Child and adolescent mental illness, mental health and emotional wellbeing Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

- This factsheet covers mental illness; along a continuum from conduct and emotional disorders to conditions including schizophrenia and psychosis; mental health and emotional wellbeing in children and young people (CYP) aged 19 years and under
- Mental illness is associated with educational failure, disability, offending and antisocial behaviour. Improved mental health is related to improved physical health and life expectancy, better educational achievement, reduced anti-social behaviour and higher levels of social interaction and participation
- Any child can experience mental health problems, but some children are more vulnerable than others including those who have experienced stressful life events such as family conflict and bullying
- The best available estimate suggests the prevalence of mental disorders among those aged 15 years and under is 9.1% but the accuracy of such estimates when applied to Tower Hamlets is debatable
- A range of local services form a spectrum of support from universal preventative to highly specialist and rehabilitative services for children and young people

Recommendations

- Priorities for improvement include:
    - Map and communicate to frontline services information on mental health services to describe target audience, thresholds, outcomes anticipated and referral pathways to/from each service.
    - Improve the intelligence on the mental health needs of children and young people
    - Improve metrics for performance monitoring of mental and emotional health services
    - Conduct an equity audit to explore inequity in access to care and in outcome post intervention
    - Map and develop mental health skills of staff to improve awareness and detection of problems
    - Develop opportunities for CYP and their parents to say what has and has not made a difference to their lives
    - Create a local Transitions Forum to review and monitor application of transition protocols and provide an arena for debate and service development
    - Support schools to commission professionals such as school counsellors or play therapists
    - Support and train schools to manage drug or alcohol abuse in the family and eating disorders
    - Develop methods of communicating with CYP so that they can understand their condition and the choices facing them

1. What is child and adolescent mental health and illness?

This factsheet covers mental illness, mental health and emotional wellbeing in children and young people aged 19 years and under. It does not cover children and young people with disabilities or speech and language impairments. It is important to note that most services (unless implicitly agreed e.g. primary schools or children's centres) see under 18 year olds but will in certain circumstances retain responsibility for young people aged over 18 years.

Mental health is 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."*[1]Emotional wellbeing is 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."*[2]A mental illness 'is a clinically recognisable set of symptoms or behaviour associated in most cases with considerable stress and substantial interference with personal functions.' (ICD-10 definition)

Mental health conditions of most relevance to children and young people are[3]:

- conduct disorders e.g. persistent/pervasive defiance, physical/ verbal aggression, vandalism
- emotional disorders e.g. phobias, anxiety, depression or obsessive compulsive disorder (OCD)
- neuro-developmental disorders e.g. attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD)
- attachment disorders e.g. children who are markedly distressed/socially impaired as a result of an extremely abnormal pattern of attachment to parents/carers

- substance misuse problems
- eating disorders e.g. anorexia nervosa/ bulimia nervosa
- post-traumatic stress disorder (PTSD)
- psychosis and bi-polar disorders
- emerging borderline personality disorder (BPD)

Half of those with lifetime mental health problems first experience symptoms by the age of 14[4] and three-quarters before their mid-20s[5] emphasizing the importance of timely detection and management.Mental health disorders in childhood can have high levels of persistence. For example 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder still had the problem three years later according to a national study[6].

Mental illness is associated with educational failure, family disruption, disability, offending and antisocial behaviour; placing demands on social services, schools and the youth justice system.

The association between physical and mental health is well recognised. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems[7]. Similarly, young people with mental

[1]World Health Organization. 2004. Promoting Mental Health: Concepts; emerging evidence; practice. Geneva: WHO
[2]As set out in two diagnostic manuals: a) World Health Organization. 2007. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines. Geneva: WHO. b) American Psychiatric Association. 2000. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Arlington: APA.
[3]Green,MGinnity, Melzer, Ford and Goodman. 2005. Mental Health of Children andYoung People in Great Britain, 2004. London: ONS
[4]Kim-cohen J, caspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* 60: 709–717. Kessler R, Berglund P, demler o et al. (2005) lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey Replication.*Archives of General Psychiatry* 62: 593–602
[5]Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the united states. *Annual Review of Public Health* 29: 115–129
[6]CAMHS Review. 2008. Children and Young People in Mind: The final report of theNational CAMHS Review. London: DfES
[7] Ibid

disorders are more likely to have poor physical health e.g. higher rates of obesity. This is due in part to higher rates of certain health risk behaviors e.g. smoking, alcohol and poor diet[8].People with severe mental illnesses die on average 20 years earlier than the general population in part due to the persistence nature of some mental illnesses.

Any child can experience mental health problems, but some children are more vulnerable than others. These include those children who have one or more risk factors in the domains below[9] [10].

While children and young people in these groups may be at higher risk, this does not mean that they are equally vulnerable to mental health problems. A range of protective factors in the individual, family and community influence whether a child or young person will either not experience problems or will not be significantly affected by them, particularly if receiving consistent support from an adult whom they trust.

