 CAMHS SUPPORT



Tier 3 CAMHS is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.[161]

5.4.1 Tier 3 CAMHS In East Sussex

Service overview: CAMHS is a specialist Tier 3 service designed to meet the needs of children and young people (up to the age of 18) with significant mental health problems. This includes vulnerable young people such as those with a learning disability, children in care, and with co-existing conditions such as SAD and ADHD. The service is made up of specialist mental health professionals who have qualifications and experience in helping children, young people and families and offer services for: the whole family (family therapy); the child/young person on their own; parents or carers on their own (individual therapy). CAMHS also provides a range of other therapies including art and play therapy. The total spend on Child and Adolescent Mental Health services in East Sussex is £5,410,529: £4,562,571 CCG contribution and an £847,958 CAMHS grant provided by East Sussex County Council.

There are three multi-disciplinary Tier 3 locality teams: Hastings and Rother, Eastbourne & Hailsham and Ouse Valley & High Weald. There are also smaller teams working with targeted groups: Looked after children mental health services (LACMHS); Learning disability and family intensive support service (CAMHSLD/FISS); Psychologists within the Youth Offending Team (YOT). Each person accessing tier 3 CAMHS will have a named individual (keyworker) to act as their point of contact to co-ordinate appropriate assessment, treatment and review of interventions with the young person and family. The CAMHS worker, child and family create a written care plan which is kept by both CAMHS and the family.[162] A key element of tier 3 CAMHS services in East Sussex is to support multi-agency working with clear care pathways and formal working agreements between: Early Intervention for Psychosis Service, Out of Hours Services (including Local Authority and Health), Adult Mental Health Teams, Children's Services, Youth Offending Teams, Targeted Youth Support Service, Children Looked After Teams, Police, Substance Misuse Services, Hospital Services, Learning Disability Services and Community Health Teams. Other services are identified on a locality basis.[163]

Referrals to Tier 3 CAMHS services can be made by GPs, adult Mental Health services, and any children's service, including schools, Targeted Youth Support Services, education services, social care, voluntary sector and self-referrals. Referrals can be for consultation and treatment. The service accepts 0-18 year olds provided they meet the following criteria:

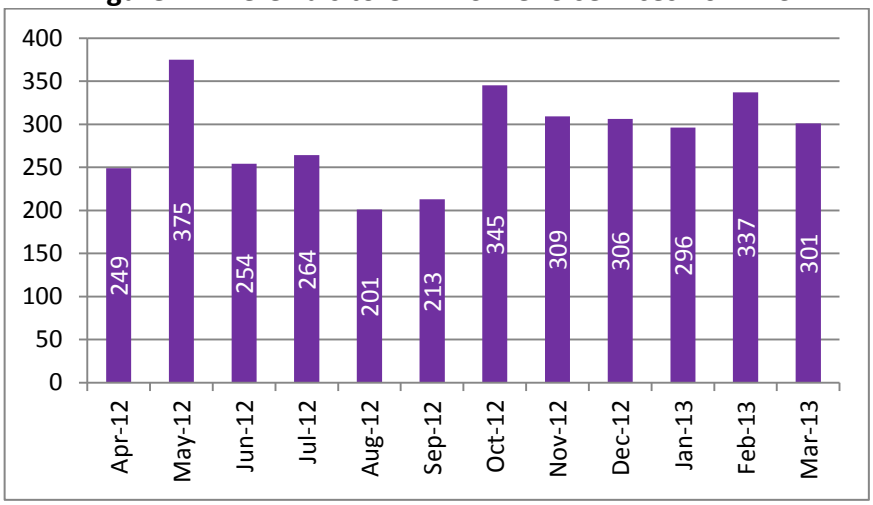
- There is concern that a young person is developing a significant psychiatric disorder
- A young person is presenting with significant and/or escalating self-harming behaviour.
- A young person presents with symptoms of prolonged or disabling distress secondary to an event or other potentially traumatising influences.
- Significant family relationship difficulties lead to symptoms of impaired mental health.
- A young person has a developmental delay, moderate learning difficulties, or autistic spectrum disorder assessed and diagnosed by the Community Paediatric service.
- A young person exhibits over-activity, impulsivity and distraction/inattention which is inappropriate for their developmental age and impedes capacity to engage and access the school curriculum and general social interactions.

Referrals not meeting the criteria are offered alternative options e.g. signposting to other services and information. Referrals meeting the criteria are assessed within 4 weeks of the referral and those assessed as high priority via an A&E admission will be seen within 4 hours. Referrals are not likely to be considered appropriate when primary concerns are school-based or where alternative community-based agencies can adequately address the needs.[164]

Service data:

Referrals: In 2012/13 there were 3,450 referrals received by CAMHS with significantly higher referrals in quarters 3 and 4 than for the rest of the year, with the exception of a high spike of referrals in May (Figure 12). Further trend data would be needed to see if this is a cohort effect. This general pattern is reflected across each area team referring.

Figure 12: Referrals to CAMHS Tier 3 services 2012-13



Source: Sussex Partnership NHS Foundation Trust

Over half all CAMHS referrals in 2012/13 were to CMHT Eastbourne (55%, n=1,900), 1.5 times the number to CMHT Hastings (35%, n=1,200). Based on estimated prevalence extrapolated from population based national data we would expect the greatest number of referrals to be from where the child population is largest, in Wealden. The larger number of referrals in Eastbourne and Hastings would suggest, in support of national evidence, that wider contextual factors such as deprivation affect the use of mental health services for children.

As at 31st January 2014, 44% of the CAMHS caseload were female and 56% male; this is consistent across all three CCGs. Approximately one fifth of the CAMHS caseload in Eastbourne, Hailsham and Seaford CCG (EH&S CCG) and High Weald, Lewes, Havens (HWLH CCG) are children under 10 years, rising to a quarter of the caseload in Hastings and Rother CCG (H&R CCG) (Table 11). EH&S CCG currently has a higher caseload of those aged 16 and over than HWLH and H&R CCGs.

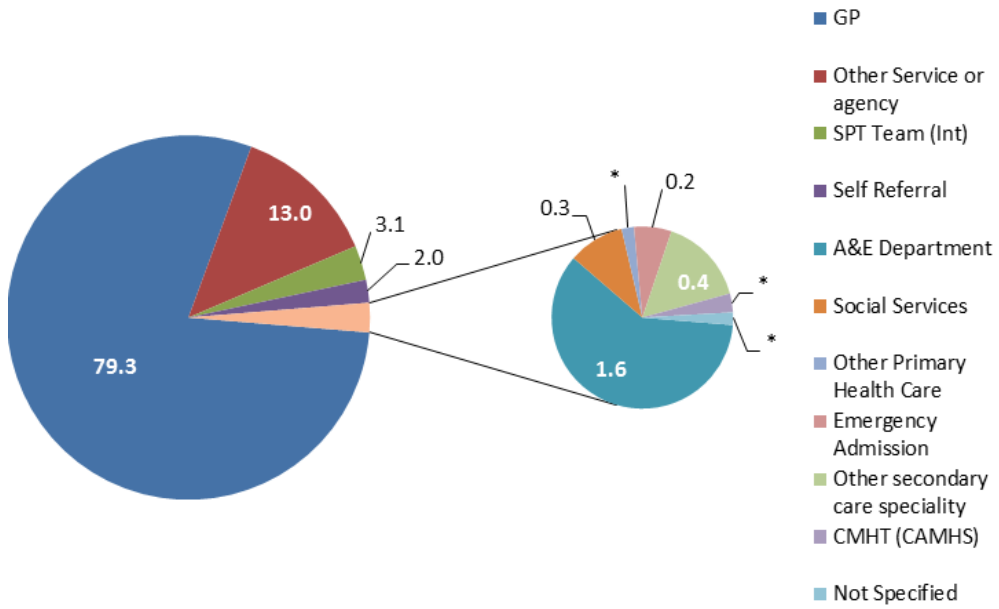
Table 11: Profile of CAMHS caseload (%) as at 31st January 2014, by CCG

	Eastbourne, Hailsham & Seaford CCG	High Weald, Lewes, Havens CCG	Hastings & Rother CCG
Current Caseload	**895 (37% of total)**	**704 (29% of total)**	**834 (34% of total)**
% recorded from BME group	3.9%	1.7%	3.9%
0-3 years	0%	0%	0%
4-10 years	22%	22%	26%
11-15 years	49%	55%	51%
16+	29%	23%	22%

Source: Sussex Partnership NHS Foundation Trust

Of all referrals to CAMHS in 2012/13, nearly 79% were received from GPs (2,750), 13% from other services and agencies (450) and 3% from the Sussex Partnership Foundation Trust (internal referrals) (100). 70 referrals (2%) were self-referrals and 50 (1.6%) were referrals from A&E (Figure 13).

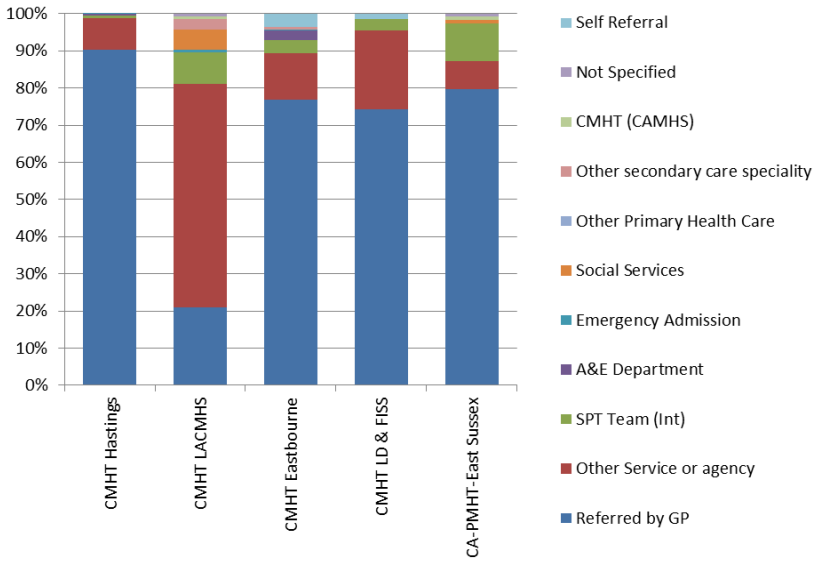
Figure 13: Main sources of referral to CAMHS Tier 3 services



Source: Sussex Partnership NHS Foundation Trust

Figure 14 shows referral source to CAMHS area team and indicates that the majority of CAMHS referrals across all teams originate from GPs, with the exception of the specialist LAC Mental Health Service where the majority of referrals are from "Other services or agencies".

Figure 14: Main sources of referral to CAMHS Tier 3 services by team



Source: Sussex Partnership NHS Foundation Trust

Appointments Activity:

Table 12 shows the average number of referrals and contacts per team, illustrating higher numbers of contacts per referral for the Looked After Children Mental Health Service (16.6 contacts per referral).

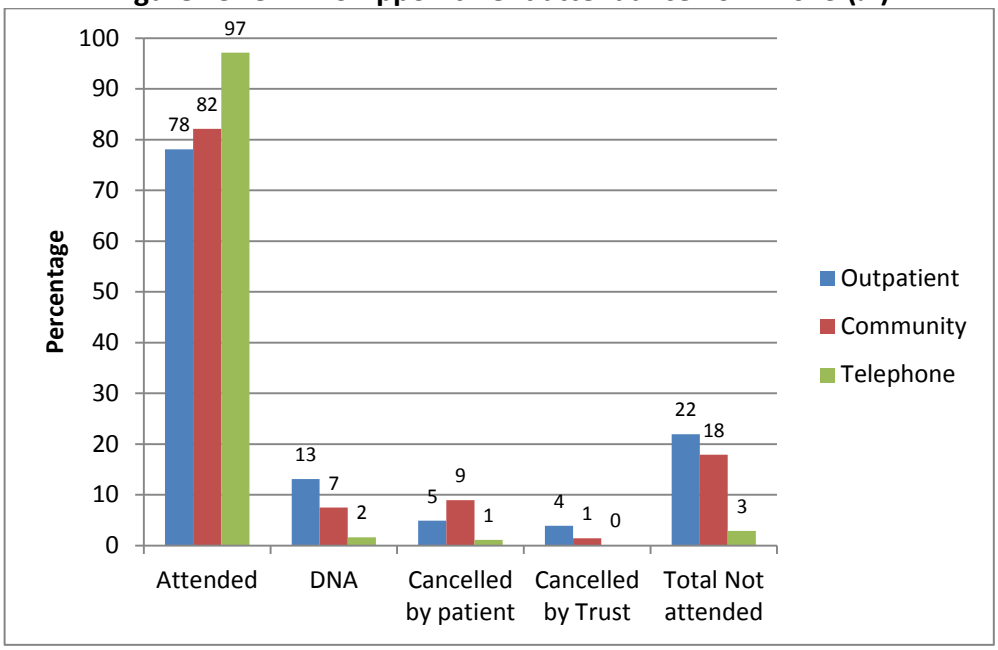
Table 12: Average number of referrals and attended contacts by area team

Area Team	Average number of referrals	Average number of attended contacts	Average contacts per referral
CMHT Hastings	100	497.9	5
CMHT LACMHS	11	183.3	16.6
CMHT Eastbourne	159	921.2	5.8
CMHT LD & FISS	5	37.7	7.5
CA-PMHT-East Sussex	9	75.5	8.4

Source: Sussex Partnership NHS Foundation Trust

In 2012/13 there were 26,400 CAMHS appointments made, including outpatient (doctors' appointments), community face to face appointments (all activities not relating to doctors' appointment) and telephone consultations. In 2012/13 telephone appointments had the highest attendance level (97%) followed by Community appointments (82%) and Outpatient (doctor) appointments (78%) (Figure 15). The most common reason for unattended outpatient and telephone appointments was patient DNAs, while for community appointments the greatest proportion of non-attendance was due to patient cancellation.

Figure 15: CAMHS Appointment attendance 2012-2013 (%)



Source: Sussex Partnership NHS Foundation Trust

Nearly half all CAMHS appointments were at CMHT Eastbourne (49%), with 27% at CMHT Hastings (Table 13). These two teams also had the greatest proportions of appointments not attended (19% compared to 16% overall) and their combined referrals accounted for 99.5% of all outpatient appointments. Those referred from specialist teams (LD/FISS and LACMHT) are more likely to be offered community appointments than outpatient appointments.

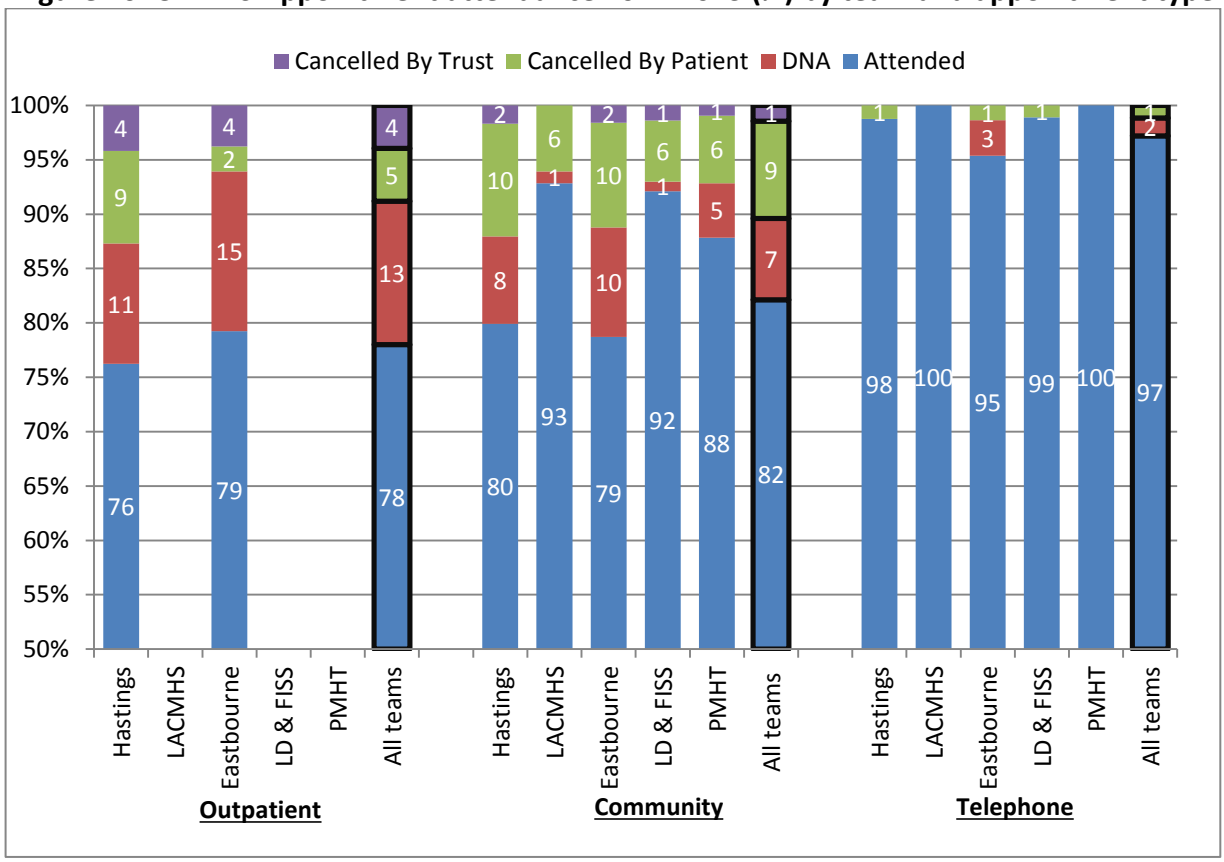
Table 13: CAMHS Appointments activity 2012-2013

Area Team	Total appointments	% of all appointments	total attended	total not attended
CMHT Hastings	7,152	**27.1**	5,809 (81%)	1343 (19%)
CMHT LACMHS	2,331	**8.8**	2,173 (93%)	158 (7%)
CMHT Eastbourne	12,972	**49.1**	10,497 (81%)	2475 (19%)
CMHT LD & FISS	3,064	**11.6**	2,881 (94%)	183 (6%)
CA-PMHT-East Sussex	879	**3.3**	789 (90%)	90 (10%)
TOTAL APPOINTMENTS	26,398	100	22,149 (84%)	4249 (16%)

Source: Sussex Partnership NHS Foundation Trust

Hastings has the greatest proportion of unattended outpatient appointments (24%) while Eastbourne has the greatest proportion of unattended community and telephone appointments (21% and 5% respectively). The smaller specialist teams are most likely to have their appointments attended while Eastbourne has the highest proportion of patients not attending (DNA) appointments of any type. Hastings has the greatest proportion of outpatient and community appointments cancelled by the patient while outpatient appointments are most likely of any appointment type to be cancelled by the Trust (Figure 16).

