# Health Needs Assessment

# Children's mental health, emotional and social well being in Bradford District

# January 2015

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## Summary

*National context*

- Mental health difficulties are common in childhood: national surveys in 2005 and 2008 showed that around 1 in 10 children aged between 5 and 15 had a mental health disorder. 25% of children with mental health disorders in 2005 had the same disorder 3 years later.

- In addition to the above figures, many more children will experience emotional or behavioural difficulties which fall short of a clinical diagnosis. Estimating this number is challenging, but a large cohort study *Growing Up In Ireland* found that 15-20% of 9 year olds had some degree of emotional or behavioural difficulties.

- Research suggests that early intervention in childhood could prevent between a quarter and a half of adult mental illness.

- Some of the most significant risk factors for emotional and behavioural difficulties in children are parenting and effective family functioning, parental mental health (especially maternal depression), and socio-economic circumstances. Children from the most disadvantaged 20% of households are three times as likely to have a mental health difficulty as the most advantaged 20%.

- Experience of bullying is also strongly associated with poor emotional well being and future mental health difficulties in children. 'Cyber-bullying' presents an increasing problem. Various national studies suggest that between 8% and 34% of children in the UK have experienced this.

- Promoting children's emotional and social well being, and developing coping skills and resilience to adverse circumstances, protects against a range of poor outcomes as adults, including poor mental health.

- NICE guidelines and national evidence support the promotion of children's emotional and social well being, particularly in schools.

- The revised Special Educational Needs Code of Practice (2014), and recent guidance on mental health and behaviour difficulties in schools, encourages staff to consider challenging behaviour in children as a potential expression of unmet mental health needs.

- Three national reports during the latter half of 2014 have expressed significant concern about CAMHS services and a national taskforce has been established.

- Extensive disinvestment in CAMHS nationally has amounted to as much as 25% in some areas.

- Data about CAMHS services is extremely limited nationally. The introduction of the CAMHS minimum dataset and CYP-IAPT may alter this situation.

*Bradford children and young people*

- Bradford has the third largest child population in the UK with some risk factors which increase the likelihood of poor wellbeing and mental health, in particular the high numbers of children living in poverty.

- The overall child population increased by 10.5% between 2002 and 2012, and is projected to grow by a further 5.5% by 2025. This population growth is likely to be concentrated in the most deprived areas of the city where birth rates are currently highest. The 10-14 age group, a key group for the onset of mental health difficulties, is projected to grow by 10.2% in the next ten years.

- A increase in the demand for emotional and mental health services at all levels including specialist CAMHS, over and above a rise in proportion with the population, is likely. Prevention, promotion and early intervention will play a very important role in protecting capacity within specialist CAMHS.

- Bradford's child population has a number of factors associated with increased risk of emotional or mental health difficulties. The most significant of these is the high number of children living in poverty and disadvantaged circumstances.

- Children in the most deprived wards in Bradford show poor levels of social and emotional development when they start school, which is associated with poorer social, emotional and mental health outcomes later in childhood. Children's mental health commissioners and providers should have strong strategic links to early years commissioners, particularly around parenting and family support.

- Based on data from national surveys, we can estimate that there are currently just under 8,500 children aged between 5 and 15 with diagnosable mental health disorders in Bradford. Between three and four children in every secondary school classroom are likely to have some form of mental health difficulty.

- The number of children with emotional or behavioural difficulties at a lower level is harder to quantify but if we applied the figure in the *Growing Up In Ireland* study to the Bradford child population between 5-15, we could estimate there to be a further 10% of children with lower level difficulties.

- While these figures should be treated with considerable caution, they would produce a total estimate of **17,000 children with some level of emotional or mental health difficulty** in Bradford.

- A rise in proportion with the increasing population in the relevant age bands would see this broad estimate rise to **23,600 children with some level of emotional or mental health difficulty** by 2025.

*Local services*

- Bradford CAMHS services are in a vulnerable position, especially community based services. In particular, the Primary Mental Health Worker service, amounting to 11% of the CAMHS budget, has no secure source of funding.

- Voluntary and community sector (VCS) services play a significant role in providing lower level intervention and protecting capacity in specialist CAMHS, as well as providing a range of options for young people experiencing difficulties. However, funding for these services is based on short term contracts and subject to increasing insecurity.

- Qualitative interviews with a range of professionals describe increasing pressure on referrals to all services, and a growing degree of complexity in the cases handled by community based and VCS services.

- Professionals describe a large group of children who present with complex and often disruptive behaviour, particularly in school, but who may fall into a 'grey area' in the absence of a diagnosis of any specific mental health difficulty or developmental condition (eg ASC, ADHD). Consideration of the needs of these children must be an integral part of an effective strategy for children's mental health services.

- Referrals to specialist CAMHS rose by 16% between 2012/13 and 2013/14, from just over 2,000 to 2,500 in 2013/14.

- The active caseload for specialist CAMHS shows a 20% increase in the 18 months between March 2013 and October 2014, from 1,719 to 2,062.

- The increasing pressure on specialist CAMHS referrals, and projected further increase in demand, is of concern in the light of threats to the sustainability of Tier 2 services.

- A regional benchmarking exercise showed the Bradford CAMHS partnership area had the lowest rate of referrals to specialist CAMHS in the region (17/1,000 children). This was lower than the national average.

- The same benchmarking exercise showed Bradford CAMHS partnership to have the second lowest rate of investment by CCG commissioners in the region: just over £20 per child. The national average in the 2012/13 exercise was £33 per child.

*What children tell us*

- 32% of children in year 4 told us they had been bullied, with levels reducing as children became older. 38% of children with SEN reported being bullied.

- 58% of children reported that their school took bullying seriously

- 5% of children reported 'cyber bullying'

- Only 24% of children in the most deprived fifth of the population had high self esteem, compared to 41% of the most deprived.

- The most significant source of worry for our young people is around school work, closely followed by problems with friends and family.

- Children and young people want to access services through someone they trust. They would like teachers, GPs and the people they see every day to have the skills to recognise and respond to emotional and mental health difficulties.

- Children and young people still report significant stigma attached to using services, particularly specialist CAMHS. They wanted awareness of mental health issues to be raised and asking for help to be normalised.

- Children and young people wanted to learn how to recognise emotional and mental health difficulties, and to learn coping and resilience skills.

- Children and young people did not feel they had enough information about the services available to them, and were dependent on professionals to relay this information. They wanted accessible, non stigmatising information about the full range of services.

- Children and young people want flexible, accessible and responsive services which, wherever possible, are based where they are – in schools, youth services and their community.

- Waiting times were perceived as very problematic for children and young people. They wanted to be able to get help quickly without needing to wait.

- Young people were less enthusiastic about online services than the ubiquitous nature of technology would suggest. They were worried about confidentiality, and wanted to be able to speak to a real person. A further barrier to online services is that a significant minority of young people in Bradford are still unable to afford smart phones, apps, or the internet data to use them, and have limited access to a computer at home.

## Recommendations

1. Avoid further direct disinvestment in children and young people's mental health services.

2. All partners should consider children and young people's emotional and mental health services as a high priority for additional investment when the financial climate allows.

3. Review and redesign services to provide maximum capacity in Tier 2, community and school based interventions, protecting the small capacity within specialist CAMHS and responding to what children and young people tell us about their ideal services.

4. Continue to support and expand workforce development and the 'skilling up' of workers in Tier 1 (universal) services who have day to day contact with children, for example through the CAMHS training programme.

5. Continue to promote the role of schools in supporting children's mental health and emotional wellbeing, and as potential direct commissioners of services.

6. Consider the potential of other professionals and organisations to extend the services they offer to meet need, for example VCS organisations, school nursing.