- low-income households
- parents unemployed or where parents have low educational attainment
- looked after by the local authority
- with disabilities (including learning disabilities)
- from BME groups
- are lesbian, gay, bisexual or transgender (LGBT)
- in the criminal justice system
- have a parent with a mental health problem
- misusing substances
- refugees or asylum seekers

- gypsy and traveller communities
- who are being abused
- experiencing stressful life events e.g. bereavement, divorce or serious illness
- physical illness (linked to onset of emotional disorders)
- family structure - those in single-parent households more likely to develop disorders
- household tenure - those in rented accommodation more likely to have emotional disorder than those who do not
- family conflict, domestic violence and bullying

Improved mental health and wellbeing is associated with a range of better outcomes including improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours, reduced risk of mental health problems and suicide, improved employment rates, reduced anti-social behaviour and higher levels of social interaction and participation.[11][12][13][14]Early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences.

Prevention of mental disorder in children and young people is thus an important public health measure to avoid

[8]McManus s, Meltzer h, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007.Results of a household survey. health and social care Information centre, social care statistics

[9]HM Government. 2010. Healthy Lives, Healthy People: Our strategy for public healthin England. London: TSO

[10] Three Years On: Survey of development and emotional wellbeing of children and young people, ONS, 2008

[11]Chevalier A and Feinstein l (2006) *Sheepskin or Prozac: The causal effect of education on mental health*. Discussion paper. London: Centre for Research on the Economics of Education, London School of Economics

[12] Meltzer h, Bebbington P, Brugha T et al. (2010) Job insecurity, socio-economic circumstances and depression. *Psychological Medicine* 40(8): 1401–1407

[13]McManus s, Meltzer h, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. nhs Information centre for health and social care

[14] Rees s (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. london: crisis and Public health Resource unit

the long term serious health and social related consequences and premature death.Both the public health white paper *Healthy Lives, Healthy People*and the mental health strategy *No health without mental health* put early intervention in particular at the heart of improving mental health outcomes for children and families.

2. What is the local picture?

Prevalence of mental disorder

Unfortunately, very little local data is available which characterises expressed need (unmet) or unexpressed need leading to an over reliance on the application of national estimates; not all of which are appropriate for an area such as Tower Hamlets. A community study of the prevalence of mental health problems in children and young people in Tower Hamlets is required to address this deficit.

From the information available, in 2011, there are estimated to be a total of 61,197 children and young people aged 19 years and under,(34,612 aged 5-16 years), in Tower Hamlets.[15] The best available (small area) estimates come from the Office for National Statistics (ONS, 2001) indicating that the prevalence of mental disorders among children and adolescents aged 15 years and under is 9.1%, compared to 9.6% for the national prevalence rate[16] [17].

The accuracy of such estimates when applied to Tower Hamlets is under debate. The scale of deprivation across the borough may suggest that this under-estimates the actual need in Tower Hamlets, conversely the existence of protective factors such as family and social cohesion and connectedness may serve to reduce the prevalence of mental ill-health.

Applying Psychiatric Morbidity Survey prevalence estimates[18]to the population estimates for 2011 and 2016 in Tower Hamlets suggests the following:

Table 1: Estimated number of children aged 5 to 16 years with mental disorders

Disorder Type	Tower Hamlets	
	2011	2016
Conduct disorders (5.8%)	2,088	2,349
Emotional disorders (3.7%)	1,332	1,499
Being hyperactive (1.5%)	519	608
Less common disorders (1.3%)	449	527

Approximately 2% of children are estimated to have more than one type of disorder (equating to approximately 720 individuals in Tower Hamlets)

National evidence suggests that between the ages of 11 and 16 the rates for both boys and girls are higher[19].The estimated number of residents aged 11-16 years in Tower Hamlets is 16,600.

[15]GLA 2009 Round Ethnic Group Projections - SHLAA (revised) for 2011

[16]The ONS (2001) small area estimate for childhood mental disorder in England at ward level is based on variables that are significantly associated with an increase in the rate of mental disorders such as age, gender, household composition/tenure, economic status, social class, and household income

[17] 3Meltzer (2003*)* Model-based small area estimation series No. 1. Childhood Mental Disorder in England: Ward Estimates. Office for National Statistics

[18] Mental Health of Children and Young People in Great Britain (2004); Office for National Statistics

The estimated number of children aged 11-16 years with mental health disorders is thus:

Table 2: Estimated number of disorders by sex for children aged 11-16 years in Tower Hamlets

Disorder Type	Estimated numbers affected		
	Males	Females	Total
Conduct disorders	672 (8.1%)	428 (5.1%)	1096 (6.6%)
Emotional disorders	332 (4%)	512 (6.1%)	830 (5%)
Hyperactive disorders	199 (2.4%)	34 (0.4%)	233 (1.4%)
Less common disorders	133 (1.6%)	92 (1.1%)	233 (1.4%)

Reliable prevalence estimates by ethnicity are unfortunately unavailable.

