Cambridgeshire
Joint Strategic Needs Assessment

The Mental Health of Children and Young People in Cambridgeshire 2013

FINAL REPORT
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Contents

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1. Introduction

There are a large number of risk factors that increase the vulnerability of children and adolescents experiencing mental health problems. These include deprivation, poor educational and employment opportunities, enduring poor physical health, peer and family relationships, witnessing domestic violence, and having a parent who misuses substances or suffers from mental ill-health. Children who have been physically and sexually abused are at particular risk. Asylum seeker and refugee children have consistently been shown to have higher levels of mental health problems, including post-traumatic stress, anxiety and depression.[1]

The way that children are parented, their diet and exercise, their school and education, experimentation with drink, drugs and other substances, along with many other factors, will all affect a child's mental wellbeing or mental ill-health.[1]

The following report examines local and national data sources and information relating to the mental health of children and young people in Cambridgeshire. This builds on the previous report 'A profile of Child and Adolescent Mental Health in Cambridgeshire 2008'.[2]

It is important to note that two of the Cambridgeshire Joint Strategic Needs Assessments (JSNA) cover mental health: The Children and Young People JSNA[3] and the Adult Mental Health JSNA.[4] There are some overlaps between the two reports for people in the older age bands, up to 18 years. In addition, there is overlap between this report and the JSNA on Physical and Learning Disability.[5]

This report starts by setting the scene with the population estimates and forecasts for children and young people, and the maps of deprivation within Cambridgeshire. It then examines the estimated prevalence of mental health disorders within the County, influencing factors on the mental health of children and specific groups of vulnerable children. The report then tackles service and benchmarking information and finally, the evidence base.

It is important to note that this profile only relates to the population of children and young people in Cambridgeshire, and the services commissioned directly by NHS Cambridgeshire and/or Cambridgeshire County Council. However, it does not relate to service catchment areas.

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1 *Child and Adolescent Mental Health, A guide for healthcare professionals, June 2006*, British Medical Association – www.bma.org.uk/ap.nsf/content/childadolescentmentalhealth

2 Cambridgeshire PCT Public Health Information Team

3 *Joint Strategic Need Assessment, Children & Young People, 2007/2008, Achieving the potential of Children and Young People in Cambridgeshire*; Cambridgeshire County Council an Cambridgeshire Primary Care Trust www.cambridgeshirepct.nhs.uk/default.asp?id=656

4 *Joint Strategic Needs Assessment, Adult Mental Health, 2007/2008*, Cambridgeshire Primary Care Trust www.cambridgeshirepct.nhs.uk/default.asp?id=656

5 Cambridgeshire Public Health, Cambridgeshire County Council

2. Executive Summary and Key Findings: what is this telling us?

The World Health Organisation 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."

If children and young people are at risk of developing poor mental health, they need to develop:

Resilience;
Self-awareness;
Social skills;
Empathy to form relationships;
Enjoyment of one's own company;
Deal with life's normal setbacks constructively.

It is in our society's best interest to help develop these capacities whilst being prepared to intervene early if problems develop, or refer them to specialist services if problems become more serious.

National estimates show that one in ten (10%) children and young people aged five to sixteen years (the statutory school age) has a clinically significant mental health problem and approximately 2% have more than one diagnosable concurrent mental health disorder.[6] In general, boys have a higher prevalence of mental disorder than girls.

The mental health disorders most relevant to children and young people are:

- conduct disorders, eg defiance, physical and verbal aggression, vandalism;
- emotional disorders, eg phobias, anxiety, depression or obsessive compulsive disorder;
- neurodevelopmental disorders, eg attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD);
- attachment disorders, eg children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major caregivers;
- substance misuse problems;
- eating disorders, for example preschool eating problems, anorexia nervosa and bulimia nervosa.
- conduct and emotional disorders.

(A more detailed guide to these is at Appendix 1 and 2)

[6] ONS: The Mental Health of Children and Young People in Great Britain (2005).

Mental health disorders in childhood can have high levels of persistence.[7] Around 50% of lifetime mental illness starts before the age of 14 and continues to have a detrimental effect on an individual and their family for many years. Potentially, half of these problems are preventable.

- According to a national study, 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder, still had the problem three years later.
- Persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively).
- Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood.

Some children are more vulnerable to mental health problems than others with a number of particular risk factors increasing the vulnerability.[8] For example, those from low-income households; families where parents are unemployed or have low educational attainment; being looked-after by the local authority; having a disability (including learning disabilities); originating in gypsy and traveller communities; within the criminal justice system; with substances misusers; and having a parent with a mental health problem.

Many children experience more than one risk factor, and four or five adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) they themselves increase the risk of developing mental health problems throughout life.[9]

7 Child and Maternal Health Observatory (ChiMat) 2011.
8 ChiMat (2011).
9 New Horizons Confident Communities, Brighter Futures: A framework for developing wellbeing. HM Government March (2010)

3. Key Findings

3.1 Demography and Prevalence

It is estimated that there are around 136,000 children and young people under the age of 19, living in Cambridgeshire. Although Huntingdonshire currently has the highest number of children, the area predicted to have the greatest increase in number of children, is Cambridge City, with a15.8% increase by 2016, whereas, Huntingdonshire will only see a 1.6% reduction.

Overall, the population of children in Cambridgeshire is due to rise by 3.9% by 2016, and by 10.3%, by 2021.

Applying national data to the Cambridgeshire population indicates total numbers within the following age groups have mental health problems:

- 5,000 children under the age of five.
- 8,000 between the ages of 5-16.
- 1,275 16-17 year-olds.

Of the children aged 5-16 years:

3,100 have an emotional disorder.
4,800 have a Conduct Disorder.
1,200 have a Hyperkinetic Disorder.
1,100 have a less common disorder, including 740 with Autism.

Conduct Disorder is still the most common diagnosis, with the majority found in boys Emotional Disorder (anxiety) is the next most common condition, the majority of which is found in girls.

Groupings of indicators (clusters) make mental health disorders more prevalent in parts of Fenland and Cambridge City. These indicators tend to mirror broad patterns of child poverty and household deprivation. North Fenland, Huntingdon North and North East Cambridge have the greatest levels of relative deprivation.

Waterlees in Fenland and Abbey in Cambridge City, have the highest levels of child poverty within the county, with over half of all children living in means- tested, benefit-reliant families. Average prevalence levels are therefore an underestimation of need in those areas, where risk levels are likely to be two to three times higher amongst some disorders (eg conduct disorder).

Based on 2009 work, the wellbeing measures available, suggest that overall, Cambridgeshire children and young people have generally better wellbeing than the England average. However, when this is broken down by area, Fenland ranked 251 out of 354 local authorities, with number one as the best performing.

Since 2010/11, the number of children and young people admitted to hospital for self-harm has increased. However, national rates have substantially decreased over the same period, with Cambridgeshire well above the national average.

3.2 Vulnerable groups

There are higher levels of mental health disorders among the following groups of children and young people, in Cambridgeshire, those with learning disabilities, looked-after children, children in need, young carers, young offenders, refugees, teenage parents, substance misusers or those who have experienced abuse.

The following local and national data highlights the need to ensure that services cater for these vulnerable groups of children and young people and aim to prevent long-term health inequalities.

3.3 Parental mental health and substance misuse

Parental mental health has a critical impact on children's mental health. There are an estimated 22,700 children and young people living with at least one parent with mental illness, in Cambridgeshire. Between one and two thirds of these children and young people are likely to develop mental health problems themselves.

Maternal mental health, particularly in the first 18 months of life, has a major impact on a child's long-term mental health. In 2011, there were 754 women with chronic post-natal depression, in the county. Services supporting vulnerable families with children, aged 0-5, and those families with children with Special Educational Needs (SEN) find high levels of mental health problems in both parents and children.

It is also estimated that 5,400 children and young people are living with a problem drinker with concurrent mental health problems, and 3,300 living with a drug user with concurrent mental health problems. A further 1,300 live with a parent with all three conditions. There are also between 27-40% young carers currently in contact with support services who care for someone in their family, with a mental health problem.

3.4 Current Services

Overall

Overall, NHS and Local Authority commissioned Tier 2 and above service capacity would have to double or treble in size to meet estimated levels of prevalence. Consequently, there is currently a considerable unmet need, but it is not clear if this is comparatively more or less than elsewhere in the country. This estimate does not take into account services provided by the voluntary sector and at Tier 1, which includes GP, health visitor, school nursing and other universal provisions. It is also based on an artificial split between estimates of need at the different Tiers, which takes no account of how effectively the whole system works to support children and young people.

Current NHS and Local Authority commissioned Tier 2 and above capacity are largely focused on those aged 15/16 years and above. This means that opportunities to intervene early in the progression of some disorders may be missed. There is, additional increasing evidence to suggest that the ideal age to impact on a child's development and improve social and emotional capability is from age 0-3 years.

Although up-to-date and clear benchmarking information is limited, NHS Benchmarking began a programme on Child and Adolescent Mental Health (CAMH) benchmarking, in April 2013, to provide useful data alongside the national data collection required of services.

Hospital Admissions

Child and adolescent psychiatry admissions rose in 2011/12, but given the small numbers, it is difficult to tell if this is a significant increase. Admissions for the under 18's, where the primary diagnosis was a mental health disorder, appears to have risen since 2009/10. Depressive episodes, eating disorders and mental health behaviours due to alcohol use, make up 47% of the admissions. The majority of admissions for children aged 0-9 are for disorders of psychological development. Again, these trends are hard to interpret given the small numbers.

Cambridge and Peterborough Foundation Trust (CPFT)

There has been a decrease in referrals and a 20% decrease in contacts (number of appointments) between 2011/12 and 2012/13. At the same time, waiting times have increased considerably across Cambridgeshire and are below the 2008/09 national benchmark. CPFT are currently running with approximately 24% of vacancies in their Cambridgeshire CAMH services, which largely explains the pattern of reduced contacts (activity). This drop in activity correlates with feedback from patients, parents and other services for children and young people. The drop in referrals may be due of the variation seen annually in referral numbers.

Other findings include:

- Referrals and contacts increase with age but contacts (activity) are more skewed to the older age band than referrals.
- Did Not Attend (DNA) rates have decreased in Cambridge[10] (City and South) but increased in Huntingdonshire and Wisbech. Overall DNA rates have remained static at 8%, with 80% of DNA appointments in eight local services.
- Hunts Health and Wisbech Locality Commissioning Groups (LCG) of GPs had longer waiting times in 2011/12 than GPs in other LCG areas.
- CATCH make fewer referrals to CPFT than other Locality Commissioning Groups of GPs. It is not clear why this is the case.
- The quality data available (CORC and a recent peer review) shows good quality CAMH services, including good outcomes where that information is available to be benchmarked nationally.
- Transition to adult services at age 17 is still seen as arbitrary by service users, with the most common post-transition problems perceived as a lack of support from the new service (GP or adult mental health). Ensuring young people feel prepared for transition is critical in reducing its impact.

[10] Association to Commission Health CATCH

Other commissioned counselling services

The YMCA and Centre 33 provide higher capacities within Cambridge and the surrounding areas than Huntingdon and Wisbech. YMCA service capacity and outcomes in the Fenlands is particularly poor, and action has been taken to address this. The NHS and Local Authority commissioned counselling services are the sole counselling services provided within schools and GP surgeries. However, this report is not comprehensive.

3.5 Benchmarking

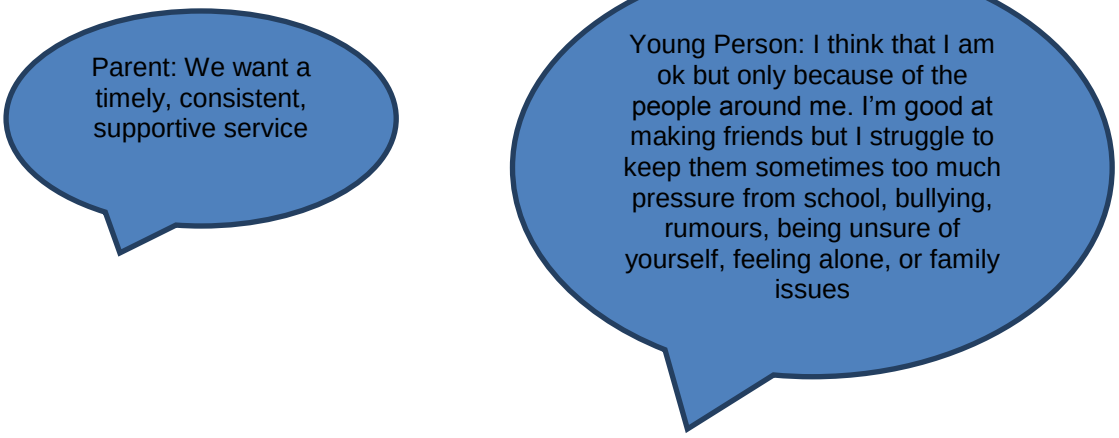
The benchmarking data available suggests that specialist CAMH services in Cambridgeshire may be understaffed, but this does not take skill mix into account and in reality, all posts are filled.

3.6 Children and Parent Views

The findings of local consultation work with children, young people and parents are described in full later in the report. In the consultation, children and young people describe what makes them feel well, what helps them recover if they are unwell and how mental health workers and services should behave. The following is a summary of feedback from children and young people, on what makes them feel well.

What makes young people well?

- Accessible support is important, rather than waiting for illness to strike.
- Support from family friends is important, as is their awareness of mental health disorders.
- Support needs to be from friendly, approachable and empathic people.
- Being protected from harm/bullying and parents.
- Learning to deal with stress, eg examinations, friends, school.



It was also found that young people may be reluctant to seek help from GPs, and generally did not know who to see and how to get help, with waiting times for services being a particular challenge. They valued available services, with confidentiality and a good balance of shared power and responsibility between the clinician and themselves being key.

Parents wanted improved access and more local venues, including GPs and schools, as well as continuity and consistency of staff and service. They requested clear signposting and sensitive listening services, with a reduction in the gaps between child and adult services.

3.7 Priority needs

- Service planning should take account of future demographics.
- Services need to cater for and monitor the number of children and young people in vulnerable groups who access mental health services.
- Service planning should take into account higher levels of prevalence in the most deprived wards.
- Prevention should focus on building resilience in children and young people.
- Improving the mental health of parents is key to improving the mental health of children and young people. For maximum impact, this should be focused on children aged 0-3 in particular.
- There should be more service focus on children and young people under the age of 15-16 years.
- CPFT activity should urgently be increased.
- Preparation of young people for transition to adult services should be the focus of future work for CAMH services.
- More mental health services should be available in local venues.

3.8 Next Steps

The findings of this JSNA will be fed into a Joint Commissioning Strategy for the Mental Health of Children and Young people, currently being compiled by NHS Cambridgeshire and Cambridgeshire County Council.

The JSNA focuses on Tier 2 to Tier 4 services, commissioned by Cambridgeshire County Council and NHS Cambridgeshire. There is a further need to map additional services provided by the voluntary sector, and by other universal NHS and social care services, to get a complete picture of how current service provision needs are met.

4. Demography

4.1 Population estimates

In mid-2011, it was estimated that there were just over 135,000 people under the age of 19, in Cambridgeshire which is approximately one-fifth of the total population. With 29%, Huntingdonshire has the highest number of children and young people within each age band of Cambridgeshire's total population. However, as can be seen in Table 2, this is forecasted to change over the next 15 years.

In comparison to the county average, Cambridge City has a relatively high proportion of 0-4 year-olds and 17-18 year-olds, in their child and young people population. East Cambridgeshire has a higher proportion of 0-4 year-olds Fenland has lower proportions of 0-4 years-olds and 17-18 year-olds, and therefore, has a higher proportion of 5-16 year-olds. The same is true for Huntingdonshire and South Cambridgeshire, which are similar to county average for all age bands reported.

Table 1: Children and young people population estimates, mid 2011

Local Authority	Age band					Percentage				Percentage of CCC total population
	0-4	5-10	11-16	17-18	Total	0-4	5-10	11-16	17-18	
Cambridge City	6,622	6,040	6,137	3,200	21,999	30.1%	27.5%	27.9%	14.5%	16.2%
East Cambridgeshire	5,558	5,935	5,903	1,938	19,334	28.7%	30.7%	30.5%	10.0%	14.3%
Fenland	5,224	5,906	6,788	2,380	20,298	25.7%	29.1%	33.4%	11.7%	15.0%
Huntingdonshire	10,125	11,673	12,695	4,250	38,743	26.1%	30.1%	32.8%	11.0%	28.6%
South Cambridgeshire	9,423	10,945	11,122	3,658	35,148	26.8%	31.1%	31.6%	10.4%	25.9%
Cambridgeshire	36,952	40,499	42,645	15,426	135,522	27.3%	29.9%	31.5%	11.4%	100.0%
England	3,328,746	3,573,327	3,771,682	1,338,690	12,012,445	27.7%	29.7%	31.4%	11.1%	

Source: mid 2011 population estimates, based on 2011 Census, Office for National Statistics

4.2 Population forecasts

The Cambridgeshire County Council Research Group forecasts that by 2016, the child and young people population of Cambridgeshire, will increase by 3.9% from the 2011 baseline, with the largest increases seen in Cambridge City, and a small decrease in Huntingdonshire. By 2021, it is anticipated that South Cambridgeshire will have the largest population of people under the age of 19, in Cambridgeshire County.

Table 2: Child and young people population forecasts, 0-18 year olds, mid 2011 based Numbers

Local Authority	2011					2016					2021				
	0-4	5-10	11-16	17-18	Total	0-4	5-10	11-16	17-18	Total	0-4	5-10	11-16	17-18	Total
Cambridge City	6,622	6,040	6,137	3,200	21,999	8,600	6,744	5,872	3,020	24,237	7,479	8,272	6,516	2,878	25,145
East Cambridgeshire	5,558	5,935	5,903	1,938	19,334	6,115	7,068	6,069	2,052	21,304	6,167	7,920	7,114	2,095	23,296
Fenland	5,224	5,906	6,788	2,380	20,298	6,223	6,655	6,136	2,301	21,316	6,123	7,737	6,753	2,082	22,694
Huntingdonshire	10,125	11,673	12,695	4,250	38,743	11,308	12,674	11,799	4,096	39,877	10,866	14,131	12,722	3,770	41,489
South Cambridgeshire	9,423	10,945	11,122	3,658	35,148	11,056	12,513	11,178	3,689	38,436	10,718	14,606	12,648	3,707	41,679
Cambridgeshire	36,952	40,499	42,645	15,426	135,522	43,302	45,654	41,055	15,158	145,169	41,353	52,665	45,752	14,533	154,303
England	3,328,746	3,573,327	3,771,682	1,338,690	12,012,445	3,682,925	3,973,057	3,553,609	1,269,423	12,479,014	3,623,217	4,369,510	3,916,935	1,207,378	13,117,040

Source: Mid 2011 based population forecasts, ONS

Table 3: Percentage change

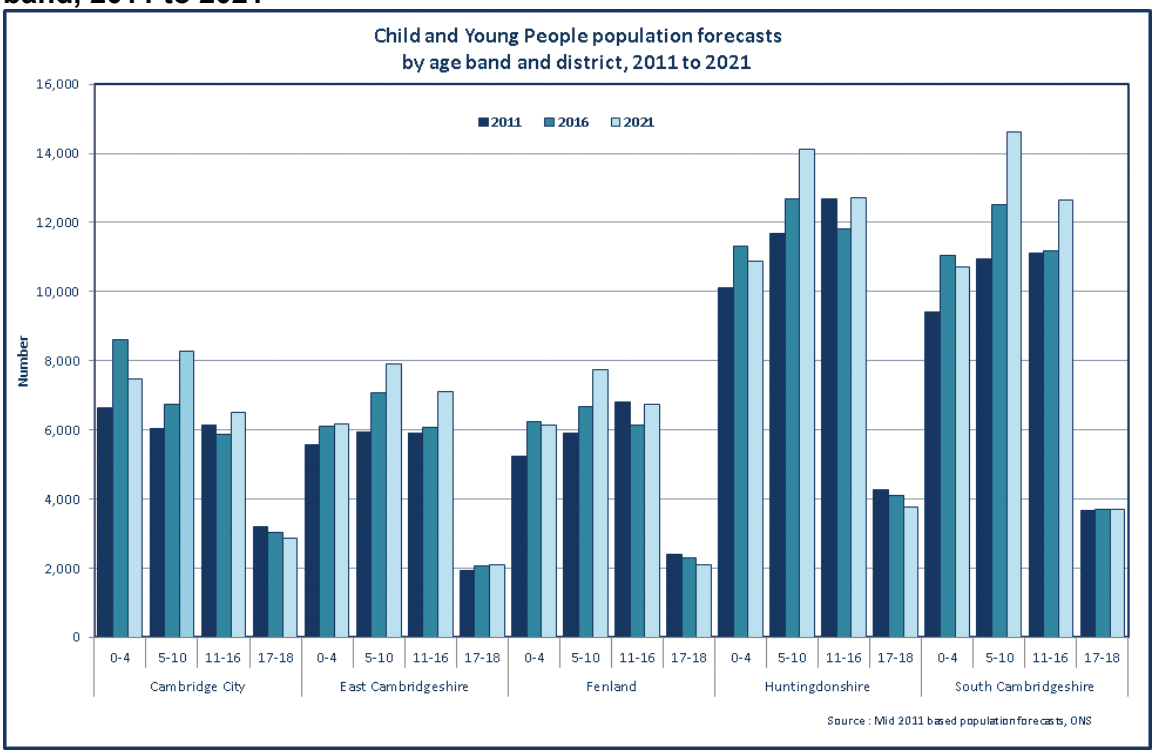
Local Authority	% change 2011 to 2016					% change 2016 to 2021					% change 2011 to 2021				
	0-4	5-10	11-16	17-18	Total	0-4	5-10	11-16	17-18	Total	0-4	5-10	11-16	17-18	Total
Cambridge City	29.9%	11.7%	-4.3%	-5.6%	10.2%	-13.0%	22.7%	11.0%	-4.7%	3.7%	12.9%	37.0%	6.2%	-10.0%	14.3%
East Cambridgeshire	10.0%	19.1%	2.8%	5.9%	10.2%	0.9%	12.0%	17.2%	2.1%	9.4%	11.0%	33.4%	20.5%	8.1%	20.5%
Fenland	19.1%	12.7%	-9.6%	-3.3%	5.0%	-1.6%	16.2%	10.0%	-9.5%	6.5%	17.2%	31.0%	-0.5%	-12.5%	11.8%
Huntingdonshire	11.7%	8.6%	-7.1%	-3.6%	2.9%	-3.9%	11.5%	7.8%	-8.0%	4.0%	7.3%	21.1%	0.2%	-11.3%	7.1%
South Cambridgeshire	17.3%	14.3%	0.5%	0.9%	9.4%	-3.1%	16.7%	13.2%	0.5%	8.4%	13.7%	33.4%	13.7%	1.3%	18.6%
Cambridgeshire	17.2%	12.7%	-3.7%	-1.7%	7.1%	-4.5%	15.4%	11.4%	-4.1%	6.3%	11.9%	30.0%	7.3%	-5.8%	13.9%
England	10.6%	11.2%	-5.8%	-5.2%	3.9%	-1.6%	10.0%	10.2%	-4.9%	5.1%	8.8%	22.3%	3.9%	-9.8%	9.2%

Source: Mid 2011 based population forecasts, ONS

The chart below shows the predicted change in population size by district and age band. Overall, Cambridgeshire is expected to experience a 2.7% increase in the number of pre-school children, with a 10.2% increase in those aged 5-11, by 2016. There will be minimal changes to the number of 11 to 18 year-olds. However, considerable changes are generally expected at district level.

In the 5-15 year and 16-18 year age bands, it is forecasted that South Cambridgeshire will have the largest populations, by 2021. Cambridge City is expected to see the largest proportional increases in all of these age bands, with a 27% increase in pre-school children, a 36% increase in 5-16 year-olds, and a 23% increase in 17-18 year-olds. Conversely, Huntingdonshire, East Cambridgeshire and Fenland are expected to see decreases in these age bands, with Huntingdonshire experiencing the most notable changes, particularly in those aged 11-16.

Figure 1: Child and young people population forecasts by district and age band, 2011 to 2021



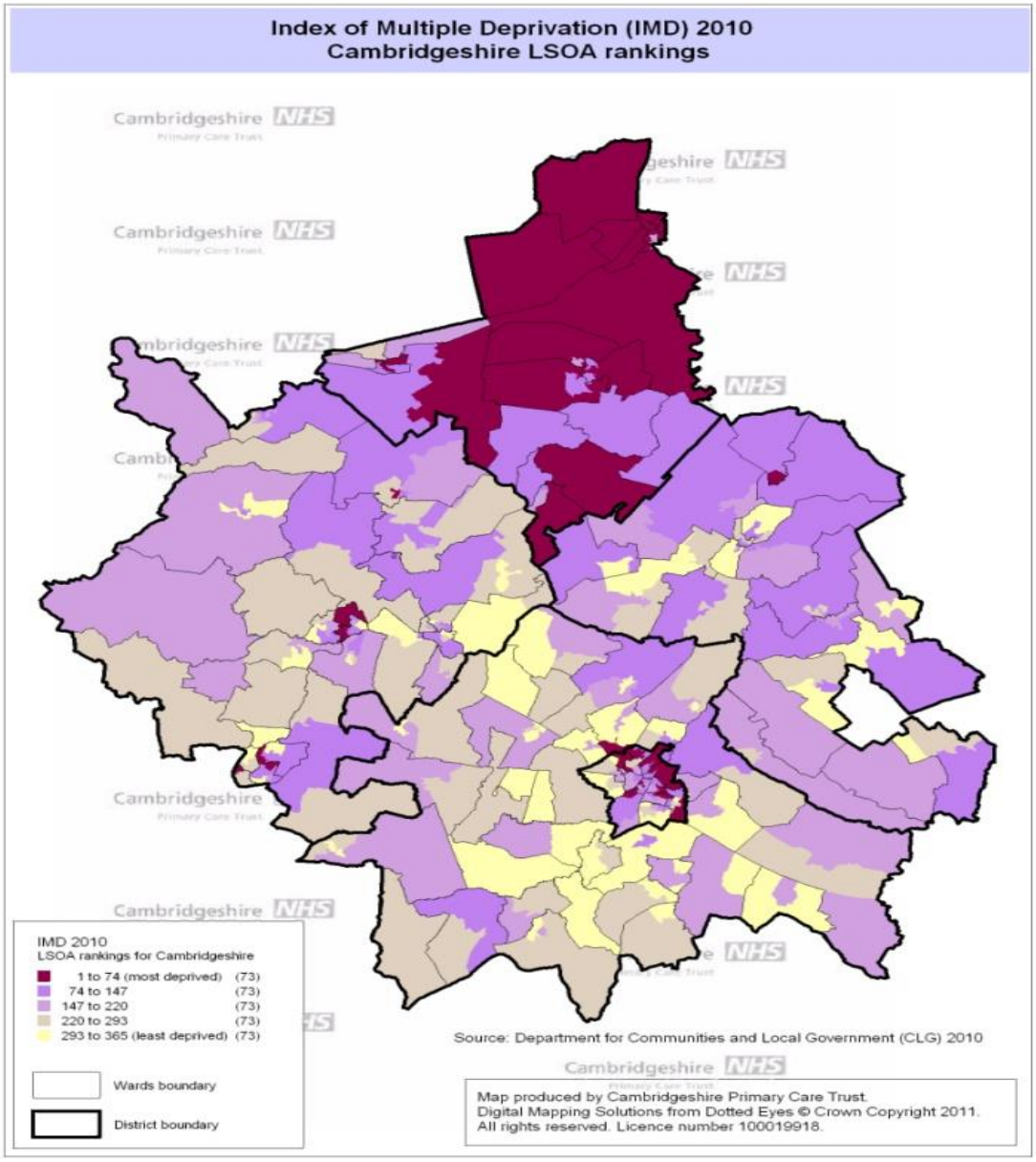
4.3 Deprivation

The following two maps show the overall levels of deprivation in Cambridgeshire and also the proportion of children and young people living in means-tested, benefit-reliant families.

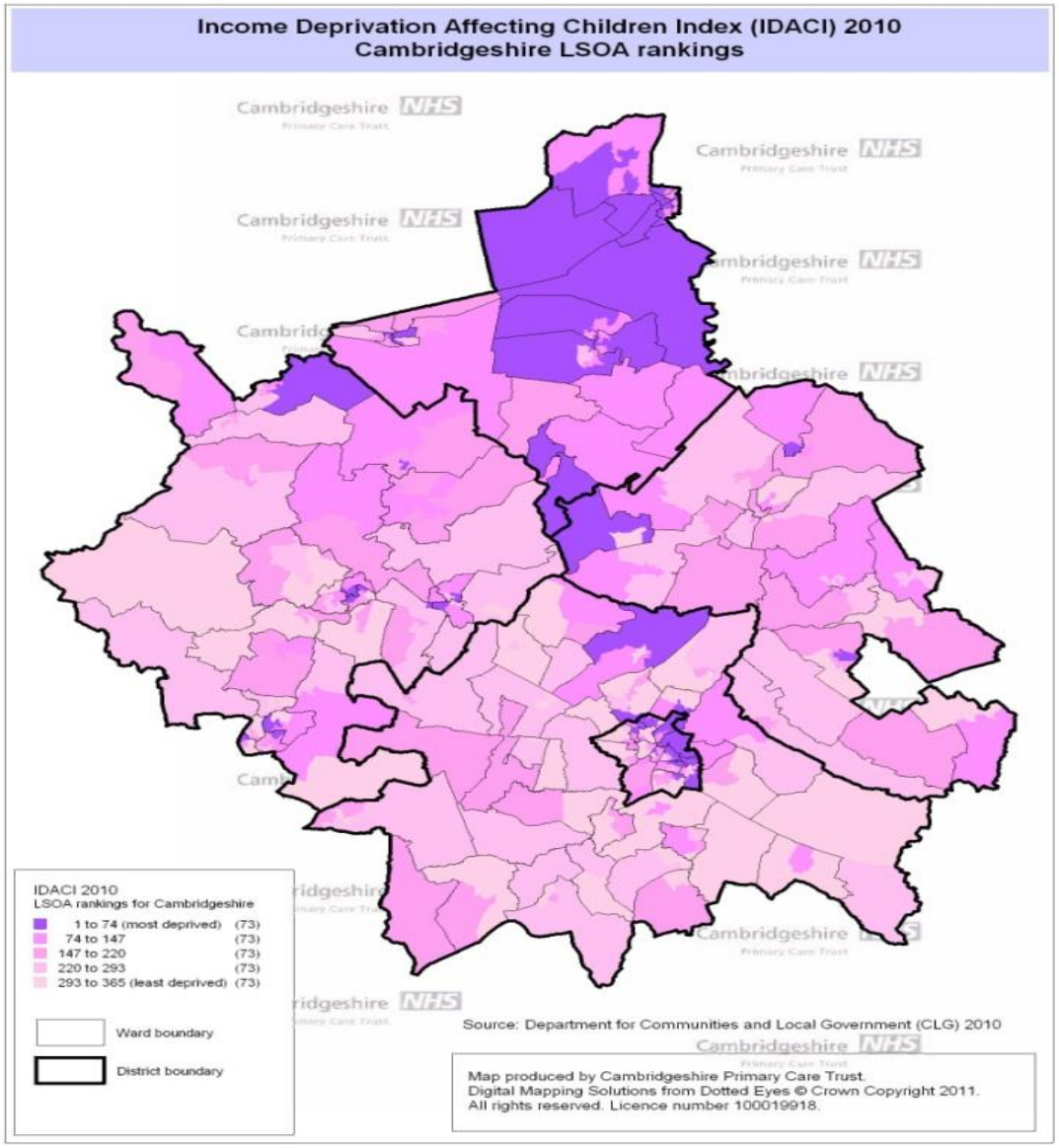
The Income Deprivation Affecting Children Index (IDACI) gives the proportion of families that are income deprived (ie, in receipt of benefits, such as income support, job-seekers allowance and working families tax credit or disabled person tax credit).

The greatest areas of overall deprivation are in north Fenland, Huntingdon North and the north east of Cambridge City. Areas within Fenland and Cambridge City have the highest proportions of children and young people living in means-tested, benefit-reliant households, with half of children and young people in an area within Waterlees living in such households.

Map 1: Index of Multiple Deprivation - 2010



Map 2: Income Deprivation Affecting Children Index (IDACI), 2010



The 2010 review of the evidence for Cambridge and South Cambridgeshire,[11] looked at the IDACI in small areas (Lower Super Output Areas), analysis that reveals a more detailed picture of where deprivation lies. The study found that material deprivation was largely concentrated in a few areas, including: Abbey, East Chesterton and Kings Hedges, with pockets of deprivation in Romsey, Arbury and Cherry Hinton. In South Cambridgeshire, three LOSAs had high levels of deprivation comparable with those in the city ie Smithy Fen, Fen Road to Milton, South of Impington. This is largely assumed to be due to higher numbers of Travellers/Gypsy/ Roma communities living in these areas.

There were also high levels of deprivation between Cherry Hinton and Fulbourn and Sawston, as well as isolated parts of other villages, such as Melbourn and Linton.

[11] Children and young people living in deprivation, the disaffected and those at risk of disaffection, Juliet Snell (March 2010)

5. Prevalence

This section of the report provides information about wellbeing of children and young people, and the numbers with mental health problems by infant, pre-school, school age and 16-17-year-olds. The prevalence of types of mental health disorder such as self-harm, autism and the risk factors that lead to higher levels of some mental health disorders in particular localities and populations.

5.1 Wellbeing

Wellbeing has been defined as, "More than just happiness. As well as feeling satisfied and happy, wellbeing means developing as a person and being fulfilled." [12]

On average, populations with high levels of wellbeing are more likely to be protected from mental ill-health than populations with lower levels of wellbeing. Therefore, rather than solely focus on treatment or prevention of mental illness, emphasis needs to be placed on maximising wellbeing that reduce overall levels of mental ill-health, in the population.[13]

Resilience factors can create a sense of hopefulness about the future and influence how individuals respond to stressful life events.[14] They can also help to overcome problems created by the presence of risk or reducing risk factors, including poverty, poor parenting experiences, child abuse and belonging to a vulnerable minority group, such as asylum seekers, travellers and looked-after children.

Strengthening factors Known to protect mental health	**Reducing factors** Known to increase risk
• Developing a sense of control	• Stigma and discrimination
• Improving coping skills and self-care	• Social injustice and inequalities
• Facilitating participation	• Violence, abuse and neglect
• Promoting social inclusion	• Social exclusion

Source: Department of Health 'Making it Happen' (DH, 2001b)

Six priority areas for promoting wellbeing in children and young people

Expanding on the idea of risk and resilience factors, the Children's Society 'Good Childhood Report' identified six priority areas for promoting wellbeing in children and young people, as follows:

- **The conditions to learn and develop**, such as access to early years play; high-quality education; good physical development; eg diet/obesity; school activities; levels of happiness at school; health and disability.
- **A positive view of themselves and an identity that is respected**, such as self-esteem; being listened to; not being bullied.

[12] New Economics Foundation (2008)
[13] Government Office for Science (2008)
[14] Weare (2010)

- **Have enough of what matters**, covering family circumstances; child poverty; household income; parental employment; access to green space.
- **Positive relationships with family and friends**, where stable and caring relationships are important (eg in the case of looked-after children, they are more likely to experience changes in caring relationships).
- **A safe and suitable home environment and local area**, eg feeling safe; privacy; good local facilities; stable home life (ie overcrowded housing or moving house a lot is a risk factor to wellbeing – positive caring relationships over-ride this).
- **Opportunity to take part in positive activities to thrive**, involving a healthy balance of time with friends and family; time to ones-self; doing homework; helping at home; being active, eg access to garden or local outdoor space.[15]

These priority areas were developed as a result of research carried out by the Children's Society, into the wellbeing of children and young people aged 8 to 15, across the UK.[16]

Many of the factors identified in this JSNA are interlinked, with some factors seen as making children and young people more susceptible to mental health problems, such as deprivation. Others factors, such as self-harm or school exclusions, could be a result of the child's pre-existing mental health problem. For many of the factors highlighted, such as the victims of bullying, it indicates it is both the cause and the result of a mental health problem.[17]

Factors that strengthen and reduce wellbeing have also been identified in local research with children and young people. The Healthy Young Minds Project[18] provides a description of the issues that affect the wellbeing of them, which includes involving the services that support them.

