Croydon Joint Strategic Needs Assessment 2012/13

Key-Topic 1: Emotional Health and Well Being of Children and Young People aged 0-18

The data in this chapter was the most recent published data as at (2012). Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the source shown under figures or listed in the appendices for the chapter for the latest information.

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1 Executive summary

1.1 Introduction

This chapter forms part of the overall 2012/3 Joint Strategic Needs Assessment (JSNA) which focuses on mental health. This chapter focuses on the mental health needs of children and young people aged 0-18 years of age. It should be read in combination with the O*verview Chapter* which focuses on prevention of mental health problems.

The aim of the children and young people's chapter is to provide an overview of current and future need, to identify gaps and assets in the management of children and young peoples' emotional health and well-being and to identify priorities for future development.

The intention of this JSNA deep dive is to also support the development of an updated Croydon wide strategy, but to also to inform commissioning intentions for future service provision.

1.2 Background

Most mental illness begins before adulthood. Half of all lifetime cases of diagnosable mental illness begin by the age of 14 and three quarters by the mid-20s. Mental health problems frequently start early in life. They can persist over long periods and affect people at crucial stages of life. Poor mental health in children and young people is associated with teenage pregnancy, bullying, violent and criminal behaviour and substance misuse. The majority of adults with mental health problems experienced mental health difficulties in childhood. These problems not only persist through adulthood but can also have an impact on the next generation.

The development of emotional health starts before a child is born, and the first two years of life are a critical period for laying the foundations for emotional health throughout childhood and into adult life, in particular through the parent/child relationship.

It is widely recognised that children who experience negative parenting, poor quality relationships and adversity in early life are at particular risk of a number of poor outcomes later on, including mental health problems. As children grow and become young adults, they need a stable and nurturing environment that supports them to develop independence and reliance, and promotes positive self-esteem.

Most children and young people are part of happy and healthy families, and their parents provide the primary support for their emotional development. Supporting

parents and carers is the key way of promoting children's mental health and well-being during the perinatal phase and in the early years. A secure parent/child relationship is a key component for the development of positive attachment and helps to build emotional resilience in children.

For older children and young people, support for parents and carers remains important. Schools, colleges and other organisations however can also enhance children and young people's emotional well-being, by reducing risk-taking behaviours, fostering the development of resilience and self-esteem and contributing to the development of social and emotional skills.

A range of other factors can also positively influence emotional health – in particular a child's everyday experiences; their friendships and peer network; and their experience of participating in play, sport and other extra-curricular activities in the community. This means that a wide range of public and voluntary sector services have a role in promoting emotional health and well-being.

Children and young people's emotional health and well-being is a key priority for Croydon's Children and Families Partnership and Croydon Health and Well-Being Board. Children and young people who are emotionally healthy achieve more, participate more fully with their peers and their community, engage in less risky behaviour and cope better with the adversities they may face from time to time. Emotional health in childhood has also important implications for health and social outcomes in adult life[1]

1.3 Prevalence of mental health need amongst children and young people in Croydon

It is estimated that during 2011, there were approximately 21,000 children and young people in Croydon with some form of mental health need and it has been estimated that this figure will rise to approximately 24,000 by 2021.

There is relatively little data about prevalence rates for mental health disorders in pre-school children. However, applying prevalence rate estimates generated from available research, it has been calculated that currently there are an estimated 4,198 children aged 2-5 years inclusive living in Croydon who may have a mental health disorder.

Similarly, research based prevalence estimates applied to school aged children aged 5-16 years of age has suggested that during 2011, there were 6343 boys and 4320 girls with a mental health disorder. Children aged 11-16 years of age are more likely to experience mental health problems than those aged 5-10 years of age.

In relation to specific mental health disorders, the most prevalent disorder type are conduct disorders, such as aggression and anti-social behaviour .It is estimated that

there are currently 3,300 children and young people with these types of disorders in Croydon, with the highest prevalence seen amongst boys aged 11-16.

The second most prevalent disorder type are emotional disorders, such as depression and anxiety. Approximately 2,100 young people in Croydon have emotional disorders, with the highest prevalence seen in girls aged 11-16 years.

Hyperkinetic disorders are 6-7 times more common in boys than girls, with the highest prevalence in boys aged 5-10 years.

Additionally, the number of children with autistic spectrum disorders (ASD) is set to rise significantly by 2021, with the number of children with autism (diagnosed) amongst 0-18 year olds expected to rise from 881 in 2012 to 1414 in 2021.

Currently, there are approximately 13,624 children and young people needing Tier 1 CAMHS services as opposed to 1,680 and 68 children and young people who are estimated in need of CAMHS services at Tiers 3 and 4.

1.4 Intervening Early

There is increasing evidence of the cost benefit of early intervention using evidence-based programmes and methods. For example, by the time they are 28 years old, individuals with persistent antisocial behaviour at age ten have cost society ten times as much as those without the condition. As conduct disorder is the most common mental disorder in childhood, the scale of the problem is very wide – and costly. At the same time, however, there is strong evidence to show that parent education and training for parents of young children can reduce behaviour and conduct problems, and that this can have medium to long term effects.

The importance of psychological well-being in children and young people, for their healthy emotional, social, physical, cognitive and educational development is widely accepted. There is widespread evidence of the effectiveness of early interventions to improve children's and young people's resilience, promote emotional health and well-being, and treat mental health problems and disorders including those children and young people with severe disorders who may need tertiary level services.

Early Intervention is at the core of the Governments approach to improving outcomes for children and families. This is clearly set out in the public health White Paper *Healthy Lives, Healthy People*[2] and the mental health strategy *No Health Without Mental Health*[3] as well as the recommendations of Graham Allen's review of early intervention.[4]

Prevention and early intervention makes sense, both ethically and financially. Intervening as early as possible can help to prevent those early indicators of problems occurring or escalating. While the benefits of intervening early are not doubted, introducing more early intervention services can be challenging for commissioners, particularly when resources are limited and the need within the

acute sector continues to grow. There is clear research to support the case for greater investment in early intervention and re-prioritising resources to this end of the spectrum.

1.5 Evidence base

There is an increasing evidence base of interventions that have a positive effect on mental health outcomes for children and young people. It is therefore essential that commissioners invest in commissioning services for good outcomes by using evidence of what works.

The National institute for Health and Clinical Excellence (NICE) and the CAMHS Evidence Based Practice Unit at University College London have produced a wealth of public health and clinical guidelines, technical appraisals, as well as suggested quality standards and care pathways and an overview of key sources of information are listed in the JSNA document.

1.6 Vulnerable groups

The needs of children and young people in vulnerable groups are not always met by local services, and targeted services remain less well developed than other aspects of CAMHS delivery. This may be because the needs of these children and young people are not always apparent or because local services are not in place or not sufficiently flexible or accessible to respond effectively.

Particular groups to be taken into account include:

- Children with learning difficulties and disabilities;
- Children with Autism Spectrum and Attention Deficit Disorders
- Looked After Children
- Refugees and asylum seekers
- Young offenders
- Teenage parents
- Lesbian, gay, bisexual and transgendered young people
- Children with physical disabilities
- Homeless young people

1.7 Services for children and young people

There are a wide range of services available in Croydon providing CAMHS support though there are significant limitations in the availability, specificity and completeness of data available. As a consequence it was difficult to accurately assess and suggest where significant gaps existed in local service provision in order to accurately quantify and recommend the level of improvement needed. There is a paucity of information on mental health outcomes and data which is acknowledged nationally. Improvements are however needed in the collection and evaluation of mental health data going forward from all associated services including universal services and GPs, and not just specialist commissioned CAMHS services.

It is important to recognise and assert that supporting children and young people with mental health needs is not just the responsibility of specialist CAMHS services. In many cases, the intervention that makes a difference can come from another service (for example schools and colleges and children's centres) and should be identified and dealt with as early as possible. It should also be noted that lack of provision in one service can impact on the ability of other services to be effective.

Partnership working is an essential requirement of high quality service provision, as well as local awareness of the level and type of support available to children with mental health needs and their families. Local practitioners should support families to negotiate their way through the system and help ensure they are signposted or referred appropriately to receive the help and support they need in a timely manner.

The JSNA identified that practitioners from a wide range of local children and young people's services were unclear of what support was available to children and their families and as a consequence referrals were either not being made or being referred inappropriately. Greater awareness and improved information is needed not only for local practitioners, but also for young people and parents and carers. Improved awareness of local care pathways and associated referral criteria should also be prioritised to also minimise inappropriate referral to specialist CAMHS services.

In order to support local practitioners to take more responsibility in the contribution they can make to supporting children and young people's mental health and well-being, improved training provision must also be prioritised.

1.8 Improving Access to Psychological Therapies (IAPT)

Children and young people's IAPT is a new initiative developed to extend access to psychological therapies to children and young people. This initiative is expected to be provided by Specialist CAMHS services often in partnership with voluntary sector organisations to provide evidence-based treatments. There has been additional money dedicated to this programme to help develop local capacity through the provision of training to targeted and specialist CAMHS staff. Croydon has been successful in securing some of this funding from the Department of Health in order to increase the number of local practitioners that can offer psychological therapies to children and young people in a range of settings.

1.9 Commissioning and investment

It has been suggested that the cost of treating child and adolescent mental health problems could double over the next 20 years. There are however strong arguments that increasing focus on prevention and provision of early intervention could save money later.

There has been significant disinvestment in local CAMHS provision over the last four to five years, with Croydon having the lowest level of spend on CAMHS in South

West London despite having the largest child population. Croydon Council and Croydon Commissioning Group are facing severe financial challenges which present difficult choices as to the priority for spend, particularly in an atmosphere of needing to deliver more for less. As a consequence an urgent review is needed of the current funding and scope of local commissioning of CAMHS related services. This review should also take account of the funding gap in relation to need and make recommendations for future commissioning priorities. It is recommended that the new Integrated Commissioning Unit help support this activity once it is in place.

1.10 Experiences of service users and carers

The chapter findings were informed by consultation with children and young people as well as associated stakeholders and parents and carers. A number of consultation exercises were undertaken including surveys and questionnaires, interviews and consultation workshops. Examples of some of the findings included:-

- Local CAMHS services were found to be generally good for those who had accessed them.
- Greater provision of support services were needed in schools and colleges.
- There is a need to improve awareness of local services, particularly counselling services.
- Although many young people identified they would approach their GP for advice and support with a mental health issue, few had found it easy to talk to their GP and felt that their concerns were not taken seriously.

1.11 Next Steps

An improved strategic approach to improving the emotional health and well-being of children and young people is urgently needed. It should be part of an integrated approach to promotion, prevention, early intervention and treatment of mental health problems and underpinned by the evidence base and local needs analysis. Action across the age ranges, addressing risk and protective factors in a number of settings is also essential to improve the emotional health of all children and young people. Support in the early years, driven through the Early Years Foundation Stage and Healthy Child Programme (for pregnancy and the first five years of life), is particularly important in terms of a long-term impact on the emotional health of children as they grow up.

A high level strategic overview is necessary to ensure that the activities of the different services are co-ordinated and complementary. This should be owned by the Children's Trust Board and any delegated governance arrangements for emotional wellbeing and mental health; and reflected in the Children and Young People's Plan as necessary.

2 Summary of Recommendations

2.1 Strategy, Governance and Commissioning

Draft Recommendation: Strategy Development

- Develop a holistic Children and Young Peoples Emotional Health and Well-Being Strategy across the whole system to improve the emotional health and well-being of children and young people in Croydon. The strategy should include the following key elements: - health education and health promotion, prevention and early intervention, specialist services and treatment, training for associated staff groups and the involvement and participation and involvement of children and young people and their parents and carers as part of the comprehensive plan (Timescale: Nov 2013)

Draft Recommendation: Funding

- Review the funding of local CAMHS services and suggest recommendations for commissioning priorities for 2014-15, taking account of the funding gap and in relation to need. (Timescales: In year 2013/14).

Draft Recommendation: Strategic Governance

- Croydon Children and Families Partnership Board to provide leadership around the issue of children and young people's emotional health and well-being, using appropriate local strategic structures, with representation from relevant local authority services, CCG and community health providers, associated mental health trust and voluntary sector services, and ensure that key senior managers act as champions.

Draft Recommendation: Ethos and values

- Develop a coherent vision and ethos that parents, managers and frontline staff can understand, commit to and be part of in order to underpin improvements in this area of work. Particular emphasis should be placed on service and individual responsibilities and the importance of relationships and resilience. (Timescales: 2013-14)

Draft Recommendation: Evidence base and best practice

- Improve awareness of the evidence base and best practice amongst commissioners and providers. (Timescales: 2013-14 and on-going).

Draft Recommendation: Data and Performance Monitoring

- Develop a CAMHS minimum data set to improve the assessment and monitoring of locally commissioned services activity, quality and improvement in associated

outcomes. *N.B. National CYP IAPT measures must be considered as part of any new data set and outcome measures in order to support national comparisons.* (Timescales: November 2013)

Draft Recommendation: Service Specifications

- Commissioners to ensure the consideration and delivery of CAMHS services are explicitly included in relevant service specifications and contracts with acute, community health and local authority providers, particularly maternity services and child health services including health visiting, school nursing, children centre provision and early years, homelessness and supporting people etc. (Timescales:2014-15 and on-going)

Draft Recommendation: Service Specifications

- Commissioners to ensure that local service specifications for commissioned CAMHS services take account of appropriate evidence base and best practice guidance, and where services are not meeting recommended practice, that plans are drawn up to address this as part of the service level agreement. Children and young people, particularly vulnerable groups of young people should also be consulted and involved in the development of locally commissioned services (Timescales: 2013/14 and on-going)

Draft Recommendation: At risk groups of children and young people

- Commissioners to consider improving access to mental health services for at risk groups of children and young people (such as children in need, children in care, those with disabilities, young offenders, young refugees, BME young people, young cares and those with behavioural, emotional and social difficulties) subject to resource constraints. (Timescales: 2013-15)

Draft Recommendation: IAPT

- Commissioners to explore opportunities to develop and increase Children's IAPT services further from 2013-14 onwards, so that more children have timely access to evidence based psychological therapies. (Timescales: In year 2013/14)

Draft Recommendation: Specialist CAMHS services

- Commissioners to ensure Specialist CAMHS services meet national standards as set out in associated NICE guidance and the CAMHS NSF. A comprehensive service review and the development of creative solution focused initiatives should be prioritised (e.g. ASD/ADHD shared care protocol) in order to address waiting lists and other pressures on specialist CAMHS services. (Timescales: 2013-15)

Draft Recommendation: Parents and Carers

- Commissioners to ensure that parents and carers (including foster carers and adoptive parents) can access advice and support when they are concerned about

their children's mental health. This should include improving awareness of local CAMHS services so appropriate referrals can be made and integrated support developed. (Timescales: In year 2013/14)

2.2 Provider Services

Draft Recommendation: Local Service Offer

- The Children and Families Partnership to clarify expectations of what universal services should do at Stages 1 and 2 of *Croydon's Model of Staged Intervention* and the local offer at Stages 3 and 4 (Timescales: 2013/14)

Draft Recommendation: Universal Offer

- Increase the support and information provided from universal services to families, and children and young people in need of mental health services. (Timescales: 2013/14)

Draft Recommendation: Early Intervention

- Improve the identification, assessment and early intervention undertaken in universal services to address emerging mental health needs of individual children and young people and ensure increased provision and delivery of Tier 1 CAMHS services in these settings. Increased provision of Tier 2 services should also be developed in universal settings.(Timescales: 2013-15)

Draft Recommendation: Schools and Colleges

- Schools and colleges should adopt a 'whole school' approach to supporting pupils' wellbeing and resilience, with an emphasis on strengthening and building protective factors. This should include both universal approaches, and targeted services for children and young people with, or at risk of developing, behavioural difficulties or emotional problems as part of strengthening the approach to inclusion. Mental health stigma should also be tackled in schools and colleges and ensure pupils, students and staffs awareness around emotional health and well-being is improved so they know when to seek help, and how to improve their own emotional health and well- being. (Timescales: on-going)

Draft Recommendation: Referrals and Care Pathways

- Specialist and Universal CAMHS providers to review local care pathways and improve the awareness and understanding amongst local professionals of associated referral mechanisms, protocols, and care pathways to support appropriate and timely intervention. (Timescales 2013-2015)

Draft Recommendation: Training and Development

- Improve training available to practitioners by evaluating current provision and ensuring a more coherent local offer for all relevant staff service groups. (Timescales: 2014)

Draft Recommendation: Transition

- Review service delivery including joint working and transition arrangements between CAMHS and AMHS and ensure an updated CAMHS transition plan and pathway is developed and clearly defined and signed up to by CAMHS and AMHS. Services should also ensure that high quality services at the point of transition are in place, including services for young people in out-of area placements. (Timescales: 2014)

3 List of Stakeholders Involved

Children and Families Partnership Board

Health and Well Being Board

Children and Families Partnership: Be Healthy Sub Group

CAMHS Partnership Commissioning Group

Emotional Health and Well Being in Schools Task Group

SLAM CAMHS Service –Croydon

Croydon Borough Council

NHS South West London –Croydon Borough Team

Croydon Health Services

Croydon Drop-In

Off The Record

Place2Be

Parents in Partnership

The Bridge

Croydon Voluntary Action

HealthWatch

Parents and Carers

Young People

4 Introduction

4.1 Background

Mental illness is cited as the single greatest source of burden of disease in the UK. No other health condition equals mental illness in the combined magnitude of prevalence, persistence and breadth of impact. Mental illness is regularly associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour. Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year.[5]

Most mental illnesses begin before adulthood and often continue through life. Half of all lifetime cases of diagnosable mental illness begin by the age of 14 and three quarters by the mid-20s.

This represents a strong contrast with physical health problems. The prevalence of all major physical health conditions shows a pronounced age gradient and the burden of physical ill health is now increasingly concentrated in old age. Mental health problems, on the other hand, frequently start early in life. They can persist over long periods and affect people at crucial stages of life: in the early years, during school, through the transition from school into adulthood into the world of work and self-management, partnership and family formation and citizenship.

It is widely recognised that children who experience negative parenting, poor-quality relationships and other adversity in early life are at particular risk of a number of poor outcomes later on, including mental health problems. As children grow and become young adults, they need a stable and nurturing environment that supports them to develop independence.

Risk factors for mental illness in childhood can be grouped as child, parental and household factors. Regarding parental factors, alcohol, tobacco and drug use during pregnancy increase the likelihood of a wide range of poor outcomes that include long-term neurological and cognitive–emotional development problems. Maternal stress during pregnancy is associated with increased risk of child behavioural problems, low birth weight is associated with impaired cognitive and language development, poor parental mental health with four- to five-fold increased risk of emotional or conduct disorders and parental unemployment with two- to three-fold increased risk of emotional or conduct disorders in childhood. Child abuse and adverse childhood experiences result in several-fold increased risk of mental illness and substance misuse later in life. Looked-after children, children with special

educational needs (SEN), lesbian, gay, bisexual and transgender (LGBT) young people and young offenders are also at particularly high risk of poor mental health.

Early mental health problems have identifiable and, in many cases, preventable risk factors. Effective treatments are available for many disorders, as described in NICE guidelines. Some of these interventions have extremely high returns. It is therefore important that we target our services effectively to meet the needs of children and young people at particular risk of developing persistent mental health problems.

Tackling mental health problems early in life will improve educational attainment, employment opportunities and physical health, and reduce the levels of substance misuse, self-harm and suicide as well as family conflict and social deprivation. Overall, it will increase life expectancy, economic productivity, social functioning and quality of life. It will also have benefits across the generations.

4.2 Aim of needs assessment

Children and young people's emotional health and well-being is a key local priority for Croydon Children and Families Partnership, and as a consequence it is one of the four main concerns for the Children and Families Partnership: Be Healthy Sub-group.

The Children and Families Partnership: Be Healthy Sub-Group was tasked in 2012-13 to review Croydon's Child and Adolescent Mental Health Strategy. It was therefore agreed by the Health and Well-Being Board and the Children and Families Partnership that it was essential that a comprehensive joint strategic needs assessment (JSNA) be undertaken to identify the range and extent of emotional and mental health issues being presented by children and young people aged under 19 in Croydon.

This intention of the JSNA deep dive was not only to support the development of an updated Croydon wide strategy, but to also inform commissioning intentions for local service provision in the future.

The deep dive chapter will explore the case for improved local public health policy and education, early intervention and CAMHS service provision for those children and young people presenting with poor emotional health and well-being and clinical mental health conditions in Croydon.

Aim: to provide an overview of current and future need, to identify gaps and assets in the management of children and young peoples' emotional health and well-being and to identify priorities for future development.

Scope: a population approach for children and young people aged 0-18 years of age to estimate and identify the level and type of mental health need amongst this age group in Croydon. Consideration of peri natal mental health of pregnant and new mothers will also be taken into consideration due to the potential impact this has on new born and young children's attachment behaviour and development of poor emotional health from an early age.

Key concerns identified at the start of the deep dive:

- Lack of available data on current and proposed estimates of future need
- Need to improve the early identification and intervention for children and young people with mental health issues
- Long waiting lists and increasing thresholds for referral to some services provided by South London and Maudsley Child and Adolescent Mental Health (SLAM CAMHS) Specialist services
- Overall lack of capacity within the wider CAMHS network to respond to the large number of children and young people in need of services.
- Lack of awareness of practitioners and parents and carers of local services and associated care pathways.
- Local transition arrangements between CAMHS and Adult Mental Health Services (AMHS).
- The need to review local commissioning plans to meet the greatest level of need and ensure the best outcomes.

4.3 Methodology

Various methods and sources were used to gather information in relation to the mental health needs of children and young people aged 0-19, in order to understand the situation in Croydon better and to recommend improvements going forward.

The JSNA deep dive sought to answer a range of key questions including:

Why is meeting the mental health needs of children and young people important? How does the perinatal mental health of mothers affect the mental health of their offspring? Who is most at risk? Literature review

What should we be doing? Where should our efforts be focussed? What are the policy drivers? Literature review looking at national and local policy and guidelines.

What type and level of need exists in our children and young people in Croydon, and how may this change in the future? Analysis of populations (epidemiological) data combined with estimates of prevalence.

How many children and young people with a mental health need receiving a service? What services do we provide? How good is local access? What are the gaps? Data on service provision, activity and outcomes from commissioners, providers and national datasets.

What do people think of the services we provide? What are we doing well? What could we do better? Consultation with stakeholders

The JSNA process was supported by the CAMHS Partnership Commissioning Group, where the JSNA process was a standing item at their monthly meetings. The

group had representation from public health, commissioning (NHS and Local Authority) and providers (NHS and voluntary sector).

4.4 Literature review

A literature review was undertaken and published articles and reports were collected from systematic reviews, guidelines, and health and social care data bases (Cochrane, Dare, Medline, Cinahl, Psych Info, Embase, Social Policy and Practice, Social Care Online, NHS Economic Evaluation Database, TRIP, Open SIGLE).

4.5 Limitations

The information gathered from the consultation exercises helped to enrich the quantitative analysis by providing vital qualitative feedback, which would help to frame and provide an invaluable additional perspective to this important piece of needs analysis. However limitations were met in both the quantitative and qualitative methods used. As a consequence, there were important limitations to the approach undertaken which should be borne in mind.

Data

The needs analysis was limited by the availability and specificity of up to date data from a range of associated national and local datasets. For example, there was limited specific mental health specific data available from Children's Social Care, Education Psychology and Croydon Health Services.

Practitioner completeness, poor recording and coding of data amongst other databases (e.g. GP data) also led to limitations in the analysis able to be undertaken.

Improvements in mental health data particularly from universal and early intervention services is needed going forward.

Participants

Given the time and resources available we could not hope to represent the views of all children and young people affected by poor mental health as well as that of their parents and carers. Considerable effort was made to try and gather the views of as many specific groups of young people as possible and particularly the views of vulnerable children and young people. As a consequence feedback was gathered from over 250 young people through a variety of means. The majority of feedback provided came from children and young people aged 10-18. Some limited feedback was also provided from parent and carers.

Had more capacity been available then more attempt could have been made to gather further feedback from parents and carers and younger children and also the views of pregnant and new mothers who had experienced perinatal mental health issues.

5 Description of Child and Adolescent Mental Health

5.1 Mental Health

'A state of well- being in which every individual realises his or her own potential, 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' [6]. The term 'mental health' is used in a positive sense and does not mean to imply the absence of mental illness.

Mental health in young people is indicated by:

- A capacity to enter and sustain mutually satisfying personal relationships.
- Continuing progression of psychological development.
- An ability to play and to learn so that attainments are appropriate for age and intellectual level.
- A developing moral sense of right and wrong.
- The degree of psychosocial distress and maladaptive behaviour being within normal limits for the child's age and context

5.2 Emotional Well-Being

'A positive sense of wellbeing which enables an individual to be able to function in society and meet the demands of everyday life; people in good mental health have the ability to recover effectively from illness, change or misfortune.'[7]

5.3 Difference between a mental health disorder and a mental health problem

A useful distinction is often drawn between mental health problems which indicate a disturbance of mood or behaviour in only one functional area, and mental health disorders defined as either a severe and /or persistent problem or the co-occurrence of multiple problems.

Mental health problems (e.g. sleep or feeding difficulties, abdominal pain without organic cause, severe tantrums, tic disorders, educational difficulty and simple phobias) are more prevalent than disorders (e.g. manic depression, schizophrenia, anorexia nervosa and attempted suicide).

Language and culture are central considerations in discussions about mental health, with huge variation seen in the range of terminology, descriptions and understanding of different mental health issues by different groups of professionals and local communities. For example, people working within education services might refer to young people who are experiencing 'emotional and behavioural' problems, while those working within health services might speak of 'psychiatric disorder' or 'psychological difficulty'.

5.4 Developing Adolescent Brain

Adolescence is the period between childhood and adulthood encompassed by changes in physical, psychological, and social development.[8] These alterations

make this period a time of vulnerability and adjustment.[9] It is well documented that that adolescents engage in behaviors that increase their likelihood of death or illness by driving a vehicle after drinking or without a seat belt, carrying weapons, using illegal substances, and engaging in unprotected sex resulting in unintended pregnancies and STDs. This serves to highlight the importance of understanding risky choices and behavior in adolescents.

Adolescence is also a time of increased emotional reactivity. During this period, the social environment is changing such that more time is spent with peers versus adults, and more conflicts arise between the adolescent and his/her parents[10]. These changes in social interactions may influence the rise of emotional reactivity. Greater emotional reactivity and sensitivity during adolescence may play a role in the higher incidence of affective disorder onset and addiction during this developmental period[11],[12].

5.5 Classification

The term mental disorder which has been defined in the International Classification of Diseases (ICD-10) as a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions. (Table 1).[13] It is important to note that a child may have more than one disorder or cluster of symptoms.

Table 1 – International Classification of Diseases

A classification of mental disorders	Examples
Emotional disorders	Phobias, anxiety states and depression. These may be made manifest in physical symptoms such as chronic headache or abdominal pain.
Conduct disorders	Stealing, defiance, fire-setting, aggression and antisocial behaviour.
Hyper-kinetic disorders	Disturbance of activity and attention.
Development disorders	Delay in acquiring certain skills such as speech, bladder control and social ability. These disorders may affect one area of development, or pervade a number of areas, as in children with autism.
Eating disorders	Pre-school eating problems, anorexia nervosa and bulimia nervosa.
Habit disorders	Tics, sleeping problems and soiling.
Post-traumatic syndromes	Post-traumatic stress disorder.
Somatic disorders	Chronic fatigue syndrome.
Psychotic disorders	Schizophrenia, manic depressive disorder or drug-induced psychoses.

5.6 What do we mean by CAMHS?

There are many services that contribute towards the mental health and psychological wellbeing of children and young people including health, education, social care and other agencies such as youth justice. High quality child care, regular sport and exercise, Personal Social Health Education (PSHE), anti-bullying policies and confidence building activities in schools are just a few examples of how universal services play an essential role in the promotion of good mental health and ensuring children and young people with mental health need be part of everyone's agenda.

Child and adolescent mental health services (CAMHS) is delivered in line with a four-tier strategic framework which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.[14]

Most children and young people with mental health problems will be seen at Tiers 1 and 2. However, it is important to bear in mind that neither services nor people fall neatly into tiers. For example, many practitioners work in both Tier 2 and Tier 3 services. The term CAMHS is often associated by professionals only with the Specialist Tiers 3 and 4 services, however CAMHS professionals can also work in schools and colleges, GP practices, alongside social services and in a variety of other settings. There are a wide range of professionals and groups that can support and improve a child or young person's psychological wellbeing. Many will also operate at a universal level such as midwives, school teachers, school nurses and community workers and will support all children and young people in their development.

There is often a misconception that a child or young person will move up through the tiers as their condition is recognised as more complex. In reality, some children require services from a number (or even all) of the tiers at the same time.

The model is not intended as a template that must be applied rigidly, but rather as a conceptual framework for ensuring that a comprehensive range of services is commissioned and available to meet all the mental health needs of children and young people in an area, with clear referral routes between tiers.

Tier 1: A primary level of care

CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.

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: A service provided by specialist individual professionals relating to workers in primary care

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services).

For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders

This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists, family therapists.

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.

These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, general psychiatric adolescent and children's inpatient units and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one borough or region.

5.7 Policy Context

5.7.1 National

Giving every child the best start in life was the key priority recommendation in the Marmot review of health inequalities.[15] Marmot observed that disadvantage starts before birth and accumulates throughout life. The review stated that action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.

The government White Paper *Healthy Lives, Healthy People* [16] adopts a life-course perspective to address the wider social factors that affect people's health at different stages of their lives. A comprehensive and holistic approach to child and adolescent

mental health is championed, with an emphasis on life stages, transitions and child poverty.

Giving equal weight to both mental and physical health, the White Paper draws on the evidence of the Marmot review to emphasise early intervention and prevention as opposed to better treatment, particularly in the crucial childhood and teenage years. Consequently, *Starting Well* and *Developing Well* are two key life stages defined in the White Paper, where physical and mental health can be most strongly influenced. Enabling good health in mothers before, during and after pregnancy is highlighted as a critical factor in giving every child the best start in life. Identifying, treating and preventing health problems, and creating resilience and self-esteem, as children negotiate the transition into adulthood, are subsequently seen as significant for supporting the development of independence. In every aspect of development, wellbeing and mental health are essential to our quality of life. All too often 'mental health' is seen as being focused solely on people with mental health problems who are being treated in specialist services, and not as a positive resource that needs to be nurtured.

In a review undertaken in 2011 of Marmots Indicators, the London Public Health Observatory concluded that addressing health inequalities was as important as ever, finding that almost half of all children entering school do not exhibit a 'good level of development. [17]

Steps to strengthen and support children and young people's emotional health and well-being and mental health are a key priority for the coalition government. Their recent mental health strategy *No Health without Mental Health* [18] outlines the Government's aspiration to mainstream mental health in England and gives prominence to the view that mental health is everyone's business, as set out by the caption 'a cross-government mental health outcomes strategy for people of all ages'. Considerable weight is particularly placed on early intervention to stop serious mental health issues developing, particularly amongst children.[19]

The six key objectives of the national strategy are:-

- More people (of all ages and backgrounds) will have good mental health;
- More people with mental health problems will recover;
- More people with mental health problems will have good physical health;
- More people will have a positive experience of care and support;
- Fewer people will suffer avoidable harm;
- Fewer people will experience stigma and discrimination.

For each of these high level objectives, the strategy identifies the key elements which will ensure the areas for improvement which will have the biggest effect on mental health outcomes as well as outlining effective evidence-based interventions,

with examples of good practice to assist local commissioners in meeting the needs of the local population.

In order to realise the objectives set out in this strategy, local areas need to strike the right balance between commissioning services for those with mental health needs and with the broader public health priorities to ensure effective education and prevention, as well as guaranteeing improving levels of early identification and intervention.

The recent Children and Young People's Health Outcomes Framework report particularly highlighted the importance of awareness raising and training.[20] The report noted that those who work with children outside of the NHS, such as youth workers, children's centre workers and teachers have an important contribution to make to improving health outcomes, but that their training in mental health is too often minimal or non-existent.

It is expected that a Mental Health Outcomes Framework dashboard and minimum data set will be developed over time in order that local areas can assess any weaknesses and improvement needed in achieving the six key objectives. It is proposed that an indicator will be included to maintain the monitoring of the emotional health and well-being of looked after children.