7. Plan and deliver a mental health promotion strategy for children and young people through schools and community settings.

8. Ensure that support for children who present with behavioural difficulties is considered as an integral part of the overall system for children's emotional well being and mental health.

9. Work to increase the amount of useful data routinely shared between commissioner and provider, particularly through CYP-IAPT and the minimum dataset when implemented

10. Continue to design services in ways that support access for children and young people from BME communities, particularly the South Asian community and the growing Eastern European community.

11. Create strong links between children's mental health services, early years services and parenting and family support. Consider representation from Health Visitors or other early years services at the Healthy Minds group.

## 1. Introduction

In her report, 'Public Mental Health Priorities: Investing in the Evidence' (Davies, 2014), the Chief Medical Officer writes that:

'Childhood is a time of great opportunity, but also of substantial risk' (p.90)

Around one in ten 5-15 year olds in the UK will have a clinically diagnosable mental health problem during their childhood (Green et al, 2004). The number of children with difficulties at a lower level is harder to estimate, but a study of Irish children estimated that a further 10% had 'borderline' difficulties (Nixon, 2012).

The case for early identification and intervention is strong: more than 75% of adults accessing mental health services had a clinically diagnosable disorder before the age of 18 (Kim-Cohen et al, 2003). 50% of all lifetime mental health disorders present before age 18, and 75% by the mid twenties (Kessler et al, 2007).

Research suggests that early intervention in childhood could prevent between a quarter and a half of adult mental illness, with corresponding individual, economic and social benefits (Kim-Cohen et al,2003)

As well as providing timely and effective treatment, we also need to promote good mental health. This requires a strategy which supports social and emotional well being, and helps children to develop the resilience and coping skills they will need to weather adverse experiences. As the Royal College of Psychiatrists describes in a position statement (2010):

Good social, emotional and psychological health protects children against emotional and behavioural problems, violence and crime, teenage pregnancy and misuse of drugs and alcohol. (p.22)

The landscape of children's mental health and emotional well being is complex, with contributions from many different commissioners and providers. The last local needs assessment was undertaken in 2004, since when much has changed. Current financial circumstances pose significant threats to important services nationally and locally. Nationally, extensive disinvestment in CAMHS services has amounted to as much as 25% in some areas (Davies, 2014).

This needs assessment considers the current and likely future numbers of children in Bradford who may experience mental health difficulties, and the broader need for services to support children's social and emotional well being, build resilience and coping skills, and promote good mental health now and in the future. It reviews the availability of services to meet that need.

### 1.1 Why is children's mental health important?

One in ten children between the ages of 5 and 16 have a mental health disorder (Green et al, 2004). For many this is persistent: successive national surveys demonstrated that 25% of children with a diagnosable mental health disorder still had the same disorder 3 years later (Parry-Langdon et al, 2008).

The majority of adult mental health disorder have their beginnings in childhood. 50% of adult mental health disorders (excluding dementia) have their onset before age 14, and 75% of disorders (again excluding dementia) before the mid-twenties (Kessler et al, 2007)

Figure 1 shows the age of onset for some common adult mental disorders.

**Figure 1: ages of onset for mental disorders**

| | |
|---|---|
| **ADHD** | 7-9 years |
| **Oppositional defiant disorder** | 7-15 years |
| **Conduct disorder** | 9-14 years |
| **Psychosis** | Late teens – early 20s |
| **Substance misuse** | 18-29 years |
| **Anxiety disorders** | 25-45 years |
| **Mood disorders** | 25-45 years |

**(**adapted from Kessler et al, 2007)

Poor mental health in childhood is associated with a broad range of outcomes including poor educational achievement, a greater risk of suicide and substance misuse, antisocial behaviour, offending and early pregnancy (RCPsych, 2010).

Children who experience poor mental health are at greater risk of adult mental health disorders (RCPsych, 2010). In adulthood, mental ill health is also associated with a broad range of poor outcomes, including lower levels of employment, relationship difficulties, criminal activity, poorer physical health and reduced life expectancy. In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by Disability Adjusted Life Years (DALYs), (RCPsych, 2010).

The Royal College of Psychiatrists propose in their position statement of 2010, based on a cohort study by Kim-Cohen et al (2003) that improved availability of early intervention services for children and young people could prevent 25-50% of adult mental illness (RCPsych, 2010). Thus identifying and intervening early in children's mental health has the potential to deliver huge improvements to individual children's life chances, and to the population as a whole.

The number of children with difficulties at a lower level is harder to estimate, but a large cohort study, *Growing Up in Ireland,* estimated that a further 10% of children had 'borderline' difficulties when they were followed up at 9 years old (Nixon, 2012). These children may not have a diagnosable mental health disorder, but are likely to nevertheless suffer 'impairing psychological distress' (Davies, 2014) which affects their social and educational functioning. Early intervention will greatly improve these children's ability to function and their educational and social outcomes.

### 1.2 Promoting good mental health, and developing well being and resilience

Promoting good mental health in our children also means building their social and emotional well being, and in particular developing resilience and coping skills.

The NICE guidelines 'Promoting social and emotional well being in primary education' and 'Promoting social and emotional well being in secondary education' stress the importance of programmes to develop children's social and emotional competence, and the role this can play in preventing future mental ill health.

NICE (2013) defines social and emotional wellbeing as:

> personal competencies (such as emotional resilience, self-esteem and interpersonal skills) that help to protect against risks relating to social disadvantage, family disruption and other adversity in life.
> (NICE, 2013, p.1)

The Royal College of Psychiatrists (2010) recommends that:

‘childhood interventions which protect health and well being, and promote resilience to adversity, should be implemented’ (p.9)

A national survey of childhood mental health and resilience (Parry-Langdon et al, 2008) found that children were at less risk of developing mental health disorders if they:

- Were rated by their parents as having a number of skills related to good social and emotional development
- Had strong social skills
- Had strong friendships
- Had higher ‘social capital’, defined as strong social networks and high levels of social support
- Were positive about living in their neighbourhood

Poor social and emotional wellbeing in childhood, conversely, has been associated with a range of poor childhood outcomes including:

- Lower educational attainment
- Smoking, alcohol and drug use
- Poorer physical health

Good mental well being is associated with better mental health as adults, and a broad range of other positive outcomes including:

- Improved educational outcomes
- Healthier lifestyles and reductions in risk taking behaviour
- Better social relationships
- Reduced likelihood of anti-social behaviour, crime and violence
- Reduced smoking/ alcohol/ drug misuse

(Campion et al, 2012)

Thus alongside the identification and treatment of mental illness, it is likely that promoting children’s social and emotional wellbeing, and the development of resilience and coping skills, will have a strong protective effect on their future mental health.

## 2. Children's mental health: the national context

### 2.1 National policy

In 2011, the Government published the national strategy 'No Health Without Mental Health' which stated that good mental health was 'everybody's business', and acknowledged the wide reaching influence of good or poor mental well being.

'Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential'.

(*No Health Without Mental Health*, p.1)

The strategy is for people of all ages, individuals and families, and acknowledges that:

A good start in life and positive parenting promote good mental health, wellbeing and resilience to adversity throughout life.
(p.1)

Supporting children, young people and families is a key priority area for the strategy, including effective intervention in the early years.

The two most relevant objectives of the six laid out in the strategy are that:

*More people should have good mental health*

And

*More people with mental health problems will recover*

In September 2014, the Chief Medical Officer's annual report for 2013, 'Public Mental Health Priorities: Investing in the Evidence' (Davies, 2014) considered the state of mental health in England and made 14 key recommendations. The report's chapter on child and adolescent mental health notes the frequency of mental health difficulties among children, and the value of early intervention.