The groups of young people interviewed for the research, outlined what they believed adults should do to support them when they felt mentally unwell. The most common feedback was receiving support and advice.

Some discussions defined the type of support this should be, eg to be readily available when bad things occur, provided by a well-known, friendly and empathic person who listens carefully to show they have been listened to, by getting to know the child or young person then taking actions based on what they were told.

Children and young people also discussed how the support should be given and how to increase activity time of activities they personally liked and chose. They sometimes preferred smaller groups of children and young people, who enabled them to have more fun, get to know each other better and share their ideas and feelings. Children and young people particularly valued support from peers and adults outside their own families.

Overall Child Wellbeing in Cambridgeshire

Overall levels of wellbeing have been measured by the child wellbeing index (CWI). The CWI index was commissioned by *Communities and Local Government*[19] and is based on the approach, structure and methodology used in the construction of the

15 Children's Society, 2012a & Children's Society (June 2012).
16 Children's Society (2012).
17 Freer et al, 2010; Weare, 2010; Salmon et al (2005).
18 Development of Child and Adolescent Mental Health Services in Cambridgeshire (2008).
19 Communities and Local Government (2009).

index of Multiple Deprivation, in 2007. The index outlined a combination of broad ranging factors believed to influence children and young people's emotional health and wellbeing, based on material wellbeing, health, education, crime, housing, environment and children in need.

The following table shows the results for Cambridgeshire, and reflects the same pattern as the cluster of social and economic factors that indicate Cambridge City and Fenland have greater prevalence levels.

Table 4: Child Well Being Index 2009

Local Authority	Average score	Rank of average scores (1 high wellbeing to 354 low wellbeing)
Cambridge	119.1	160
East Cambridgeshire	88.4	80
Fenland	166.5	251
Huntingdonshire	93.8	97
South Cambridgeshire	60.3	14
Cambridgeshire	99.6	

Source: Department for Communities and Local Government, Child Well-being Index, 2009

The table below shows the figures and information relating to the emotional health of all children and young people, for 2009-2010, in Cambridgeshire. It indicates that on average, Cambridgeshire is either in line with or better on these measures than the rest of England. It is also worth noting that given the reduction in the provision of youth services, these figures are likely to have since changed.

Table 5: Emotional health (figures are the percentage of children and young people)

	Young people's participation in positive activities (2009-2010)	Substance misuse by young people (2009-2010)	Children who have experienced bullying (2009-2010)
Cambs.	80.4	9.6	28.1
England	65.8	9.8	28.8

Sources: The Department for Children Schools and Families; Department for Education

The Health Related Behaviour Survey 2012

Bullying

A factsheet produced by The Royal College of Psychiatrists,[20] reports that 'Being bullied can seriously affect a child's physical and mental health which results in a lack of self-confidence; ie they feel bad about themselves; have few friends and spend too much playtime alone. Others become exceptionally anxious, have difficulty sleeping feel depressed or even suicidal. Such problems can continue long after bullying has stopped'.

Children and young people who are regularly bullied at school are six times more likely to contemplate suicide than those who are not bullied.[21]

In 2012, a quarter of Year 8 pupils and 15% of Year 10 pupils, reported that they had been bullied in school or within the vicinity, during the previous 12 months. Over the same period, 10% of Year 8 pupils and 8% of Year 10 pupils reported being bullied away from school. Approximately one quarter of all pupils surveyed said they were 'sometimes', 'often' or 'very often' afraid of going to school, due to bullying.

Table 6: Pupils response to: 'Do you ever feel afraid of going to school due to bullying?' – 2012

Response	Year 8		Year 10	
	Male	Female	Male	Female
Never	74%	65%	85%	75%
Sometimes	21%	28%	12%	20%
Often	3%	4%	1%	3%
Very often	3%	3%	1%	2%
Number of pupils	2,299	2,235	2,101	2,095

Source: Health Related Behaviour Survey 2012, Schools Health Education Unit

Self-esteem and worrying

As can be seen in the table below, a healthy self-esteem is generally higher in boys than girls and is similar in both school years. The table reveals a composite index for pupils responding to questions on feelings, in areas such as relationships, friend, loneliness and schools.

[20] *Factsheet 18: The emotional cost of bullying, Factsheet for parents and teachers, 2004*, Royal College of Psychiatrists
www.rcpsych.ac.uk/mentalhealthinforamtion/mentalhealthandgrowingup/18bullyandemotion.aspx

[21] *Children and young people and mental health*, Factsheet, Mind
www.mind.org.uk/information/factsheets/children/children+and+young+people+and+mental+health.htm

Table 7: Composite score on self-esteem, 2012

Composite self esteem score	Year 8		Year 10	
	Male	Female	Male	Female
Values 0-4 (low)	5%	7%	4%	7%
Values 5-9 (med-low)	16%	26%	13%	23%
Values 10-14 (med-high)	34%	41%	35%	42%
Values 15-18 (high)	46%	26%	48%	28%
Number of pupils	2,276	2,226	2,091	2,097

Source: Health Related Behaviour Survey 2012, Schools Health Education Unit

The table below shows pupils' response to relationships, friends, loneliness and schools with girls tending to worry more than boys and with the worrying increasing with age.

Table 8: Composite score on self-esteem, 2012

% of pupils responding about worry issues	Year 8		Year 10	
	Male	Female	Male	Female
Never	2%	0%	2%	0%
Hardly ever	3%	1%	2%	0%
A little	19%	11%	14%	5%
Quite a lot	26%	26%	30%	21%
A lot	47%	60%	49%	73%
Unknown	4%	2%	3%	1%
Number of pupils	2,431	2,298	2,194	2,144

Source: Health Related Behaviour Survey 2012, Schools Health Education Unit

There are currently no regional or national comparisons for the health- related behaviour survey and so it is not possible to tell if these levels of bullying and self-esteem are low or high, compared to other places.

Promoting Resilience

It is important to remember that most children and young people grow up emotionally and mentally healthy, even when subject to the risk factors identified in their lives. A range of protective factors in the individual, family and community, will influence whether a child or young person experiences problems, or not be significantly affected by them, particularly when receiving consistent support from an adult, whom they trust. The National Mental Health Development Unit (2010)[22] provides an evidence-based checklist of protective factors that enables commissioners and service providers to enhance such factors, including:

- **Early Years**: Foundations for good mental health lie in pregnancy, infancy and early childhood. Parenting style and attachment are the key factors. The quality of the 'home learning environment', quality of pre-school and the amount of time in preschool are all associated with greater 'self-regulation', an attribute strongly linked to improved educational outcomes.

[22] National Mental Health Development Unit 2010, 'Mental well-being checklist'. www.nmhdu.org.uk

- **Adolescence**: Protective factors include: attachment to school; family and community; positive peer influence; opportunities to succeed; and problem solving skills. 'Social capital' indicators including friends, support networks, valued social roles and positive views on neighbourhood, are closely related to risk and severity of emotional and behavioural disorders.

It is evident that the protective factors for mental health problems are also very likely to protect against poor outcomes in other areas of the child's wellbeing, such as educational achievement and achieving economic wellbeing. It is therefore important that all strategies for early intervention consider mental health outcomes.

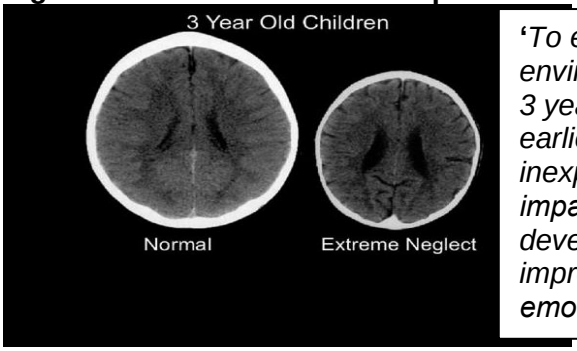
Early brain development and infant mental health

It is estimated that the prime window for emotional development in the infant brain is up to 18-months. This is when the formation of the part of the brain that governs emotional development has been identified to be taking place. The antenatal period is equally as important as infancy, due to the strong impact that maternal behaviour has on the developing foetus.

Studies[23] indicate that maternal depression is a prime factor in determining behavioural problems and impedes brain development for many children. These emotional deficits are difficult to overcome once this early period has passed.

Research also shows the importance of infants having secure attachments with those close to them, leading to the development of empathy, trust and wellbeing. Conversely, people with insecure attachments to those closest are more likely to have social and emotional difficulties. Studies have also found a link between aggression, non-compliance and temper tantrums and low maternal responsiveness towards children of 10-18 month. However, no similar effect was found after 18 months.[23]

Figure 2: The Graham Allen Report 20122



'*To establish the right environment for those aged 0-3 years old, is to seize the earliest, best and most inexpensive chance to have an impact on a child's development and, therefore, improve social capability and emotional capacity.'*

Source: Early Intervention: The Next Steps. Graham Allen MP. Jan 2011, Front cover and p13.

5.2 Prevalence of Mental Disorders by age Group

The following section examines the prevalence of mental health disorders in children and young people, by age group. In 2004, a significant study was carried out on the mental health of children and young people aged five to 16 years, living in private households in the UK. This section will also discuss children under five years of age and vulnerable children, such as looked-after children, refugees and young offenders.

[23] Early Intervention: The Next Steps. Graham Allen MP. (Jan 2011).

5.2.1 Pre-school children

There is relatively little data on prevalence rates for mental health disorders in pre-school age children. A Department of Health report, in 2012, recommended that a new survey should support measurement of outcomes for children with mental health problems. In particular, they plan a survey on a three-yearly basis to look at prevalence of mental health problems in children and young people, which could build on the work of the survey, for the, 'Mental health of children and young people in Great Britain, 2004'.[24]

A literature review of four studies looked at 1,021 children, from two to five years of age, inclusive, which found that the average prevalence rate of any mental health disorder was 19.6%.[25]

In the publication, 'Statistics on Mental Health: A factsheet from the Mental Health Foundation',[26] the Mental Health Foundation states that:

- 15% of pre-school children will have mild mental health problems;
- 7% will have severe mental health problems.

This equates to 5,500 children under five years of age, in Cambridgeshire, with mild mental health problems, and 2,600 with severe mental health problems.

We know by referrals from peer support (part of the Home and Community Support Contract), that there is increasing demand for help by parents with children aged 0-5 years, with mental health problems (see section on Parental Mental Health).

An active 'Infant Mental Health Group' in Cambridgeshire has undertaken a mapping exercise to understand the current services available to support infant mental health.

5.2.2 Children and young people aged 5 to 16 years

In August 2005, the Office for National Statistics published the report 'Mental health of children and young people in Great Britain, 2004'.[27] The report provides a wealth of data on the prevalence of mental disorders in children and young people, aged five to 16 years, living in private households.[28] The prevalence data from the 2004 report remains the most up-to-date reference with comprehensive estimates applied to the overall Cambridgeshire population.

The report used the term 'Mental Disorder', as defined by the International Classification of Diseases Tenth Revision (ICD10), to imply a clinically recognisable set of symptoms or behaviour associated with considerable distress and substantial interference with personal functions.

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[24] Children and Young People's Health Outcomes Forum: Department of Health, p.32 (2012).
[25] Egger, H et al (2006).
[26] *Statistics on Mental Health: a factsheet from the Mental Health Foundation*, The Mental Health Foundation www.mentalhealth.org.uk
[27] Mental health of children and young people in Great Britain, 2004, Office for National Statistics www.statistics.gov.uk/downloads/theme_health/GB2004.pdf
[28] *The mental health of children and adolescents in Great Britain, 1999,* Office for National Statistics www.statistics.gov.uk/downloads/theme_health/childadol_mental_health_v1.pdf

5.2.3 16 and 17 year-olds

The paper, *Working at the CAMHS/Adult Interface: Good practice guidelines for the provision of psychiatric service to adolescent/young adults,*[29] provides prevalence estimates of mental disorders in people aged 16 to 17 years of age.

Due to these high rates of mental disorder for 16 year-olds, included in both national data sets, this report has also applied the adult rate of mental health problems to the Cambridgeshire population, for 17 year olds.

It is estimated that one-in-six adults[30] will experience at least one diagnosable mental health problem at any given time. If this proportion is applied to the population of 17 year-olds, in Cambridgeshire, it is feasible that slightly more than 1,275 17 year-olds may have a mental health problem.

The research cited above also reveals that one of the main concerns for this age group is the transition they make from children's to adolescent mental health services, as, locally, no patients in this age group were admitted to hospital under the care of an adult mental health consultant.

5.3 Prevalence in Cambridgeshire for five to 16 year-olds

Approximately one in ten children (10%) and young people have a clinically diagnosable mental health disorder. This equates to **8,000** children and young people, aged five to 16 years, in Cambridgeshire. Huntingdonshire district currently have the largest five to 16 year-old population as shown in Table 1 and therefore have the highest number of children and young people with any mental health disorder.

Prevalence is highest in conduct disorders, followed by emotional disorders. However, there are differences between sexes, ages and other variables, as detailed later in this report. The number of children and young people estimated to have a clinically diagnosed mental health disorder has changed little since 2008, due to only small changes in the overall five to 16 year-old population since. The estimates suggest a substantial change in population will result in an increase in the volume of referrals, by 2016 and 2021 respectively.

This section also examines the prevalence of mental health disorders in children and young people by specific factors, such as ethnicity, household income, family composition and parental education. National data provides national prevalence levels, but when specific local factors are taken into account, some areas within Cambridgeshire have clearly shown to have a higher prevalence of mental health disorders for children and young people.

The chart below shows the estimated national prevalence of any mental health disorder by age and sex. In general, the prevalence of mental health disorders in children and young people increases with age and is higher in boys than girls, with the exception of emotional disorders, where prevalence is higher in girls.

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[29] *Working at the CAMHS/Adult Interface : Good practice guidance for the provision of psychiatric services to the adolescent/young adults.* A joint paper from the Interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists. Lamb C, Hall D, Kelvin R, Van Beinum M, May 2008

[30] *Psychiatric morbidity among adults living in private households,2000,* National Statistics www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf

However, as will be examined in the following sections of this report, many indicators have proven to influence the mental health of children and young people, but are not necessarily highest in the areas where large numbers of children and young people reside.

Figure 3: Prevalence of any mental disorder, Great Britain, 2004

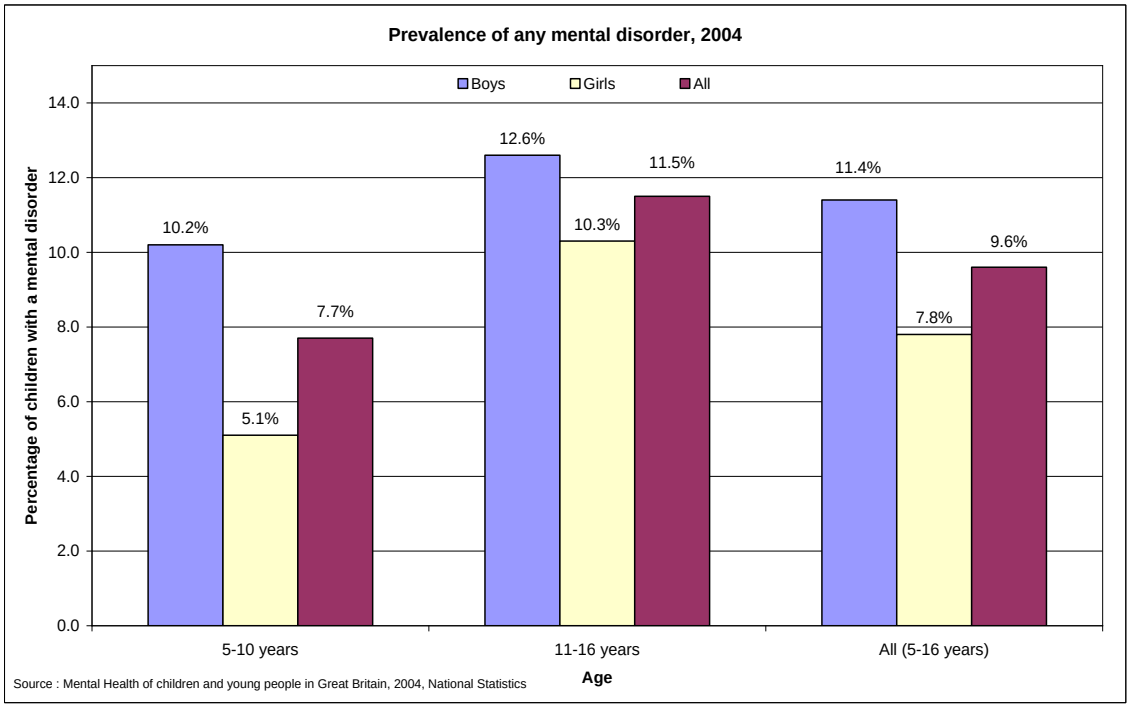


Table 9: Estimated number of children and young people aged 5 to 16 years with any mental disorder, by age and sex, 2011

Local Authority	Boys			Girls			Total		
	5-10 years	11-16 years	Total	5-10 years	11-16 years	Total	5-10 years	11-16 years	Total
Cambridge City	300	400	700	100	300	500	500	700	1,200
East Cambridgeshire	300	400	700	100	300	400	500	700	1,100
Fenland	300	400	700	100	300	500	500	800	1,200
Huntingdonshire	600	800	1,400	300	600	900	900	1,500	2,300
South Cambridgeshire	600	700	1,300	300	600	800	800	1,300	2,100
Cambridgeshire	2,100	2,700	4,900	1,000	2,100	3,100	3,100	4,900	8,000

Source: Mental Health of children and young people in Great Britain, 2004, National Statistics and mid 2011 population estimates, ONS

5.4 Prevalence by type of mental disorder

In 2004, 10% of children and young people aged five to 16 years, had a clinically diagnosed mental health disorder; 4% had an emotional disorder; 6% had a conduct disorder; 2% had a hyperkinetic disorder; and 1% had a less common disorder.

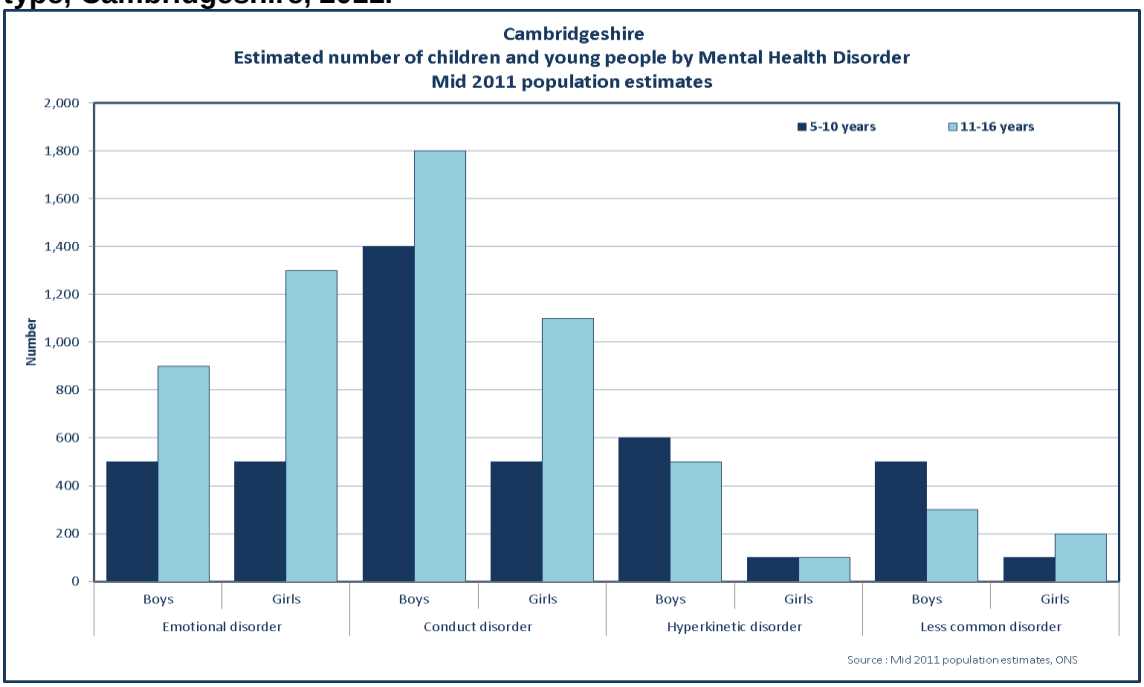
The table and chart below show the estimated number of children and young people in Cambridgeshire, with a mental disorder, by disorder type, age and sex. The chart clearly shows the higher prevalence in boys and young people, as well as the high prevalence in girls with emotional disorders.

Table 10: Prevalence from National Statistics 'Mental health of children and young people in Great Britain 2004' Applied to Cambridgeshire

Disorder	Sex	Prevalence estimates			Estimated number in Cambridgeshire		
		5-10 years (%)	11-16 years (%)	All (5-16 years) (%)	5-10 years	11-16 years	Total
Any disorder	Boys	10.2	12.6	11.4	2,100	2,700	4,900
	Girls	5.1	10.3	7.8	1,000	2,100	3,100
	All	7.7	11.5	9.6	3,100	4,900	8,000
Emotional disorder	Boys	2.2	4.0	3.1	500	900	1,300
	Girls	2.5	6.1	4.3	500	1,300	1,700
	All	2.4	5.0	3.7	1,000	2,100	3,100
- Anxiety disorder	Boys	2.1	3.6	2.9	400	800	1,200
	Girls	2.4	5.2	3.8	500	1,100	1,500
	All	2.2	4.4	3.3	900	1,900	2,700
- Depression	Boys	0.2	1.0	0.6	0	200	300
	Girls	0.3	1.9	1.1	100	400	400
	All	0.2	1.4	0.9	100	600	700
Conduct disorder	Boys	6.9	8.1	7.5	1,400	1,800	3,200
	Girls	2.8	5.1	3.9	500	1,100	1,600
	All	4.9	6.6	5.8	2,000	2,800	4,800
Hyperkinetic disorder	Boys	2.7	2.4	2.6	600	500	1,100
	Girls	0.4	0.4	0.4	100	100	200
	All	1.6	1.4	1.5	600	600	1,200
Less common disorder	Boys	2.2	1.6	1.9	500	300	800
	Girls	0.4	1.1	0.8	100	200	300
	All	1.3	1.4	1.3	500	600	1,100

Source: Mental Health of children and young people in Great Britain, 2004, National Statistics and mid 2011 population estimates, ONS.
Note: a child may have fall into more than one of these categories and therefore the numbers do not add to the Cambridgeshire total of 8,000 children.
Estimated number in Cambridgeshire, using rounded mid-2011 population estimates

Figure 4: Estimated number of children with a mental disorder, by disorder type, Cambridgeshire, 2011.



Autism

It is estimated that approximately 1% of children and young people, aged five to 16 years, have an Autistic Spectrum Disorder (ASD).[31] Autism is a subset of the 'less common mental health disorders', which equates to approximately **750** children and young people, in Cambridgeshire.

Table 11: Estimated number of children and young people with autism in Cambridgeshire, 2011

Age band	Sex	% with Autism Spectrum Disorder	Estimated number in Cambridgeshire
5-10 years	Boys	1.9	400
	Girls	0.1	20
	All	1.0	400
11-16 years	Boys	1.0	220
	Girls	0.5	100
	All	0.8	340
All	Boys	1.4	600
	Girls	0.3	120
	All	0.9	750

Source: Mental Health of children and young people in Great Britain, 2004, National Statistics and mid 20011 population estimates, ONS.
Note: Totals may not agree due to rounding.

[31] Mental Health of children and young people in Great Britain (2004), 2004, Office for National Statistics www.statistics.gov.uk/downloads/theme health/GB2004.pdf

The table below shows the primary needs for pupils (maintained schools only) who have a Statement or School Actions Plus. In January 2012, 871 pupils recorded as having an autistic spectrum disorder, which accounted for 12% of all statements.

Table 12: **Primary needs for pupils with School Action + and Statements, January 2012**

SEN Primary Need for pupils with SA+ and Statements	No. of pupils	% of pupils
Behaviour, Emotional & Social Difficulties	1,702	23.9%
Moderate Learning Difficulty	1,357	19.0%
Speech, Language and Communication Needs	1,149	16.1%
Specific Learning Difficulty	901	12.6%
Autistic Spectrum Disorder	871	12.2%
Severe Learning Difficulty	305	4.3%
Other Difficulty/Disability	289	4.1%
Physical Disability	215	3.0%
Hearing Impairment	138	1.9%
Profound & Multiple Learning Difficulty	105	1.5%
Visual Impairment	76	1.1%
Multi-Sensory Impairment	16	0.2%
Total	7,124	100.0%

Source: School Census 2012, Children and Young Peoples Services, Cambridgeshire County Council

Children and young people with autistic spectrum disorders are predominantly boys (82%). However, there is no difference between autistic children and young people and other children and young people in their age, ethnic profiles or other measures of family size or composition.

Many of the characteristics of autism differ from those of children and young people with more common mental disorders. For example, children and young people with autism who have more highly-qualified parents, eg 46% of parents with educational qualifications above GCSE level, compared to 35% of children without autism.

The prevalence of emotional, conduct and hyperkinetic disorders is much higher where parents did not have any educational qualifications but there is no difference in prevalence of mental health disorders where neither parent works, in which case the prevalence of autism is higher, as it is for other more common mental health disorders. The report states: “The unusual combination of high educational status and low economic activity rates among parents of autistic children probably reflects their heavy caring responsibilities.”

Of the majority of autistic children and young people with a physical or developmental problem (89% compared to 54% of children and young people who do not have autism), the most common complaints were:

- Speech or language problems (67%).
- Difficulty with co-ordination (47%).
- Bed wetting (29%).
- Eyesight problems (23%).
- Stomach and digestive problems (19%).
- Soil their pants (19%).

Just under a third (30%) of autistic children and young people had a further clinically recognisable mental disorder; 16% had an emotional disorder (usually anxiety disorder) and 19% also had a diagnosis of conduct disorder (often severe challenging behaviour). Over one-tenth of children and young people (13%) with autism were taking some form of medication, for over-activity and inattention. Almost 90% of parents had sought help within the previous 12 months, and of these, 86% had sought professional help or advice with teachers as the most commonly used source.

Around half of autistic children and young people were reported as having marked difficulty with reading and mathematics (48% compared to 6% of children without autism) and over half had difficulty with spelling (58% compared to 9% of other children). Overall, they were three times as likely as other children and young people to be behind in their overall intellectual development, with two-fifths being more than two years behind. Almost all the children and young people with autistic spectrum disorder had special educational needs and the majority had written statements.

The study used the General Health Questionnaire (GHQ12) to assess the interviewed parents' (more usually the mother's) mental health where a score of three or above is indicative of an emotional disorder. The parents of autistic children were almost twice as likely as parents without autistic children to have score of three or more (44% versus 24%).

Family functioning was measured using the FAD-GFS scale in which parents rate 12 statements about family relationships. Families that scored over two were considered to have unhealthy functioning. A third of autistic children and young people lived in families classified as having unhealthy functioning (37%) and were twice as likely as other children to be in such families (37% versus 18%).

As autism is present from infancy onwards, there is no reason to believe that exposure to stressful life events in childhood causes autism. However, autistic children and young people were more likely than other children and young people to have experienced two or more stressful life events. The study concluded that it may be a coincidence, but more likely is that autism can actually trigger life events by placing extra stress on the family.

The study was unable to present data on a child's social functioning, including: smoking; alcohol consumption; drug use or self-harm, the numbers of autistic children and young people being too small to answer such questions. However, 25% of parents with an autistic child reported instances of self-harm.

5.5 Self-harm, suicide and hospital use

Self-harm

Self-harm and suicide can be a symptom of underlying unhappiness or emotional disorder. Research suggests that the incidence of self-harm is increasing among young people. A 2002 survey of school children in England found that 6.9% of young people had committed an act of self-harm, and was more common in girls (11.2%) than boys (3.2%), with the average age of onset of self-harm at 12 years old.[1]

Table 13 Self Harm

Age	National prevalence	Population	Estimated number in Cambridge shire
5-15 years	1.3%	75,868	986
15-16 years	13.0%	14,564	1,893

Source CHIMAT

Suicide rates are very low in children, but risk starts to increase from age 11, with boys and young men aged 15-24 most at risk. Attempted suicide is more frequent with as many as 2-3% of girls attempting suicide at some point in their teenage years, and attempted suicide is primarily a problem in older adolescents. Depression, serious mental health problems and the misuse of drugs are all key factors related to suicide attempts. Young people who have already tried to kill themselves, or know someone who has tried, are also at greater risk of attempting suicide.[1]

Nationally reported data on self-harm[27] from both the parents and child's view (for children aged 11 to 16 years) indicate that parents of a child or young person with a mental disorder were more likely to think that their child had self-harmed than those who had children with no mental disorder. Levels of actual self-harm, as reported by the child, were higher than their parents' reports, especially for children and young people with emotional disorders. Overall reported self-harm by disorder type was:

- 28% of children with an emotional disorder;
- 21% of children with a conduct disorder;
- 18% of children with hyperkinetic disorder.

If these proportions are applied to Cambridgeshire's children and young people (five to 16 years), with mental health disorders, there could be up to **1,300** children and young people who have had tried to harm or kill themselves.

In Cambridgeshire, between 2009/10 and 2011/12, there were 444 hospital admissions (inpatient or day case) for young people, under 18-years of age, who had been admitted to hospital for self-harm. A small proportion of these will have been admitted more than once. Over this time period, Cambridge City has the highest rate but this is not significantly different to other local authority areas.

The number of children (under 18-years of age) admitted to hospital, increased from 142 children (2010/11) to 182 children (2011/12). The rate in 2011/12, was 141.00 per 100,000 population. However, national rates have substantially decreased over the same time period, from 158.80 per 100,000 population in 2010/11, to 115.50 per 100,000, in 2011/12.

Over 70% of hospital admissions, in 2010/11, were for people aged 15-17 years, of which 80% were females. Over half had intentionally self-poisoned, with exposure to non-opioid analgesics, antipyretics and antirheumatics, and a further fifth admitted for intentional self-poisoning by exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, unclassified elsewhere. For three-quarters of admissions the self-harm incident had occurred at home. Just under half of admissions also had one of the ICD10 mental and behavioural disorder codes against the record. A quarter of all admissions had a code recorded for a depressive episode.

More detailed analysis, not presented here due to small numbers, indicates that self-harm hospital admission rates are highest in areas of greater relative deprivation.

Table 14: **Hospital admissions due to deliberate self-harm, 2009/10 to 2011/12**

Local Authority	Number of admissions	Crude rate per 100,000 population	95% confidence intervals
Cambridge	81	135.7	(107.8 - 168.7)
East Cambridgeshire	52	94.0	(70.2 - 123.3)
Fenland	56	99.0	(74.8 - 128.5)
Huntingdonshire	139	126.0	(105.9 - 148.8)
South Cambridgeshire	116	117.3	(96.9 - 140.6)
Cambridgeshire	444	116.6	(106.0 - 128.0)

Source: Admitted Patient Care Commissioning Data Set, Serco

Table 15: **Trend in hospital admissions for self-harm, under 18 year- olds**

Local Authority	2007/08	2008/09	2009/10	2010/11	2011/12
Cambridge	26	36	25	19	37
East Cambridgeshire	20	18	12	18	22
Fenland	22	15	12	18	26
Huntingdonshire	44	50	35	49	55
South Cambridgeshire	42	23	38	38	40
Cambridgeshire	154	142	122	142	180

Source: Admitted Patient Care Commissioning Data Set, Serco

Whilst the rate per 100,000 population of young people self-harming in Cambridgeshire (2010/11) is lower than England's rate, it is not significantly so (113.0 and 124.8 respectively).[32] Comparison data is unavailable for 2011/12.

Suicide and injury undetermined

On average, there is one death a year from suicide and undetermined injury, in Cambridgeshire, for people under 18-years of age. Due to the small number, further analysis is not included here.[33]

5.6 Prevalence of mental disorders by the wider determinants of health

The following section examines the prevalence of mental health disorders within Cambridgeshire by some of the wider determinants of health eg, parental qualifications and household income, and therefore has higher proportions of children and young people with mental disorders.

It is widely acknowledged that certain factors increase the risk of developing mental health problems. Children and young people with one or more of the factors in the following domains are more vulnerable to mental illness.[34]

[32] Child Health Profiles 2012, ChiMat
[33] Annual extract of deaths, Vital Statistics, NHS Cambridgeshire, 2009-2011
[34] No Health Without Mental Health

- Low-income household/parents who are unemployed
- Looked-after children
- Disabilities
- Black and other ethnic minority groups
- Lesbian/gay/bisexual or transgender
- Those in the criminal justice system
- Those who have a parent with mental health problems
- Those who experience negative parenting
- Refugees, asylum seekers and young homeless
- Gypsy and other traveller communities
- Those who have been abused
- Substance misuse

The table below (adapted and updated from the 2006 Profile of Child and Adult Mental Health in Peterborough) sets out a range of risk factors and shows where possible the evidence of the impact on the rate of disorder.[35]

Table 16: Risk Factors and Their Impact on Mental Health Problems

Risk factors		Impact on rate of disorder
In child/ young person	Physical illness • chronic health problem • brain damage	 • 3 times increase in rate • 4-8 times increase in rate
	Sensory impairments • hearing (4/1000) • visual (0.6/1000)	 • 2.5 times more disorder • No values
	Learning difficulties	6 times more likely to have disorder[36]
	Language and related problems	4 times increase in rate
	Self-harm	Associated higher risk of disorder
	Teenage onset depression (regarded as experiencing 'normal' adolescent turmoil)[37]	Associated higher risk of disorder
In family	Family breakdown/severe marital discord	Associated with increase in disorders such as depression and anxiety
	New mothers with mental health needs (c. 15-20% of new mothers)	Low maternal responsiveness during first 18 months linked to depression, mental disorders, violence and child abuse in later life[38]
	Large family size	Increased rate of conduct disorder and delinquency in boys with large families. Rates increase with increasing numbers of children in the family and step-children.
	Child Looked After	• 5 times increase in disorder • 4-5 time increased risk of suicide as an adult.
	Lone parent families	• 2 times rate compared to children in families where parents are married

35 Reproduced from Fitzjohn 2006 and cited as adapted from Wallace et al in Raftery & Stevens (1997)

36 How To Guide: How to support young people with learning disabilities and mental health issues, 2009 NCB. Taken from www.youngminds.org.uk/training_services/policy/useful_statistics

37 Cambridgeshire and Peterborough Shadow Clinical Commissioning Group (2012) Joint Commissioning Strategy for Mental Health and Well-Being of Children and Young People 2012-16, p11

38 Allen (2011) and Paterson (2011) and Marmot.

		or cohabiting.
	Parental Mental Illness • Schizophrenia • Maternal psychiatric disorder	 • 8-10 times rate • 1.2 – 4 times rates
	Teenage Mothers	Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth[39]
	Parental criminality	• 2-3 times rate
	Physical and emotional abuse • Physical abuse • Neglect	Of those on the child protection register • 2 times rate • 3 times rate
	Sexual abuse • Boys 6-62% • Girls 3 – 31%	 • 2 times rate • 2 times rate
	Parental educational qualifications	Prevalence is one-fifth where parents have no qualifications and five-times higher than if parents have degree level qualifications.
	Parents receiving disability benefits	• 3 times rate
In environment	Socio-economic circumstances	Three times rate in household where parent is in semi-routine or routine occupational group. Levels one fifth of those aged 11-16 in homes where income is less than £100 a week.
	Unemployment	One-fifth of children in households where their parents don't work.
	Housing and homelessness	Eight times increase (if living in temporary accommodation) and two times higher in those who rent compared to those who own.
	Young Offenders in Custody	95% of imprisoned young offenders have a mental health disorder. Many have more than one disorder[40] • Young men age 15-17 18 times risk of suicide. • Women under 25 – 40 times risk of suicide.
	School environment	• 9% Grades 1-9 bullying victims • 7-8% reported bullying of other children.
Life events	Traumatic events	• 3-5 times rate.