In June 2010, the government at that time commissioned Frank Field to chair an independent review on child poverty and life chances. Many of the findings and recommendations are relevant in relation to improving children and young people's emotional health and well-being. The review found overwhelming evidence that children's life chances are most heavily based on their development in the first five years of life. The things that matter most are a healthy pregnancy; good maternal mental health; secure bonding with the child; love and responsiveness of parents along with clear boundaries, as well as opportunities for a child's cognitive, language and social and emotional development.[21]

The review highlighted that later interventions to help poorly performing children can be effective but, in general, the most effective and cost-effective way to help and support young families was in the earliest years of a child's life.

Research has shown that by the age of three, a baby's brain is 80% formed and his or her experiences before then shape the way the brain has grown and developed and ability profiles at that age are highly predictive of profiles at school entry. By school age, there are very wide variations in children's abilities and the evidence is clear that children from poorer backgrounds do worse cognitively and behaviourally than those from more affluent homes. Frank Field's report asserted that schools do not effectively close that gap; children who arrive in the bottom range of ability tend to stay there.

There are a range of services available to support parents and children in those early years and beyond. It is therefore essential that those families and children who would benefit from local support and early intervention are aware of the availability of this provision and are able to access services easily and quickly.

Graham Allen was also commissioned by the government to undertake an independent report on early intervention, which published in 2011 built on the findings and recommendations in Frank Fields review. In Graham Allen's report, he used the term *Early Intervention* to refer to the general approaches, and specific policies and programmes, which help to give children aged 0–3 the social and emotional foundation they need to reach their full potential; and to those which help older children become the good parents of the future.[22] Allen's report asserted that many of the expensive and damaging social problems in society are created because we are not giving children the right type of support in their earliest years.

The report highlighted the economic benefits of early intervention and provided examples of programmes that demonstrated good returns on investment, such as the Family Nurse Partnership. The report emphasised that intervening later is more costly and often cannot achieve the results that early intervention is able to deliver, and yet demonstrated that frequently there is little expenditure on early intervention in comparison to later interventions and that we need to redress this balance. Huge parallels can be found in Allen's report with respect to the prevention and reduction of poor mental health amongst children and young people. Greater focus is needed on early intervention in order to promote social and emotional development of children and young people which in turn can significantly improve their mental and physical health, educational attainment and future employment opportunities. It has also been demonstrated that early intervention can also help to prevent criminal behaviour especially violent behaviour, drug and alcohol misuse and teenage pregnancy, which are many of the risk factors for poor mental health.

The Special Educational Needs and Disability (SEND) Green Paper has also considered how to make sure that there is better early intervention and targeted support to prevent later problems for children with special educational needs and disabilities, including those who have underlying or associated mental health problems.[23]

The Children's NSF (Standard 9) published in 2004[24], set out a clear ten-year improvement programme for CAMHS. Specific recommendations were incorporated to cover a wide spectrum of need amongst children and young people as well as covering issues such as mental health promotion, early intervention and specialist services for children and young people with complex, severe and persistent needs.

In 2009, the Department of Children, Families and Schools published guidance for Children's Trusts around delivering NI 50, whose aim is to promote the emotional health of children and young people. This was supported by additional guidance published in 2009 for Children's Trusts around delivery of NI 50.

Additionally that year, the Department of Children, Families and Schools published the document *'Statutory Guidance on promoting the Health and Well-Being of Looked after Children.'*[25] which clearly laid out the expectations placed on local authorities and PCTs in relation to meeting the health and well-being needs of looked after children. Specific guidance was included around the assessment of emotional and behavioural difficulties and in the provision of support from CAMHS.

5.7.2 Local

Improving the emotional health and well-being of children and young people in Croydon and improving the outcomes of looked after children and young people are key priorities for the Children and Families Partnership. As a consequence specific actions have been identified and included in the Croydon Children and Young People's Plan[26] to ensure improvement in the emotional health and well-being of Croydon's children and young people, including those who are looked after.

Currently, responsibility for improving the emotional health and well-being of children and young people lies with the Children and Families Partnership: Be Healthy Sub-Group, supported by the CAMHS Partnership Commissioning Group and the Emotional Health and Well-Being in Schools task group. Responsibility for improving the emotional health and well-being of looked after children is additionally supported by actions developed and agreed by the LAC Strategic Partnership. Representation from public health, local authority and NHS commissioning, the local authority, Croydon Health Services, SLAM, and the voluntary sector sit on all associated strategy groups.

Additionally, the theme of this year's Joint Strategy Needs Assessment (JSNA) is around mental health. Three deep-dives are currently being undertaken, of which one is focusing on the emotional health and well-being of children and young people aged 0-18 years of age in Croydon. It is expected that the findings and recommendations will inform local commissioning intentions for 2013-14 and support the development of the updated Children's and Young People's Emotional Health and Well-Being Strategy in Croydon.

5.8 Evidence Base

5.8.1 NICE

The National Institute for Health and Clinical Excellence (NICE) produces best practice guidance on a range of health and social care issues. NICE has produced considerable clinical guidelines, public health guidance and a number of technical appraisals in relation to the emotional health and well-being and the mental health needs of children and young people.

5.8.1.1 Technical Appraisals

- Methylphenidate, atomoxetine and dexametamine for attention deficit hyperactivity disorder (ADHD) in children and adolescents NICE, March 2006 Methylphenidate-atomoxetine-and-dexamfetamine-for-attention-deficit-hyperactivity-disorder-adhd (TA98)
- Aripiprazole for the treatment of schizophrenia in people aged 15 to 17 years: NICE Jan 2011 Aripiprazole-for-the-treatment-of-schizophrenia-in-people-aged-15-to-17-years (TA213)

5.8.1.2 Clinical Guidelines

- Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults; NICE, Sep 2008, Attention deficit hyperactivity disorder (ADHD) (CG72)
- Autism spectrum disorders in children and young people; NICE, Sept 2011, Autism in children and young people – Assessment & diagnosis (CG128)
- Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders; NICE, Jan 2004, Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (CG9)
- Depression in children and young people: identification and management in primary, community and secondary care; NICE, Sep 2005,Depression in children and young people (CG28)
- Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care; NICE, Mar 2005, Post-traumatic stress disorder (PTSD) (CG26)
- Psychosis and schizophrenia in children and young people (not yet published); NICE, Mar 2011, Psychosis with coexisting substance misuse (CG120)
- Conduct disorders in Children and Young People : NICE April 2013 Conduct Disorders In Children and Young People (CG158)

- Self-harm: the short term physical and psychological management and secondary prevention of self-harm in primary and secondary care: NICE, July 2004, Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (CG16)
- Self Harm Longer Term Management: NICE, Nov 2011, Self harm (longer term management) (CG133) (8 yrs and older)
- Pregnancy and complex social factors: NICE, Sep 2010, Pregnancy and complex social factors (CG110)
- Psychosis and schizophrenia in children and young people: NICE Jan 2013, Psychosis and schizophrenia in children and young people (CG155)
- Borderline personality disorder: NICE, Jan 2009, Borderline personality disorder (BPD) (CG78)
- Antisocial personality disorder: NICE, Jan 2009, Antisocial personality disorder (CG77)
- Drug Misuse –psychosocial interventions: NICE, Jul 2007, Drug misuse: psychosocial interventions (CG51)
- Drug Misuse- opioid detoxification: NICE, Jul 2007, Drug misuse: opioid detoxification (CG52)
- The Management of bipolar disorders in adults, children and adolescents in primary and secondary care: NICE, Jul 2006, Bipolar disorder (CG38)
- Obsessive –compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder: NICE, Nov 2005, Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (CG31)
- Post –traumatic stress disorder in adults and children in primary and secondary care: NICE, Mar 2005, Post-traumatic stress disorder (PTSD) (CG26)
- Common Mental Health Disorders: NICE May 2011 Common-mental-health-disorders (CG123)

5.8.1.3 Public Health Guidance

- Tobacco –harm reduction approached to smoking: NICE June 2013 Tobacco harm reduction (PH45)
- Promoting children's social and emotional wellbeing in primary education; NICE, Mar 2008, Social and emotional wellbeing in primary education (PH12)
- Promoting young people's social and emotional wellbeing in secondary education - nurturing young people's social and emotional well -being: NICE, Sept 2009, Social and emotional wellbeing in secondary education (PH20)

- Social and Emotional well-being –early years: NICE Oct 2012, Social and emotional wellbeing -early years (PH40)
- Promoting the quality of life of looked-after children and young people; NICE, Oct 2010, Looked-after children and young people (PH28)
- Interventions to reduce substance misuse among vulnerable young people: NICE, Mar 2007, Interventions to reduce substance misuse among vulnerable young people (PH4) ,
- When to suspect child maltreatment: NICE, July 2009, When to suspect child maltreatment (CG89)
- Alcohol-use disorders-preventing harmful drinking: NICE, Jun 2010, Alcohol-use disorders - preventing harmful drinking (PH24)
- School- based interventions to prevent smoking: NICE, Feb 2010, School-based interventions to prevent smoking (PH23)
- Promoting physical activity for children and young people: NICE, Jan 2009, Promoting physical activity for children and young people (PH17)
- Preventing the uptake of smoking in children and young people: NICE, Jul 2008, Preventing the uptake of smoking by children and young people (PH14)
- Maternal and child nutrition: NICE, Mar 2008, Maternal and child nutrition (PH11)
- Physical activity and the environment: NICE, Jan 2008, Physical activity and the environment (PH8)
- School based interventions on alcohol: NICE, Nov 2007, School-based interventions on alcohol (PH7)

5.8.1.4 Quality Standards

- Alcohol dependence and harmful alcohol use: NICE, Aug 2011,Alcohol dependence and harmful alcohol use (QS11)
- Drug Use disorders: NICE, Dec 2012, Drug Use Disorders (QS23)
- Health and well-being of looked after children: NICE, Apr 2013 Health and well-being of looked after children (QS31)
- Self Harm: NICE, June 2013, Self-harm (QS34)
- Conduct disorders (Children and Young People): NICE Conduct disorders - children and young people (QS58) Expected March 2014

5.8.1.5 NICE Guidance in development (with estimated publication date)

- NICE,Overweight and obese children and young people - lifestyle weight management services, Oct 2013
- NICE,Autism - management of autism in children and young people, Aug 2013
- NICE Depression-in-children-and-young-people (CG28) Sept 2013
- NICE,Preventing and reducing domestic violence, Feb 2014
- NICE,Sexually harmful behaviour among young people, TBC
- NICEOffenders: prevention and early treatment of mental health problems, TBC

5.8.2 Other key evidence base guidance and reports

- Promoting emotional health and wellbeing through the National Healthy School Standard (NHSS), HDA (2004) Promoting emotional health and well-being through the National Healthy School Standard

6 Need

6.1 Rates and Trends

This section will identify the prevalence of the different types of mental health need amongst children and young people in Croydon and will also provide some additional information of the estimated prevalence amongst specific vulnerable groups.

6.1.1 Pre-school children

There is relatively little data about prevalence rates for mental health disorders in pre-school age children. The Report of the Children and Young People's Health Outcomes Forum (Department of Health, 2012, p.32) "recommends a new survey to support measurement of outcomes for children with mental health problems. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H et al, 2006). Applying this average prevalence rate to the Office for National Statistics (ONS) mid-year population estimates for 2011, suggests that there are 4,198 children aged 2 to 5 years inclusive, living in Croydon who may have a mental health disorder.

6.1.2 School-age children

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green et al (2004)[27]. Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria, with the mental health disorder causing distress to the child or having a considerable impact on the child's day to day life.

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

Table 2a: Estimated number of children with mental health disorders by gender

	Estimated number of boys aged 5-10 yrs with mental health disorder (2011)	Estimated number of boys aged 11-16 yrs with mental health disorder (2011)	Estimated number of boys aged 5-16 yrs with mental health disorder (2011)
Croydon	1424	1794	6343

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

It is estimated that there are approximately 6343 boys aged 5-16 years of age with a mental health disorder in Croydon.

Table 2b: Estimated number of children with mental health disorders by gender

	Estimated number of girls aged 5-10 yrs with mental health disorder (2011)	Estimated number of girls aged 11-16 yrs with mental health disorder (2011)	Estimated number of girls aged 5-16 yrs with mental health disorder (2011)
Croydon	703	1413	4340

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

It is estimated that there are 4340 girls aged 5-16 years of age with a mental health disorder in Croydon. Prevalence varies by age and gender, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems.

These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders[28]. The following tables show the estimated number of children with conduct, emotional, hyperkinetic and less common disorders in Croydon, by applying these prevalence rates. (*N.B the numbers in this table do not add up to the numbers in the previous table because some children have more than one disorder*).

Table 3: Estimated number of children with conduct disorders by age group and gender

	Estimated number of children with conduct disorders aged 5-10 yrs (2011)	Estimated number of children with conduct disorders aged 11-16 yrs (2011)	Estimated number of boys aged 5-10 yrs with conduct disorders (2011)	Estimated number of boys aged 11-16 yrs with conduct disorders (2011)	Estimated number of girls aged 5-10 yrs with conduct disorders (2011)	Estimated number of girls aged 11-16 yrs with conduct disorders (2011)
Croydon	1358	1843	963	1153	386	700

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

It is estimated that there are approximately 3200 children and young people with conduct disorders in Croydon. Boys have a higher prevalence than girls for this disorder. The largest number of children with this type of disorder are seen amongst boys aged 11-16 years of age

Table 4: Estimated number of children with emotional disorders by age group and gender

	Estimated number of children with emotional disorders aged 5-10 yrs (2011)	Estimated number of children with emotional disorders aged 11-16 yrs (2011)	Estimated number of boys aged 5-10 yrs with emotional disorders (2011)	Estimated number of boys aged 11-16 yrs with emotional disorders (2011)	Estimated number of girls aged 5-10 yrs with emotional disorders (2011)	Estimated number of girls aged 11-16 yrs with emotional disorders (2011)
Croydon	665	1396	307	570	345	837

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

It is estimated that there are approximately 2100 young people in Croydon with emotional disorders. The highest prevalence is estimated in girls aged 11-16 years of age.

Table 5: Estimated number of children with hyperkinetic disorders by age group and gender

	Estimated number of children with hyperkinetic disorders aged 5-10 yrs (2011)	Estimated number of children with hyperkinetic disorders aged 11-16 yrs (2011)	Estimated number of boys aged 5-10 yrs with hyperkinetic disorders (2011)	Estimated number of boys aged 11-16 yrs with hyperkinetic disorders (2011)	Estimated number of girls aged 5-10 yrs with hyperkinetic disorders (2011)	Estimated number of girls aged 11-16 yrs with hyperkinetic disorders (2011)
Croydon	444	391	377	342	55	55

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

The prevalence of children with hyperkinetic disorders are 6-7 times more common in boys than that in girls, estimates indicate that the largest number of children with hyperkinetic disorders are amongst boys aged 5-10 years of age, closely followed by boys aged 11-16.

Table 6: Estimated number of children with less common disorders by age group and gender

	Estimated number of children with less common disorders aged 5-10 yrs (2011)	Estimated number of children with less common disorders aged 11-16 yrs (2011)	Estimated number of boys aged 5-10 yrs with less common disorders (2011)	Estimated number of boys aged 11-16 yrs with less common disorders (2011)	Estimated number of girls aged 5-10 yrs with less common disorders (2011)	Estimated number of girls aged 11-16 yrs with less common disorders (2011)
Croydon	360	391	307	228	55	151

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

Estimates indicate that more boys than girls suffer from less common mental health disorders, with the highest level of need seen in boys aged 5-10 years of age.

A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 inclusive living in private households. The tables below show the number of16 to 19 year olds that would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Croydon.

Table 7: Estimated number of males aged 16 to 19 with neurotic disorders

	Mixed anxiety and depressive disorder (males 16-19 yrs) (2011)	Generalised anxiety disorder (males 16-19 yrs) (2011)	Depressive episode (males 16-19 yrs) (2011)	All phobias (males 16-19 yrs) (2011)	Obsessive compulsive disorder (males 16-19 yrs) (2011)	Panic disorder (males 16-19 yrs) (2011)	Any neurotic disorder (males 16-19 yrs) (2011)
Croydon	490	154	86	58	86	48	826

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

Table 8: Estimated number of females aged 16 to 19 with neurotic disorders

	Mixed anxiety and depressive disorder (females 16-19 yrs) (2011)	Generalised anxiety disorder (females 16-19 yrs) (2011)	Depressive episode (females 16-19 yrs) (2011)	All phobias (females 16-19 yrs) (2011)	Obsessive compulsive disorder (females 16-19 yrs) (2011)	Panic disorder (females 16-19 yrs) (2011)	Any neurotic disorder (females 16-19 yrs) (2011)
Croydon	1141	101	248	193	83	55	1766

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

Girls aged 16-19 years of age have approximately twice the level of neurotic disorders in comparison to boys, with mixed anxiety and depressive disorders being the most common neurotic disorder seen. Numbers of young people who suffer from obsessive compulsive and panic disorders are seen in similar numbers in both males and females. Additionally, it is estimated that three times more females than males suffer from depressive episodes, whereas boys are one and half times more likely to suffer from generalised anxiety disorders.

6.1.3 Autistic Spectrum Disorder (ASD)

The European Commission highlights the problems associated with establishing prevalence rates for Autistic Spectrum Disorders. These include the absence of long-term studies of psychiatric case registers and inconsistencies of definition over time and between locations.[29]

Nonetheless the Commission estimates that according to the existing information, the age-specific prevalence rates for 'classical autism' in the European Union (EU) could be estimated as varying from 3.3 to 16.0 per 10,000. These rates could however increase to a range estimated between 30 and 63 per 10,000 when all forms of autism spectrum disorders are included. Debate remains about the validity and usefulness of a broad definition of autism.

In a survey undertaken by Baron-Cohen et al, autism-spectrum conditions amongst children aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ratio of known to unknown cases is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases.[30]

It has been estimated that the number of children with autism (diagnosed) amongst 0-18 year olds is expected to rise from 881 in 2012 to 1414 in 2021.

6.1.4 Estimated need for services at each tier

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been provided by Kurtz.[31] The following table shows these estimates for the population aged 17 and under in Croydon.

Table 9: Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS

	Tier 1 (2011)	Tier 2 (2011)	Tier 3 (2011)	Tier 4 (2011)
Croydon	13254	6185	1635	66

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

It is estimated that during 2011, there were approximately 21,000 young people in Croydon with some form of mental health need, with the majority of children and young people potentially requiring a Tier 1 CAMHS service. It is estimated that this figure will rise to approximately 24,000 by 2021 (See Table 12).

Levels of need at Tier 1 are approximately 200 times greater than the number of children who require services at Tier 4 and 8 times greater than the levels seen at Tier 3.

6.1.5 Projected future prevalence for children aged 0 to 18.

Table 10: Estimated numbers of children with mental and emotional health conditions in Croydon, projected to 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
46) Conduct disorder (diagnosed+undiagnosed)	3,263	3,318	3,362	3,414	3,478	3,547	3,618	3,685	3,748	3,813
47) Emotional disorder (diagnosed+undiagnosed)	2,082	2,117	2,145	2,178	2,219	2,263	2,308	2,351	2,391	2,432
48) Attention deficit hyperactivity disorder (diagnosed+undiagnosed)	844	858	869	883	899	917	936	953	969	986
49) Attention deficit hyperactivity disorder (diagnosed)	470	498	532	566	601	636	671	707	744	781
50) AutismSpectrum Disorder (diagnosed)	881	933	990	1,049	1,108	1,168	1,229	1,289	1,352	1,415
51) Learning disability (diagnosed+undiagnosed)	1,292	1,302	1,313	1,327	1,342	1,360	1,383	1,404	1,428	1,455
52) Learning disability (diagnosed)	311	313	318	323	324	332	337	342	348	358
53) Eating disorder (diagnosed+undiagnosed)	192	195	198	201	205	210	214	218	222	226
54) Eligible CAMHS Tier 1 (diagnosed+undiagnosed)	13,427	13,624	13,827	14,031	14,235	14,428	14,612	14,779	14,945	15,115
55) Eligible CAMHS Tier 2 (diagnosed+undiagnosed)	6,266	6,358	6,453	6,548	6,643	6,733	6,819	6,897	6,975	7,054
56) Eligible CAMHS Tier 3 (diagnosed+undiagnosed)	1,656	1,680	1,705	1,731	1,756	1,779	1,802	1,823	1,843	1,864
57) Eligible CAMHS Tier 4 (diagnosed+undiagnosed)	67	68	69	70	71	72	73	74	75	76

Source: Croydon Public Health Intelligence Team (C-PHIT)

46) Estimated diagnosed and undiagnosed prevalence of conduct disorders in children aged 5-16. Prevalence rates from Mental Health of Children and Young People in Great Britain 2004, Office for National Statistics. Assumes prevalence rate is same as national and remains the same.

47) Estimated diagnosed and undiagnosed prevalence of emotional disorders in children aged 5-16. Prevalence rates from Mental Health of Children and Young People in Great Britain 2004, Office for National Statistics. Assumes prevalence rate is same as national and remains the same.

48) Estimated diagnosed and undiagnosed prevalence of attention deficit hyperactivity disorder in children aged 5-16. Prevalence rates from Mental Health of Children and Young People in Great Britain 2004, Office for National Statistics. Assumes prevalence rate is same as national and remains the same.

49) Diagnosed attention deficit hyperactivity disorder in children aged 0-18. Linear trend from prevalence numbers 2010-2012. Assumes trend in prevalence among children continues.

50) Diagnosed autism spectrum disorder in children aged 0-18. Linear trend from prevalence numbers 2011-2012. Assumes trend in prevalence among children in Croydon continues.

51) Estimated diagnosed and undiagnosed prevalence of learning disability including people with mild learning disabilities who are less likely to be known to services in children aged 5-16. Prevalence rates from 'Estimating the Current Need/Demand for Supports for People with Learning Disabilities in England', Eric Emerson & Chris Hatton, Institute for Health Research, Lancaster University, 2004. Assumes prevalence rate is same as national and remains the same.

52) Diagnosed learning disability in children aged 0-18. Current Croydon prevalence rates by age and sex applied to population projections and adjusted for deprivation. Assumes prevalence rate remains the same and deprivation continues to increase at the same rate.

53) Estimated diagnosed and undiagnosed prevalence of eating disorder in children aged 5-16. Prevalence rates from Mental Health of Children and Young People in Great Britain 2004, Office for National Statistics. Assumes prevalence rate is same as national and remains the same.

Table 11: Estimated number of children / young people in Croydon who may experience mental health problems appropriate to a response from CAMHS, projected to 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Tier 1 (15.0%)	13,427	13,624	13,827	14,031	14,235	14,428	14,612	14,779	14,945	15,115
Tier 2 (7.0%)	6,266	6,358	6,453	6,548	6,643	6,733	6,819	6,897	6,975	7,054
Tier 3 (1.85%)	1,656	1,680	1,705	1,731	1,756	1,779	1,802	1,823	1,843	1,864
Tier 4 (0.075%)	67	68	69	70	71	72	73	74	75	76

Source: Croydon Public Health Intelligence Team (C-PHIT)

6.2 Specific groups of young people

The reasons why a child or young person experiences mental health problems are likely to be complex. However, certain factors are known to influence the likelihood of an individual experiencing poor mental health. Research has shown more vulnerable groups of children and young people, including those socially excluded or living in poverty, children in care, young offenders and children with learning disabilities are at greater risk of developing a mental illness and subsequently requiring targeted interventions.

6.2.1 Vulnerable Children in Croydon

Croydon Council figures shows there are high levels of vulnerable children within the borough with 2502 children in need (CIN) identified as of 31st March 2012. There were 6513 children in need identified during 2011-12, which reflected a rate of 449.6 per 10,000 children aged 0-17. This is higher than the England and London rates of 325.9 and 361.8 per 10,000 children respectively. With Croydon having the second highest rate of children in need in outer London and is the 7th highest in London as a whole.

The highest number of children in need were seen amongst males aged 16 and over (1036 during 2011-12) and the second highest seen in males aged 10-15. White and Black/Black British ethnic groups made up the largest ethnic groups seen amongst the local children in need population.

There were also 346 children in Croydon who became the subject of a child protection plan (CPP) during 2011-12. Croydon has the fourth highest number of children with a CPP in London, with only Ealing, Greenwich and Hillingdon having larger numbers.

6.2.2 Children and young people with learning disabilities and special educational needs

People with learning disabilities are more likely to experience mental health problems[32]. However, estimation of the population prevalence of learning disability is problematic and should be treated with caution.

Furthermore Emerson et al,[33] estimates that there are 286,000 children and young people (180,000 boys and 106,000 girls) aged 0 to 17 with learning disabilities in

England. Further Emerson et al, estimates that 2.46% of girls and 4.01% of boys, aged 7 to 15 years in 2011 were identified at School Action Plus or with a Statement of Special Educational Need (SEN), with a primary SEN associated with learning disabilities. (*Note: School Action Plus is used when there is evidence that a child is not making progress at school and there is a need for action to be taken to meet learning difficulties; the school will seek external advice from the LEA's support services, the local Health Authority or from Social Services*).

In addition, Emerson calculated prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 years: 0.97%; 10 to 14 years: 2.26%; and 15 to 19 years: 2.67%[34]. Using these percentages, the following prevalence of children with a learning disability can be estimated.

Table 12: Estimated total number of children with a learning disability

	Children aged 5-9 yrs with a learning disability (2011)	Children aged 10-14 yrs with a learning disability (2011)	Children aged 15-19 yrs with a learning disability (2011)
Croydon	224	522	630

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

These rates for different age groups reflect the fact that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities[35] estimates an upper limit of 40% prevalence for mental health problems associated with learning disability, with higher rates for those with severe learning disabilities. The following table shows the estimated prevalence of mental health need amongst children with learning disabilities in Croydon.

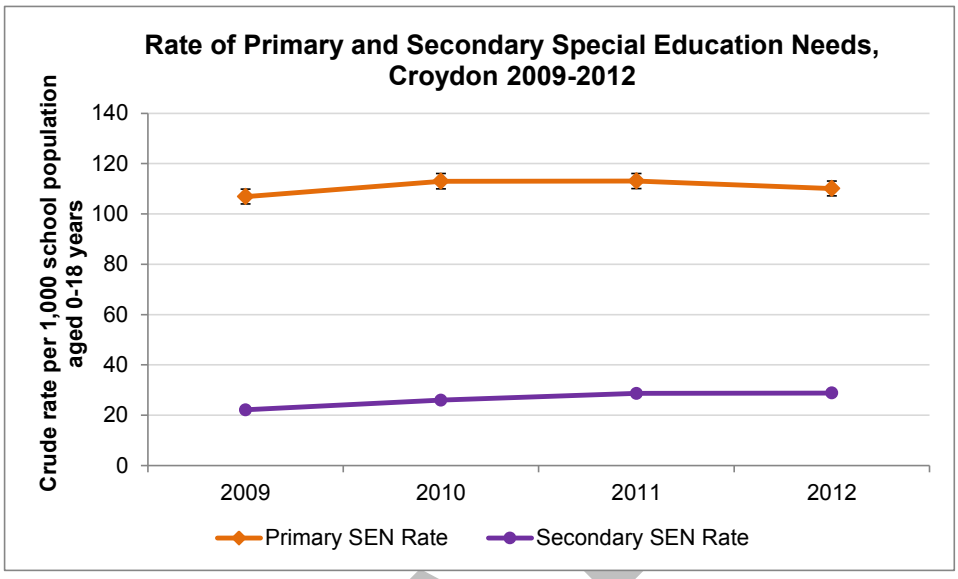
Table 13: Estimated total number of children with learning disabilities with mental health problems

	Children aged 5-9 yrs with a learning disability with mental health problems (2011)	Children aged 10-14 yrs with a learning disability with mental health problems (2011)	Children aged 15-19 yrs with a learning disability with mental health problems (2011)
Croydon	89	209	252

Source: CHIMAT –CAMHS Needs Assessment. Croydon LB Geographies: Local Authority

In Emmerson's research it was proposed that children with learning disabilities are six times more likely to have a mental health problem than other children and more than 40% of families with learning disabled children feel they do not receive sufficient help from medical professionals, social workers or mental health services.

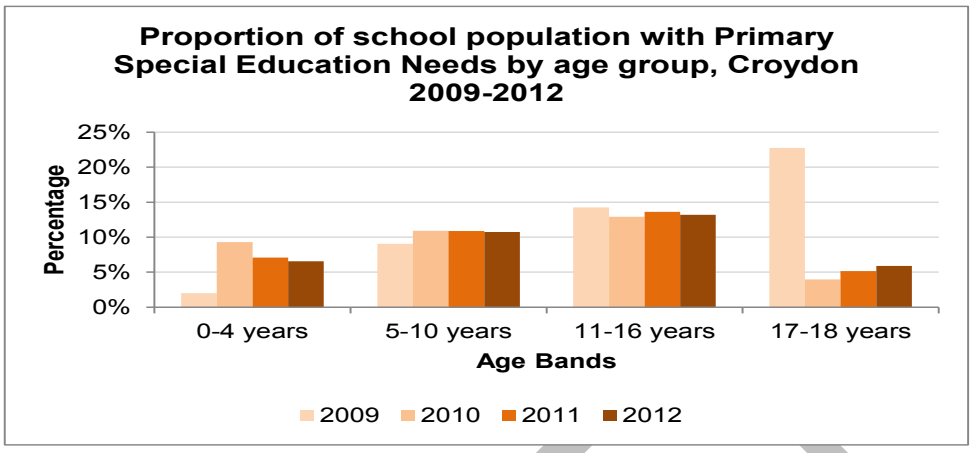
Figure 1: Rate of Primary and Secondary Special Educational Needs (SEN) amongst Croydon pupils 2009-2012



The previous graph shows the rate of Primary and Secondary Special Education Needs (SEN) amongst children aged 0-18 between 2009-2012. In 2012, the rate of Primary Special Educational Needs was 110.14 per 1000 children and 28.82 per 1000 children for Secondary Special Education Needs. Primary SEN indicates the rank order of a pupil's special educational need, recorded in Pupil SEN type. The most significant is referred to as the primary need, and the secondary need as the less significant.

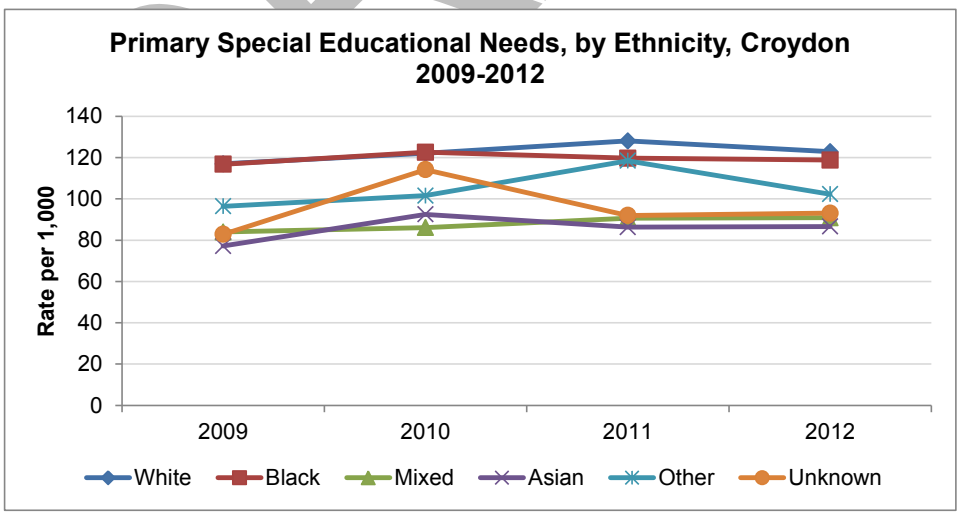
Gender breakdown of Primary and Secondary SEN need has remained relatively consistent over the period 2009-2012, with males showing just over double the rate of SEN need in comparison with females.

Figure 2: Proportion of school population with Primary Special Education Needs by age group amongst Croydon pupils, 2009-2012



During 2012, 7% of children aged 0-4 were identified as having a Primary Special Education Need, this increased to 11% amongst 5-10 year olds and 13% amongst 11-16 year old children and 6% of 17-18 year old children. Overall, in 2012 the proportion of all cases of Primary SEN seen were highest (49%) amongst Primary aged children, closely followed by Secondary aged children (43%). This reflects a change in the proportional breakdown seen over the four year period with an increase in the proportion of Primary SEN seen amongst 5-10 year old children and a decrease in the proportion of Primary SEN amongst 11-16 year old children.