Figure 16: CAMHS Appointment attendance 2012-2013 (%) by team and appointment type



* Percentages have been omited where total number of appointments is less than 10

Source: Sussex Partnership NHS Foundation Trust

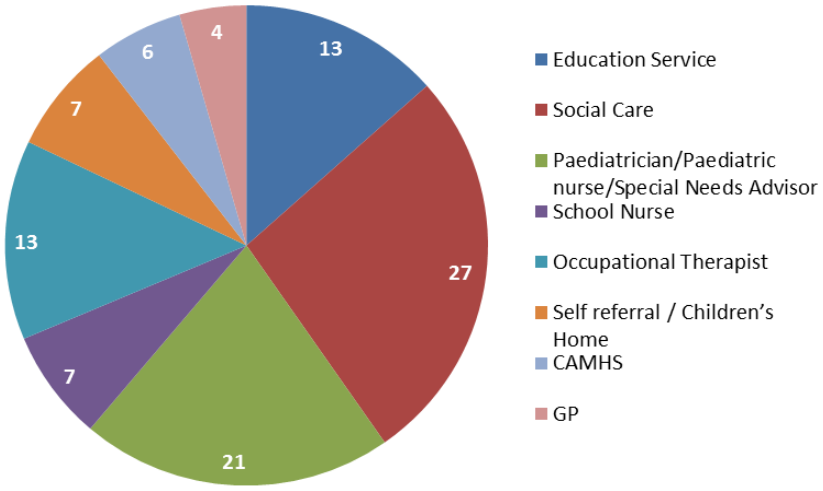
5.4.2 Family Intensive Support Service

Service overview: The Prime Ministers Strategy Unit found that mental health services for children with learning disabilities are often under-resourced within Child and Adolescent Mental Health Services (CAMHS).[73] CAMHS-LD/FISS is a multi-disciplinary specialist Learning Disability (LD) team providing support to those up to the age of 19 years with moderate/severe learning disabilities or global developmental delay and complex communication and emotional/behavioural needs. The team comprises of Team Leader, Consultant Clinical Psychologist, Consultant Child & Adolescent Psychiatrist, Clinical Nurse Specialist, Clinical Psychologists, Speech & Language Therapists, Family Support Workers and Administrators but currently has no provision for an Occupational Therapist with specialism in sensory integration/processing which is a perceived gap by the service. The service also provides training and consultancy and is involved in service development. The overall aim in the service is to increase the opportunities for the child to participate fully in family life as well as activities outside the home in a flexible and creative way, working to the Family Partnership Model.[165] Interventions and support currently offered include: parent/carer groups; systems work; home and family based work; individual therapy and individual therapy with siblings.

Service data: Between October and December 2013 there were 116 young people accessing the Family Intensive Support Service (FISS). Of these young people, 30% were aged under 11 years, 42% 11 to 15 years and 27% 16 years and over, representing a decrease of those aged under 11 years and an increase in those aged 16 years and over from January 2013. Over two thirds of those accessing FISS were male (68%), and 88% were of White British ethnicity.

In 2012/2013 there were 61 referrals to the service, 27 of which were considered appropriate (45%). Of the 34 not taken onto the caseload in this period 13 (38%) had a level of learning disability not appropriate to the service, 9 families (25%) did not want the service and 7 (20%) were referred on to the key-worker service.[166] This indicates an apparent high number of inappropriate referrals for children with less severe learning disability. Of all referrals, 27% were from Social Care and 21% from Paediatricians (Figure 17).[167]

Figure 17: Main sources of referral to FISS 2012-2013 (%)



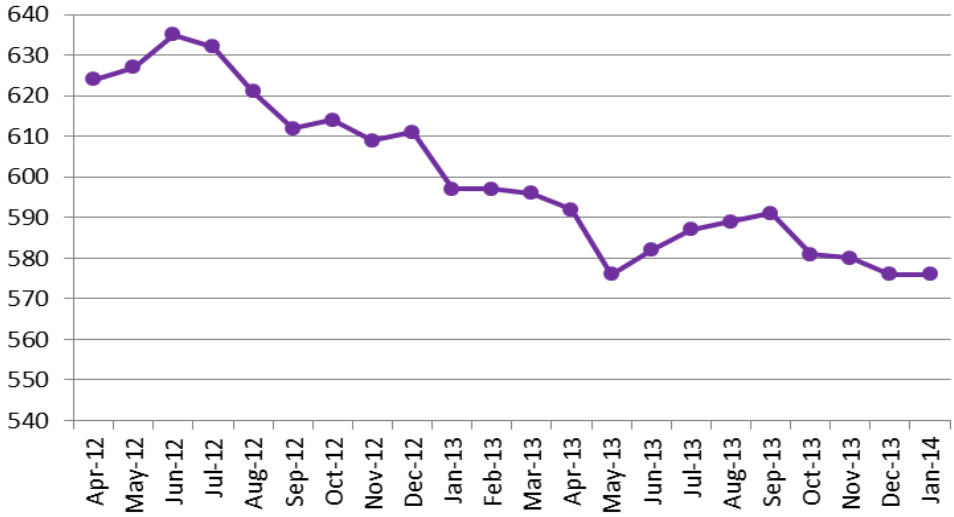
Source: East Sussex FISS quarterly report

Between January and December 2013 young people stayed on the FISS caseload for an average of 2 years and 10 months. A 2012/2013 service evaluation noted strengths of the service to be: staff response to queries; supportive staff; empowering parents; continuity of support; group work allowing peer support, expertise in autism and speech therapy and home visits. Weaknesses included waiting time too long and a lack of funding for the service.[168]

5.4.3 LACMHS (Looked After Children's Mental Health Service)

Local Information: As of mid-February 2014, there were a total of 3,667 children and young people being supported by Social Care: 531 looked after children, 2,544 Children in Need, 554 with a Child Protection Order and 38 who are looked after children with a child protection order.[169] In 2011/12 the overall rate of Child Protection Plans per 10,000 (0 to 17 year olds) was 65 for East Sussex compared to the England average of 38, although the number has fallen since. Over half of children and young people who are looked after (including LAC with a CP order) are supported primarily by the LAC team, 19% by the Family Support Team and 9% by the Care leavers' service. This has remained a consistent distribution for the last six months. There has been a decrease in looked after children in East Sussex over the last two years (figure 18), particularly in those aged 1-4 years, although there has been a slight increase in LAC aged under 1 year. The greatest numbers of looked after children are aged 13-17 years.

Figure 18: Numbers of Looked After Children Apr 12 to Jan 14



Source: East Sussex Social Care; CareFirst Database

Of the total number of LAC children, 7% are recorded as having a Learning Disability (42), 6% a Behavioural issue (31) and 3% as being diagnosed with Autism/Aspergers (19). Between April 2012 and January 2014 there has been a slight decrease in percentage of LAC children diagnosed with Autism/Aspergers. Over half of LAC are with social care for reasons of abuse or neglect (59%), 17% due to family dysfunction and one in ten due to families being in acute stress.[170] If we apply national estimates to East Sussex that 45% of 5-17 year olds who are looked after by local authorities are likely to experience mental health problems, we would expect an estimated 196 Looked After Children in East Sussex to be experiencing mental health problems.

Service overview: The Looked After Children's Mental Health Service (LACMHS) is a multidisciplinary service managed by Sussex Partnership Foundation Trust (SPFT) and co-located with Children's Services. LACMHS provides a specialist service for children and young people who are in the care of the local authority and for whom the plan is 'permanence' (young people involved in court proceedings there has been a Final Hearing and a Full care Order granted with a Care Plan either through Fostering or Adoption), and who present with emotional and/or behavioural difficulties and are not already open to East Sussex Specialist CAMHS. LACMHS has a remit to: contribute to placement stability by supporting mental, emotional and behavioural needs of the looked after child, and to promote positive attachment with new carers. Functions of the LACMHS include:

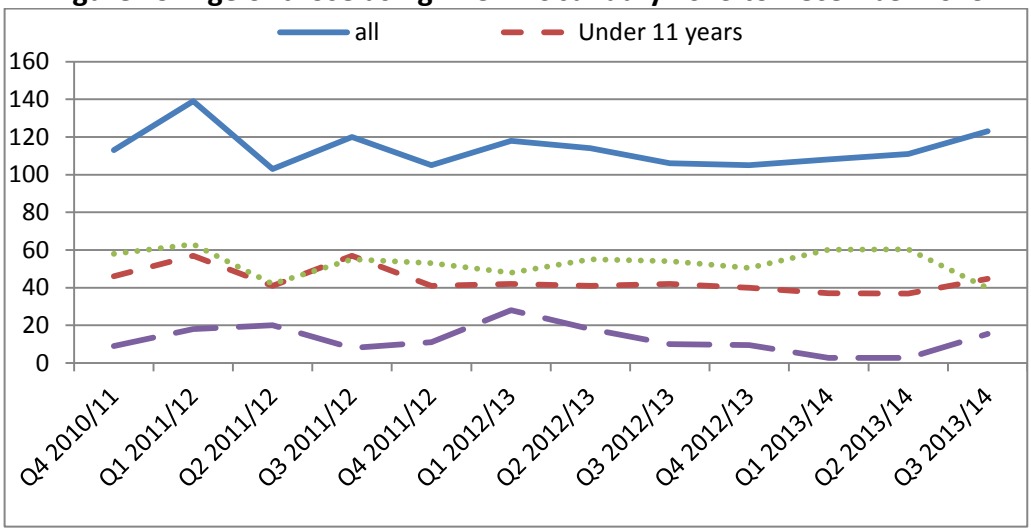
- Providing mental health assessment, consultation and therapeutic input
- Providing two 12-week Therapeutic Parenting Groups for foster service carers per year
- Providing weekly consultation to Homefield and Broderick residential homes
- Consultation and direct work for those in Lansdowne Secure Unit
- Providing monthly 'Drop In' consultation sessions in/to the Fostering and LAC teams
- Attending the two monthly Permanency Planning Groups

Referrals to LACMHS should be in collaboration with the child's social worker or foster carer's supervising social worker.

Service data: In comparison to the number of young people using LACMHS over the last three years indications are that numbers are currently rising, from 105 in January 2013 to 132 in December (Figure 19). Over the three years the age distribution of young people using

LACMHS has varied slightly, but 11-15 year olds have consistently been the largest cohort, followed by young people aged under 11 years.

Figure 19: Age of those using LACMHS January 2013 to December 2013



Source: East Sussex LACMHS quarterly performance reports

Between December 2010 and December 2011 there was, on average, 15% per quarter more males than females using the service. However between January 2011 and December 2013 the number of females exceeded males by an average of 19% per quarter although the number of males has been rising again since April 2013. Between Jan 1st and Dec 31st 2013 36 drop in sessions were offered by LACMHS attended by 71 professionals, and 67 initial consultations were provided. There are currently 18 young people on the waiting list for the LAC CAMHS service but there have been staffing issues which are currently being addressed which have influenced a rise in those on the waiting list.

5.4.4 Care leavers

Service Overview: National evidence indicates that care leavers have poor access to emotional and mental health services and are at greater risk of living chaotic lives involving insecure housing, substance misuse, sexual exploitation and difficulties getting into education, employment or training. However, there is little known about this population in relation to emotional and mental health need. In East Sussex there has been discussion about establishing a care leavers service but there is not yet a clear picture of what the local emotional and mental health needs are and how to best address them. A part time mental health nurse has recently been employed within the SWIFT service to work with care leavers.

Care Leavers data (Jan 2013 to Jan 2014):

Average number of care leavers	Not in Education, employment or training (NEET)
200	Approximately 40%

Between January 2013 and January 2014, on average 40% of care leavers were not in education, training or employment (NEET), a known risk factor for mental health issues.

5.4.5 ADCAMHS (Adoption Mental Health Service)

Service Overview: The CAMHS adoption support service (ADCAMHS) was developed around specified needs of the Adopted Families Group to support 0-18 year olds and their families

who present with significant emotional and behavioural difficulties and are in post adoption. ADCAMHS has a dedicated therapy service, consultation, intensive individual therapy, as well as family therapy for adopted children, their families and professionals supporting them. A number of Looked After Children become adopted and have a range of needs that ADCAMHS aims to meet including pre-placement issues, attachment issues, and disruption. The service also delivers professional consultation including to schools and children's services. Referrals are from social workers and CAMHS (including referrals they receive from GPs or schools).[171]

ADCAMHS Service Data:

Number of Looked After Children placed for adoption in Jan 2014	Average number of Looked After Children placed for adoption per month - 2013	Average number of children approved for adoption per month - 2013
34	37	6

Source: East Sussex Looked After Children Team (2014) Looked After Children Dashboard

Feedback from the LAC mental health services therapeutic parenting group indicates deepened parents understanding of those attending these groups of both the actions of their foster child and their own roles and needs. Parents feel more able to cope with challenging behaviours and report that this type of course should be available to all foster carers.[172]

5.4.6 Community eating disorder service

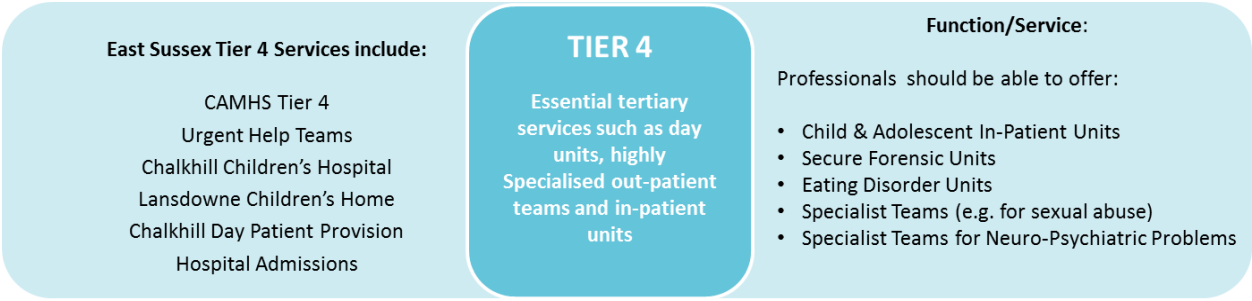
Service Overview: The Community Eating Disorder Service is an intensive home treatment service provided across East and West Sussex which enables, where possible, support on an outpatient basis to reduce inpatient admission. The service aims to empower young people to manage their eating disorder without interruption to other aspects of their lives such as education. The service offers: weekly outpatient appointments with a lead nurse for physical and mental health monitoring; parent support; family therapy; home and school visits at meal times; treatment through medication where appropriate; monitoring by telephone or text as appropriate; telephone consultation for young people and parents as required; joint working with Tier 4 Services if appropriate, and referral to the Family Group Service.