Looked after children (LAC)

In 2003 the Office for National Statistics (ONS) published data comparing the prevalence of mental disorders in children aged 5 – 17 who were looked after by a local authority. The prevalence of mental disorder for all LAC was 44.8%. The most recent available data suggests that Tower Hamlets has a rate of 71/10,000 children aged under 18 years who are looked after. The Tower Hamlets rate equated to 345 children and applying the ONS prevalence figure to Tower Hamlets suggests that approximately 155 of these would have experience of some form of mental disorder.

Response from CAMHS

An additional publication provides an estimate[20] of the number of children/young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4. Table 3 shows these estimates when applied to the 2011 Tower Hamlets population aged 17 and under (a total estimate of 56,155).

Table 3: Estimated number of children/young people aged 17 years and under who may experience mental health problems appropriate to a response from CAMHS (2011 estimate)

CAMHS Tier	Tower Hamlets
Tier 1 (15%)	8,805
Tier 2 (7%)	4,109
Tier 3 (1.85%)	1,086
Tier 4 (0.075%)	44

Autism

A recent study in South East London[21], estimated the prevalence of childhood autism at 38.9 per 10,000 and that of other Autistic Spectrum Disorders (ASD) at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per

[19] Ibid

[20] Kurtz Z. *Treating Children Well* London: Mental Health Foundation, 1996

10,000 or approximately 1%[22]. The European Union Commission highlights the problems associated with establishing prevalence rates for ASD e.g. the absence of a long-term study of psychiatric case registers and inconsistencies of definition over time and between locations. Nonetheless the Commission estimates that according to the existing information, the age-specific prevalence rates for 'classical autism' in the EU could be estimated as varying from 3.3 to 16.0 per 10,000[23]. If the prevalence rate found by the South London study were applied to the population aged 5 to 16 years of Tower Hamlets this would estimate approximately 346 cases.

Suicide and self-harm

A conservative estimate is that there are 24,000 cases of attempted suicide by adolescents (of 10-19 years) each year in England and Wales, which is one attempt every 20 minutes[24]. Self-harming in young people is not uncommon (a separate study suggests that 10–13% of 15–16-year-olds have self-harmed)[25]. A Samaritans study found that four times more adolescent females self-harmed than adolescent males[26].

Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide. Of particular relevance to Tower Hamlets, young South Asian females seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors. As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months. The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage male; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; social isolation, substance misuse, comorbid mental health problems and previous admission to a psychiatric hospital[27].

The most recent data from the Office for National Statistics (ONS) indicate that in 2005 there were 125 deaths of 15 to 19 year olds from suicide or undetermined injury in England and Wales. This is a rate of 3.6 deaths per 100,000 population aged 15 to 19 years (ONS Vital Statistics and 2005 ONS Mid Year Population Estimate). According to the Public Health Mortality file, deaths among young people aged 19 years and under fromTower Hamlets numbered less than 5 in 2010/11 and to prevent compromising anonymity, the details of these are not reported here. In the preceding 5 years across the Inner North East London sector, 11 suicides were reported in this age group.

Special Educational Needs

Schools can expect that as many as one in five of their children may at some stage have a SEN (special educational need) that requires them to make additional and different arrangements in how they support children's learning. In some schools there can be significantly greater numbers of pupils whose needs are best

[21] Baird et al, Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP), The Lancet 2006; 368:210-215

[22]This study supercedes the Medial Research Council study which estimated the prevalence of ASD at 60 per 10,000 population aged less than 8 years.

[23]These rates could however increase to a range estimated between 30 and 63 per 10,000 when all forms of autism spectrum disorders are included.

[24]Hawton, K, Simkin, S, Harriss, L, Bale, E and Bond, A, (unpublished), (1999b), "Deliberate Self-harm in Oxford 1999", enquiries to Professor Hawton, University Dept of Psychiatry, Warneford Hospital, Oxford OX3 7JX

[25]Hawton k, Rodham k, Evans E and Weatherall R (2002) deliberate self harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211

[26]Samaritans, (2003), "Youth and self harm: Perspectives – A report". www.samaritans.org

[27] Ibid

met by their school providing individual or group interventions from within their own resources. According to DfES (2006)[28] around 3% of school children nationally have statements of SEN. This is when the Local Authority decides that it should assist schools with additional resources to meet an individual pupils needs. The Children, Schools and Families department makes no judgment on whether a child has a mental disorder. However it is does record a child's main presenting SEN. Two groups of children and young people are more likely to have emotional difficulties, those identified as being on the Autistic Spectrum (ASD) and those with Behavioural Social and/or Emotional Difficulties (BESD). In Tower Hamlets in 2011, there were 308 (ASD) & 225 (BESD) children with statements of SEN out of 162 statements in total**.**

3. What are the effective interventions?

Mental health promotion/prevention and early detection[293031]:

A range of services and agencies from the statutory and non-statutory sector have a role to play in improving the mental health of children and young people and preventing problems from developing, taking into account both risk and protective factors across a range of social and environmental domains and at different ages. Prognosis following diagnosed mental illness is improved when it is detected, diagnosed and managed early and individuals are provided with timely access to information, advice and support.The Common Assessment Framework (CAF) has a key function as the shared assessment and planning framework for use across all children's services and local areas in England. It aims to help the early identification of children's additional needs and promote co-ordinated multi-agency service provision to meet them.