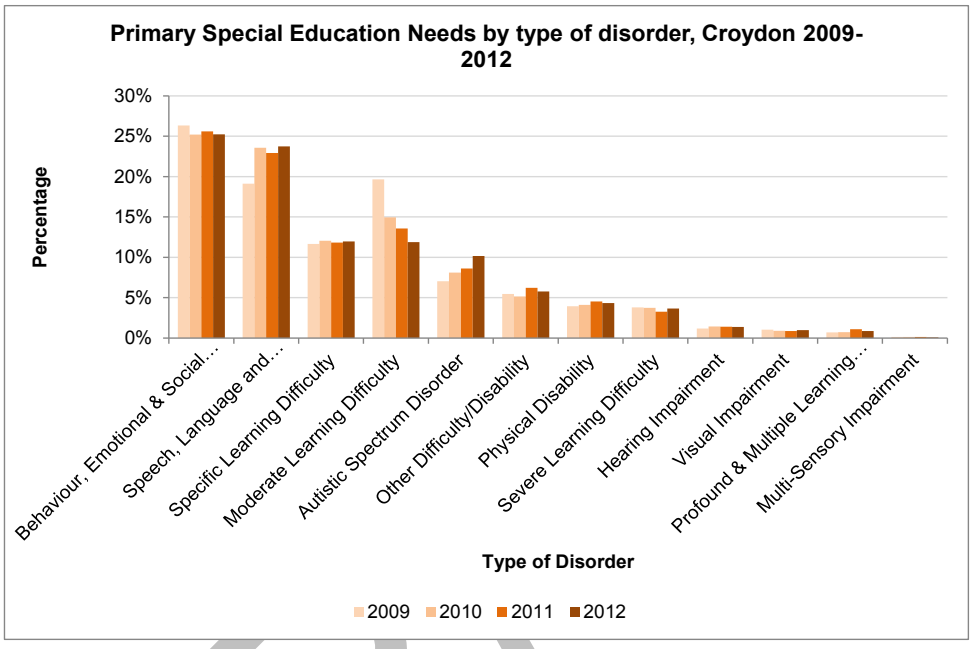
Figure 3: Primary Special Educational Needs by Ethnicity amongst Croydon pupils 2009-2012



In 2012, rates of Primary Special Education Need were highest amongst White (122.9 per 1000) and Black (118.8 per 1000) ethnic groups. However over the period

2009-2012 the greatest percentage increase in Primary Special Education Need have been seen amongst Asian and Mixed ethnic groups with percentage increases of 12% and 8% being seen respectively.

Figure 4: Primary Special Educational Needs by type of disorder, Croydon 2009-2012



In 2012, the largest percentage of Primary Special Education Need was in relation to *behavioural, emotional and social difficulties* (25%) closely followed by *speech, language and communication difficulties (24%)*. The largest increases seen were amongst *speech, language and communication difficulties,* with an increase of 335 children identified with this type of need over the period 2009-2012. Additionally, year on year increases were seen in relation to the percentage of children identified with needs due to Autistic Spectrum Disorder (ASD). Overall in 2012, 10% of children with an identified Primary Education Need were identified as having ASD. Reductions were seen in the percentage of children with *moderate learning difficulties* during 2009-2012 and percentages remained fairly consistent in all other Special Education Need types over the four year period.

Additionally, the largest percentage of Secondary Special Education Need seen during 2009-2012 were in relation to *behavioural, emotional and social difficulties* (26%), closely followed by *severe learning difficulties* (22%) and *moderate learning difficulties* (18%).

The following table shows the primary and secondary SEN needs identified in children and young people of school age by Family Engagement Partnership (FEP) cluster area in 2012.

It should be noted that some FEP Clusters may have larger numbers of specific types of need by virtue of the difference in size of the area covered by a particular cluster

Table 14: Primary and Secondary SEN Needs by Family Engagement Partnership (FEP) Cluster for 2012.

		FEP Cluster				
		Central	East	North	South	West
Primary SEN Needs	Autistic Spectrum Disorder	68	113	139	189	49
	Behaviour, Emotional & Social Difficulties	315	232	450	251	138
	Hearing Impairment	12	13	18	9	24
	Moderate Learning Difficulty	86	143	196	125	103
	Multi-Sensory Impairment	<5		<5		<5
	Other Difficulty/Disability	65	68	103	47	33
	Physical Disability	35	26	26	51	100
	Profound & Multiple Learning Difficulty	<5	26	<5	6	13
	Severe Learning Difficulty	10	73	10	15	92
	Specific Learning Difficulty	120	108	201	196	32
	Speech, Language and Communication Needs	274	249	288	271	223
	Visual Impairment	15	5	20	9	5
Secondary SEN Needs	Autistic Spectrum Disorder	10	55	<5	11	5
	Behaviour, Emotional & Social Difficulties	87	84	99	56	54
	Hearing Impairment	5	<5	<5	<5	<5
	Moderate Learning Difficulty	47	40	73	45	59
	Multi-Sensory Impairment		<5		<5	
	Other Difficulty/Disability	23	23	17	23	23
	Physical Disability	19	11	6	7	9
	Profound & Multiple Learning Difficulty		<5			
	Severe Learning Difficulty	<5		<5	15	
	Specific Learning Difficulty	58	41	31	37	8
	Speech, Language and Communication Needs	54	80	67	47	69
	Visual Impairment	<5	<5		<5	10

6.2.3 Looked-after children (LAC)

Looked-after children are more likely to experience mental health problems[36]. It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic.[37]

Variation was also shown depending on the type of placement made with two-thirds of children living in residential care found to have a mental health disorder compared with four in ten of those placed with foster-carers or their birth parents.

Based on this research, it can be estimated that in Croydon 292 LAC were suffering from some form of mental health disorder during 2011-12. Approximately 240 LAC would be expected to have had clinically significant conduct disorders, 78 with emotional disorders such as anxiety or depression and approximately 45 who were hyperkinetic.

6.2.4 Young Offenders

There are a number of studies which provide insight into the mental health of young people who have had contact with the criminal justice system. In 2011/12, Croydon had 699 young people on the caseload of the Youth Offending Service (YOS).

Based on research undertaken by Vermeiren et al[38] the following prevalence estimates of specific mental health disorders were identified when applied to the Croydon YOS caseload for 2011-12.

Table 15: Estimates of young offenders aged 12-17 who have a mental disorder (2011/12)

Disorder	Percentage	Number
Conduct disorders	53%	355
Hyper kinetic disorders	19%	127
Substance Abuse	24%	161
Depression	14%	94
Psychotic symptoms	4%	27

6.2.5 Black, Minority Ethnic (BME) Groups

In recent years there has been some acknowledgement, at the level of both national[39] policy and in relation to service delivery [40],[41] that many mainstream services are failing to address the mental health needs of children and young people from Black and minority ethnic (BME) communities. The inadequacies highlighted cover both planning (e.g. population needs assessments, commissioning, collection and use of relevant monitoring data) and provision (e.g. accessibility, culturally sensitive services and interventions) of appropriate and responsive services.

Over the last decade or so, there have been some welcome initiatives and focus on the mental health needs of BME communities, however, these have not given sufficient focus to BME children and young people[42], [43] One consequence of this lack of focus is that subsequent reviews of initiatives have also failed to look at the impact particular policy and practice initiatives have made on provision for BME children and young people.

The evidence on the incidence of mental health problems in BME groups is complex. The term BME covers many different groups with very different cultural backgrounds, socio-economic status and experiences in wider society. People from BME groups often have different presentations of problems and different relationships with health services. Some black groups have admission rates around three times higher than average, with some research indicating that this is an illustration of need. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are two to eight times at greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

Over-representation in adult mental health inpatient services of patients from some BME groups[44], combined with under-representation in CAMHS suggests a lack of effective intervention at an early age. Young people from some BME groups are disproportionately over-represented in the youth justice system, social services looked after provision, exclusion from school and educational underachievement. The adverse effects of these systems and situations on young people are well documented and their mental health needs are identified as a key concern.

Recent research has revealed that although 20% of children are believed to have a mental health need, it is unclear of the relative statistics for BME populations. Children and young people with mental health issues face stigma, bullying and harassment and it can be assumed that those who come from BME backgrounds may also have to deal with the additional elements of racism, racial harassment and racial bullying. In a report by the Afiya Trust it was identified that that agencies, including social services, are “systematically failing” to address the mental health needs of black and minority ethnic (BME) children and young people. It also discovered that BME children’s mental health needs are overlooked by professionals, and highlighted a lack of data on this issue.[45]

6.2.6 Refugees and Asylum Seekers

The experiences of young refugees, asylum seekers or migrants can vary enormously according to the circumstances within their country, their status, political or religious beliefs, gender, journey and many more variants. There are some shared experiences which affect the majority of this group. Services for migrant communities require a culturally sensitive approach, taking into account pre, peri and post migration. There are high levels of social exclusion, poverty and unemployment. Many new migrants lack access to decent housing and frequently live in more deprived areas. Mental and physical health problems are common and often unsupported, leading to difficulties managing past trauma and depression. The combination of these problems, in addition to uncertain immigration status, increases

the chances that young people and adults will rely on familiar or negative coping mechanisms. This in turn, places more children at risk.

Many families arriving in the UK have a deep rooted religious culture and different child rearing practices. The clash of cultures and belief systems can be difficult to manage and requires a sensitive approach from professionals. Religious values, traditions and beliefs can be an important coping mechanism – if criticised or attacked this can be perceived as further rejection or a lack of understanding. In turn, this contributes to increased rigidity around beliefs and practices and further confirmation that they are not accepted. The outcome of this can result in a withdrawal from services, particularly in relation to a need where there is often a stigma attached, such as mental health services. This directly affects young refugees and asylum seekers within families, limiting access to support.

While refugee parents and children may be psychologically distressed it is important that resilience and resourcefulness are recognised and respected. Some families come from cultures with perceptions of mental illness that are very different to our own and for whom the suggestion of "referral for counselling" is meaningless and therefore unhelpful. This is not to say distress should not be acknowledged or support not offered. It should also be remembered that response to stress might manifest itself with physical signs.

Children can also be affected by their parents psychological state. Parents suffering from the effects of their own traumatic experiences and preoccupied with making sense of life as an asylum seeker will find it difficult to provide their children with a self confident and strong role model. Nor are they likely to be as emotionally available to support and encourage their children as they might wish.

Unaccompanied refugee and asylum seeking minors (UASC) are an often neglected group that have a complex set of needs[46]. They are at great risk of mental health problems and exploitation without adequate support[47]. These issues mean that asylum seekers and refugees often experience high levels of stress when attempting to settle. Displacement, social exclusion, isolation and even the experience of racism can have profound consequences[48]. This, in addition to the pre-flight and flight trauma they have faced, means that many are more prone to problems such as depression, anxiety, insomnia, behavioural issues and post-traumatic stress disorder (PTSD) to name but a few. Conditions such as TB and HIV/AIDS are also of greater concern within this population[49].

Young people themselves have identified a number of issues that affect their wellbeing. When groups of young asylum seekers (aged 12 to 16) were consulted in South London they included loss of family members, loneliness, feeling cold, being depressed and lack of money and language barriers as key issues. Bullying

emerged as a major concern as did difficulty in accessing all services not just health. More than a half felt their health had deteriorated since arriving here.[50]

Although the number of unaccompanied minors in Croydon has dropped dramatically over recent years, Croydon still has high levels of UASC. As of April 2013, there were 329 unaccompanied minors in Croydon with the majority aged between 15-17 years of age and 86% males. Croydon has one of the highest unaccompanied minor populations in the country and as a consequence, specific consideration is needed to ensure that sufficient provision of appropriate mental health services are provided for this very vulnerable group of young people.

6.2.7 Homelessness

It has been shown that homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including HIV[51]. Two major studies of this group in London[52] and Edinburgh[53] found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation.
In a study of 16 to 25 year olds who were sleeping rough in London it was found that 67% had mental health problems[54]. Applying these rates to the population in Croydon would suggest there at least 15 young people estimated with mental health problems who are sleeping rough.

6.2.8 Children with Physical Disabilities

Children and teens with physical disabilities can also be more likely to experience anxiety, depression or other mental health issues which often go undiagnosed and untreated. Children with long-lasting physical illness are twice as likely to suffer from emotional problems or disturbed behaviour. This is particularly true of physical illness that involves the brain, such as epilepsy and cerebral palsy.[55]

6.2.9 NEET Young People

Being in education, employment and training between the ages of 16-18 increases a young person's resilience.[56] Just under 10% of 16-18 year olds in England, 4.5% of Londoners and 6.1% of Croydon young people are not in education, employment or training (NEET)[57]. Young people not in education, employment or training are more likely to be depressed, feel disengaged from wider society and potentially turn to crime.

Trends for young people who are NEET show seasonal variations, and increase significantly in August and September after the end of the academic year. NEET levels generally reduce in October when this group enrol in further education or enter employment. Additionally, higher levels of NEET can be seen in those wards with greater levels of deprivation.[58]

6.2.10 Teenage Parents

Croydon has seen its teenage conception rate drop dramatically over recent years, along with a significant reduction in the percentage of teenage conceptions that lead to a birth.

Despite this welcome improvement, it has been widely shown that young mothers are three times more likely to suffer post-natal depression than older mothers and to suffer mental health problems for up to three years after the birth.[59] Poor emotional health not only affects the well-being of the young mother but also affects her ability to be an attentive and nurturing parent, which can lead to an increased risk of accidents and behavioural difficulties for her child. Some young mothers may have pre-existing poor emotional health and this is exacerbated by the demands of parenthood, particularly when they lack family support, are in conflict with their partner, or are isolated in poor quality housing.

There is compelling evidence that strong social and emotional skills help to shape young people's level of self-awareness and self- esteem, their ability to build warm relationships and empathise with others, and their levels of motivation and confidence in taking control of their lives. This in turn has a positive impact not only on young people's learning and educational attainment, but also on their emotional and mental health and that of their children.

NICE clinical guidelines on mental health problems during pregnancy and in the first year after giving birth includes recommendations for healthcare professionals on relevant screening questions to better identify sub-clinical and early signs of depression, in order to ensure appropriate care and treatment of at-risk groups of mothers, of which teenage parents is one such grouping.

Ensuring the emotional and mental health support needs of teenage mothers and young fathers is considered as part of local early intervention and support arrangements is particularly crucial. Particular attention should be paid to early mediation and relationship support to help resolve family breakdown or partner conflict, and ensuring support services are provided in non-stigmatising and accessible settings.

The benefits of fathers' involvement on children's cognitive development has also been well illustrated and evidence shows that positive involvement of fathers leads to better child outcomes in relation to: educational attainment; attendance and behaviour at school; involvement in crime and substance misuse; peer relationships; and mental health. It is therefore essential that improvements are made to identify young fathers through local CAF and targeted youth support processes.

Family Nurse Partnership (FNP) is a preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. Family nurses build supportive relationships with families and use behaviour change methods so that the parents they are supporting adopt:- healthier lifestyles for themselves and their babies, provide good care for their babies and plan their futures.

The programme uses in-depth methods to work with young parents on attachment, relationships and psychological preparation for parenthood, helping them to overcome adverse life experiences. Thirty years of high quality US research into FNP has shown significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes including:

- improvements in antenatal health
- reductions in childhood injuries, neglect and abuse
- improved parenting practices and behaviour
- fewer subsequent pregnancies and greater intervals between births
- improved early language development, school readiness and academic achievement
- increased maternal employment and reduced welfare use
- increases in fathers' involvement

6.2.11 Lesbian, Gay, Bisexual and Transgender Young People (LGBT)

A high percentage of LGBT young people have mental health problems, aspects of which are often related to coming to term with their sexual orientation, or due to stigma and peer victimisation. Mental health and emotional health and well-being services often do not ask about or know the sexual orientation or gender identity of the young person who access their services.

It is estimated that 22% of LGBT people have a common mental disorder, 9% have attempted suicide, 1% have probable psychosis and 10% have alcohol dependence. It is therefore important to be aware that a proportion of young people being referred to CAMHS or to Accident and Emergency Departments in relation to drug and alcohol misuse, self-harm or attempted suicide, are likely to be in this vulnerable group.

Croydon Youth Development Trust (CYDT) is currently commissioned by Croydon Council to provide LGBT support services in Croydon and is now in its fourth year. The aim of '*The Bridge* ' is to provide a young person led, safe, social and support space for young people aged 13-21 years of age identifying as LGBT whilst also providing information, advice and guidance to young people, parents/carers and professionals.

The Bridge provides an environment where young people can engage in various youth club based social and leisure activities, whilst also providing an opportunity for young people to explore and discuss their experiences and feelings in relation to their sexuality, sexual orientation and gender identity. It was identified early on in the development of *the Bridge* that many of the LGBT young people attending the group had a high level of mental health needs. This led to the implementation of a one to one support service for all young people accessing *the Bridge.*

Nearly 50% of young people attending *the Bridge* have received on-going additional support outside of *The Bridge* youth club hours, with a high percentage being in relation to emotional well- being and mental health needs. Support varies from one to one support sessions, telephone support, home visits and family support to signposting and supporting young people to access and attend other appropriate services such as; counselling services, Turnaround Centre services, housing, social services and leaving care etc. Due to resource limitations *the Bridge* has begun utilising the support of volunteers in order to build capacity, capability and increase service delivery.

6.3 Other Issues

6.3.1 Suicide

Suicide is a complex issue and one which requires further research to understand better the specific risk factors associated with it. Looking at suicides in the UK between 1997 and 2003, it was observed that three times as many young men as young women aged between 15 and 19 committed suicide.[60] Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults. Looking at the difference between genders, 20% of young women were in contact with mental health services compared to only 12% of young men.

According to ONS, in 2010 there were 121 deaths of 10 to 19 year olds from intentional self-harm or undetermined intent in England and Wales. This is a rate of 1.8 deaths per 100,000 population aged 10 to 19 years. If this rate were applied to the population of Croydon this would equate to an estimate of less than one deaths from intentional self-harm or undetermined intent per year.

6.3.2 Self-harm

Self-harming in young people in not uncommon (10-13% of 15-16 years have self-harmed)[61]. Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds[62].

Self-poisoning was the most common method of self-harm, involving paracetamol in 58.2 % of episodes[63]. Presentations, especially those involving alcohol, peaked at night. Repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year).[64]

Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors.[65]

As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months.[66]

The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Knowledge of risk factors is limited and can be used only as an addition to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a greater level of risk: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital.[67]

6.3.3 Violence

Experience of violence and abuse is associated with an increased risk of poor mental health in childhood and adult life. Child physical and sexual abuse is particularly important to address given it is associated with several fold increases in rates of all mental disorder and suicide. Prevention of child maltreatment can also reduce the prevalence of many common mental disorders.[68]

Parent training programmes result in reductions in unintentional injury[69] and abuse of children[70], as well as reduced aggression, violence[71] [72], offending[73], antisocial behaviour[74] and bullying[75] by their children. Family Nurse Partnerships reduce behavioural problems in children and result in a 39% reduction in reported child maltreatment as well as reduced child abuse and neglect[76]. Family intervention projects in the UK have resulted in 61% reduction in domestic violence and 89% reduction in families with four or more antisocial behaviour problems[77]. School development programmes also result in reduced violence[78]

6.3.4 Domestic Violence

Domestic violence is a continuing and pervasive problem. It crosses all ages, classes and ethnicities. Researchers reviewed data from 41 studies worldwide and found that men and women with mental health disorders, across all diagnoses, are more likely to have experienced domestic violence than the general population.[79]. Compared to women without mental health problems, women with depressive disorders were around 2.5 times more likely to have experienced domestic violence over their adult lifetime (prevalence estimate 45.8 per cent); women with anxiety

disorders were over 3.5 times more likely (prevalence estimate 27.6 per cent); and women with post-traumatic stress disorder (PTSD) were around 7 times more likely (prevalence estimate 61.0 per cent) to have experienced domestic violence.

Women with other disorders including obsessive compulsive disorder (OCD), eating disorders, common mental health problems, schizophrenia and bipolar disorder were also at an increased risk of domestic violence compared to women without mental health problems. Similarly, men with all types of mental disorders were also at an increased risk of domestic violence. However, prevalence estimates for men were lower than those for women, indicating that it is less common for men to be victims of repeated severe domestic violence. Approximately 130,000 children are currently (2011/ 2012) living with domestic abuse[80]

Additionally, high levels of mental health need are also seen amongst women who have been victims of sexual assault and/or domestic violence. It is important to note that Croydon has been shown to have the highest number of rapes, sexual offences, and domestic violence in London. Data for the 12 month period running from July 2011 to June 2012 show there were 5,955 allegations recorded in this period. Of those 1,779 (30%) were for more serious types of violence. Females are at far greater risk than males and when the level of violence increases the proportion of female victims increases by 13% from 70% to 83%. The majority of victims are aged 20-34 years of age. This is also the case for males. Local data suggests that the most at risk groups are White European and Afro Caribbean Women. With 20 -24 year olds seeing the highest level of victimisation for both females and males among all ethnic groups.

Children's Social Care received 8601 referrals between 09/02/2011 and 08/02/2013 of which 1158 were specifically in relation to domestic violence. This accounts for just 13% of referrals across the 2 years, which when considering the high incidence of reports to the police would suggest a low level of reporting and identification. It should be borne in mind that as referrals are made in relation to concerns of abuse or neglect in relation to children, any underlying issue of domestic abuse is often not identified until the point of assessment. It has been suggested that up to 90% of allocated social care cases have identified domestic violence being present.

A whole-family approach that addresses mental health together with other issues, such as domestic violence or alcohol misuse, has been shown to reduce the risks associated with mental health problems.

7 Education

7.1 Mental health need and educational outcomes

There has been a wealth of research undertaken which demonstrates the close links between learning, educational outcomes and well-being. Having a behavioural or emotional difficulty can have a significant impact on a child's academic achievement and other outcomes.

In 2012, Morrison Gutman and Vorhaus showed in a piece of research they undertook on the impact of pupil behaviour and well-being on educational outcomes that:

- Children with higher levels of emotional, behavioural, social and school wellbeing, on average have higher levels of academic achievement and are more engaged in school, both concurrently and in later years.
- Children with better emotional well-being make more progress in primary school and are more engaged in secondary school.
- Children with better attention skills experience greater progress across the four key stages of schooling in England. Those who are engaged in less troublesome behaviour also make more progress and are more engaged in secondary school.
- Children who are bullied are less engaged in primary school, whereas those with positive friendships are more engaged in secondary school.
- As children move through the school system, emotional and behavioural wellbeing become more important in explaining school engagement. While demographic and other characteristics become less important.
- Relationships between emotional, behavioural, social and school well-being and later educational outcomes are generally similar for children and adolescents, regardless of their gender and parents educational level.[81]

Additionally, it has also been shown that children with persistent conduct or emotional disorders are

- More likely to be excluded from, school
- Less likely to engage in out –of-school programmes to help them manage their behaviour and improve literacy
- More likely to be assessed with special educational needs, and
- More likely to leave school without educational qualifications[82]

Children with conduct disorders and severe Attention Deficit Hyperactivity Disorder (ADHD) may be four to five times more likely to struggle to attain literacy and numeracy skills.[83]

Promoting the emotional health and well-being of children and young people and providing effective support for those with emotional and behavioural difficulties will help ensure that they have the essential skills needed to cope with the ups and downs of life, to develop good relationships, ensure resilience and help them to achieve their full potential. Schools have a vital role in promoting emotional health and well-being, intervening early to prevent behavioural and emotional difficulties and contributing to the support needed by individual children and their families who have a mental health need.

There needs to be a whole school approach to children and young peoples' emotional health and well-being. This should include supporting the emotional health and well-being of all pupils and providing targeted support for those with identified mental health needs.

In line with the Healthy Schools ethos and associated standards, schools should be healthy places that support the emotional health and well-being of their pupils and staff. For this to happen the school needs to have an open and honest culture, which promotes and is respectful of both pupils and staff. Shared decision making has been shown to be a key aspect of implementing a whole school approach, such as through the involvement of school councils. Schools should also use opportunities to integrate emotional health and well-being into the curriculum, inclusion in assemblies and in other opportunities that exist in the school. A good pastoral system and staff such as learning mentors, teaching assistants and school nurses are also all important resources to call upon when children are experiencing difficulties.[84]

School-based interventions can be very cost effective and schools are increasingly able to use their devolved budgets to commission additional support services to meet the needs of their pupils. The *Pupil Premium* is available for schools to support the children and young people from the most deprived backgrounds. These funds can be used to commission support for young people with behavioural and emotional difficulties, and promote emotional health and wellbeing. Young people from low socio economic backgrounds are more likely to have behavioural and emotional difficulties, so there is a good rationale for using these funds to support these pupils' difficulties and improve their emotional and mental wellbeing. Many providers of mental health services in schools are expressly focussing on how counselling and other interventions can help close the attainment gap. This sort of evidence can justify the use of Pupil Premium to commission support for young people with behavioural and emotional difficulties in schools.

Additionally, many local areas including Croydon are also using the *Early Intervention Fund* to support the promotion of emotional and mental wellbeing in schools.

7.1.1 Healthy Schools

Children and young people who attend a Healthy Schools tell us that they feel healthier, happier and safer. Their parents tell us that they feel more involved in their child's health and learning and often feel better themselves. Schools tell us that the National Healthy Schools Programme has brought sustained improvement in behaviour, standards of work and school management. The whole school approach involves working with children and young people, parents, school staff and the whole school community to provide a solid foundation from which developments and improvement are embedded in a systematic way.
The National Healthy Schools Programme has four themes:

- Personal, Social and Health Education (PSHE), including SRE and drugs education
- Healthy Eating
- Physical Activity,
- Emotional Health and Well-Being, including bullying.

The four core themes relate to both the school curriculum and the emotional and physical learning environment in school. Each theme includes a number of criteria that schools need to fulfill in order to achieve National Healthy School Status.

Despite reductions in the local Healthy Schools Team, Croydon continues to prioritise and support schools in the achievement in their National Healthy School Status award. Many local initiatives have been developed over the years and continue to be provided to support schools in ensuring the positive emotional health and well-being of their pupils.

7.1.2 Targeted Mental Health Services in Schools (TAMHS)

Croydon has for many years now provided support to schools around improving the mental health and well-being of their pupils, as part of the Croydon Healthy Schools Programme.

In 2011, Croydon participated in a one-year government funded Targeted Mental Health in Schools (TaMHS) pilot programme. TaMHS was a government programme aimed at supporting the development of innovative models of therapeutic and holistic mental health support in schools for children and young people aged 5 to 13 at risk of, and/or experiencing, mental health problems, and their families.

The work was based on evidence-informed interventions for children and families at risk of and experiencing mental health problems, which are planned according to local need and grounded in our increasing knowledge of 'what works'.

The broad aims for the project were to:

- Increase the understanding of emotional health and wellbeing (EHWB) amongst the children's workforce within the schools in the project
- Initiate and/or develop programmes to support children and young people particularly those transferring from primary to secondary schools identified as vulnerable and/or 'feeling sad, worried or troubled'
- Develop a model of integrated working between services responsible for meeting the emotional needs of children

A number of evidence-based interventions and activities were identified and offered to schools as a consequence including:

- Art therapy;
- ELKAN communication training;
- Emotional Literacy Support Assistant (ELSA) training
- Headstart Training;
- Place2Be sessions;
- Primary SEAL
- Restorative approaches
- Small group work

Whilst the TaMHS Programme is no longer being continued by the current government, work in schools is still being supported by the local Healthy Schools Programme and through Specialist support from the Emotional Health and Well-Being in Schools sub-group. This sub-group is a is a multi-agency group responsible for supporting the development of emotional health and well-being of children and young people aged 5-19 years of age in schools and colleges with representatives.

Some of the areas of work that this sub-group has recently been involved in include:

- On-going delivery of ELSA Training and other training for schools as part of the Healthy Schools Network opportunities.
- Development of the schools Emotional Health and Well-Being Toolkit
- Development of *Accessing Talking Therapies: Guidance for schools on commissioning therapeutic support from non-statutory services*
- Initial steps on the development of an Emotional Health and Well-Being Centre of Excellence in the Waddon Inclusion Network (WIN) cluster.

7.2 Capacity Building Project

The London CAMHS Capacity Building Project (CBP) aimed to train Tier 1 staff working in a range of different education and health settings within child and adolescent mental health services to recognise and manage mild to moderate mental health needs, and to increase awareness of when and how to refer children and young people onto specialist services (e.g. CAMHS Tier 2 and higher). The

project was set up in April 2011 and ran for two years, after which two different types of evaluation were undertaken.

Across the four pilot sites, the majority of participants reported improvements in their competency across a number of domains including:-

- Understanding of what is meant by mental health:
- Knowledge of risk and resilience factors in children and young people;
- Understanding of CAMHS;
- Skills to identify and support children and young people experiencing difficulties and/or to liaise with other specialist mental health practitioners.

The evaluation found that involvement in the CBP, and in particular the work discussion groups that were set up as part of the project, helped to facilitate a greater understanding and appreciation of the different participants. Participation brought benefits in terms of encouraging greater team sharing and consultation about dilemmas. There was however only limited evidence of significant organisational change in the four pilot sites as a result of the CBP and it was therefore acknowledged that achieving cultural change would require leadership at a senior level.[85]

As a result of the pilot that Croydon participated in, discussions and plans are taking place with Croydon Early Intervention and Family Support service to develop and maintain the CBP longer term. The aim is to train Tier 1 staff workings in a range of education and health settings to recognise and manage mild-to moderate mental health problems and increase professional awareness of when to work with an individual child and when to refer to specialist services.

7.3 SLAM CAMHS Clinical Advisory Group (CAG)

Slam CAMHS CAG is launching a new offer for schools and colleges with the option to purchase a range of services such as training, consultation and clinical work. SLAM CAMHS Health Trust are offering these services to professionals working in schools and educational settings. This new offer is due to be launched in September 2013.

7.3.1.1 Educational Attainment

7.3.1.1.1 Early Years

Good levels of attainment by the age of 5 years of age, helps to support positive emotional health and well-being in children and other outcomes when children start school and supports development as children grow older. The Early Years Foundation Stage Profile (EYFSP) covers six areas of learning around a child's physical, intellectual, emotional and social development. It is measured by 13 assessment scales broken down by the following six areas of learning:

- Personal, Social and Emotional Development
- Communication, Language and Literacy
- Problem Solving, Reasoning and Numeracy
- Knowledge and Understanding of the World
- Physical Development, and
- Creative Development

When children achieve a score of 78 points or more across the 13 assessment scales (i.e. at least 6 out of 9 points per scale) they are deemed to be reaching a good level of development. By the end of the Early Years Foundation Stage, the profile provides a way of summarising each child's development at that point.

Table 16: Early years Foundation Stage (EYFS) Profile 2012 Results

	Croydon (6+)	National (6+)
Dispositions & Attitudes	93	92
Social Development	90	88
Emotional Development	87	85
Personal, Social & Emotional Development	**85**	**82**
Language for Communications & Thinking	87	87
Linking Sounds & Letters	84	83
Reading	82	79
Writing	72	71
Communications, Language & Literacy	**67**	**66**
Numbers as Labels & for Counting	93	91
Calculating	84	80
Shape, Space & Measures	88	86
Problem Solving, Reasoning, Numeracy	**84**	**77**
Knowledge & Understanding of the World	**88**	**86**
Physical Development	**94**	**92**
Creative Development	**88**	**85**
6+ in PSE and CLL and total of 78 or more	**65**	**64**
Total of 78 or more	**83**	**81**

Source : Statistical First Release, DfE, October 2012 update.

The table above shows that in relation EYFS results Croydon is performing better than the England average.

7.3.1.2 School Attendance and School Exclusions

School absenteeism and school exclusions is a key risk factor for violence, injury, involvement with the criminal justice system, risk taking behaviour including drug and alcohol misuse, economic deprivation and poor mental health. As a consequence these are important issues which contribute to children's risk of developing a mental health need.

School attendance remains high overall for Croydon primary and secondary schools with over 94% of the children in attendance during 2010-11. Authorised absences in both the primary and secondary schools were shown to be below the national average. [86] Unauthorised absences in Croydon schools are higher than the national average. Croydon's secondary persistent absence levels have gone up to 6.9%,

however this is below the national average. Persistent absence levels in primary schools have increased to 4.2% which is above the national average.

There has been a downward trend in Croydon's exclusion rate over the last five years. However, last academic year there was a slight increase in overall permanent exclusions. This is attributable to a significant increase in permanent from a single school which had transferred to an academy in September 2010. In the primary phase there was significant improvement. [87]

In 2010-11 there were 0.16% of permanent exclusions. This is a poorer performance than the London average of 0.10%, the England average of 0.08%, and our statistical neighbours. However, Croydon schools overall have generally improved their processes for maintaining pupil discipline without the need for the ultimate sanction of permanent exclusion from school. [88]

The two most common reasons for exclusions in 2010/2011 were as a result of persistent disruptive behaviour (502 incidents) and physical assaults against other pupils (385 incidents). Of the total number of exclusions, more than 3 in 4 (76.8%) were attributed to disruptive behaviour and verbal and physical assaults on another pupil or an adult.