It notes in particular that child mental health disorders have increased in prevalence between 1974 and 1999, and that most CAMHS services have reported an increase in the severity and complexity of problems presenting to their service since 2011 (Davies, 2014). This goes alongside significant disinvestment in CAMHS services in many local areas, and reductions in social work and education funding that pose major challenges to joint working and commissioning.

A key recommendation of the report is that:

'Local authorities should prioritise against further disinvestment in children and young people's mental health services'.

In November 2014, the House of Commons Select Committee published the report of its national inquiry into CAMHS (HMSO, 2014). Key conclusions and recommendations included:

'The lack of reliable and up to date information … means that those planning and running CAMHS services have been operating in a fog'

.

' … Compelling arguments have been made to this inquiry that the focus of investment in CAMHS should be on early intervention – providing timely support to children and young people before mental health problems become entrenched … However in many areas these are suffering from insecure or short term funding, or being cut altogether'

' … While demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. … we are concerned that insufficient priority is being given to children and young people's mental health. (p.4)

The Select Committee recommended that NHS England and the Department of Health should increase investment in CAMHS until the Committee could be assured that services were operating at an acceptable level.

In addition, it expressed concern at the insecure funding position of many early intervention services, and recommended that the National Taskforce (see below) be given an explicit remit to audit the commissioning of early intervention services in local areas, and to consider the best mechanisms for securing stable, long term funding.

National recognition of the complexities surrounding children and young people's mental health services has led to the recent establishment of the Children and Young People's Mental Health Taskforce, set up in late 2014. Co-chaired by the Department of Health and by NHS England, the taskforce aims to:

*… agree recommendations, solutions and actions which set out what is needed from the national and local leadership across health, social care and education, and how we can best work together to ensure better outcomes for children and young people's mental health and well-being.*

The taskforce will report on its findings in the spring of 2015.

In the meantime, this needs assessment takes place in the context of significant national concern about the commissioning and provision of

CAMHS, and a recognition that in most areas of the country, services are under tightening financial pressures, subject to increasing referrals, and struggling to provide timely and effective intervention for children with emotional or mental health difficulties.

### 2.2 Tier 4 review

In April 2013 NHS England acquired responsibility for the commissioning of what are known as 'Tier 4' services – inpatient services for children and adolescents, together with some highly specialised outpatient services.

In July 2014 they published a review of Tier 4 services (NHS England, 2014), with the intention of mapping current services and identifying areas for improvement.

Although Tier 4 services are commissioned and funded by NHS England, the availability and effectiveness of local services will have a significant effect on the demand for Tier 4 services. Locally, Bradford CAMHS has a strong track record in managing young people at what is informally known as 'Tier 3.5', where they remain at home with intensive support from specialist CAMHS teams. This is particularly necessary because the only inpatient units in the region are in York and Sheffield, meaning that young people requiring admission will face being placed a considerable distance from their families.

Because of limitations on capacity in this needs assessment, and because of the existence of the national Tier 4 review, this report focuses on the local need and provision in relation to Tiers 1-3 of CAMHS.

However, the recommendations of this needs assessment will need to be considered by commissioners alongside those of the Tier 4 review.

### 2.3 Children and Young People's Improving Access to Psychological Therapies

The third key national initiative is Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT).

Launched in 2011, CYP-IAPT is a service transformation programme, led by NHS England, that aims to work with CAMHS services covering 60% of the child population by 2015.

The programme focuses on the expansion and transformation of CAMHS services, particularly developing an integrated system which identifies problems early and supports young people throughout the pathway. It includes the development of community based services and the promotion of resilience. It will also transform the way in which outcomes are measured and

reported on, with the measurement and reporting of outcomes becoming integral to each therapeutic session.

Bradford District CAMHS has been approved to participate in the fourth wave of CYP-IAPT, which will be launched in 2015.

### 2.5 CAMHS minimum dataset

Lastly, the CAMHS minimum dataset is due, despite delays, to be delivered in the fairly near future. This will mandate a nationally agreed dataset to be returned nationally by CAMHS providers, permitting a much greater understanding of activity and outcomes in CAMHS services. The CAMHS minimum dataset is discussed further in Section 5 of this needs assessment.

### 2.6 The tiered model of CAMHS

Responsibilities relating to the commissioning of CAMHS and services to support children's emotional well being are complex, and underline the importance of joint working.

CAMHS services have been widely described for a decade in terms of a tiered model, on a spectrum from the universal to the specialist inpatient service (DCSF,2010). It is important to note that the tiered model is a conceptual framework and not a rigid set of commissioning rules.

#### Tier 1

Services at Tier 1 are delivered by practitioners working in universal services who have contact with children and young people but are not mental health specialists. Examples include GPs, school nurses, teachers, social workers and youth workers.

#### Tier 2

Workers at Tier 2 tend to be specialists working within the community, providing early intervention for mild to moderate problems. They form a key link between universal services at Tier 1 and more specialist services at Tier 3. They may also have a role in training and 'skilling up' universal services to work with children with mental health difficulties, for example by providing teacher training programmes.

Typical services include primary mental health workers, voluntary sector counseling services, school-based counselling services, 'skilled helping teams' in schools, and school nursing advice services.

**Tier 3**

Tier 3 services are provided by specialist teams, usually as part of a Child and Adolescent Mental Health Service (CAMHS). They will be delivered by specialist teams, for children who have more severe mental health difficulties and require specialist or intensive input.

**Tier 4**

Tier 4 services are provided to children and young people who have severe mental health difficulties and require inpatient treatment, or very specialised outpatient treatment (for example, young people with gender dysphoria).

## 2.5 Commissioning responsibilities

In broad terms, responsibility for the commissioning of mental health services for children is divided between local authorities and Clinical Commissioning Groups (CCGs).

Clinical Commissioning Groups (CCGs) have a responsibility to commission health services for children's physical and mental health (NHS England,2012)

From April 2013, when public health responsibilities transferred to local authorities, local authorities acquired responsibility for 'public mental health services' and for the public health of 5-19 year olds (DH, 2011). This creates a clear responsibility for local authorities to commission services that promote and protect the mental health and emotional well being of children and young people. They must also consider the role that the promotion of emotional well being plays in the achievement of other key outcomes for the young people in their care: for example, educational attainment.

Tier 4 services have been the responsibility of NHS England since April 2013 (see above). However, the availability and effectiveness of Tier 4 services will affect commissioning decisions about the local system, particularly if young people with severe needs cannot be found effective provision and continue to be managed within the local Tier 3 service.

When these commissioning responsibilities are set against the tiered model of CAMHS services, it is clear that individual agencies cannot be readily allocated to different 'tiers' of the system. Tier 1 services, for example, may

only provide effective support if specialist services at Tiers 2 and 3 have the capacity to train, advise and 'skill up' practitioners in universal services.

The Joint Commissioning Panel for Mental Health, in '10 key messages for commissioners' (2013) comments that:

As CAMHS is a multi-agency service, a multi-agency approach to commissioning is required. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to better meet the needs of the populations they serve, and achieve wider system efficiencies.

(p.2)

### 2.6 Alternative conceptual models of CAMHS

While the tiered CAMHS model has served commissioners well for many years and is widely understood, it is not mandatory and other models have been proposed which may better facilitate effective joint commissioning.

The Anna Freud Centre (Wolpert et al,2014) has recently published proposals for the THRIVE model of CAMHS, which is based around the intensity of input required by the child or young person, rather than an 'escalator model' of increasing severity and complexity of problems. At the heart of the model is

Figure 2 is a pictorial representation of the THRIVE model

**Figure 2 : The THRIVE model**


(Wolpert et al, 2014)

In the long term, commissioners may wish to consider alternative options for conceptualising the delivery of CAMHS services, which better reflect joint responsibilities and facilitate joint commissioning.