Clearly many of these factors overlap and cluster for a child or young person, and looking at the summary table of factors below it indicates that Cambridge City and Fenland would be likely to see the highest prevalence of mental health disorders, taking into account the wider determinants.

[39] Department for Education and Skills (2010) Teenage Pregnancy: Accelerating the Strategy to 2010. London: DfES.

[40] Office for National Statistics (1997): Psychiatric morbidity among young offenders in England and Wales. London: Office for National Statistics. Taken from www.youngminds.org.uk/training_services/policy/useful_statistics.

Table 17: **Clustering of Risk Factors in Cambridgeshire**

Indicator where mental disorder prevalence is higher	District where highest in Cambridgeshire	Source
Lone parent families	Cambridge City and Fenland	Census 2011
Stepchildren in family	Fenland	Census 2001
Higher number of children in household	East Cambridgeshire	Health Behaviour Survey 2006
No parental qualifications	Fenland	Census 2011
Neither parent works	Fenland	Census 2011
Low household income	North Fenland, parts of Huntingdonshire and East Cambridgeshire and east of cambridge city.	CACI 2006
In receipt of disability benefit	Fenland	May 2012 CCC
Semi-routine or routine Socio-Economic classification	Fenland	Census 2011
Social rented accommodation	Cambridge City	Census 2011

The *Mental Health of children and young people in Great Britain, 2004,* [27] study presented detailed information on the characteristics of children with emotional, conduct or hyperkinetic disorders compared to children with no mental disorder. The characteristics that were noticeably different for each mental disorder are presented in Appendix 2.

There are many consistent characteristics across mental health disorders, such as having parents with no educational qualifications, living on low incomes, in receipt of disability benefits, in social sector rented accommodation, in routine or semi-routine social-economic classification occupation groups and single parent households. However, there are variances between mental health disorders. For example, emotional disorders are higher in girls and conduct disorders and hyperkinetic disorders are higher in boys. Hyperkinetic disorders had the only disorders with a noticeable difference in ethnicity, with 97% of children from a white ethnic group, compared to 89% with no mental disorder.

All children with a mental health disorder (compared to those without a mental health disorder) were more likely to have:

- 'Fair or bad' health – highest in emotional disorders.
- Have another mental disorder – highest in hyperkinetic disorders.
- Some or marked difficulty with reading, maths and spelling – highest in hyperkinetic disorders.
- Behind in intellectual development – highest in hyperkinetic disorders.
- Special educational needs – highest in hyperkinetic disorder.
- Absent from school – highest in emotional disorders (there was no difference for hyperkinetic disorders).
- A parent that was considered to have an indicative emotional disorder – highest in emotional disorders and conduct disorders.
- Live in 'unhealthy' functioning families – highest in conduct disorders.
- Two or more stressful life events – highest in emotional disorders.
- Less ability to empathise with others – highest in hyperkinetic disorder.
- Relationship problems with friends – highest in hyperkinetic disorder.
- Low social support – highest in conduct and hyperkinetic disorder.
- Low participation in groups, clubs or organisations.

- Higher levels of smoking, drinking and drug use – highest in conduct disorders.

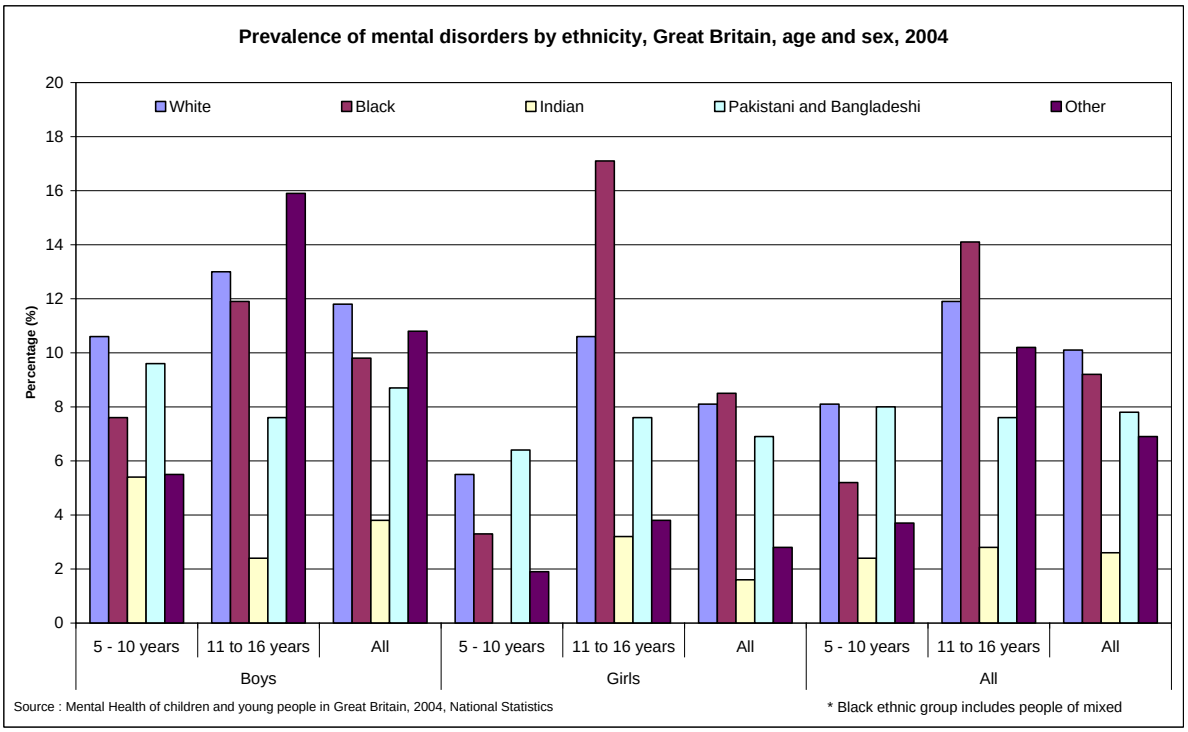
Children and young people with emotional disorders were more likely to help others. However, the opposite was true of children with conduct disorders and there was no difference at all in children with a hyperkinetic disorder. The taking of medication was noticeably higher for children with hyperkinetic disorders, at 43%. Living in families with stepchildren was only noticeably different for children with conduct disorders (compared to children without).

People seeking help with a mental health disorder was especially high for those with hyperkinetic disorders and at 95%, were more likely to have contacted a professional source. Those with emotional disorders, although still high, were lower than others who had contacted professional help. A quarter of people with hyperkinetic disorders who had not contacted a professional source, said it was due to difficulty in being referred.

Ethnicity

Evidence suggests that the rates of mental health problems tend to be higher among people from Black, Minority, Ethnic (BME) groups, as they are more likely to experience risk factors associated with poor mental health. The charity, YoungMinds published a survey *Minority Voices* in 2005,[41] on the availability of mental health services to young people, aged 12-25 years, from BME backgrounds. These young people face a variety of specific barriers to accessing services, such as cultural barriers, different understandings of what mental health is, language barriers and racism within the mental health services.[1]

Figure 5: Prevalence of mental disorders by ethnicity, Great Britain, age and sex, 2004



Source: Mental Health of children and young people in Great Britain, 2004

41 *Minority Voices : Research and guide,* 2005, YoungMinds
www.youngminds.org.uk/publications/all-publications/minority-voices

With approximately 10% of white children and young people having a mental health disorder, this ethnic group have the highest prevalence of any mental health disorder, followed by black children. Children and young people from Indian ethnic groups have the lowest prevalence rates, while black girls have higher proportions of mental health disorders than white girls.

In general, Cambridgeshire has a predominantly White population, with a noticeably lower proportion in Cambridge City. East Cambridgeshire has the highest proportion of White school-age children, while Huntingdonshire has the highest number.

Table 18: Ethnicity - Proportion of children (school age) by Local Authority, 2011

Ethnicity		Cambridge		East Cambridgeshire		Fenland		Huntingdonshire		South Cambridgeshire		Cambridgeshire	
		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
White	White British	7,072	61.7%	9,670	88.3%	10,986	87.5%	19,858	87.7%	16,312	84.3%	63,898	83.0%
	White: Irish	*	*	23	0.2%	*	*	38	0.2%	79	0.4%	237	0.3%
	Irish Traveller	*	*	17	0.2%	*	*	19	0.1%	60	0.3%	104	0.1%
	Gypsy/Traveller	117	1.0%	55	0.5%	163	1.3%	63	0.3%	115	0.6%	513	0.7%
	White: Other	1,276	11.1%	518	4.7%	798	6.4%	762	3.4%	925	4.8%	4,279	5.6%
	Total	8,553	74.6%	10,283	93.9%	11,964	95.3%	20,740	91.6%	17,491	90.4%	69,031	89.7%
Mixed	White/Black Caribbean	197	1.7%	31	0.3%	69	0.5%	151	0.7%	122	0.6%	570	0.7%
	White/Black African	127	1.1%	34	0.3%	27	0.2%	81	0.4%	85	0.4%	354	0.5%
	White/Asian	221	1.9%	84	0.8%	60	0.5%	174	0.8%	228	1.2%	767	1.0%
	Other	291	2.5%	171	1.6%	84	0.7%	267	1.2%	301	1.6%	1,114	1.4%
	Total	836	7.3%	320	2.9%	240	1.9%	673	3.0%	736	3.8%	2,805	3.6%
Asian	Indian	332	2.9%	41	0.4%	42	0.3%	93	0.4%	218	1.1%	726	0.9%
	Pakistani	97	0.8%	*	*	*	*	254	1.1%	44	0.2%	403	0.5%
	Bangladeshi	433	3.8%	*	*	*	*	68	0.3%	31	0.2%	561	0.7%
	Other Asian	327	2.9%	36	0.3%	39	0.3%	165	0.7%	177	0.9%	744	1.0%
	Total	1,189	10.4%	99	0.9%	96	0.8%	580	2.6%	470	2.4%	2,434	3.2%
Black	Black Caribbean	70	0.6%	*	*	*	*	19	0.1%	43	0.2%	148	0.2%
	African	141	1.2%	47	0.4%	40	0.3%	124	0.5%	91	0.5%	443	0.6%
	Other	60	0.5%	*	*	*	*	42	0.2%	47	0.2%	176	0.2%
	Total	271	2.4%	64	0.6%	66	0.5%	185	0.8%	181	0.9%	767	1.0%
Chinese		180	1.6%	40	0.4%	20	0.2%	87	0.4%	114	0.6%	441	0.6%
Other Ethnic		239	2.1%	31	0.3%	37	0.3%	83	0.4%	82	0.4%	472	0.6%
Unknown		200	1.7%	115	1.1%	127	1.0%	289	1.3%	268	1.4%	999	1.3%
Total		11,468	100.0%	10,952	100.0%	12,550	100.0%	22,637	100.0%	19,342	100.0%	76,949	100.0%

Source: 2011 School Census, Cambridgeshire County Council
Note: District is based on location of school
* denotes fewer than 10 pupils or has been removed to avoid disclosure

Socio-economic classifications

Children and young people in families where the household reference person was in a semi-routine or routine occupational group, were almost three-times more likely to have a mental health disorder than children and young people whose reference person was in a higher professional group.

Fenland has the highest proportion of people from semi-routine or routine occupations, at 35%, while the county average is 22%.

Figure 6: Prevalence of mental health disorders by socio-economic classification, Great Britain, age and sex, 2004

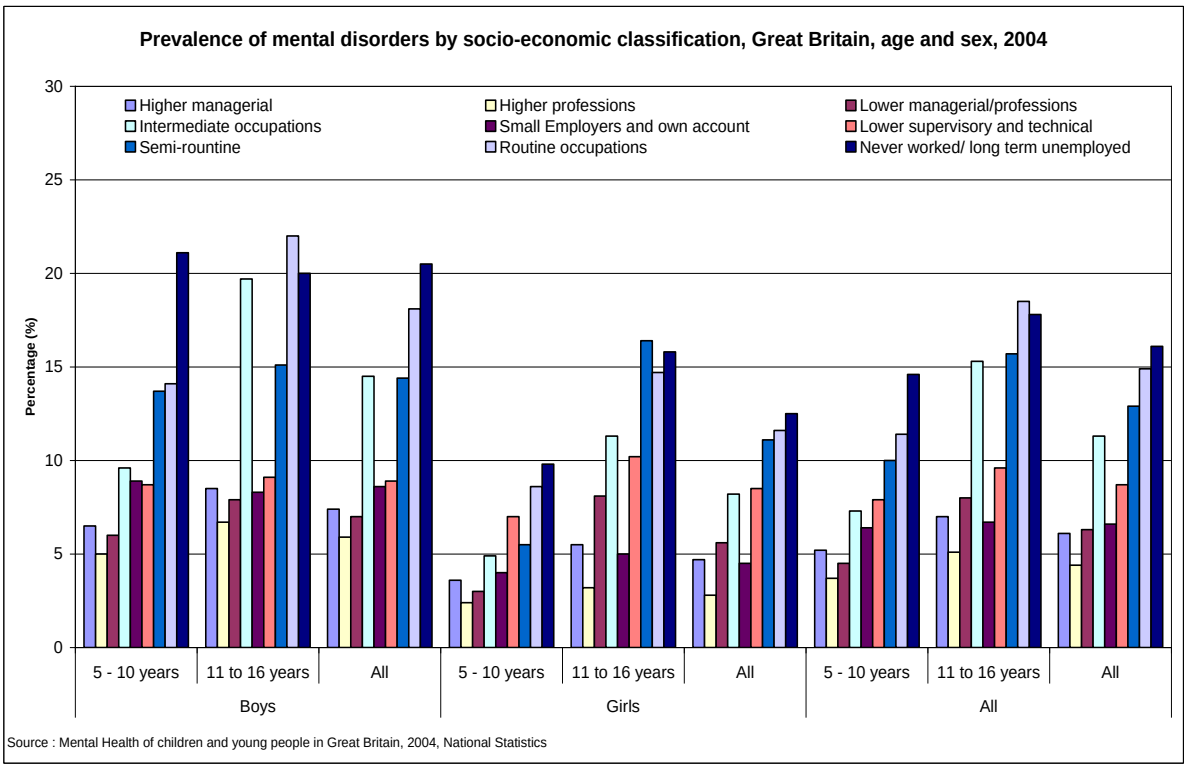


Table 19: Socio-Economic Classification, people aged 16 to 74 years, 2011

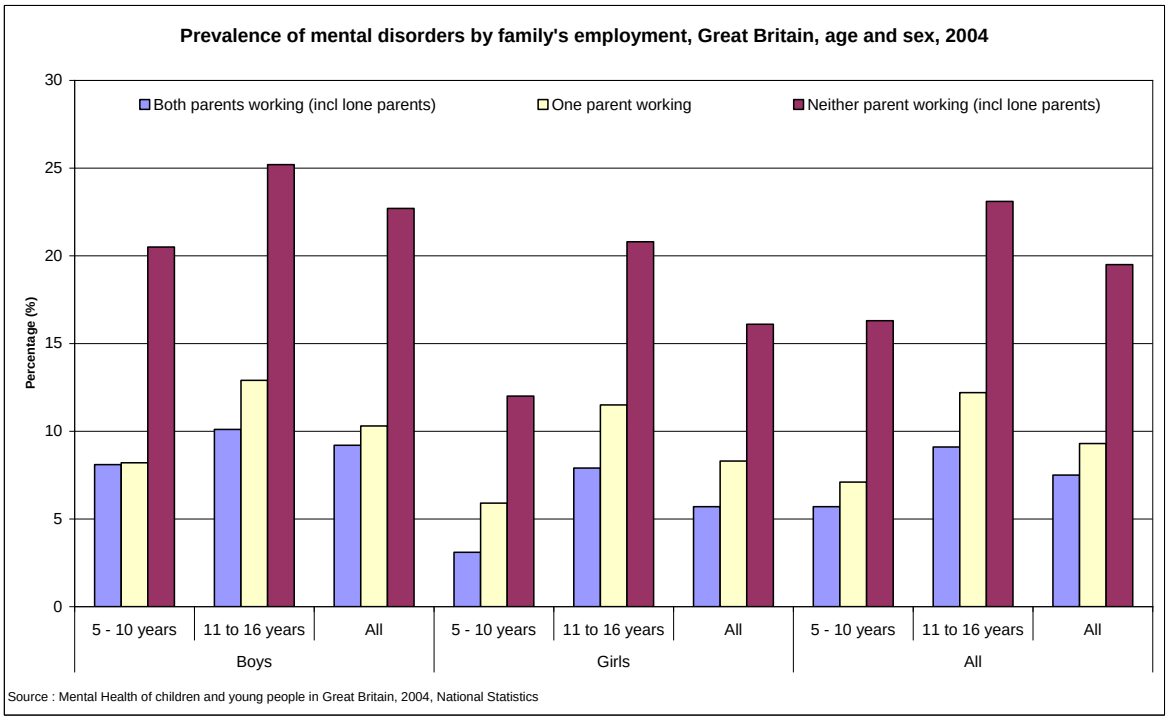
National Statistics - Socio-Economic classification

Local Authority	1. Higher managerial, administrative and professional occupations		2. Lower managerial, administrative and professional occupations		3. Intermediate occupations		4. Small employers and own account workers		5. Lower supervisory and technical occupations		6. Semi-routine occupations		7. Routine occupations		8. Never worked and long-term unemployed		Not classified (Full time students)		Total
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	
Cambridge City	18,867	19.2%	17,971	18.3%	7,587	7.7%	5,289	5.4%	4,113	4.2%	8,267	8.4%	6,421	6.5%	3,054	3.1%	26,714	27.2%	98,283
East Cambridgeshire	7,869	13.0%	14,038	23.1%	7,912	13.0%	7,008	11.5%	4,503	7.4%	8,394	13.8%	6,204	10.2%	1,658	2.7%	3,128	5.2%	60,714
Fenland	4,118	5.9%	11,363	16.4%	8,617	12.4%	7,494	10.8%	6,241	9.0%	13,504	19.5%	10,940	15.8%	3,409	4.9%	3,572	5.2%	69,258
Huntingdonshire	15,883	12.7%	29,720	23.7%	18,176	14.5%	11,461	9.1%	9,326	7.4%	17,080	13.6%	12,710	10.1%	3,851	3.1%	7,139	5.7%	125,346
South Cambridgeshire	20,597	19.1%	27,321	25.3%	13,884	12.9%	10,825	10.0%	6,444	6.0%	11,285	10.5%	7,891	7.3%	2,471	2.3%	7,061	6.6%	107,779
Cambridgeshire	67,334	14.6%	100,413	21.8%	56,176	12.2%	42,077	9.1%	30,627	6.6%	58,530	12.7%	44,166	9.6%	14,443	3.1%	47,614	10.3%	461,380
England	4,045,823	10.4%	8,132,107	20.9%	4,972,044	12.8%	3,662,611	9.4%	2,676,118	6.9%	5,430,863	14.0%	4,277,483	11.0%	2,180,026	5.6%	3,504,299	9.0%	38,881,374

Source: Census 2011

Employment

Figure 7: Prevalence of mental health disorders by family's employment, Great Britain, age and sex, 2004



It is apparent that the prevalence of mental health disorders in children and young people are greatest in families where neither parent works which is 20% of children and young people, aged five to 16 years-old.

At the time of the 2011 Census, Cambridge City and Fenland had noticeably the highest proportions of parents who did not work, in Cambridgeshire, as shown below. However, neither figure is above the England average.

Table 20: **Employment of parents aged 16 to 74 years with dependent children, 2011**

Local Authority	Number			% not in employment		
	Male	Female	Total	Male	Female	Total
Cambridge	180	1,790	1,970	30.6%	41.5%	40.5%
East Cambridgeshire	162	1,292	1,454	21.0%	32.8%	31.5%
Fenland	311	2,268	2,579	33.8%	40.5%	39.7%
Huntingdonshire	405	3,268	3,673	22.2%	32.5%	31.4%
South Cambridgeshire	307	2,221	2,528	13.7%	26.2%	24.7%
Cambridgeshire	1,365	10,839	12,204	23.9%	34.4%	33.3%
England	151,744	1,412,937	1,564,681	32.6%	41.4%	40.5%

Source: Census 2011 © Crown Copyright

When looking at households with dependent children, Fenland has the largest proportion of adults in employment, and at least one person with a long-term health problem or disability. The proportion of lone parents' not in employment and in receipt of out-of-work benefits shows the same pattern.

Table 21: **Employment, households with dependent children, 2011**

Local Authority	Household with dependent children and no adults in employment		Household with dependent children and one person with a long term health problem or disability	
	Number	%	Number	%
Cambridge	1,255	2.7%	1,500	3.2%
East Cambridgeshire	704	2.0%	1,307	3.8%
Fenland	1,552	3.8%	1,878	4.6%
Huntingdonshire	1,708	2.5%	2,871	4.1%
South Cambridgeshire	945	1.6%	2,232	3.7%
Cambridgeshire	6,164	2.5%	9,788	3.9%
England	922,192	4.2%	1,019,932	4.6%

Source: Census 2011 © Crown Copyright

Table 22: **Employment, number of lone parents not in employment, 2011**

Local Authority	Number of lone parents not in employment			% of all lone parents that are not in employment		
	Male	Female	Total	Male	Female	Total
Cambridge	180	1,790	1,970	30.6%	41.5%	40.5%
East Cambridgeshire	162	1,292	1,454	21.0%	32.8%	31.5%
Fenland	311	2,268	2,579	33.8%	40.5%	39.7%
Huntingdonshire	405	3,268	3,673	22.2%	32.5%	31.4%
South Cambridgeshire	307	2,221	2,528	13.7%	26.2%	24.7%
Cambridgeshire	1,365	10,839	12,204	23.9%	34.4%	33.3%
England	151,744	1,412,937	1,564,681	32.6%	41.4%	40.5%

Source: Census 2011 © Crown Copyright

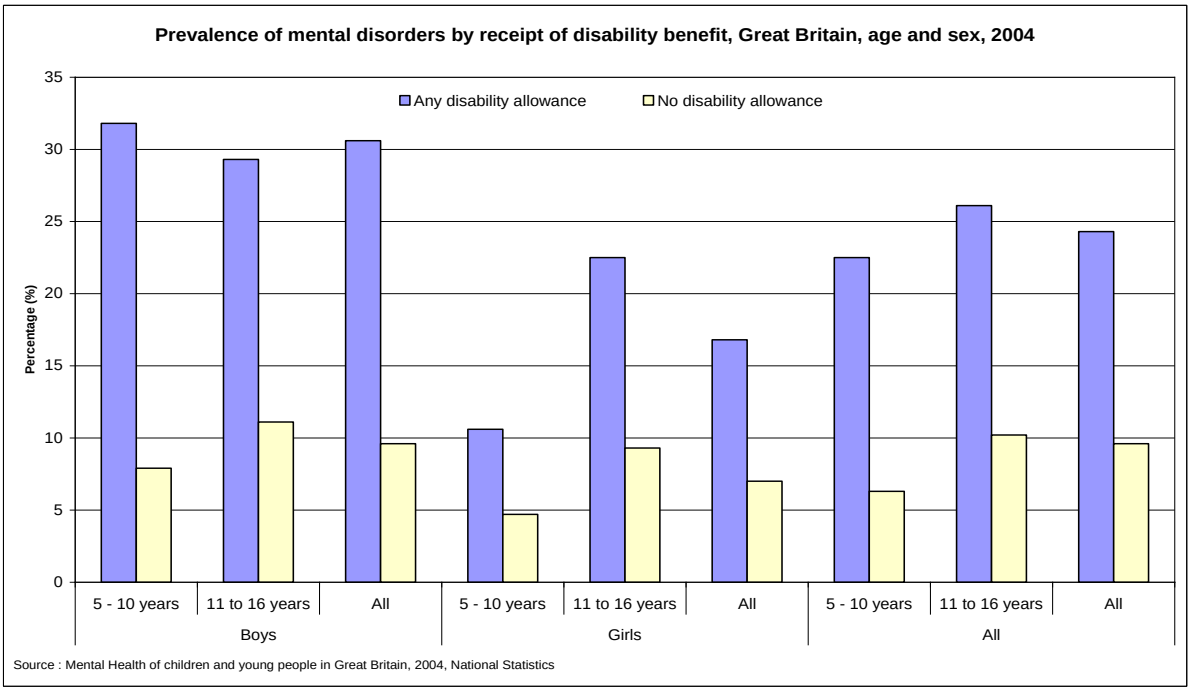
Table 23: **Employment, lone parents in receipt of out-of-work benefits, February 2012**

Local Authority	Number	% of total working age population
Cambridge	660	0.7
East Cambridgeshire	390	0.7
Fenland	890	1.6
Huntingdonshire	970	0.9
South Cambridgeshire	560	0.6
Cambridgeshire	3,480	0.9
England	506,980	1.5

Source: NOMIS

Disability benefit

Figure 8: Prevalence of mental health disorders by receipt of disability benefit, Great Britain, age and sex, 2004



The prevalence of mental health disorders in children and young people in households that are in receipt of disability benefits is higher than those in households not in receipt of such benefits, most notably for boys. Prevalence is higher for boys aged five to 10 years old, which is different to most trends seen in other indicators, presented in this report.

Children and young people living in households in receipt of disability benefits were three times as likely to have a mental health disorder if they were not in receipt of such benefits.

Prevalence of Mental Health Disorder by Type of Disability Benefit

According to disability benefits, there appears to be a difference between both the sexes and age bands in relation to prevalence of a mental health disorder. There is little difference between the prevalence in girls, aged five to 16 years, for carer allowance and disability living/attendance allowance, and boys, aged five to 10 years. However, there is a notable difference between these two types of disability allowance for boys aged 11 to 16 years, with a higher prevalence in carer allowance households.

As can be seen in the table below, Fenland has by far the highest benefit claimant rate for all the types of disability benefit listed.

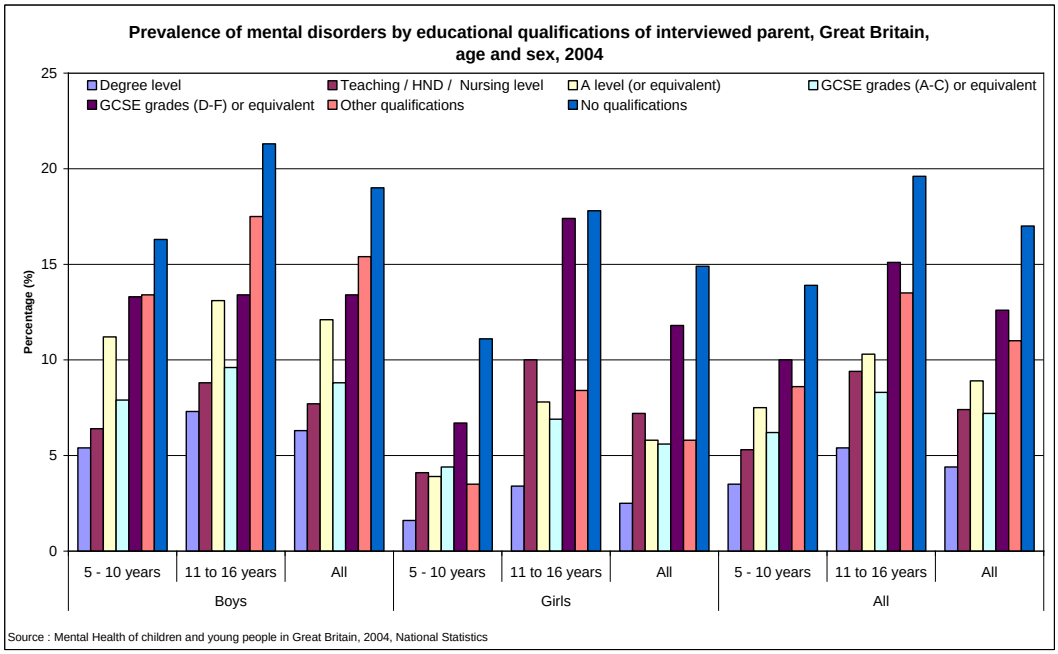
Table 24: **Number of Disability Living Allowance claimants and estimated number with emotional disorders, February 2012**

Local Authority	Number of claimants aged 5 to 15 years	Rate per 1,000	95% Confidence Intervals	Estimated number with mental disorders (based on ONS 2005 estimate of 24.3%)
Cambridge	360	32.4	(29.1 - 35.9)	90
East Cambridgeshire	350	32.1	(28.9 - 35.7)	90
Fenland	590	51.2	(47.2 - 55.5)	140
Huntingdonshire	900	40.5	(37.9 - 43.2)	220
South Cambridgeshire	550	27.3	(25.1 - 29.7)	130
Cambridgeshire	2,750	36.2	(34.9 - 37.6)	670

Source: NOMIS

Qualifications

Figure 9: Prevalence of mental health disorder by educational qualifications of parent, Great Britain, age and sex, 2004



The prevalence of mental health disorders in children and young people is noticeably higher where the parent does not hold any qualifications (This relates to the parent interviewed for the study, usually the mother).

Almost one fifth of children and young people aged 11 to 16 years, had a mental health disorder, where the parent had no educational qualifications and is nearly five times higher than if the parent was educated to degree level.

As a proxy for this measure, the table below shows the proportion of people aged 16 years and over with no qualifications, from the 2011 Census. Nearly a third of adults in Fenland had no qualifications at the time of the last Census. This is noticeably the highest proportion in Cambridgeshire, where the average is just under 20%.

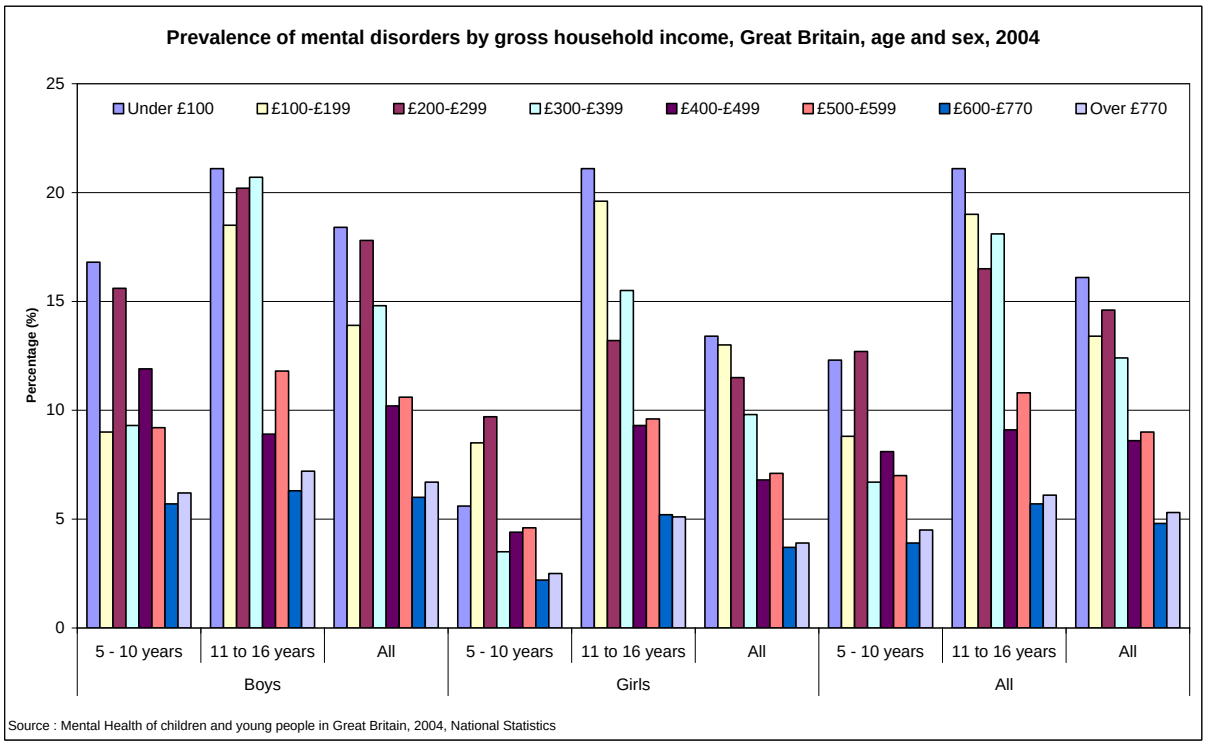
Table 25: Numbers over 16 with no qualifications

Local Authority	All Usual Residents Aged 16 and Over	No Qualifications	
		Number	%
Cambridge	106,007	12,606	11.9
East Cambridgeshire	67,481	14,127	20.9
Fenland	78,482	24,523	31.2
Huntingdonshire	137,157	26,361	19.2
South Cambridgeshire	119,342	18,248	15.3
Cambridgeshire	508,469	95,865	18.9
England	42,989,620	9,656,810	22.5

Source: Census 2011 © Crown Copyright

Household income

Figure 10: Prevalence of mental health disorders by household income, Great Britain, age and sex, 2004.

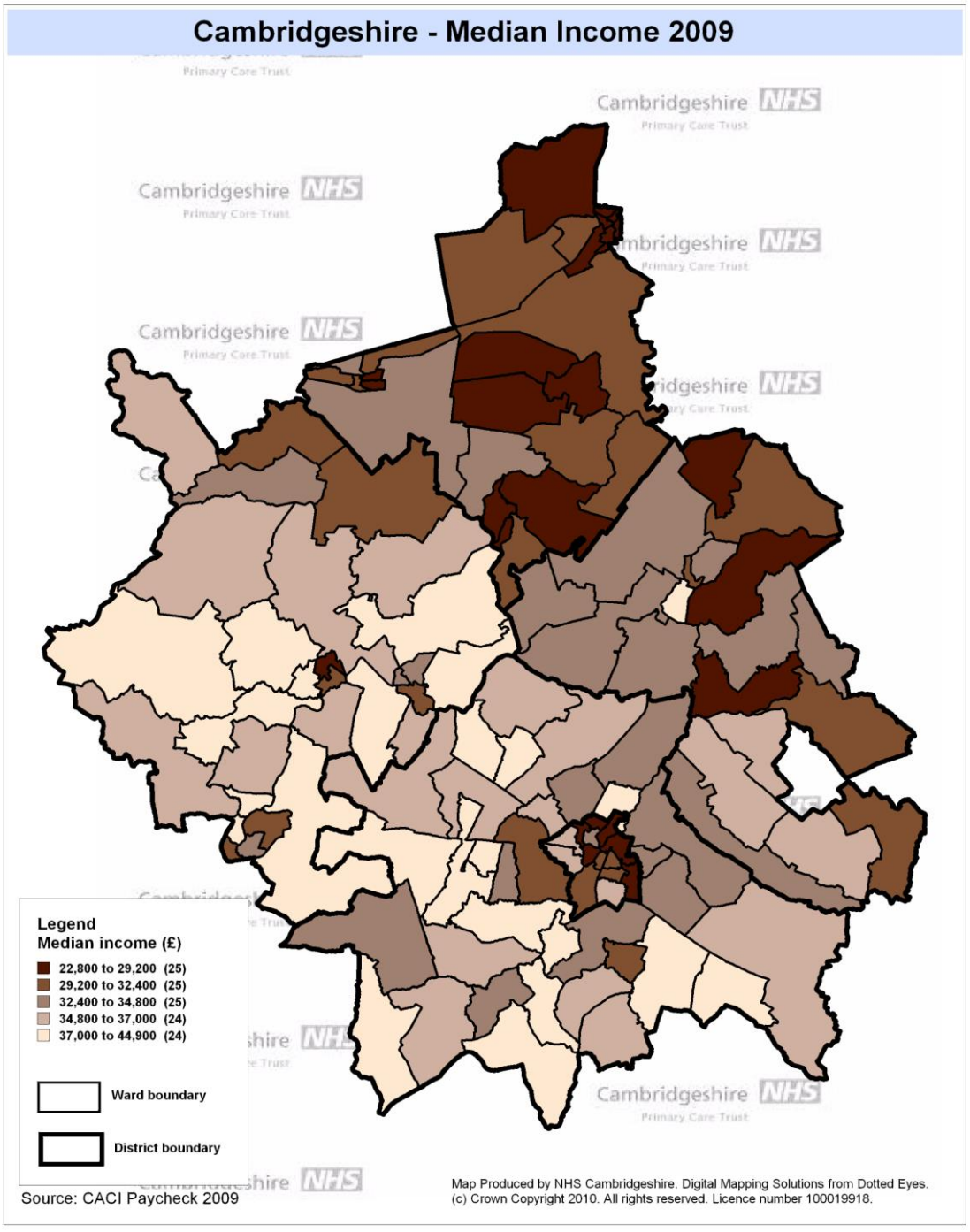


In general, the prevalence of mental health disorders in children and young people increases where gross weekly income decreases.