Permanent exclusions of SEN pupils with statements have decreased from 53 during 2008/9 to 42 in 2010/11. There is little change in exclusions of looked after children with 59 fixed term exclusions and 2 permanent exclusions in 2010/11 (55 fixed term and 1 permanent in 2009/10).

8 Early Intervention and Family Support

8.1 The importance of early intervention

Early Intervention enables every baby, child and young person to acquire the social and emotional foundations upon which our success as human beings depends. Most parents give this to their children, often by instinct and common sense alone, but all children deserve nothing less.

The early years are a very sensitive period when it is much easier to help the developing social and emotional structure of the infant brain, and after which the basic architecture is formed for life. However, it is not impossible for the brain to develop later, but it becomes significantly harder.[89] Developing a child's essential social and emotional capabilities means they are less likely to adopt antisocial or violent behaviour throughout life. It means fewer disruptive toddlers, fewer unmanageable school children, fewer young people engaging in crime and antisocial behaviour. Early Intervention can forestall the physical and mental health problems that commonly perpetuate a cycle of dysfunction.[90]

It is essential to recognise that disadvantage in a child's early years can have a life-long, negative effect on their health and wellbeing.[91] Evidence shows that poor social

and emotional health predicts a range of negative outcomes in adolescence and adulthood. Childhood behavioural problems have been shown to be predictors for mental health problems, involvement in crime and violence, substance misuse and unsafe sex.[92]

It is important that vulnerable children at risk of developing (or who are already showing signs of) social and emotional difficulties and behavioural problems are identified as early as possible by children and family services. These include general practice, maternity services, health visiting, the Healthy Child Programme, children's centres and related networks, nurseries and child minders with outcomes for ensuring healthy child development ,'readiness for school' and for preventing mental health and behavioural problems.[93]

Research has shown that the areas of personal, social and emotional development, communication and language, and physical development are the essential foundations for healthy development, for positive attitudes to relationships and learning, and for progress in key skills such as reading and writing. Monitoring progress in these areas is key to identifying special educational needs and disability, especially needs that might not be immediately recognisable, so children are equipped for life and ready for school.[94]

8.2 Croydon's Early Help Strategy: Staged Intervention Approach

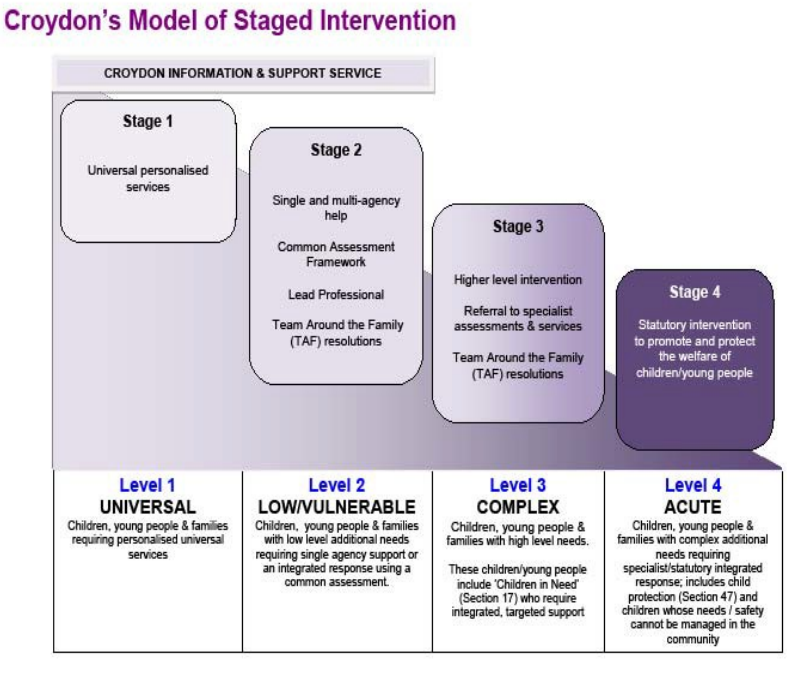
Staged intervention is a process to identify, assess and support the needs of children and young people. It is an inclusive approach that involves parents/carers, children and young people, relevant staff and support services. Staged intervention provides a solution-focussed approach to meeting needs at the earliest opportunity, with the most appropriate and least intrusive level of intervention that enables services to plan how best to meet the needs of individual children, young people and families. It should assist in clearly setting out the support that is available and when it should be offered. It should also enable practitioners to provide 'early help' by effectively identifying, understanding and supporting the needs of children, young people and families.

Croydon's model of staged intervention identifies four levels of need:
1. Universal
2. Low / Vulnerable
3. Complex
4. Acute

The needs of most children and young people will be met at Level 1 by personalised universal services. However, as they develop and their needs change they may move between these levels and require extra support at different stages.

The 'Wedge' model has below has been developed in Croydon to help practitioners from all agencies understand the different levels of need, as well as the support and services that are available at each stage.

Figure 5: Croydon's Model of Staged Intervention



5

8.2.1 Croydon Information Support Service (CRISS)

As part of the Early Intervention restructure the Family Information Service was replaced by the Croydon Information Support Service (CRISS) from June 2011. The new service acts as a central information hub providing telephone and web-based support to professionals, the public, children, young people and families. The service provides information and advice at two levels of support:

- *Stage 1*: providing information about childcare, children's centres, education, family support services and leisure and activities.
- *Stage 2:* advice and guidance to practitioners on integrated working, booking onto Early Invention Surgeries, advising on Common Assessment Framework (CAF) processes and services identified.

All Croydon CAF's are now being recorded centrally by CRISS. Youth Early Support (YES) panels are continuing to develop managerial oversight and support for improving the quality of CAFs for young people.

8.2.2 CAF Analysis Findings

The first annual report of the new CRISS Service (CRISS 2012) shows a steady increase in the quantity and quality of CAFs being completed. The new integrated recording system provides management oversight and analysis with closed CAF summaries being used to identify issues and emerging patterns that will feed into the commissioning of services across Early Intervention and Family Support Services (EIFS) and Integrated Youth Support Service (IYSS).

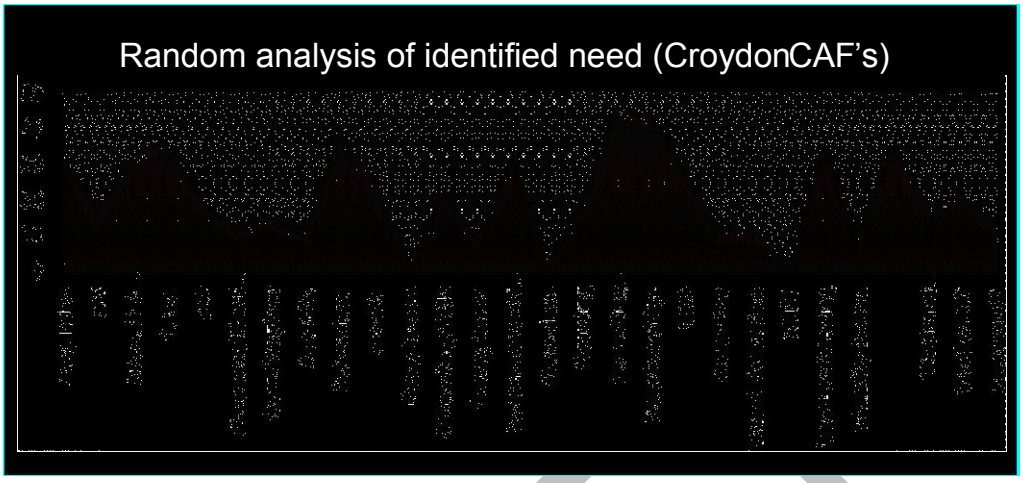
From June 2011- April 2012 there has been 196 CAF episodes registered with CRISS. In the same period the age profile has seen a shift in CAFs being completed for children under 4 (including unborn). Rising from under 20% in the six months previous to 40%.This positively reflects Croydon's service development to identify and identify and target the vulnerable early years more effectively and for families to progress. [95]

Table 17: Age profile of CAF assessments undertaken between June 2011 – March 2012

Age Profile of CAFs	June 2011 – March 2012
Unborn children	3%
Children under 2	15%
Children 3-4	25%
Children 5-11	23%
Young people 12-16	32%
Young people 17-18	2%

A random evaluation of 50 CAFs have been also carried out to begin to identify the pattern of need emerging. Significantly, behaviour issues, parenting, relationships and underachievement all ranked highly. All of which are key determinants of social and emotional well-being.

Figure 6: Analysis of Identified Need amongst Croydon CAFs



The annual report also identified that the high level of behavioural issues identified was reflective of the increased identification and support to families and settings in the early years from the ABC and early intervention teams

Workshops are planned for practitioners on 'child and family assessment' to explore the presenting issues in more detail. Work with the Special Educational Needs Co-ordinators (SENCOs) and the Inclusion and Access Team are also expected to be further developed to ensure that CAFs are used consistently and that CRISS can better support settings where it is likely that joint work is needed between the school, CRISS and behavioural support or Special Educational Needs (SEN) practitioners.

9 Services

9.1 Level 1: Universal

9.1.1 Healthy Child Programme

The Healthy Child Programme is a national public health programme for children and young people, providing a robust evidence based framework, and setting out good practice for prevention and early intervention services for children and young people. [96] Pregnancy and the first five years of life sets out a schedule of health reviews providing a system for early identification of need .

9.1.1.1 Ante-natal and post-natal

The starting point of this core requirement is the Health and Social Care Assessment carried out by midwives at 12 weeks of pregnancy. Croydon University Hospital midwifery services currently achieve (95%) coverage of this first review.

Health professionals in antenatal and postnatal services need to be able to identify factors that may pose a risk to the child's social and emotional wellbeing. This includes any risks to the mother's social and emotional wellbeing which could impact on her capacity to provide a loving and nurturing environment e.g. her mental health, substance or alcohol misuse, family relationships, circumstances and networks of support.

9.1.1.2 Maternal Mental Health

Revised best practice guidance was published in August 2012 with a recommended Maternal Mental Health Pathway. The pathway is a guidance document to support a structured approach to addressing the common issues associated with maternal mental health and well-being, from pregnancy through the early months after the birth. It sets out the benefits and principles of integrated working, focusing on the role of the health visitor, but also recognising the essential contributions of partners in midwifery, mental health, general practice and the third sector.[97]

9.1.1.3 Child Health and Development Reviews

Health visitors should identify any risk factors that were not evident at the antenatal stage, as part of an on-going assessment of the child's development. For an infant or child, factors could include being withdrawn, unresponsive or showing signs of behavioural problems. For parents, this could include indifference to the child or insensitive or harsh behaviour towards them.

Croydon Community Health Services –delivery of the child health and development reviews in the Healthy Child Programme 0-5 are currently variable. Full coverage has been achieved of new- born health and development reviews by 14 days. Capacity issues however have resulted in low coverage of the under one year and two-to- two-half year reviews which are currently under review with commissioners to improve coverage along with increasing staffing capacity through the *National Health Visitor Implementation Plan.*[98]

There are potentially significant future opportunities ahead for professionals to come together around the time of these Healthy Child Programme health and development reviews to intensify support. Tickell's review of Early Years and Family Support (EYFS) identified that the 2-year-old review looks at areas including physical and emotional development and communication skills and support of positive relationships in families which has strong overlaps with the prime areas of learning proposed for the EYFS.[99]

This could provide the opportunity for the early years practitioner's already working with disadvantaged children in early years provision to share their observations with the health visitor. Such early intervention could contribute to reducing significantly the proportion of children who are school unready.

9.1.1.4 Healthy Child Programme 5-19 years

Young people's social and emotional wellbeing is important in its own right but also because it affects their physical health (both as a young person and as an adult). Good social, emotional and psychological health helps protect young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol[100] ,[101] ,[102]. It can also help them to learn and achieve academically, thus affecting their long-term social and economic wellbeing.[103]

Many mental health problems start in childhood and are associated with a number of known risk factors, including inequality. One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood. Half of those with lifetime mental health problems experience symptoms by the age of 14.

9.1.2 Children's Centres

Croydon is one of a number of payment by results (PBR) pilot areas. National and local measures have been developed which children's centres will work towards achieving as part of the scheme. These include ensure vulnerable children have the opportunity to attend high quality preschool education (from the age of 2 years) to enhance their social and emotional wellbeing and build their capacity to learn.

Croydon Early Intervention and Family Support Service (EIFS) are leading the development of children's centre collaborations. Reshaping family support services to enabling targeting to supporting vulnerable families. These newly designed teams will consist of Family Engagement key workers and Family Support and will be a key part of delivering services to families identified through the FEP referral process

9.1.3 Primary Care

The annual rate of identification of different mental health disorders amongst children and young people aged 0-19 was generally low amongst local GPs. It is unclear whether this was due to low levels of assessment and diagnosis, or due to poor adherence and utilisation of associated read codes. The highest annual incidence rates of specific mental health disorders seen over the period 2007-2012 were attributed to personality disorders (1.83 per 1000); other disorder of psychological development (1.33 per 1000); severe mental illness (1.00 per 1000) and learning disability (0.63 per 100).

The greatest number of children identified were in relation to autistic spectrum disorder and attention deficit disorder, anxieties disorders and depression

Table 18: Diagnoses of mental health disorders by GPs amongst children and young people aged 0-19 years of age for the period April 2007- March 2012

Group 2	Group 1	Total
Anxiety disorder	Generalised anxiety disorder	29
	Mixed anxiety and depressive disorder	118
	Other anxiety disorder	106
	Panic disorder	137
	Phobia	67
	Separation anxiety disorder	10
Attention deficit hyperactivity disorder	Attention deficit hyperactivity disorder	553
Childhood emotional disorder	Childhood emotional disorder	18
Conduct disorder	Conduct disorder	66
Disorder of psychological development	Autistic spectrum disorder	859
	Developmental disorder of scholastic skill	117
	Disorder of speech and language development	282
Dissociative disorder	Dissociative disorder	14
Eating disorder	Eating disorder	138
Mood disorder	Bipolar affective disorder	<5
	Depression	244
	Mania	<5
Mutism	Mutism	17
Obsessive-compulsive disorder	Obsessive-compulsive disorder	10
Organic mental disorder	Organic mental disorder	11
Other	Abuse of non-dependence-producing substances	<5
	Other mental health disorder	6
	Pica of infancy and childhood	<5
Personality disorder	Personality disorder	24
Psychogenic sensory disturbance of skin	Psychogenic sensory disturbance of skin	49
Psychotic disorder	Psychotic disorder	35
Somatoform disorder	Somatoform disorder	59
Stress and adjustment reaction	Stress and adjustment reaction	32
Substance misuse or alcohol misuse	Alcohol misuse	35
	Substance misuse	23
Tic disorder	Tic disorder	61
Grand Total		3128

Additionally, it should also be noted that worryingly low levels of identification of antenatal and postnatal mental health need was identified amongst pregnant and new mothers by GPs, but this could be due to the fact that most ante and postnatal

support is provided by community midwives and health visitors . For the period April 2007- March 2012 only 79 women were recorded as suffering from antenatal and postnatal mental health issues. It is unclear if this is due to this issue not being routinely being considered by GPs in the antenatal and postnatal period, or whether identification of this need is considered and simply not recorded appropriately.

9.1.4 Accident and Emergency

Accident and emergency admissions data shows that in 2011-12 there were 5,469 emergency admissions amongst children and young people aged 0-19. Of these the majority were amongst children aged 0-4 years of age. There has been a significant increase in the number of admissions amongst children and young people over the period 2007-2012 with an associated 28% increase.

Table 19: Emergency Admissions for Croydon residents aged 0-19 by year

Year	2007/08	2008/09	2009/10	2010/11	2011/12
0-4	2000	2221	2478	2825	2823
5-10	694	700	809	882	865
11-15	711	817	783	910	797
16-19	878	969	1035	1024	984
20+	21904	24050	26104	25562	26867

Of the total admissions amongst children and young people, there was a total of 436 admissions due to unintentional and deliberate injuries amongst children and young people aged 0-19 years of age. In 2011-12 the majority of admissions were amongst adolescents aged 16-19 years of age. Numbers have dropped by 12% across 0-19 year old children and young people during the period 2007-2012.

Table 20: Emergency Admissions for unintentional and deliberate injuries for Croydon residents aged 0-19 by year.

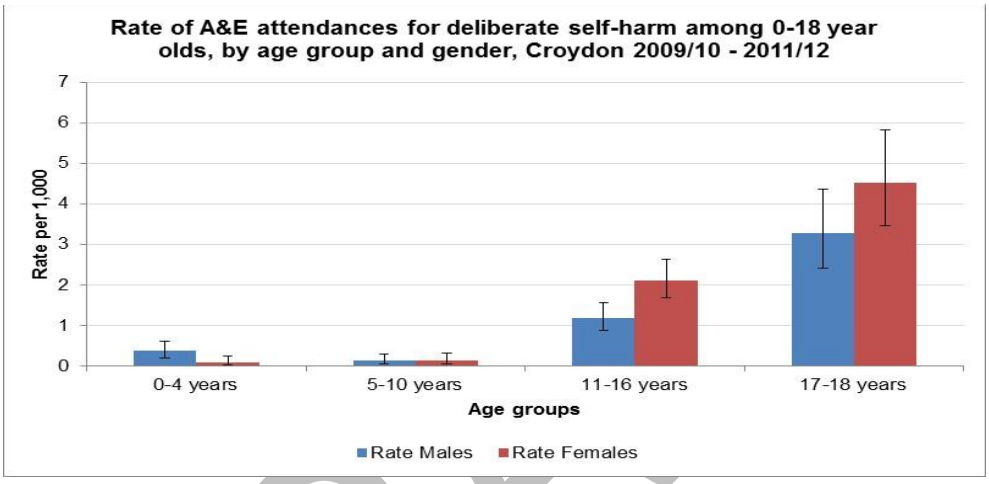
Year	2007/08	2008/09	2009/10	2010/11	2011/12
0-4	82	104	94	121	99
5-10	65	38	67	70	59
11-15	139	147	132	152	119
16-19	212	196	203	162	159
20+	2443	2375	2577	2473	2659

There has been a small drop in the number of admissions due to self-harm amongst young people aged 0-17 years of age over the period 2007-1012. The highest rates of attendance for self- harm are amongst 17-18 year olds, with the greatest rate being seen in females at a rate of 4.53 per 1000 in comparison with a rate of 3.28 per 1000 seen amongst males of the same age.

Table 21: Emergency admissions for self-harm Croydon residents aged 0-19 by year

Year	2007/08	2008/09	2009/10	2010/11	2011/12
0-17	93	90	63	81	72
18-19	39	33	54	33	39
20+	438	365	460	416	453

Figure 7: Rate of A & E attendances for deliberate self-harm among 0-18 year olds, by age group and gender, Croydon 2009-2012



For the period 2009-2012, ten wards in Croydon had rates of accident and emergency attendance for deliberate self- harm amongst children and young people aged 0-18 greater than the average Croydon rate. The greatest rates were seen in Fieldway, Fairfield, Bensham Manor and Selhurst. It is worth noting that the rate seen in Fieldway was double the Croydon average for this period.

Figure 8: Rate of Accident and Emergency attendances for deliberate self-harm for ages 0-18 years, by electoral ward, Croydon 2008-2012

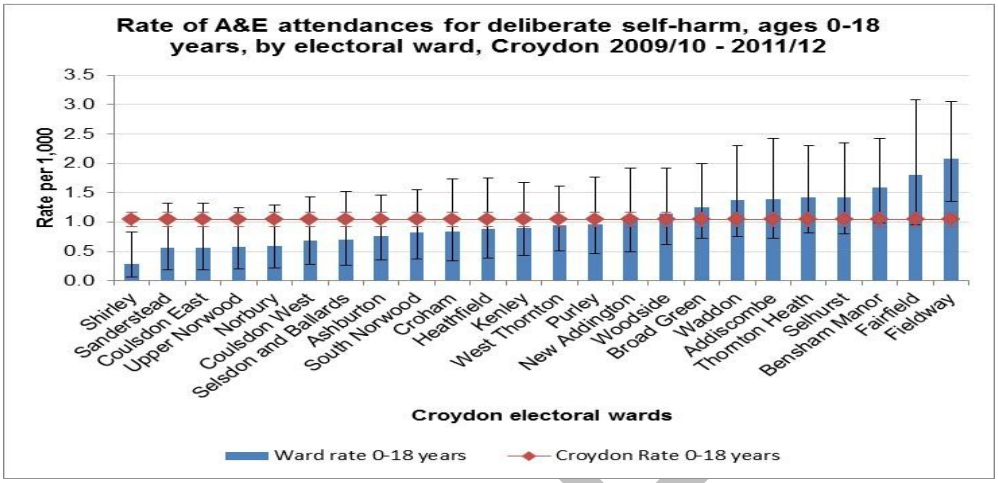


Table 22: Attendances at Accident and Emergency at Croydon University Hospital for assault for Croydon residents aged 0-19 years of age.

Year	2008/09	2009/10	2010/11	2011 to Dec 2011
0-4	8	4	13	8
5-10	11	12	18	20
11-15	179	194	164	123
16-19	324	319	296	259
20+	1221	1149	1152	1180

The number of attendances at Croydon University Hospital for assault seen amongst children and young people aged 0-19 has been reducing over the period 2008-2011.

The greatest rate of accident and emergency attendances for assault amongst 0-18 year old children and young people were amongst adolescents aged 17-18 years of age. The greatest rate was seen amongst males with a rate of 2.79 per 1000, followed by females with a rate of 1.82 per 1000.

Figure 9: Rate of accident and emergency attendances for assault amongst 0-18 year olds, by age and gender for the period 2009-2012

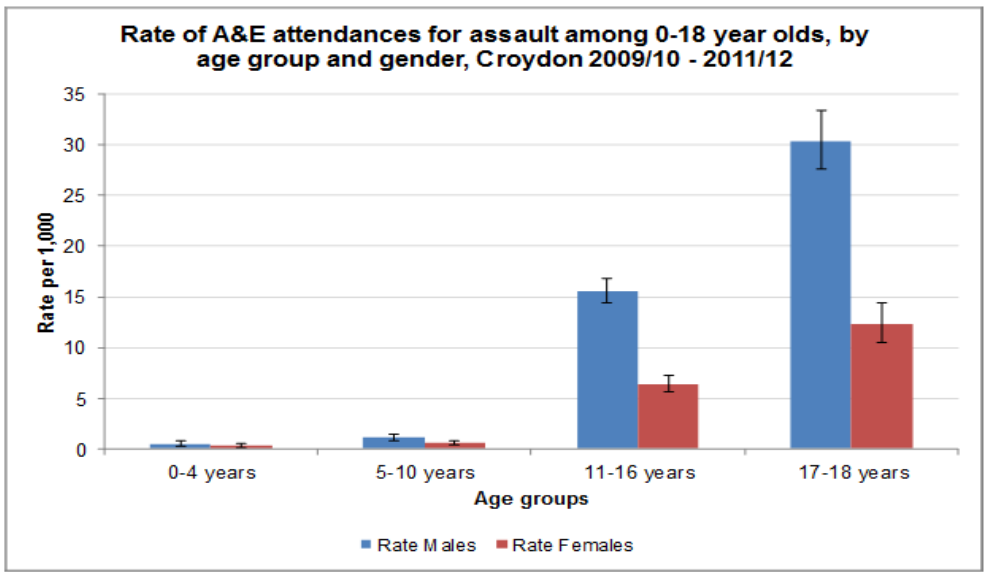
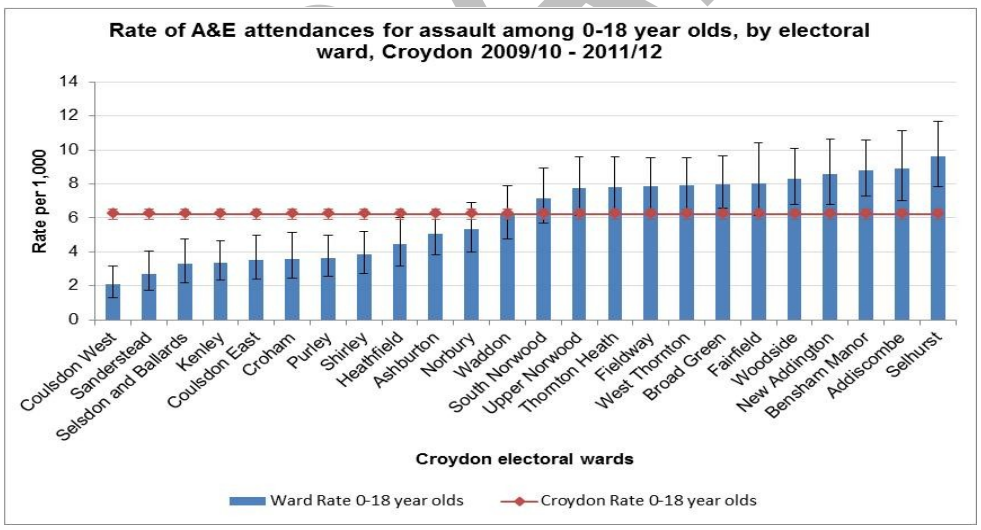


Figure 10: Rates of accident and emergency attendances for assault amongst 0-18 year olds by electoral ward for Croydon 2009-2012.



Rates of attendance for assault amongst children and young people aged 0-18 years of age were seen in greater rates amongst children and young people from Selhurst, Addiscombe, Bensham Manor and New Addington. As expected rates of assault were higher in more deprived SOAs and lower in those areas with lower levels of deprivation.

9.1.5 Croydon Health Services

Croydon Health Services Trust provide a wide range of health services at all four levels of staged intervention, but those services they contribute most widely on are in Levels 1 and 2. Unfortunately, this JSNA Chapter is unable to consider the wider level of emotional and mental health need identified and supported by community health service professionals working in Croydon Health Services, particularly those professionals working in Croydon Child Health Services and the Children's Universal Service. Despite considerable discussion and attempt by the Chapter Author, appropriate service data was not made available for further analysis and review by Croydon Health Services Trust and additional information and commentary was not provided on the range and level of support services available. It is therefore unclear what level of additional service provision is available at CAMHS Tiers 1 and 2 which would help support the assessment of gaps in local provision based on the identified need of our local population.

Through information available to Public Health Croydon through the Family Needs Health Assessment, which is undertaken with new mothers 10-14 days after a new birth it can be shown that unsurprisingly, incidence of postnatal depression is higher amongst new mother living in wards with greater rates of deprivation. Also, there have been significant decreases in the proportion of mothers that report postnatal depression in very young and older mothers. More moderate reductions have been seen in mothers aged 20-29 years of age and a slight increase in mothers aged 30-39 years of age. Additionally, highest levels of postnatal depression are being seen amongst new mothers of mixed and black ethnic origin.

Figure 11: Proportion of mothers by age that report current depression after delivery 2008-2011

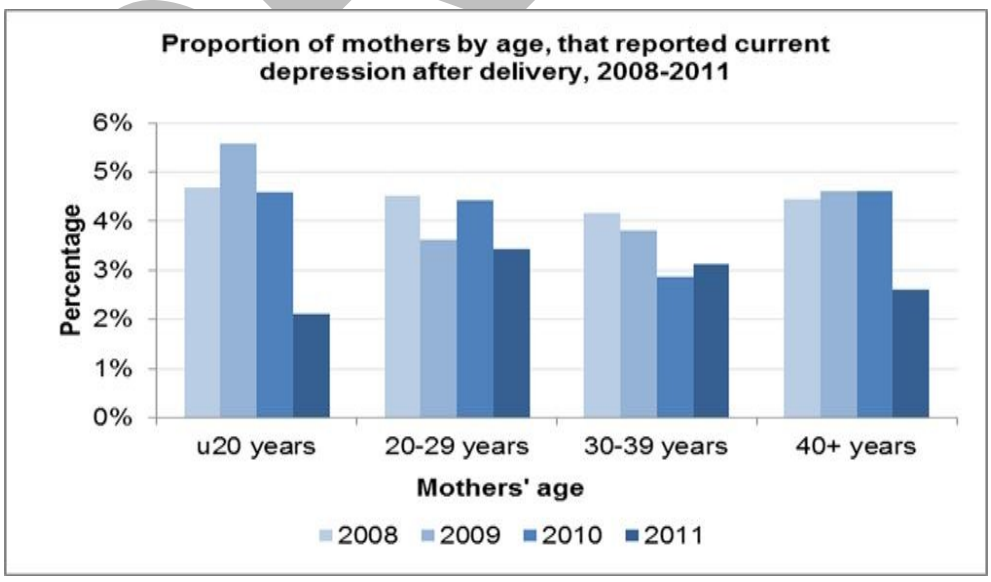
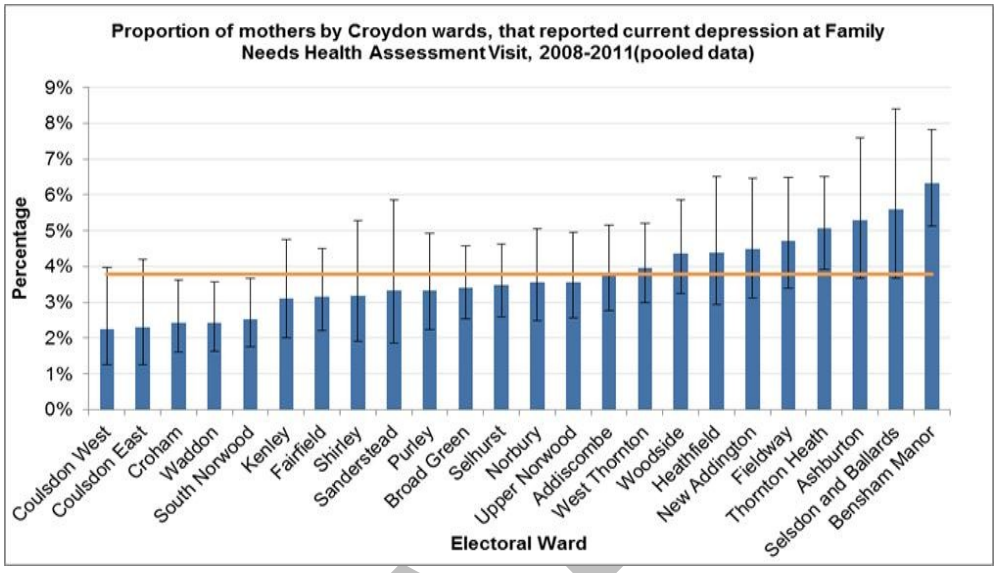


Figure 12: Proportion of mothers by wards that report current depression after delivery 2008-2011



9.1.6 School Nursing Service

The Healthy Child Programme identifies the school nursing service as pivotal in the effective delivery of evidence based support and the importance of children and young people being able to access the expertise of school nurses and their teams. School nursing services are crucial to both identifying need and providing a response through the service offer and in working with partners, thus ensuring effective early help is available. School Nurses are well positioned to identify mental health issues and provide every support to ensure problems do not escalate to crisis point and where appropriate to refer to specialist services.

Nationally, *'A new Vision and Model for School Nursing Services,'* [104] is being developed including plans *to* support local areas, in local workforce planning for school nurse numbers and appropriate skill mix using national data and dissemination of good practice.

As part of this process, the National Children's Bureau (NCB) sought the views of young primary school children about school nursing services. Results drew particular attention to the numbers of children asking for help when they have problems at home (51%), when they have worries about a friend (49%), and when they might be feeling sad (49%). These are indicators that suggest the need for school nurses to provide emotional and social support and assistance to children at times of distress across school life.

Like many other areas up and down the country Croydon Health Services currently have few qualified school nurses their skill mixed team continues to deliver a targeted 'drop-in' service to some secondary schools supporting young people's social and emotional needs and delivering some limited Personal Social and Health Education (PSHE) sessions in classrooms.

9.2 Level 2 – Low/Vulnerable

9.2.1 The Family Engagement Partnership

The Family Engagement Partnership forms an important part of the Croydon Early Help Strategy. It aims to improve engagement and support for families with very young children at the earliest opportunity.

From September 2012, the Family Engagement Partnership (FEP) brought together key people from health and children's services. Regular monthly multi-agency meetings have been developed to ensure there is better joining up of services for families with very young children (including unborn) who require a response from more than one agency and have been assessed as having level 2 needs and requiring stage 2 services or are stepping down from Stage 3. The FEP approach is family centred and consent based.