## 3. Children's mental health: local context

### 3.1 Local strategic and policy context

The main multi-agency steering group for children and young people's mental health in Bradford is the 'Healthy Minds Strategy' group, established in 2005. The group has been recently reinvigorated following a period where it fell into abeyance.

The group has representation from the CCG, local authority, VCS and input from young people.

Its main objectives are:

An improvement in the mental health of all children and young people across the district;

That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention services and also meet the needs of children and young people with established or complex problems;

That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

In addition, the local strategy 'Mental Health Matters in Schools' was set up in 2014, working in tandem with the Healthy Minds group. Its aim is:

To develop and deliver a core offer, across all Bradford Schools, to promote the emotional and psychological wellbeing of children aged 3- 18, through universal and targeted approaches to building resilience and addressing risk.

Bradford has also recently begun participation in the CYP-IAPT project, providing a significant opportunity to transform CAMHS services and extend access to psychological therapies for children and young people in the District. Again, this is a significant opportunity to improve services, and will require commitment from all local commissioners.

### 3.2 Local services

As section 2 demonstrates, the services available and how they are funded make up a complex picture. The key to a successful mental health system is providing comprehensive services which cover the four tiers of service:

### 3.2.i Tier 1

Services currently provided at Tier 1 include:

**Mental Health Matters**

A recently established steering group, supported by local authority Public Health funding, which is implementing a strategy to promote children's emotional and psychological wellbeing across Bradford, to support the development of resilience and emotional wellbeing in schools, and to deliver training to school staff.

The strategy group delivers assemblies on the theme of 'Getting Through Tough Times', has provided resource hubs in all schools, and is delivering programmes of training. Historically, training to school staff had been offered through the CAMHS co-ordinator and the Educational Psychology team. The Mental Health Matters strategy has made it possible to co-ordinate this training much more effectively and reach more schools.

**School nursing and Family Consultation Service**

The school nursing service play a key role in supporting children with mental or emotional health issues, and in managing referral to specialist CAMHS.

Most referrals to CAMHS, with the exception of emergencies, are expected to come via school nursing. School nurses work closely with Primary Mental Health workers through the Family Consultation service. The Sharing Voices worker also described the importance of a close working relationship with school nurses in the schools where she works with young people.

**CAMHS workforce training programme**

CAMHS offer a training programme for workers within universal services. The aim is to equip teachers, GPs, social care staff and other professionals who have contact with young people, with knowledge about mental health issues and the ability to respond and seek further support on behalf of young people.

### 3.2.ii Tier 2

Tier 2 services are a crucial part of the system for children and young people in Bradford. The growing child population, significant risk factors and low investment/staffing in specialist CAMHS means that the system is only likely to be effective with a broad, strong base of services at Tier 2 offering intervention for mild to moderate problems, and effective gatekeeping of referrals to specialist CAMHS.

Current services provided at Tier 2 include:

#### Primary Mental Health Workers

This team is employed by CAMHS and consists of ten workers who act as the first line of intervention for children and young people with mild to moderate difficulties. The team provides early assessment and intervention for children and young people presenting with mild to moderate difficulties, onward referral to specialist CAMHS where required, and advice and consultation to other agencies and professionals.

Funding for this service is only secured until October 2015. Agreement was reached for the CCG to fund the service for this period following a withdrawal of local authority funding.

A steering group has been set up to review the service and implement alternative arrangements, but a sustainable future remains to be identified.

#### VCS counselling services

Counselling services provided by a range of VCS organisations make a significant contribution to the range of provision at Tier 2 for children and young people. These include:

#### '*Off the Record' counselling services*

Off the Record is a third sector counselling organsation, supported by grant funding from the Clinical Commissioning Group (CCG). They provided 1,000 hours of counselling in 2013/14.

#### *Relate Bradford*

Relate Bradford are a significant provider of counselling and therapeutic services to young people, having seen 183 young people in 2013/14.

They provide counselling and therapeutic interventions, taking referrals from school nurses, CAMHS, or social care where children have complex social circumstances.

The organisation's work is supported by a mixture of CCG and local authority grant funding.

Waiting lists have risen from 2 to 12 weeks, and the organisation feels that they are dealing with increasingly complex cases, which would in the past have been seen within CAMHS. Many of the young people referred to them have significant social difficulties or challenging circumstances such as domestic violence, sexual exploitation or substance misuse within the family.

***YMCA***

YMCA have a small grant from the local authority to provide some counselling services.

***Sharing Voices***

Sharing Voices is a community development organisation which works to support adults and children with mental health difficulties. The organisation also employs a children and young people's worker who undertakes specific mentoring, befreidning and support work in five schools in inner-city Bradford.

This professional works closely with school nursing to direct appropriate referrals either to CAMHS or to alternative sources of support. She will often, for example, work with children to support them through difficult life events – for example, she described supporting a young man whose friend had taken his own life.

She also provides a drop in service in schools, which she stressed can be of great importance as many of the children and young people she sees are reluctant to engage with services. Easily accessible services provided close to where children and young people are is extremely important.

**Behavioural support teams and nurture groups**

The specialist behavioural, emotional and social (BESD) support teams comprise 9 specialist teachers and 7 specialist inclusion mentors, and are funded by the Schools Forum via 'de-delegated' funding agreements (ie schools agree to a top slice of their delegated budgets to fund the service).

The team work primarily with primary schools, due to historical funding arrangements, and provide training and consultancy, especially around the development of nurture groups (see below). They also work individually with children whose social, emotional or behavioural needs mean that they may require an EHC Plan (previously a statement of special educational needs).

Ultimately the aim of the service is to build capacity and skills in the school, rather than importing expertise.

Nurture groups are supported in 27 primary schools in Bradford, which is a considerable number compared to most local authorities. They provide an intervention over two to four terms for children whose social and emotional development has been delayed and who are not 'ready for school'. Led by two adults, the class size is between 6 and 10 and children can form close attachments and replicate the early social and emotional experiences they may have missed out on.

### 3.2.iii Tier 3 services

Tier 3 services are provided by Bradford District Care Trust, where the specialist Child and Adolescent Mental Health Services teams are based. The range of services provided include:

- Eating disorders service
- ADHD service
- Family therapy
- Individual and group therapy
- Learning disability services
- Autistic Spectrum Disorder (ASD) services
- Substance misuse
- Mental health difficulties such as depression, anxiety, obsessive-compulsive disorder
- Psychotic disorders

### 3.2.iv Tier 4 services

Currently, Bradford children and young people requiring inpatient admission will be admitted to adolescent in patient units at York or Sheffield. The Tier 4 review (NHS England, 2014) identified under provision of Tier 4 facilities in Yorkshire and the Humber and young people sometimes have to be admitted to facilities outside the region.

Bradford has a strong track record of providing 'Tier 3.5' services, where children and young people are maintained at home with intensive visiting from specialist services. This is an established model in the eating disorders service, for example.

The NHSE Tier 4 review has committed to increasing capacity at Tier 4 for children who need inpatient admission, and to increasing the number of inpatient beds available in Yorkshire and the Humber.

### 3.3 Services provided directly by schools – a gap in understanding

A key gap in understanding identified by this needs assessment is a full description of the services currently provided directly by schools, and the level of intervention they offer.

All schools in Bradford have the freedom to purchase support services out of their delegated budgets. Secondary schools in Bradford include academies, free schools and maintained secondaries. Although a survey was distributed to schools as part of this health needs assessment, the response rate was minimal, with only two questionnaires returned.