Service Data: Between October and December 2013 there were 30 young people accessing the community eating disorder service, a slight increase from the previous two quarters (27 young people). Of these young people, 80% are aged between 11 and 15 years and 20% 16 to 18 years. This represents a 20% increase in 11 to 15 year olds accessing the service between January 2013 and December 2013. Nine in ten young people accessing the eating disorder service are female which corresponds with national data.[173]

5.4.7 OWLS Outreach

Service Overview: CAMHS OWLS service is an outreach service to improve discharge outcomes and reduce referrals back into specialist CAMHS. The service is for young people and their families who are engaged in specialist CAMHS services. It provides support for those needing it outside of the clinical environment and outside of normal working hours. The OWLS service provides: community Family/Parent support for families engaged with specialist CAMHS services; sibling relationship work; therapeutic support; mentoring; community participation and inclusion and crisis intervention as required.

5.5 TIER 4 CAMHS SUPPORT



Tier 4 CAMHS are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.[174]

5.5.1 CAMHS Tier 4 Services

Service Overview: Tier 4 services in East Sussex are funded by the area team and provided by Sussex Partnership Foundation NHS Trust (SPFT) according to a Sussex-wide specification. Tier 4 services are delivered through a child and family centred multi-agency, stepped care approach providing: a comprehensive intensive home assessment service; a bespoke day service for under 12s and 5-8 day places for over 12s in the inpatient environment; 16 in-patient beds for young people from West Sussex, East Sussex and Brighton & Hove; and contribution to a 24/7 CAMHS crisis response service. The primary aims of the service are to alleviate distress caused by mental health problems, to encourage people to develop the skills required to maximise their potential, and to assist recovery by:

- assessment of need in collaboration with the team around the child;
- weekly acute service team meetings;
- use of care programme approach to maintain collaboration in care planning;
- planning treatment interventions with the young person and their support network;
- providing consistent contact with the care co-ordinator and multidisciplinary team delivering the treatment plan;
- access to occupational and psychological therapies and professionals;
- working closely with the family to feel safe for the young person to be at home.

Referrals to Tier 4 CAMHS services can be made by locality Tier 3 teams, Early Intervention Services or through on call mental health services called to assess a young person detained in police custody, or attending A&E department or paediatric ward. Young people aged between 12 and 18 years are eligible for Tier 4 CAMHS services provided that:

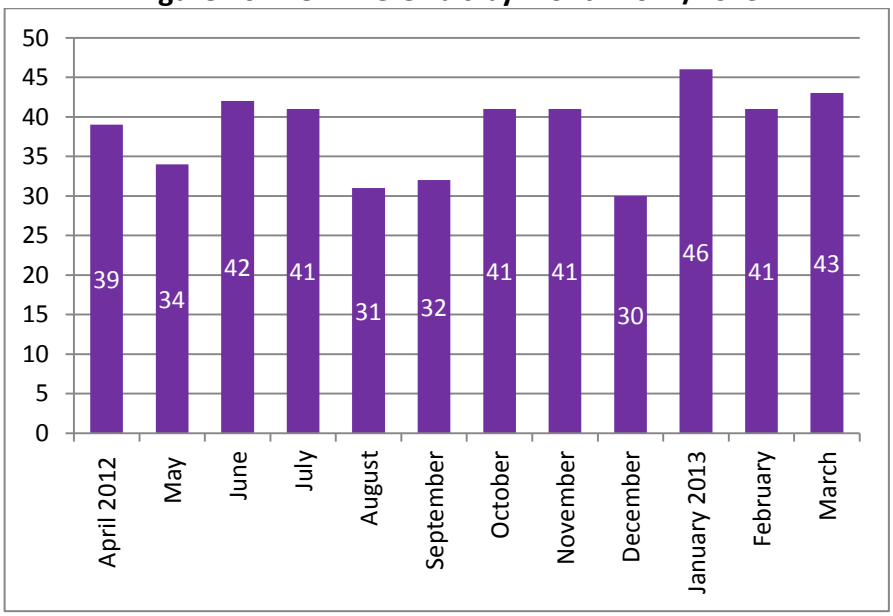
- There are severe mental health needs and levels of risk are so high that needs can only be provided within a specialist mental health in-patient setting;
- Acute mental health needs, behaviours and risks require 24 hour specialist service contact;
- There is significant harm to self or others, or deterioration in behaviour or function that cannot be managed in the home or placement environment if in the care system;
- Co-existing substance misuse issues and/or learning and communication difficulties including Autistic Spectrum Disorder & Asperger's Syndrome;
- Other behavioural disorders including ADHS requiring inpatient assessment and or short-term stabilisation before discharge to Tier 3 or Community Tier 4.

Referrals are not considered appropriate for level 4 provision if they involve: known Acquired Brain Injury; substance misuse problems where there is no co-existing mental health issue; Known learning disability where there is no co-existing mental health issue; primary presenting need is somewhere to live; an eating disorder requiring specialist inpatient services.[175]

Service data:

Referrals: In 2012/13 there were 461 referrals to Tier 4 services, 18% (79) of which were from East Sussex Downs and Weald PCT (ESD&W PCT) and 14% (58) from Hastings and Rother PCT (H&R PCT).[176] There were slightly lower numbers of referrals in 2012/13 in August/September and in December (Figure 20).

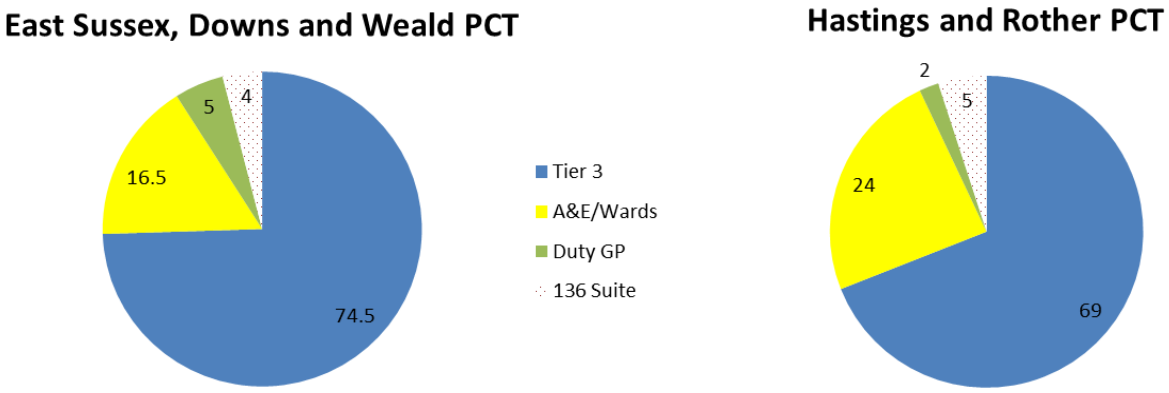
Figure 20: Tier 4 Referrals by month 2012/2013



Source: Sussex Partnership NHS Foundation Trust

In 2012/13 99 referrals were from Tier 3 CAMHS provision, equating to 75% of all ESD&W PCT referrals and 69% of all H&R PCT referrals to Tier 4 CAMHS (figure 21).[177] The total number of referrals (137) for East Sussex is significantly higher than expected from prevalence estimates for East Sussex (79).

Figure 21: Source of Tier 4 Referrals 2012/2013



Source: Sussex Partnership NHS Foundation Trust

Appointments Activity: In 2012/13 there were 1,067 face to face contacts attended by those referred from East Sussex; 775 from ESD&W PCT and 292 from H&R PCT. Of those from East Sussex referred to Tier 4 services, 3% were known to be young offenders and 7% had a recorded learning disability, including autism spectrum disorder. The ten most prevalent presentations at acute services in 2012/13 were: Hyperkinetic Disorders, Emotional Disorders, Conduct Disorders, Eating Disorders, Psychotic Disorders, Deliberate Self-Harm, Substance Abuse, Habit Disorders, Developmental Disorders, and Autistic Spectrum Disorders. [178]

5.5.2 Urgent help teams

Service Overview: To support the work between community mental health and acute admissions to mental health beds such as Chalk Hill an urgent help service has been commissioned to support discharge planning and hospital admission if required. Urgent help teams in East Sussex are in place to react quickly to those in crisis or urgent need, avoiding where possible the need for an inpatient stay and reducing the length of admission if required. Young people can be seen in crisis, out of hours, at evenings and at weekends, in A&E, paediatric wards and custody suite or in their own homes. Hospital paediatricians, social services and A&E doctors refer to this service.

5.5.3 Chalkhill Inpatient Facility

Service Overview: Early contact with CAMHS and Children's Social Care is essential to ascertain what resources are available to support the young person and to establish if a care plan exists. Should there be a requirement for admission to hospital following a mental health assessment, CAMHS are responsible for arranging a bed, if possible at Chalkhill on the Princess Royal site at Haywards Heath which is the CAMHS inpatient facility.[179]

Chalkhill Inpatient Facility (2012/13) Service Data:

Inpatient admissions	Females referred	Males referred	% of referrals from East Sussex		Type of admission		Average length of stay		Number discharged
			ESD&W PCT	H&R PCT	planned	Emergency Out of Hours	ESD&W PCT	H&R PCT	
71	58	18	26%	10%	46 (18 from E. Sussex)	25 (8 from E. Sussex)	50.4 days	40.1 days	58 (88% to home)

Source: Sussex Partnership Foundation Trust, Acute Services, Feb 2014

The diagnostic categories of the ESD&W and H&R PCT young people discharged during this period were: Emotional Disorders; Conduct Disorders; Eating Disorders and Psychotic Disorders. In Q4 of 2012/13 there was an acute shortage of Tier 4 beds across England; reflecting a national demand for Tier 4 beds for complex mental health issues. This trend has continued locally with Chalkhill running at full capacity with an average of 99.7% occupancy.

5.5.4 Lansdowne Secure Children's Home

Service Overview: Lansdowne Secure Children's Home is based at Lansdowne Children's Centre, Hailsham. It provides a regional resource for young people who are at significant risk of harming themselves or others and who cannot be cared for safely in open conditions. The core concepts for practice, within the SCH are based upon clear planning, appropriate interventions, evaluation and positive outcomes. Lansdowne SCH is currently undertaking construction work to expand the site. This will extend the number of placements from five to

seven.

Service Overview: Residents at Lansdowne are aged between 10 and 17 years old, with approximately three quarters female. The average length of stay is three and a half months and residents typically have a history of constant moves from one place to another. In 75% of cases the main reason for admission is a high risk of absconding or significant harm. For girls this is usually linked to sexual exploitation. Drugs are often also involved as is self-harm. For boys, there is often a history of violence. The young people admitted to Lansdowne SCH typically have very complex emotional and behavioural needs, which invariably have led to multiple breakdowns in previous placements. A high proportion of residents require mental health and substance misuse support. Discharge is generally to foster care, home or another secure unit. The most common mental health needs of children are reported to be (in order of the most common first): self harm; acute anger; eating disorders; learning difficulties; and attachment disorder.[180] Findings from a 2012 needs assessment concluded that Lansdowne Secure Children's Home provides a good level of care but there are issues of delays in engaging services such as smoking cessation and substance misuse services which can add to the issues of young children, and there is a need for more LAC nursing support, a wider spectrum of screening and health assessment at admission and improved multi-disciplinary communication.

5.5.5 Chalkhill Day Patient Provision

Chalkhill Day Patient (2012/13) Service Data:

Day patients at Chalkhill	Day patient attendances	E. Sussex Day patient attendances	
		ESD&W PCT	H&R PCT
29 (8 from E. Sussex)	351	29 (8%)	15 (4%)

The most prevalent presentations at day services in 2012/13 were: Emotional Disorders, Eating Disorders, and Psychotic Disorders.[181]

5.5.6 Hospital Admissions for Mental Health Conditions

Local Information: National evidence indicates an inpatient admission rate for mental health conditions in East Sussex of 82.3 per 100,000 of the 0-17 year old population. This equates to 86 inpatient admissions in 2011-12 due to mental health conditions in 0-17 year olds. This compares to a rate of 91.3 for England and 119.1 for the South East. Similarly admission rates for mental health disorders lasting over three days (12.5 per 100,000 0-17 year olds) are lower than both regional and national rates (26.4 and 14.8 respectively).[182]

Service Data: Nationally hospital admissions for self-harm in children have increased in recent years, with admissions for young females being much higher than admissions for young males. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.[183] Nationally held data indicates that there was a rate of 130.9 (per 100,000 0-17 year olds) hospital admissions as a result of self harm in East Sussex in 2010-11. This equates to 137 hospital admissions due to self-harm in 2010-11. Multi-agency pathways have been developed for young people who deliberately self-harm to ensure the young person is quickly assessed and receives the help they need.

A summary table of services available for the most at risk young people in East Sussex can be found in appendix 1.

SUMMARY: LOCAL SERVICE PROVISION

TIER 2

- In 2012/13 the **Flexible Learning Educational Support Service** received a third more referrals than in 2011/12
- In general, children and young people in East Sussex report a greater prevalence of **bullying** (66%) and physical bullying (43%) than nationally (52% and 29% respectively). 2012/13 saw a 132% increase in contacts with the anti-bullying service than in 2011/12
- Since the inception of **Targeted Youth Support** the number of Children In Need open to social care youth support teams has decreased by 13%.
- Over half accepted referrals to **Targeted Youth Support** (54%) are for emotional wellbeing.
- In 2013 Primary Mental Health Workers reported a noticeable **rise in consultation for depression/low mood**, and a 76% increase in consultation with school based keyworkers.
- The **SWIFT** service is effectively creating positive outcomes for parental and child health by tackling the effect of substance misuse issues on the whole family.
- A quarter of those in **Youth Offending Service** have emotional or mental health problems and complexity of need and risk for those accessing the service have been growing.
- There has been a yearly increase in families using multidisciplinary **Autism support groups**
- Currently 12 schools and services in East Sussex have achieved **Autism Accreditation**.

TIER 3

- There has been a slight increase in referrals to the **Community Eating Disorder** service over the last year, 9 out of 10 of those accepted are females.
- There has been a decrease in the number of **Looked After Children (LAC**) over the last 2 years, although LAC children under 1 year old have slightly increased.
- There appears to be increasing numbers of **looked after children** and young people with a child protection order requiring emotional and mental health support.
- The numbers of young people using the **LAC mental health service** has increased steadily in 2013 despite numbers of LAC children in East Sussex decreasing. However, the current caseload (120) is lower than the estimated 200 local LAC with mental health problems.

TIER 4

- Referrals **to Tier 4 services** are higher than expected from national estimates.
- The national shortage of **Tier 4 beds** for complex mental health issues is reflected locally
- East Sussex has lower than national and regional rates (91.3 and 119.1 per 10,000) of **hospital admissions for mental health conditions** in the 0-17 year old population (82.3);
- A 68% **increase in young people admitted to hospital for self harm** over the last 10 years, although rates fell in 2012-13.

6. Service User and Carer Voice

It is important to recognise that service users and carers have direct knowledge and experience of services which should inform the way services are designed and delivered. The information outlined below has not been collected specifically for the needs assessment but consists of existing consultation with children, young people, parents and carers obtained through a consultation exercise conducted as part of the re-procurement of school nursing and through routine feedback to specialist CAMHS. The main themes from existing service user/parent/carer consultation were:

6.1 SPECIALIST CAMHS

Service user experience of CAMHS services is collected via customer postcards. Of the postcards submitted in 2012/13, East Sussex achieved some of the highest satisfaction scores relating to service provision across Sussex. However, when asked whether service users felt involved in decisions about their care, 76% of East Sussex respondents responded positively compared to 79% across Sussex.

Tier 3 CAMHS have a range of engagement events, groups, forums, activities and projects to capture feedback from children and young people with mental health issues and their families.[184] Feedback suggests families find CAMHS staff to be responsive, sensitive, kind and willing to go the extra mile to be helpful. Of particular value to families are: when staff can be flexible in terms of appointment time and place; help with issues such as education or schooling which can impact on mental health; when young people can get hold of their clinician quickly e.g. via phone or email; alternative routes to CAMHS access such as peer support through participation forums; the value of peer support and shared experiences for carers and being seen as a person, not as a condition.