Supporting parents and carers is the key way of promoting children's mental health during the perinatal phase and in the early years. A secure parent/child relationship is a building block for the development of positive attachment and helps to build emotional resilience in children. The following are particularly supported in the literature: promotion of sensitive parenting and child development, early years education programmes, fostering greater involvement of fathers in parenting, techniques to promote a trusting relationship and develop problem solving abilities among parents, social support or counselling for mothers experiencing depression or anxiety and intensive support through for example Family Nurse Partnerships to at risk first time mothers.

Conduct disorder is the most common mental disorder in childhood. By the time they are 28 years old, individuals with persistent antisocial behaviour at age ten have cost society ten times as much as those without the condition[32]. Specific parent education and training programmes to manage early signs of conduct disorder can have good medium to long term effects at relatively low cost[33]. Total gross savings over 25 years have been found to exceed the average cost of a parenting programme by a factor of approximately 8 to 1.Education services are likely to recoup the immediate cost of the intervention in 5 years but there are substantial wider benefits stemming from this intervention e.g. relating to reduced costs incurred by the criminal justice system.

There is evidence from NICE (PH 12 – Social and Emotional Wellbeing in Primary Education and PH 2 - Social and Emotional Wellbeing in Secondary Education) and other sources[34]that schools and colleges can enhance children and young people's emotional wellbeing through the whole school curriculum as well as through specialist

[28] Department for Education and Skills (2006) Special educational needs in England in 2006

[29]Mental health promotion and mental illness prevention: the economic case. (2011) Department of Health

[30] No health without mental health. A cross governmental mental health outcomes strategy for people of all ages. (2011) Department of Health

[31] Better mental health outcomes for children and young people: a resource directory for commissioners (2011) National CAMHS Support Service

[32]Scott, Spender, Doolan, Jacobs and Aspland. 2001. Multicentre controlled trial of parenting groups for child antisocial behaviour in clinical practice. British Medical Journal 323:194-197.

[33]Scott, Knapp, Henderson and Maughan. 2001. Financial cost of social exclusion: follow up study of antisocial children into adulthood. British Medical Journal 323: 191-194

[34]Weare and Markham. 2005. What do we know about promoting mental healththrough schools? Promotion & Education (12) (3-4): pp14-18.

activities and programmes with a particular focus on disadvantaged families. Schools' position at the centre of a cluster of multi-agency services suggests that they are well placed to identify children's wider needs and commission provision tailored to their particular needs. This emphasises the importance of commissioner engagement with schools in the wider commissioning agenda. Examples of good practice cited in the literature include interventions targeted at reducing risk taking behaviours and programmes that build self-esteem and support the development of social and emotional skills e.g. through PSHE. The Healthy Schools initiative also provides guidance and support to schools on promoting physical and mental wellbeing.

School based interventions to reduce bullying (which has adverse long term effects on both psychological wellbeing and educational attainment) are also supported in the literature; such interventions offer value for money on a long term perspective though further evidence is needed about which specific interventions are most effective and whether any impact is sustainable.

The first indications of psychosis typically manifest when the individual is young (80% occur between the ages of 16-30 years). Early Detection (ED) and Early Intervention (EI) services are recognised by the literature as effective and the(national) savings associated with providing such services rather than standard mental health care for patients with prodromal symptoms of psychosis or schizophrenia are conservatively estimated at £50 million p/a. These savings relate to increased work, decreased suicide and decreased homicide. Savings are estimated to decrease over time as there is no current evidence to suggest that reductions in inpatient stays are maintained when patients are discharged from the early intervention team.

High quality care and treatment of children and young people with mental health problems

To achieve the best possible outcomes, children and young people with mental health problems should:

- Have timely access to high quality services as defined by National Institute for Health and Clinical Excellence (NICE) clinical guidance and by the Department of Health Policy – Improving Access to Child and Adolescent Mental Health Services
- Receive the most appropriate treatment for their condition, which is delivered to a high standard as well as being cost effective. There is a growing evidence base of effective interventions for a range of disorders including conduct disorder, depression, eating disorders, attention deficit disorder and developmental disorders (see NICE). The National mental health strategy also particularly emphasises the important contribution that can be made by talking therapies, the Family Nurse Partnership, multisystemic therapy, early intervention in psychosis and better multi-agency transitional support for young people moving from child/adolescent to adult services across both health and social care. It also underlines the significance of reducing stigma and discrimination among young people experiencing mental health problems
- Be able to access a full range of appropriate support. Longstanding problems persist for some particularly vulnerable young people and the Equality Act 2010 (Ch 1; 149(3)(b)) requires public sector providers to have 'due regard' to the need to take steps to meet the needs of people with a 'protected characteristic' (e.g. they are disabled or LGBT), where these needs are different from people who do not share this characteristic. It is thus prudent for commissioners to be aware of the full range of available services in the public and voluntary sector and those which can offer additional knowledge and expertise for particular vulnerable groups.Current policy in the UK and elsewhere places emphasis on the provision of mental health services in the least restrictive setting as an alternative to inpatient care, whilst also recognizing that some children will require inpatient care. As a result, a range of mental health services have emerged to manage young people with serious mental health problems who are at risk of being admitted to an inpatient unit; such alternatives are provided in community or outpatient settings. The quality of the evidence base however currently provides very little guidance regarding the further development of such services.[35]

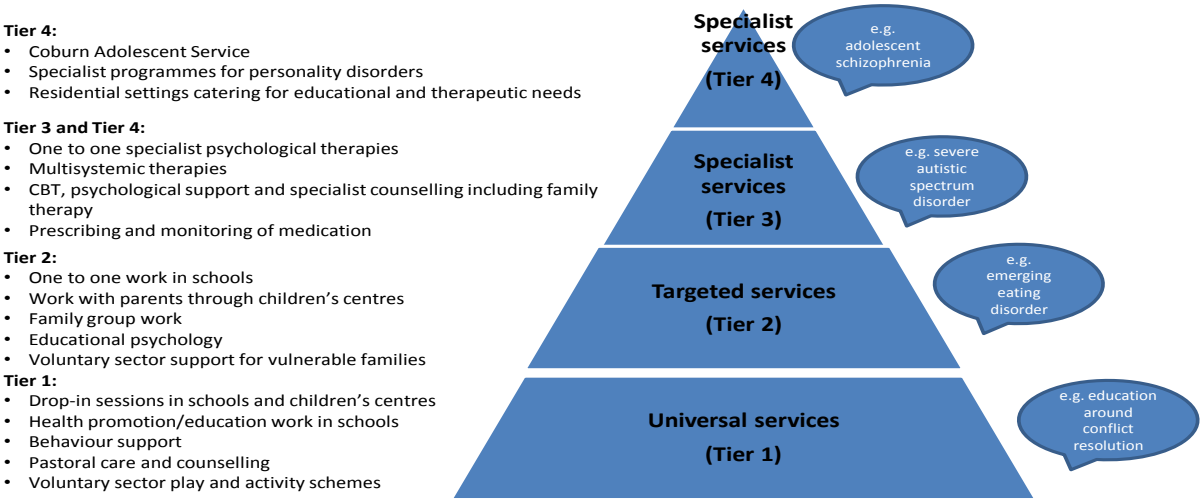
[35]Shepperd S, Doll H, Gowers S, James A, Fazel M, Fitzpatrick R, Pollock J. (2009) Alternatives to inpatient mental health care for children and young people. Cochrane Database of Systematic Reviews, Issue 2.

4. What is being done locally to address this issue?

There are a range of services, delivered by partners across the statutory and voluntary sectors, to support the emotional and mental health of children and young people in Tower Hamlets. This forms a comprehensive spectrum of support from universal through to highly specialist and rehabilitative services.

- Universal CAMHS (Tier 1) coverage includes services whose primary function is not mental health care e.g. primary care, schools and social services
- Targeted CAMHS (Tier 2) is intended for children and/or families with needs that are more intensive and/or more complex than those that can be accommodated within universal services. These needs require additional specific support to prevent them from escalating or to prevent external factors having a serious negative impact on children's abilities to achieve the five Every Child Matters outcomes. Targeted support for families can include interventions which vary in their level of intensity and complexity
- Specialist CAMHS (Tier 3) services are for children and/or families whose difficulties have caused significant adverse effects or poor outcomes and need specialist multi-disciplinary support to address their needs
- A further enhanced and highly specialised tier of health services (Tier 4) is provided to children and adolescents with severe and/or complex mental health problems and risk behaviours through either in-patient, day patient or outpatient settings via the Coburn Service. The in-patient services at the Coborn are closely integrated to the CAMHS sectors and the Paediatric Liaison team at the Royal London Hospital.
- Children are expected to move between tiers as their needs change and may use services from more than one tier concurrently.

Figure 1: The 4-tier structure of mental health services for children and young people in Tower Hamlets[36]



Services can be conceptualised as follows:

- Specialist services work with children and families who are experiencing difficulties that have already caused significant adverse effects
- Targeted services are for cases where the child/family have needs that are more intensive or complex than those that can normally be accommodated within good quality inclusive and differentiated universal services
- Universal services are for the whole Tower Hamlets population. Some children/families may require some more general support available through Tier 1.