Evidence to the Commons Select Committee (2014) estimated that between 61% and 85% of schools in the UK offer school-based counselling in some form. This would make counselling in schools one of the largest and potentially most effective early interventions for mental health difficulties. To date, we do not know where schools in Bradford stand in relation to this figure.

As described in the section above, the BESD support team provide a very significant level of training, support and consultancy to many schools in Bradford. However, this still remains dependent on the commitment of individual schools – there is, for example, no planned provision of nurture groups in specific schools to meet understood need.

Beyond the BESD model in primary schools, interviewees who work with schools described a great variety of provision, with some schools having very minimal provision and others supporting significant services from their delegated budgets. 3 of the Bradford academies, for example, have continued to employ a Targeted Mental Health in Schools (TaMHS) worker after the end of the national initiative.

Interviewees described committed Headteachers who had ‘everything going’ and others, less supportive or understanding of mental health issues, who provided the bare minimum.

Those two schools who did respond described situations where their ability to respond to their pupils’ needs was very limited, and it was difficult for staff to know how to get the right help for pupils.

Both had access to school nursing and VCS counselling services, but described this as ‘not enough’. One school had had access to ‘skilled helper

teams' but had since lost this. Both schools suggested that pupils with more immediate, pressing needs would be referred while those with lower level needs tended to lose out.

Conversely, professionals interviewed emphasised the importance of schools as key players in children's mental health and emotional well being. Children spend much of their waking day in school. It is there that difficulties may be most apparent, and where the greatest opportunity for helping young people 'where they are' is likely to exist. Services provided within school are readily accessible to young people and, if their needs demand it, will not always require parental involvement.

National policy also emphasises the importance of schools as a forum for promoting social and emotional well being, and delivering early interventions around mental health. Evidence given to the Health Select Committee (2014), by teachers and experts, highlighted the opportunity, as well as some of the difficulties:

'…young people refer themselves for help; it is almost unprecedented within CAMHS, but they will do that in a school where there is a CAMHS presence. It can be done discreetly, in their lunch hour or after school, on their terms, the way they feel comfortable.'

(evidence to Select Committee, p.80)

'Schools are completely vital in identifying early signs of mental health [difficulties] or low level problems that might develop into something serious' (evidence to Select Committee, p.79)

However, evidence to the Committee also described some of the difficulties. Schools were said to be under pressure to prioritise academic achievement over emotional and social development and well-being, with this sometimes leading to the exclusion of pupils with behavioural difficulties.

While it was said to be vitally important that teachers had an understanding of mental health and the promotion of social and emotional development, evidence to the Committee was clear that this formed a very small part of teacher training. Local discussions with professionals backed this up, with many commenting that teachers lacked confidence in approaching mental health issues and found it challenging to deal with more complex problems such as self harm.

Children and young people also asked the Committee for more education about mental health issues: they wanted to know how to recognize the signs

of mental health difficulties, and how to help themselves and look after their own mental and emotional wellbeing.

Locally, our children and young people have asked for similar things in services. Many of them would like to receive information directly about what services are out there (rather than relying on professionals). They feel it important to raise awareness of emotional and mental health issues, and to give young people confidence about asking for help when they need it.

The 'Mental Health Matters' strategy has a key role to play in developing our understanding of what schools currently offer, what they would like to offer, and how they can be supported, commissioned or 'skilled up' to do so. Schools need to become an integral part of the conversation around commissioning and provision of mental health services, and the MHM strategy offers an essential route by which they can do so.

### 3.4 Impact of financial constraints locally

Specialist CAMHS services are provided by Bradford District Care Trust, with the main commissioner being the CCG. VCS counselling and therapeutic services also make a significant contribution to services in Bradford, being commissioned partly by the CCG and partly by the local authority.

National financial cuts imposed on local authorities have created significant pressures on services, and some very immediate threats to the children's mental health system locally.

Bradford Metropolitan District Council had, until 2013, provided funding to CAMHS through the Healthy Minds grant, a total of £323,000 per annum, equivalent to around 10% of the total CAMHS budget. In 2013 this funding was withdrawn, and the Primary Mental Health Worker service, a key element of Tier 2/3 provision, came under threat of closure. At present the CCG have agreed short term funding until October 2015, but there is as yet no clear way forward for the service after this date.

The development of the 'Early Help Strategy' also raises significant concerns around the stability of the children's mental health system, alongside the opportunities it brings for early intervention. The 'Early Help' strategy aims to provide help to families and children when needs are identified rather than intervention when a problem arises.

The redesign of services to meet the Early Help offer may involve the reallocation of budgets to Early Help, and potential recommissioning of services.

Thus there is an immediate threat to a significant proportion of the Tier 2/3 system, in the context of rising demand and pressure on referrals (see Section 6). Strong joint working will be essential in order to preserve an effective system in this very challenging financial climate, and to make well considered decisions about future commissioning.

### 3.5 Scope of this needs assessment

To cover the entirety of the specialist CAMHS and wider mental health system in this needs assessment would have demanded far greater time and capacity than there was available.

This needs assessment therefore focuses largely on the overall current and future prevalence of mental health difficulties within Bradford's child and adolescent population, and the overall availability of services to meet that need.

Since Tier 4 is a national specialised commissioning responsibility and is covered by the recent review (see above), it was not considered as part of this needs assessment. However, the recommendations of this needs assessment should be read in conjunction with the NHS England Tier 4 review.

The needs assessment considers the overall need, activity and demand for Tier 3. However, there was little data available to break this information down and consider in more detail the need and demand for individual services within CAMHS. This will be a key area for further needs assessment work as and when more data becomes available.

Recommendations about gaps in services, and the need for future services, are largely focused on the lower tiers of the system, from prevention and promotion at Tier 1, through community based provision in Tier 2, to the interface between Tiers 2 and 3.

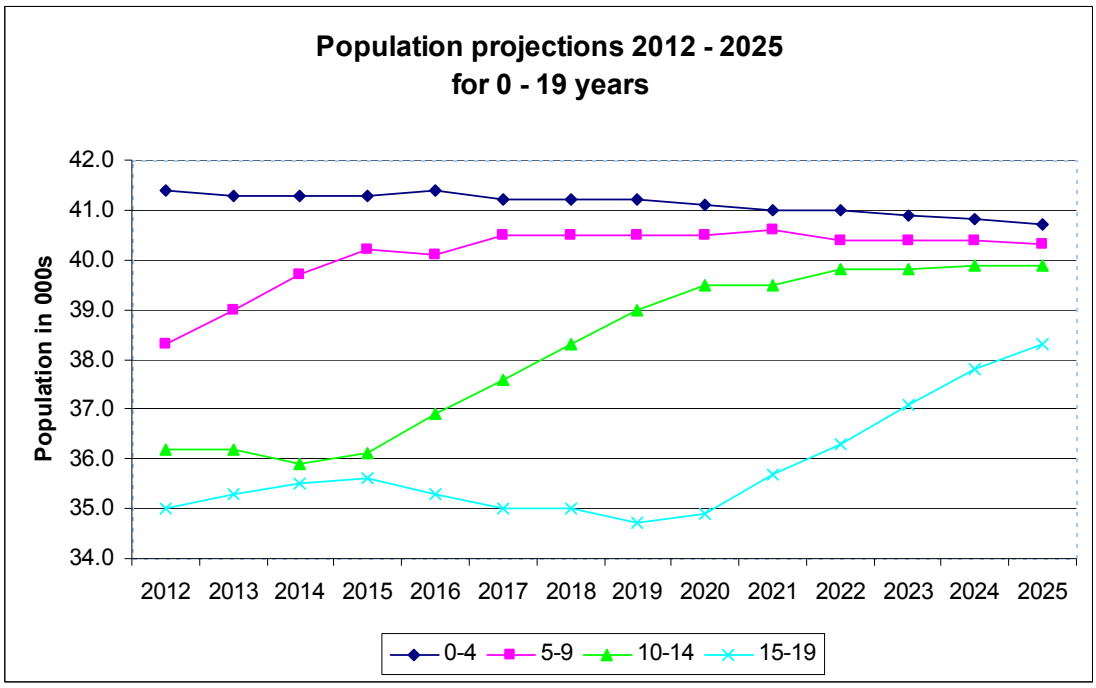
## 4. Establishing the need: size of the child population, risk and protective factors

### 4.1 Bradford's child population

Bradford has an exceptionally young population, the third youngest in the UK, which is forecast to grow over the next 5 years. Based on the most recent mid year estimate from the Office for National Statistics (2013), there are 151,800 children and young people aged 0 - 19 in the District, and children make up 28.8% of the population.