Key issues raised by parents include: a desire for greater involvement in decisions; a lack of understanding of how therapy sessions relate to behaviours encountered at home; a need for more age appropriate information and accessible CAMHS environments; feeling isolated, struggling with their child's behaviours and feeling judged by others parents; a perceived cultural gap between child and adult services; and a lack of opportunity for their child to socialise. Children and young people report feeling isolated, being bullied in the school setting, and a lack of understanding about their behaviours feeding in to the stigma of mental health. Young people would like to express feelings in creative ways other than talking, and find communicating with others with similar experiences helpful. [185]

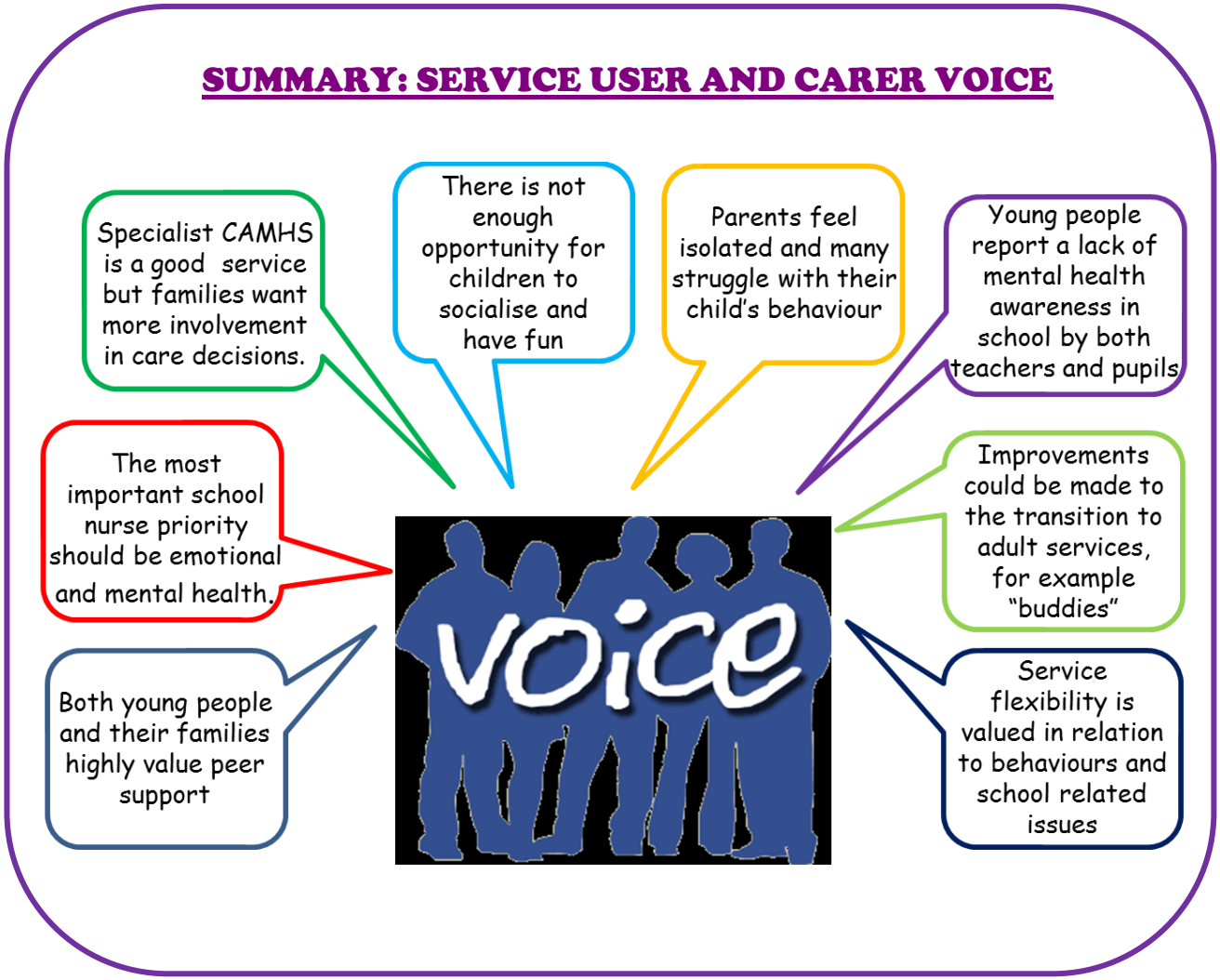
CAMHS has responded to feedback by: developing a social media website, twitter account and Facebook page; increasing numbers of art and play therapies and therapists; developing tools (Bullseye tool), booklets (Getting to know you) and opportunities to participate in service design and delivery; activities and outings for families to foster peer support and a film produced by young people to address mental health issues for use in schools and teaching settings. [186]

6.2 EMOTIONAL AND MENTAL HEALTH AND WELLBEING

The proportion of 14-15 year old pupils unhappy with their lives has increased over the last 5 years, and there has been a statistically significant decrease in the proportion of pupils scoring high levels of self-esteem. Particular worries relate to exams/tests and physical appearance (girls), and exams/tests and careers (boys).[187]

In the local 2013 Safer Schools survey of 10,500 students, the most common reason given for bullying was 'your appearance' (45%), followed by 'how you act or your personality' (40%). When taken as a whole, prejudiced based bullying (e.g. bullying due to race, religion, sexual orientation, physical appearance, special educational needs or disability), was mentioned by two-third of those who reported being bullied (66%), a significant increase of 18 per cent on the previous year.[188] In general, children and young people in East Sussex report a greater prevalence of bullying (66%) and physical bullying (43%) than nationally (52% and 29% respectively).[189]

Consultation with stakeholders including schools, services such as the Targeted Youth Service, GPs and health visitors, and children and young people was carried out in December 2013 to inform a review of the school nursing services and indicated mental and emotional health to be the most important priority for a School Health Team in both primary and secondary school. This finding is supported by consultation with over 11,000 local 11-18 year olds who identified zero tolerance on bullying and mental health services and education to be priorities for young people.[190,191]



7. Provider and Professional Voice

Those who provide services have a unique understanding of the perspective of how CAMHS in its wider form serves the needs of the population. The views of providers and GPs were elicited as part of needs assessment through a consultation exercise involving: a postal questionnaire, face-to-face interview, telephone interview or email questionnaire. A questionnaire of open ended questions regarding service provision was disseminated to GP's in East Sussex to provide the GP perspective of emotional and mental health provision for children and young people. In total 25 GPs responded to the questionnaire from a total of 75 practices that the questionnaire was sent to.

Semi structured interviews were conducted with key providers and partners to provide a provider perspective of emotional and mental health provision for children and young people in East Sussex. From an initial consultation list of 8 providers identified by commissioners, a further 33 were proposed either by commissioners or as a result of interviewee recommendation. A total of 41 key providers were therefore approached to inform this needs assessment, and of this number, 34 contributed, 27 via interview and 7 via email.

Providers interviewed included: CAMHS Tier 3; CAMHS Tier 4; Youth Offending; Targeted Youth Support; Specialist Mental Health Services; School Nursing; Community Voluntary Sector; Youth Employability Service; Primary School; Keyworker Service; CRI; Inclusion Services; Disability Services; Consultant Psychiatrist; Youth Support; Children's Centre Keywork; CAMHS Participation; Looked After Children; Transition; Flexible Learning Educational Support Service and the Family Intensive Support Service. There were 5 key questions asked to all providers interviewed:

1. In your opinion, what is **working well** for, or is particularly valued by, young people with emotional and mental health concerns and their families with regards to specialist provision.
2. Is there anything in terms of service provision and support locally that you think could be **done differently or improved**?
3. What, in your opinion, are the needs of children and young people with emotional and mental health concerns that are **not being met**?
4. Are there any **particular groups** of children and young people with mental or emotional health problems/disorders whose needs are not currently being met?
5. What, in your opinion, are the **priorities for commissioners** to address in the future plans?

Figures 22 and 23 summarise the issues raised by three or more providers or GPs according to the questions asked. The larger the bubble, the greater the number of providers that raised the issue (the total number is in brackets after each comment).

Detailed analysis of the key themes emerging from consultation with providers and professionals in East Sussex can be found in Appendices 2 and 3.

FIRGURE 22: KEY THEMES FROM GP CONSULTATION

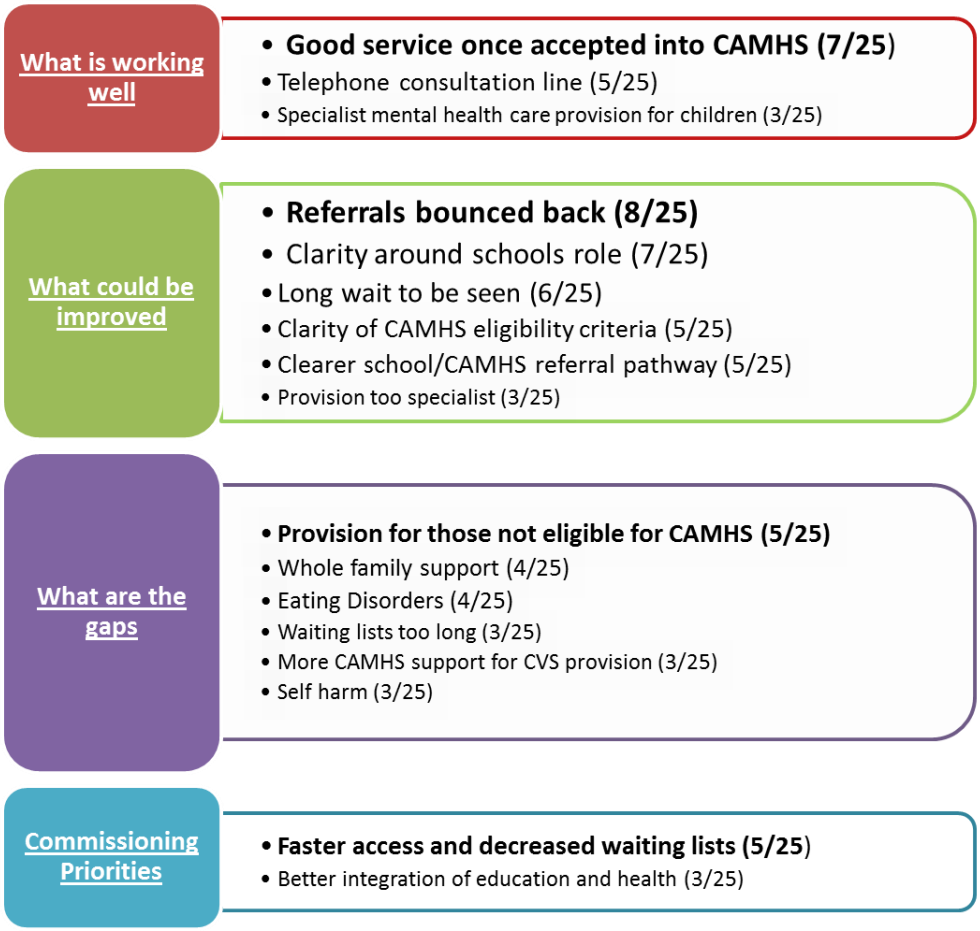


FIGURE 23: KEY THEMES FROM PROVIDER CONSULTATION

FINDINGS FROM PROVIDER AND GP CONSULTATION

Consultation with GPs and providers provides a very mixed view of CAMHS provision in East Sussex, with certain aspects, such as multi-agency partnership approaches working particularly well for some but needing improvement for others. The key themes which emerged from the consultation relate to: East Sussex's strategic approach; practicalities of provision; specific types of provision and access. Each of these areas will be looked at in turn.

The East Sussex Strategic Approach

The consultation highlighted a lack of understanding of the overall strategic approach to child and adolescent mental health services in East Sussex. Insight from providers and GPs indicates that there is confusion as to the strategic framework for organising and managing child and adolescent emotional and mental health, with two aspects being particularly highlighted:

- **Multi-agency partnership working** – Whilst much work has taken place to develop joint protocols and working practices it was felt that there are still important improvements to be made. Although multiagency working has been developed within more targeted services, including clear support pathways, complex planning processes and integration of specialist CAMHS support in wider services (e.g. Keyworkers, Targeted Youth Services and Under 19s substance misuse service) there is a perceived lack of such working methods with wider services. In developing partnership working, the keyworker role of single co-ordinator of care is highly valued. Providers and GPs feel that specialist Tier 3 practitioners should be part of a more widely integrated system consulting/advising those working with people not eligible for Tier 3 services. The effectiveness of this is felt particularly where CAMHS is co-located through services such as Targeted Youth Support and Primary Mental Health Workers.

- **Focus on early intervention –** In provider and GP opinion, investment in Tier 2 services would enable more people to deliver mental health support before crisis as well as better addressing the gaps in service provision for lower level/behavioural needs. Some providers suggested that East Sussex has a tendency to be reactive with young people sometimes having to wait until they are at crisis before they receive the support that they need, so it is essential early intervention and prevention services are further developed with the expert input of CAMHS to ensure the right skills are available at all levels of support. Providers feel that improving access to CAMHS consultation and advice for all services working with children and young people would enable earlier intervention and prevent subsequent referrals to Tier 3 services well as inappropriate referrals now.

Operational approach

The consultation raised a number of themes relating to the practicalities of CAMH provision in East Sussex in terms of the structured and sustainable development of a skill base and support system for children and young people with emotional and mental health issues. These themes broadly fall into the categories of training, information sharing and strengthening links particularly between education and CAMHS:

- **Training –** Mental health awareness training for all services, as well as the need for more specialist training for staff particularly in Tier 2 services were strong themes throughout the consultation. Twilight training was mentioned by many providers as particularly valuable for all those working with child mental health issues, but courses

need to be longer and in more depth to help staff support the rising complexity of behavioural needs presenting at Tier 1 and 2. In this vein improved training for school staff and nurses is perceived as a particular gap needing to be addressed, as well as improved support for community and voluntary services to help to meet lower level presenting needs. It was also suggested that more mental health training within the GP forum would be beneficial.

- **Information Sharing** – Providers and GPs feel that improvements could be made with the prioritisation of information sharing between specialist mental health services and other services as this has deteriorated over time. It is felt that CAMHS input is not always available when it is needed, for example when mental health support is initiated with families, and information sharing can be dependent on who the individual CAMHS worker is rather than through structural processes. The CAMHS telephone consultation line is particularly valued for addressing some of the concerns around borderline cases, signposting and preventing unnecessary referrals, but it is strongly felt that the opening times of the consultation line should be extended to meet increasing demand for specialist mental health consultation and advice.

  Practical issues were also raised specifically in relation to a lack of remote access to CAMHS information systems causing pressures on resources through time and travel, and the lack of joined up recording and monitoring across services. A more structured and sustainable and timely system of multi-agency communication would enable more effective and efficient support of emotional and mental health issues.

- **Strengthening of links between education and CAMHS –** The consensus from those consulted is that there is a need for additional emotional and mental health awareness and support within schools in particular. School nurses are regarded as a valuable resource but one that is under-resourced which has had a knock on effect to the level of emotional and mental health support that can be provided. Availability of support within schools is seen to vary considerably, particularly since budgets and prioritisation for some services, including behaviour support services, become nationally delegated from local authorities to schools. It is also felt that there needs to be greater clarity on the role of schools and school nurses and that communication, referral pathways and joint working between CAMHS and schools has to be improved. Improvements in these ways would enable earlier intervention and prevent delays or gaps in support for children. For example, currently some children who could be supported within schools as a first point of contact, are identified with a need and often referred to their GP, then on to specialist services and then back to the school.

Specific Types of Provision

Providers and GPs highlighted the importance of providing a holistic CAMH service for all children and young people needing support in East Sussex as well as their families:

- **Those not eligible for specialist services** - There is a strong message from providers that there is currently a large amount of unmet need for young people with issues which do not meet the criteria for Tier 3 CAMHS support. For example, those with behavioural and emotional wellbeing issues including high functioning ASD, ADHD, anxiety, school phobia, and self-harm. These issues are perceived to be increasing in presentation to services and support is not currently aligned to changing need. GPs in particular feel the number of lower level support workers in Tier 1 and 2 to be

"woefully insufficient" for the severity and amount of low level mental illness presenting, particularly behavioural problems, which GPs feel they are managing largely unsupported. Providers and GPs alike suggested that ideally services such as the school nurse service could be better utilised to provide level two services to fill a perceived gap in provision, although there was acknowledgement that there are currently limited resources to achieve this.

- **Whole family approach -** Whilst much work has been undertaken to the more holistic, whole family approach to mental health provision, for example through the work of keyworkers, the need for improved whole family support was raised by several providers and GPs who feel it would positively impact on family behaviours, mental health of the young person, and would allow for better support for parents and carers of young people to manage behavioural issues and develop coping mechanisms. It was noted that some emotional and behavioural needs are not mental health problems but are related to family context and behaviours, and promoting wider family behaviour changes would prevent these emerging issues developing into more complex mental health issues. Issues relating to specific risks such as self harm and eating disorders are also perceived to be increasing in prevalence without appropriate support available, and it is suggested that improved parental advice and family therapy would help to address these issues.