Families have their needs clearly identified using an appropriate tool such as a Common Assessment Framework (CAF) or Family Outcome Star. All referrals to the FEP are considered and agreement reached on the appropriate services which can be offered to best support the needs of the family and will develop family resilience. Dependent upon the level of consent provided by the family the FEP will ensure appropriate information is shared between agencies. Having appointed a lead agency/professional identified for the family, the FEP will continue to monitor and review progress of this Family Plan at their scheduled meetings.

In practical terms this requires the assessment process to have considered what risk factors are present which might impact on the child's social and emotional well-being and what are the qualities or situations that might reduce the likelihood of negative outcomes. As it is the presence of 'protective factors' which enables resilience to be cultivated ; the FEP will seek to promote other protective factors in a child's life identifying the strengths and capabilities of the family, as well as factors that pose a risk to the social and emotional wellbeing of the child[105]

9.2.2 Education Psychology Service

Croydon Education Psychology Service (EPS) has fourteen educational psychologists who provide regular consultative support to all Croydon's mainstream and specialist schools, resource bases, the early years sector and a range of pupils currently outside the school system. The Educational Psychology Service receives 600-800 referrals per year. The Education Psychology Service uses broad Special

Education Needs categories to record their data and do not routinely record additional categories of need that relate to mental health and well-being. It has therefore been impossible to produce robust data on the level and type of mental health need dealt with within the EPS.

The overall aims of the service are:

- to promote early intervention and preventative work via the Special Educational Needs Code of Practice;
- to support the identification and assessment of needs and action planning in response;
- to advice the Local Authority (LA) on the effective targeting of resources and
- to use psychological principles to promote the development and well- being of children and young people within their learning environment.

The response to individual pupils includes consultative advice and support to parents and school staff, direct pupil work, referral to alternative resources, statutory work and multidisciplinary liaison.

The Service provides therapeutic input via a small team of psychologists who offer family therapy. In-service training is offered to school staff in areas such as Emotional Literacy e.g. ELSA (Emotional Literacy Support Assistant) , together with support for the school as a system. Group work with pupils and parent support activities are also available. Educational psychologists can bring a range of specialist skills to the school community and are able to offer support in promoting the emotional growth and well-being of all pupils.

The key constraints on the service are high numbers of referrals often driven by the most obvious presenting needs and statutory processes. This can mask the more subtle presentations that would benefit from psychological intervention. This links to the issue of raising awareness of the importance of emotional health and wellbeing within a system with often conflicting priorities.

9.2.3 Integrated Youth Support Services

IYSS aims to reach young people in a differentiated way appropriate to need, focusing the decreasing resources available to the Local Authority on the young people in Croydon who are in most need. It is constructed of six key strands that come together to create an offer tailored to the needs of individual young people and the communities in which they live:

- **Turnaround** – youth crime prevention and victim support – working with young people who are at risk of getting into the trouble, providing intensive support to young people to divert them from their current trajectory.
- **Youth Early Support**– early identification of need – working with young people to identify additional needs as early as possible, to put in place a multi-agency package of support to meet the needs of the young person and their family.

- **Information, Advice & Guidance**– providing access to impartial high quality information, advice and guidance, to empower young people to make informed choices about their lives.
- **Journeys**– a new programme of youth engagement in positive activities designed to have long term sustainable impact on the young people who participate and the community in which they live.
- **Open Access**– a variety of provision, responding to local needs and wants supporting the young people to access the Youth Offer and empowering them to get involved in its planning, development and delivery.
- **Specialist Provision**– supporting groups of young people, who may experience difficulties in making the transition to early adulthood. The reasons for these difficulties are varied and are often related to barriers young people face. This will include provision for young people with learning difficulties and disabilities, young people from black and minority ethnic groups, lesbian, gay, bisexual young people, substance misusing young people and some young parents in need of support. The provision will vary from focused support to developmental activities, but all with a view to reduce the inequalities these groups may experience.

The Service has 64.6 WTE staff, including agency staff, though the service is currently being restructured and the service offer is expected to change from 2014. . It currently contracts out the following services: - Drop In Zone; Youth Localities Fund; LGBT; Young Carers and the Young Peoples Substance Misuse Service.

9.2.4 The Place2Be

The Place2Be provides an integrated, responsive and flexible school-based mental health service: A whole school solution, including one-to-one counselling and a self-referral service for children and young people. The Place2Be also provides support for teaching and non-teaching school-based staff, parents and carers. There are Place2Be teams based in 200 primary and secondary schools across the UK. They are supporting 75,000 children up to the age of 13, often in areas of great deprivation.

The service benefits the whole school community by building capacity, developing skills and supporting lasting change to enhance the emotional literacy of the school environment. This is achieved through a range of accredited programmes. The aim is to give children the chance to explore their problems through talking, creative work and play, in order to help them cope with current stresses and distress and help prevent more serious mental health and behavioural problems in later life. When children are happier and less preoccupied with problems, they find it easier to learn, and their educational chances are improved, with potential knock-on benefits throughout their adult life.

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Services are available to children coping with a range of complex problems such as bereavement, family breakdown, alcohol and drug misuse, domestic violence, physical and emotional abuse, trauma and bullying.

9.2.4.1 The Place2Be's school-based services

The Place2Be offers a wide range of interventions, including universal, targeted, individual and group work, to meet children's and families' needs

- one-to-one counselling sessions
- group sessions
- The Place2Talk - a lunchtime self-referral service, open to all pupils in a Place2Be school (both individuals and in groups)
- Transition work – supporting Year 7 and 8 pupils
- The Place2Think - advice and guidance to teachers and school-based staff
- A Place for Parents – a counselling service for parents and carers
- liaison and collaboration with other educational and children's welfare organisations and agencies
- training in promoting children's mental and emotional health for schools and community groups

9.2.4.2 Service Activity

In 2011-12, the Place2Be delivered emotional and therapeutic support services to seven primary schools and one primary school in the Croydon hub, reaching a total population of 3,450 children.

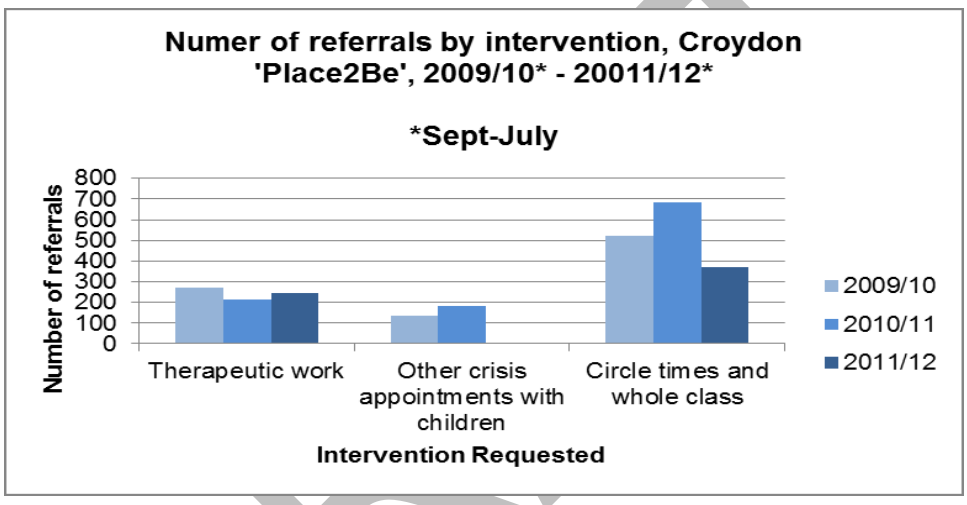
During 2011-12,

- 1,012 children attended Place2Talk services in a total of 2,816 visits.
- 128 children attended one-to one counselling in a total of 2,469 sessions
- 64 children attended group counselling in a total of 69 sessions and 89 circle time sessions were held.
- Referrals were largely made by SENCOs who referred nearly half of the children seen (47%), 24% were referred by teachers, with the remainder being referred by Inclusion Managers and parents.
- 51% of children seen were boys.
- More boys were seen in one-to-one counselling (59%) and more girls were seen in group counselling (67%).
- 47% of children seen were from BME groups, reflecting a higher representation accessing the service compared to the 39% of BME children in the 0-15 resident population
- Those children accessing Place2BE services tended to come from households with low income in comparison to other children in the local area.
- 42% of children accessing one-to one counselling were from lone parent families, compared to 31% of children attending group counselling.
- 62% were receiving free school meals (FSM).

- A high number of children had Special Educational Needs (SEN) with 44% on school action or school action plus. 5% had a full statement.
- A greater proportion of children with SEN attended one to one counselling (55%) than group counselling (35%).
- Many children faced difficult circumstance in their home lives, with 4% of children who were looked after (LAC) and 10% subject to a child protection plan.
- 53% of children and their families were involved with another agency at the time of referral; the most common agency involved with families was social care.

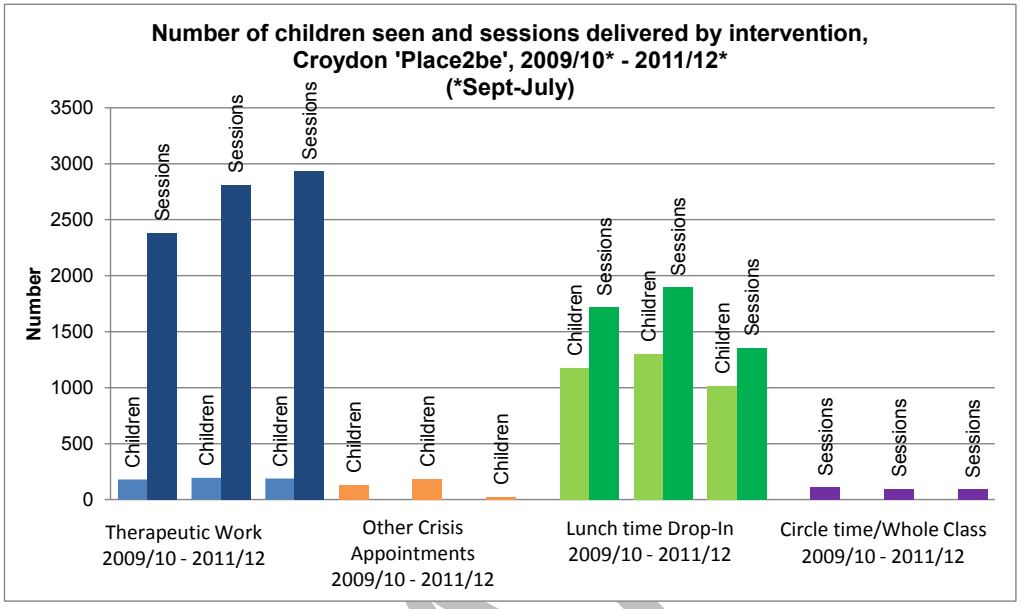
Please note it has only been possible to provide very limited trend analysis for this service.

Figure 13: Place2Be Number of referrals by intervention 2009-2012



There was a 43% decrease in the number of referrals seen by Place2Be in 2011-12, due to a decrease in the number of referrals made for circle time and whole class interventions. Additionally, there were just 23 crisis appointments offered during 2011-12, which relects an 88% decrease from 2010-11 levels. A slight increase was seen in the number of referrals for therapeutic work during 2011, from 2010-11.

Figure14: Number of children seen and sessions delivered by intervention for Croydon Place2Be, 2009-2012



An increase was seen in the number of therapeutic sessions delivered in 2011-12 by Croydon Place2Be, but a reduction in the number of lunch time drop-in sessions held in 2011-12.

9.2.4.3 Improvement in outcomes

Place2Be continues to make an impact on improving children's mental health and well-being, with it being reported that 64% of children with the greatest difficulties making clinical recovery and 83% of all children seen having reduced emotional and behavioural difficulties according to parents.

Preliminary findings showed that children who started one-to-one counselling in 2011-12 achieved above average progress in *writing*, and made average progress in *reading* and *maths.* Children who started the furthest behind at the beginning of the school year made excellent progress in all three subjects.

9.2.5 SLAM CAMHS –Early Intervention Services

9.2.5.1 Early Intervention Service - Schools Service (Headstart)

SLAM CAMHS provide a CAMHS -Tier 2 early intervention service based within secondary schools, colleges and specialist schools. This service also roles out training for other professionals e.g. teachers, support workers. The service called *Headstart* offers assessment, advice and treatment for children and young people, who live in London Borough of Croydon, aged 11-18 and who have mental health problems and learning disabilities.

Croydon SLAM –CAMHS service provide regular mental health and well-being services through school based clinics to Croydon pupils as commissioned by secondary schools and PRUs.

An individual Mental Health Worker is allocated to the individual school and offers mental health assessment and treatment options to pupils and their parents/carers and families who meet the criteria for targeted services. The Headstart Worker provides targeted mental health services to young people aged 11-19 years of age who are living, studying or working within the borough. Therapeutic support is provided through regular sessions. Identified pupils are seen for the duration of 6-12 sessions, then reviewed, discharged or referred to other agencies. If it becomes apparent that a pupil needs more intense treatment or Tier 3 services, then a referral to alternative agencies or the core SLAM-CAMHS service is discussed with the pupil, family and school and appropriate action taken.

9.2.5.2 SLAM -Child Early Intervention Service - Incredible Years

Incredible Years is a Tier 2 Service offering parent group training and support to families with children under the age of 12 who live in the London Borough of Croydon. The service is supported by SLAM and provided by a team of health and social care professionals delivering the service at Children's Centres. The service provides early assessment within a clinic setting prior to referring the families into the most suitable programme. The groups can be intensive and dependent on condition last between 8 and 12 weeks.

9.2.6 Off the Record

9.2.6.1 Overview

Off the Record provides clinical counselling to young people aged 14-25 who live, study or work in the borough of Croydon with the aim of promoting young people's mental health and well-being and supporting young people to manage the current and future challenges in their lives.

The counselling service offers in excess of 100 counselling sessions per week and counselling is offered through a team of experienced paid clinicians and volunteer counsellors who predominantly come to the charity as part of their clinical training. Volunteer counsellors are professionally supervised and supported in their work and currently provide around 45% of all counselling within the service.

In the last year, Off the Record has seen a continuous increase in demand for the service. In a climate where young people are finding it harder to find employment, and the pressure on all support services has increased, Off the Record's counselling service increased its capacity during 2011/2012. Off the Record have sought to manage the extra pressure on the service in different ways including offering a weekly 'open session' where clients on the waiting list and new clients can access

the service without booking. They have also offered short term counselling, with less waiting time, to those clients where it has been deemed appropriate.

The long term answer to the increased demand however lies in further increased capacity. With that in mind Off the Record have recently undertaken additional recruitment, with the aim of increasing their volunteer counselling team from 16 to 20.

As of 2012-13, Off the record were funded a total of £183,917 jointly by Croydon Council and NHS South West London (Croydon CCG) to provide early intervention and therapeutic counselling treatment to young people requiring support to improve their mental health and well-being. The majority of this funding comes from the Adult Mental Health grant and supports the delivery of the counselling service and agency core costs. An additional £33,935 is provided by Croydon Council as part of local CAMHS monies. This funding provides a Counselling Service Co-ordinator, a counsellor, an office manager, finance officer, volunteer counsellors supervision and training costs and general agency costs.

The 'CAHMS' grant to Off the Record funds one WTE counsellor post, currently split between 3 part time posts. These posts are responsible for the bulk of counselling assessments in the service (supplemented mainly by the Assistant Director and Counselling Co-ordinator), direct on going client work and a small amount of time set aside for service development.

These paid counsellors tend to see the most complex on-going clients who present to the service with such issues as complex trauma, significant suicide risk, long term abuse and/or neglect. The service aims to offer initial counselling assessments to young people within two weeks of first contact and those indicating significant risk to self or others will be seen within a few days.

The service is essential to young people who for reasons of stigma, long waiting lists or not fitting statutory criteria cannot or will not use other services. Additionally research undertaken by Mind in Croydon in 2011 [106] shows that clients from BME communities are more likely to be concerned about issues of confidentiality. The high level of confidentiality that Off the Record is able to offer tends to make it particularly attractive to a young diverse client group.

Approximately 32 of the 35 hours per week funded by 'CAMHS' monies is allocated on direct face-to-face provision with another 10-15 hours of counselling (according to need) provided by the Director, the Assistant Director and the Counselling Co-ordinator who are all qualified counsellors. All other counselling at the agency is provided by a changing team of volunteer counsellors. At full capacity the agency can provide around 110 clinical sessions per week, around 10 of which are assessments.

The 'CAMHS' grant underpins the agency's ability to offer clinically safe and effective counselling assessments in the service enabling the agency to offer appropriate support to those with more complex needs and ensuring clients are placed with counsellors who have a suitable level of experience. Paid counselling staff are present throughout the service's extended opening hours and have an essential role in offering clinical support and information to the volunteers they work alongside. Without this back up of qualified and experienced paid staff, the agency's capacity and ability to provide an appropriate service for all young people, but particularly young people with complex needs would diminish greatly.

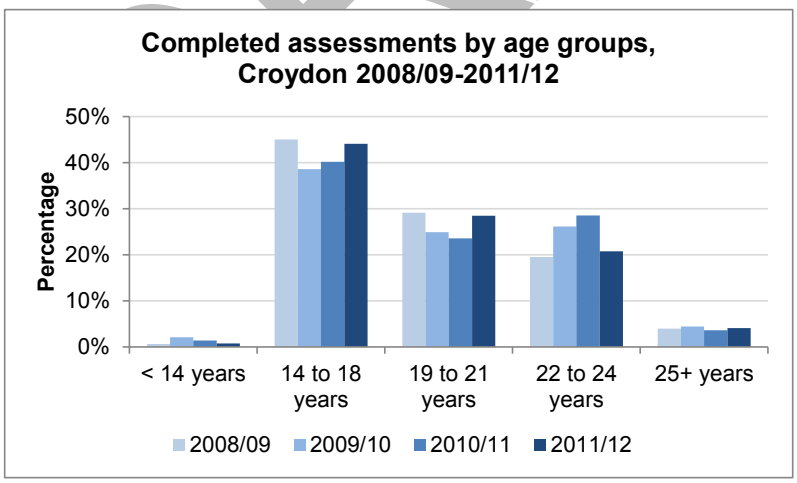
9.2.6.2 Generic Counselling Service Activity

In 2011-12, Off the Record's generic young people's counselling service was able to offer a service to 390 young people. This is an increase of 31 young people during the previous year; individual counselling sessions also increased by 275 sessions.

Off the Record statistics for 2011/12 showed that 47% of clients accessing the counselling service described themselves as White British, the remaining 53% being from a range of ethnic minority groups.
(See Section 5.4.3.3 for statistics relating to Off the Record's specialist young refugee and asylum seekers counselling service).

Between July 2011 and the end of February 2012 the counselling service was also open as a referral route from Croydon's Adult Improving Access to Talking Therapies (IAPT) service due to some interim funding.

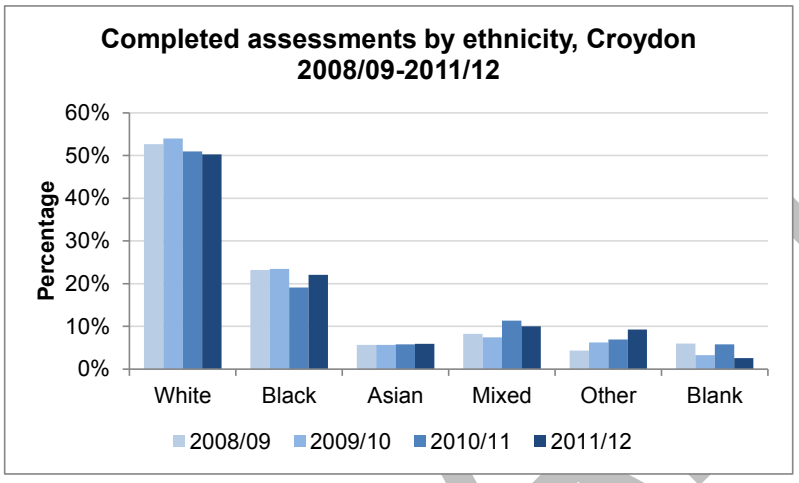
Figure 15: Completed assessment percentage breakdown by age for period 2008-2012



During 2008-2012, the largest percentage of completed assessments undertaken were amongst the 14-18 year old age group. This also reflects a 29% increase over the four year period with a total of 172 assessments undertaken in this age group.

Numbers seen amongst under 14 year olds remain the lowest uptake amongst all age groups seen and have decreased over the four year period. It is also worth noting that there has been a 29% increase during 2008-2012 in the number of assessments undertaken overall with a total of 390 assessments undertaken in 2011-12.

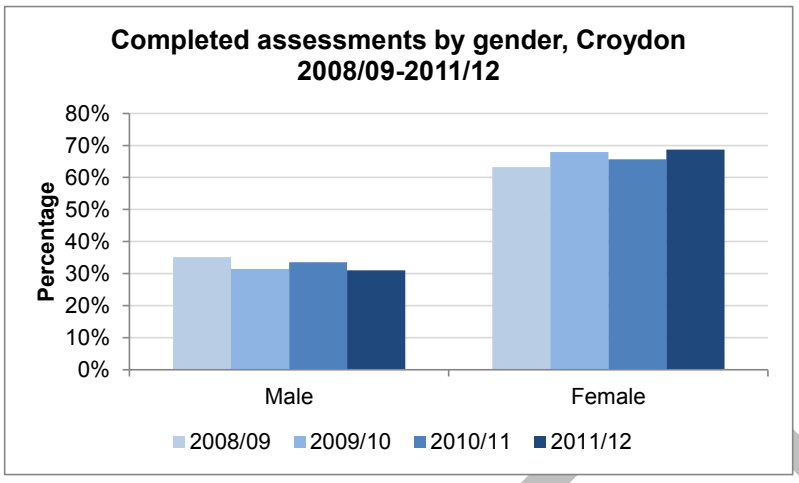
Figure 56: Completed assessment percentage breakdown by ethnicity for period 2008-12



Approximately 50% of all counselling assessments undertaken in 2011 were for children and young people of White origin. A further 22% were of Black ethnic origins and an additional 9% of Mixed ethnic origin.

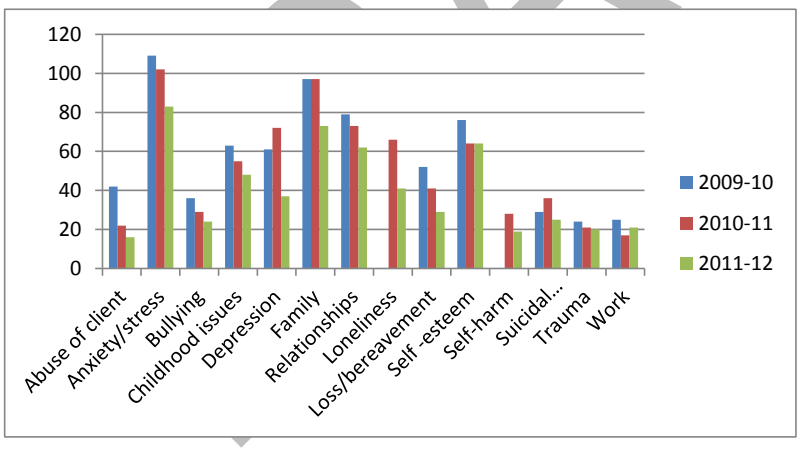
In 2011, an increase was seen in the percentage of assessments undertaken for young people of Black and Other ethnic origins.

Figure 67: Completed assessment percentage breakdown by gender, 2008-12



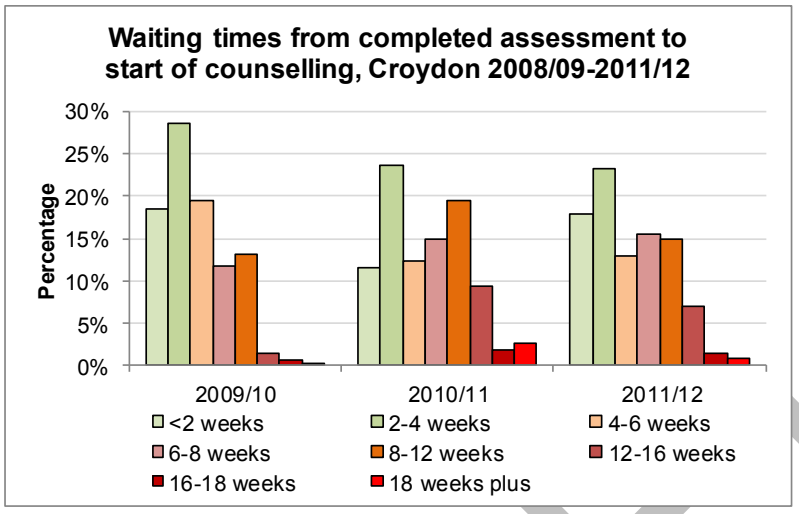
The overall breakdown of assessments undertaken by gender has remained relatively similar over the period 2008-2012. With an approximate 1: 2 breakdown of males to females. In 2011, 69% of assessments were amongst females and 31% amongst males.

Figure 18: Breakdown of need for all clients seen during the period 2009-12



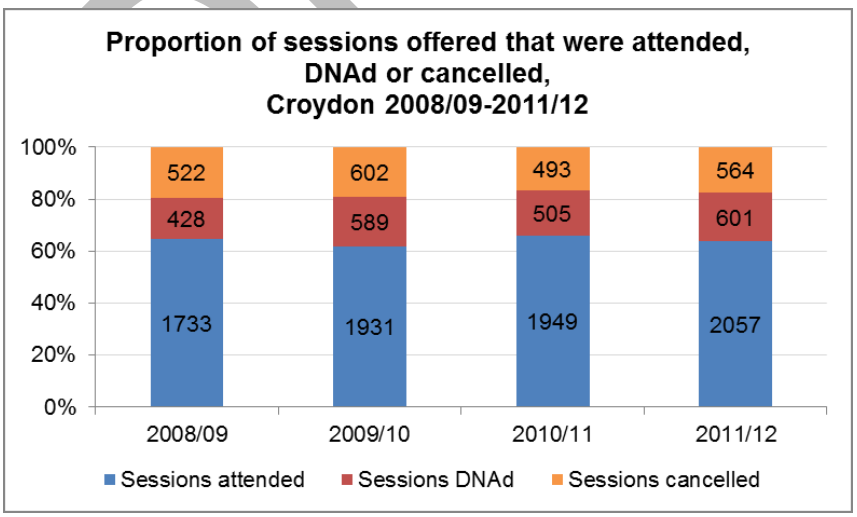
There were 390 young people who received counselling from Off the Record during 2011-12, this was an 8% reduction from the 2010-11 position. The most frequent presenting issues were in relation to anxiety/stress, family issues as well as self-esteem and relationship issues. An increase in work related issues were also seen during 2011-12.

Figure 19: Waiting times from completed assessment to start of counselling 2008-2012



Improvements have been seen during 2011-12 of waiting times from completed assessment to start of counselling at Off the Record. 41% of young people are seen within 4 weeks and 70% within 8 weeks. Just 9% had to wait longer than three months for their counselling to start from the point of their assessment. A steady increase was also seen during 2008-2012 of the percentage of assessments that started counselling after an assessment was completed. 87% of referrals assessed went on to start counselling and reflected a 13% improvement from 2008-9.

Figure20: proportion of sessions offered that were attended, cancelled or Did Not Attend



In 2011, 64% of sessions were attended, 18% of sessions were cancelled and 19% of sessions where the client did not attend.

Outcomes
Outcomes of counselling within Off the Record are measured through CORE (Clinical Outcomes in Routine Evaluation), an outcome measurement tool used nationwide in mental health services, and broadly used in the NHS. CORE is a self-assessment tool where measures are collected in four dimensions - well-being; reported problems or symptoms; functioning (ability to attend to necessary/desired tasks; and risk (both risk to self and others). Measurements are taken before, during and after counselling.

Off the Record outcome measures for 2011-12 show that there was an average reported improvement in all clients of 42% in relation to well-being; 39% improvement in problems/symptoms and 38% improvement in functioning. The highest recorded average improvement is in the area of risk, where risk was reduced by 58% on average across all clients. This represents a 75% decrease in risk scores for young men and 52% decrease in risk amongst young women.

Hence outcomes from the counselling service measured through CORE are:

- Significant reduction in the level of risk to self and others
- Improved daily functioning
- Improved sense of well-being
- Decreased level of reported problems/symptoms

In addition to CORE, the counselling service collates service user evaluation at the end of counselling. Outcomes from these evaluations include:

- Increased resilience to cope with future life events
- Decrease in levels of stress and anxiety
- Clearer sense of direction and purpose in life
- Stronger social relationships both with peers and family

9.2.6.3 Other Off the Record Services offered
As well as providing 1-to-1 counselling to individual young people at the main centre, a range of other complementary services are provided by Off the Record which help to ensure the maintenance and improvement of positive mental health amongst local young people.

9.2.6.3.1 Compass
The Compass Project provides individual counselling and group work support for young people who are refugees, asylum seekers or forced migrants within Croydon secondary schools, colleges or at the main Off the Record Office in Thornton Heath. Counselling is generally short-term and delivered through schools and colleges. Compass is currently funded until August 2014 by Comic Relief and the Trust for London.

Currently, Compass provides individual counselling within ten local schools and colleges and within counselling provision at Off the Record. Counselling can be offered through interpreters if necessary.

An important aspect of Compass's work has been the development of a culturally sensitive counselling service specifically addressing the needs of young refugees and asylum seekers. Compass provide an opportunity to explore past or present issues confidentially, to identify needs and how these may be met and to feel heard and accepted. For many clients this is a first experience of counselling and so care is taken not to put any pressure on individuals to talk about anything they don't want to. Offering a school based service significantly reduces the barriers to accessing mental health support for both accompanied and unaccompanied young refugees.

Group work is offered in schools and colleges to explore issues such as anxiety, anger, self- harm and access to services. The Compass Boys Group provides weekly flexible support, offering an opportunity to develop new friendships, get involved in activities and access wider services.

Professional training is available to any local organisation working closely with refugee and asylum seekers. Training covers the issues facing young refugees, asylum seekers and forced migrants both in and out of school, the impact of loss and trauma and how these might present as mental health difficulties. Specific training is available to explore specific issues, such as self- harm, depression or post-traumatic stress.

9.2.6.3.2 Compass Service Data

Client Data

- In 2011/12, Compass dealt with 306 young people aged between 11 and 21 years of age, of which 70% were unaccompanied minors and the remaining 30% within families.
- A total of 407 referrals were made from 14 different agencies; 42% of referrals were self-referrals;
- 73% of clients were aged between 15-18 years of age;
- Clients came from 30 different countries, with the majority (48%) coming from Afghanistan
- Compass responded to 486 requests for additional support or onward referral.

Individual counselling

- 143 young people accessed individual one-to-one counselling;
- 29% of one-to one counselling clients returned to Compass during this period for additional counselling;
- 64% had not accessed any mental health support before their approach to Compass;
- 22% needed an interpreter to access counselling;

- Compass offered 902 counselling sessions, of which 702 were attended, 95 cancelled and 123 missed appointments
- Attendance for one-to –one counselling were accessed mainly by young men where 74% clients male, 26% clients female;

Group work

- During 2011-12 there was a total of 112 participants across four school and college settings in Croydon.
- Group breakdown was made up of 72% male and 28% female

Compass Boys Group

Consists of a total of 138 members;

- Average weekly attendance of 25
- 23 members attended 10+ times in the reporting period
- 95% of the boys Group members are unaccompanied minors
- 18% are refused asylum seekers who find it difficult to access support elsewhere
- Of those, 50 young people needed an interpreter to access support agencies visited the group during 2011-12 to increase awareness of local support available and to and reduce barriers to access.

Assessment Tools

Existing assessment and outcome tools have been trialled with this client group since 2008. These proved too linguistically complex and culturally inappropriate. They also do not take in to account the limited capacity that asylum seekers have to make changes to their life. As a result Compass have developed an assessment based on the improvement of coping strategies. This measures the impact of the intervention and actions identified and agreed, rather than external change.