Between 2002 and 2012, the number of children and young people aged 0 - 19 increased by 14,400 (10.5%) and is expected to increase by a further 8,300 (5.5%) to 159,200 by 2025. The largest projected increase is in the 10-14 year old age group (10.2%) from 36,200 in 2012 to 39,900 in 2025; followed by the 15 – 19 age group (9.4%).

**Figure 3 : Child population and projected increases, 2012-15**




Thus the simple numbers suggest that as the population of children increase, we can expect a corresponding increase in demand for services.

Thus just as in every other area, the sheer numbers of children in our population mean that children's emotional well being and mental health must be a key priority, and the predicted increase in the child population means that we should expect a corresponding increase in demand for services.

It is also important to note that although Bradford's child population is large, the greatest group proportionately is currently in the 0-4 age band. The expected prevalence of difficulties in this age group which require specific interventions from mental health services is low, although there is significant evidence that supporting social and emotional development, parenting skills and family functioning in the early years is likely to have a protective effect against future mental health difficulties.

However, as these children grow up the numbers of children in the critical age bands, where many common mental health difficulties are first seen, will rise

disproportionately to the overall increase in the child population. The largest projected increase is in the 10-14 year old age group.

We can also expect this population increase to be concentrated in the most deprived areas of Bradford. Almost one-third of all births in the District in 2011 were in the 6 most deprived wards, and over half all births were in the most deprived 12 wards. Thus as the child population grows, the proportion who are living in poverty, and hence at greatly increased risk of emotional and mental health difficulties, will also grow.

Thus commissioners should anticipate at least a 5% increase in demand for services, but should consider that this may well be higher as the adolescent population increases, and becomes concentrated in more deprived areas.

## 4.2 Vulnerable groups in Bradford's population

In every child's history and circumstances there will be factors which may help to build emotional resilience and protect them against mental health difficulties ('protective' factors), or others which, conversely, may make future problems more likely ('risk' factors).

We also know that certain groups of children are much more likely to experience mental health difficulties than the population at large (JCPMH, 2013)

Table 1 describes specific vulnerable groups within Bradford's population.

**Table 1: Vulnerable groups in Bradford's population**

| Vulnerable groups | Situation in Bradford |
|---|---|
| **Children with learning difficulties and disabilities** | A recent needs assessment identified 19,219 children and young people with a special educational need or disability. For just over 50% (9,940 children) this need related to learning.<br>Our local Children and Young People's Health and Lifestyle Survey (2013) found that children with special educational needs were more likely to have low self esteem |
| **Refugee and asylum seekers** | Published Home Office figures show that as of July 2014 (Migration Yorkshire, check source), around 400 asylum seekers were being supported while awaiting a decision on their claim.<br>Sharing Voices, a BME mental health advocacy support organization, report working with significant numbers of refugee and asylum seeking families, many of whom have experienced severe trauma. |
| **Children with chronic physical health problems** | Bradford has the highest prevalence of children in the region with complex medical conditions considered 'life limiting' – there were estimated to be 595 such children in Bradford in 2011 (Fraser,2011)<br>335 children are currently receiving support through the Children with Complex Health and Disabilities Team. |
| **LGBT young people** | There are no officially available statistics on the numbers of LGBT young people in Bradford. Between 5 and 7% of the adult population are estimated to be LGBT – this would equate to 1,750 out of the 35,000 15-19 year olds in Bradford. |
| **Looked after children** | 876 children were looked after at 31 March 2013, a slight decrease on the previous year. Bradford has a slightly lower rate of LAC per 1,000 population than the regional average. |
| **Children and young people in the criminal justice system** | Bradford's Child Health profile shows there were 284 first time entrants to the youth justice system in 2013/14, which was slightly better than the England average. The rate has shown a reduction for four consecutive years (Childrens Plan) |

While the proportion of children who are looked after or who are entering the criminal justice system are comparatively low in relation to regional and

national averages, and to peers with similar demographics and levels of deprivation, the high proportion of children in the District still means that the absolute numbers of children from these vulnerable groups needing support for emotional or mental health difficulties will be high.

Conversely, the District does have proportionately greater numbers of other vulnerable groups, especially children with complex medical problems or physical disabilities, and children with learning disabilities. This group of children will be at significantly greater risk of developing emotional or mental health difficulties.

The very high numbers of children in the District with life limiting conditions or disabilities will also play a significant role. Bradford has a higher proportion of children with life limiting conditions than any other authority in the region (Fraser, 2011). The experience of caring for a child living with life limiting illness, and of bereavement, is almost certain to have a major impact on the emotional well being of the entire family, parents and siblings, as well as the child themselves.

The needs of these families should be given significant consideration in planning for emotional and mental health support in the District (Fraser, 2011).

### 4.3 The determinants of good mental health and emotional well being

In determining the likely prevalence of mental health difficulties in the child and adolescent population locally, it is also important to consider those factors which may increase the likelihood of children developing mental health difficulties. We should also consider those factors which have been shown to affect children's social and emotional well being.

The causes of different mental health problems in children are complex, as is their relationship to social and emotional well being. Some mental health disorders, such as ADHD, are strongly heritable, although their development is still affected by environmental experiences (Davies, 2014). In other cases, we know that children with particular adverse life experiences are at greater risk of developing mental health difficulties as adults (Parry-Langdon et al, 2008). Children from the most disadvantaged backgrounds are three times as likely to develop a mental health disorder (Davies, 2014).

We also know that different factors in children's lives appear to affect their subjective sense of social or emotional well being. Some mental health difficulties are more strongly linked to good social and emotional well being than others, but poor emotional well being and a lack of resilience is associated with a greater risk of mental health difficulties as adults (Parry-Langdon et al, 2008)

The Children's Society series of 'Good Childhood Reports' published annually from 2010, correlates specific factors about children's circumstances with a national survey of subjective well being and how happy children are with their lives (Children's Society, 2014), while the Chief Medical Officer's Report (Davies, 2014) and the 2004 national survey of mental health disorders (Green et al, 2004) summarises some of the key determinants of mental health difficulties.

### 4.3.i Family and home

The Children's Society (2014) identifies family functioning as one of the most important components of children's wellbeing. In particular it suggests that the quality of children's relationships within their family is far more important than the specific family structure they live within. Children who felt their family did not get along together were much more likely to have low well being (Childrens Society, 2014)

Children who did not feel safe at home (a small minority in the survey) were much more likely to have low well being, and children who had experienced at least one change of home in the past year were over twice as likely as average to have low well being. (Children's Society, 2014).

### 4.3.ii Parental well being and mental health

In the Children's Society 2014 survey, children's parents or primary carers were also asked to complete a survey of their subjective well being. There was a strong correlation between the parent's perception of their own well being and the child's own subjective well being (Children's Society, 2014)

Parental depression scores taken from the Millenium Cohort Study also correlated strongly with the subjective well being of children: children living with a parent with depression were significantly more likely to have low subjective well being. (Children's Society, 2014).