Access

The consultation raised a number of themes relating specifically to accessibility of mental health support for children and young people. While Specialist CAMHS provision is highly regarded among providers and GPs there is a perceived level of difficulty getting into the service. Themes relating to accessibility of service fall broadly into clarity of structure, clarity of eligibility criteria and clarity of referral process and pathways:

- **Clarity of structure –** Just under a third of GPs who responded to the consultation specified that Tier 3 CAMHS provision was working well, but the majority added a caveat of "when seen" or "after getting into the system" due to access difficulties and long waiting times. There is perceived ongoing restructuring of specialist CAMHS provision which is not being effectively communicated to those who may refer to or access the service in terms of how the system is structured, who is in charge and routes of access. From a wider perspective it is felt that drivers for change are lacking within child mental health provision across all tiers of support and there needs to be a stocktake of how structure and delivery has changed over the last few years and the impact of these changes on effective provision.

- **Clarity of eligibility criteria** – A strong theme across both providers and GPs was a lack of wider understanding of eligibility criteria, and which specific symptoms or young people to refer to Tier 3 services and which to refer elsewhere. It is felt that there is a lack of transparency and communication around CAMHS eligibility criteria, who works with who and how best to meet the needs of children. Issues were also raised with different eligibility criteria between adult mental health services and child mental health services making continuity of care difficult in the transition between services and it was suggested that more support is needed for easier transition from child to adult support.

- **Clarity of referral processes and pathways –** Effective multi-agency working will not be possible unless communication is improved between specialist services and Tier 1 and 2 providers in particular feel there is no clear, sustainable system in place of who to consult about mental health issues or how to consult, particularly for schools. Both providers and GPs feel that referral criteria and pathways for ALL services working with mental health issues need to be collated and widely disseminated to ensure referral and consultation is available via sustainable and clear pathways rather than reliant on individual relationships. GPs in particular perceive there to be high levels of referrals "bounced back" from specialist CAMHS to GPs or school nurses with little reason given or information on alternative routes to support making it very difficult to support the child.

The findings from this work show that specialist CAMHS services are viewed in a positive light, meeting the needs of children and young people who access these services. However, the strategic approach appears to be ill-defined and further work is needed to develop a holistic CAMHS service including early intervention, whole family approach, and specific diagnosis. Access issues around clarity of structure, eligibility criteria and referral processes and pathways act as a barrier to providing a service that effectively meets the needs of the population.

8. Conclusions

This Needs Assessment has outlined that East Sussex has an extensive array of services in place to support the mental and emotional well-being of children and young people, and that there has been quite considerable activity to improve services and to meet national targets over the last couple of years. The delivery of CAMHS at all levels is a complex task. The demand to keep up with population changes and the constant pressures of the emotional and mental health needs presented by children, young people, parents and carers, is an ongoing challenge. However, alongside this is a growing evidence base and body of practice learning that frontline practitioners and managers and the commissioners of services can draw upon – and this needs assessment adds to and enhances this body of knowledge of emotional and mental health provision as a whole. Nevertheless, and not surprisingly in a large diverse area such as East Sussex which poses a range of socio-economic difficulties, there are still areas of CAMHS provision that need to be further developed or aligned to meet current needs. The following conclusions outline the key findings of the needs assessment from which the recommendations of the needs assessment have been drawn:

8.1 SERVICE DESIGN AND DELIVERY

The needs assessment process has indicated difficulties identifying current prevalence of mental health issues in children and young people due to both inconsistency of data collection across services and the constantly changing needs of the local population. Estimates of prevalence based on national data have been provided to enhance available local information. The needs assessment has also highlighted that improvements are needed in promoting understanding and acceptance of emotional and mental health issues within the wider community. Consultation with providers and GPs in particular has indicated widespread confusion of thresholds and referral criteria across all mental health services.

There is good joint working across some services, particularly where there is a mental health specialist collocated or accessible such as a Primary Health Worker and multi-agency, integrated, outcome focussed services are working particularly well to meet need. However there is a lack of effective communication between specialist mental health services and Tier 1 and 2 services.

8.2 GAPS IN SERVICE PROVISION

The evidence outlined in this needs assessments has highlighted several areas where improvements could be made and where there are currently apparent gaps in provision:

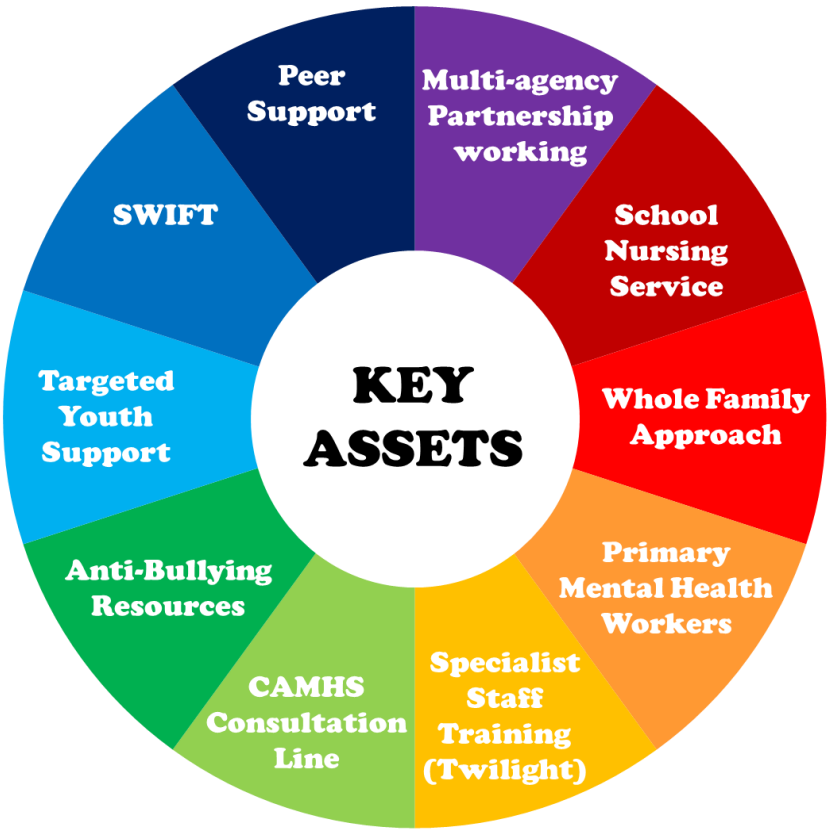
- Those with milder needs or emotional or behavioural difficulties often don't meet eligibility criteria for specialist mental health services and there is sometimes confusion as to where then to refer to.
- The School nursing service is valued by parents and carers but it is believed there needs to be increasing resource and emphasis on emotional and mental health support.
- There is a lack of mental health awareness in services and the general population.
- Providers perceive there to be a need for greater support for children with ASD and their families, particularly from mental health services and for behavioural needs.
- There appears to be a big cultural gap between child and adult support for emotional and mental health problems in terms of different ways of working, different thresholds and different eligibility criteria.

- Service providers identified that awareness of pathways to emotional and mental health support for schools and education is insufficient.
- Support in schools is variable and dependent in part on prioritisation of mental health by the school, especially in light of mental health support being funded out of school budgets.
- There are inequities in level of provision for pupils with behaviour related SEN compared to that provided for pupils with physical disabilities.
- CVS services do not seem to be effectively linked in with mental health services in East Sussex and could be better utilised to support emotional and mental health needs of young people.
- There is an apparent gap in follow-up support for young people who do not or are unable to attend appointments with specialist CAMHS services.
- Prevalence of behavioural and emotional issues is rising with limited targeted provision.
- There is a lack of local information on the **emotional and mental health needs** of young people who are known to be at greater risk of mental health issues, including:

Young Careleavers	LGBT young people
Homeless young people	Black & Minority Ethnic young people

8.3 KEY ASSETS

This needs assessment has identified a number of assets, such as services or ways of delivering support that are working particularly well or are particularly effective to meet the complex range of emotional and mental health needs of young people in East Sussex.



The main assets identified are:

- Services which have **multi-agency, partnership working** are very effective at meeting need, particularly where **CAMHS is integrated** into wider service provision such as within the Targeted Youth Support Service and the Youth Offending Team.
- Where it has been employed, the **whole family approach** provides holistic, contextualised support for children's emotional and mental health which is beneficial in the longer term by improving the resilience of both the young person and their family.
- **Primary Mental Health Workers** are very highly regarded as a vital link to Specialist CAMHS services and knowledge, particularly when co-located within wider services.
- **Specialist staff training** on emotional and mental health is essential and highly valued – particularly the Twilight Training Sessions.
- The **CAMHS consultation line** is particularly valued by professionals for helping with borderline cases and preventing unnecessary referrals.
- The **key worker** role is very highly regarded for the in-depth knowledge of the child and their needs, and as single point of contact for parents and services, creating more efficient communication and less duplication.
- East Sussex **anti-bullying resources,** produced to support SEND children and young people were used to inform the development of national training resources which are being rolled out to all Achievement for All schools in the country.
- Children and young people and their families particularly value groups enabling **peer support**, such as CAMHS woodland project and participation forums.
- The introduction of **Targeted Youth Support** is proving to work effectively as a gatekeeper service to Tier 3 specialist CAMHS services.
- The **school nursing service** is valued by parents and carers

Recommendations

RECOMMENDATION 1: The strategic vision for CAMH services in East Sussex needs to be clarified. In order to meet the mental health needs of children and young people now and into the future, a holistic CAMH service requires effective multi-agency working, an emphasis on early intervention and further development of the whole family approach.

RECOMMENDATION 2: Strengthen provision of universal services to reflect the increasing volumes and complexity of low level emotional, behavioural and mental health needs within the general population.

- Early recognition of emotional and mental health issues
- Developing parenting skills and promoting whole family resilience
- Building capacity within the universal workforce.
- Mental health and wellbeing promotion for the whole population

RECOMMENDATION 3: Ensure the workforce has the knowledge and skills to meet the emotional and mental health needs of children and young people across all tiers.

TIER 1

- Provide more training to promote early recognition and appropriate referral
- Build capacity through new partnership working with the voluntary sector

TIER 2

- Provide a consultation and advice role to lower Tier providers, specifically specialist advice and support to schools
- More co-location of mental health specialists into wider services to create a more holistic model of provision and foster greater links to Tier 3 CAMHS

TIER 3

- Extend the opening hours of the CAMHS consultation line
- Provide a consultation and advice role to lower Tier providers

ALL TIERS INCLUDING TIER 4

- The further development of multi-agency, multi-disciplinary pathways
- Pathways and protocols in place
- Access to website information provided by services

RECOMMENDATION 4: Develop a multi-disciplinary framework enabling a common set of data to be collected about individuals accessing all tiers of mental health services which can be regularly reviewed to better align provision to changing service trends and populations at risk. To include:

- Implementation of a multi-disciplinary framework for CAMHS across all agencies
- Development of clearer pathways
- Clarity around thresholds/eligibility criteria

RECOMMENDATION 5: Improve transition from children's to adult services, to include:

- Development of clearer pathways
- Clarity around thresholds/eligibility criteria
- Better alignment of ways of working to bridge the cultural gap between being supported as a young person and being supported as an adult.

RECOMMENDATION 6: Further work is required to fully understand and better meet the emotional and mental health needs of service users.

- Young people accessing Tier 1 and 2 services regarding their experiences.
- Specific high risk groups of mental health issues for whom there is currently little local information about their emotional or mental health needs:
  - Care leavers
  - LGBT young people
  - BME young people
  - Homeless young people

12. Appendices

APPENDIX 1: SUMMARY OF SERVICES AVAILABLE BY VULNERABLE GROUP

The following information outlines services that are available for some of the most vulnerable young people with emotional and mental health issues in East Sussex. These services support includes some degree of emotional or mental health provision. This represents a summary of the information in the following East Sussex CAMHS Directories of Support Services:

- Comprehensive CAMHS in Lewes, Uckfield, Heathfield And the Havens
- Comprehensive CAMHS In Eastbourne and Hailsham
- Comprehensive CAMHS in Hastings and Rother

More information can be found on each of these services in the CAMHS comprehensive directories on the Connexions website:
http://www.connexions360.org.uk/search/Pages/results.aspx?k=CAMHS&s=connexions&v1=relevance

Figure xx: Emotional and Mental Health Support for Vulnerable Groups: East Sussex

Vulnerable Group	Support Services
Significant Mental Health Problems	CAMHS (Child & Adolescent Mental Health Service), Dialogue, Early Intervention Service in Psychosis, Fegans Child & Family Service, Health In Mind Looked After Children Mental Health Service, Summerhayes Counselling, Sussex Downs College Student Support, Sussex Oakleaf, Urgent Help Service
Children with Learning Disabilities (LD)	Anti-Bullying Team, CAMHS LD and FISS (where a learning disability is present) Child Development Team (where a developmental problem is present), Children's Integrated Therapy Service COPES, CRI Connexions, Early Years Teaching & Support Services, Educational Psychologist, FISS (where a moderate to severe learning difficulty is present), FLESS, Information for Families, Language & Learning Support Service, School Nurses, SENCO's, Something Special Sussex Downs College Student Support SouthDowns Outreach Service Youth Employability Service YMCA School Counselling Service
Children with Physical illness	Children's Centres Keywork Team Children's Therapy Service Duty and Assessment team Health Visiting Service School Nursing Teams, Time to Talk/Mediation Plus Youth Support Team, Children's Services
Substance and Alcohol Misuse	Action for Change, Children's Centre Family Keyworkers, Clued Up Info,

	COPES, CRI Families & Parenting Service, Duty and Assessment Team ESCC, Health Visiting Teams, School nurse Teams, Shaftsbury Centre, Sussex Downs College Student Support, SWIFT Specialist Family Service, Targeted Youth Support Under 19s Substance Misuse Service.
Homeless young people	Home Works Lewes Foyer Targeted Youth Service YMCA Clued Up Info
Eating Disorders	Community Eating Disorder Service
Young LGBT	Allsorts Youth Project, Rainbow Families
Child Protection	Duty and Assessment Team ESCC East Sussex Family Group Conference FISS (where a moderate to severe learning difficulty is present) Health Visiting Teams, School nurse Teams, Named and designated doctors and nurses in each Provider Trust Sussex Downs College Student Support Youth Support Team
Looked After Children	Looked After Children Mental Health Service (LACMHS) Health Visiting Teams, School nurse Teams, Named and designated doctors and nurses in each Provider Trust
Young Offenders	CRI Families and Parenting Service Targeted Youth Support Youth Offending Service
Autism Spectrum Disorder (ASD)	ASD Monitoring and Support Group, Autism Sussex, Child Development Team, Children's Integrated Therapy Service, CRI Connexions, Early Years Teaching and Support Service, Families for Autism, FISS (where a moderate to severe learning difficulty is present), Health Visiting Team, Language & Learning Support Service, Music Well (Rye only) MyTime, SALT (see Children's Integrated Therapy Service), School Nurses, SENCO's, Spectrum, Sussex Downs College Student Support
Self-harm and suicide	CAMHS (Child & Adolescent Mental Health Services), Counselling Plus (16+) Fegans Child & Family Services, FISS (where a moderate to severe learning difficulty is present), Health Visiting Teams MyTime Samaritans School Nurse Teams Sussex Downs College Student Support Targeted Youth Support

APPENDIX 2: KEY THEMES FROM PROVIDER CONSULTATION

As part of the needs assessment process semi structured interviews were conducted with key providers and partners to provide a provider perspective of emotional and mental health provision for children and young people in East Sussex. In total 41 key providers were approached and 27 were interviewed with a further 7 contributing by email. Providers interviewed included: CAMHS Tier 3; CAMHS Tier 4; Youth Offending; Targeted Youth Support; Specialist Mental Health Services; School Nursing; Community Voluntary Sector; Youth Employability Service; Primary School; Keyworker Service; CRI; Inclusion Services; Disability Services; Consultant Psychiatrist; Youth Support; Children's Centre Keywork; CAMHS Participation; Looked After Children; Transition; Flexible Learning Educational Support Service and the Family Intensive Support Service. The following outlines in detail the key themes emerging from the provider consultation.

Q1. In your opinion, what is working well for, or is particularly valued by, young people with emotional and mental health concerns and their families with regards to specialist provision.

Just under half of providers consulted specified that CAMHS works best when there is effective **multi-agency, partnership working** and particularly where it is integrated into wider service provision. For example, the CAMHS psychologists in the Youth Offending Team (YOT) enable much needed mental health support without going through the CAMHS referral process (where they may not be eligible anyway), as well as providing mental health support for the caseworker particularly by attending home visits, screening those entering the YOT for mental health risks and enabling earlier support.

Where there are multi-agency meetings, clear support pathways, and multi-disciplinary complex planning processes, for example in the YOT and the Under 19s substance misuse service, mental health support has been much more accessible and intervention has been more effective. Primary Mental Health Workers were mentioned by several providers as an example of successful multi-agency partnership working. In a climate of reduced workforce and increasingly targeted services this model is also perceived to have made balancing workforce and targeting easier to manage.