Over one-fifth (20%) of 11 to 16 year olds in households with a gross weekly income of under £100 have a mental health disorder.

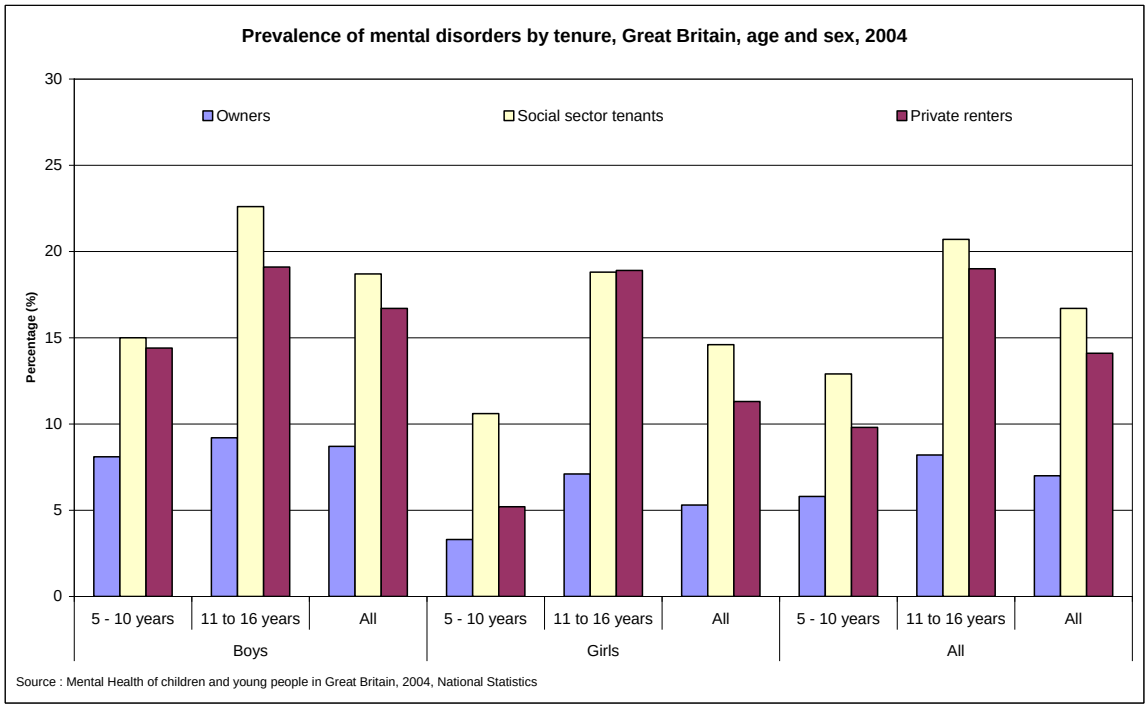
The map below shows the percentage of households by ward and median income. As can be seen, areas to the north of Fenland, parts of Huntingdonshire and East Cambridgeshire and the east of Cambridge City, have the highest proportions of households on lower incomes.

Map 3: Proportion of households by Median income 2009



Tenure

Figure 11: Prevalence of mental health disorders by tenure, Great Britain, age and sex, 2004



Children and young people in rented accommodation, particularly those from the social sector, have higher prevalence rates of mental health disorders. In fact, they are twice as likely to have a mental health disorder than those in owned accommodation. Cambridge City has the highest proportion of social rented households.

There is evidence to show that homelessness can lead to poor mental health and lower educational attainment.[1] As homelessness is a complex issue, those with poor mental health are at an increased risk of becoming homeless as young people and adults.[42]

Table 26: Tenure, 2011

Local Authority	All Households	Percentage (%)							
		Owned		Shared Ownership	Social rented		Private rented		Living Rent Free
		Outright	With a mortgage or loan		Rented from Council (Local Authority)	Other	Private Landlord or Letting Agency	Other	
Cambridge	46,714	24.9	22.5	1.1	15.2	8.4	23.9	2.3	1.6
East Cambridgeshire	34,614	32.2	36.3	1.5	1.3	13	12	1.2	2.5
Fenland	40,620	35.7	34.3	0.5	2.2	10.2	14.3	1.3	1.4
Huntingdonshire	69,333	32	39.3	0.7	2.6	10.3	12.5	1.6	1
South Cambridgeshire	59,960	34.6	35.6	2.1	9.1	5.1	10.4	1.6	1.4
Cambridgeshire	251,241	31.9	34.1	1.2	6.3	9.1	14.3	1.7	1.5
England	22,063,368	30.6	32.8	0.8	9.4	8.3	15.4	1.4	1.3

Source: Census 2011© Crown Copyright

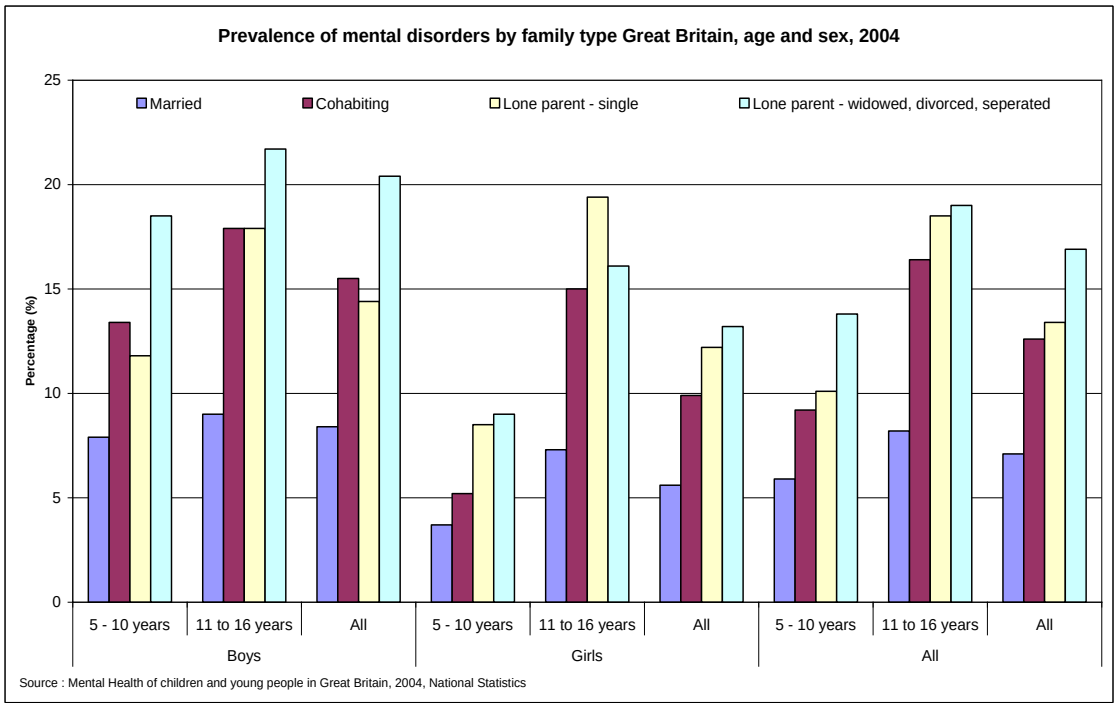
[42] Tackling homelessness and exclusion: Understanding complex lives, Joseph Rowntree Foundation, September 2011

Family composition

The following section examines families, as the structure of families can impact on the prevalence of mental disorders in children and young people, as demonstrated below.

Family type

Figure 12: Prevalence of mental health disorders by family type, Great Britain, age and sex, 2004



It is apparent that prevalence of mental health disorders is greatest in lone parent families, and is particularly high for boys. The prevalence rate of mental disorders in children and young people in lone parent families is double that of married or co-habiting couple families.

Almost a quarter of households with dependent children in Fenland are lone parent households, which is similar to the England average but noticeably higher than the Cambridgeshire average.

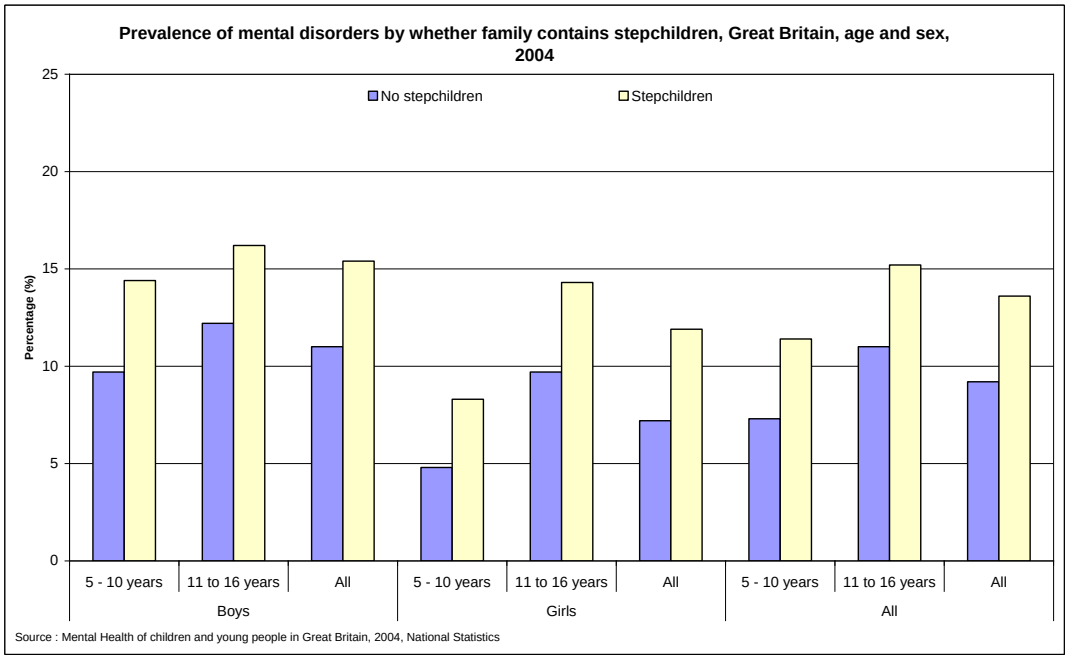
Table 27: Dependent children households, family type, 2011

Local Authority	% of households with dependent children			
	One family only			Other household types
	Married or Same-Sex Civil Partnership Couple	Cohabiting Couple	Lone Parent	
Cambridge	57.9%	14.3%	17.6%	10.2%
East Cambridgeshire	64.3%	15.0%	14.1%	6.7%
Fenland	50.1%	17.4%	23.4%	9.1%
Huntingdonshire	60.9%	14.8%	17.6%	6.7%
South Cambridgeshire	68.2%	12.3%	13.6%	5.9%
Cambridgeshire	61.1%	14.5%	16.9%	7.4%
England	52.6%	13.9%	24.5%	9.1%

Source: Census 2011 © Crown Copyright

Stepchildren

Figure 13: Prevalence of mental health disorders by family type, Great Britain, age and sex, 2004



In terms of families, one of the indicators examined was whether having stepchildren within a family increases the prevalence of mental health disorders in children and young people. As can be seen in this chart, it does appear that prevalence increases where there are stepchildren in the family.

In Cambridgeshire, approximately one-in-eight families with dependent children are step families, with Fenland having a higher proportion and Cambridge City and South Cambridgeshire having lower proportions.

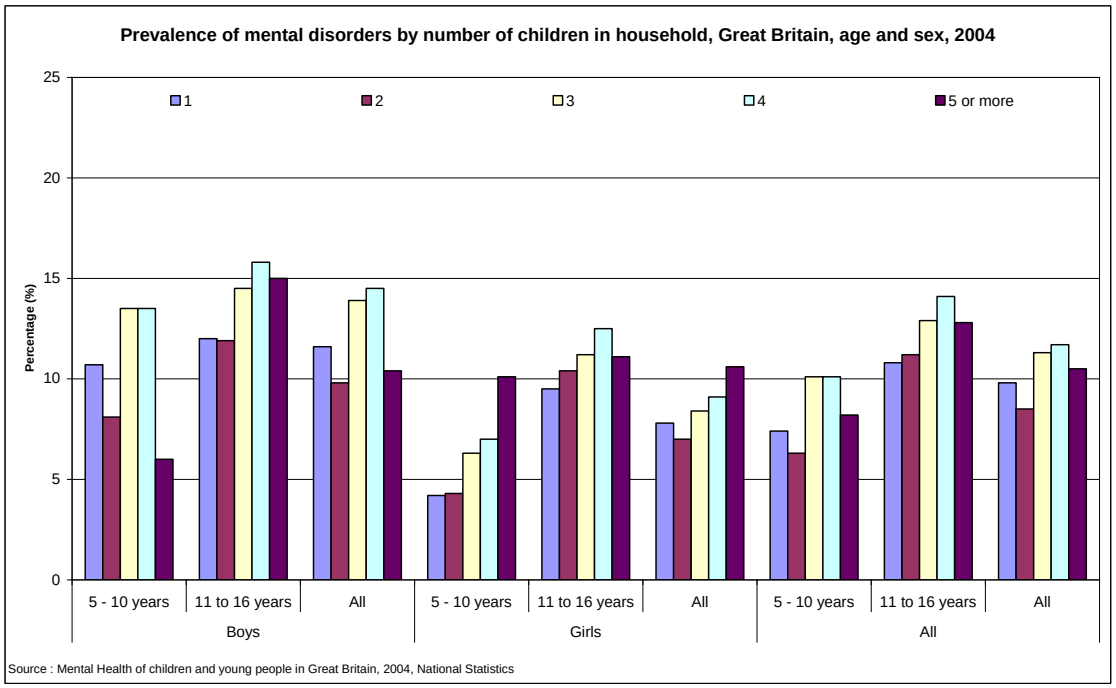
Table 28: Step families, children aged 0-18 years, 2001 (more recent figures not yet available)

Local Authority	Lone parent family	Non step family	Step family	Not in family
Cambridge City	21%	68%	10%	1%
East Cambridgeshire	12%	75%	12%	0%
Fenland	19%	66%	14%	1%
Huntingdonshire	15%	72%	13%	1%
South Cambridgeshire	12%	78%	10%	0%
Cambridgeshire total	15%	72%	12%	1%

Source: Census 2001 © Crown Copyright 2003 – Theme table T01
Note: The low proportion in Cambridge City is as a result of the high proportion of lone parent families.

Number of children in household

Figure 14: Prevalence of mental disorders by number of children in household, Great Britain, age and sex, 2004



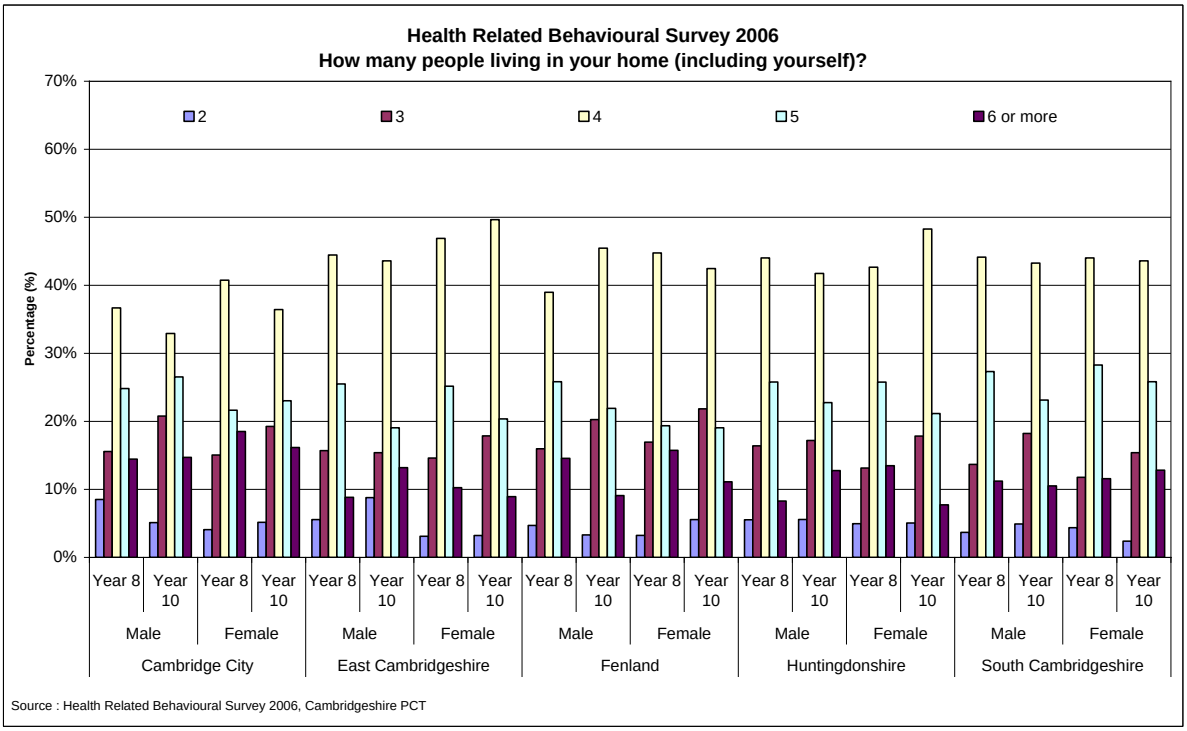
The prevalence of mental health disorders in children and young people increases where there are higher numbers of children and young people living in one household. This is most apparent for the 11 to 16 year age group, and is higher for boys than girls in this age band.

The relevant and most up-to-date data on numbers of people in Cambridgeshire families is from the Health Related Behavioural survey undertaken in schools, for Year Eight (12-13 year olds) and Year 10 (14-15 year olds) pupils. The last survey was conducted in 2006. This data, however, relates to the total number of people in a household and not just the number of children.

In Cambridgeshire, the majority of children and young people live in a four-person household (43%), a quarter live in households with five people and almost one-in-10

households have over five people living in them. Cambridge City has the highest proportion of both Year Eight and Year 10 pupils, living in households with six or more people, for both males and females.

Figure 15: Number of people living in households, Year 8 and Year 10 pupils, 2006 (this is the most recent data available)



Parents with mental health problems or who are substance misusers

Four out of five adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) increases the risk of developing mental health problems throughout life.[43]

Parental mental health, particularly a mother's mental health, is an important factor in the persistence of mental health disorders. According to a national study, 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder, still had the problem three years later. Persistence rates were higher in both cases (37% and 60% respectively) for children whose mothers had poor mental health.[44]

It is estimated that across Cambridgeshire, there are 22,700 children and young people under the age of 18, living with a parent with a mental health problem. Between one and two-thirds of these children and young people are likely to develop mental health problems themselves.

[43] New Horizons Confident Communities, Brighter Futures: A framework for developing wellbeing. HM Government, March 2010

[44] Child and Maternal Health Observatory Website (Chimat)

The table below gives estimates for Cambridgeshire's children and young people living with adults who have varying degrees of alcohol and other substance misuse problems.[45] Those most at risk are the estimated 1,300 children and young people who live with a problem drinker who also has mental health problems and uses drugs. Approximately 7,700 children and young people live with a dependent drinker, 10,200 live with an illicit drug user, and 4,600 are living with a problem drinker who also uses drugs. This indicates the degree to which adult alcohol and drug treatment services impact on the mental health of children and young people.

Table 29: **Children and young people under 18 years of age, living with parents who have mental health problems or who are substance misusers, 2011**

Indicator	Percentage of children and young people exposed	Estimated numbers					
		Cambridge City	East Cambridgeshire	Fenland	Huntingdon shire	South Cambridgeshire	Cambridgeshire
Population aged under 18 years		20,159	18,431	19,140	36,649	33,365	127,744
Living with a parent with mental illness	17.8%	3,600	3,300	3,400	6,500	5,900	22,700
Living with at least 1 binge drinking parent	30.0%	6,000	5,500	5,700	11,000	10,000	38,300
Living with a hazardous drinker	22.1%	4,500	4,100	4,200	8,100	7,400	28,200
Living with a dependent drinker	6.0%	1,200	1,100	1,100	2,200	2,000	7,700
Living with an illicit drug user	8.0%	1,600	1,500	1,500	2,900	2,700	10,200
Living with a problem drinker who has concurrent mental health problems	4.2%	800	800	800	1,500	1,400	5,400
Living with a problem drinker who also uses drugs	3.6%	700	700	700	1,300	1,200	4,600
Living with a drug user who has concurrent mental health problems	2.6%	500	500	500	1,000	900	3,300
Living with a problem drinker who has concurrent mental health problems and uses drugs	1.0%	200	200	200	400	300	1,300

Source: Liverpool CAMH report page 85 – which sources Haltona & St.Helens JSNA: Looked-after Children (McAteer, 2012) and Mid 2011 population estimates, 2011

A proportion of young carers', care for adults with mental health problems. Support services for young carers in Cambridgeshire (Centre 33 and Crossroads) found that in quarter three of 2012/13 (October - January), 29% of young carers cared for someone in their family with a mental health problem. This has been as high as 40% in other quarters, in the same period. Of all young carers, 32% cared for their mother and 8% for their father.

The Parent Partnership Service recently undertook a light touch review of 134 cases from January 2012 to February 2013 from East Fenland and Huntingdonshire. The service is countywide and mainly supports parents with children with SEN statements with signposting, information and advice.

[45] Based on the survey reported by Manning et al 2009.

They found that 30% of children were described as having mental health or emotional issues. Of these children, 40% had reported perceived bullying incidents to their parents. Over 50% of bullied girls were self-harming. Most of this group were waiting for access to mental health services (CAMH or other counselling services) for up to six months or had accessed them before.

27% of parents described their own mental health or emotional wellbeing as under threat. The majority of parents reporting these symptoms were receiving support from their GP, counselling, psychiatric or specific therapeutic services or waiting to access assistance. The group represented disproportionately high levels of single parents, parents with more than one child with SEN or additional needs. Other factors associated with diminished mental health included parents with disabilities or medical conditions and a history of domestic abuse/trauma in relationship breakdown. Many parents who had children and young people with mental health issues found the delay in being able to access timely and appropriate professional support for their children, negatively impacted on their own mental health.

The Home and Community Support contract supports young families (with children aged 0-5) across Cambridgeshire, to cope with common parenting difficulties. In July 2011 a snapshot of current cases (150) found that 82% of families being supported by these providers had a mental health condition.

The most common mental health disorder experienced by parents of young children in this group was depression 56% (64 cases). Of this, 30% is postnatal depression, 34% severe clinical depression, 21% of parents identified as having anxiety-panic attacks, phobias and obsessive compulsive disorders.

In April 2012, Home Start in Huntingdonshire, East Cambridgeshire and Cambridge have found an increase in the number of parents with mental health conditions being referred and supported by them. There has been a 27% increase in the number of cases where they are supporting parents with severe mental health conditions. Data from Fenland and South Cambridgeshire is not yet available as new providers have only recently been appointed.

Postnatal depression

Postnatal depression in either mother or father can affect children socially, psychologically, physically and emotionally if left untreated. Postnatal depression interferes with an infant's communication and cognition skills and, if it persists, is accompanied by limited cognitive development in later months.[46]

Anxiety and postnatal depression affect 10-13% of mothers, shortly after birth, and 22% of mothers one year after birth. Parental depression is associated with a five-fold increased risk of later mental health problems for the child and can affect the child's cognitive and emotional development. Income, occupational position, marital status and number of children are significant predictors of postnatal depression, with more than half of low-income urban mothers experiencing postnatal depression in the three months following birth. Teenage mothers have a three times higher risk of postnatal depression and poor mental health for three years after the birth.[47]

[46] Early Intervention: The Next Steps. Graham Allen MP. January 2011

[47] No Health Without Mental Health: Delivering better mental health outcomes for people of all ages. Department of Health 2011

The table below estimates the number of women with postnatal depression in Cambridgeshire and each district.

Table 30: **Estimates of postnatal depressions, 2011**

Local Authority	Number of live and still births	Estimated number of women with major postnatal depression
Cambridge	1,405	141
East Cambridgeshire	1,127	113
Fenland	1,148	115
Huntingdonshire	2,045	205
South Cambridgeshire	1,817	182
Cambridgeshire	7,542	754

Source: Number of deliveries 2011, Compendium of Clinical and Health Indicators

Vulnerable groups

Many services are partially targeted to the needs of vulnerable groups of children and young people. These include children and young people with learning disabilities, looked-after children, young carers and young offenders.

The following section provides an insight into the number of children in these categories and, where possible, historical trends.

Children with multiple mental disorders

The *Mental Health of children and young people in Great Britain, 2004*[27] report presented data on children and young people with multiple mental health disorders. One in five children with a mental health disorder was diagnosed as having more than one of the main categories of mental health disorder which equates to almost 2% of all children. The most common combinations were conduct and emotional disorders and conduct and hyperkinetic disorders. Nearly three-quarters of children with multiple mental disorders were boys, reflecting the high proportion of children with conduct disorders in this group.

About three-quarters (75%) of children and young people with multiple disorders also had a physical or developmental problem, compared to two-thirds (66%) of those with a single disorder.

Almost two-thirds (66%) of children and young people with multiple disorders were behind in their intellectual development (compared to 49% with a single disorder), with 40% more than a year behind (compared to 27% with a single disorder).

Children and young people with multiple disorders accounted for approximately one-third of those using specialist mental health services.

Mental Health and Disabilities

Children with a long-term physical illness are twice as likely to suffer from emotional or conduct disorder problems.[48] People with physical disabilities may experience a higher rate of mental health conditions compared to people without disabilities. However there is a lack of literature in this area, especially amongst children with disabilities[49]

Based on the ONS 2005 estimate of 24.3% prevalence, there are an estimated 670 children and young people in Cambridgeshire with mental health disorders and disabilities.

Children and young people with learning disabilities are more likely to develop mental health problems than other children and young people. There is a 40% prevalence of diagnosable mental disorder with the learning disabled population of children, young people and adults. For children and young people with severe learning difficulties the incidence rate is 3-4 times higher than in the general population. A review of the evidence[50] found that the presence of intellectual disabilities should be considered a highly significant risk factor for the development of some specific forms of psychiatric disorders (conduct disorders, anxiety disorders, attention deficit and hyperactivity disorders/hyperkinesis and pervasive developmental disorders).

For more detail on Physical and Learning Disabilities please see the Physical and Learning Disability through the Life Course JSNA.

Looked-After Children

Looked-after children are particularly at risk of poor mental health.[12] In England, 45% of looked-after five to 17 year olds had a mental health disorder, compared to 10% from private households.[51]

Young looked-after children ie five to 10 year-olds, are five times more likely to have a mental health disorder compared to those living in private households. Looked-after children aged 11 to 15 years are four times more likely to have a mental health disorder compared to those living in private households. It is apparent from the next chart that the prevalence of conduct disorders is significantly higher in looked-after children than in private households.

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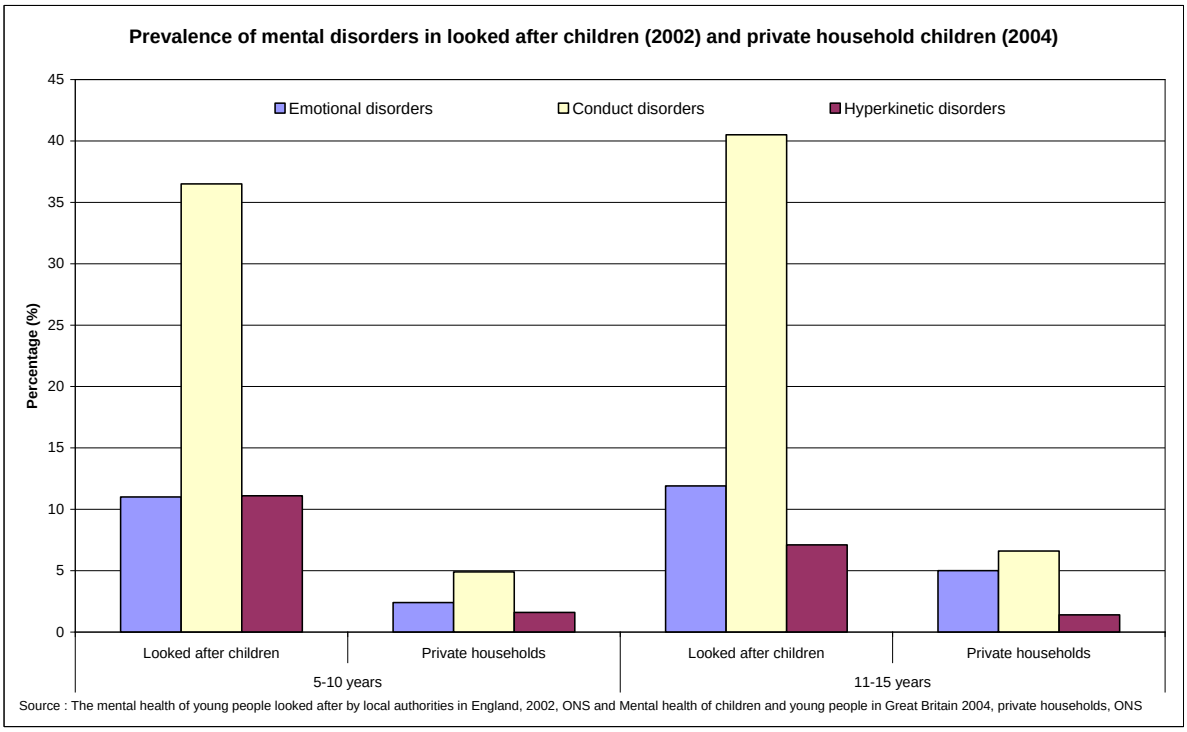
48 DH 2011 No Health without mental health

49 Children and young people's emotional health and wellbeing needs assessment: Merseyside. Liverpool Health Observatory October 2012

50 Young London Matters: the emotional well-being and mental health of young Londoners: a focused review of the evidence. Thomas Coram Research Unit, University of London

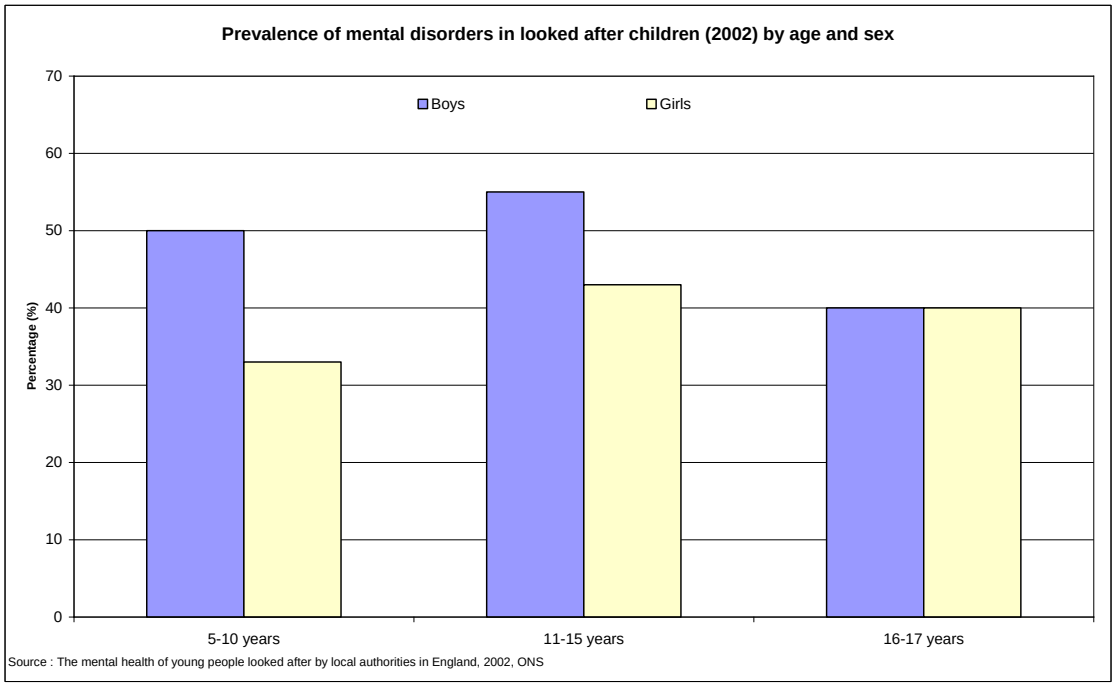
51 *The mental health of young people looked after by local authorities in England, 2003*, Office for National Statistics www.statistics.gov.uk/downloads/theme_health/childrensmentalhlth.pdf

Figure 16: Prevalence of mental health disorders in looked-after children and private household children



The prevalence of mental health disorders in looked-after children is higher in boys than girls, in the 11 to 15 year age band. However, the proportion is the same for both boys and girls in the 16 to 17 year age band.

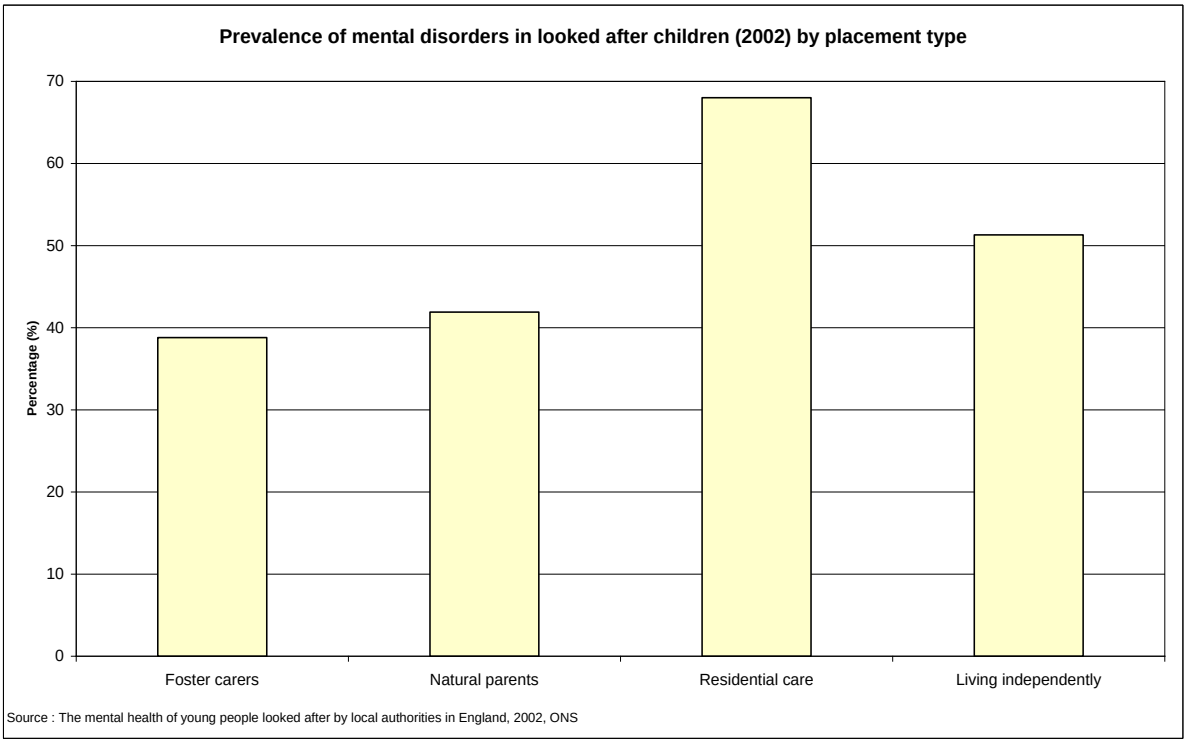
Figure 17: **Prevalence of mental health disorders in looked-after children by age and sex, 2002**



The study of the mental health of looked-after children in England in 2002[52] found that 37% of five to 17 year-olds had conduct disorders, 12% had emotional disorders and 7% were diagnosed with hyperkinetic disorders. This was significantly higher than children and young people from private households.