For the 2014 report, the researchers investigated the correlation of various positive parenting behaviours with subjective well being, by administering specific survey questions to Year 10 children.

All positive parenting behaviours were associated with higher subjective well being and greater life satisfaction in children, but the strongest correlation was with emotional support (eg supporting young people when they were upset, helping them if they had problems).

In relation to mental health difficulties, there is a correlation between parental mental health difficulties or poor mental health and children's mental health. When data from the 2004 national survey (Green et al,2004) and the

subsequent 2007 survey were combined, parental psychological distress was one of the factors which predicted whether a child who had a mental disorder in the 2004 survey would still have one three years later (Parry-Langdon et al, 2008)

### 4.3.iii Money and possessions

In an earlier version of the 'Good Childhood Report', children living in the poorest 20% of households had much lower well being than average. Above that threshold although there is a discernible link between household income and well being, its relative effect is small (Childrens Society, 2012)

However, relative measures of children's perceived material situation, such as having a lot less money than their peers, had a much stronger link with well being. (Childrens Society, 2012). Children who had about the same resources as their peers tended to have slightly higher well being than those who reported having either less or more. (Childrens Society,2012).

The Children's Society devised an index based on children's perception of a number of material items that were important to them. A measure of material deprivation based on the extent to which a child did not have, and wanted these critical items was strongly related to children's well being.

Over a third (36%) of children reported that the economic crisis had affected their family 'a fair amount' or 'a great deal', and these children were likely to experience lower well being.

Although the relationship is with wider disadvantage rather than simply material deprivation, there is a strong relationship between socio-economic deprivation and future mental health difficulties. Children from the most disadvantaged households are three times as likely to have a mental health difficulty as those growing up in better off homes (Davies, 2014)

### 4.3.iv Recent experiences of bullying, friendships and school difficulties

There is a strong association between bullying and subjective well being. The Children's Society found that children who were bullied more frequently were significantly more likely to have low well being, as were children who bullied others more frequently. (Children's Society, 2014).

Children who had recently experienced bullying (at least three times in the past three months) were much more likely to have low well being than children who had not. Whether children looked forward to going to school was also strongly associated with their sense of well being.

Children who had very few friends, or who reported frequent arguments with their friends, were more likely to have low well being.

Experience of bullying is also more directly associated with diagnosed mental health difficulties. Bullying may precipitate or exacerbate mental health problems in childhood, and is associated with increased risk of anxiety, self harm and depression in adulthood (Davies, 2014).

'Cyber-bullying' presents an increasing problem, with figures reported between 2008 and 2011 suggesting that between 8 and 34% of young people in the UK had experienced bullying through social media. Girls were twice as likely as boys to experience persistent cyber bullying. (Davies,2014)

### 4.3.v Sports and active games

Children who played sports or active games most days were around half as likely to have low well being, in the Children's Society report as those who never did so (Childrens Society,2014)

This underlines the importance of strategies that provide access to sport and leisure opportunities, and safe places for children to play outdoors.

## 4.4 The determinants of mental health and well being in Bradford children

### 4.4.i Parenting, effective family functioning and early years support

Supporting effective family functioning and good parenting skills through education, social care and early years services is likely to have a strong protective effect on future well being and against the development of mental health difficulties.

The strong correlation between parental and child well being also emphasises the need to support parents socially, emotionally and practically in order to promote well being and good mental health in children. This may begin as early as the perinatal or even ante-natal period.

At present, the greatest proportion of our child population is in the 0-4 age band, almost the largest cohort of very young children in the UK. There is an opportunity to provide interventions now which may improve their social and emotional development, and promote future good mental health and well being as they grow up and reach the school and adolescent years. The

potential to improve the overall well being of Bradford's population, and to protect against future pressure on treatment services, is very significant.

Bradford has recently become one of the pilot sites for a major initiative funded by the Big Lottery, 'Better Start Bradford'. 'Better Start' will deliver interventions aimed at improving outcomes for 0-3 year olds in three of the city's most deprived wards.

From the work undertaken in preparation for the bid, we know that many of our children are struggling with social and emotional development well before they reach the school years in which they might conventionally be identified as having a 'mental health difficulty'. In Bradford as a whole, only 49% of children reach a 'good level of development' (which includes social and emotional development) at the end of reception. In the Better Start Bradford area, only 63% of children achieve a good level of personal, social and emotional development, compared to the national average of 76%.

This evidence of a gap in social and emotional development for some of our children, is supported by qualitative evidence from discussion with local professionals. The head of the BESD team emphasised the importance of identifying and supporting children in the early years:

There's far too many children hitting reception where everyone is really surprised that they're not coping … We shouldn't be surprised that they can't cope, schools should be prepared for them. (*Head of BESD Team*)

Given the strong links between parental well-being and mental health, family functioning, and children's mental health and emotional well being, supporting parenting skills and considering the family as a unit is an important element of effective services, and needs to begin in the earliest years.

Better Start Bradford, will, in its three wards, be supporting 22 projects, many of which will aim to promote parenting skills and social and emotional development in the early years. These include:

- Incredible Years parenting courses offered universally
- Assessments of attachment and support for parent-infant attachment in the earliest years
- Perinatal support programme and Infant Mental Health programme for mothers who have, or are at risk of, poor perinatal mental health
- Expansion of Family Nurse Partnership and Family Links Antenatal Programmes
- Family Links Nurturing Programme to support families
- Homestart Better Start programme to support families
- 'Baby Steps' antenatal programme for parents at risk of poor emotional well being during the transition to parenthood
- Language and communication development interventions for 2 year olds

Better Start is funded for a ten-year period, and as understanding develops about how these interventions can promote good social and emotional development, and protect against future mental health difficulties, it will be important to share learning and roll interventions out more widely across the District.

In the interim, more overt strategic links should be developed between children's mental health commissioners and early years commissioners, to ensure a strong joint strategic approach which recognises the importance of interventions around early years and parenting. Early years professionals should be represented at the Healthy Minds strategic group.

### 4.4.ii Bullying and peer relationships

The highly detrimental effect of experiencing bullying (Davies, 2014), and the protective effect of good social support and friendships (Parry-Langdon et al,2008) underlines the vital role of schools as the main forum in which children experience life amongst their peers.

The Children and Young People's Lifestyle Survey, conducted locally ,asked 9,372 children in years 4, 7 and 10 about their experiences of bullying.

32% of children in year 4 reported that they had been bullied at or near school in the past 12 months, reducing with age so that only 17% of year 10 pupils reported having been bullied. At this stage, young people were more likely to report 'problems with friendships', which may reflect different conceptualisations of similar situations. Nevertheless, 1 in 3 of our children is reporting having been bullied at school, which is known to be a significant risk factor for poor well being and the development of future mental health difficulties.

A higher proportion of pupils with special educational needs or disabilities said that they had been bullied. 38% of pupils with SEN in Year 4 reported having been bullied in the past 12 months.

5% of children reported having received 'nasty emails', 'nasty text messages' or 'seen nasty/threatening things about you online'. This is around the lower limit of national estimates, which suggest that between 8% and 34% of children have experienced 'cyber-bullying', and may reflect the more limited access to technology and internet reported by young people. Nevertheless, it represents a significant minority which is likely to increase, and monitoring any trends may be important.

58% of pupils reported that they felt their school takes bullying seriously, which is encouraging, but leaves room for improvement. Schools need to be key players in setting and supporting an anti bullying agenda, and supporting children's mental health and well being.

### 4.4.iii Poverty and deprivation as a determinant of mental health

A key determinant affecting the prevalence of mental health difficulties in Bradford is poverty, both relative and absolute.