Just under a third of stakeholders stressed the importance of **whole family support** and taking into consideration the wider context and support network of the young person when discussing intervention. By managing and supporting holistic family need the mental health of both the young person is further improved by strengthening their support system (family centred practice). Providers also indicated that a peer review element of whole family support, for both young people and their parent/carers, helps build coping mechanisms and tackles social isolation and stigma, whether it's via a support group or an arranged activity.

A quarter of providers highlighted the effectiveness and necessity of **staff training** on issues relating to emotional and mental health. Over half specifically mentioned Twilight Training as particularly valuable to look at different strands of need for new and existing staff alike. Training for behavioural issues, borderline emotional problems and issues with attachment and school refusal were specifically noted as advantageous for providers.

In addition to considering the wider context of the individual, providers also noted that considering the wider context of intervention was also very effective. **Non-clinical interventions**, for example through creative activities, are effective as young people do not feel like they are getting therapy through more creative interventions and so come of the stigma and unwillingness to attend is removed. Examples given of effective non-clinical interventions included CBT, motivational interviews, art and music therapy and CAMHS outings and activities. However some providers noted the increasing targeting of support and resource has affected the ability of staff to be more creative in the interventions given.

School Based Support, particularly school nurses, school based counselling and support for parents is found to be working well, but over half those mentioning school support added a caveat that levels and availability of support is highly variable across schools/geographical areas and is under-resourced.

A single point of contact (keyworkers), expert CAMHS consultation (where available) and Tier 2 services such as the Under 19s substance misuse service, community services and the Looked After Children offer were also highlighted as particularly effective ways of working with those who are more vulnerable, harder to engage and/or outside the threshold of CAMHS support.

Q2. Is there anything in terms of service provision and support locally that you think could be done differently or improved?

The greatest area of improvement required by providers is **communication between services,** particularly between CAMHS and wider services, both in relation to ways of accessing CAMHS mental health support and consultation, and in relation to updated information on CAMHS and mental health commissioning and strategy. A quarter of providers raising this issue particularly wanted improved communication between CAMHS and education with regards to expectations and practicalities of levels of provision available and needed within schools. Providers also stated one of the biggest barriers to effective working is the ability to have the *right* conversations with the right *people*. Several providers noted that care and support can be reliant on personal relationships with individual practitioners and this communication pathway is lost if the person is no longer in post. In this respect a more structured and sustainable system of multi-agency communication needs to be implemented.

While many providers noted the value of **multi-agency partnership working**, the perception is services do not work together as effectively as they could. Suggested improvements include:

- Recognising each other's skills and using shared expertise to best effect (ending silo working);
- A holistic, joint commissioning approach (for example replicating the model of adult service investment in child substance misuse within child mental health). Multi-agency working is perceived to be especially pertinent during this time of ongoing change within children's services in relation to the best way to address the impact and gaps caused by these changes within the current financial climate.
- Improved attendance at multi-disciplinary meetings. Providers feel little CAMHS presence in multiagency meetings relating to education and child protection. They also report disengagement with some meetings (e.g. Children's Boards) as they do not feel partnerships are making a difference. It is felt that this disengagement is meaning that expert insight is lost;
- Clearer joint protocols for coordination of care. For example, children seen in A&E could be checked on the Children's Index for links with other services.
- Closer working with Adult Services, particularly around communicating and preparing for the different systems of support provided by child and adult services.
- Developing greater partnership working between Tier 3 and Universal Tier 1 and Tier 2 services, including those provided by the voluntary and community sector (VCS). Insufficient partnership working in relation to skill-building around more complex and chaotic behaviours, and expert consultation, is preventing earlier intervention which has a knock on effect on young people needing to access specialist support later.

Improved communication and partnership working should be facilitated by **improved working relationships** between mental health services and wider services supporting the young person. In addition to the communication issues outlined above, the reliance on "who you know" is perceived to be in place of an effective relationship between CAMHS and wider services, including known referral pathways and sustainable processes. The need for improved relationships is particularly noted between CAMHS and schools. Support in schools is found to be variable and dependent in part on the prioritisation of mental health by individual schools, especially in light of mental health support being funded out of school budgets. It is felt that there is currently delay in accessing preventative advice and support and improved working relationship between mental health services, schools and school

nurses would improve the ability of schools to support their pupils' emotional and mental health. Providers also suggested use of each other's facilities for teaching, appointments, telephone and internet in between appointments etc. would facilitate such closer working relationships.

Improved and strengthened Tier 2 provision is needed specifically for young people with mental health issues and behaviours which are not eligible for CAMHS provision, such as behavioural and emotional issues or ASD. Improvement to Tier 2 provision is felt to decrease pressure on Clinical Tier 3 services. Building the skills and provision available through lower tier support would make it more accessible through earlier, preventative interventions and may enable some elements of CAMHS to be delivered in Tier 2 offers. Of particular note (with acknowledgement of associated resource implications) were greater utilisation of services such as school nurses and those provided by voluntary and community sector.

Providers noted that clarity is needed around **CAMHS eligibility criteria and referral processes** for all services so that there is increased awareness where the criteria do not fit, and where assessment and/or involvement of CAMHS is needed. In addition to this it was noted that often the criteria may not fit eligibility for CAMHS, yet expert consultation and advice would be beneficial both for the young person and for those supporting them. Providers note that more **in-depth training** in mental health awareness and skills is needed across all services, especially schools, doctors and health teams. It was felt that while Twilight training sessions, for example, were extremely well regarded, the length and depth of training needs to be greater to have a stronger impact on provision, particularly regarding behavioural problems and managing emotional and mental health issues not eligible for CAMHS.

Q3. What, in your opinion, are the needs of children and young people with emotional and mental health concerns that are not being met?

Providers widely acknowledge the benefits of **multi-disciplinary, partnership working**, but note that there are major gaps in this model of service provision locally. Support for children and young people's mental health is currently not seen to be SMART (specific, measurable, attainable, realistic and timely). To become SMART, mental health services need to more effectively work with other services (current perception is that mental health services work in silo with the family), towards the outcomes of one care plan. This could be achieved by:

- Specialist Tier 3 practitioners being part of an integrated system consulting and advising those working with young people not eligible for Tier 3 services;
- Clinicians paying more regard to wider individual contexts rather than making decisions primarily on medical diagnosis.
- More integrated, multi-agency pathways to provision and wider knowledge of these pathways to enable appropriate referrals;
- Better joint working and information sharing around the step-down from Tier 3/4 services into community provision.

Providers also cited the need for **specialist multi-agency training** across services as a major gap. It was felt that these should be provided along the lines of THRIVE training, but on a longer term basis and in more depth. For example, there has been training on skills to enable a child to communicate issues or needs, but there isn't sufficient knowledge of what to do if a professional starts noticing behaviours or if a child starts disclosing issues of emotional health and where to refer to. According to providers, specialist training should include early help prevention and screening training and could help staff to:

- Share skills and knowledge,
- Better work with young people and families (where appropriate) to change lifestyles and develop coping strategies;
- Address some of the increasing complexity of needs rather than refer elsewhere;
- Build the amount of emotional and mental health support for the increasing numbers of young people in East Sussex whose needs do not meet the criteria for CAMHS.

A separate point raised by providers is the need for **support and training particularly in schools.** For example, both providers and GPs cited examples of schools referring to GPs who refer to CAMHS who refer back to schools as the young person is not eligible for specialist support. Therefore, more emotional and mental health awareness training is needed for all school staff, some of whom are currently dealing with situations they feel are beyond their skills and knowledge. It was suggested that where schools have need only for occasional mental health support, one mental health professional could serve a cluster of schools as a preventative measure for future CAMHS service use. CAMHS support for school staff is also needed to provide counselling support.

Providers also reiterated the need for **improved communication** between CAMHS and wider services, with over half of providers raising this issue citing a lack of feedback from CAMHS as to why a young person is not eligible for CAMHS support and where alternative provision can be accessed. Providers also noted that, where appropriate, CAMHS should improve communication with other services who are also working with the young person so care can be coordinated in partnership. Communication was also raised by several providers as a separate issue in relation to wider services not having a clear picture of **CAMHS eligibility criteria, referral pathways and processes**. Providers repeated that links to CAMHS tend to be due to individual relationships rather than clear processes, and more clarity is needed both in general and specifically regarding how to access mental health support in an unexpected or emergency situation as there is no CAMHS emergency service. Clarity over pathways would also prevent inappropriate referrals to CAMHS, particularly amongst GPs where the perception is that inappropriate referrals to CAMHS are high.

One of the other greatest perceived gaps is Tier 1 and 2 provision for young people with **lower levels needs** who do not meet the criteria for CAMHS and for whom there is no clear process about who is best placed to respond between health, social care, schools and GPs. Providers consider there to be more emphasis recently on higher level needs and some perceive this to be to the detriment of Tier 1 and 2 early prevention and support. It was noted that there is an upper limit as to the mental health support Tier 1 and 2 services can provide, and there is an apparent gap between this support and the eligibility criteria for CAMHS. In particular there are noted gaps in mental health provision for: behavioural issues including ADHD and anger management; issues which are not necessarily mental health issues such as conduct disorder and school phobia; anxiety and ASD.

Q4. Are there any particular groups of children and young people with mental or emotional health problems/disorders whose needs are not currently being met?

The most cited group of young people with unmet need in relation to emotional and mental health support were those with **behavioural issues**, including ADHD. Providers noted that young people with challenging behaviours who "act out" and have poor emotional wellbeing have similar needs to those who are introvert but do not necessarily receive the same level of support. It was noted that in some cases behaviours are not related to mental health issues and changes to parent's behaviour can address these issues. However, blanket parenting courses do not address these individual family issues adequately.

It is also believed that the needs of young people with **emotional issues**, including school phobia, low mood, high levels of **anxiety** and social isolation are also not being adequately met. While some support is accessible and considered very effective, for example FLESS support for school phobia, it is considered that this is not enough for the complexity of emotional issues currently being presented. Defining these types of emotional and mental health issues is seen as particularly subjective, which means there is more need for structured screening and development of coping strategies at an earlier stage to prevent significant input being required later. There are also practical issues noted by providers which need to be overcome to effectively support emotional issues. The need for better **outreach support** was noted both in relation to emotional problems such as anxiety preventing a young person from leaving the house, and if a young person has particularly chaotic behaviour, or their

parents/carers have mental health issues then they are more likely to miss an appointment with mental health services and it is felt that in these cases there is a lack of flexibility to support the child. Similarly to GPs, providers also perceived there to be a gap in provision for young people lower on the spectrum or with high functioning **Autism Spectrum Disorder (ASD)**. If a child is not eligible for CAMHS or the Child Disability Service there is a gap in support in relation to the impact of ASD on both the child and their family. Providers acknowledge that services such as Autism Sussex are very positive in terms of peer support, but this is a voluntary service which some parents can be reluctant to access due to labelling and stigma, and the service is often fully booked with little alternative support available.

Of note, providers stated that **self harm** is increasing amongst young people and mental health provision is not necessarily meeting these young people's needs, and young **offenders** and **care leavers** are also noted as being at greater risk of mental health issues but lacking provision for emotional and mental health needs.

Q5. What, in your opinion, are the priorities for commissioners to address in the future plans?

Building on the qualitative evidence outlined above, the greatest priority is the need to build **multi-agency, partnership working, including commissioning of services** so that services become integrated (including **co-location** of mental health professionals), outcome focussed and SMART. More strategic development is needed in the ways services can collaborate, share information jointly commission, and work with **clear multi-disciplinary pathways** between health, education and social care services. There is a perceived danger that if specific multi-agency direction is not provided, funding cuts will mean that people will increasingly work in silo.

Improved multi-agency working should involve **CAMHS consultation and advice to wider services** build capacity in terms of capability and skills and to facilitate early intervention and prevention. This would enable higher levels of need to be addressed within Tier 2 to prevent escalation of young people's needs to requiring Tier 3 intervention.

Investment in Tier 2 services would enable more people to deliver mental health support before crisis as well as better addressing the gaps in service provision for lower level/behavioural needs. There is a perception that in some cases young people have to wait until they are at crisis before they receive the support that they need. It was suggested that East Sussex has a tendency to be reactive, and as such it is essential that **early intervention and prevention** services are further developed with the expert input of CAMHS to ensure that the right skills are available at all levels of support. The effectiveness of primary mental health workers being attached to early help teams was an example given of effective multi-disciplinary early intervention. Providers also particularly noted that while there needs to be **more mental health education and training** for all staff working with children and young people to increase awareness and skills, it would not be effective to place too many skills on individual roles in place of having specialist knowledge and provision.

SUMMARY OF SERVICE PROVIDER VOICE

The main themes were as follows:

- **Multi-agency partnership working** – Whilst much work has taken place to develop joint protocols and working practices it was felt that there are still important improvements to be made. Although multiagency working has been developed within more targeted services, including clear support pathways, complex planning processes and integration of specialist CAMHS support in wider services (e.g. Keyworkers/YOT/Under 19s substance misuse service) there is a perceived lack of such working methods with wider services. In developing partnership working, the keyworker role of single co-ordinator of care is highly valued.

- **Improved communication –** Providers perception is that effective multi-agency working will not be possible unless communication is improved between services. Tier 1 and 2 providers feel there is no clear, sustainable system in place of who to consult about mental health issues or how to consult, particularly for schools. The most successful communication pathways appear to be where there are existing relationships at an individual level across services rather than through clear referral and consultation processes. Referral criteria and pathways for ALL services working with mental health issues need to be collated and widely disseminated.

- **CAMHS consultation with wider services –** Providers feel that improving access to CAMHS consultation and advice for all services working with children and young people would enable earlier intervention and prevent subsequent referrals to Tier 3 services well as inappropriate referrals now. The perception is that specialist Tier 3 practitioners should be part of a more widely integrated system consulting/advising those working with people not eligible for Tier 3 services. The effectiveness of this was indicated as where CAMHS is co-located through services such as Targeted Youth Support and Primary Mental Health Workers.

- **Improved school based support –** The consensus from those consulted is that there is a need for additional emotional and mental health awareness and support within schools. School nurses are regarded as a valuable resource but one that is under-resourced which has had a knock on effect to the level of emotional and mental health support that can be provided. Four providers mentioned a current issue being the fact that availability of support within schools varies considerably as funding for mental and emotional health support is now the responsibility of individual schools and whether they prioritise it.

- **Multi-agency mental health training** - Mental health awareness training for all services, as well as the need for more specialist training for staff particularly in Tier 2 services were strong themes throughout the consultation. Twilight training was mentioned by many providers as particularly valuable for all those working with child mental health issues, but courses need to be longer and in more depth to help staff support the rising complexity of behavioural needs presenting at Tier 2. In this vein improved training for school staff and nurses is perceived as a particular gap needing to be addressed.

- **Investment in tier 2 services –** Provider perception is that investment in Tier 2 services would enable more people to deliver mental health support before crisis as well as better addressing the gaps in service provision for lower level/behavioural needs. There is an additional perception sometimes young people have to wait until they are at crisis before they receive the support that they need. Some providers suggested that East Sussex has a tendency to be reactive, so it is essential early intervention and prevention services are further developed with the expert input of CAMHS to ensure the right skills are available at all levels of support.

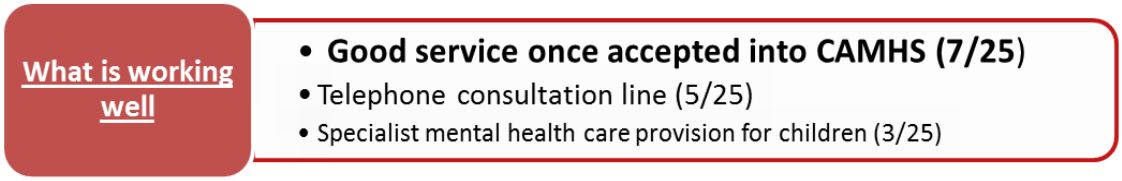
- **Support for behavioural and emotional needs** - There is a strong message from providers that there is currently unmet need for young people with issues which do not meet the criteria for Tier 3 CAMHS support such as behavioural and emotional wellbeing issues including high functioning ASD, ADHD, anxiety, school phobia, and self-harm. These issues are perceived to be increasing in presentation to services and support is not currently aligned to changing need.

- **Holistic whole family support -** The need for whole family support was raised by several providers both in relation to the impact of family behaviours and mental health on the young person, and in relation to the need for better support for parents and carers of young people particularly with regard to managing behavioural issues and development of parental coping mechanisms. Providers noted that some emotional and behavioural needs were not mental health problems but were related to family context and behaviours, and promoting wider family behaviour changes would prevent these emerging issues developing into more complex mental health issues.