The report placed children and young people into four categories – residential care, foster care, living with their natural parents (subject to care orders) and living independently. It found that children living with their natural parents or in residential care were about twice as likely as those in foster care to have emotional disorders. Children in residential care were more likely than those in foster care or those living with their natural parents to have conduct disorders. There was little difference in placement type for those with hyperkinetic disorders.

Figure 18: Prevalence of mental health disorders in looked-after children by type of placement, 2002



Of all looked-after children, over 75% of children with a mental health disorder had at least one physical complaint, compared with 57% with no mental health disorder.

Children with any mental health disorder were one and a half times more likely to have visited their GP in the past two weeks than those with no disorder (12% compared to 8%) and almost twice as likely to have visited an emergency department within the previous three months (15% compared to 8%). There was little difference between those with and without a mental health disorder in terms of inpatient admissions, except for children with an emotional disorder, who were almost three times as likely to have had a hospital stay. Children with a mental health disorder were more likely to have gone to hospital either as an outpatient or as a day case within the last three months than those without a mental health disorder (22% compared to 15%). Specialist services were also commonly used. 35% of children assessed as having a

[52] Time trends in adolescent mental health, Stephen Collishaw, Barbara Maughan, Robert Goodman and Andrew Pickles, Journal of Child psychology and Psychiatry 45:8 92004), pp 1350 - 1362

mental health disorder had been in touch with a child mental health specialist and 23% with special educational services.

Looked-after children and young people with a mental health disorder (compared to those without) were:

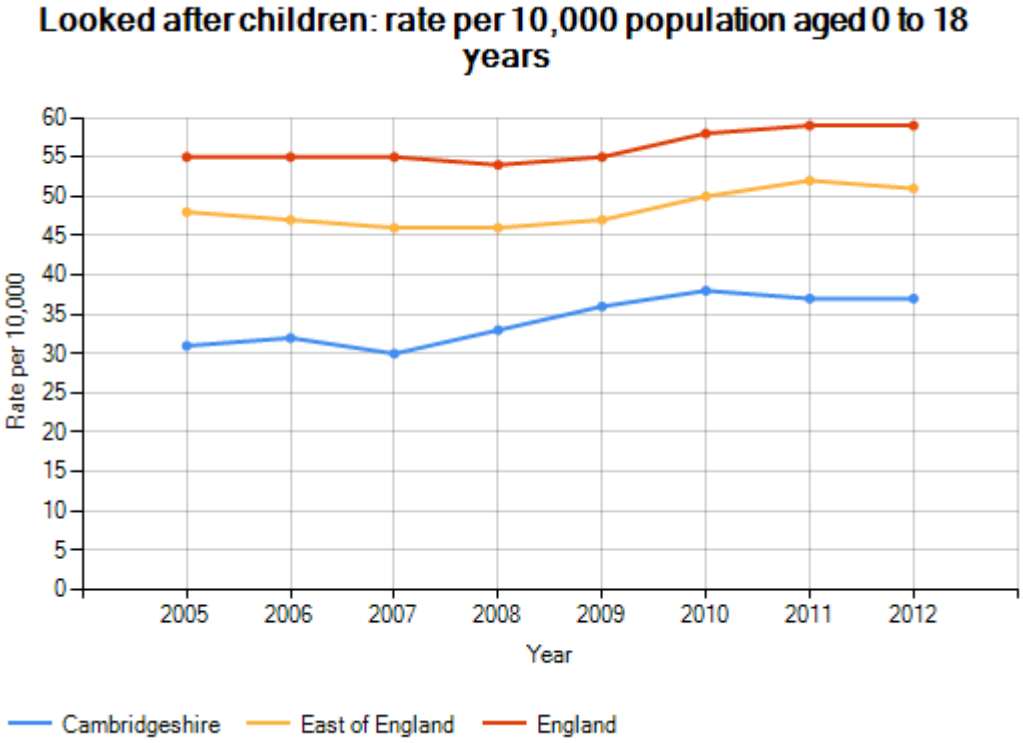
- Over five times more likely to have been in trouble with the police (26% compared to 5%) Of those with a significant problem, 10% had seen a justice worker.
- Nearly twice as likely to have marked difficulties with reading, mathematics and spelling.
- Three or more years behind in their intellectual development (35%).
- 42% had a statement of special educational need.
- Four times more likely to report not spending any time with their friends (other friendship measures were the same for those with mental health disorders than those without).
- Over half were current smokers (compared to 19% without a mental disorder).
- More likely to be regular drinkers and more likely to start at a young age.
- Three times likely to have used cannabis.

More likely to have had sexual intercourse (40% compared to 26%).
The chart below shows the trend in the rate of looked-after children. The following table shows actual counts of looked-after children. Please note that data are shown for the local education authority associated with Cambridgeshire.

As of 31 December 2012, there were 474 Looked-After Children in Cambridgeshire, with the highest numbers in March, Chatteris, Wisbech and Cambridge South. Almost 75% of children were looked-after due to abuse/neglect.[53]

[53] Children and Young People Services, Cambridgeshire County Council

Figure 19 Looked-after children: rate per 10,000 population aged 0 to 18 years



Source: Department for Education

Table 31: Looked-after children

	2005	2006	2007	2008	2009	2010	2011	2012
Children looked after at 31 March (count)								
Cambridgeshire	380	390	375	410	450	475	470	470

Source: Department for Education

There will also be a number of looked-after children from other counties placed in Cambridgeshire and therefore accessing Cambridgeshire health services.

From April 2008, all local authorities in England have been required to provide information on the emotional and behavioural health of the children they look after. Data is collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a summary figure for each child (the total difficulties score) is submitted to the Department through the SSDA903 data return.

The table below shows information relating to the emotional health of all children and young people and of children in care in Cambridgeshire

Table 32: **Emotional Health**

	Emotional and behavioural health of looked after children: Average score per child (2012)
Cambridgeshire	14.10
England	13.80

Sources: The Department for Children Schools and Families; Department for Education

Children 'in need', children in care or subject to a child protection plan

'Children in need' are defined in the Children's Act (1989) as those in need of additional services from the local authority in order to attain a reasonable standard of health and development (including those with disabilities).

As of March 2012, there were 2,815 children classed as Children in Need, in Cambridgeshire, with 55% boys and 44% girls, half were under 10 years old. The majority had a primary need of 'Abuse or Neglect'. One fifth had been classed as a Child in Need, for under three months and a third for two years and over.

Physical and sexual abuse/violence can affect a child's mental health. Studies have found that half of psychiatric inpatients have histories of physical and/or sexual abuse and incidence of personality disorders were five times higher in people who had been abused. Research also suggests that emotional abuse is associated with parents who are alcoholic or abuse street drugs or other substances, have depression, or domestic violence in the family and among children with physical disabilities and their siblings.[21]

Figure 20: Children in need, as at March 2013

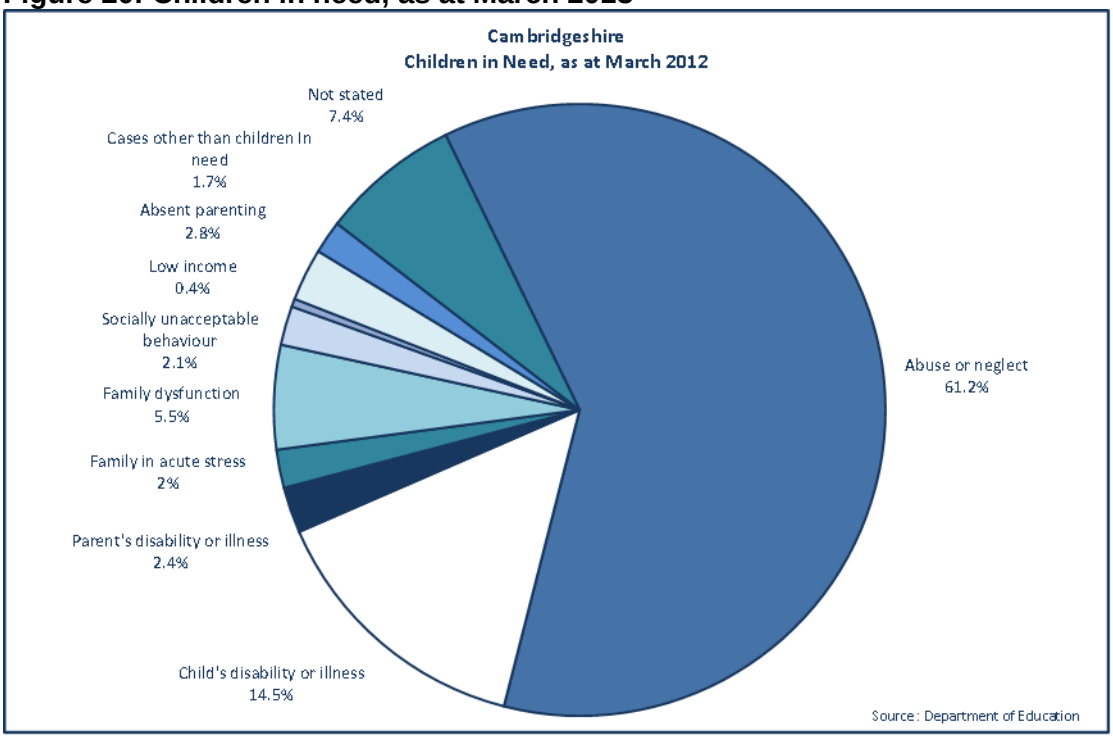
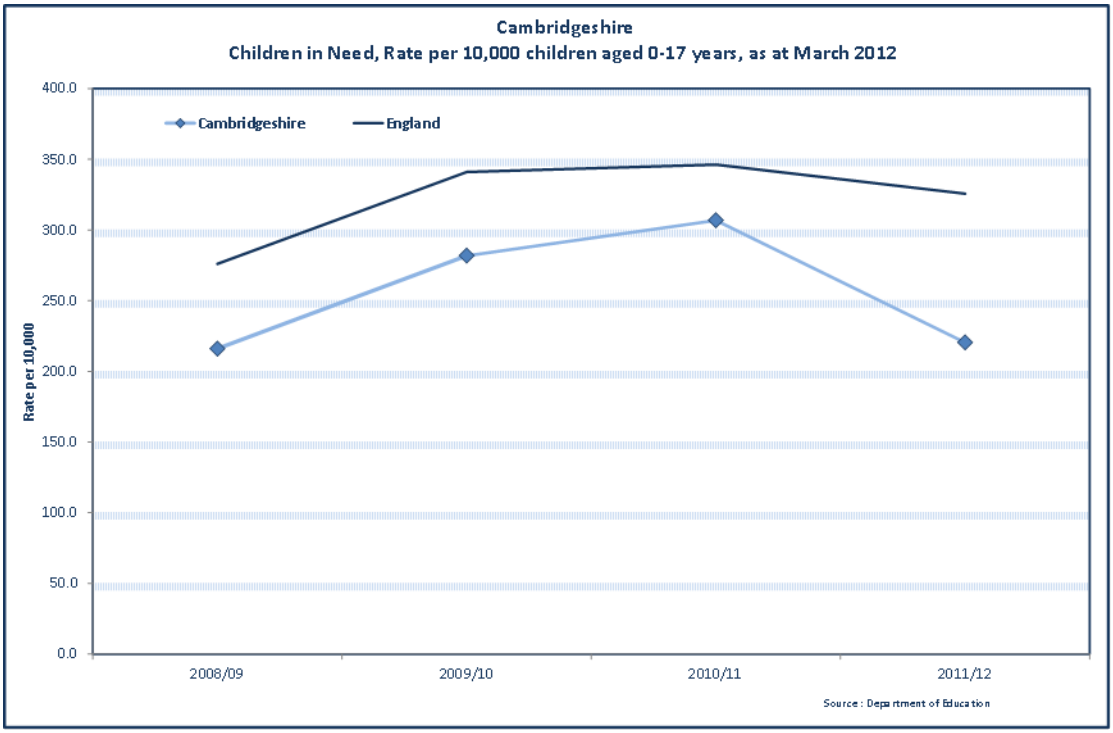


Figure 21: Children in Need, Rate per 10,000 children aged 0-17 years, as at March 2012



In December 2012, there were 177 children on the Child Protection Register, with the highest number in Wisbech, Cambridge North and Cambridge South. Over three-quarters of children were on the Child Protection register due to neglect/abuse.

Young Carers

We know that young carers often have higher levels of mental health need compared to other children and young people.

The recent Health Related Behaviour Survey, for Cambridgeshire (2012),[54] found that young carers, who represented about 5% (452) of their sample (9,065), worried more, had lower self-esteem and had experienced more bullying than other children and young people. The report does not say if these differences are significant.

Question	Young carers	All sample
They worry about at least one of the issues listed 'quite a lot' or, 'a lot'.	90%	82%
They worry about relationships with friends 'quite a lot' or, 'a lot'.	54%	47%
Said they worry about their own health.	48%	38%
Have a medium to low self-esteem score.	37%	25%
Have a high self-esteem score.	25%	37%
They feel afraid to be in school because of bullying at least 'sometimes'.	35% (boys) 46% (girls)	21% (boys) 30% (girls)
There has been shouting and arguing between adults at home at least 'once or twice' in the last month that frightened them.	36%	22%

Source: Young People in Cambridgeshire Schools[54]

Young offenders

The BMA report *Child and Adolescent Mental Health, A guide for healthcare professionals*[1] reported that young offenders are at high risk of suffering mental health problems, with 40% having a diagnosable disorder, and that of the total caseload of CAMHS, 5% were young offenders (does not include those in secure provision in the independent sector).

In 2009/10, there were 723 10 to 17 year-olds who received their first reprimand, warning or conviction, in Cambridgeshire, statistically, a rate that was significantly higher than the national average.[55]

In Cambridgeshire, young people are referred to the Clinical Psychologist within the Youth Offending Service (YOS) team by YOS Officers and Specialist Workers. Referrals can be made after a client meeting the assessment threshold or if there are particular concerns.

The total number of referrals made to the Clinical Psychologist between July 2011 and June 2012, was 119, higher than the number made in the previous 12 months (77).

Table 33: **The Referral Rate to the Clinical Psychologist in YOS over time**

Six-month Period	Number of Referrals
July 2010 – Dec 2010	37
January 2011 – June 2011	40
July 2011 – December 2011	53
January 2012 – June 2012	66

[54] The Health Related Behaviour Survey 2012. A report for Young Carers. The schools health education unit.
[55] Child Health Profiles 2012, ChiMat

Of the 66 new referrals that were received between January 2012 and June 2012, 53 (80%) were male and 13 (20%) were female, aged between 11 and 17 years. Two thirds of those referred had had prior contact with mental health services, and in the previous six months the figure was three-quarters. Of those referred between January and June 2012, 14% had had a previous diagnosis of mental health disorder, 41% had a history of self-harm and 27% had a history of a suicide attempt. Of their client group, a high number were assessed as having difficulties with emotional regulation of low mood, anxiety and/or anger, which is similar to previous six month periods.

There is also multi-systemic therapy for problem sexual behaviour available in Cambridgeshire. As at December 2012, three young people were being treated, with two where the case originated in the Youth Offending service. There is also multi-systemic therapy for substance abuse available, and this service received 36 referrals (largely from social care), between May 2012 and November 2012.

Travellers

The study, *The Health Status of Gypsies and Travellers in England,*[56] undertaken by The University of Sheffield, concluded that women were twice as likely as men to be anxious, even when education, smoking and carer status were taken into account. Self-reported anxiety was one of the aspects of health that showed the most marked inequalities. The *Cambridgeshire Sub Region Traveller Needs Assessment 2005-2010,*[57] commented that 13% of respondents reported having 'nerves'.

Although no specific data appears to be available on the mental health of Gypsy and Traveller children and young people, this group identified as having significant mental health problems, and as seen previously in this report, the mental health of parents can impact the mental health of their children's development.

In January 2011 there were just over 100 Irish Traveller children and approximately 510 gypsy/traveller children attending schools in Cambridgeshire, with South Cambridgeshire, Fenland and Cambridge City having the highest numbers.[58]

Refugees

It is estimated that there are over 120,000 asylum-seeking and refugee children and young people in the UK. Some are supported in the school SEN system, with many referred to the Medical Foundation. A small number come to the attention of Child and Adolescent Mental Health Services.[59]

A recent review of the evidence[60] for individual, family, community, and societal risk and protective factors of the mental health outcomes of children and adolescents who have been displaced and are resettled in high-income countries is summarised below.

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56 *The Health Status of Gypsies and Travellers in England, Summary of a report to the Department of Health 2004*, The University of Sheffield www.shef.ac.uk/content/1/c6/02/55/71/GT%20report%20summary.pdf

57 *Cambridge sub-region traveller needs assessment, May 2006*, Cambridgeshire County Council www.cambridgeshire.gov.uk/nr/rdonlyres/42B16143-1733-44FE-9A32-5484F627BFDA/0/travellerssurveryfinalreportrevisededition18_02_08.pdf

58 School Census 2011, Children and Young People's Services, Cambridgeshire County Council

59 *Working with refugee children, 2003*, Joseph Rowntree Foundation www.jrf.org.uk/bookshop/ebooks/1859351395.pdf

60 Fazel M, et al, Lancet 2012; 379:266-82

Table 34: Summary of Risk and Protective Factors for Mental Health Outcomes in Forcibly Displaced Children

	Domain assessed	Number of studies*	Total number of children†	Risk or protective factor
Exposure to premigration violence	Individual	13	3099	Risk
Female sex	Individual	11	3425	Risk (mainly for internalising or emotional problems)
High parental support and family cohesion	Family	4	1576	Protective
Self-reported support from friends	Community	4	397	Protective
Unaccompanied	Family	3	3690	Risk
Perceived discrimination	Community	3	1548	Risk
Exposure to postmigration violence	Individual	3	1489	Risk
Self-reported positive school experience	Family	3	1441	Protective
Several changes of residence in host country	Community	3	1031	Risk
Parental exposure to violence	Family	3	517	Risk
Poor financial support	Family	2	1601	Risk
Same ethnic-origin foster care	Family	2	386	Protective
Single parent	Family	2	359	Risk
Parental psychiatric problems	Family	2	162	Risk

Only factors that were validated in at least two studies resulting in the same direction of effect, were included in the Review. *Reported as one study if the same sample was used in more than one reported study. †Includes forcibly displaced children and comparator groups, hence high numbers of participants.

Table 4: Summary of risk and protective factors for mental health outcomes in forcibly displaced children

Source: Fazel M, et al, Lancet 2012;379:266-82

Lesbian, gay, bisexual and transgender (LGBT) young people

Lesbian, gay and bisexual people are at higher risk of mental health disorders, including suicidal ideation, substance misuse and deliberate self-harm.[61]

The recent schools survey, in Cambridgeshire identified 172 young people in the LGBT group, who worried more about bullying, experienced more shouting at home and had lower self-esteem scores.

Question	LGBT	All sample
They worry about at least one of the issues listed 'quite a lot' or 'a lot'.	91%	86%
They worry about relationships with friends 'quite a lot' or 'a lot'.	58%	50%
Have med-low self-esteem score.	45%	22%
Have high self-esteem score.	17%	39%
They worry about being bullied 'quite a lot' or 'a lot'.	15% boys 27% girls	9% boys 14% girls
They feel afraid to be in school because of bullying at least 'sometimes'.	29% boys 44% girls	14% boys 24% girls
There has been shouting and arguing between adults. at home at least 'once or twice' in the last month that frightened them	39%	20%

Source: Young People in Cambridgeshire Schools. The Health Related Behaviour Survey 2012.

[61] King M, Semlyen J, See Tai S et al. 2008 Mental Disorders, Suicide and Deliberate Self-harm in Lesbian, Gay and Bisexual People. London: National Mental Health Development Unit

Teenage parents

Teenage mothers have higher rates of poor mental health after birth than older mothers, and these rates are evident for up to three years after the birth. Social isolation and high relationship breakdown are key factors that contribute to this situation.[3]

In 2010/11, there were 74 delivery episodes where the mother was under 18 years of age. Statistically, this rate is significantly lower than England's average.[62]

As can be seen below, Fenland has the highest teenage conception and maternity rates in the county, as well as a low percentage of conceptions leading to abortion.

Table 35: **Teenage Conceptions, 2010**

Local Authority	Under 18 years old				
	Number of Conceptions	Conception rate per 1,000 women	Maternity rate per 1,000 women	Abortion rate per 1,000 women	Percentage of conceptions leading to abortion
Cambridge	51	27.7	10.3	17.4	62.7
East Cambridgeshire	24	17.4	6.5	10.9	62.5
Fenland	66	40.2	26.8	13.4	33.3
Huntingdonshire	75	23.5	11.3	12.2	52.0
South Cambridgeshire	48	18.3	6.1	12.2	66.7
Cambridgeshire	264	24.7	11.6	13.1	53.0
England	32,552	35.4	17.6	17.8	50.3

Source: ONS

Alcohol and substance misuse

Alcohol and substance misuse can sometimes be linked to mental health problems. Some research suggests that young people who use a significant amount of cannabis are more likely to have mental health problems, and develop mental illnesses later in life.[1]

As discussed earlier in this report (see Appendix 2), smoking, drinking and drug use is higher in children and young people with emotional, conduct and hyperkinetic disorders.

In Cambridgeshire, approximately 10% of Year 10 pupils smoke regularly, four in ten have drunk alcohol in the last week, and one in five have taken an illegal drug in the last month. Overall, 1% of Year 8 pupils and 10% of Year 10 pupils reported that they had used cannabis leaf/resin within the last month.[63]

Overall, when compared to the rest of the East of England, Cambridgeshire has a relatively low, but not significantly low, rate of young people aged 15 years and under, in treatment for drug and alcohol problems. Around two thirds of young people in drug treatment use cannabis as their primary drug.

62 Child Health Profiles 2012, ChiMat
63 Health Related Behavioural Survey 2012, Schools Health Education Unit

Cambridgeshire has a higher percentage of male young people in drug or alcohol treatment compared to the East of England.

Statistically, Cambridgeshire has a significantly higher rate of young people with hospital stays due to alcohol, compared to the rest of the East of England.[64]

Between 2008/09 and 2010/11, 149 people under 18 years of age were admitted to hospital with alcohol-specific conditions. Cambridge City had the highest rate of people admitted but it did not differ significantly compared to Cambridgeshire or England. Statistically, East Cambridgeshire, Huntingdonshire and South Cambridgeshire all had significantly lower rates compared to England. There is a downward trend in the rate of under 18 years-olds admitted for alcohol-specific conditions, in all districts.

Table 36: **Under 18 year-olds admitted to hospital for alcohol-specific conditions**

Local Authority	2008/09 to 2010/11			Trend in crude rate per 100,000 population				
	Number of under 18s admitted	Crude rate per 100,000 population	95% Confidence Intervals	2004/05-2006/07	2005/06-2007/08	2006/07-2008/09	2007/08-2009/10	2008/09-2010/11
Cambridge	33	56.68	(39.02 - 79.59)	83.85	86.48	88.87	57.66	56.68
East Cambridgeshire	13	23.73	(12.63 - 40.57)	25.05	38.05	37.58	31.46	23.73
Fenland	25	44.22	(28.62 - 65.28)	65.30	88.15	70.38	68.67	44.22
Huntingdonshire	41	37.00	(26.55 - 50.19)	61.57	67.61	53.70	47.70	37.00
South Cambridgeshire	37	38.15	(26.86 - 52.59)	42.19	41.85	37.20	42.91	38.15
Cambridgeshire	149	39.49	(33.40 - 46.36)	55.47	62.90	55.08	48.84	39.49
England	18,444	55.79	(54.98 - 56.60)	69.62	71.34	66.41	61.81	55.79

Source: Local Alcohol Profiles for England, North West Public Health Observatory

Key Findings

Demography and Prevalence

It is estimated that there are around 136,000 children and young people under aged 19 living in Cambridgeshire. Huntingdonshire has the highest number of children but Cambridge City is the area predicted to have the greatest increase in number of children by 2016 (15.8% increase) while Huntingdonshire will see a 1.6% reduction by 2016. Overall, the population of children in Cambridgeshire is due to rise by 3.9% by 2016 and 10.3% by 2021.

Applying national prevalence data to the local population shows that there are approximately 5,000 children under the age of five with mental health problems, 8,000 between the ages of 5-16 and 1,275 16-17 year olds. It is estimated that of children aged 5 to 16 years in Cambridgeshire 3,100 have an emotional disorder; 4,800 have a conduct disorder; 1,200 have a hyperkinetic disorder; and 1,100 have a less common disorder, including 740 with autism. Conduct disorder is still the most common diagnosis, the majority of which is found in boys, and emotional disorder (anxiety) is the next most common, the majority of which is found girls.

There is a clustering of indicators which make mental health disorders for more prevalent in parts of Fenland and Cambridge City. These indicators tend to mirror broad patterns of child poverty and household deprivation. North Fenland,

[64] Substance Misuse, Fingertips, erpho

Huntingdon North and North-east Cambridge, have the greatest levels of relative deprivation. Waterlees in Fenland and Abbey in Cambridge City, has the highest levels of child poverty within the county, with over half of children living in means-tested benefit-reliant families. Average prevalence levels are therefore an underestimation of need in these areas, where risk levels are likely to be two to three times higher amongst some disorders (eg conduct disorder).

The wellbeing measures available, based on 2009 work, suggest that overall, Cambridgeshire children and young people have generally better wellbeing than the England average. However, when this is broken down by area Fenland ranked 251 out of 354 local authorities with number one as the best performing.

Since 2010/11, there has been an increase in the number of children and young people admitted to hospital for self-harm. However, the national rates have substantially decreased over the same period, leaving Cambridgeshire well above the national average.

Vulnerable groups

There are higher levels of mental health disorders among the following groups of children and young people in Cambridgeshire. Those with learning disabilities, looked- after children, children in need, young carers, young offenders, refugees, teenage parents, those who are substance misusers or those who have experienced abuse.

The local and national data highlights the need to ensure that services cater for vulnerable groups of children and young people and this will help prevent long-term health inequalities.

Parental mental health and substance misuse

Parental mental health has a critical impact on children's mental health. There are an estimated 22,700 children and young people living with a parent with mental illness in Cambridgeshire. Between one and two-thirds of these children and young people are likely to develop mental health problems themselves.

Maternal mental health, particularly in the first 18 months of life, has an impact on a child's long-term mental health. There are an estimated 754 women with major post natal-depression in Cambridgeshire based on births in 2011. Services supporting vulnerable families with children aged 0-5, and the families of children with Special Educational Needs (SEN) find high levels of mental health problems in parents and children.

It is also estimated that 5,400 children and young people live with a problem drinker who has concurrent mental health problems; 3,300 are living with a drug user with concurrent mental health problems; and 1,300 live with a parent with all three. There are also between 27-40% of young carers currently in contact with support services who care for someone in their family with a mental health problem.

Services

Mental Health Services for children and young people are provided in four tiers, as detailed below:

Tier 1: A primary level of care. Practitioners will be able to 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.

Tier 2: Practitioners at this level tend to be CAMHS specialists, working in community and primary care settings, eg primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. These services are used by young people with moderate disorders.

Tier 3: This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service. It provides a specialised service for children and young people with more severe, complex and persistent disorders.

Tier 4: These 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.

A 1996 study estimated the number of children and young people experiencing mental health problems appropriate for a response from mental health services at tiers 1, 2, 3 and 4.[65] Table 37 shows these estimates for the population of Cambridgeshire aged 17 and under.

Table 37: **Estimated number of children and young people experiencing mental health problems appropriate for a response from CAMHS.**

	Cambridgeshire
Tier 1 (15%) (2010)	1,8981
Tier 2 (7.0%) (2010)	8,858
Tier 3 (1.85%) (2010)	2,341
Tier 4 (0.075%) (2010)	95

Source: Estimates based on ONS population data produced by Chimat (Feb 2013).

Other estimates suggest that out of the 10% of children aged 5-15 identified as having a mental health disorder in the ONS 1999[26] survey, around 6-7% need up to Tier 2 service level input, while the remaining 3-4% would need Tier 3 and in a few cases, Tier 4 services. [66] [67]

[65] *Treating Children Well,* Z. Kurtz, (1996) The Mental Health Foundation

[66] Child and Adolescent Mental Health Services : Strategy, planning, delivery and evaluation : Edited by Richard Williams & Michael Kerfoot, (Pp 556), Oxford University Press, 2005-09-27

[67] Kelvin, R.G. (2005). *Capacity of Tier 2-3 CAMHS and Service Specification : A Model To Enable Evidence Based Service Development*. CAMHS Journal ACPP Vol. 10, No. 2, pp 64-74

Based on the ONS 2004 prevalence, 8,000 children and young people are estimated to have a mental disorder in Cambridgeshire. This would suggest that:

- Between **4,800 and 5,600** would require up to **Tier 2** services.
- Between **2,400 and 3,200** would require **Tier 3** services and a few cases would require Tier 4.

Child and Adolescent Mental Health Services, located in Cambridgeshire

In this section, the focus is upon those services commissioned by either Cambridgeshire County Council or NHS Cambridgeshire. It does not describe the many voluntary and other organisations that provide services for children and young people with mental health issues.

In the previous section, Cambridge City and Fenland Local Authorities were identified as the areas in Cambridgeshire with the highest of many 'risk' indicators. These local authorities are therefore likely to be the areas of greatest need.

The following section examines current resources and services and asks if they match needs. However it is important to be mindful that:

- Huntingdonshire did not appear high on any of the risks for mental health disorders but this is key, as the area within Cambridgeshire with the current highest child population.

- There are predicted changes in the child population within Cambridgeshire eg the greatest forecasted increases in the child population of South Cambridgeshire and Cambridge City.

- This report only focuses on Tier 2 and above services and only considers the Cambridgeshire population.

Hospital Admissions

The following section presents data on child and adolescent mental health hospital admissions from the Admitted Patient Care Commissioning Dataset, maintained by Serco. In general, the numbers are relatively small and therefore prone to fluctuations that make it difficult to draw firm conclusions. An admission is anyone who attended hospital as either an inpatient or a day case.

Child and adolescent psychiatry admissions – In 2011/12, there were 96 admissions to hospital for people admitted to the care of a Child and Adolescent Psychiatrist (specialty code 711). The majority by far (46%) were for a healthy person accompanying a sick person. A further 20% of admissions had no primary diagnosis, while the remaining numbers are too small to draw conclusions. All 96 cases were inpatient cases, admitted to the Ida Darwin site of CPFT.

Self-harm admissions – (see section on self-harm)

Primary diagnosis for admissions in 2011/12, for people under 18 years of age

In 2011/12, there were 92 admissions to hospital (any hospital, any ward) for children and young people under 18 years of age, where the primary diagnosis for admission was a Mental and Behavioural disorder code ie ICD10 F. Almost half of admissions are for eating disorders, mental health behaviours due to the use of alcohol and depressive episodes.

The majority of admissions were for children under 10 with psychological development disorders. A third of admissions were for 10 to 14 year-olds, with no dominant primary reason for admission. Mental health behaviour, due to alcohol and eating disorders, were the main reasons for admissions in 15 to 17 year-olds. The number of primary diagnosis admissions has risen steadily since 2009/10; with 55 in 2009/10; 78 in 2010/11; and 91 in 2011/12. This represents an increase of 15%, from 2010/11 to 2011/12. Length of stay also increased in 2011/12, but the small numbers and recording make this figure unreliable.

Table 38: Number of admissions where a Mental and Behavioural code (ICD10 F code) was a primary reason, under 18 years of age, 2011/12

Primary diagnosis group	Number of admissions	% of total
Behavioural and emotional disorders with onset usually occurring in	10	10.9%
Behavioural syndromes associated with physiological disturbances and	17	18.5%
Disorders of psychological development	13	14.1%
Mental and behavioural disorders due to psychoactive substance use	17	18.5%
Mood [affective] disorders	13	14.1%
Neurotic, stress-related and somotoform disorders	10	10.9%
Other	12	13.0%
Total	92	

Source: Admitted Patient Care Commissioning Data Set, Serco

Any diagnosis for admissions in 2011/12, for people under 18 years of age

In 2011/12, there were 871 hospital admissions for those under 18 years of age, where a Mental and Behavioural disorder code was recorded in their admission record, eg an ICD10 F code. This means that if a person is admitted with a primary diagnosis unrelated to mental health, eg a physical injury, a mental health code was still present in their record. In fact, in 2011/12, one in ten such admissions were due to poisoning by drugs, medicaments and biological substances - the highest reason for any admissions.

Table 39: **Number of admissions where a Mental and Behavioural code (ICD10 F code) was anywhere in the admissions record, aged under 18 years, 2011/12**

Mental Health description	Number of admissions	% of total
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	101	11.6%
Behavioural syndromes associated with physiological disturbances and physical factors	20	2.3%
Disorders of psychological development	310	35.6%
Mental and behavioural disorders due to psychoactive substance use	187	21.5%
Mental retardation	9	1.0%
Mood [affective] disorders	104	11.9%
Neurotic, stress-related and somotoform disorders	114	13.1%
Organic, including symptomatic, mental disorders	8	0.9%
Schizophrenia, schizotypal and delusional disorders	12	1.4%
Other	6	0.7%
Total	871	100.0%

Source: Admitted Patient Care Commissioning Data Set, Serco

Cambridgeshire and Peterborough Foundation Trust Inpatients

The Cambridgeshire and Peterborough Foundation Trust provided data on the region's hospital discharges from their CAMH Wards, for the first nine months of 2012/13. The data revealed that of 131 discharges, the majority (31%) were for anorexia nervosa. Associated length of stay data showed that the Phoenix Centre has the longest average length of stay (105 days), followed by Darwin Crisis (71 days), Darwin Young People Unit (65 days) and Croft Children's Unit (56 days).

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

Cambridge and Peterborough NHS Foundation Trust (CPFT) provides mental health services for children and young people at Tiers 2-4 in both Cambridgeshire and Peterborough. The services provided at level three and four by CPFT are described in the table below (as of October 2012).

- CASUS (Cambridgeshire drug and alcohol services for young people)
- Learning disability services
- Community CAMH Services provided by clinicians such as:

    - Child and adolescent psychiatrists
    - Psychologists
    - Nurses
    - Psychotherapists
    - CBT therapists
    - Family therapists

Cambridgeshire Community CAMH Services are supported by an Intensive Support Team.[68] This team provides care and support for families and children and young people who might otherwise need to be admitted to hospital for in-patient or day patient care or to support them after discharge from hospital services.