[36] Tower Hamlets Children and Young People's emotional health and wellbeing development plan 2010-2013

Universal provision

Children's centres: The 23 children's centres across Tower Hamlets provide a range of services to children aged less than 5 years and their families. The nature of the support to emotional health and well-being varies from family stay and play sessions through to clinically therapeutic interventions offered by CAMHS.

Schools: SEAL is a comprehensive approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools. It proposes that the skills will be most effectively developed by pupils and staff through: using a whole-school approach to create the climate and conditions that implicitly promote the skills and allow these to be practiced and consolidated; direct and focused learning opportunities (during tutor time, in focus groups and outside formal lessons); using learning and teaching approaches that support pupils to learn social and emotional skills and consolidate those already learnt; continuing professional development for the whole staff of a school. The3 year Tower Hamlets SEAL project offered all schools' the following: curriculum resources (all schools), SEAL curriculum for emotional literacy in all primary schools, support to secondary schools to provide lessons in atleast one area of PSHE and/or Citizenship and awareness raising regarding emotional literacy and needs. Work to develop links between universal programmessuch as SEAL and targeted/specialist provision is being reviewed in a climate of reduced funding availability. To maintain provision of support through SEAL new links are being formed with existing school support services such as the Healthy Schools Team. Almost all Tower Hamlets schools have either achieved, or are pursuing, healthy schools accreditation[37].

Voluntary sector provision: A range of organisations from the 3rd sector provide extra-curricular activities to enhance emotional wellbeing, confidence, self-efficacy and social skills among young people in the borough. A number also provide courses and training to equip young people with the skills to enter higher education, employment and training.

Targeted provision

Midwifery: The Gateway midwife provides ante-natal support to vulnerable mothers which includes those who have mental health problems.

Educational Psychology (EP) early intervention work in children's centres: The EP team provide support for children or young people who are experiencing problems within an educational setting with the aim of enhancing their learning. Challenges may include social or emotional problems or learning difficulties. Work can take place with individuals or groups; advising teachers, parents, social workers and other professionals. Direct work with the child involves an assessment using observation, interviews and test materials. A range of appropriate interventions may be indicated e.g. learning programmes or collaborative work with teachers or parents. The team also provide in-service training for teachers and other professionals, parents and families on issues such as managing child behavior. Referrals for the EP team typically originate from children's centres but can also be received from health visitors, hospital and schools. Specific work is being undertaken to support parents of disabled children to enable them to understand the implications of their child's diagnosis.

TaMHS – Targeted Mental Health in Schools: The TaMHS project, supported by the EP and CAMHS teams, recently discontinued, provided time limited in-reach to a number of schools in the borough. TaMHS was designed to complement existing national initiatives such as the Healthy Schools Programme and SEAL programme by enabling schools to identify children and young people aged 5-13 years who were at particular risk of experiencing mental health difficulties and by providing access to more intensive support and therapeutic interventions for those individuals e.g. through CBT and systemic work. Interventions were also targeted at teaching staff on areas ranging from developing skills to creating a positive atmosphere for learning; managing behaviour and emotional reactivity of students to identifying/managing conduct disorder.

Children with Special Educational Needs (SEN): The educational psychology service provides targeted support to young people with SEN in Tower Hamlets across the range of local schools, special schools and pupil referral units. In addition, Connexions provides an advice and information service (over the short or long term) for

[37] http://www.education.gov.uk/schools/pupilsupport/pastoralcare/a0075278/healthy-schools - accessed 8.8.2011

young people between the ages of 13-19 years and up to 25 years with SEN. Connexions advisers work with (among others) CAMHS, Youth Offending Team (YOT), Leaving Care Service (LCS), Pupil Referral Units and the teenage pregnancy service. The Connexions Transition Support Team (New Team) work with Tier 1 young people at risk of entering Tier 2 and also with young people known to Tier 2 services.
Services from the voluntary sector: A number of 3rd sector organisations provide a range of services and activities to children and young people with specific needs or who are particularly vulnerable including those with learning difficulties, those who have experience of domestic violence, to young people with autism and families with parental mental illness – among others.

Specialist services
CAMHS consists of multi-disciplinary tier 3 and tier 4 services that provide assessment and treatment to children and young people from 0 to their 18th birthday who experience complex and persistent mental health difficulties. The CAMHS community based provision in Tower Hamlets is delivered around multi-disciplinary services based in the East Sector and West Sector , and a Pediatric Liaison Team based at the Royal London Hospital. Local Referral Panels manage the weekly referral and allocation of case to the 5 care pathway delivery systems - Emotional and Behavioral, Conduct Disorder, Psychosis and Bi-Polar, Neurodevelopmental and Looked After Children. The only non-clinical pathway, LAC, ensures an appropriate focus on children who are known to be disproportionately affected by emotional and mental health problems and who will require particular support. Each pathway is designed to deliver evidence-based assessment and treatment packages to the child and in support of the family, using NICE guidelines and other clinically robust evidence bases. The aspiration is to move to a single, central referral panel or a single point of entry for all new referrals.