APPENDIX 3: KEY THEMES FROM GP CONSULTATION

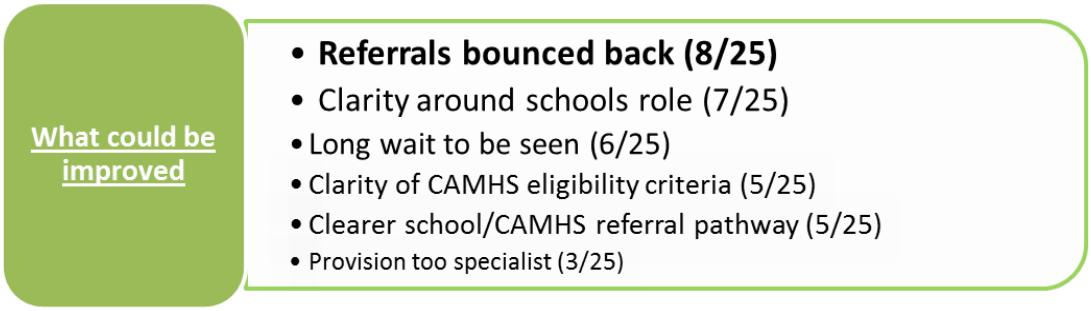
A questionnaire of open ended questions regarding service provision was disseminated to GP's in East Sussex to complement existing data and provide the GP perspective of emotional and mental health provision for children and young people. In total 25 GPs responded to the questionnaire from a total of 75 practices that the questionnaire was sent to. The issues outlined below are those raised by multiple GPs as areas to note. The larger the font, the greater the number of GPs that raised the issue (the total number is in brackets after each comment).

Q1. What is working well for, or is particularly valued by, young people with emotional and mental health concerns and their families with regards to specialist provision.



Just under a third of GPs who responded to the consultation specified that **Tier 3 CAMHS provision** was working well, but all added a caveat of "when seen" or "after getting into the system", implying a level of difficulty getting into the service. The **CAMHS consultation line** is particularly valued by GPs for helping with borderline cases, signposting and preventing unnecessary referrals. Access to specialist mental health care and trained psychological support is also valued by GPs.

Q2. Do you have any specific comments on current specialist provision (including inpatient) and what could be done differently?

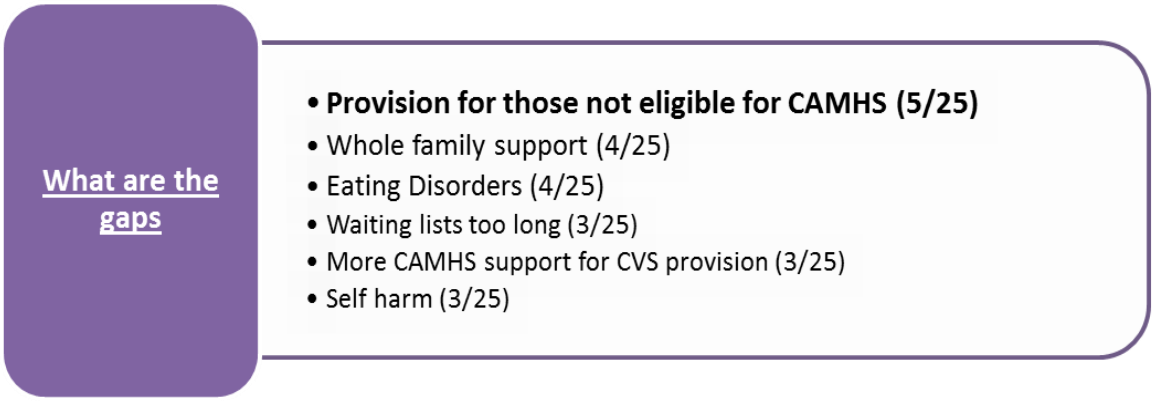


The main area of improvement raised by a third of GPs was that **referrals** to Tier 3 CAMHS are often bounced back either to GPs or to school nurses with inadequate or no advice as to why the referral was not accepted. The perception is that this lack of explanation makes it very difficult to support the child and results in the child being "bounced around" between the school, GP and CAMHS. This adds to the perceived issue of **waiting times to see CAMHS** being too long. GP's stated that it takes too long for patients to be seen after referral, or for CAMHS to internally discuss cases which are then bounced back to the school. Furthermore, GPs raised the need for clarity around the **roles of schools** and school nurses with regards to emotional and mental health support. GPs perceive "overt pressure" from school for parents and carers to go to the GP without using internal resources such as school nurses and counselling services first. This can cause additional delays in cases where CAMHS then refer the young person back to the school to deal with. GPs note that a **clearer school/CAMHS referral pathway** would clarify some of these issues, as would clarity around **CAMHS eligibility criteria**.

A number of GPs stated a lack of clarity over how the Tier 3 CAMHS system works, who to refer to and which specific symptoms to refer to Tier 3 services and which to refer elsewhere. It was suggested that more mental health training service within the GP forum would be beneficial. The final emerging theme was that current **CAMHS provision is too specialist** and that there is a lack of responsive lower

level support workers to help "bread and butter emotional/behavioural problems" which leave GPs feeling that they are managing problems unsupported.

Q3. What, in your opinion, are the needs of children and young people with emotional and mental health concerns not being met?



The gap most often cited by GPs is for those with lower level needs that are **not eligible for Tier 3 CAMHS support** (5/25), with Tier 1 and 2 provision, including the school nursing/counselling support available being "woefully insufficient" for the severity and amount of low level mental illness presenting, including for children who have behavioural problems as opposed to "mental illness".

Whole family support, particularly parental advice and family therapy is perceived to be a gap in current emotional and mental health provision, particularly regarding behavioural difficulties, and issues such as eating disorder and self-harm. Additionally GPs noted the inadequacy of appropriate psychological support for those with **eating disorders** and for those who **self harm** both of which are seemingly increasing in number). GPs also noted that there needed to be: more **support for voluntary sector provision**, particularly regarding behavioural support and advice giving, and **reduced waiting lists**.

Q4. What, in your opinion, are the priorities for commissioners to address in the future plans?

The main priority GP's cited for commissioners to address is the need for **faster, improved access to mental health services and reduced waiting lists**. They wanted better integration and improved pathways between **health and education**, involving better mental health awareness and greater clarity around referral processes. GPs also noted that there needed to be: greater Tier 1 and 2 provision as there are gaps in managing mental health issues outside of Tier 3 CAMHS; more counselling services intervening at an earlier stage; a clearer idea of resources available to assist appropriate triage and more mental health education and training for GPs and those working with young people.

SUMMARY OF GPs VOICE

- **Access to Specialist CAMH services –** Just under a third of GPs who responded to the consultation specified that Tier 3 CAMHS provision was working well, but the majority added a caveat of "when seen" or "after getting into the system", implying a level of difficulty getting into the service. Particular access issues include timeliness of assessment, a lack of wider understanding of eligibility criteria and confusion over referral processes and which specific symptoms to refer to Tier 3 services and which to refer elsewhere. It was suggested that more mental health training within the GP forum would be beneficial.

- **Improved communication, consultation and advice** – GPs perceive there to be high levels of referrals "bounced back" from specialist CAMHS to GPs or school nurses with little reason given or information on alternative routes to support. The perception is that this lack of explanation, and the time it takes to communicate an unaccepted referral, makes it very difficult to support the child and results in the child being bounced around between the school, GP and CAMHS. While GPs particularly value the CAMHS telephone consultation line for addressing some of the concerns around borderline cases, signposting and preventing unnecessary referrals, it is strongly felt that the opening times of the telephone consultation line should be extended to meet an increasing demand for specialist mental health consultation and advice.

- **Support for lower level needs or behavioural issues** – Similarly to providers, GPs feel there is currently unmet need for young people with issues which do not meet the criteria for Tier 3 CAMHS (with lower level needs or behavioural issues that are not clarified as "mental illness"). GPs feel Tier 1 and 2 the number of lower level support workers (including school based support) to be "woefully insufficient" for the severity and amount of low level mental illness presenting, particularly behavioural problems which GPs feel they are managing largely unsupported.

- **Better Integration and Improved pathways between health and education –** GPs feel there is a need for clarity of the role of schools and school nurses in relation to emotional and mental health support and that communication, referral pathways and joint working between CAMHS and schools needs to be improved. This would enable earlier intervention and prevent delays or gaps in support for children which could be provided through, for example schools counselling services but instead is referred to the GP or specialist services before being referred back to the school to deal.

- **Holistic whole family support -** The need for whole family support was raised by several GPs, particularly in relation to parental advice, family therapy and issues relating to specific risks such as self harm and eating disorders which GPs perceive to be increasing in prevalence without appropriate support available.

Acknowledgements

I would like to acknowledge the contribution of all those who have given their time and have provided information and expertise for this Needs Assessment, in particular:

Alastair Lee Manager	Data and Information
Alison Borland	Head of Children's Disability Services
Alistair McGrory	Operations Manager, Targeted Youth Support
Anita Barnard	Senior Schools & Community Services Manager YMCA
Ann-Marie Skarstam	Consultant Child and Adolescent Psychiatrist
Brian Hughes	Head of Youth Justice and Targeted Youth Support
Carol Jackson	Business Manager
Caroline McKiddle	Partnership Manager Education, Employment & Training
Catherine Watson	Hastings Voluntary Action
Chris Gurney	Information Systems Manager
Christine Unsworth	CEO Fellowship of St Nicholas
Claire Findlay	Hailsham Community College
Dave Burbidge	Research and Information Manager Youth Offending Team
David Standing	CEO Sussex Central YMCA
Debbie Mentessi	School Nursing Team Leader
Fay Mitchell	Operations Manager Children's Centre Keywork
Jacqui Batchelor	Deputy Service Director SPFT
Jane Clarke	Information Systems Analyst
John Kahn	Strategic Lead Officer Anti-Bullying Initiative
Julie Turner	Transition Service Manager
Lara Tonkin	Youth Employability Service Partnership Broker
Lesley Brown	Services Promotion Manager FSN
Louise MacQuire-Plows	Project Manager Organisational Development
Lorraine McGlone	Business Support Manager
Marian Williams	FISS Head of Service
Mark Menning	TYS Emotional Wellbeing Practice Manager
Mark Woodgate	Practice Manager 5-13yrs early help
Matthew Stone	Specialist Services East Sussex and Brighton & Hove CYPD
Mick McGlynn	Operations Manager Youth Support Community Teams
Nathan Caine	Interim Head of Inclusion Support Services
Neil Small	Castledown Primary School Head Teacher
Nick Clarke	CAMHS Acute Service Manager
Pauline Edwards	Senior Project Worker CRI families and parenting service
Peter Joyce	General Manager East Sussex and Brighton & Hove CYPD
Rachel Swann	Clinical Psychologist
Rivkah Cummersome	CAMHS Youth Engagement and Participation Manager
Sally Carnie	Head of LAC services
Stephen Hudson	Information Analyst
Sue Davies	CAMHS Team Leader
Sue Marsh	FLESS Manager
Tania Riedel	Youth Offending Team Manager
Teresa Lavelle-Hill	Head of LAC services
Tina Frost	Family Support Keywork Service Manager
Vicky Finnemore	Head Of Specialist Services - Children's Service Division

[1] Wolpert, M. Update on the Children's NSF- Mental Health and Psychological Wellbeing Module. 2003.
[2] DH NSFC. Child and Adolescent Mental Health, 2010
[3] World Health Organization. 2004. Promoting Mental Health: Concepts; emerging evidence; practice. Geneva: WHO.
[4] As set out in two diagnostic manuals:

- World Health Organization. 2007. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic Guidelines. Geneva: WHO.
- American Psychiatric Association. 2000. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Arlington: APA.

[5] National CAMHS Support Services (2011) Better Mental Health Outcomes for Children and Young People A resource directory for commissioners Www.chimat.org.uk/camhs/commissioning

[6] Green H. et al (2005) Mental health of children and young people in Great Britain, 2004,ONS

[7] English and Welsh Civil and Social Justice Survey (CSJS)

[8] With Rights in Mind Youth Access (2009)

[9] Department of Health (2009) (Confident Communities, Brighter Futures: A Framework for Developing Wellbeing

[10] Street et al (2007) Maintaining the Momentum: towards excellent services for children and young people's mental health The NHS Confederation.

[11] Department of Health (2004) CAMHS Standard, National Service Framework for Children, Young People and Maternity Services

[12] Department of Health (2008) Children and young people in mind: the final report of the National CAMHS Review

[13] Department of Health (2011) No Health Without Mental Health: Delivering better mental health outcomes for people of all ages

[14] Department of Health (2011) Talking therapies: a 4 year plan of action

[15] Department of Health (2011) No Health Without Mental Health: Implementation Framework

[16] Department of Health (2012) Preventing Suicide in England – A cross-government outcomes strategy to save lives

[17] Department of Health (2013) Making mental health services more effective and accessible

[18] Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services

[19] Eastbourne, Hailsham and Seaford CCG (2013) Eastbourne, Hailsham and Seaford CCG formal Governing Body Meeting Item Number: Date of meeting: 11 September 2013 172/13: Joint Commissioning Strategy for Children and Young People 2013-15.

[20] Hallam (2008) The Effectiveness of Interventions to address health inequalities in the early years: a review of the relevant literature. Scottish Government, Health Analytical Service Division

[21] NICE (2012) Social and emotional wellbeing: early years NICE public health guidance 40

[22] Chief Medical Officer (2012) The first Critical 1001 days: the importance of conception to age 2 – cross parliamentary group publication

[23] Chief Medical Officer (2012) The first Critical 1001 days: the importance of conception to age 2 – cross parliamentary group publication

[24] East Sussex County Council (2013) Children's Services Portfolio Plan 2013/14 – 2015/16

[25] East Sussex County Council (2013) Annual Report of the Director of Public Health 2013/14

[26] Department of Health (2011) Children and Young People's Emotional Wellbeing and Mental Health National Support Team The learning: 'What good looks like'

[27] Department for Education (2011) Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011

[28] PHAST (July 2013) East Sussex Health and Wellbeing Strategy Literature review – Priority Area 5: Enabling people to manage and maintain their mental health and wellbeing.

[29] Pickin, M (2013) East Sussex Maternity and Paediatric Needs Assessment, Public Health.

[30] Association of Public Health Observatories (Mar 2011) Child poverty - IMD 2010 IDACI

[31] Association of Public Health Observatories (Mar 2011) Child poverty - IMD 2010 IDACI http://www.apho.org.uk/resource/item.aspx?RID=97317

[32] East Sussex Public Health Intelligence Team (Jan 2013) Indicator scorecards: LA view.

[33] Egger, H et al (2006) Common emotional and behavioural disorders in preschool children: presentation, nosology and epidemiology. Journal of psychology and psychiatry 47. 313-37

[34] CHIMAT (2013) Service Snapshot Child and Adolescent mental health services East Sussex Geogrraphies

[35] McCrone, P; Dhanasive, S; Patel, A; Knapp, M. and Lawton-Smith, S. (2008) Paying the Price: The cost of mental health care in England to 2026, The Kings Fund

[36] Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. and Meltzer, H. (2001) Psychiatric morbidity among adults living in private households, 2000. Office for National Statistics. London. HMSO.

[37] HSCIC (Feb 2014) Hospital admissions due to anxiety and stress per 100,000 of population by age. December 2012 – November 2013

[38] National Institute for Health and Clinical Excellence (Sept 2011) Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum NICE clinical guideline 128 guidance.nice.org.uk/cg128

[39] National Institute for Health and Clinical Excellence (Sept 2011) Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum NICE clinical guideline 128 guidance.nice.org.uk/cg128

[40] Taylor, B. et al (Oct 2013) Prevalence and incidence rates of autism in the UK: time trend from 2004–2010 in children aged 8 years BMJ open Vol 3, Issue 10

[41] Baird G, Simonoff E, Pickles A, Chandler S, Loucas T, Meldrum D. (2006) Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). Lancet 2006; 368: 210–5.

[42] Taylor, B. et al (Oct 2013) Prevalence and incidence rates of autism in the UK: time trend from 2004–2010 in children aged 8 years BMJ open Vol 3, Issue 10

[43] http://www.bacch.org.uk/publications/other_service_improvement.php

[44] Baron-Cohen S et al. Prevalence of autism-spectrum conditions: UK school-based population study. The British Journal of Psychiatry (2009) 194: 500-509

[45] National Autistic Society (accessed July 2016) Autism Facts and History http://www.autism.org.uk/about/what-is/myths-facts-stats.aspx

[46] Emerson, E. and Baines, S. (2010) *The estimated prevalence of autism among adults with learning disabilities in England*. Stockton-on-Tees: Improving Health and Lives.

[47] The National Autistic Society, cited by PANSI, accessed March 2016.

[48] Emerson, E. and Baines, S. (2010) *The estimated prevalence of autism among adults with learning disabilities in England*. Stockton-on-Tees: Improving Health and Lives.