As a consequence,

- 68% of clients have strengthened or developed at least one coping strategy as a result.
- 22% strengthened or developed 5 or more strategies
- 40% specifically developed strategies to manage anxiety

Client Need

- 60% of Compass clients experience high levels of anxiety and stress;
- >50% report difficulties relating to identity and cultural issues, have experienced the loss of a parent or both parents, have difficulties managing anger and problems within school or college;
- >40% report sleep problems and nightmares, isolation and loneliness
- >30% experience intrusive thoughts, have difficulties with peer relationships, have low self- esteem and suffer with Post Traumatic Stress;
- >20% are age-disputed, have difficulties with their family, fear on going persecution, have both housing and legal difficulties, suffer with depression, report the loss of siblings and have had their asylum claim refused;

- >10% have reported physical abuse, flashbacks, financial difficulties, prolonged traumatic stress, ill health, suicidal thoughts or actions, problems controlling aggression and have been a victim of violence;

9.2.6.3.3 Young Carers Project

Off the Record's Young Carers Project is a free, friendly and professional service, offering support to young people who are caring for a parent or sibling. The service is offered to young people aged 7-25, who may be caring for someone with a physical disability, mental health issue, long-term illness or learning difficulty. The project is funded through local authority funding and independently raised trust and charitable funding.

The Young Carers Project offers a wide range of activities to support young carers, including:

- **Trips and Activities** - all sorts of activities are organised for all ages during the holidays to ensure young carers have the opportunity to have a break and some fun, as well as providing opportunities to meet other young carers.
- **Emotional Support and Counselling** - one to one emotional support and confidential counselling sessions are offered to help young carers with any issues they may be facing.
- **Educational Support**- support is provided around any issue to do with school, college or training. A weekly Learning Support Club is also offered.
- **Family Support** - support is given to parents, where appropriate. Regular informal coffee mornings are also run to get together and consult with parents.
- **Monthly Boys and Girls Groups**– are held to give young carers the chance to just get together. Different activities are held every time

Currently, 450 young carers are registered with the project of whom 50% are from BME groups and 50% male and 50% female. The average age of newly registered young carers is 10 years and approximately 40% are defined as having high or very high caring roles. 20% are caring for someone with a physical disability, 35% are caring for someone with a physical illness, 25% for mental health issues, 12% for learning disabilities and 8% due to drug and alcohol misuse issues. 80% are from single parent households, 5% care for both prents, 60% care for one parent and 35% care for a sibling.

9.2.6.3.4 BME Community Development Workers

Off the Record BME Community Development Workers service helps the Black and Minority Ethnic (BME) community to develop mental health services. The aim is to help the development of services for young people and young adults aged 0-35 years by providing support to mental health and community organisations.

The BME Community Development Workers support mental health services and community organisations to engage Black and Minority Ethnic (BME) communities in their work by:

- Empowering BME communities to play a key role in the development of services.
- Identifying barriers to accessing mental health services.
- Raising awareness of mental health issues and challenging mental health stigma within BME communities.
- Acting as a supportive link between BME communities and mental health services.
- Helping organisations to build capacity.
- Bridging the gap between community organisations and statutory services, providing information and advice on how to engage with BME groups.

9.2.6.3.5 Family Navigators

In 2011, Off the Record was chosen as one of the partners in Croydon Voluntary Action's (CVA) Big Lottery, Family Power bid. The bid consisted of three key areas of delivery and one of these areas was the Family Navigator Programme. As of October 2012, 6 of the agencies involved were allocated a Family Navigator worker for 2-3 days a week for 2.5 years. The role of the Family Navigator in Off the Record is to work with young carer or refugee families where the oldest child is aged between 5 and 10 years supporting them in accessing local support services.

9.2.7 Croydon Drop In

Croydon Drop-In (CDI) is a multi-faceted charitable organisation that provides provision and intervention services to young people aged 11 to 25 who live, work or study in the borough of Croydon. In the main, the ages of young people using their services are aged 11 to 19 years of age. Croydon Drop-in provide a drop-in counselling, advice and advocacy service alongside a provision of 60 counselling sessions per week, all are free and confidential. Croydon Drop-In also deliver a commissioned:

- Counselling service in primary, secondary schools and PRUs
- An Outreach Team which delivers a variety of health education and health promotion programmes, through the Schools Outreach Health Education Programme and their mobile unit Talkbus
- Accredited and non-accredited training and group work to young people and professionals.

As of 2012-13, Croydon Drop-In are funded a total of £101,435 jointly by Croydon Council and NHS South West London (Croydon CCG) to provide early intervention and therapeutic counselling treatment to young people requiring support to improve their mental health and well-being. This funding provides 50% of the Agency Directors post, 50% of the Agency Co-ordinator, 1 full-time paid Counselling and Clinical Manager, a specialist Solution Focused Therapist and 18 qualified volunteer counsellors who provide no less than three hours per week each of counselling and

2 volunteer administrative support workers. The Integrated Youth Support Service (IYSS) Counselling and Information Advice and Guidance (IAG) contract of £85K provides the other 50% of the Director and Agency Co-ordinator post as well as 1 FTW Advice and Advocacy Worker and a further Advice and Advocacy volunteer.

9.2.7.1 Style and orientation of counselling provision

Integrative Approach –Person Centred
This is a style of counselling that is utilised mostly by the volunteer team; the core conditions of the "person centred approach2 are combined with *Egans Skilled Helper* model which is focused on an empowering and goal orientated approach. This type of counselling at Croydon Drop-In is not time bound, but reviews are held with the young person every 6 weeks. The average relationship is approximately 12-18 weeks in duration.

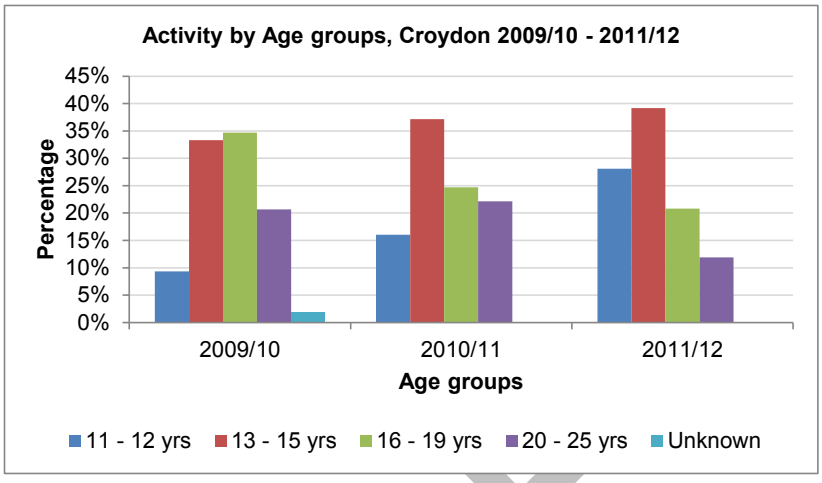
Solution Focused
This is a time-bound intervention lasting no more than 8-12 sessions. This helps the individual to focus on step by step progress towards solving current difficulties or problems. The young person and therapist may use a number of ways to identify and solve the issues concerned.

Hypnotherapy
This is a short intervention, no more than six session and is specifically used for trauma, anxiety, panic attacks, unwanted fears and habits and some physical symptoms of ill-health.

Cognitive Behaviour Therapy (CBT)
This is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. Most therapists working with patients dealing with anxiety and depression use a blend of cognitive and behavioral therapy. This technique acknowledges that there may be behaviors that cannot be controlled through rational thought. CBT is "problem focused" (undertaken for specific problems) and "action oriented" (therapist tries to assist the client in selecting specific strategies to help address those problems).

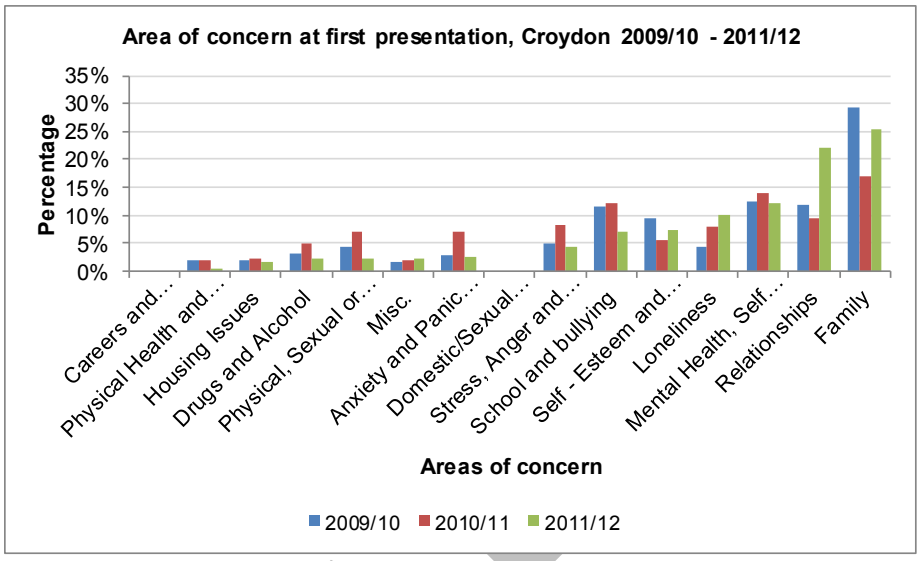
9.2.7.2 Service Activity

Figure 21: Croydon Drop-In counselling activity by age group 2009-2012



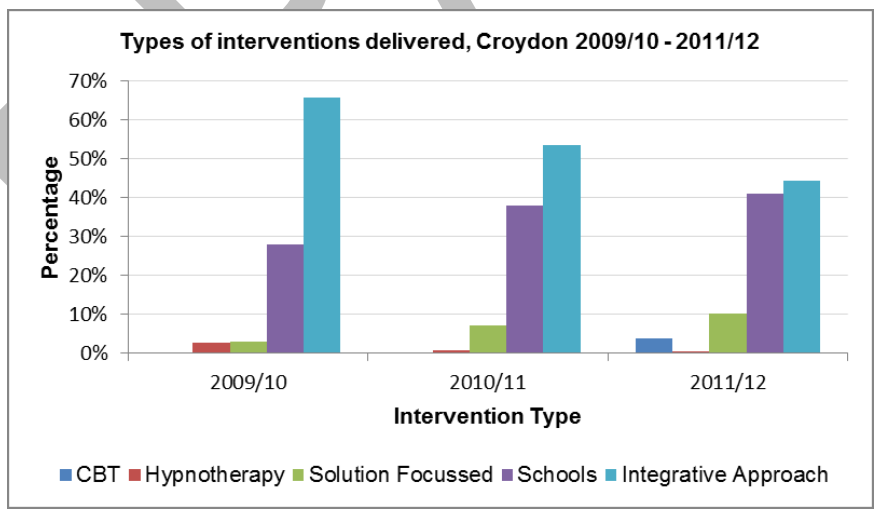
The numbers of young people seen by Croydon Drop-In have remained fairly consistent over the three year period with an average of 375 young people seen per year. What has changed however is the significant increase in 11-12 year olds and 13-15 year olds seen over that period with a 19% and 6 % increase respectively. Additionally, significant decreases have been seen in the 16-19 and 20-25 year old age groups with a drop of 14% and 9% over the three year period. The largest percentage (39%) of young people seen by Croydon Drop-In, in 2011-12 for counselling are amongst 13-15 year olds, with a total of 145 young people seen.

Figure 22: Area of concern at first presentation for counselling support 2009-12



The largest reasons for seeking support by young people during 2011-12 are due to family, relationship, mental health, self-harm and suicide or loneliness. Interestingly, school and bullying concerns have reduced over the three year period.

Figure 23: Type of counselling intervention delivered by Croydon Drop-In 2009-2012



Integrative or 'person centred' counselling remains the most popular type delivered by Croydon Drop-In though this has reduced by 22% over the three year period, with 164 in 2011-12 young people receiving this form of counselling as opposed to 239, in 2009-10. There has been a significant increase in the level of *school based*

counselling provided making a total of 41% of all counselling delivered by Croydon Drop-In during 2011-12. Delivery of *solution focused* and *CBT* styled counselling therapy have also increased over the three year period. The only type of therapy that has reduced is *hypnotherapy*, with this due to the reduction in capacity to deliver this type of therapy rather than due to the lack of demand.

9.2.7.3 Croydon Drop-In Services

As well as providing 1-to-1 counselling to individual young people at the Croydon Drop In Centre, a range of other complementary services are provided by Croydon Drop-In which would play a role in helping to meet ensure the maintenance and improvement of positive mental health amongst local young people.

Counselling in Schools

This provision has been developed over several years and started out as a pilot in St Giles school which was originally funded by the CAMHS grant. In 2009, Croydon Drop-In started to offer school based counselling as a commissioned service and are currently providing school based counselling in the following schools:- Harris Academy (Crystal Palace); Riddlesdown; Shirley High; Elmwood and St Giles. The schools contracts are generally annual in nature and provided by experienced volunteer counselling therapists. Most of Croydon Drop-Ins school counselling is either *Solution Focused* or *CBT* in style. In 2012/13 the Counselling in Schools service offered 736 appointments and supported 120 young people, 119 who were under the age of 18 years.

Some examples of the feedback received include

'Counselling helped me to speak about things and not hold it in, and also made me realise anger is not a way to solve things.'

'Counselling has helped me to recognise when I'm being distracted and how to control it. My behaviour is slowly changing and I'm not getting into as much trouble.'

Advocacy and Advice Service

The advocacy and advice service is managed by a qualified counsellor or advice worker and provides advice and advocacy support for local young people. The needs of the young people accessing this service are varied and often complex and as a consequence some the cases can be very challenging and time consuming. Croydon Drop In see a large number of young people seeking housing and homelessness support and this is one of the top reasons young people cite for seeking advice and advocacy support. It is widely acknowledged that homelessness can create and worsen areas of concern such as mental health and drug and alcohol misuse.

Family Navigators
In 2011, Croydon Drop-In was chosen as one of the six partners in Croydon Voluntary Action's (CVA) Big Lottery, Family Power bid. The bid consisted of three key areas of delivery and one of these areas was the Family Navigator Programme. As a consequence, as of October 2012 all the agencies involved were allocated a Family Navigator worker for 2-3 days a week for 2.5 years. The role of the Family Navigator in Croydon Drop-In is to work with young people and their family unit, to support, advocate and direct these vulnerable families to appropriate services and to work closely with Croydon Family Resilience service and CRISS.

Outreach Service
The Outreach Team provides a programme which aims to increase access for young people to Croydon Drop-In and other appropriate services. They work with young people in a variety of ways, including:-

- providing interactive sessions on health and wellbeing in school and youth work based settings as part of the curriculum and ECM five outcomes. Sessions are focussed upon specific issues identified in consultation with the young people involved, examples include personal safety, sexual health, drugs, self-esteem, smoking, careers and stress management.
- visiting neighbourhoods, colleges, housing projects, festivals, holiday schemes and street work with TALKBUS, a mobile information project. Delivering work in partnership with other agencies who utilise the TALKBUS in their delivery
- helping to make links with other agencies and services that support young people's needs.
- delivering the Information Board Peer Education project across the borough
- championing of both local and national campaigns for example, *No Smoking Day*, *Black History Month, Mental Health Awareness, Tackling Drugs* etc.

In 2009/10 the Outreach Team had contact with 13002 young people via it's TALKBUS and Outreach Health Education Work, in 2012/13 this had reduced to 4159 as a consequence of a loss of funding from public sector commissioning streams.

Service User Feedback
For many young people using Croydon Drop-In services have often felt that they had nowhere else to go or anyone else to turn to.

"*I was suicidal when I came but did not want to take antidepressants. Drop-In helped me to get out of depression and now I have had the strength to find a new job, face problems in my personal life as well as accept things from my past"*

"I am a lot happier now and I feel more confident in who I am and how much respect I deserve from other people. I used to push problems I had to the back of my head and not deal with them until they became too much to handle. I've learnt that I was wrong to do that and it only made things worse."

9.2.8 Improving Access to Psychological Therapies (IAPT)

CYP IAPT is a new initiative to extend access to psychological therapies to children and young people. This initiative will reach a number of areas in the UK over the next three years. This initiative is expected to be provided by Specialist CAMHS services often in partnership with voluntary sector organisations to provide evidence-based treatments and is based on a model of session by session outcome monitoring. There has been additional money dedicated to this programme to help develop local capacity through the provision of training for targeted and specialist CAMHS staff. In 2012, SLAM, Croydon Drop-In, Off the Record and Croydon Place2Be were successful in securing funding from the Department of Health to increase the number of local practitioners that could offer psychological therapies to children and young people.

There is a very clear goal of local service transformation which is being discussed within a multi-agency steering group. Croydon is one of the complex partnerships that have been funded, but this may present new opportunities for different and improved ways of working.

9.3 Level 3 - Complex

9.3.1 Family Nurse Partnership (FNP)

FNP sits at the intensive end of the prevention pathway for more vulnerable children and families. The Croydon FNP programme started in October 2010 and now delivers to 105 young families across Croydon. The FNP is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two.

FNP has three aims: to improve pregnancy outcomes, child health and development and parents' economic self-sufficiency. The programme uses in-depth methods to work with young parents on attachment, relationships and psychological preparation for parenthood. Family nurses build supportive relationships with families and guide first-time teenage parents so that they adopt healthier lifestyles for themselves and their babies, provide good care for their babies and plan their futures.

The FNP programme's effectiveness in promoting social and emotional well-being of children has focused on more indirect outcomes such as less child abuse, with the potential for improved well-being at a later age. None of the US trials reported on

child emotional or behavioural outcomes in any detail until children were aged six. [107] here is strong evidence from three longitudinal RCT's of the impact on children's socio-emotional development at later ages, such as a 67% reduction in behavioural and emotional problems at six years of age[108], 28% reduction in 12-year olds' depression and anxiety[109]and reductions in adolescent antisocial and criminal behaviour were also found at age 15-19 years in the children from the first US trial.[110]

As the evidence for FNP is from the US, currently in the UK a three year formative evaluation has been completed and a large scale research trial is due to report early findings in 2014. Evidence so far suggests that FNP children appear to be developing in line with the population in general which is very promising as this group usually fare much worse.[111]

It has also been identified that Croydon's FNP caseload has a higher percentage of clients who present with anxiety/depression issues at 6 weeks infancy than the FNP national average Local profile data identifies that 8.7% of the caseload in 2012-13 was currently receiving specialist CAMHS services and 4.34% of caseload had received Tier 4 CAMHS in patient mental health care, though this finding is not necessarily surprising given the large number of very vulnerable clients on the FNP programme that have high or complex levels of need.

9.3.2 Family Resilience Service

The Family Resilience Service is Croydon's response to the governments 'Troubled Families Programme (Communities and Local Government 2012) which aims to support and develop new ways of working with families often with long standing problems characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour.

The challenge is to find new ways of working with families which focus on lasting change which in the longer term will to reduce costs and improve outcomes.

The reason some children succeed when faced with risks and adversity is resiliency—an individual's, family's, or community's ability to cope or "bounce back" from significant adverse life situations or stresses in such ways that are not only immediately effective, but also result in an increased ability to respond to future adversity[112]. This service aims to work with families to develop and so benefit themselves and others from the qualities of resilience.

The criteria for consideration of the service reflect broadly national guidance:

- Household with one or more under 18 crime proven offence in the last 12 months or an anti-social behaviour

- Crime and Anti-social behaviour –household with one or more under 18 crime proven offence in the last 12 months and or
- Household with one or more member with an anti-social contract or family subject to housing related ASB .(789 households identified in Croydon)

- Household affected by truancy or exclusion from school. (1,169 identified in Croydon)

As of February 2013, the Family Resilience Service had been identified 355 eligible families and were working with 103 families and a total of 284 children.[113]

The following case studies provide some examples of the type of children that the Family Resilience Service supports with respect to identified mental health needs.

Case Study One

A family of three children ages 11, 9, 2 and their mother were referred to the Family Resilience Service from Education. The middle child was displaying aggressive behaviour at school and was at risk of exclusion. This child struggled with making friends with other children and displayed violent behaviour towards the mother. All of the children had witnessed physical and emotional violence at home. They all found it difficult to express themselves. The mother struggled with looking after the children. She had no routines in place to help manage family life and had difficulty dealing with the emotional needs of her children, setting few boundaries and giving little praise. The middle child's violent bullying behaviour towards her made her angry and upset and she dreaded being outside the home with the child. The younger child was missing nursery frequently.

The Service worked with the whole family to set boundaries at bedtime, tea time and mornings and the mother supported to manage these new routines. She was encouraged to take up parenting courses and to take care of her own health needs. Close working with the schools ensured the oldest child had a smooth transition into secondary school. The children's attendance was closely monitored. The middle child was referred to Child Adolescent Mental Health Services (CAMHS) for assessment and the process of statutory assessment for special educational needs started. The mother was supported to establish routines to enable the youngest child to be taken and collected from nursery. The whole family were encouraged to get involved in positive activities.

Progress: The mother is now consistent in setting boundaries at home and is engaged on a parenting course (Webster Stratton Incredible Years training). The mother reports there has been no aggressive or violent incidents at home involving the middle child since; this child now attends and enjoys after school activities several days per week. The oldest child has settled well into secondary school and attendance has improved. The youngest now attends nursery school regularly.

Case Study Two

Family of three children 15, 5, 2, mother and stepfather referred by Education. Oldest child had poor school attendance, history of running away from home and not getting along with step-father. Had made contact with biological father who had a violent history but felt very negative about their relationship. The step-father found it difficult to support mother with boundaries for oldest child which were very erratic; he had issues with anger management himself.

The service key worker supported the eldest child with her emotions about her real father providing one to one sessions and accompanying to counselling. Family Support Project places offered together with Step-father to build their relationship. Mother and step-parent supported to set consistent and appropriate boundaries. Close liaison with school established to communicate any issues arising.

Progress: Improvement in child's attendance at school. Family Relationships have improved and positive progress has been made between step-father and oldest child. Mother reports some improvements in the morning and evening routines and is more confident to challenge behaviours when boundaries are not adhered to.

9.3.3 Family Justice Centre

9.3.4 Social Care

The Children's Social Care Service of Croydon Council started a major restructuring and remodelling in 2012. The drivers for this were two-fold:

- To respond to the messages from Eileen Munro's national review of child protection.

- To deliver the significant improvements in outcomes for children and quality of service that our audits and inspection findings highlighted as being needed.

Important changes are being rolled out in in the models of social work and management practice that are being used in Croydon. The model of social work practice being introduced, have the following characteristics:

- Relationship based
- Clear theoretical framework and uses evidence-based methods of help

- Outcome focussed.
- Reflective and supported
- Connected creativity

The new children's social care structure came into being in April 2013 with three key service areas.

The Children in Need Service
This is responsible for the receiving of child protection and children in need referrals; the assessment of children in the community; undertaking of direct work with children subject to child protection and children in need plans. The service is responsible for taking children into care, and working with them for three months to either return home or start the first stages of planning for permanence e.g. through adoption. This service also includes social care services for children with a disability.

The Looked After Children Service
This service is responsible for all looked after children for whom the plan is permanence i.e. adoption, specials guardianship, long-term fostering. This includes all unaccompanied asylum seeking children. It comprises the social work units undertaking the direct work and care planning with the children, and the fostering and adoption services. It also includes the support service for care leavers.

The Safeguarding and Looked After Children Quality Assurance Service
This service is responsible for a range of functions: the independent chairing of statutory reviews for looked after children and child protection conferences, and the management of the systems for both; undertaking quality assurance exercises; the LADO function and lead for missing children monitoring; management of the Local Safeguarding Children Board, and the social work training / development.

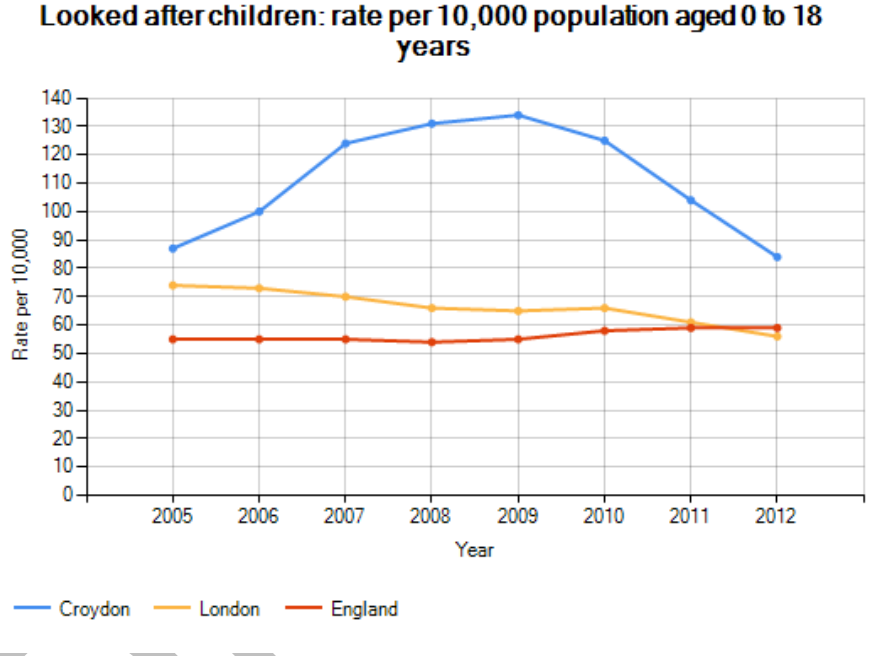
Table 23: Croydon - Children in Need Numbers 2009-12

	31st March 2009	31st March 2010	31st March 2011	31st March 2012
4. CIN and CIN CPP	Number	Number	Number	Number
Children In Need	3700	4545	4616	4011
of those, Children in Need with CPP	290	346	331	288

Source: CIN Census

The chart below shows the trend in the rate of looked after children between 2005-2012. Croydon's rate of LAC has reduced significantly over recent years to a level similar to that seen in 2005. At its peak in 2009 Croydon was responsible for 1,075 LAC. Data available at December 2012 shows Croydon has 749 LAC aged 0-18 years of age under its responsibility, with 55% that are indigenous LAC and 46% Unaccompanied Asylum Seeking Children (UASC). These reflect the highest and lowest percentages respectively of indigenous and UASC LAC seen since 2005.

Figure 24: Looked After Children rate per 10 000 population aged 0-18 years



Source: Department for Education

From the table below it can be shown that the make up of our LAC population is changing slightly with time. The lowest age group seen of LAC remains those aged under 1 year of age making up approximately 2% of the total LAC population. The majority of LAC are aged 16 and over (43% in 2012) and 10-15 years of age (335 in 2012). Increases in the percentage of LAC are being seen in the 1-4 and 5-9 year old age group over the same period with the total percentage of LAC in those age groups increasing to 10% and 11% of the overall total.

Breakdown of LAC by gender has remained relatively consistent over the period 2009-12 with71% of the total LAC population being male and 29% being female.

Table 24: Croydon LAC Age Group and Gender 2009-2012

	31st March 2009			31st March 2010			31st March 2011			31st March 2012		
1. LAC Age Group & Gender	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Under 1:	9	10	19	10	13	23	9	6	15	6	10	16
1 - 4:	28	31	59	38	35	73	42	29	71	49	29	78
5 - 9:	43	25	68	40	42	82	33	32	65	45	37	82
10 - 15:	318	94	412	234	76	310	184	85	269	166	81	247
16 and Over	413	100	513	421	99	520	345	80	425	258	62	320
Total	811	260	1071	743	265	1008	613	232	845	524	219	743
Source: SSDA903	1071			1008			845			743		

The ethnic make up of Croydon's LAC population has changed considerably over the last four years with a significant reduction being seen in the percentage of LAC of white origin, which currently makes up 27% of total population and reflects a drop of 15% from levels seen in 2009 levels. The largest increases have been seen in the Asian and Asian British and Black or Black British LAC population with the total percentage of LAC seen in these respective groups being 33% and 28% respectively.

Table 25: Croydon LAC -Ethnic Group

	31st March 2009	31st March 2010	31st March 2011	31st March 2012
2. LAC Ethnic Group	Number	Number	Number	Number
White	447	340	190	202
Mixed	87	88	79	82
Asian or Asian British	253	297	340	244
Black or Black British	247	245	223	205
Other Ethnic Groups	37	38	13	10
Total	1071	1008	845	743

Considerable focus and improvements have been seen in 2012-13 in the percentage of eligible LAC who have completed a *Strengths and Difficulties Questionnaire* (SDQ). An SDQ assesses the level of behavioural and emotional difficulties among looked after children and is measured on a scale from 1-40 where 1 is least difficulties and 40 is most difficulties.

The average SDQ score has however increased over recent years with an average SDQ of 11.5 being seen in 2012. Despite this increase Croydon LAC still have one of the lowest average SDQ score in London. However, it is generally accepted that this score does not accurately reflect the level of mental health need in Croydon's LAC population due to the low SDQ uptake amongst LAC.

Overall, in 2012 it was assessed that 65% of eligible LAC had a *normal* SDQ score, 15% had a *borderline* SDQ score and 20% had a score that was considered a *concern*.

Table 26: LAC Uptake and Score of the Strengths and Difficulties Questionnaire

3. LAC SDQ	31st March 2009 Number	31st March 2010 Number	31st March 2011 Number	31st March 2012 Number
No. of LAC who Took SDQ	310	320	280	250
Average SDQ Score (0-40)	11.5	8.1	11.1	11.5

Source: SSDA903

9.3.5 Youth Offending Service

There has also been a 50% reduction in young people from Croydon entering the criminal justice in system for the first time largely as a consequence of a successful youth "diversion" scheme in partnership with the police. There has also over the last 3 years been a steady reduction in the number of offences committed by young people known to Croydon Youth Offending Service. In 2011/12, 1194 offences were committed by YOS clients. Serious youth violence remains the chief concern for the borough and with this our gangs profile indicates around 90 young people are believed to be associated with gangs and criminal activity. 40% of this group are the most gang-active and pose the highest risk of harm to others. The peak age of offending is 17 with no increase in young women who represent 14% of young offenders.

In terms of ethnicity, there is an overrepresentation of black youth in the criminal justice system making up 19% of Croydon's youth offending population. However, this is consistent with other London borough with similar demographics and deprivation.

The Youth Offending Service has 59.5 full time equivalent posts, including agency staff and seconded staff (2 police officers; 1.5 CAMHS workers; 1 Housing Support Officer; 1 Probation Officer and 1 Prospects Worker). There are additionally 28 sessional staff; 45 community panel members; one student and someone undertaking a work placement.

9.3.6 Example Case –Studies

Case Study A

R came to the attention of the Youth Offending Service at the age of 13, following a charge of sexual assault which took place at school against a female peer. He had a further charge for criminal damage. He received a 12 month order.

He was referred to CAMHS due to his offence of sexual assault and on assessment it was discovered that he suffered bedwetting, smoked cannabis daily, drank alcohol had a low mood and suffered with outbursts of anger. He had been prescribed antidepressants from his GP and described feeling sedated.

He had a complex family background and was homeless; he had been taken in by a friends parent and had no contact with parents or extended family. His parents had had him at 14 years of age and had separated. R was excluded from school and was being home tutored which was not going well. He was further arrested and was kept in a police cell as he had nowhere to live.

A package of care was put in place to address:

Education:
R was assisted in obtaining a school place and he is now pursuing his GCSE'S and planning a career in music and media.

Mental Health:
R came off his antidepressants, learnt coping strategies for managing his anger. He was assisted in improving his social skills in order to establish good peer relationships and help steer him away from the gang he had attached himself to. He also was supported to re-build a relationship with his parents and extended family that he was very angry with for abandoning him. R also displayed inappropriate sexualised behaviour and had regular casual sex, interventions took place to manage this and R is now aware of this and is in an age appropriate relationship and no longer engages in sexual activity.

R engaged with primary care services attended his GP, dentist and optician and now wears glasses). He also attended the sexual health clinic.

Parents and family support:
Both parents were approached and engaged in work to look at their parenting of R. Both parents are now involved in his care, R lives with his father who was assisted with accommodation and received support in obtaining joint parental responsibility thus meaning he was jointly responsible for any decision making in relation to R. R now has a loving and supportive relationship with both parents and his father is setting clear boundaries which R is respectful of.

Substance misuse:
R was selling and smoking cannabis on a daily basis and also drinking spirits with peers. He is no longer smoking any substances and no longer drinking alcohol.

YOS:
R successfully completed his order and there has been no further offending behaviour. Despite his order ending he is still engaged with CAMHS at his request although contact is reduced.

Case Study B

K was 13 years old when she came into contact with Youth Offending Service for a low level offence and received a short order.

She was referred to CAMHS because of her impulsive and risky behaviour. On assessment she appeared older than her years was independent and street wise however very vulnerable. She had been described by her parents as problematic and the cause of the family breakdown. There was violence between her and her parents and the family resilience service were involved.

On assessment it was noted that she was impulsive, angry and extremely promiscuous. She reported being raped and described a different family situation regarding her parents and their drinking which she stated nobody ever believed her, there were safeguarding issues regarding violence between her and her father. Her parents were trying to discourage contact with her younger sister because of her behaviour. She had also been excluded from school and was involved in gangs.