- The Croft
- Darwin Centre for Young People
- Phoenix Centre for Young People

All referrals are made to a single point of access within the Cambridgeshire Multi-agency Referral Unit (MARU).

CPFT also run Cambridgeshire and Peterborough Assessing, Managing and Enhancing Outcomes (CAMEO) service, for people aged 14-35, who experience symptoms of psychosis. The service aims to recognise and treat psychotic experiences early, leading to better outcomes and an improved chance of recovery.

CPFT provided data on referrals, contacts, waiting times and details on patients who did not attend their appointments in 2011/12 and 2012/13. The following section examines and compares this data with NHS Cambridgeshire, for the same period. At the time of analysis, data for April to December 2012 was only available for the financial year April 2012 to April 2013. To give a full year effect, the data was therefore

[68] Source: Cambridgeshire Community Child and Adolescent Mental Health Services (CAMHs) leaflet, for professionals.

estimated for the fourth quarter by replicating the pattern of activity in the final quarter of 2011/12.

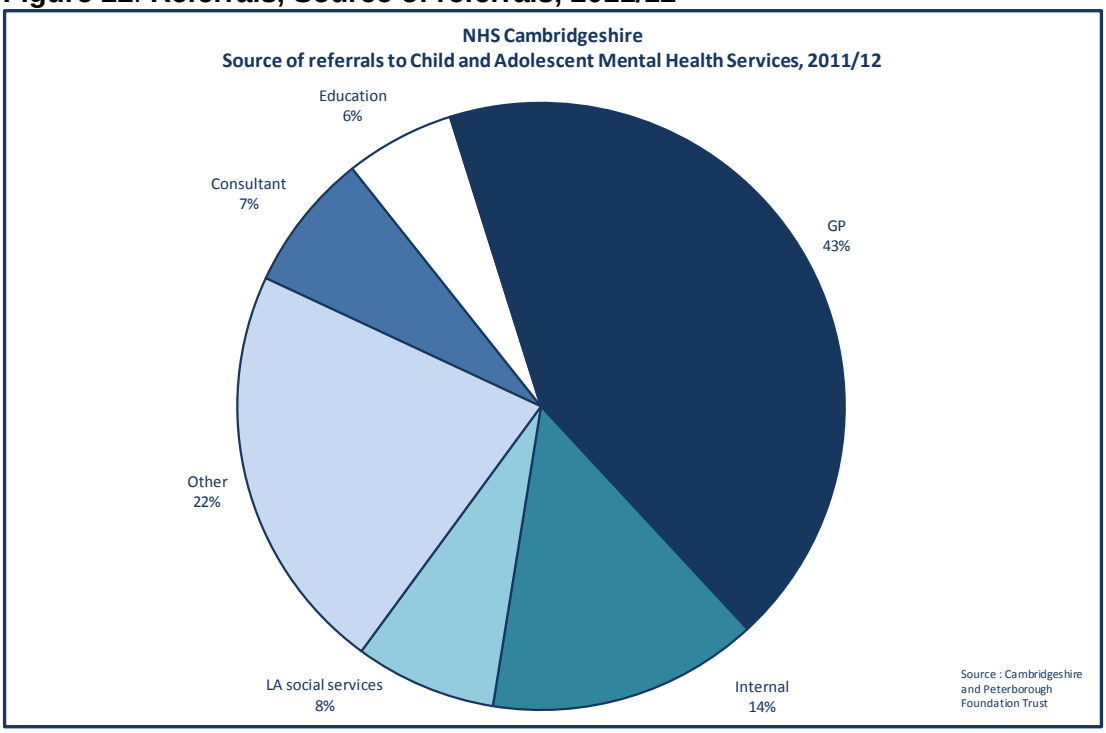
The data shows an approximate drop of 20% in activity (contacts) in 2012/13, which correlates with feedback from patients, parents and other services, for children and young people. This is particularly explained by the number of current vacancies in the Cambridgeshire service. There were 17.22 whole time equivalent (wte) vacancies at the end of January 2013, from a staffing compliment of 70.42 wte, in Children's Mental Health Services, in Cambridgeshire, or approximately 24% of vacant posts. As of 27 March 2013, 37 of these posts were clinical (excluding learning disability posts/admin and managerial).

CPFT provided data analysis for 2011/12 and 2012/13, on 14 January 2013, presented on 1 February at the Joint Children's Commissioning Board. CPFT intends to take action to resolve these issues, with an action plan for March and April agreed on the 6 February, by CPFT and commissioners.

Referrals

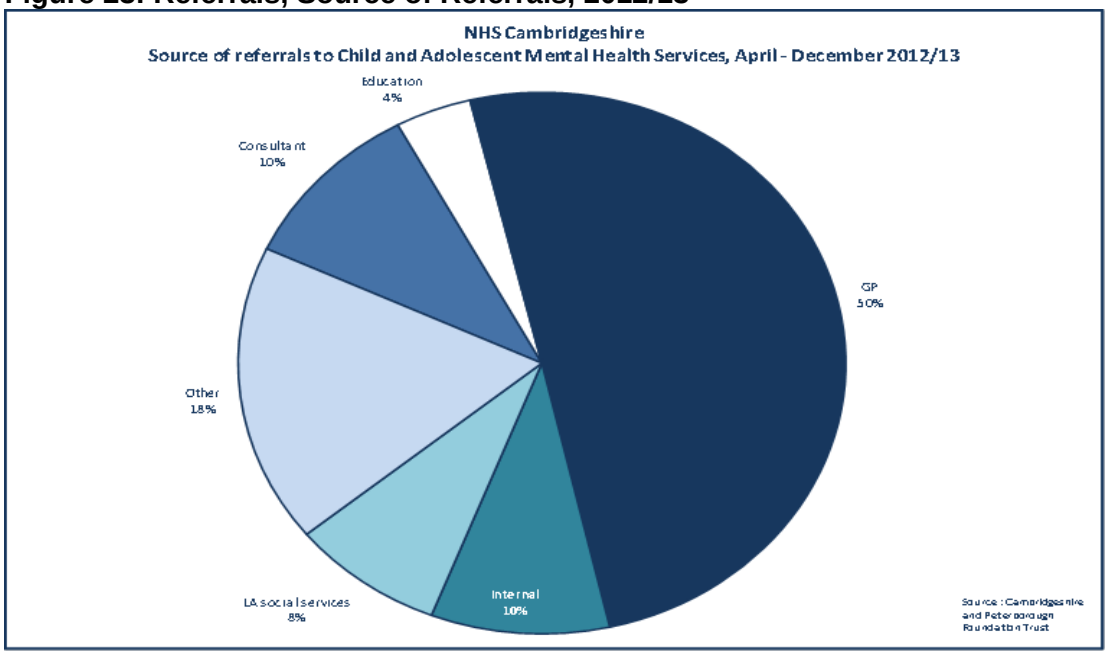
In 2011/12, there were almost 3,300 referrals to Child and Adolescent Mental Health Services, provided by CPFT, with a forecast for 2012/13 indicating a reduction of 11%. To date, this drop is fairly evenly spread between referrers. As shown in Figure 22 and Figure 23, the majority of referrals originate from GP's. However, this drop is unlikely to be a reflection of a drop in need, as referrals have generally dropped for children under the age of 13. Since 2006, referral trends indicate that levels vary year-on-year, and therefore the recent reduction may be the usual variation.

Figure 22: **Referrals, Source of referrals, 2011/12**



Source: Cambridgeshire and Peterborough Foundation Trust

Figure 23: Referrals, Source of Referrals, 2012/13



Source: Cambridgeshire and Peterborough Foundation Trust

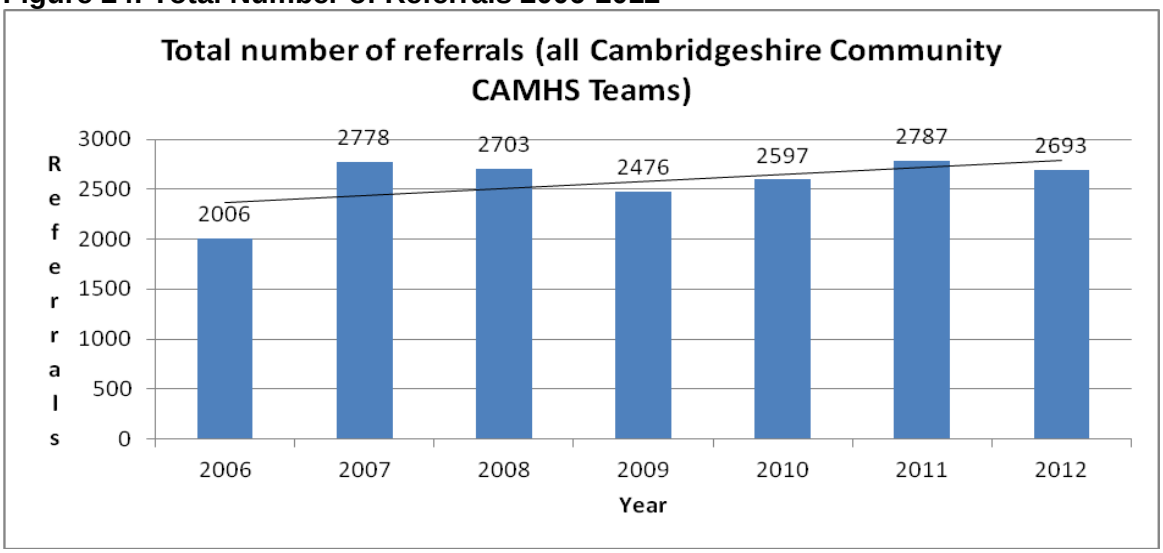
Table 40 shows referral outcomes for 2011/12. Of the 518 referrals rejected, 49 were rejected for being inappropriate. The reason for rejection was unspecified in 349 cases. CPFT are auditing reasons for referral rejection through the introduction of a new single point of access, which began in December 2012, therefore referral patterns are likely to change. The reasons for rejecting referrals is key to understanding how children and young people mental health services are interacting and should be routinely available for discussion.

Table 40: Referral outcome 2011/12

	Referral rejection reason							Total
Referral status	Different age criteria	Inappropriate referral	Not acceptable	Not Specified	Requires non-Trust service	Requires other Trust service	Wrong catchment area	
Authorised / Graded	0	1	0	2,641	0	7	1	2,650
Awaiting Assessment	0	0	0	10	0	0	0	10
Not Specified	0	0	0	95	0	0	0	95
Pending	0	0	0	5	0	0	0	5
Rejected	21	49	2	349	23	65	9	518
Total	21	50	2	3,100	23	72	10	3,278

Figure 24 shows the number of yearly referrals received by Cambridgeshire Community CAMH teams. The figures for 2012 (below) are for a January-to-January year, while the figures in the table above are for the 2011/2012 financial year. In general, there appears to be an upward trend in referrals since 2007, but fluctuations in the number of referrals exist from year-to-year, meaning that any decreases during this period may not be significant.

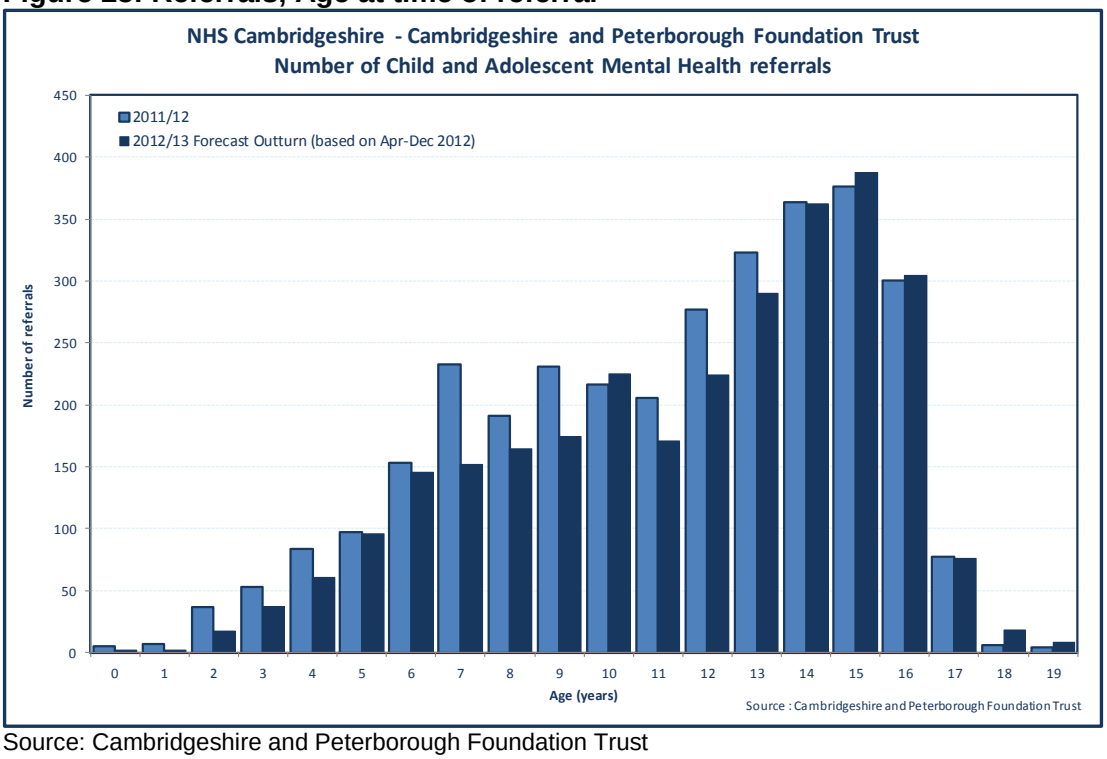
Figure 24: Total Number of Referrals 2006-2012



Source: Graph provided by Cambridge and Peterborough Foundation Trust.
Note: 2006 figures are incomplete as a new recording system was introduced and not all activity was captured.

Figure 25, indicates referrals for 2011/12 and 2012/13 increases by age, peaking at 15 years old.

Figure 25: Referrals, Age at time of referral

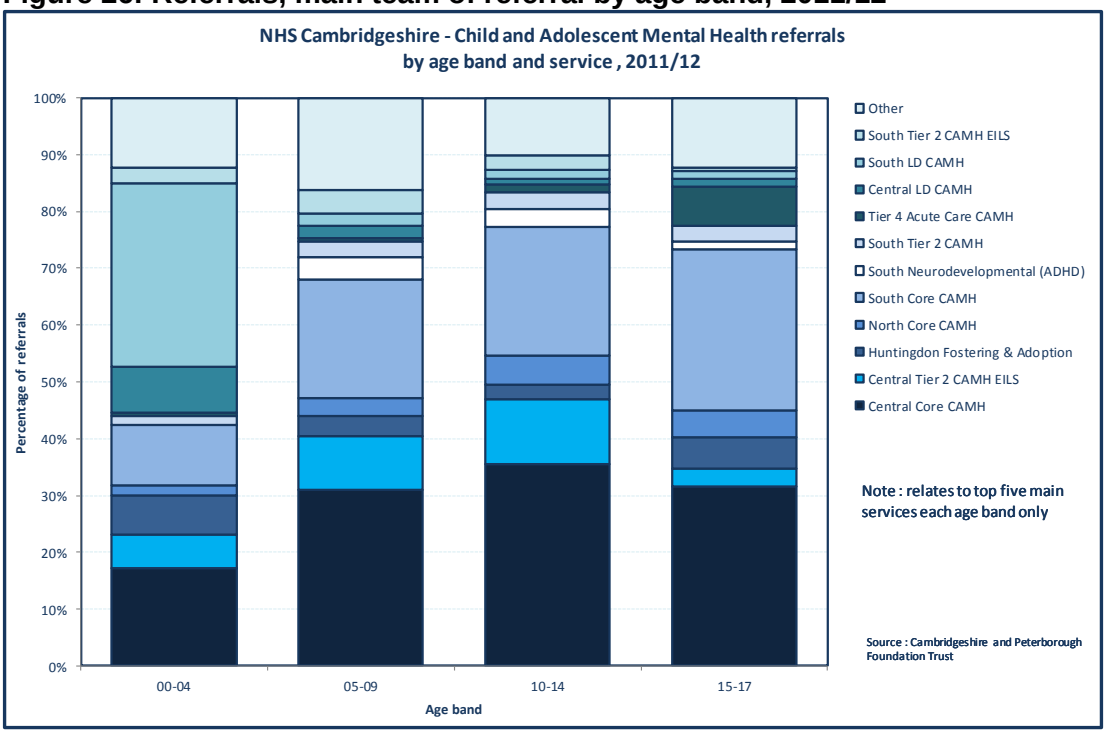


Source: Cambridgeshire and Peterborough Foundation Trust

Patients are referred to different CAMH teams' dependant on their age.

Figure 26 shows that the majority of 0-4 year-olds are referred to the South Learning Disability team, with the majority of other reported age bands being referred to the Central Core CAMH and South Core CAMH teams.

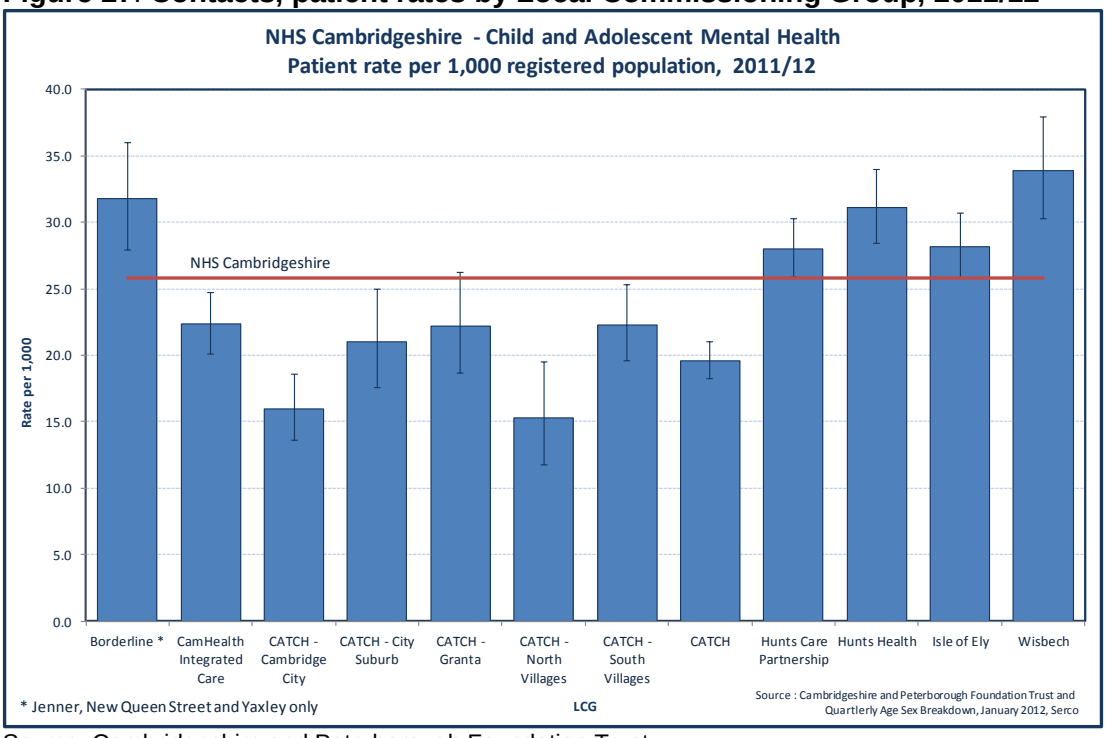
Figure 26: Referrals, main team of referral by age band, 2011/12



Source: Cambridgeshire and Peterborough Foundation Trust

Figure 27 shows the rate of referrals to CAMH services by Local Commissioning Group in 2011/12. It is noticeable that referral rates are lowest in the CATCH areas. One possible explanation is that young people are accessing other health services provided in the south of the county, such as Centre 33, or there is a higher quality Tier 1 service. The referral pattern appears to be the same for 2012/13.

Figure 27: **Contacts, patient rates by Local Commissioning Group, 2011/12**



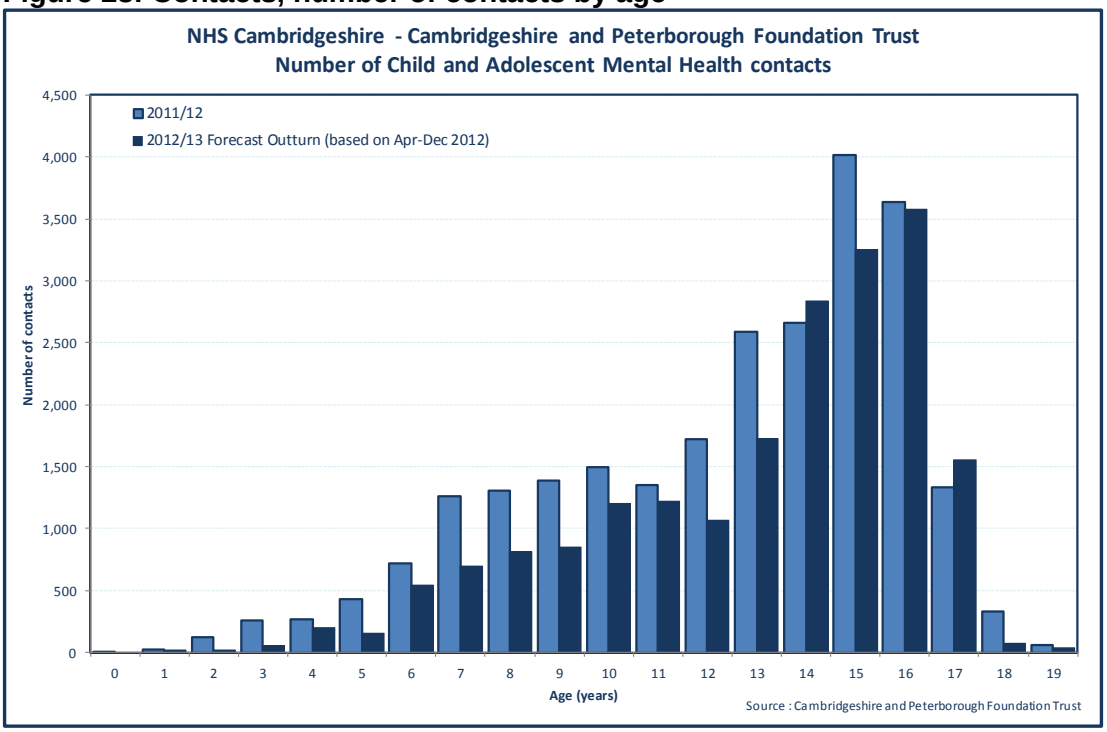
Source: Cambridgeshire and Peterborough Foundation Trust

Contacts

In 2011/12, there were 24,950 contacts at CAMH services provided by CPFT and are forecasted to be 19,900 for 2012/13, a decrease of a fifth (20%). The number of contacts increases with age, but with a much more noticeable bias towards the older age bands than seen in the pattern of referrals.

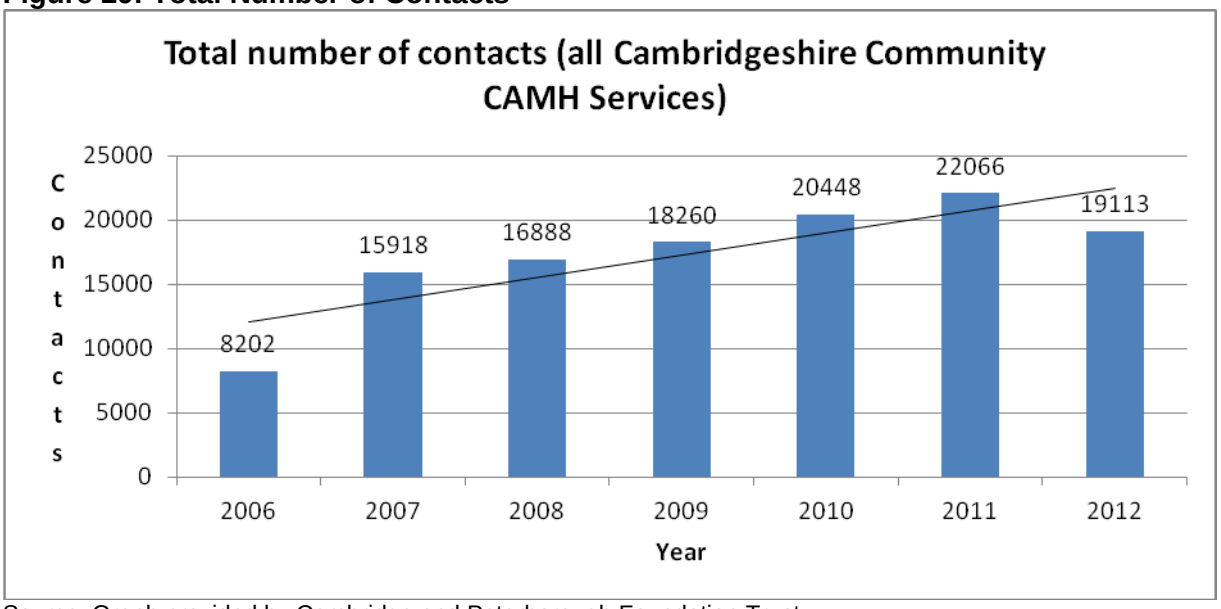
Using the January-to-January year, the number of contacts from 2006 to 2012 reveals an upward trend. However, with a decrease of 13.5%, in 2012, compared to 2011, and comparing the annual year 2011 to 2012, or the financial year 2011/12 to 2012/13, there is a noticeable reduction in the number of contacts, with 2012 being the first year with reduced contacts for five years.

Figure 28: Contacts, number of contacts by age



Source: Cambridgeshire and Peterborough Foundation Trust

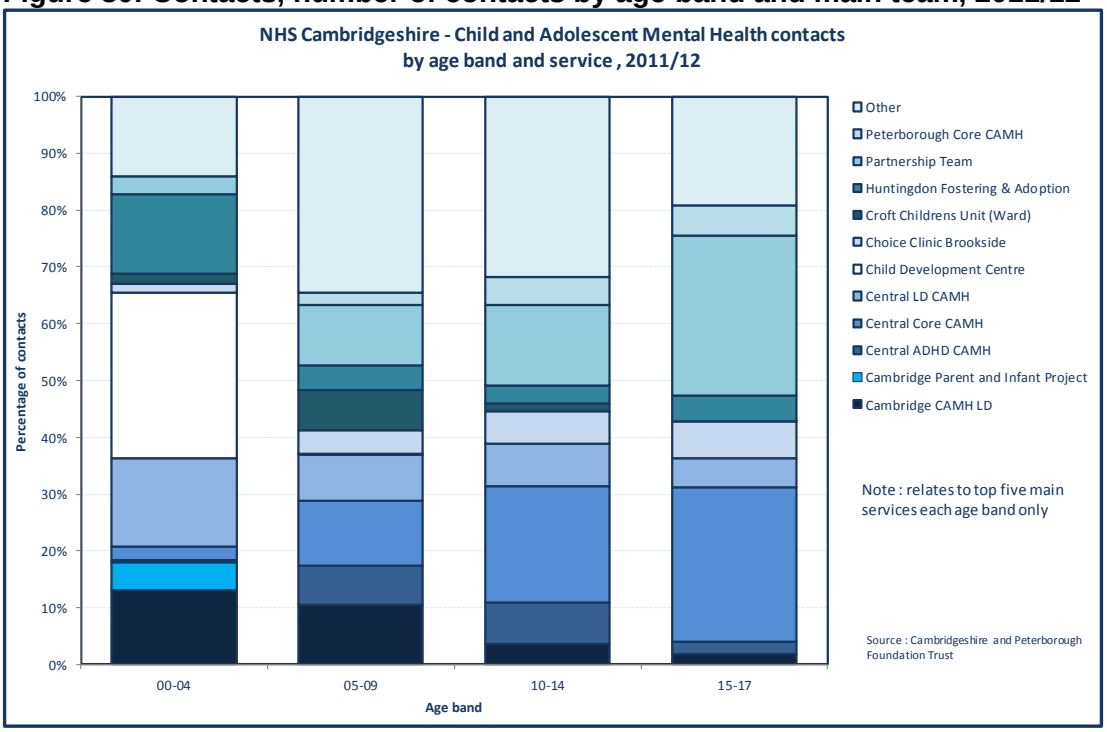
Figure 29: Total Number of Contacts



Source: Graph provided by Cambridge and Peterborough Foundation Trust.
Note: 2006 figures are incomplete as a new recording system was introduced and not all activity was captured.

As would be expected, the main services seen (contacts) by children and young people varies by age band. The majority of children under five are seen by the Child Development Centre, while a majority of 15 to 17 year-olds are seen by the Partnership Team and Central ADHD team. The five to 14 year-olds were varied, and without a dominant team.

Figure 30: Contacts, number of contacts by age band and main team, 2011/12



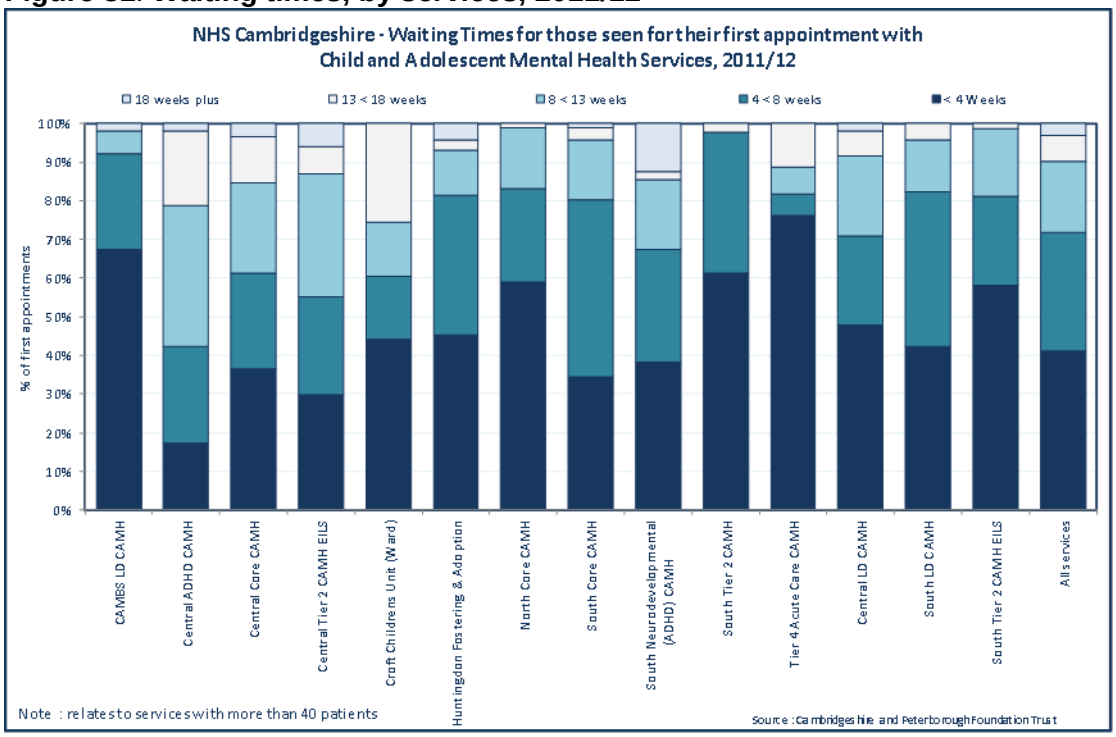
Source: Cambridgeshire and Peterborough Foundation Trust

Waiting times

Figure 31 and

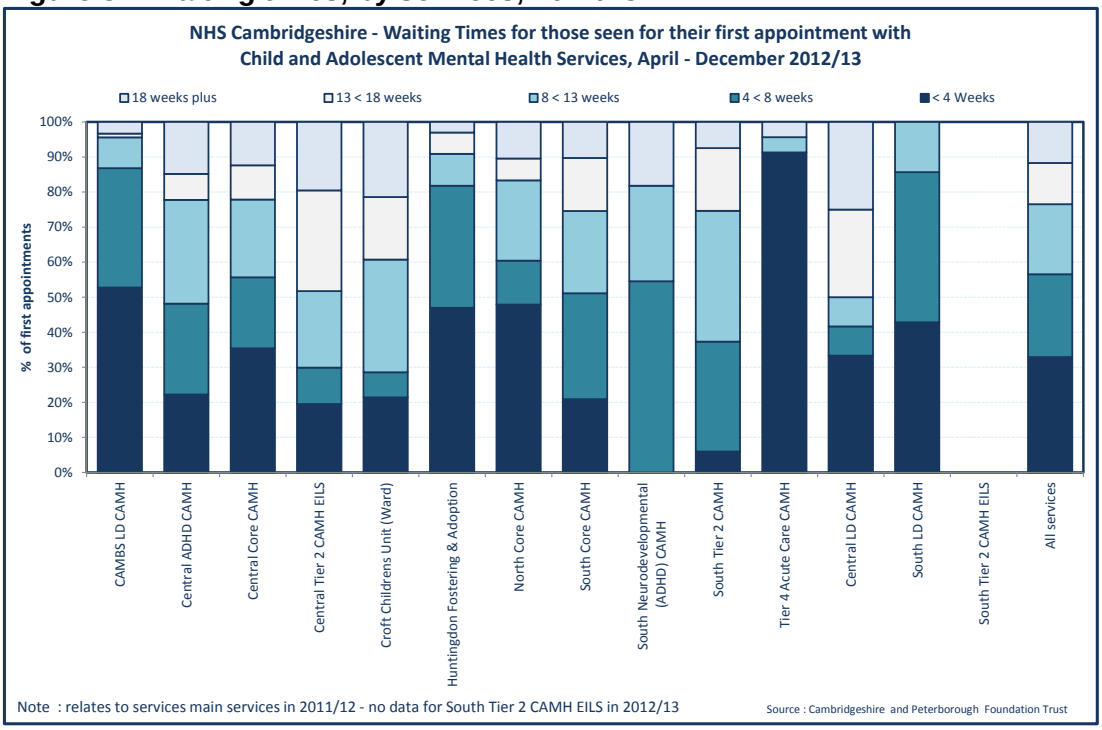
Figure 32 show the waiting times for a first appointment by team (where there were more than 40 patients). As can be seen, waiting times increased in the majority of services between 2011/12 and 2012/13. It is important to note that there are some long stays due to data recording issues. However, our analysis suggests that these do not skew the data and there is agreement with CPFT that the charts reflect the 2011/12 and current services.