The Paediatric Liaison Team see children and young people presenting at A&E in crisis (self-harm) and those admitted to hospital with comorbid physical and emotional/mental health needs.

The Tier 4 service operates from the Coburn Centre which provides services on an in and day-patient basis to young people suffering with severe mental health problems in need of additional specialist support with the aim of helping young people through the most acute phase of their difficulties and reintegrating them back into their communities. The Centre treats young people with acute and severe forms of mental illness which include major mood disorders, psychosis, severe obsessive compulsive disorder, eating disorders and some emerging personality disorders.

5. What evidence is there that we are making a difference?

A range of services across the borough fulfil best practice guidance in terms of both the types of service and the nature of interventions and support delivered. To demonstrate the effectiveness of investment in this area would require more robust measures of uptake, outcomes and progress across the full range of services. Available data from services is set out below:

CAMHS

The most recent complete dataset for CAMHS suggests that 1435 individuals were accepted onto the service caseload for 2010; a consistent 82% of all referrals received, as for 2009, but an increase in 2010 of 96 cases accepted. This brought the CAMHS caseload to a total of 2367 cases in 2010, 136 more patients than the preceding year. 42% of children and young people on the CAMHS caseload are from an Asian background (which given the ethic profile of the borough may be an under-representation of those expected) and the majority of referrals originate from primary care (39% of all referrals to CAMHS, 19% from child health and 15% from education).

The majority of children present to CAMHS with an emotional disorder (34% of presentations) followed by conduct disorder (17%). Comparison to local prevalence data suggests an under-representation of children with conduct disorder in CAMHS services. This may be a result of cases being recorded under the more generic 'emotional and behavioural' category. The reshape of the service to deliver along care pathways will better capture and report numbers of clients presenting with a conduct disorder and test the assumption of under-representation. A quarter of all those in contact with CAMHS services present with more than one condition which complicates a comparison of unexpressed and met need.

The most recent available CORC (CAMHS Outcome Research Consortium) data suggests that 1099 outcome questionnaires were completed (46% of the total possible) and that 87% of children showed an improvement.

Educational Psychology (EP)

Referrals for the EP team typically originate from children's centres but can also be received from health visitors, hospital and schools. Most recent available data was reported by quarter from October 2009 to September 2010. Some families were the subjects of longitudinal support others received support on a short term basis. In Quarter 1 84 families received support through home visits, 80% of whom were new to the service. In Quarter 2, 92 families received support, 52% of whom were new clients. In Quarter 3 109 families received support; 59% were new clients. In Quarter 4 89 families received support, 51% of whom were new clients.

The majority of families worked with were, unsurprisingly given the demographic profile of children and young people in the borough, Bangladeshi in origin followed by white English. The most improvement related to levels of reported parental concern for children's behaviour, as concern was reported to consistently fall post intervention. A range of courses and workshops are run for children, their parents and families through children's centres on topics including 'managing children's behaviour', 'learning through play', 'transition to nursery' and 'attachment and bonding'.

6. What is the perspective of the public on support available to them?

Views from school-age children

The most recent survey in schools (TellUs 4 in 2009, subsequently discontinued) suggested that of the 1129 respondents in Tower Hamlets, just under 50% had experienced bullying in school (41% compared to national reported bullying of 46%); of these approximately 1/3 had been bullied in the previous year (compared to 26% nationally). However, 32% of respondents (compared to 25% nationally) felt that their schools dealt with bullying very well suggesting some confidence in schools' ability to manage occurrences of bullying.

Views from local schools

Approximately 30% of Tower Hamlets schools (25/83), responded to a local survey asking for their views about the emotional well-being needs of their children in 2010. The vast majority of responses received were from

primary schools (23/25). The EP and CAMHS services were reported as the most frequently used by schools to address emotional wellbeing issues. 80% of schools use their learning mentors to work with pupils in promoting emotional wellbeing. One in five schools employs their own counsellors and the same number employ their own play therapists. All schools saw themselves as good at enabling pupils to develop trusting relationships and all except one felt comfortable at addressing bullying. 16% of schools thought they were no better than satisfactory at helping pupils develop emotional literacy suggesting a need for additional support in this area. When asked about targeted interventions for vulnerable groups, schools felt they were less effective at coping with drug or alcohol abuse in the family and coping with eating disorders which may suggest a need for further training or support in this area.