A package of care was put in place to address:

Behaviour:
Following extensive assessment she was diagnosed as having ADHD and prescribed medication. 1:1 interventions were offered weekly to help her address her anger and behavioural issues and steer her away from the antisocial peer group she had got involved with; mainly older males. Her promiscuity was addressed to reduce the risk of her being exploited sexually and she is now engaged with local sexual health services.

Safeguarding:
A referral was made to children's social services and she was initially made subject to a Children in Need plan and is now formally a LAC child. She is in foster care and has a much better relationship with her parents and younger sister. It has become clear that her parents do drink regularly and that the violence within the family was not always provoked by K, but was prompted by poor inconsistent parenting. K is now more aware of her behaviour and is able to reflect on this and manage her anger therefore there is less conflict within the family when she visits. K was supported to report her rape and is now more sexually aware and less impulsive regarding her sexual activity.

Education:
K has been receiving tutoring which is going well we are now in the process of organising a school placement now that her behaviour is more stable.

YOS:
K was on a short order and she successfully completed this but remains engaged with CAMHS who are involved in her LAC reviews. There has been no further involvement with the criminal justice system.

9.3.7 South London and Maudsley (SLAM) – Croydon Specialist and Targeted CAMHS Services

SLAM is commissioned by NHS South West London and Croydon Borough Council to provide a range of specialist and targeted CAMHS Services. It is a multi-agency integrated service committed to delivering both mental health and related social care services in one setting for children and adolescents with persistent and severe mental health problems, their families and professionals working with them

SLAM Croydon Child and Adolescent Specialist Mental Health Service provide a comprehensive service offering:

- assessment
- treatment
- advice
- training
- consultation

SLAM –CAMHS services aims are:

- To offer diagnostic assessment and therapeutic intervention to children and adolescents who have a serious mental health disorder or psychological difficulties, and to their families
- To provide assessment and treatment where the disturbance of functioning may result in physical and mental harm to the child, especially if without therapeutic input there might be deterioration in the child's mental health or in achieving optimum developmental potential
- To offer an urgent and non-urgent specialist service

Referrals are accepted for children and young people (up the age of 18) and their families. Referrals are made with the referees' knowledge and agreement. They typically exhibit persistent and significant disturbance of functioning where there is a likelihood of one of the following:

- psychotic illness
- affective disorder
- anxiety disorder or phobia
- Obsessive Compulsive Disorder (OCD)
- developmental disorders (Childhood Autism; Asperger's Syndrome)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Post-traumatic Stress Disorder or traumas related to child protection issues
- severe behavioural disturbance with underlying treatable condition
- eating disorders
- deliberate self harm

SLAM-CAMHS Specialist service accept referrals where it is thought that family functioning severely impairs the social and emotional development of the child. Any professional or agency that has carried out an assessment and is in a position to provide sufficient information to meet the criteria regarding the child and the family. They may be GPs, paediatricians, Social Services, educational psychologists, head teachers, health visitors and others. Self referrals are not accepted.

SLAM CAMHS Specialist Services – Croydon

Child and Adolescent Specialist Service Team
The Child and Adolescent Specialist services team is a Tier 3 child and adolescent mental health service (CAMHS). It provides an integrated mental health service, including outpatient assessment, treatment and care co-ordination. SLAM care for people, up to the age of 18, registered with a GP in the London Borough of Croydon. Tier 3 CAMHS are provided by a team of specialists in a community mental health clinic, GP surgery and hospital outpatient clinic. This service is for children and young people who have had severe and complex problems for some time. A number of specialist clinics are provided e.g. Family Therapy, Cognitive Behaviour Therapy, ADHD review clinics (ARC) and specialist assessment to diagnose and treat children with mental health conditions.

Team members in the Tier 3 service are to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, family and occupational therapists.

Young Offenders Service
Croydon CAMHS YOS service provides a Tier 2 and 3 community and out-reach service for children and young people aged 10-18 years of age who are registered with a Croydon GP are supervised by Croydon YOS and who have a mental health problem. There are times when the service is involved in the provision of Tier 4 interventions i.e. facilitating admission to hospital or referral to specialist services.

The service accepts referral of children showing behavioural and biological symptoms which suggest that they may be suffering from a moderate to severe mental health disorder as defined by ICD-10 and the DSM-IV criteria. Common reasons for referral are anxiety, depression, self-harming and ADHD. Many of the young people referred have experienced trauma including domestic violence, war, and also trauma associated with parental mental illness and/or substance misuse.

Looked after Children's Service
This service is a Tier 2 and 3 child and adolescent mental health service providing outpatient assessment, treatment and care for looked after children and young people up to the age of 18, with severe emotional, behavioural and mental health

problems. The service cares for children and young people who are looked after and who live in the London Borough of Croydon.

The CAMHS service is provided by a team of specialists in a community mental health clinic or hospital. This service is for children and young people who have had severe and complex problems for some time. The service is provided at Christopher Wren House and if necessary home visits can be arranged. The service also offers consultation to other agencies to assist in supporting this vulnerable and complex group of children and young people.

Team members in this service are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, clinical therapists.

9.3.8 Service Activity

Referral data is collected within the SLAM CAMHS service based on out-dated team frameworks and as a consequence considerable limitations were placed on the level and type of analysis that could be undertaken.

Over the period 2009-2012 there were 5048 referrals to SLAM CAMHS services. Referrals have dropped steadily over the three year period with referrals numbers dropping by 61% between 2009-10 and 2011-12. The largest number of referrals were seen in the 11-16 year old age group, with the majority of referrals being made to the Early Intervention Team (Adolescence).

Figure 25: Numbers of patients seen by SLAM Specialist CAMHS Teams 2009-2012

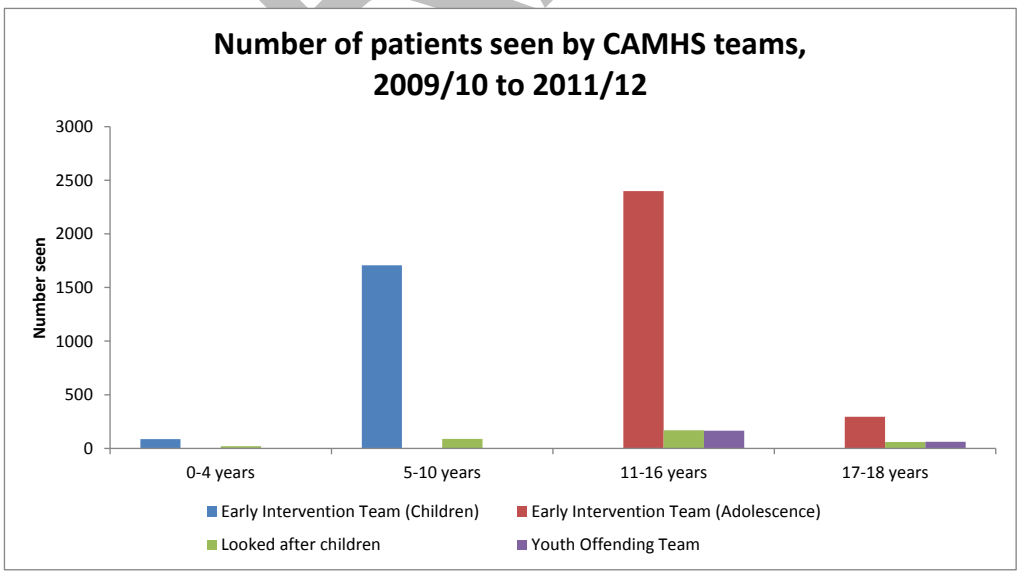
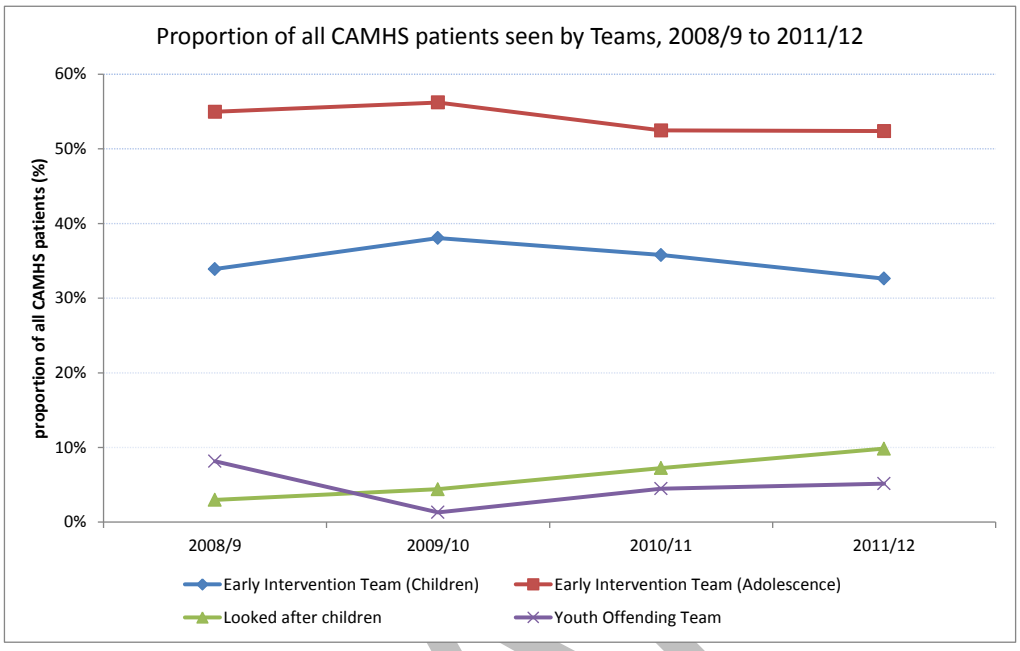
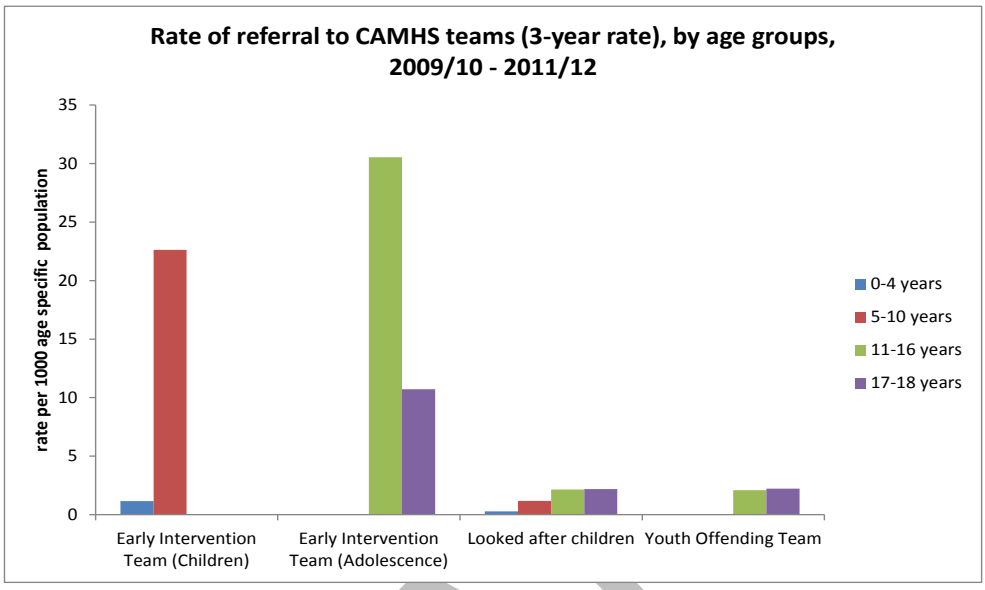


Figure 76: Proportion of referrals to SLAM CAMHS Service seen by distinct SLAM CAMHS Teams 2008-2012



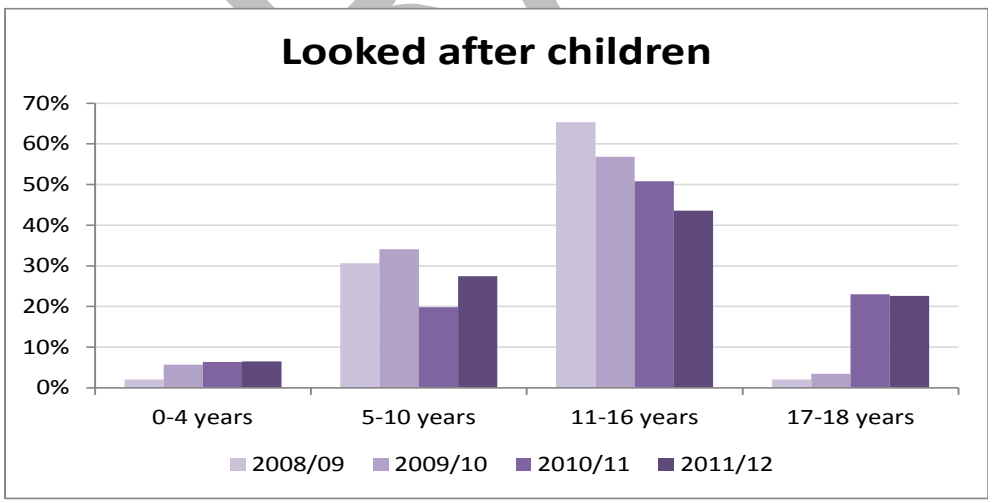
The highest proportion of referrals seen in to the Early Intervention Team (Adolescence) consistently accounting for over 50% of referrals. The second highest proportion of referrals was to the Early Intervention Team (Children) which accounted for over 30% of the total referrals. A small decrease was seen in the percentage of referrals made to both these teams over the four-year period. Consistent increases were seen to the CAMHS -LAC Team with an increase of approximately 7% in the proportion of referrals received between 2008-2012. The proportion of referrals seen to the CAMHS –YOT team have shown a small increase in 20010-11 and 2011-12.

Figure 27: Rate of Referral to SLAM Specialist CAMHS Teams by age group 2009-12



For the period 2009-12, the highest rates of referral were seen in the 11-16 age group and the 5-10 year old age group with lowest levels of referral seen amongst children aged 0-4 years of age.

Figure 88: Proportion of referrals by age to SLAM Specialist LAC Team 2008-2012



For the period 2008-9 to 2011-12, increases have been see in the percentage of referrals amongst 17-18 year old LAC and 0-4year old LAC to the SLAM-CAMHS service, rising from 2% to 23% in the 17-18 year old age group and from 2% to 6%

amongst the 0-4 year old age group. A steady decrease has also been seen in the proportion of referrals seen in the 11-16 year old age group, dropping from 65% of total referrals in 2008-9 to 44% in 2011-12.

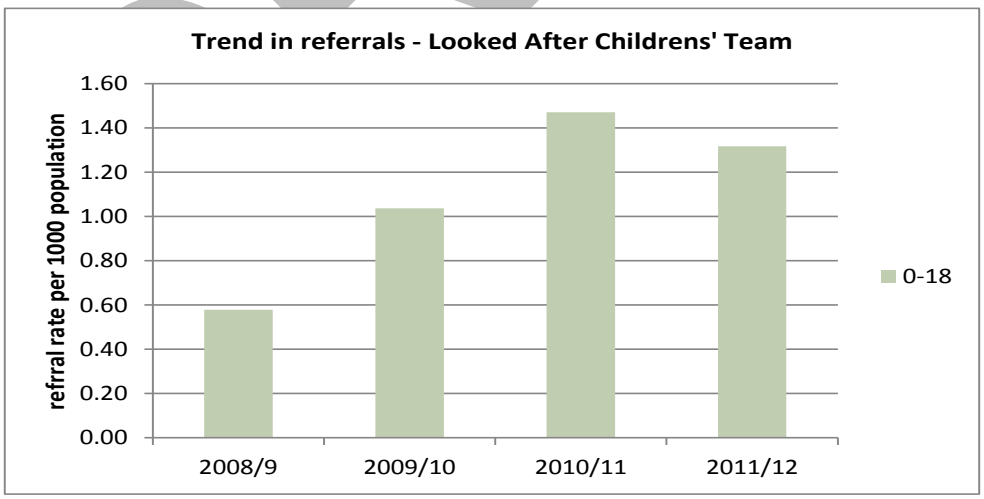
The percentage of referrals of LAC accepted by the SLAM-CAMHS service dropped from 96% to 87% of the total referrals received over ther period 2009-12. Of those appointments made, 77% were attended. This reflected a 10% drop in attndance levels from 2008/9. Increases were also seen in the percentage of Did Not Attend (DNA) appointments from LAC over the period of 2008/9 to 2011/12 with a total of 16% of DNA appointments seen in 2011/12 amongst this client group.

The number of LAC seen by the SLAM-CAMHS service in 2011/12 was 268, this was a significant drop from it's peak of 661 LAC seen in 2009/10. A total of 120 new LAC patients were seen during 20011/12, in comparison to 305 seen in 2010/11.

In 2011/12, the greatest type of diagnosis amongst LAC was in relation to emotional disorders with the percentage rising from 24% in 2008/9 to 39%. A moderate decrease was seen amongst the percentage of LAC being diagnosed with behavioural disorders during that period with a drop to 21% from 24% seen in 2008/9. More significant decreases were seen in the the diagnosis of neurodevelopmental disorders during the same period with a drop from 15% to 7% of LAC being diagnosed with this type of disorders.

Additionally, in 2011/12, the average number of weeks that a LAC had to wait from the point of referral to their first assessment was 5.9 weeks which was an increase of 3 weeks from waiting times seen in 2009/10.

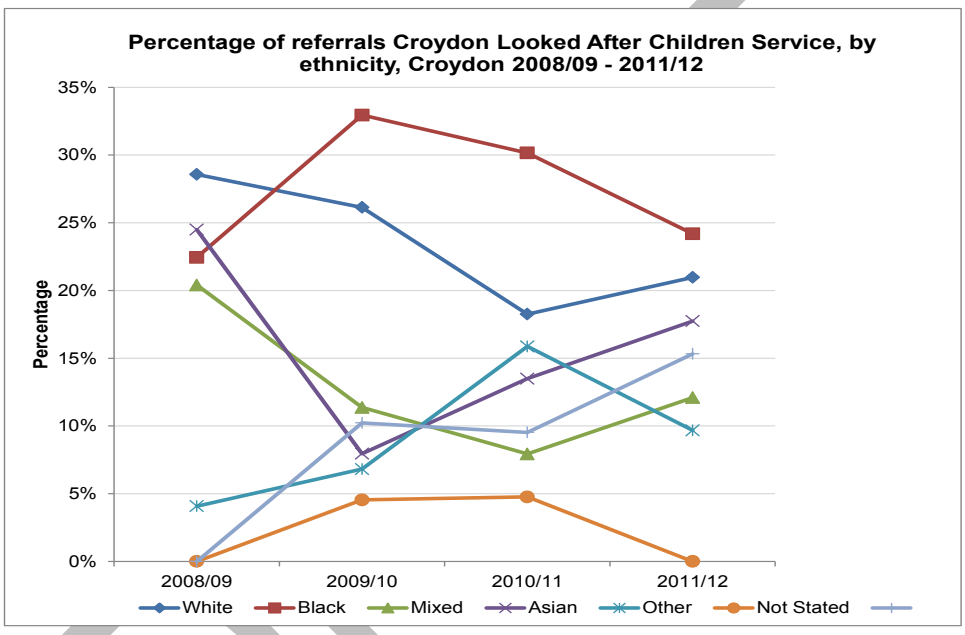
Figure 99: Referral Rate to SLAM Specialist LAC Team 2008-2012



Rates of referrals of looked after children to SLAM –CAMHS services has increased by 128% over the period 2008-2012. The rate of referral was highest in 2011-12 when the rate was 1.47 per 1000.

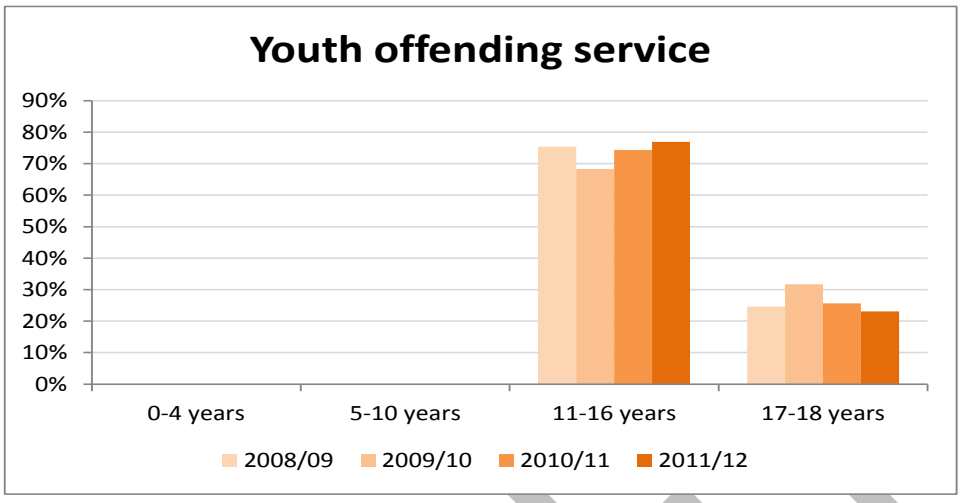
The relative gender breakdown of referrals has changed over the last four years with the percentage of referrals from female LAC, decreasing from 41% in 2008/9 to 30% in 2011/12. The percentage of male LAC referrals were consequently 70% in 2011/12.

Figure 30: Percentage of referrals to SLAM CAMHS –LAC Team by ethnicity 2008-2012



In 2011/12, the majority of referrals from LAC come from children and young people of Black origin (24%), closely followed by referals from those of White (21%) and Asian (18%) origins.

Figure 31: Proportion of referrals by age to SLAM Specialist YOS Team 2008-2012



The proportion of referrals to the SLAM –CAMHS YOS Team have remained relatively similar over the four year period, with approximately three quarters of referrals being seen in the 11-16 year age group and a quarter being seen in the 17-18 year old age group. In 2011-12, 77% of referrals were seen amongst 11-16 year old young offenders and 23% in the 17-18 year old age group.

The percentage of referrals of for young offenders accepted by the SLAM-CAMHS service has remained relatively stable beween 2008/9 to 2011/12 with only a drop of 1%, to 98% acceptance level of referrals received. Of those appointments made, 69% were attended by young offenders and reflected a 3% drop in attendance levels from 2008/9. A decrease was however seen in the percentage of Did Not Attend (DNA) appointments from young offenders over the period 2008/9 to 2011/12, with a total of 19% of DNA appointments seen in 2011/12 amongst this client group.

The number of young offenders seen by the SLAM-CAMHS service over the four year period remained relatively static with a total of 89 young offenders seen in 2011/12 just a drop of 1 patient from levels seen in 2008/9. A total of 49 new patients were seen during 20011/12, in comparison to 56 seen in 2010/11.

In 2011/12, amongst young offenders, the majority ofg mental health need greatest type of diagnosis was in relation to behavioural disorders with the percentage rising from 15% in 2008/9 to 38% amongst young offenders. Increases in the percentage of young offenders being diagnosed with emotional and neurodevelopmental disorders also increased during this period with 20% and 12% of young offenders being diagnosed with these type of disorders respectively.

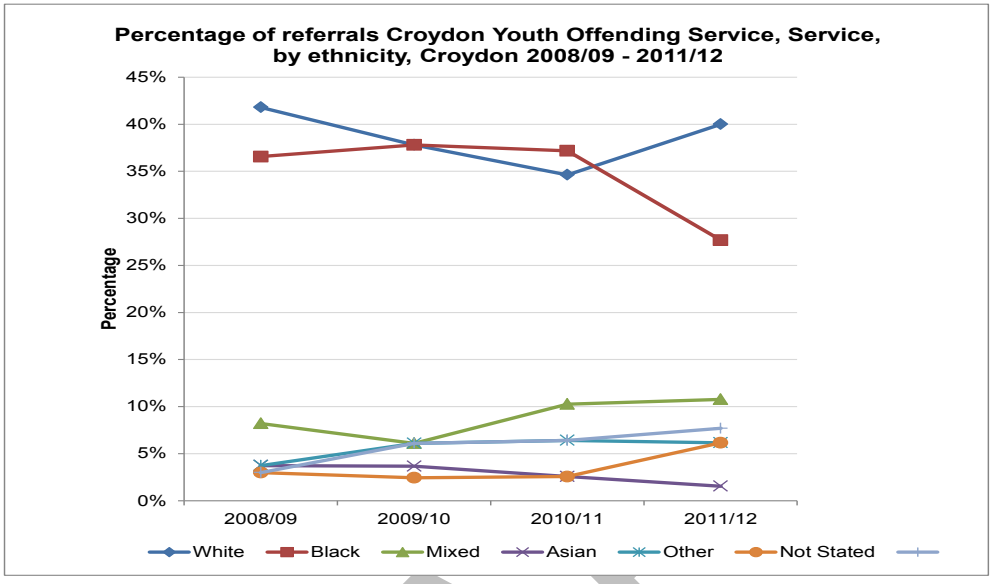
Additionally, the average number of weeks that a young offender had to wait from referral to the point of their first assessment was 3.0 weeks in 2011-12 which was the same level of waiting time in 2009/10.

Figure 32: Rate of referral by year, to SLAM Specialist YOS Team 2008-2012

Over the period 2008-2012 there has been a 56% drop in the rate of referrals of young offenders with mental health needs to the SLAM-CAMHS YOS Team. The rate has dropped from 1.58 per 1000 at its peak in 2008-9 to 0.69 per 1000 in 2011-12.

The relative gender breakdown of referrals has changed over the last four years with the percentage of referrals from female young offenders, decreasing from 30% in 2008/9 to 26% in 2011/12. The percentage of male young offender referrals were consequently 74% in 2011/12.

Figure 33; Percentage of referrals to SLAM CAMHS –YOS by ethnicity 2008-2012

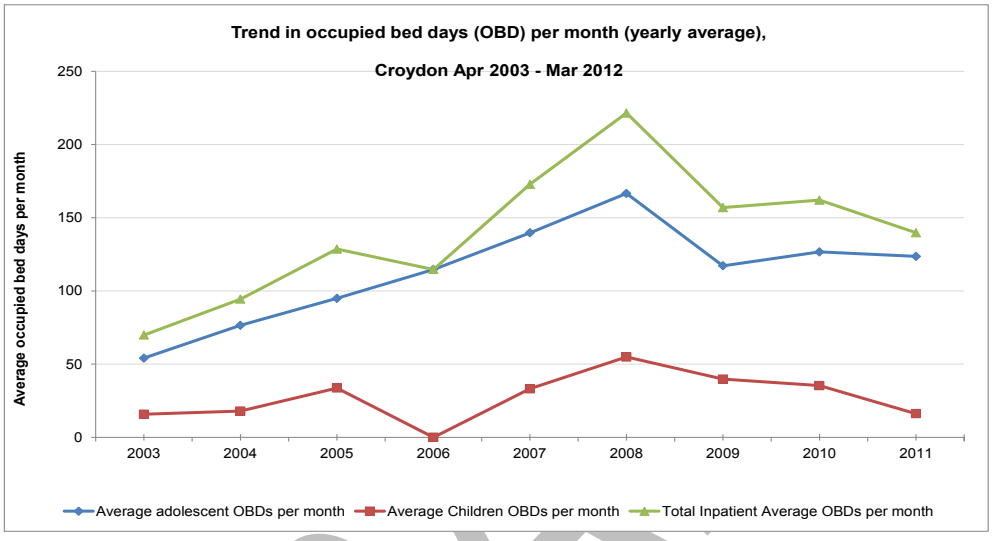


In 2011/12, the majority of referrals from young offenders came from children and young people of White origin (40%), closely followed by referrals from those of Black (28%) and Mixed (11%) origins.

9.4 Level 4

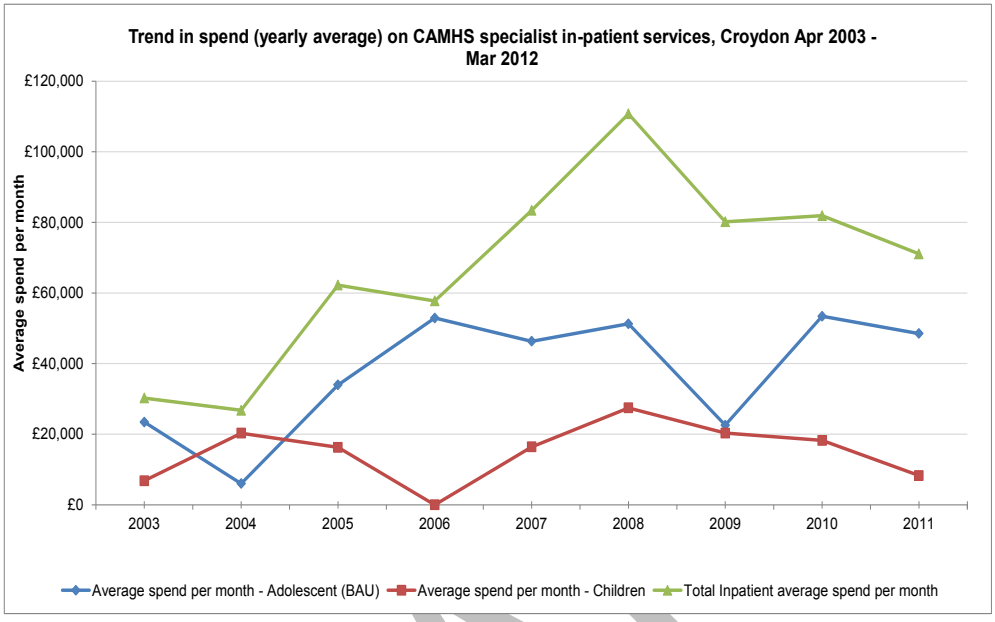
9.4.1 SLAM CAMHS Specialist Services (Additional commentary awaited from SLAM)

Figure 34: Trend in occupied bed days, yearly average 2003-2012



Some children and young people will require more costly Tier 4 in-patient CAMHS services. The average number of occupied bed days (OBDs) per month has increased significantly since 2003, but a downward trend has started to be seen over recent years from the highest levels seen in 2008. The average total OBDs seen in 2011 dropped to 140 per month from its highest point of 222 in 2008.The average adolescent OBDs in 2011 was 124 in comparison to 167 OBDs seen in 2008, and the average children OBDs per month seen in 2011 were 16 which were similar to levels seen in 2003 and a reduction of 39 OBDs from figures seen at its highest level in 2008.

Figure 35: Trend in spend (yearly average) on CAMHS specialist in-patient services, April 2003- March 2012



The highest monthly spend on Tier 4 – CAMHS services was seen in 2008, when the average spend per month was approximately £111K. This has dropped to an average expenditure of £71K per month in 2011. Over the years, consistently higher spend has been seen amongst adolescent in-patient stays with the exception of in 2004. The average spend per month seen in 2011 was £48.5K amongst adolescents in-stays and approximately £8K amongst children in-stays.

10 Transition Issues

Transition services are designed to meet the needs not only of young adults (usually in the age range 16-18) who are moving from CAMHS to Adult Mental Health Services (AMHS), but also those making other types of transition It should also include those not in receipt of CAMHS provision and who are also experiencing transition e.g. those whose needs become more acute as adolescence progresses.

Transition is distinct from transfer: the latter refers to termination of care by a children's health care provider which is re-established with an adult provider[114]. Transition is more than merely the means of an individual moving from one service to the next, but instead is 'a way to enable and support a young person to move towards and onto a new life stage'.[115]

Concerns about the quality of transition for young people from CAMHS to AMHS, or out of mental health services altogether have existed for some time. Frequently

these transitions have been poorly planned and managed resulting in young people aged 16-18 not receiving appropriate services or 'falling through the net.'

The ages 16-18 are a particularly vulnerable time when a young person is more susceptible to mental illness, due to going through a period of physiological change, and having to make important transitions in their life and education.

Research such as the SDO Track study[116] of young people's transitions from CAMHS to AMHS has found that up to a third of teenagers are lost from care during the transition and a further third experience an interruption in their care.

Generally CAMHS are designed to meet the needs of children and young people with a wide range of disorders and problems such as autistic spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), whereas Adult Mental Health Services (AMHS) tend to focus on services for people with severe and lasting illnesses such as psychosis or severe depression.

Many young people with on-going mental health needs find that AMHS do not provide the same level of specialist care and experience poorer quality of care.