Figure 31: **Waiting times, by services, 2011/12**



Source: Cambridgeshire and Peterborough Foundation Trust

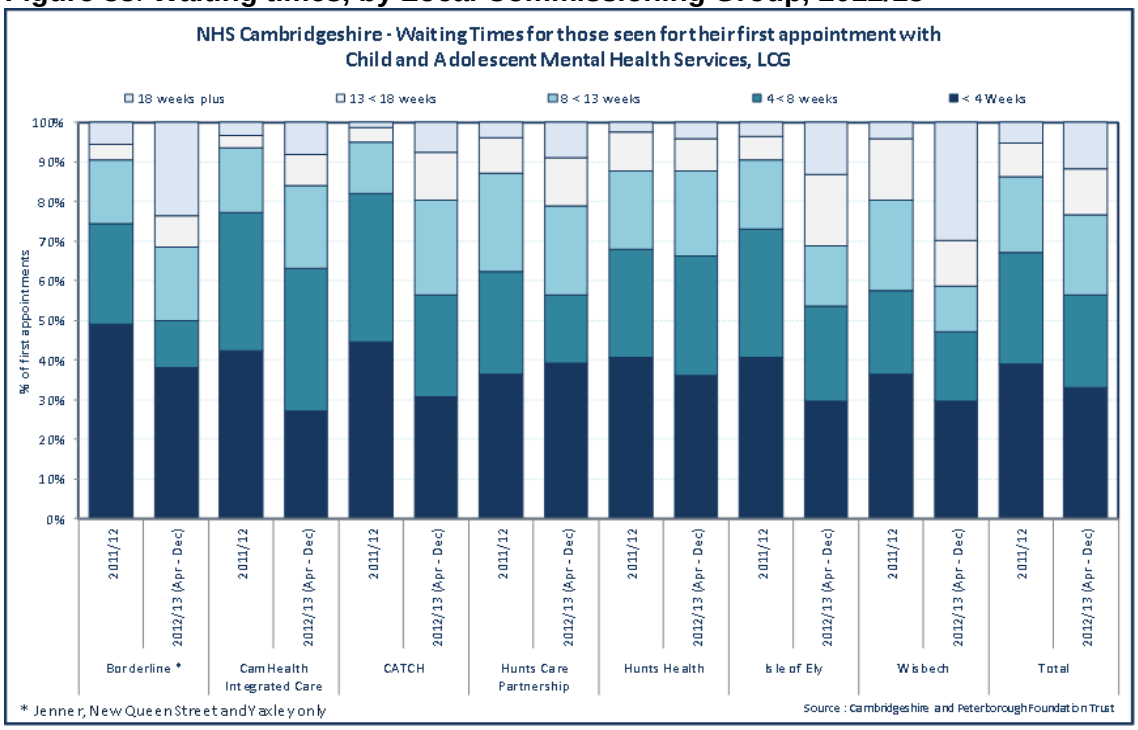
Figure 32: **Waiting times, by services, 2012/13**



Source: Cambridgeshire and Peterborough Foundation Trust (CPFT)

Figure 33 shows the same information as the LCG and compares the two years together. Numbers of people in Hunts Health and Wisbech, who were seen by a doctor within four weeks, in 2011/12, were particularly low. Again, this indicates that waiting times have increased in all LCG's.

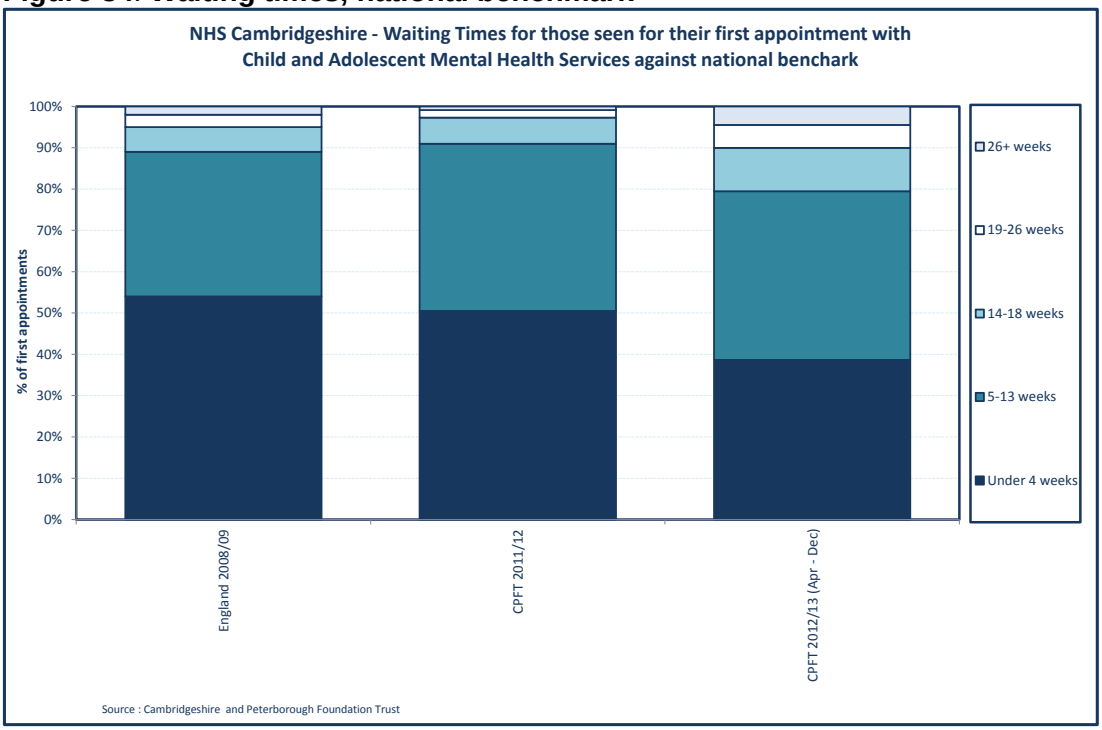
Figure 33: **Waiting times, by Local Commissioning Group, 2012/13**



Source: Cambridgeshire and Peterborough Foundation Trust

Figure 34 shows the latest waiting times against the national benchmark for 2008/09. This benchmark data is now out-of-date, and the NHS Benchmarking programme are currently working on a new programme to benchmark CAMH Services. Until that information is available, the 2008-09 national mapping exercise is used. In 2008, this found that the majority of new cases (54%) had to wait less than four weeks to be seen by a CAMH team, 35% of new cases waited for 5-13 weeks, 6% for 14-18 weeks, 3% for 19 to 26 weeks and 2% for over six months. As can be seen below, the 2012/13 position is well below the national level for 2008/09.

Figure 34: **Waiting times, national benchmark**



Did Not Attends (DNA's)

CPFT provided details about the number of children and young people that did not attend for their appointment, which equates to around 8% of all contact appointments. As can be seen in

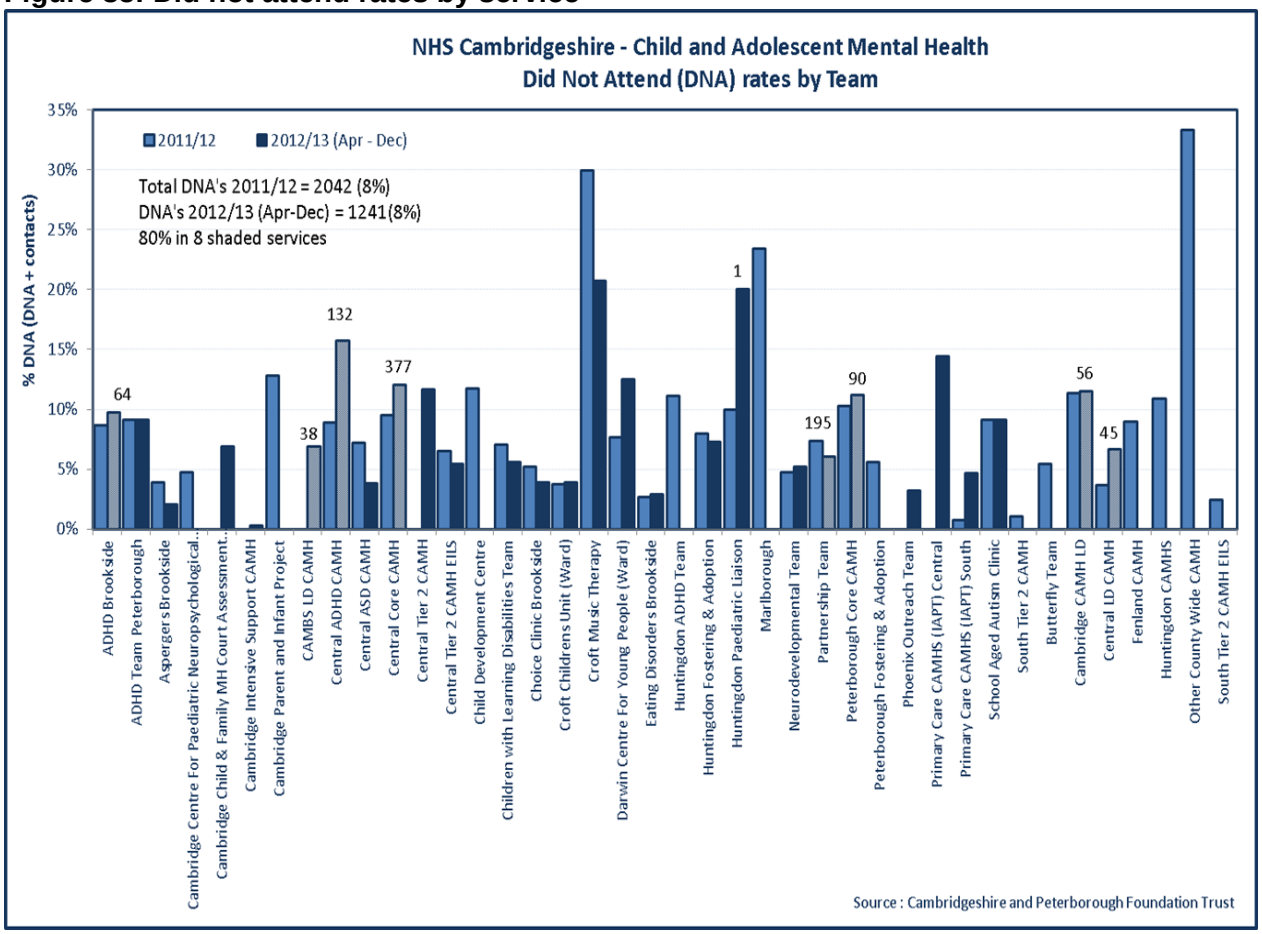
Table 41, there was an improvement in missed appointments in CATCH, but higher DNA rates in the Huntingdonshire and Wisbech systems. Overall DNA rates were 8% in 2011/12 and remained so in 2012/13. Figure 35 shows the rates by services, and real numbers (rather than rates) of DNA's above the shaded bars. 80% of all DNA's are concentrated in eight services and these are the obvious services to focus on for a reduction in DNA's.

Table 41: Did not attend Rates by Local Commissioning Group

LCG	2011/12			2012/13 (Apr - Dec)		
	DNA	Total number of contacts	Approx DNA rate	DNA	Total number of contacts	Approx DNA rate
Borderline *	163	1,688	8.8%	105	1,140	8.4%
CamHealth Integrated Care	218	3,037	6.7%	144	2,021	6.7%
CATCH - Cambridge City	85	1,042	7.5%	45	687	6.1%
CATCH - City Suburb	76	1,104	6.4%	55	530	9.4%
CATCH - Granta	106	1,195	8.1%	42	624	6.3%
CATCH - North Villages	36	443	7.5%	20	345	5.5%
CATCH - South Villages	188	2,211	7.8%	71	1,362	5.0%
CATCH	491	5,995	7.6%	233	3,548	6.2%
Hunts Care Partnership	431	4,601	8.6%	280	2,534	10.0%
Hunts Health	353	3,582	9.0%	254	1,923	11.7%
Isle of Ely	255	3,633	6.6%	136	2,170	5.9%
Wisbech	114	1,789	6.0%	80	897	8.2%
Total	2,025	24,325	7.7%	1,232	14,233	8.0%

Source: Cambridgeshire and Peterborough Foundation Trust

Figure 35: Did not attend rates by service



Transition to adult services

The transition to adult services has been recognised as problematic for many young people, with as many as one third not engaging successfully with the new service.[69] Transitions of care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK study): a study of protocols in Greater London.[70]

Information is not available on young people who access adult mental health services from CPFT, other than inpatient services. However, CPFT participated in a recent research study which provides helpful information about local transitions.

In 2011/12, there were seven 17 year-olds admitted and one 15 year-old (seven to the CPFT and one to Humber Mental Health Teaching Trust) to adult mental health consultant care.

Between April 2012 and September 2012, there were seven, 17 year-olds admitted to CPFT and one to Norfolk and Waveney Mental Health Partnership Trust. The TC17 study,[71] interviewed 26 participants preparing for transition, then 21 after transition. The findings of the study should be treated with caution due to a small sample size. However, the research is useful for its important findings and service planning. The following conclusions are from the provisional report of the study:

Conclusions:

26 CAMHS users were interviewed, pre-transition, and post-transition data was collected on 21 of the original group and partial information on one more. Key service-related observations were:

I. At their pre-transition interviews, over two-thirds of the participants reported feeling positively towards the forthcoming change of service provision. This continued in the main at follow-up, where 12 months later, only four (15%) young people said they had felt unprepared and only one had manifestly disagreed with the transition decision made.

II. Over three-quarters (20 – 77%) of the group met criteria for a DSM IV clinical diagnosis as they were preparing to move on from CAMHS. It was encouraging to find a significant reduction to eight (31%) in the 12-month follow-up period.

III. Despite the reduction in DSM IV diagnoses overall, the level of self-reported psychological distress (GHQ- 12) remained high and stable over the follow-up period. Post-transition GHQ score was not associated with current diagnosis, as had been the case pre-transition.

IV. The majority, 18 (69%) were discharged to GP care. Of these 18, 15 (83%) met DSM IV criteria for a current psychiatric diagnosis.

[69] Singh, S.P et al, 2008

[70] BMC Health Services Research, 8, 135

[71] Dunn et al.{DATE? Transfer of Care at age 17 (TC-17) – an investigation of factors which influence young people in CAMHS facing transitional care at 17. Valerie Dunn, Ian Goodyer, Jessica Memarzia, Matt Owens, Michelle St Clair, Jasmeet Thandi. CLAHRC. Cambridge University.)

V. Only three participants had been transferred to MHS and only one of those successfully engaged with the service. One young person was transferred to the specialist substance and alcohol service, CASUS.

VI. As the 12-month follow-up, one-third of those with depressive disorder (three of nine) pre-transition, continued to be depressed throughout the 12 months.

VII. There was also a reduction in self-harming, with no new cases presenting with this behaviour during the follow-up period.

Our young people had a lot to say about the transition process, much of it positive. Key quality statements extracted from the service-users responses were:

The most common post-transition problem was a perceived lack of support from the new service (whether GP or adult service). Only one-third reported transitions to have been discussed regularly and almost one-quarter said it had been discussed only once, with 7% saying, not at all.

Young people wanted to be involved in the decision-making process, involving their lives. There is a clear need for improved communication, better and timelier information, preparation and joint planning.

There should be an assessment of readiness for transition procedure. A policy regarding the governance of transitions would be valuable but only if fully-implemented. Offering information without explanation and transition support may be little better than offering no information at all.

The transition age of 17 is profoundly arbitrary and is seen by users as serving the needs of professionals and organisations, not users and carers and is certainly not client-centred. Service planning should be more bespoke, offering the flexibility to move on at a pace that suits the client, in discussion with service providers.

CAMH Outcome Research Consortium data (CORC)

CORC is a nationally run research consortium where CAMH services volunteer to submit data on outcomes and the CORC team analyse the position of the service compared to all other CAMH services. In particular, CORC data looks for significant differences in:

- Patient reported experience of service measures.
- Patient reported symptom outcome measures.
- Clinician reported outcome measures.
- The measure of added value based on parent reported outcome measures.

Only a small proportion of all cases seen by CAMH are submitted to the CORC. However, those cases submitted by CPFT are higher than those submitted by other mental health services who participate in this programme. The voluntary participation relies on clinicians completing the CORC paperwork for their cases. The data produced by the CORC provides the best national benchmarking data on quality of services.

The CORC data is based on information provided by Mental Health Services, between the years 2008-2011. The findings below are based on 62-76 CPFT cases. However, participation in the CORC provides useful information to benchmark services.

Overall, the CORC shows good outcomes for the CPFT CAMH services.

Statistically, service was significantly different from the Rest of CORC for...	Statistically indistinguishable from the Rest of CORC for...
Child CHI-ESQ on items **'Listened to', 'Easy to talk to', 'Treated well', 'Views and worries', 'Know how to help', 'Given enough explanation', 'Working together', 'Comfortable facilities', 'Recommend to a friend', 'Good help'**, with children and young people seen by CPFT CAMHS rating experience more positively.	All other Child CHI-ESQ (Measures of improvement for children) items.
Parent CHI-ESQ on items **'Listened to', 'Treated well', 'Views and worries', 'Know how to help', 'Given enough explanation', 'Working together', 'Comfortable facilities', 'Recommend to a friend', 'Good help'**, with parents of children and young people seen by CPFT CAMHS rating experience more positively.	All other Parent CHI-ESQ items.
Child helpfulness of service with children and young people seen by CPFT CAMHS rating improvement more positively than the Rest of CORC.	Child problem improvement.
Parent problem improvement with parents of children and young people seen by CPFT CAMHS rating improvement higher than the Rest of CORC.	Parent helpfulness of service.
Parent SDQ total difficulties scores which were on average lower at Time 2 than the Rest of CORC.	Change in parent SDQ total difficulties scores from Time 1 to Time 2; both CPFT CAMHS and Rest of CORC showed significant improvement.
Child SDQ total difficulties scores which were on average lower at Time 2 than the Rest of CORC.	Change in child SDQ total difficulties scores from Time 1 to Time 2; both CPFT CAMHS and Rest of CORC showed significant improvement.
Average added value score which was higher for CPFT CAMHS than the Rest of CORC.	Level of CGAS scores at Time 2.
	Change in level of CGAS scores from Time 1 to Time 2; both CPFT CAMHS showed significant improvement.

Quality Network for Community CAMHs (QNCI) report findings

The Quality Network for Community CAMH was established in 2005, and forms part of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). This is a voluntary scheme that services choose to participate in.

Participating teams rate themselves against the ten sections of the QNCI Service Standards via an annual process of self and peer review. The Brookside Family Consultation Clinic took part in a comprehensive review looking at all ten sections of the service standings, as they did in 2011. As part of this process, there was also a peer review visit to the clinic on 7 December 2012. The visiting team spent a day at the service talking to staff (two interviews), young people (one interview) and parents (two interviews).

Overall, the team concluded that Brookside performed well against the standards, either equalling or improving on their performance, in 2011, reporting that:

> *"*The team is operating in difficult organisational circumstances, and despite loss of staff and a great deal of uncertainty we are coping….They have still been able to pioneer new ways of working (Young People's Improving Access to psychological therapies - YP IAPT) and achieve good outcomes through good leadership and training."

Cambridgeshire Community Services (CCS)

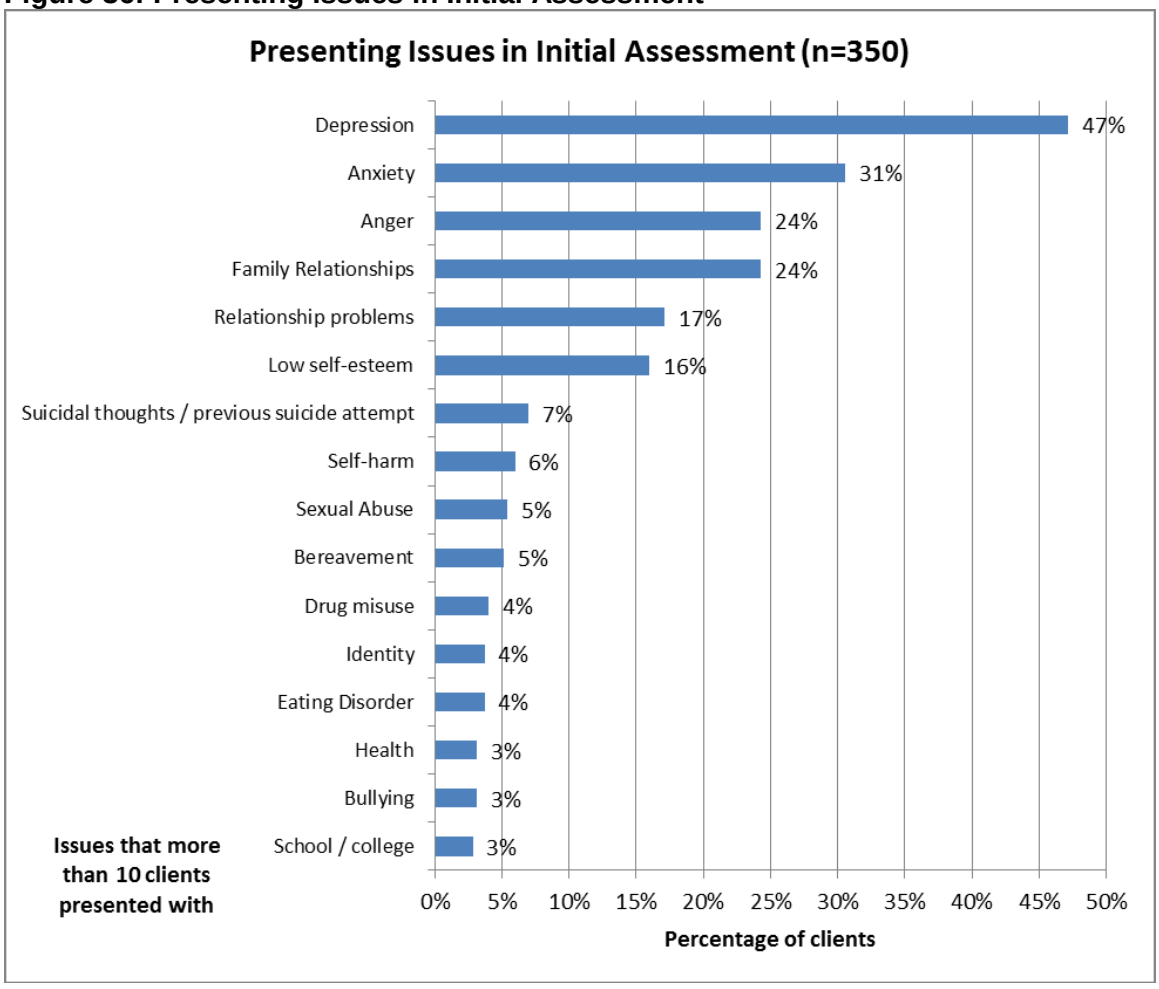
Cambridgeshire Community Services provide community paediatric services. Through the early years' service at the Child Development Centre, the service saw 1,093 children between April 2011 and April 2012. The incidence of Autistic Spectrum Disorder and related disorders was approximately 20%. A small number of these children will be referred on to the Children's Disability Team for child and adolescent mental health support. Cases would include those with ADHD, anxiety or depression with significant co-morbidity, where diagnosis has been difficult and severe behavioural problems with global developmental delay. Further details of the CCS Early Support work are provided in the JSNA on Learning and Physical Disability.

Other Tier 2 services

Centre 33 Mental Health Counselling Service

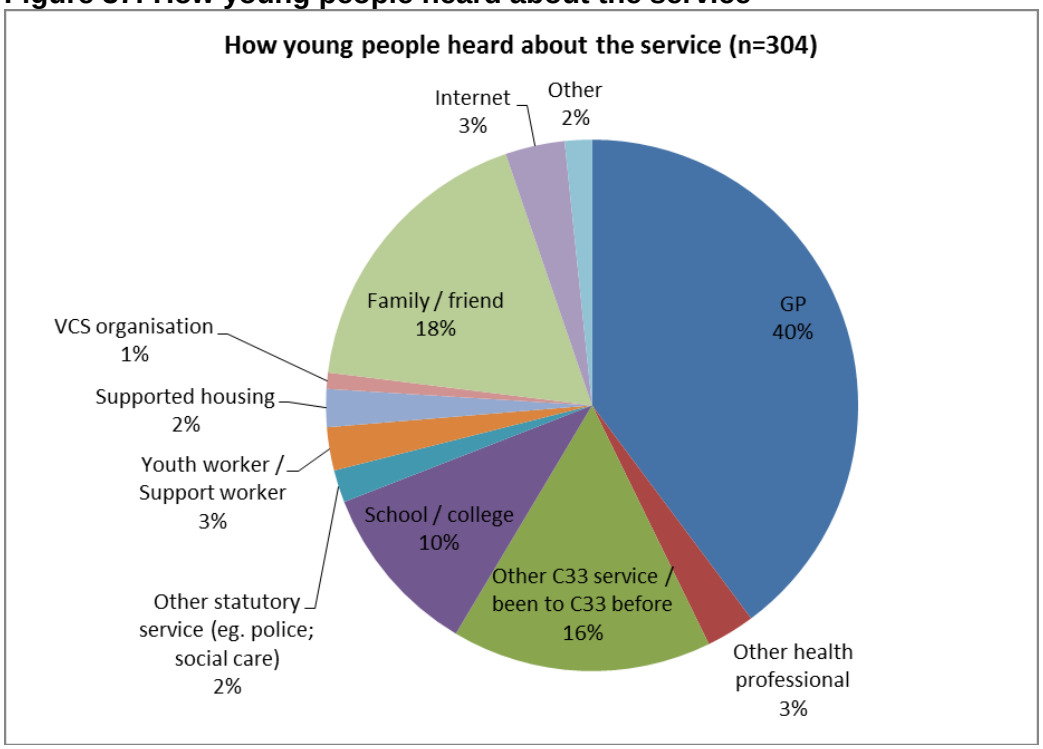
From April 2011 until April 2012, 350 young people accessed the service - a 12% increase on the previous year. 65% of clients were female with the majority aged from 16-21. The presenting issues are provided in Figure 36.

Figure 36: Presenting Issues in Initial Assessment



Source: Centre 33 Mental Health and Counselling Annual Report April 2011- March 2012.

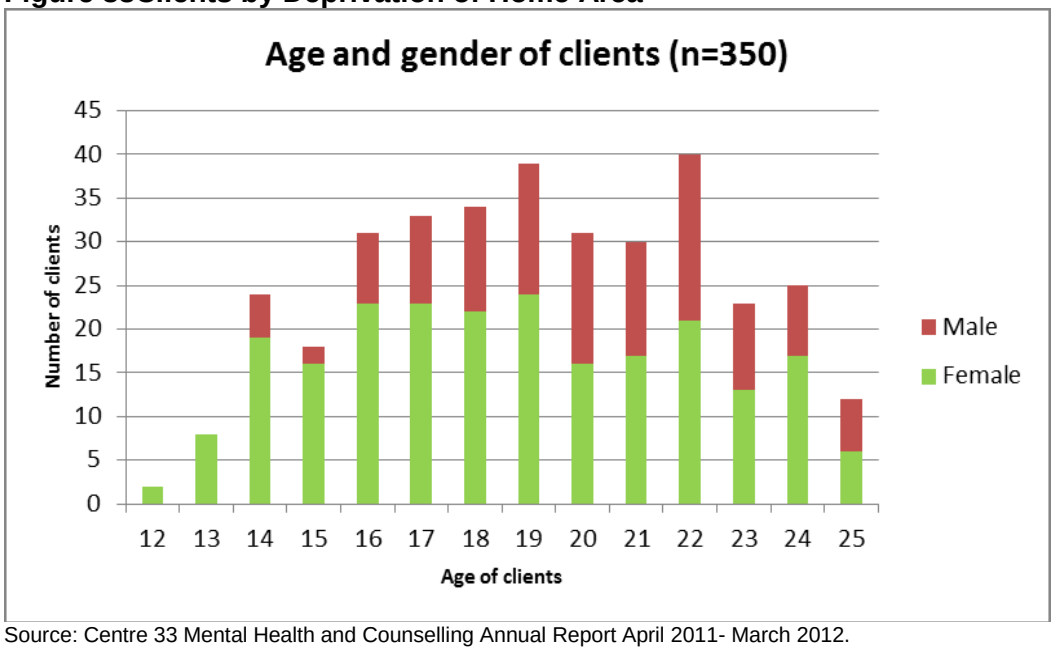
Figure 37: How young people heard about the service



Source: Centre 33 Mental Health and Counselling Annual Report April 2011- March 2012.

With a gender bias towards female clients, and knowledge that young men are at higher risk of emerging mental disorders, it is important to reach out more and focus on this in 2012/13.

Figure 38Clients by Deprivation of Home Area



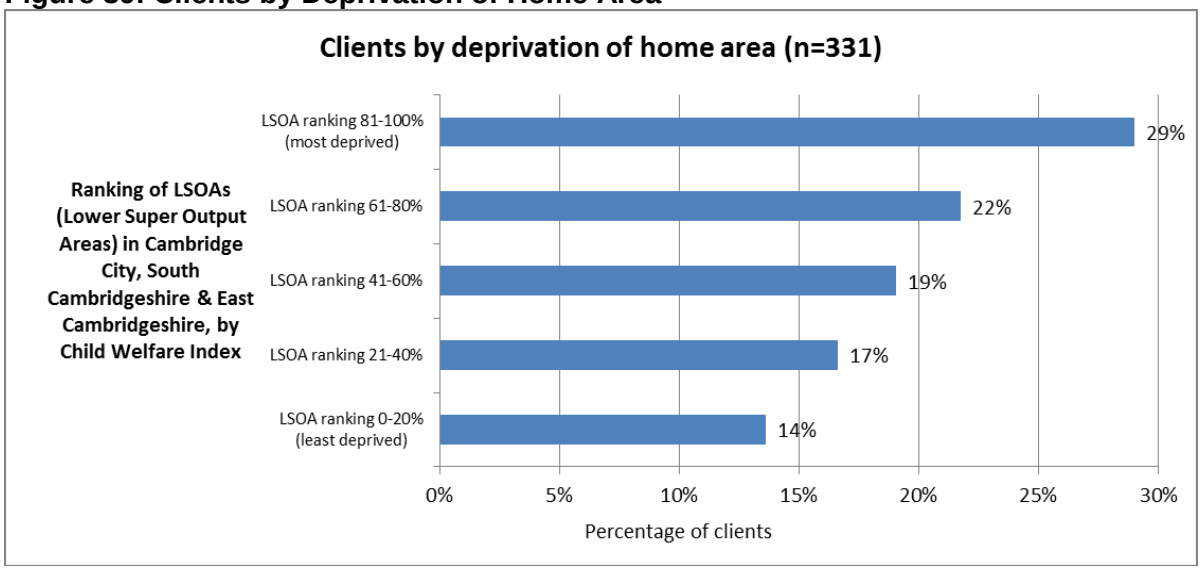
Source: Centre 33 Mental Health and Counselling Annual Report April 2011- March 2012.

Error! Reference source not found. shows that most of the clients were aged 16-21 - a period of transitions with particular peaks at ages 19 and 22.

Figure 39 shows our clients by levels of deprivation of their home area. We collected data for 331 clients, using their postcodes to calculate which Lower Super Output Area (LSOA) they lived in. The LSOA is a localised area of about 1,500 residents.

This reveals that a high number of young people accessing the service (29%) came from the 20% most deprived LSOAs within Cambridge City, South Cambridgeshire and East Cambridgeshire. There were also 14% from the least deprived, and of those offered an initial assessment, 13% did not attend.

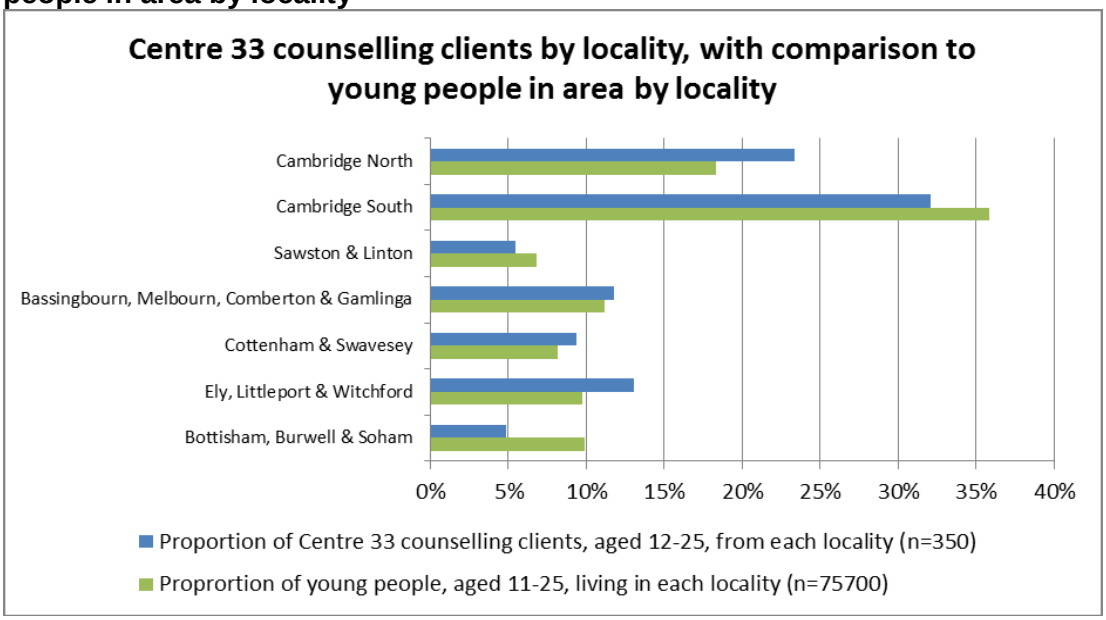
Figure 39: Clients by Deprivation of Home Area



Source: Centre 33 Mental Health & Counselling Annual Report April 2011- March 2012.

The largest proportion of clients are from South Cambridgeshire, with the proportion of clients largely in line with the proportion of young people living in an area. There were more clients proportionally from North Cambridge and Ely, Littleport and Witchford but these are small numbers. Clients from Bottisham, Burwell and Soham locality are slightly under-represented.

Figure 40: Centre 33 Counselling clients by locality, with comparison to young people in area by locality



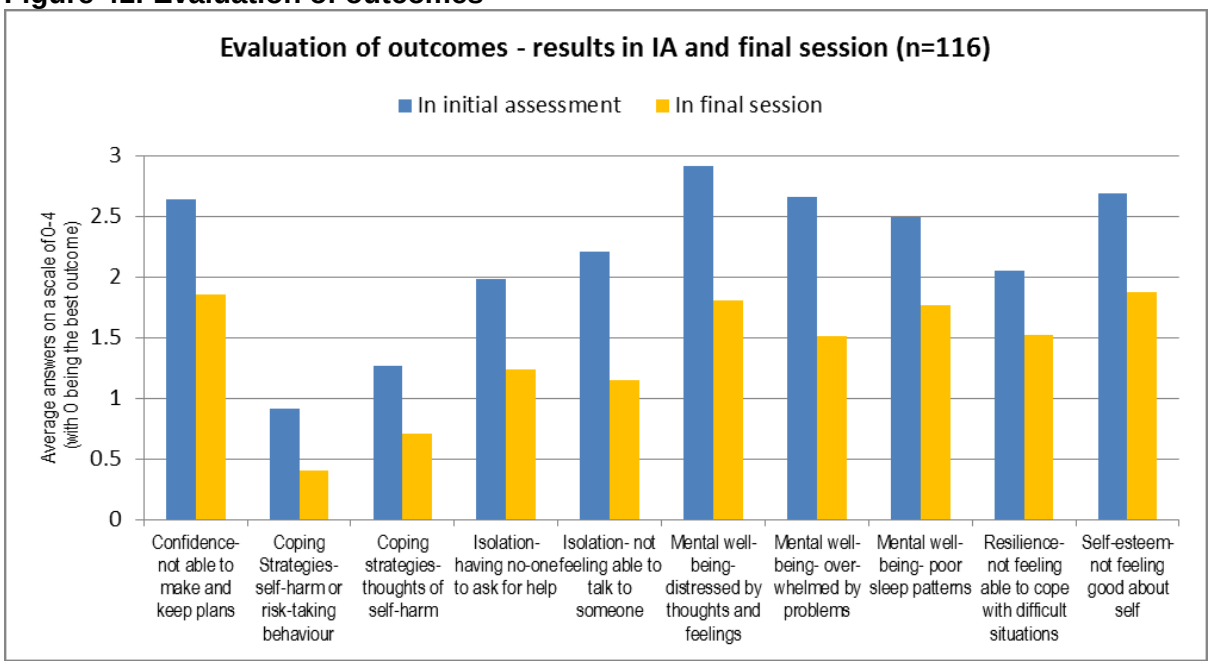
Source: Centre 33 Mental Health and Counselling Annual Report April 2011- March 2012.

The number of days waited for an initial assessment, in 2011/12, varied between seven and 16 days, with an average of 11/12 days. The waiting time for on-going counselling varied between seven and 29 days, but stayed within four weeks throughout the year.

In 2011/12, 20% (71) of clients were 'high risk clients', including suicidal ideation and planning, very concerning self-harming, or risk-taking behaviour. 27 complex cases were seen by the mental health project worker over the year.