[49] Emerson and Hatton (2008) People with Learning Disabilities in England. Centre for Disability Research

[50] Based on 2016 numbers of school pupils in East Sussex, provided by Data Research and Information Team, Children's Services, ESCC

[51] East Sussex County Council (2012) East Sussex Children's Services Annual Report for Autism Spectrum Disorder 2011-12

[52] NICE Clinical Guidance (2008) Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults
[53] Kurtz, Z. (1996) Treating children well : a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.
[54] McCrone, P; Dhanasive, S; Patel, A; Knapp, M. and Lawton-Smith, S. (2008) Paying the Price: The cost of mental health care in England to 2026, The Kings Fund
[55] Department of Health (2011) No Health Without Mental Health: Delivering better mental health outcomes for people of all ages
[56] World Health Organization. 2004. Promoting Mental Health: Concepts; emerging evidence; practice. Geneva: WHO.
[57] HM Gov (2010) Confident Communities, Brighter Futures: A Framework for Developing Wellbeing, Department of Health
[58] Department for Children, Schools and Families (October 2009) Children with special educational needs 2009: an analysis.
[59] WHO (2004). Prevention of Mental Disorders. Effective interventions and policy options. Geneva: World Health Organization.
[60] National Institute for Health and Clinical Excellence. Costing Statement: Pregnancy and complex social factors, September 2010.
[61] Passive smoking and children. Report by the Tobacco Advisory Group of The Royal College of Physicians, March 2010.
[62] East Sussex Maternity and Paediatric needs assessment (2013) Public Health: ESHT, BSUH and MTW maternity unit 2012/13 delivery data
[63] O"Connor TG, Heron J, Golding J et al (2003) Maternal antenatal anxiety and behavioural/emotional problems in children: A test of a programming hypothesis. *J Child Psychol Psychiat,* 44,1025-1036.
[64] Bergman K, Sarkar P, O'Connor TG et al (2007) Maternal stress during pregnancy predicts cognitive ability and fearfulness in infancy. J. Am. Acad. Child. Adolesc. Psychiatr, 46, 1454-1463
[65] East Sussex Maternity and Paediatric needs assessment (2013) Public Health
[66] Colman I, Ploubidis GB, Wadsworth MEJ et al (2007) A longitudinal typology of symptoms of depression and anxiety over the life course. *Biol Psychiatry*, 62, 1265–1271
[67] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO
[68] Office for National Statistics, VS1 Series (Published in ESIF November 2012). Tables, charts & maps | Population & households | Birth and death rates | Low birth weight rates, 2000-2011 - districts
[69] NSPCC (2011) All Babies Count Campaign
[70] Gavin NI, Gaynes BN, Lohr KN *et a.* (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynecology*, *106*, 1071–1083.
[71] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO
[72] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.
[73] Office of National Statistics (2013) Adults not in employment and dependent children and persons with long-term health problems or disability for all households
[74] Meltzer H, Gatward R, Corbin T et al (2003) Persistence, onset, risk factors and outcomes of childhood mental disorders. ONS, London TSO
[75] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.
[76] Office of National Statistics (2013) Highest level of qualification by number of dependent children by hours worked by sex
[77] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.
[78] CACI PayCheck data (Published in ESIF July 2010). Tables, charts & maps | Economy, jobs & prosperity | Earnings, income and wealth | Households in poverty, 2012 - wards
[79] HM Revenue & Customs, Child poverty statistics (Published in ESIF October 2012).
Table produced from the data in Tables, charts & maps | Deprivation | Children living in poverty | Children living in poverty, 2006-2010 – super output areas
[80] ACE measures nine adverse childhood experiences occurring before the age of 18: physical abuse, sexual abuse, verbal abuse, exposure to domestic violence, parental separation, and living with a household member who has alcohol problems, uses drugs, is mentally ill or is incarcerated. Centres for Disease Control and Prevention (2005) Adverse Childhood Experiences Study http://www.cdc.gov/
[81] Collishaw S, Pickles A, Messer J et al (2007) Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect*, 31, 211–229
[82] Cawson (2002) Child maltreatment in the family: the experience of a national sample of young people. London: NSPCC.
[83] Children's Right's Director Annual Monitoring Report (2011) Office of the Children's Rights Director
[84] Safer Schools Survey (2013) Anti-bullying Team
[85] Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001) Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. JAMA, 286(5), 572-9.
[86] Povey D, Coleman K, Kaiza P, Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime in England and Wales 2007/08). Home Office Statistical Bulletin
[87] Zammit S, Allebeck P, Andreasson S et al (2002) Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study. BMJ, 325(7374),1199.
[88] NatCen. (2009) Smoking, drinking and drug use among young people in England in 2008, schools survey. NHS Information Centre for Health and Social Care
[89] The Schools Health Education Unit. Young People in East Sussex Schools: the health behaviour of young people aged 14-15 in 2012
[90] Emerson E, Hatton C (2007) Mental health of children and adolescents with intellectual disabilities in Britain. British Journal of Psychiatry,191, 493-499.
[91] Wright, B., Williams, C., and Richardson, G. (2008) Services for children with learning disabilities, in Psychiatric Bulletin (2008), 32, 81/84
[92] Emerson E and Hatton C. 2007. The Mental Health of Children and Adolescents with Learning Disabilities in Britain. Lancaster University
[93] Department for Children, Schools and Families (October 2009) Children with special educational needs 2009: an analysis
[94] Emerson and Hatton (2008) People with Learning Disabilities in England. Centre for Disability Research
[95] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS
[96] East Sussex SEN team (2013) Department for Education Form SEN2 2013
[97] Parry-Langdon N, Clements A, Fletcher (2008) Three years on: Survey of the development and emotional wellbeing of children and young people. ONS.
[98] Health Survey for England (2009) 2008 trend tables
[99] Mental Health Foundation (2002) The mental health needs of homeless young people. Barnardos.
[100] Pleace N, Fitzpatrick S (2004) Centrepoint Youth Homelessness index. An estimate of youth homelessness for England. Centre for Housing Policy. University of York
[101] Coleman, J; Brooks, F. and Treadgold, P. (2011) Key Data on Adolescence 2011 London; Association for Young People's Health (AYPH)

[102] Child and Maternity Health Observatory (2014) Child Health Profile, East Sussex 2014. ChiMat is funded by the Department of Health
[103] Fergusson D, Horwood JL, Ridder EM et al (2005) Sexual orientation and mental health in a birth cohort of young adults. Psychological Medicine, 35, 971-81
[104] Stonewall (2012) Mental Health Stonewall Health Briefing http://www.stonewall.org.uk/documents/mental_health.pdf
[105] Stonewall (2012) Mental Health Stonewall Health Briefing http://www.stonewall.org.uk/documents/mental_health.pdf
[106] Metro/Youth Chances (2014) Youth Chances Summary of First Findings – the experiences of LGBTQ young people in England
[107] Metro/Youth Chances (2014) Youth Chances Summary of First Findings – the experiences of LGBTQ young people in England
[108] Fazel S, Benning R, Danesh J (2005) Suicides in male prisoners in England and Wales, 1978–2003. *Lancet*, 366(9493), 1301-1302
[109] Fazel S (2009) Suicides in female prisoners in England and Wales, 1978–2004 *The British Journal of Psychiatry,* 194, 183-184.
[110] Lader D, Singleton N, Meltzer H (2000) Psychiatric Morbidity among Young Offenders in England and Wales. ONS
[111] Green H. et al (2005) Mental health of children and young people in Great Britain, 2004,ONS
[112] Child and Maternity Health Observatory (2014) Child Health Profile, East Sussex 2014. ChiMat is funded by the Department of Health
[113] Meltzer H, Corbin T, Gatward R, Goodman R, Ford T (2003) The mental health of young people looked after by local authorities in England. ONS
[114] Vinnerljung, B (2006) Children in care have a high risk of mental illness as adolescents and young adults. Journal of Child Psychology and Psychiatry, 47,723-33
[115] DfE (2010) Children Looked After by Local Authorities in England (including adoption and care leavers) - year ending 31 March 2010. http://www.education.gov.uk/rsgateway/DB/SFR/s000960/index.shtml
[116] Office for National Statistics (2004) The mental health of young people looked after by local authorities in England
[117] Department of Health (2011) No Health Without Mental Health: Delivering better mental health outcomes for people of all ages
[118] Richards M, Abbott R (2009) Childhood mental health and life chances in post-war Britain. Insights from three national birth cohort studies. http://www.scmh.org.uk/pdfs/life_chances_report.pdf
[119] East Sussex Inclusion support Services (October 2013)
[120] Cornaglia et al (2012) Mental health and education decisions. Centre for the economics of education
[121] University and College Union/ComRes (2013) NEETS Survey Headline Findings.
[122] NEPHO (2013) Community Mental Health Profiles: East Sussex. Department of Health
[123] East Sussex (January 2014) Standards & Learning Effectiveness Service
[124] Windfuhr, K., While, D., Hunt, I., Turnbull, P. , Lowe, R., Burns, J., Swinson, N., Shaw, J., Appleby, L., Kapur, N. and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2008) Suicide in juveniles and adolescents in the United Kingdom. Journal of Child Psychology and Psychiatry, 49 (11),1157–67.
[125] Association for young people's health (2013) Key Data on Adolescence 2013
[126] CHIMAT (2013) Admissions for mental health
[127] YoungMinds (2011) 100,000 children and young people could be hospitalised due to self-harm by 2020 warns YoungMinds. London: YoungMinds.
[128] Child and Maternity Health Observatory (2014) Child Health Profile, East Sussex 2014. ChiMat is funded by the Department of Health
[129] Hawton, K. and James, A. (2005) Suicide and deliberate self harm in young people. BMJ, 330 (7496), 891-894.
[130] CHIMAT (2013) Admissions for mental health
[131] Child and Maternity Health Observatory (2013) Child Health Profile, East Sussex 2013. ChiMat is funded by the Department of Health
[132] National Collaborating Centre for Mental Health (2012) Eating Disorders. Leicester: BPS
[133] Health and Social Care Information Centre (2012) 'Eating disorder hospital admissions rise by 16 percent in a year'. Downloaded 25 April 2012 from http://www.hscic.gov.uk/article/2239/Eating-disorder-hospital-admissions-rise-by-16-per-cent-in-a-year
[134] Association for young people's health (2013) Key Data on Adolescence 2013
[135] NHS Standard Contract for Community Services Schedule 2 Part 1 Service Specification Tier 3 Specialist Child and Adolescent Mental Health Services April 2012-March 2013
[136] DCSF The National Indicator "Effectiveness of CAMHS" – CHIMAT 2014
[137] DCSF (2010) Every Child Matters: The four tiers of CAMHS
[138] National Mental Well-being Impact Assessment (England) (2011) Mental Well-being Impact Assessment Toolkit
[139] National Mental Well-being Impact Assessment (England) (2011) Mental Well-being Impact Assessment Toolkit
[140] East Sussex School Nursing Service, February 2014
[141] DCSF (2010) Every Child Matters: The four tiers of CAMHS
[142] East Sussex Children and Young People's Trust Executive Group (26 September 2013) THRIVE update including Family Keywork Programme
[143] A list of Children's Centres: http://www.eastsussex.gov.uk/childrenandfamilies/childcare/parentsandcarers/childrencentres/search.htm
[144] East Sussex County Council (Dec 2012) Targeted Youth Support and Youth Offending Services Review Report V 17.0
[145] East Sussex County Council (February 2014) Children's Services
[146] East Sussex County Council (Dec 2012) Targeted Youth Support and Youth Offending Services Review Report V 17.0
[147] East Sussex County Council (Dec 2012) Targeted Youth Support and Youth Offending Services Review Report V 17.0
[148] East Sussex Anti-Bullying Coordinator (2012) Achieving better outcomes for children & young people
[149] East Sussex County Council (2013) Summary Report of the Outcome Based Accountability Framework for the Academic Year 2012-13
[150] East Sussex County Council (2013) Anti-bullying co-ordinator
[151] East Sussex County Council Anti-Bullying Service: charged services to schools.
[152] East Sussex County Council (2013) Summary Report of the Outcome Based Accountability Framework for the Academic Year 2012-13
[153] [153] East Sussex County Council (2013) Summary Report of the Outcome Based Accountability Framework for the Academic Year 2012-13
[154] East Sussex Primary Mental Health Worker Quarterly Reports
[155] East Sussex Primary Mental Health Worker Quarterly Reports
[156] http://www.connexions360.org.uk/education/Pages/CRIConnexions.aspx and the Youth Employability Service
[157] East Sussex County Council (Dec 2012) Targeted Youth Support and Youth Offending Services Review Report V 17.0
[158] East Sussex Drug and Alcohol Action Team (2012) East Sussex Adult and Young People's Drug and Alcohol Treatment Needs Assessment 2012
[159] East Sussex Drug and Alcohol Action Team (2012) East Sussex Adult and Young People's Drug and Alcohol Treatment Needs Assessment
[160] East Sussex Multiagency Transition Strategy: Transition from Child to Adulthood March 2009
[161] DCSF (2010) Every Child Matters: The four tiers of CAMHS
[162] NHS Standard Contract for Community Services Schedule 2 Part 1 Service Specification Tier 3 Specialist Child and Adolescent Mental Health Services April 2012-March 2013

[163] NHS Standard Contract for Community Services Schedule 2 Part 1 Service Specification Tier 3 Specialist Child and Adolescent Mental Health Services April 2012-March 2013
[164] NHS Standard Contract for Community Services Schedule 2 Part 1 Service Specification Tier 3 Specialist Child and Adolescent Mental Health Services April 2012-March 2013
[165] "The Family Partnership Model is an innovative approach based upon an explicit model of the helping process that demonstrates how specific helper qualities and skills, when used in partnership, enable parents and families to overcome their difficulties, build strengths and resilience and fulfil their goals more effectively" Taken from the Centre for Parent and Child Support website http://www.cpcs.org.uk
[166] East Sussex County Council (2013) CAMHS commissioned services: quarterly performance report Quarter 1 2013/2014
[167] East Sussex County Council (2013) CAMHS commissioned services: quarterly performance reports
[168] East Sussex County Council (2013) CAMHS commissioned services: quarterly performance report Quarter 1 2013/2014
[169] East Sussex Carefirst database, February 2014
[170] East Sussex Carefirst database, February 2014
[171] Adoption Support Services Specification East Sussex.
[172] Looked After Children Mental Health Service (March 2014) SPFT
[173] East Sussex County Council (2013) CAMHS commissioned services: quarterly performance reports
[174] DCSF (2010) Every Child Matters: The four tiers of CAMHS
[175] CAMHS Tier 4 Specialist Inpatient Services – Draft CAMHS Tier 4 Specification East Sussex
[176] Sussex Partnership NHS Foundation Trust (2014) Tier 4 services – Service Manager.
[177] Sussex Partnership NHS Foundation Trust (2014) Tier 4 services – Service Manager.
[178] Sussex Partnership NHS Foundation Trust (2014) Tier 4 services – Service Manager.
[179] AMHP Handbook – Bed Finding Chapter 11
[180] PHAST (2012) Future Commissioning and needs assessment for health of children and young people in Lansdowne Secure Children's Home Final report December 2012
[181] Sussex partnership Foundation Trust (2014) Children and Young People's Division
[182] CHIMAT (2013) Child Health profile 2013 Hospital admissions for mental health conditions
[183] CHIMAT (February 2014) Admissions for self harm
[184] East Sussex CAMHS Youth engagement and participation manager (Feb 2014)
[185] Sussex Partnership NHS Foundation Trust (2012) CAMHS Earthwise- LGF update
[186] East Sussex CAMHS Youth engagement and participation manager (Feb 2014)
[187] The Schools Health Education Unit. Young People in East Sussex Schools: the health behaviour of young people aged 14-15 in 2012
[188] Safer Schools Survey (2013) Anti-bullying Team
[189] Children's Right's Director Annual Monitoring Report (2011) Office of the Children's Rights Director
[190] The national 'Make your Mark' campaign is a public vote of 11 to 18 year olds across the United Kingdom. In East Sussex 2,270 valid votes were cast in 2013 across 11 schools and colleges to decide priority issues. The fifth highest priority for young people who voted in East Sussex was zero tolerance on bullying (208 young people/9.2%) while 183 young people (8.1% of the total) voted that mental health services and education should be improved in East Sussex.
[191] The Big Vote 2013 was an online and paper ballot election of 27,131 registered voters in East Sussex between 11 to 18 years old, voting on issues of concern to young people. Of this number, 11,347 votes were cast (42%): 7,233 paper ballots and 4,114 online ballots across 29 schools and colleges. Similarly to results of the "Make your Mark" campaign, tackling and preventing bullying and improving mental health awareness and education were in the top ten issues of concern for young people.