Current commissioning models also place CAMHS and AMHS within different strategic frameworks and care planning systems. CAMHS is planned and commissioned as part of children's services which brings the advantages of closer links between physical and mental health services and between CAMHS and other universal and targeted services for children and young people. However, it also means that AMHS and CAMHS commissioning strategies and care pathways are generally developed separately, which can create problems for young people with mental health problems as they move on from CAMHS and other services for young people.

The result of such different service provision is that young people in receipt of a service from CAMHS may find that on reaching adulthood, their condition and presentation does not change, but AMHS are not appropriately designed to support them.

Sir Ian Kennedy highlighted these issues in his report *Getting it right for children and young people,*[117]where ' Arrangements must be agreed, regarding funding and other matters, to address the changing needs of children and young people as they mature, including greater continuity of care into adulthood.

Ensuring a smooth transition between children's and adults' services should be a priority for local commissioners'.

A number of factors have been identified that present barriers to young people's transitions from CAMHS to AMHS.[118] These include:

- lack of planning

- training of those professionals involved
- financial factors, including difficulty accessing resources
- poor inter-agency co-ordination
- lack of adult mental health professionals with skills to work with young people

There is no one set prescribed 'best practice' model to meet the needs of young people in transition. Many different models can be found across the country and services should be developed in line with local need and settings. The good practice guidance, *Working at the CAMHS/Adult Interface,* describes a range of models which have been developed to support young people as they move from child to adult services.[119] It recommends any of the following service models, delivered singly or in combination:

- a designated stand-alone transition service
- a designated transition team within an existing AMHS or CAMHS service
- designated staff trained in working with young people seconded to AMHS teams.

In summary, CAMHS and AMHS commissioning needs to be better integrated as poor transition can contribute to poor outcomes in the short, medium and long term. It can impact upon a young persons' chance of achieving a wide range of outcomes, such as achieving employment, accessing education, maintaining independence and successfully and seamlessly moving from adolescence into adulthood.

11 Views of stakeholders

11.1 The importance of consultation

The consultation and involvement of patients, carers and service users in the design and development of health and social care is a theme which runs through recent government legislation. It is also an essential element in any JSNA and in the associated planning and commissioning of services. A comprehensive understanding of the mental health needs, experiences and views of children and young people, their parents and carers as well as local stakeholders is vital in identifying strengths and weaknesses in care.

Services achieve better outcomes with children and young people when they are engaged not just in their own health care and treatments, but also in designing and developing services that meet their health and support needs. [120] ,[121] Young people that are consulted must include a range of service users from across the statutory and voluntary sector, as well as representation from groups of young people who have an increased risk of developing a mental health disorder. Parent and carer opinions and feedback should also be sought and be an intrinsic element of any child and young people focused JSNA.

Acting on children and young people's views brings positive outcomes: in improving service developments; increasing young people's sense of citizenship and social inclusion; enhancing their personal development as well as leading to increased accountability.

11.2 Consultation with children and young people

11.2.1 Young Carers

In June 2012, Off the Record Young Carers Project held a focus group with young carers in order to understand and identify any gaps or needs regarding this specific group of young people. The event was undertaken in a local school during half-term. The young people invited were selected by the staff team who knew the young carers and of their circumstances and were aware that there was a mental health issue within their family. Ten young carers were invited and of those five attended, which included two males and three females and who ranged in age between 14 and 18 years of age.

Consultation questions were designed by the Young Carers Co-ordinator in conjunction with the Young Carers Mental Health Workers. The young carers were briefed about the purpose of the consultation exercise and asked to contribute individually in a carousel set up, with a debrief session afterwards.

The main findings gained from the young people were:

- A high degree of stigma exists in relation to mental health issues and contributes to a reluctance amongst young carers in accessing support services
- More awareness of mental health issues is needed, as well as improved publicity and awareness of local CAMHS services
- Mental health issues are not routinely discussed with parents or family members and that young people find comfort in discussing mental health issues with their peers.
- Local support was reported as being good by those who have received it
- More support is needed through schools
- The internet is the most effective way of circulating information.

11.2.2 Black Minority and Ethnic Young People

A set of two focus groups were undertaken with BME young people, facilitated by BME Mental Health Community Development Workers based at Off the Record.

The first focus group was undertaken at Winterbourne Children's Centre in conjunction with their Young Parent Support Group. Twelve members of the group participated in the focus group, eleven of who were female. Participants age ranged from 17-24 years of age with 42% of the group aged 18 or under. 90% of participants were from BME backgrounds.

Due to the nature of the group, the majority of participants reported they would turn to their GP or health visitor with any mental health problems. Generally, feedback was positive on how easy it was to discuss mental health issues with their health visitor. Feedback in relation to support from GPs was more negative highlighting that the participants did not find their GP approachable or many felt that they did not listen or take their concerns seriously. Lack of time was a frequent complaint

'Even though I go to my GP, I do not find him very helpful. He is always in a rush, never listens to me and never gives me enough time.'

Those participants who would not approach a professional if they needed help cited that they would only approach a professional if they desperately needed help or if support was needed for their child.

Other findings included:

- Lack of awareness of local mental health services and the support they can provide, prevented approaches being made for support when needed.
- Some of the participants felt the term *counselling* would prevent them using services for young people because of the stigma involved.
- A range of different settings were recommended for the provision of local services, including schools, colleges and children's centres.

A second focus group was undertaken with six BME young people at Waddon Youth Centre in conjunction with the Off the Record BME Mental Health Community Development Worker. The original intention of using participatory appraisal activities as the chosen data collection method was abandoned as the group felt more comfortable holding open discussions to each element of enquiry.

Of the six participants, four were male and two female and their ages ranged from 16-21 years of age. A broad range of ethnic backgrounds were also represented.

The key findings raised as a consequence of the consultation were

- The majority of participants would approach their GP for support with a mental health issue, with the remainder seeking support from relatives or friends.
- Individual experiences of support when it had been required had been variable.
- Majority of participants had not used or were familiar with local mental health services due to the low level of need identified within the group.
- A range of recommendations were provided in order to promote local services such as improving publicity and increased awareness raising in schools, colleges and other young people settings.

11.2.3 Looked After Children

11.2.3.1 Indigenous

In August 2012, Croydon Children's social care - LAC Indigenous Team undertook a survey with indigenous LAC aged 10 -18 years of age supported by the service. A questionnaire designed with a range of open and closed questions was utilised. A total of 46 questionnaires were returned. The ages ranged from 9-17 years of age with the average age of those surveyed being 13.8 years old. Females and males accounted for 57% and 43% of respondents respectively. The majority of respondents were of White origin (43%), though surveys were completed by indigenous LAC from a broad range of ethnic backgrounds. Those identified as Black British, Black Caribbean or of Black African descent made up 39% of the total returns.

A broad range of information was collected, with the main findings being:

- In the main, carers and relatives were cited as the people indigenous LAC would approach if they were feeling sad, angry or worried, with only 4% of those questioned stating they did not have someone to talk to if they were worried about something.
- The majority of those surveyed had friends at school and felt happy about life and being themselves.
- 54% had used counselling, therapy or special support in relation to a mental health issue and 58% would recommend this to a friend.
- Parents and carers were the most popular choice of support that respondents would recommend friends approach if they were worried or troubled about something, closely followed by teachers.
- Activities and days out that were fun were identified as key elements that should be included when developing services to help support young people with their worries. Though young people were unsure where best to place such services. There was no overall consensus of whether such services should be placed in schools.
- 46% of respondents indicated they had ever been bullied, 17% had been bullied via a mobile phone, social network site or computer and just 2% stated they did not have anyone to talk to if they were being bullied.
- The majority of those surveyed stated they had enough help in making choices and decisions.
- Very few of those surveyed did not enjoy school (4%) though a significant proportion (35%) did not enjoy school all the time.
- Poor self-esteem and conduct disorders were common themes identified from individual feedback. Particularly concerns about an individual's looks, personality and anger management being identified as things those surveyed would like to change about themselves in order that people would like and care for them more.

11.2.3.2 Unaccompanied Minors

Over the summer of 2012, feedback was gathered from individuals who receive support from Compass. Compass is a project based within Off the Record which provides counselling and support to refugees, asylum seekers and forced migrants. A range of questions were asked within individual counselling sessions as part of the Compass Boys Group, where it was felt appropriate to do so. Due to the significant language, conceptual barriers and associated cultural issues, questions were only asked of those who were happy to contribute and those who were identified as being able to answer most of the questions.

In total, twelve young people were consulted with a breakdown of two females and ten males. Of this eight were unaccompanied minors, with the rest within asylum seeking or refugee families or were unaccompanied asylum seekers aged over 18. The majority were from Afghanistan or other middle eastern countries.

The key issues raised that would prevent this group of young people asking for help included: language barriers, a lack of awareness of local services and the support that was available; fear and difficulty in disclosing vulnerable and personal information as well as a sense of responsibility for the feelings this may raise in the professional or '*listener'* and concerns about professionals limited cultural awareness.

Factors raised that would help improve an individual's ability in asking for help included: information being available in different languages and access to interpreters; availability of help and support in settings that are familiar; greater understanding and awareness by practitioners of the type of mental health problems faced by unaccompanied minors, refugees and asylum seekers; recommendations from other young people.

Overwhelming feedback provided showed that this group of young people would prefer services to be offered in schools. This fitted in with other comments by teaching staff or agencies visiting schools and colleges that they were often approached for help by unaccompanied minors, refugees and asylum seekers with different problems.

Feedback on the key benefits identified that services might support included: having someone to talk to and help with any problems, providing information and advice; help to reduce the sense of isolation and improving feelings of safety and hope for the future.

11.2.4 Young Offenders

Consultation was undertaken with young offenders, held on the YOS CAMHS Worker's caseload during July 2012. A survey was developed to assess the patient satisfaction with the CAMHS support they receive. A total of seven young offenders were consulted and the key themes raised from the questionnaire were:

- High levels of satisfaction with the support received from local CAMHS Workers. The majority of young offenders consulted felt their CAMHS Worker listened to them all of the time and that they were able to talk about important things. The young people surveyed had a high level of trust in their CAMHS Worker, who was able to make useful suggestions to help them.

- Unsurprisingly, a high degree of anxiety was reported about the personal questions being asked, though the majority were able to talk openly about personal or private things with their individual CAMHS Worker either some or all of the time.

- Access overall was good with the majority of young people being given a choice of appointment days and times all of the time, with a choice of worker being offered to the majority either all or most of the time.

- Interestingly, views were polarised on whether the support provided had helped the individual young person to get on in their life, with a fairly even breakdown between those who felt support had helped them all of the time and those who didn't know.

- The initial CAMHS referral had been discussed with all of the young people surveyed apart from one, and the majority had a choice in whether the referral to CAMHS was initially made.

- In terms of improving the support provided, some of the young people did not feel any improvements were needed to the service, with other recommending the provision of longer sessions, as well considering offering activities or trips.

11.2.5 Croydon Drop-In

In July 2012, Croydon Drop In Outreach and Duty Teams undertook a survey in relation to the emotional health and well –being of young people accessing Croydon Drop-In services. A total of eighty -five questionnaires were collected, with forty four returned by females and forty one from males. Ages of respondents ranged from 11 to 18 years of age, with the majority being aged 14 years of age. The vast majority of respondents (73%) were of BME origin.

The main findings of the survey were:

- The majority of respondents lived with their parents or their mother;
- The majority were in secondary education;
- Generally those who responded rated their emotional health and well-being over the past year as excellent or very good;

- The things that respondents worried most about were family health problems, brothers and sisters and the way an individual looked. Bullying was an issue that was least reported by those who completed the survey;
- Friends were reported as the people young people trusted most to discuss their personal worries with.
- For those who reported being bullied, the majority cited school as the main setting where bullying had taken place. The next most frequent setting cited was at home.
- The Turnaround Centre was the least familiar service known amongst young people which they could contact for help and advice. Teachers and tutors were the most familiar advisors young people were aware of to approach for help and support.
- Unsurprisingly given Croydon Drop-In's lead on the survey, Croydon Drop-In Services were the most popular agency that young people would turn to for support, closely followed by GPs.

11.2.6 Croydon Youth Council

As a consequence of the civil disturbances in London in 2011, Croydon Youth Council hosted an event for young people called *Together We Matter* at John Ruskin college in February 2012.

The day-long event was attended by forty young people who discussed the Youth Council priorities. These priorities were based on the outcome of the civil disturbance consultations and the priorities of the Children and Families Partnership. The emotional health and well-being of young people was one of the priorities that was discussed.

The young people fed back that greater provision of counselling, support services and the opportunity to *have someone to talk to* was needed in Croydon and that increased provision should be made available in educational and non-educational settings. Additional activities and extra curricula opportunities were also recommended for children and young people in Croydon.

As a result the following tasks were proposed for implementation by the young people who attended.

- Greater involvement of children and young people is needed in the assessment of services and in identifying gaps.
- Young people should be involved in the assessment of mental health services already provided
- Youth Council to explore the possibility of undertaking a survey around mental health provision
- Youth Council to look into what more could be done and what young people would like in order to improve the emotional and mental health needs of children and young people in Croydon.

11.3 Consultation with stakeholders

11.3.1 Stakeholder Event

A Croydon wide consultation event was held on the 19th September for all key stakeholders, including parents and carers. This event was attended by 43 people, including representatives from NHS South West London and Croydon CCG, various Croydon Council Departments, voluntary sector organisations as well as parents and carers.

The morning session provided an opportunity for a number of presentations to be made which gave an overview of the emerging data being collated as part of the JSNA process, as well as provide some further information and context on locally commissioned CAMHS services. Participants were then asked to participate in a number of workshop style consultation exercises which would be used to inform recommendations going forward.

It is important to note that when participants were asked what Croydon does well to support children and young people's emotional health and well-being a wide range of assets were identified. Some examples of those provided included:-

- Good clinical outcomes across local CAMHS providers;
- Mental health Peri-Natal Team;
- Anti-bullying being a Children and Family Partnership '*Stay Safe*' priority;
- CAMHS provision commissioned to deliver *Early Childhood Professional Development* (EPEC) and *Incredible Years* from early intervention & family support monies;
- An Emotional Health and Well-Being Centre of Excellence being developed by a local network of schools;
- Restorative approaches being developed in schools;
- Developing improved use of common assessment framework (CAF) and assessment of family needs;
- Dedicated Specialist CAMHS service for looked after children and young offenders;
- Good satisfaction from young people and parents of local services;

A wide range of universal, early intervention and specialist services were identified by participants as being available in Croydon in relation to supporting children and young people's emotional health and well-being.

When participants were asked to identify what they felt needed to change locally to improve the emotional health and well-being of children and young people, a total of 11 key themes emerged. In descending order of priority these were:-

- Improve collaborative working across local agencies;
- Invest more resources into early intervention services;
- Improve awareness of local services and referral criteria;
- Use schools as a setting for improving and promoting emotional health and well-being;
- Provide more training and education for those working in universal services about emotional health and well-being;
- Address unacceptable waiting lists for some specialist CAMHS services and improve referral to treatment times.;
- Improve participation and involvement of service users in the delivery and design of services;
- Improve health promotion and education around emotional health and well-being in universal settings;
- Improve access to services e.g. opening times;
- Improve services and support for parents and carers;

A range of recommendations were then developed to support delivery of the top five areas of improvement needed, with consideration being given to the ease of implementation of the identified recommendation on a scale of difficult to easy versus the overall benefit to emotional health and well-being ranging from low to high.

11.3.2 Social Workers

A piece of work was undertaken in the Autumn of 2012, whereby all Children's Social Care staff were asked to complete a survey pro-forma during a defined time period in relation to the children on their individual caseloads. The purpose being to provide a snapshot of the level of mental health needs identified in children in need and looked after children known to Croydon Children's Social Care, using the Croydon Model of Staged Intervention and CAMHS Tier 1-4 system.

As a result, a questionnaire was circulated to all social workers and independent reviewing officers within Children's Social Care for completion. A total of nine responses were received. Based on average caseloads locally this meant the needs of approximately 100 children were assessed. Of those 42% were identified as having a mental health need that could be accommodated by universal services or through Tier 1 CAMHS services, 26% were identified as having low to moderate mental health needs which would benefit from early intervention and services provided by Tier 2 CAMHS provision, 23% were identified as having complex needs which would need Tier 3 CAMHS support and 9% were assessed as likely to require Tier 4 CAMHS services due to having acute mental health needs. The percentage of children considered, who received the support they needed was variable across all levels, with those identified with low/moderate or acute needs as those least likely to

have received the necessary support and those identified as having complex needs being the most likely to have received appropriate support.

Considerable concern had been raised by Managers within Children's Social Care that social workers were not referring to Specialist CAMHS Services when identifying children in need and looked after children with mental health needs. As a consequence, social workers were also asked to feedback the reasons why a looked after child or child in need would benefit from support from Specialist CAMHS provision, but had not been referred whilst under their care. The main reason for this was that social workers were not clear what services were available, or there was a perception that thresholds were too high or that improved outcomes could be better achieved elsewhere. The least frequent reasons identified for not referring were due to a belief that the child would not co-operate or that the parent or carer would object or undermine treatment.

There was mixed feedback provided from social workers in relation to their experience of local Specialist CAMHS provision.

'' I do not currently have any problems with accessing CAMHS. In the past I have been told that the waiting list is very long, but they also state that they can make exceptions for emergencies. In my experience the only problem I have experienced in parents not engaging regularly or expecting the magic wand effect of a quick solution to a very complex situation.''

"CAMHS threshold is too high this leaves a lot of vulnerable children who possibly need mental health support without the correct support. Social workers are left to find a service which may not accurately meet the needs of the child, but is all that is available. In the short term this is ok but doesn't deal with the concern in the long term. "

11.4 Other local service user feedback sources

Croydon Shadow HealthWatch Pathfinder is the borough's local patient involvement network. Local involvement networks or LINKs give people an opportunity to have a say on how their local health and social care services are commissioned and being delivered. During 2012, Croydon Shadow HeathWatch Pathfinder worked closely with the Chairs and Vice-chairs of the Sexual Health and Teenage Pregnancy and the Sustaining, Improving and Maintaining Mental Health task groups to prepare and deliver a presentation on 'Youth Engagement'. Questions were then designed by members of these task groups for use by the Community Involvement Worker at Croydon College Health Week on 17th and 18th January 2012.[122]

Using a range of participation tools 60 young people aged between 16-25 years of age were consulted on mental health and sexual health services in Croydon. Of the 60 young people, 53% were male and 47% female. Just over half (54%) of the

participants lived in Croydon while the remaining 46% were from neighbouring boroughs.

The Improving and Maintaining Mental Health task group decided to survey ask three questions to establish y6oung people's understanding of mental health issues and assess their knowledge of what services were available locally. Young people's understanding of mental health focussed on poor mental health and predominantly in relation to complex mental health disorders such as bi-polar disorder, schizophrenia and various personality disorders rather than highlighting issues in relation to stress, self-harming or depression. Little mention was made of positive mental health and well-being and awareness of local services was patchy, though Croydon Drop In was the most recognised local service known amongst young people surveyed.

The majority of young people surveyed fed back that flyers and posters were the least effective form of awareness raising. Young people suggested service providers and commissioners should embrace alternative ways of getting their attention, i.e. face to face interaction, school and college visits or getting young people involved in mental health campaigns designing and producing online videos on YouTube.

Key recommendations made were:

- To address the limited understanding and awareness amongst young people, further work is required to educate young people more fully on the full spectrum of mental health problems, disorders and associated terminology.
- Health information should be more accessible and engaging to young people.

12 Investment in Child and Adolescent Mental Health

12.1 National Estimates

Mental ill health represents up to 23% of the total burden of ill health in the UK –the largest single cause of disability.[123] Nearly 11% of England's annual secondary care health budget is spent on mental health[124] and more than £2 billion is spent annually on social care for people with mental health problems.[125] Additionally, estimates have also suggested that the cost of treating child and adolescent mental health problems could double over the next 20 years.[126]

Preventing even a small percentage of mental health problems will improve the quality of life for individuals, their families and communities. Prevention and promotion activities are part of a strategic, sustainable population approach which will reduce the burden and cost of mental illness, promote well-being and reduce inequalities. In particular, a number of studies have demonstrated significant cost benefits from early –years interventions, particularly for long-term outcomes, with

savings achieved mainly through reduced welfare and criminal justice costs and economic activity.

Croydon Council and Croydon Commissioning Unit are facing severe financial challenges which present difficult choices as to priorities for spending, and place them under greater and greater pressure to deliver more with less. Therefore a more general focus on promoting health and preventing ill-health, together with early intervention services for mental health problems, is of critical importance, particularly when we consider that about 75% of adults with mental health problems first experienced mental health problems in childhood.[127]

Investment in early intervention for children and young people with mental health problems can potentially save millions of pounds for the NHS and for the education system. Further savings would also be made in reducing the costs of unemployment, social care and benefits, and costs to the criminal justice system in later adult life

The Department of Health recently commissioned a piece of research to identify and analyse the costs and economic payoffs of a range of interventions in the area of mental health promotion, prevention and early intervention. Interventions were chosen for economic analysis only where there was strong evidence in the published research literature for their effectiveness in improving mental health or well-being. Early intervention was shown to be more cost-effective in a wide range of mental health disorders.[128]Some of the NICE models put forward in relation to child and adolescent mental health, covered elements such as:

- Health visiting and reducing postnatal depression
- Parenting interventions for children with persistent conduct disorders
- School based social and emotional learning programmes to prevent conduct problems in childhood
- School based interventions to reduce bullying
- Early detection for psychosis

All of the models put forward showed significant financial benefits over time, as well as wider benefits and improvements in quality of life. The largest benefits seen were from the models proposed in relation to the prevention of conduct disorders through social and emotional learning programmes and early interventions for conduct disorders. This has important bearing if we consider that conduct disorders are the most prevalent type of mental health disorder seen in children and young people. Additionally, research from the London School of Economics found that by the age of 28 the cumulative costs of public services were 10 times higher for individuals with conduct disorder compared with those with no problems.[129]

12.2 Regional and statistical neighbour analysis

From benchmarking information available, NHS South West London (Croydon Borough Team) as was, is the lowest investor in community CAMHS in the South East sector (where SLaM is the main provider) particularly given population and other factors.

Table 27: SLaM London Borough's CAMHS Budgets

Borough	Child Population	Budget
Southwark	61,400	£4.113m
Lambeth	59,177	£3.725m
Lewisham	62,844	£3.241m
Croydon	88,496	£2.822m

Comparative information with other London Boroughs for children living in poverty, where SLaM is the main NHS provider, this shows that the numbers of children living in poverty in Croydon are almost as high as the borough of Lambeth. Yet when comparing NHS unit cost spend on CAMHS by both boroughs, Lambeth spend an average of £62.95 per child population on CAMHS, compared with Croydon spend of £31.89. (Subject to final clarification at 29/08/2013.)

Table 28: Child Poverty levels amongst SLaM London Boroughs

Borough	Child Population	% of 0-15yr olds living in poverty	No. of 0-15yr olds living in poverty
Southwark	61,400	33.9	20,815
Lambeth	59,177	43.2	25,564
Lewisham	62,844	37.3	23,440
Croydon	88,470	28.3	25,044

12.3 Croydon CAMHS Grant

12.3.1 Reductions in PCT and Local Authority CAMHS grant allocations.

Both the PCT and the LA CAMHS grants have significantly reduced over the years since the 'ring fence' was lifted, as indicated below.

Table 29: Croydon Borough Council and NHS SWL CBT CAMHS funding 2009-12

Financial year	LA £	PCT £	Total £
2009/10	1,047,000	241,888	1,288,888
2010/11	744,983	188,647	933,630
2011/12	600,000	*131,250	731,250

**This includes £53,250 transferred to Croydon Health Services in respect of the Children's Learning Disability Co-ordinator post.*

Central government reduced the CAMHS grant provided to local authorities from 2009/10. For Croydon, the grant of £1,047,000 in 2009/10 was reduced to £744,983 in 2010/11 and further reduced to £600,000 in 2011/12. Because commissioning arrangements were not robust due to frequent staff changes, adjustments were not made to manage the reduction in 2010 /11, resulting in an overspend of £124,629 to the local authority. The local authority had to ensure that no such overspend happened in 2011-12; hence some service funding had to be withdrawn in-year.

Primary Care Trust (PCT) funding was similarly reduced with respect of its uncommitted expenditure, which had traditionally been used to fund non re-current and fixed term pilot projects whilst longer term decisions were being taken regarding on-going investment.

12.3.2 Removal of local authority posts previously integrated with CAMHS.

This, when combined with reductions to the CAMHS 'grant' gives a disinvestment figure of approximately £860k, with £110k of this relating to disinvestment from the PCT. (Subject to final clarification at 29/08/2013)

12.3.3 ADHD dis-investment

The 'virtual team' approach for ADHD in Croydon was nationally recognised as an area of good practice. The service was developed with the support of a Steering Group, and led by a new 'ADHD Development Worker' post, which was funded through the Children's Fund, in addition to added Speech and Language Therapy (SALT) and Occupational Therapy (OT). When the fund ended in 2008, NHS SWL CBT picked up the costs of the therapy posts. Unfortunately the local authority was unable to do this in respect of the Development Worker (an Educational Psychologist) and this has affected the continued leadership of the team and co-ordination of services across agencies.

12.3.4 Workforce

The National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) 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). On this basis, the minimum workforce requirement for Croydon would be 13 WTE (non-teaching services). No further guidance on this figure is available from Standard 9 of the NSF.

York, A. et al however have estimated that specialist CAMHS require 20 WTE per 100,000 population to meet the needs of children and young people aged 15 years or less[130].. This would indicate a requirement for Croydon of 16 staff, including 4 Primary Mental Health Workers (PMHW).

The following table shows local authority workforce employed in CAMHS.

Table30: Local authority workforce rate per 100,000 population aged 0 to 18 years

	Croydon	London	England
All local authority CAMHS workforce per 100,000 population aged 0-18 years (inclusive) (2010)	367.88	N/A	460.55
Local authority workforce specifically for children's services per 100,000 population aged 0-18 years (inclusive) (2010)	233.57	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)	40.88	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)	11.68	N/A	18.09
Local authority workforce in community homes for children looked after per 100,000 population aged 0-18 years (inclusive) (2010)	52.55	N/A	53.28
Local authority workforce in Specialist Needs Establishments per 100,000 population aged 0-18 years (inclusive) (2010)	29.20	N/A	10.20

Source: Office for National Statistics / Health and Social Care Information Centre

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 allocate to a local authority meaningfully. The data are published on the Information Centre for health and social care website: www.ic.nhs.uk/workforce

13 Recommendations

Outlined below are some of the key recommendations suggested as a consequence of this needs assessment. Some of the recommendations are extremely broad and so will require further work as part of the development of a new Children and Young Peoples Emotional Health and Well-Being Strategy. Additional action is also required to scope the full-range of universal and targeted activity which contributes to improving the emotional health and well-being of children and young people.

Careful consideration is also required in relation to the impact the economic downturn is having on local families and the associated impact on children and young people as well as the considerable effect budget and staffing reductions currently has had and will continue to have on associated universal and targeted services and the impact this will have on the support that will be able to be provided to those children, young people and families with mental health needs.

13.1 Key Recommendations

Strategy, Governance and Commissioning

Draft Recommendation: Strategy Development

- Develop a holistic Children and Young Peoples Emotional Health and Well-Being Strategy across the whole system to improve the emotional health and well-being of children and young people in Croydon. The strategy should include the following key elements: - health education and health promotion, prevention and early intervention, specialist services and treatment, training for associated staff groups and the involvement and participation and involvement of children and young people and their parents and carers as part of the comprehensive plan (Timescale: Nov 2013)

Draft Recommendation: Funding

- Review the funding of local CAMHS services and suggest recommendations for commissioning priorities for 2014-15, taking account of the funding gap and in relation to need. (Timescales: In year 2013/14).

Draft Recommendation: Strategic Governance

- Croydon Children and Families Partnership Board to provide leadership around the issue of children and young people's emotional health and well-being, using

appropriate local structures, with representation from relevant local authority services, CCG and community health providers, associated mental health trust and voluntary sector services, and ensure that key senior managers act as champions.

Draft Recommendation: Ethos and values

- Develop a coherent vision and ethos that parents, managers and frontline staff can understand, commit to and be part of in order to underpin improvements in this area of work. Particular emphasis should be placed on service and individual responsibilities and the importance of relationships and resilience. (Timescales: 2013-14)

Draft Recommendation: Evidence base and best practice

- Improve awareness of the evidence base and best practice amongst commissioners and providers. (Timescales: 2013-14 and on-going).

Draft Recommendation: Data and Performance Monitoring

- Develop a CAMHS minimum data set to improve the assessment and monitoring of locally commissioned services activity, quality and improvement in associated outcomes. *N.B. National CYP IAPT measures must be considered as part of any new data set and outcome measures in order to support national comparisons.* (Timescales: November 2013)

Draft Recommendation: Service Specifications

- Commissioners to ensure the consideration and delivery of CAMHS services are explicitly included in relevant service specifications and contracts with acute, community health and local authority providers, particularly maternity services and child health services including health visiting, school nursing, children centre provision and early years, homelessness and supporting people etc. (Timescales:2014-15 and on-going)

Draft Recommendation: Service Specifications

- Commissioners to ensure that local service specifications for commissioned CAMHS services take account of appropriate evidence base and best practice guidance, and where services are not meeting recommended practice, that plans are drawn up to address this as part of the service level agreement. Children and young people, particularly vulnerable groups of young people should also be consulted and involved in the development of locally commissioned services (Timescales: 2013/14 and on-going)

Draft Recommendation: At risk groups of children and young people

- Commissioners to consider improving access to mental health services for at risk groups of children and young people (such as children in need, children in care,

those with disabilities, young offenders, young refugees, BME young people, young cares and those with behavioural, emotional and social difficulties) subject to resource constraints. (Timescales: 2013-15)

Draft Recommendation: IAPT

- Commissioners to explore opportunities to develop and increase Children's IAPT services further from 2013-14 onwards, so that more children have timely access to evidence based psychological therapies. (Timescales: In year 2013/14)

Draft Recommendation: Specialist CAMHS services

- Commissioners to ensure Specialist CAMHS services meet national standards as set out in associated NICE guidance and the CAMHS NSF. A comprehensive service review and the development of creative solution focused initiatives should be prioritised (e.g. ASD/ADHD shared care protocol) in order to address waiting lists and other pressures on specialist CAMHS services. (Timescales: 2013-15)

Draft Recommendation: Parents and Carers

- Commissioners to ensure that parents and carers (including foster carers and adoptive parents) can access advice and support when they are concerned about their children's mental health. This should include improving awareness of local CAMHS services so appropriate referrals can be made and integrated support developed. (Timescales: In year 2013/14)

Provider Services

Draft Recommendation: Local Service Offer

- The Children and Families Partnership to clarify expectations of what universal services should do at Stages 1 and 2 of *Croydon's Model of Staged Intervention* and the local offer at Stages 3 and 4 (Timescales: 2013/14)

Draft Recommendation: Universal Offer

- Increase the support and information provided from universal services to families, and children and young people in need of mental health services. (Timescales: 2013/14)

Draft Recommendation: Early Intervention

- Improve the identification, assessment and early intervention undertaken in universal services to address emerging mental health needs of individual children and young people and ensure increased provision and delivery of Tier 1 CAMHS services in these settings. Increased provision of Tier 2 services should also be developed in universal settings.(Timescales: 2013-15)

Draft Recommendation: Schools and Colleges

- Schools and colleges should adopt a 'whole school' approach to supporting pupils' wellbeing and resilience, with an emphasis on strengthening and building protective factors. This should include both universal approaches, and targeted services for children and young people with, or at risk of developing, behavioural difficulties or emotional problems as part of strengthening the approach to inclusion. Mental health stigma should also be tackled in schools and colleges and ensure pupils, students and staffs awareness around emotional health and well-being is improved so they know when to seek help, and how to improve their own emotional health and well- being. (Timescales: on-going)

Draft Recommendation: Referrals and Care Pathways

- Specialist and Universal CAMHS providers to review local care pathways and improve the awareness and understanding amongst local professionals of associated referral mechanisms, protocols, and care pathways to support appropriate and timely intervention. (Timescales 2013-2015)

Draft Recommendation: Training and Development

- Improve training available to practitioners by evaluating current provision and ensuring a more coherent local offer for all relevant staff service groups. (Timescales: 2014)

Draft Recommendation: Transition

- Review service delivery including joint working and transition arrangements between CAMHS and AMHS and ensure an updated CAMHS transition plan and pathway is developed and clearly defined and signed up to by CAMHS and AMHS. Services should also ensure that high quality services at the point of transition are in place, including services for young people in out-of area placements. (Timescales: 2014)

14 Appendices

15 References

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