Centre 33 measures a number of factors at initial assessment and final session. The available data shows improved outcomes.

Figure 41: Evaluation of outcomes



Source: Centre 33 Mental Health and Counselling Annual Report April 2011- March 2012.

YMCA

The YMCA provides one-to-one counselling for children and young people, up to age 25, and are commissioned to provide this service in Huntingdonshire and Fenland.

Huntingdonshire

The service saw double the amount of women compared to men, with clients ranging in age from 13 to age 25, but with the most clients aged 15.

The vast majority of clients were white British, as corresponds with the majority of the population. The top reasons for referral were depression (18%), relationship issues (17%), and stress (13%). Over half of all referrals were self-referrals (57%), with health (17%) and school/college (16%) the next largest referral source. Over half (55%) of clients were seen at Huntingdon Connexions.

In 2011/12, 77 clients ended their counselling with the service, with 48% actually attending their last session. Of those who completed the questionnaire, all but one found the service easy to contact, well explained, and would recommend it to friends. 41% felt that the counselling had met all their needs, and 50% felt they were much improved. Over the year, 31% of sessions were not attended by clients (19% of these were cancelled in advance). Action is being taken to reduce the numbers not attending.

Fenland

The Fenland service saw nearly triple the amount of women compared to men. The age of clients ranged from 13-25, again with a peak at age 15. 67% of clients were school aged. The main reasons for referral were depression (20%), bullying (15%), and relationships (17%). Data for 18% new clients is unavailable for reasons of referral. 44% were self-referrals and 28% were referred from schools, with 64% of clients accessing the service from schools. The largest number of clients were seen at Thomas Clarkson Community College, Wisbech (20%), Neale Wade Community College, March (22%), and March library (22%).

65 clients ended their counselling in Fenland, in 2011/12, but only 11 of these (17%) completed feedback forms. Of those who did complete the forms, 37% felt they had seen some improvement, 18% felt they were much improved and 36% felt it met all their needs. However, 29% of sessions were not attended by clients, with 17% of these cancelling in advance.

STARs

STARs co-ordinates and provides a bereavement service for children, young people and their families, who have experienced the death of a significant person in their lives. Pre-bereavement support is also offered.

STARs currently cater for all children and young people, from birth to 25 years-old, who reside within Cambridgeshire and Peterborough. Support is provided in an environment that is comfortable for the child and young person eg at school, college or a GP surgery. Between April 2012 and September 2012, STARs received 64 referrals with 40 to 45% of referrals 6-12 months from post-bereavement, the most common age group being 11-16 years old. In approximately 50% of cases the death was of a carer or parent.

Benchmarking

Programme Budgeting data

Programme budgeting data has been collected since 2003-04. The annual programme budgeting data collection requires primary care trusts to analyse their expenditure by specific healthcare conditions, such as cancer and mental health. There are currently 23 programme budgeting categories, based on the World Health Organisation (WHO) International Classification of Disease (ICD10).[72]

Table 42 shows the CAMHS budgetary information for NHS Cambridgeshire (Primary Care Trust). Totals for both the Cambridgeshire region and England, are provided for comparison.

However, given the variety of costs associated with this programme, budgeting figures should be interpreted with **caution**. An analysis of costs that contributed to the programme budget, include, secure units, drug and alcohol services for children and young people, crisis accommodation for children, mental health work with homeless children and under 18-year-olds admitted to hospital with a primary mental health diagnosis.

Historically, there is variation between Primary Care Trusts in how they have reported programme budgeting data, and therefore, these figures should only be a guideline alongside other information. Overall, they indicate that the spend associated with 'Community Care,' makes up approximately £8m of the Cambridgeshire spend, which appears to be higher than the national and SHA average spends in this area. The difference makes up the majority of programme budget spends per head, between Cambridgeshire and England. The coding categories for 'Community' or 'Community Care' are listed in table 42, for information.

Table 42: CAMHS programme budget

	Programme budget (2010-2011)	Programme budget per head (2010-2011)
Cambridgeshire	12,013,000	88.94
East of England	67,447,000	51.24
England	712,475,000	60.79

Source: Department of Health. Provided by Chimat (Feb 2013).

[72] Department of Health, 2012

Table 43: Programme Budgeting coding for 'Community' in the Child and Adolescent Mental Health programme budget line (5d)

Mental Health Specialist Teams – Child	Crisis Resolution Home Treatment Teams	Community
Mental Health Specialist Teams – Child	Assertive Outreach Teams	Community
Mental Health Specialist Teams – Child	Early Intervention in Psychosis Services	Community
Mental Health Community Services	Drug & Alcohol Services : Child : First Contact	Community care
Mental Health Community Services	Other Services : Child : First Contact	Community care
Mental Health Community Services - Specialist Services	Eating Disorder Services : Child : First Contact	Community care
Mental Health Specialist Teams – Child	Homeless Mental Health Services	Community
Mental Health Specialist Teams – Child	Crisis Accommodation Services	Community
Mental Health Specialist Teams – Child	Drug & Alcohol Teams	Community
Mental Health Specialist Teams – Child	Other Mental Health Specialist Teams	Community
Mental Health Community Services	Drug and Alcohol Services (Child)	Community
Mental Health Community Services	Eating Disorder Services (Child)	Community

Source: NHS Finance Manual Guidance 2010/11

Workforce

The National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004)[73] recommends a minimum ratio of 15 whole time equivalent (wte) for every 100,000 children, aged 0 to 17 years (non-teaching services) or a ratio of 20 WTE for every 100,000 (teaching services).

However, York, A. et al (2006) estimate that specialist CAMHS require 20 wte per 100,000 of the population, to meet the needs of children and young people, aged 15 years or less. In addition, this report recommends that five wte of these posts should be Primary Mental Health Workers (PMHW).

Using the National Service Benchmark (NSF) benchmark, this would suggest that Tier 3 teams in Cambridgeshire would require between 93 and 124.5 wte. Assuming that all current wte vacancies are recruited for CAMH, in Cambridgeshire, 70.4 are wte. This also assumes the NSF benchmark is for all staff, clinical and non-clinical. At 27 March CPFT had 37 clinical staff (not including learning disability admin and managerial staff).

This method of benchmarking the workforce takes no account of the skill mix within teams and the grades and experience of staff. Therefore, these figures should not be interpreted without this additional information.

Table 43 shows the local authority workforce employed in CAMHS. The data also broadly suggests that the figures are for England, apart from the local authority workforce in homes mainly for children with learning disabilities.

[73] National Service Framework for Children, Young People and Maternity Services, Department of Health, *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089114*

Table 44: Local authority workforce rate per 100,000 population aged 0 to 18 years

	Cambridgeshire	East of England	England
All local authority CAMHS workforce per 100,000 population aged 0-18 years (inclusive) (2010)	407.22	N/A	460.55
Local authority workforce specifically for children's services per 100,000 population aged 0-18 years (inclusive) (2010)	244.33	N/A	276.25
Local authority workforce in other specialist teams (such as mental health) per 100,000 population aged 0-18 years (inclusive) (2010)	85.15	N/A	102.82
Local authority workforce in homes mainly for children with learning disabilities per 100,000 population aged 0-18 years (inclusive) (2010)	51.83	N/A	18.09
Local authority workforce in community homes for children looked after per 100,000 population aged 0-18 years (inclusive) (2010)	25.91	N/A	53.28
Local authority workforce in Specialist Needs Establishments per 100,000 population aged 0-18 years (inclusive) (2010)	-	N/A	10.20

Source: Office for National Statistics / Health and Social Care Information Centre provided by Chimat (Feb 2013)

In addition to the local authority workforce, there are many CAMHS members of staff employed by the NHS. This workforce is often employed by a hospital trust and may work with adults as well as children and young people. Consequently, this workforce is difficult to meaningfully allocate to a local authority.

Key Findings – Current Services

Overall

In terms of overall NHS and Local Authority commissioned Tier 2 and above service capacity, the service would have to double or treble in size to meet estimated levels of prevalence. Therefore, this considerable unmet need is not clear when compared with elsewhere in the country. This estimate also fails to consider services provided by the voluntary sector and at Tier 1, including GP's, health visitors, school nurses and other universal provisions. It is also based on an artificial split between estimates of need at the different tiers, which takes no account of how effectively the whole system works to support children and young people.

Current NHS and Local Authority commissioned Tier 2 and above capacity, are largely focused on those aged 15/16 years and above. This means that opportunities to intervene early in the progression of some disorders may be being missed. Additionally, there is increasing evidence that the ideal age to impact on a child's development and improve social and emotional capability, is at ages 0-3 years-old.

Up-to-date and clear benchmarking information is limited. NHS Benchmarking recently began a programme on CAMH benchmarking that will in the future provide useful data, alongside the national data collection required of services, from April 2013 onwards.

Hospital Admissions

Although child and adolescent psychiatry admissions have risen for 2011/12, it is difficult to tell if this is a significant increase, given the small numbers. The numbers of admissions under the age of 18 where the primary diagnosis was a mental health disorder has risen since 2009/10, with eating disorders, mental health behaviours due to alcohol use, and depressive episodes making up 47% of admissions. The majority of admissions for children aged 0-9 are for psychological development disorders. Again, these trends are hard to interpret given the small numbers.

Cambridge and Peterborough Foundation Trust (CPFT)

Between 2011/12 and 2012/1, there has been a decrease in referrals and a 20% decrease in contacts (number of appointments). At the same time, waiting times have increased considerably across Cambridgeshire and are below the 2008/09 national benchmark. CPFT are currently running with approximately 24% vacancies in their Cambridgeshire CAMH services, which explains the pattern of reduced contacts (activity). This drop in activity correlates with feedback from patients, parents and other services for children and young people. The drop in referrals may be due annual variations in referral numbers.

Other findings include:

- Referrals and contacts increase with age but contacts (activity) are more skewed to the older age band than referrals.
- Did Not Attend (DNA) rates have decreased in Cambridge Association, to Commission Health CATCH (Cambridge City and South) but increased in Huntindgonshire and Wisbech. Overall DNA rates have remained static at 8%. Eighty-percent of DNA appointments are in eight local services.
- Hunts Health and Wisbech Locality Commissioning Groups (LCG) of GPs, had longer waiting times in 2011/12 than GPs in other LCG areas.
- CATCH make fewer referrals to CPFT than other Locality Commissioning Groups of GPs. It is not clear why this is the case.
- The quality data available (CORC and a recent peer review) shows good quality CAMH services, including good outcomes where that information is available to be benchmarked nationally.
- Transition to adult services at age 17, is still seen as arbitrary by service users, and the most common post-transition problem is a perceived lack of support from the new service (GP or adult mental health). Young people feeling prepared for transition is critical to reducing its impact.

Other commissioned counselling services

There is a higher capacity in Cambridge and the surrounding areas through Centre 33 than in Huntingdon and Wisbech, through access to the YMCA. Outcomes and capacity in the YMCA service for Fenland appear to be particularly poor, and action has been taken to address this. These are only the NHS and Local Authority

commissioned counselling services. Other counselling services are provided within schools, GP surgeries and other settings, but are not covered in this report.

Benchmarking

The benchmarking data available suggests that specialist CAMH services in Cambridgeshire may be understaffed when there are no vacancies, but this does not take skill mix into account.

Children, Young People and Parent views on services

A number of sessions were held with Children, Young People and Parents to get their views on current services, between October 2012, and January of this year. A summary of the feedback from those sessions follows:

Children and Young People

The key message from children and young people are summarised below.

What makes young people well?

- Accessible support in general is important, rather than waiting to be 'ill'.
- Support from family friends is important, as is their awareness of mental health.
- Support needs to be from friendly, approachable and empathic people.
- Being protected from harm/bullying, parents.
- Learning to deal with stress, eg exams, friends, school.

"I think that I am ok but only because of the people around me. I'm good at making friends but I struggle to keep them, sometimes too much pressure from school, bullying, rumours, being unsure of yourself, feeling alone, or family."

What should mental health workers do?

- Talk
- Sit together and work together
- Be quick
- Listen and talk through- make plans together.

"Listen, co-operate, be able to hold a conversation and not seem patronising."

What makes young people recover if they feel unwell?

- Talking both to family, friends and co-workers.
- Creative activities- art, music, sport.
- Talking to someone local, who is approachable, accessible and non-judgemental.
- Being assured that you will be ok and someone can help.
- Friends.

"Music, hanging around with people they like, talking to a friendly adult doing a hobby they love, having a pet."

How should mental health workers behave?

- Friendly, smiley
- Cool
- Respectable
- Kind
- Non-judgmental
- Not scary
- Trustworthy.

"Approachable, cool, amusing but also a good listener and understanding."

What should mental health services be like:

- Local
- Places that help with all sorts of other issues too
- In city/town centres
- Cosy
- Warm
- Accessible but not obvious what it is.

A recent study looked at understanding how young people make sense of their counselling experience in a community setting.[74] The study draws on semi-structured interviews, conducted with six young people between the ages of 16 to 22, to explore how they made sense of the experience of accessing and engaging with a counselling service in the Cambridgeshire community. It included those who had not engaged as successfully, and provided useful learning, particularly for young people who need mental health support, engage with the support and learn how to maximise engagement.

Although the sample size is small, this study provides some interesting, in-depth information feedback useful for service planning, including the following:

- Young people are likely to question the severity of their own symptoms before seeking support from their GP or another service. Their perceptions of other people's symptoms are also important, eg, "Am I more ill or less ill than other people?" The threshold set by young people was particularly high compared to professional interpretations of their symptoms.
- Young people tend to see support from their GP as relating to physical symptoms.
- Professional validation of symptoms and need for help is important in encouraging engagement, ie young people engage better when they are told that their symptoms are important and that they are have a 'right' to gain support, but this needs to be balanced against fears of stigma.
- Young people often do not understand the terminology of mental health services- such as 'counselling' and 'therapist', and will not have much knowledge of what to expect. Therefore, they will be told what the room will look like, or what they are expected to say. This lack of knowledge makes engagement harder.
- Young people were generally very ignorant of whom to see and how to get help.
- Young people find the waiting time for a service particularly challenging.
- Young people prioritised the experience of being 'cared' about by a clinician, and the clinician showing 'interest'.
- Young people recognised and valued professional detachment (someone 'separate' or removed), although they disengaged if this detachment went too far.
- Young people recognised the value of mutual collaboration and their responsibility to be involved, but again found it frightening if too much

[74] Reisert, C (2012)

responsibility was passed to them. Getting a good balance of shared power and responsibility was key.

- Young people found confidentiality very important, and needed clarity and openness on this, as well as consistent and reliable services in their information sharing.
- Young people valued a single session in terms of 'release' and 'relief'.
- Young people recognised that counselling quickly enabled them to talk to others (family, friends) and made them more able to challenge perceived or feared stigma.

Parents

A number of themes consistently came through from different events. These are summarised below.

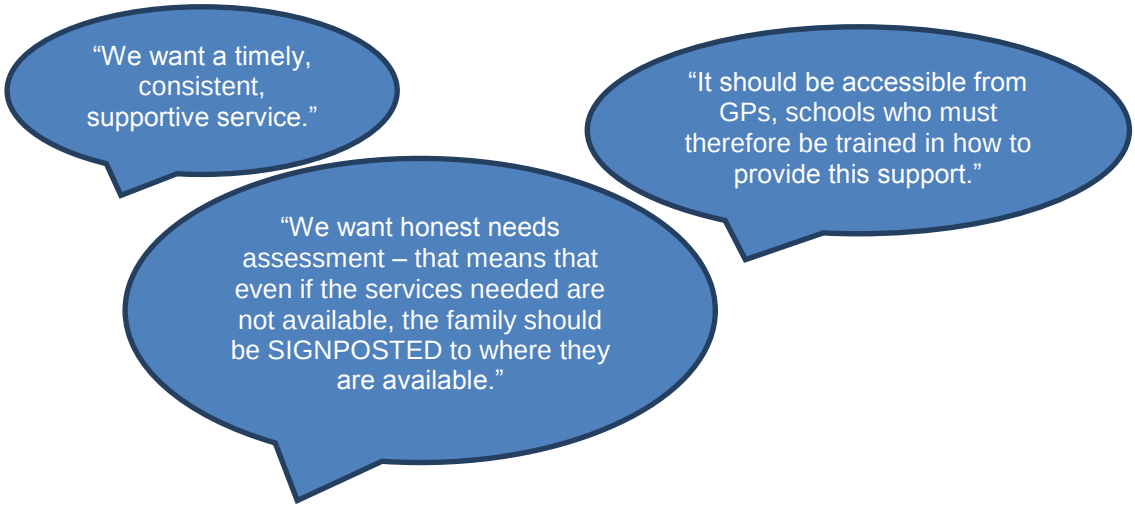
Parents wanted:

- Continuity and consistency of service and staff
- When help isn't available, parents should be signposted to other services. If there are barriers/problems these should be explained to parents along with what they are entitled to and where they can go to receive additional support. Services need to take time to learn about other services, for signposting.
- Sensitivity to children and parents is key (eg the first point of contact must be sympathetic – receptionists/telephone operators should also be trained).
- Confirmation of the minimum entitlement of the child.
- Schools to have more services available or be able to signpost.
- More interaction between schools and mental health services.
- Make information available in hard copy (do not assume parents have Internet).
- A choice of venue and shorter travel distances.
- A service that listens to parents.
- A contact person who understands the illness/condition; someone to talk to; helpline; not just leaflets.

Parents described:

- Access issues, including waiting times that were too long and a lack of local venues to visit. Parents felt there was no consideration of how to get to a venue or the most appropriate venue for the child.
- The six-month time limit on waiting lists was too long. The ability to access services via GPs or schools should exist.
- Gaps in support for parents in some areas of mental health, eg eating disorders.
- Stigma of venues' names and words used. Children and the young do not want to be seen receiving treatment, as it could lead to bullying if others learn of it.
- Gaps between child and adult services, particularly from age 17-18 years. Settings need to be age appropriate. Emotional age of a child can be different from their chronological age.

- Positive experiences of ‘Early Birds’ and ‘The Croft’.



Key Findings – Children, Young People and Parent Views

The findings of local consultation work with children, young people and parents, are described in full, above. In the consultation, children and young people describe what makes them well, what helps them recover if they are unwell and how mental health workers and services should behave and do to help.

It was also found that young people may be reluctant to seek help from GPs and did not know who to see and how to get help. They found waiting times for services particularly challenging. They valued services, but confidentiality and a good balance of shared power and responsibility between the clinician and themselves was key.

Parents want improved access and more local venues, including GPs and schools, as well as continuity and consistency of staff and service. They want clear signposting and sensitive listening services, and reducing gaps between child and adult services.

Evidence

Table 45 provides a matrix of Evidence Based Interventions taken from the ‘Children and Young People’s Emotional Health and Wellbeing Needs Assessment’ for Merseyside.[75] Since the Health Needs Assessment was published, NICE has produced three further sets of relevant guidance, listed below:

- Clinical guideline 155 – Psychosis and schizophrenia in young people.
- Public Health guidance PH40 – Social and emotional wellbeing – early years.
- Clinical guideline (currently in draft) – Conduct disorders in Children and young people (due for publication 24 April 2013).

Further work is being undertaken by the Cambridgeshire Public Health team, looking at the evidence base for ‘Early Intervention’ in mental health services for children and young people.

[75] Liverpool Public Health Observatory report series number 90, October (2012).

Table 45: Matrix of evidence based interventions

Children and Young People's Emotional Health and Wellbeing Needs Assessment Evidence Based Interventions Matrix					
	Age Range				
Level of Need	0-4 years	5-10 years	11-15 years	16-19 years	Source of Evidence
Tier 1 (universal)	Healthy Child Programme 0-5	Healthy Child Programme 5-19			Ages 0-5: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf Ages 5-19: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107566
	Routine postnatal care of women and their babies (includes 'mental health & wellbeing')				http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf
	NICE CG110 Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors				http://publications.nice.org.uk/pregnancy-and-complex-social-factors-cg110
	Positive parenting -				http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
		NICE PH7 Schools-based interventions on alcohol			http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7

	0-4 years	5-10 years	11-16	Source of Evidence
		'Resilience and Results: How to improve the emotional and mental wellbeing of children and young people in your school'. Guide for schools from the Children and Young People's Mental Health Coalition (2012).		http://tinyurl.com/93qpvuh
		NICE PH12 social and emotional wellbeing in primary education	NICE PH 20 social and emotional wellbeing in secondary education	http://publications.nice.org.uk/social-and-emotional-wellbeing-in-primary-education-ph12 http://publications.nice.org.uk/social-and-emotional-wellbeing-in-secondary-education-ph20
			NICE PH4 Interventions to reduce substance misuse among vulnerable young people	http://publications.nice.org.uk/interventions-to-reduce-substance-misuse-among-vulnerable-young-people-ph4
	NICE PH17 Promoting physical activity for children and young people			http://publications.nice.org.uk/promoting-physical-activity-for-children-and-young-people-ph17
	Training for non-mental health professionals			http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
	NICE CG45: Antenatal and postnatal mental health/depression *(overlaps into Tier 2)*			http://publications.nice.org.uk/antenatal-and-postnatal-mental-health-cg45
Tier 2 (targeted)	Family Nurse Partnership Programme			http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf
	NICE CG89 When to suspect child maltreatment			http://publications.nice.org.uk/when-to-suspect-child-maltreatment-cg89
	NICE TA102 Parent-training/education programmes in the management of children with conduct disorders			http://publications.nice.org.uk/parent-trainingeducation-programmes-in-the-management-of-children-with-conduct-disorders-ta102

	5-10 years	5-19	Source of Evidence
	NICE PH28 Looked After Children		http://publications.nice.org.uk/looked-after-children-and-young-people-ph28
	NICE CG128 Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum		http://publications.nice.org.uk/autism-diagnosis-in-children-and-young-people-cg128
	NICE CG28: Depression in children and young people: Identification and management in primary, community and secondary care		http://publications.nice.org.uk/depression-in-children-and-young-people-cg28
	Talking therapies: A four-year plan of action. Department of Health, 2011:		http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123759
Tier 3 (specialist)	Family Nurse Partnership Programme		http://www.dh.gov.uk/health/files/2012/07/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf
		NICE CG16 Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	http://www.nice.org.uk/guidance/CG16 *note on short & long term self harm guidance:* no age group given although likely to cover from 11years onwards mostly. Guidance covers any age of person who self harms, child or adult.
Tier 4 (highly specialist)		NICE 131 Self-harm: longer-term management	http://publications.nice.org.uk/self-harm-longer-term-management-cg133
		NICE CG77 Antisocial personality disorder. Although mostly about treatment of adults it does include prevention amongst children & adolescents	http://publications.nice.org.uk/antisocial-personality-disorder-cg77
	NICE CG72 Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults		http://publications.nice.org.uk/attention-deficit-hyperactivity-disorder-cg72

Acknowledgements: *original from Paula Simpson. NHS Knowsley and developed by Sharon McAteer, NHS Halton*

Appendix 1: Guide to common mental disorders in children and young people

Conduct disorder

Conduct Disorder (CD) is a group of behavioural problems where a child is aggressive, antisocial and defiant to a much greater degree than expected for the child's age.

Characteristics of conduct disorder include:

- Fighting and physical cruelty;
- Destructiveness;
- Lying and stealing;
- Truancy (including running away from home).

To get a diagnosis of Conduct Disorder, your child must have shown at least three of these characteristics over the past year, with at least one of the characteristics shown in the last six months.

There are two types of conduct disorder:

- **Early onset -** where the child shows at least one characteristic before the age of 10 (this is often associated with ADHD).

- **Adolescent-onset type** - where a child doesn't show any of the characteristics before the age of 10. This is the most common type. It is not specific to ADHD, but may occur with ADHD.

Emotional Disorders

Depression

Certain symptoms of depression, such as temporary periods of feeling low in mood, sad or tearful, are common in young people.

However, depressive illness is different in scale, with such symptoms occurring most of the time, during most days, over several weeks.

It is often accompanied by other symptoms such as:

- Losing interest and motivation to do things that used to be enjoyable.
- Withdrawing socially and not wanting to see people.
- Difficulty concentrating on schoolwork, leading to falling grades.
- Tiredness, aches and pains.
- Changes in sleeping pattern (difficulty sleeping or sleeping more than usual).
- Changes in appetite and weight (feeling more hungry or less hungry).
- Feeling useless, worthless and unloved.
- Black, pessimistic thoughts about the future.
- Thoughts of death and acts of self-harm.

These symptoms can cause distress, or difficulty coping with schoolwork or affect relationships with friends and family.

After the age of about eight, the symptom patterns of depression are similar to those of adults and include many or most of the symptoms described above. However, children and adolescents may seem irritable rather than sad, which can be confusing, particularly if the young person withdraws and shuts themselves away.

Depressive symptoms can also occur as part of other psychiatric disorders, or in physical illness. Depressed children and adolescents often have other psychiatric problems as well, such as behaviour problems or anxiety, which may mask the underlying depression.

Anxiety

Anxiety is a normal response to stress or danger. At times, it is helpful because it can prepare the body for action, and improve performance in a range of situations.

Anxiety becomes a problem when it is experienced intensely and persistently interferes with a person's daily life.

Depression and anxiety commonly occur together. Not everybody who is anxious is depressed, but most depressed patients have some symptoms of anxiety.

Obsessive Compulsive Disorder

Obsessive compulsive disorder (OCD) is a mental health condition where a person has obsessive thoughts and compulsive behaviour.

An obsession is an unwanted, unpleasant thought, image or urge that repeatedly enters a person's mind, causing them anxiety.

The word ‘obsession’ usually describes something enjoyable, but in OCD the obsession is unpleasant and frightening.

A compulsion is a repetitive behaviour or mental act that someone feels they need to carry out to try to prevent an obsession coming true.

Phobias

A phobia is more than a simple fear. It develops when a person begins to organise their life around avoiding the thing they are afraid of, whether it is an animal, object, place or situation.

A phobia is a type of anxiety disorder. If you have a phobia, you will have an overwhelming need to avoid all contact with the source of your anxiety. Coming into contact with the cause of your phobia or even the thought of this can make you anxious and may cause you to panic.

Attention deficit hyperactivity disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. Attention deficit disorder (ADD) is a sub-type of ADHD.

Common symptoms of ADHD include:

- A short attention span.
- Restlessness or constant fidgeting.
- Being easily distracted.

ADHD can occur in people of any intellectual ability. However, many people with ADHD also have learning difficulties. They may also have additional problems, such as sleep disorders.

Symptoms of ADHD tend to be first noticed at an early age, and may become more noticeable when a child's circumstances change, such as starting school.

Young children are naturally active and easily distracted. However, if these features are excessive for a child's age and general developmental level, affecting their daily life, it may indicate ADHD.

The World Health Organisation brought out a second definition in 1992, ‘Hyperkinetic Disorder’, which is a narrower definition than ADHD, comprising of the more serious cases.

Autistic spectrum disorder (ASD)

Autism and Asperger syndrome are both part of a range of related developmental disorders known as autistic spectrum disorders (ASD). They begin in childhood and last through adulthood.

ASD can cause a wide range of symptoms, grouped into three categories:

- Problems and difficulties with social interaction – including lack of understanding and awareness of other people's emotions and feelings.
- Impaired language and communication skills – including delayed language development and an inability to start conversations or fully engage in them.
- Unusual thought patterns and physical behaviour – including making repetitive physical movements, such as hand tapping or twisting (the child develops set routines of behaviour and can get upset if the routines are broken).

Attachment disorder

Attachment disorder is a broad term intended to describe disorders of mood, behavior, and social relationships, arising from a failure to form normal attachments to primary carers in early childhood, resulting in problematic social expectations and behaviors. Such a failure would result from unusual early experiences of neglect, abuse, frequent change of caregivers or excessive numbers of caregivers, lack of caregiver responsiveness to child communicative efforts and abrupt separation from caregivers from six months of age, before the age of three.

Eating disorders

Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour.

A person with an eating disorder may focus excessively on their weight and shape, leading them to make unhealthy choices about food with damaging results to their health.

Types of eating disorders

Eating disorders include a range of conditions that can affect someone physically, psychologically and socially. The most common eating disorders are:

- Anorexia nervosa - when someone tries to keep their weight as low as possible, eg, by starving themselves or through excessive exercising.
- Bulimia - when someone tries to control their weight by binge eating, deliberately making themselves sick or using laxatives (medication to help empty their bowels).
- Binge eating - when someone feels compelled to overeat.

Content from www.nhs.uk and www.netdoctor.co.uk

Appendix 2 – Characteristics of mental disorders in children aged 5 to 16 years

The following tables reveal the indicators that were found to show the greatest differences between children with a mental health disorder and those without, from the study *Mental Health of children and young people in Great Britain, 2004.*[27] These show the percentage for children with a mental health disorder, to those without mental health disorders. For example, 31% of children with an emotional disorder lived with a widowed, divorced or separated lone parent, compared to 15% of children without a mental health disorder.

Demographics	Emotional disorder	Conduct disorder	Hyperkinetic disorder
Sex	Girls (54% v 49%)	Boys (69% v 50%)	Boys (86% v 50%)
Age	11-16 (62% v 46%)	11-16 (55% v 47%)	No diff but 55% 5-10 yrs
Ethnicity	No diff	No diff	White 97% v 89%

Family characteristics	Emotional disorder	Conduct disorder	Hyperkinetic disorder
Family type	Widowed, divorced or seperated lone parent (31% v 15%)	Cohabiting parents (12% v 8%), single lone parents (14% v 7%), widowed, divorced or seperated lone parent (27% v 15%)	Single lone parent (15% v 8%), Widowed, divorced or seperated lone parent (23% v 16%)
Number of children in household	3+ siblings (37% v 32%)	4+ siblings (17% v 10%)	No diff
Stepchildren	No diff	18% v 10%	No diff

Parental eduction and socio-economic characteristics		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Parent qualifications	No qualifications	35% v 20%	39% v 20%	36% v 21%
Employment	Neither parent working	30% v 14%	34% v 14%	31% v 14%
Socio-economic classification	Semi routine or routine	48% v 38%	51% v 38%	routine (25% v 12%)

Housing and income		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Accomodation	Social sector	41%v 23%	50% v 23%	41% v 24%
Income	Under £300 gross per week	54% v 33%	58% v 33%	52% v 34%
Benefits	Claiming disability benefit	20% v 8%	20% v 8%	27% v 8 %

Area characteristics		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Acorn	Hard pressed	34% v 23%	41% v 23%	36% v 24%

Childs general, physical and mental health		Emotional disorder	Conduct disorder	Hyperkinetic disorder
General health	Fair or bad	23% v 5%	17% v 5%	18% v 7%
Physical and developmental	Specific complaint	72% v 53% - asthma, stomach or digestive problems, migraine or severe headache	65% v 53% - Bedwetting, speech or language problems, co-ordination, asthma and eyesight	70% v 54% - co-ordination difficulties, bed wetting, speech or language
Other mental disorders		27% v 5% (23% conduct disorders)	35% v 4% (19% emotional disorder, 17% hyperkinetic disorder)	66% v 8% (62% conduct disorder , 12% emotional disorders)
On medication		7%	9%	43%

Uses of services	Emotional disorder	Conduct disorder	Hyperkinetic disorder
had sought help	73%	81%	95%
had contacted a professional source	64%	76%	93%
- teachers	47%	60%	70%
- family and friends	34%	34%	35%
- primary care staff	29%	32%	46%
- specialist child mental health	24%	28%	52%
- special educational service	18%	24%	37%
- social services	10%	16%	15%
Reasons not contacted			
- belief specialist not be able to help	8%	10%	10%
- lack of awareness of services	7%	14%	15%
- difficulty in getting referral	5%	14%	23%

Scholastic ability and attendance at school		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Basic skills -	Reading	40% v 23%	56% v 21%	64% v 23%
Some or marked	Mathematics	45% v 24%	57% v 23%	63% v 25%
difficulty	Spelling	46% v 30%	64% v 29%	75% v 30%
Behind in intellectual development		44% v 24%	59% v 24%	65% v 24%
	by 2+ years	13% v 4%	36% v 9%	40% v 8%
Special educational needs		35% v 16%	52% v 15%	71% v 16%
School absence	In previous	81% v 68%	79% v 68%	No diff
	Longer	Yes	Yes	Yes
	Unauthorised	21% v 9%	28% v 8%	No diff
	Truancy	16% v 3%	22% v 3%	11% v 3%
	Exclusion	12% v 4%	33% v 2%	29% v 4%
	Excluded 3+	5% v 1%	15% v 0%	12% v 1%

Social functioning of the family		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Mental health of parent	Score of >=3 *	51% v 23%	48% v 23%	43% v 24%
	Score 9+ *	18% v 4%	14% v 4%	10% v 4%
Family functioning	FAD-GFS >2 unhealthy **	33% v 18%	42% v 17%	36% v 18%
Stressful life events				
- Parents seperation		55% v 30%	54% v 30%	49% v 31%
- Parent who had had severe mental illness		28% v 7%	17% v 7%	17% v 8%
- Parents - major financial crisis		No diff	22% v 13%	21% v 13%
- Parents - in trouble with police		No diff	15% v 5%	18% v 6%
- Child - had a serious illness that required a stay in hospital		No diff	21% v 13%	23% v 13%
Two or more stressful life events		59% v 25%	50% v 25%	47% v 26%

***** General Health Questionnaire – score 0 (no psychological distress) to 12 (severe psychological distress). A score of 3 is generally taken as the threshold with scores at this level or higher being considered indicative of an emotional disorder.

** FAD-GFS scale – 12 statements about family relationships. A score of over 2 considered to have unhealthy family functioning.

Child's social functioning		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Social aptitude	Lower quartile for ability to empathise with others	48% v 24%	69% v 22%	83% v 24%
Relationships with friends				
- found it harder than average to make friends		35% v 9%	24% v 9%	32% v 10%
- found it harder to keep friends		22% v 5%	33% v 4%	44% v 5%
- fewer than 2 friends		20% v 5%	20% v 5%	25% v 6%
- no friend to confide in		29% v 21%	35% v 20%	50% v 21%
Parental unapproval of friends		35% v 15%	46% v 14%	43% v 16%
Social support	Lowest quartile - extent of network of family and friends	42% v 27%	54% v 27%	54% v 28%
Views of neighbourhood				
- not enjoy living there		23% v 7%	21% v 7%	No diff
- unsafe walking alone in day time		18% v 6%	No diff	No diff
- few or no neighbours could be trusted		37% v 17%	32% v 18%	No diff
- unlikely lost bag would be returned		62% v 42%	65% v 42%	No diff
Help provided to others	Help family or relative	97% v 93%	84% v 94%	No diff
	Help non relatives	52% v 39%	No diff	No diff
	Sick relative	42% v 33%	No diff	No diff

Social aptitude and Social Support were assessed by using statements and then the scores being grouped into quartiles. The lowest quartile represents a quarter of the lowest scores.

Participation in groups, clubs and organisations		Emotional disorder	Conduct disorder	Hyperkinetic disorder
Group club or organisation	School based	68% v 79%	56% v 79%	59% v 78%
	Outside school	55% v 67%	55% v 67%	No diff
	Do not want to participate	28% v 15%	22% v 15%	-

Smoking drinking and drug use	Emotional disorder	Conduct disorder	Hyperkinetic disorder
Smoke (11 - 16 yrs)	23% v 8%	34% v 8%	21% v 9%
Drug use (11 - 16 yrs)	20% v 8%	28% v 8%	23% v 8%
Drinking (14 - 16 yrs)	23% v 17%	32% v 16%	28% v 17%

Self harm	Emotional disorder	Conduct disorder	Hyperkinetic disorder
Parents view (all ages)	14% v 2%	16% v 2%	14% v 2%
Parents view (11-16 year olds)	19% v 2%	18% v 2%	14% v 3%
Child self reported (11-16 year olds)	28% v 6%	21% v 6%	18% v 7%