CAMHS:

Generating service users' views on CAMHS is a challenge. However, CAMHS Outcomes Research Consortium (CORC) data is routinely gathered and analysed to ascertain user satisfaction with the service and to consider whether there has been an improvement in users emotional health and wellbeing. During 2010, 141 user satisfaction questionnaires were completed and 97% reported satisfaction with the service received. CAMHS focus groups meet regularly to consider and advise on key service developments. Findings from the most recent structured focus group of five 12-18 year olds asked participants to comment on a series of statements. A snapshot of some of the responses received includes:

- On whether young people would like to see letters about them: 'I would want to see. My new counsellor lets me see the letters she sends out, which gives me a chance to speak to my worker and ask what things mean, if I don't understand…..I'm not sure I would be able to say something if I thought she had got something wrong about me'
- On the length of time it takes to know what help is being offered: 'I think it is good to take your time to understand how someone is feeling, as it is better than jumping to conclusions and think you have the answer about what is bothering someone …….. I know it takes time to work this out'
- On seeing the same person from start to finish: 'I have been in the service for a long time and have had a few workers….. every time I have to change a worker it makes it worse for me'
- Young people reported positively on their involvement in the focus group and were keen for their involvement to continue

7. What more do we need to know?

- Improve the intelligence available on the expressed (but unmet) and unexpressed mental health needs of children and young people for the needs assessment cycle through a partnership community study
- Improve metrics for performance monitoring of mental and emotional health services
- Conduct an equity audit to explore any inequity in access to care and in outcome post intervention across the 9 protected characteristics across the borough
- Map the mental health skills of staff working with children and young people to enable these skills to be utilized both to develop services and to improve awareness and early detection of emotional and mental health problems of children and young people
- Explore options for developing community-based alternatives for children with the most complex needs as an alternative to inpatient provision
- Establish extent of local application of NICE clinical and public health guidance in local practice

8. What are the priorities for improvement over the next 5 years?

- Map mental health services among statutory and voluntary sectors to describe the target audience, thresholds for inclusion in the service, concordance with NICE guidance, outcomes anticipated and referral pathways to/from each service. The results should be communicated to all services with an interest in young people's mental health including for example schools, children's centres and health visitors
- Children, young people and their parents must be offered opportunities to speak of their experiences, to say what has and has not made a difference to their lives. Surveys, focus groups and internet-based approaches ensure that their experiences are captured consistently. A young people's parliament provided through

ELFT to discuss needs and local services exists and consideration should be given to the expansion of this technique to other youth mental health services

- Tailored, age-appropriate methods are needed to communicate with children and young people so that they understand their condition and the choices facing them e.g. a website exists in Hackney for young people on mental health and services available, such a website could be created in Tower Hamlets
- Children, young people and their families need access to appropriately trained and qualified professionals in all services. Some conditions can be challenging to identify or diagnose. Thus training and education in managing potential mental health needs are particularly important. Both specialist and primary care clinicians should be involved in this process to ensure any assessment of young people with long term conditions includes an assessment of any mental health needs e.g. the literature supports the delivery of training in suicide prevention among general practice staff.
- Young people report anxiety regarding the process of transition from youth to adult mental health services. While efforts are made to anticipate and plan for transition (see ELFT transition policy), some transitions are unplanned resulting in anxiety to the child and family and risks to their care. The complexity of transfer is compounded by a number of factors including e.g. the presence of different care planning systems (for example, Common Assessment Framework vs Care Programme Approach), care teams, differences between CAMHS and AMHS regarding acceptance criteria, professional differences and service configurations. A local Transitions Forum is recommended, including representatives from CAMHS, AMHS, the voluntary sector and service user groups to review and monitor application of transition protocols, and provide an arena for debate and service development. The existing transitions protocol requires a refresh which could include guidance regarding alternative care pathways for young people who do not meet the threshold for CAMHS, models of joint working for CAMHS and AMHS, guidance regarding risk assessment and sharing of information between CAMHS and AMHS, procedures for evaluating the transition process with young people as well as devising transition protocols and care pathways at a multi-agency level to reflect the breadth of young adult support services across the borough
- Commissioners need to understand what alternative services are available for young adults who do not meet AMHS severe and enduring thresholds, but require further support
- Transition groups should form a specific qualitative and quantitative focus of future JSNAs (to include the number of young people who have left CAMHS, where they went, their experience of changing services and whether any groups are more likely to drop out of services than another)[38]
- Schools should be offered guidance and support to ensure there is quality assurance in place when they commission Mental Health professionals such as school counsellors or play therapists
- Schools report feeling that they are less effective at coping with drug or alcohol abuse in the family and coping with eating disorders which may suggest a need for further training or support in this area

9. Key Contact

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Date updated:		**Updated by:**	Marie-Carmen Burrough		**Next Update Due:**		
Date signed off by Senior JSNA Leads:		**Signed off by (Public Health Lead):**	Esther Trenchard-Mabere	**Date signed off by Strategic Group:**		**Sign off by Strategic Group:**	Be Healthy
		Signed off by (LBTH Lead):	Mary Durkin				

[38] Planning mental health services for young people – improving transition. A resource for health and social care commissioners. National Mental Health Development Unit (2011)