A quarter of Bradford's children and young people live in poverty (defined as total household income being less than 60% of the national median income). This equates to over 35,000 children, half of whom live in just 8 of the District's wards (Bradford District JSNA, 2014)

Bradford is also one of the most deprived local authorities overall in England, ranked at 26 in the Index of Multiple Deprivation. Thus large numbers of Bradford children will live in households with incomes in the lowest 20% nationally, a measure linked with much lower well being and life satisfaction , and with almost threefold risk of future mental health disorders(Children's Society, 2014: Davies, 2014).

As described in section 4.1, the proportion of the child population living in the most deprived areas of Bradford will grow. Almost one third of births in Bradford in 2011 were in the most deprived 6 wards, and over half in the most deprived 12 wards. Research suggests that these children will be three times more likely to have a mental health difficulty than their most advantaged peers (Davies, 2014).

As well as the children living in the most severe disadvantage, there will be many more who perceive themselves to have less than their peers, whether locally or as represented in the media, and whose parents cannot afford items that many children their age would view as important. This sense of relative deprivation will also be linked to lower well being and potential emotional and mental health difficulties.

The District's Child Poverty strategy will play a key part in addressing this determinant of mental health. In planning and commissioning services to support children's mental health, commissioners must also be aware that the high and increasing numbers of children locally living in significant deprivation will increase the numbers of children with social, emotional and mental health difficulties.

## 5. Availability of data

### 5.1 National data

Data to support the understanding of child and adolescent mental health nationally is recognised as problematic. The Chief Medical Officer's report notes that:

'up to date, comprehensive statistics are urgently needed'
(p.100)

while the House of Commons Select Committee commented that CAMHS commissioners and providers were operating 'in a fog' (HMSO, 2014)

At present, specialist CAMHS services do not provide a regular dataset to commissioners describing the number and type of referrals, analogous to Hospital Episode Statistics (HES).

Until 2009-10, CAMHS services were required to conduct a national mapping exercise led by Durham University, which provided some data about staffing and caseload, and the ability to benchmark services against other local authorities. In 2010 this mapping exercise was discontinued.

Subsequently, efforts have been underway to establish a national minimum dataset for CAMHS. All providers were expected to be ready to report on this minimum dataset from 1 April 2013, and it was expected that they would start to 'flow' data to the Health and Social Care Information Centre and thence to commissioners in 2013/14. However, there have been significant delays to the implementation of the infrastructure required for data to flow, and it may not be implemented until late in 2015.

When implemented, the minimum dataset should provide a regular flow of data covering:

- demographics
- background
- family history
- targeted needs
- referrals to CAMH services
- encounters
- care planning
- interventions
- outcome measures
- inpatient stays
- presenting problems and diagnoses

This will significantly enhance our ability to assess the demands on CAMHS services and the extent to which services are able to meet that demand. Ensuring that we are ready for its rapid implementation will be a key priority for both providers and commissioners in all local authorities.

### 5.2 Local data

The 'fog' created by limited data is as dense in Bradford as it is nationally: the amount of routinely available data shared between partners is limited, and I am grateful to providers and commissioners for their efforts to extract and provide what data they do have.

In line with the national picture, Bradford District Care Trust are commissioned to provide CAMHS on a block contract basis, and do not routinely share activity and referral data with the Clinical Commissioning Group.

Some historical information from the CAMHS mapping exercise was accessed to support this needs assessment, but the available data is nearly five years out of date. In the context of Bradford's rapidly growing child population which increased by 10% between 2002 and 2012, this severely limits its usefulness.

However, BDCT have been able to extract local referral and active caseload data for the last three years (see Section 6). Although it was not possible to break the data down into specific referral types, a discussion with CAMHS managers gave some perspective on the service areas felt to be associated with rising referrals.

The needs assessment has also benefited from the recent regional benchmarking exercise conducted by the Strategic Clinical Network CAMHS lead. This exercise was an aggregation and analysis of returns from CAMHS, CCGs and local authorities across the region, and will be dependent on the quality of the data submitted by individual organisations. However, it remains of significant value because for the first time, it provides a sense of where Bradford's services stand in comparison to others in the region.

### 5.3 Further possible sources of data

The CAMHS minimum dataset, despite the current delays, is likely to become a reality in 2015 or 2016. However, the initial expectation was that providers would be set up to collect the relevant data items by April 2013.

Exploring the potential for supplying at least some of these data items to commissioners would be of great benefit. Both providers and commissioners need to be ready to maximise use of the minimum dataset once it is finally implemented.

Another potentially rich source of data, which we have struggled to reach, relates to services provided by schools. We know that some schools commission additional services through third sector counselling organisations

such as Off the Record, and that three of the academies in Bradford commission a worker on the TaMHS model.

Data from these services would provide a much greater understanding of need and current provision across Bradford's secondary schools.

Although we attempted to undertake a survey of schools through the Behaviour and Attendance Collaboratives, only two schools responded.

This remains a key gap in understanding children's mental health and well being services. Further work to obtain and analyse information and data from schools, potentially through the 'Mental Health Matters' schools strategy, would be of great benefit.

### 5.3 Outcome data

There is, to date, limited readily accessible and routinely reported measures of the outcomes of any of the interventions commissioned throughout the District. Some individual third sector organisations report their own self-monitored outcome measures to commissioners, but there is no consistent approach to monitoring and reporting the impact of interventions on individuals.

This lack of reported and shared outcome measures limits our ability to develop a joined-up strategy where we can be assured that we are commissioning services and interventions that are proven to make a difference to children's well being and mental health.

The CAMHS minimum dataset, when implemented, will include data about outcomes which may facilitate this discussion.

Likewise, a key part of the implementation of CYP-IAPT is to embed routine outcome monitoring into clinical practice, and this transformation will again provide an opportunity to understand the effectiveness of different interventions, and to inform commissioning across different providers.

Dialogue with the CYP-IAPT project as it develops will also allow routine outcome measures (for example, the Strengths and Difficulties Questionnaire), to be incorporated into service specifications for interventions commissioned from providers other than specialist CAMHS, increasing comparable understanding of the impact of different interventions.

## 6. Local need in Bradford

### 6.1 Predicting numbers of children with mental health difficulties

As Section 3 demonstrated, the large and growing child population in Bradford, and the specific risk factors (notably high levels of poverty) present in the population, predicts high numbers of children with mental health difficulties, which is likely to increase.

The actual numbers of children with mental health difficulties can be estimated by applying the findings of national research to our local population in Bradford.

The most recent national survey of mental health disorders in young people was carried out by the Office for National Statistics in 2004 (Green et al, 2004). Although conducted a decade ago, this remains the most authoritative national survey and provides the best information with which to predict the likely levels of need in a local population.

Table 2 shows the estimated numbers of children and young people in Bradford with different mental health disorders. These figures include only those problems which are clinically diagnosable.

In addition to these figures there will be a much larger population of children and young people with lower-level or transient emotional, behavioural or social problems which will nevertheless have a significant impact on their educational, social and family functioning and will require intervention. Estimated numbers of these children are discussed below in section 6.2.

**Table 2: Estimated numbers of young people in Bradford with mental health disorders**

| Age Range | | Number of Children in Bradford by age band (2011 census estimates) | Percentage of the child population in 2004 study (Green et al) | Estimated number of children in Bradford with a mental health disorder |
|---|---|---|---|---|
| 5 - 10 years | Female | 21,975 | 5.1 | 1,120 |
| | Male | 22,739 | 10.2 | 2,319 |
| | All 5 – 10 | 44,714 | 7.7 | 3,443 |
| 11 – 16 years | Female | 21,437 | 10.2 | 2,186 |
| | Male | 22,157 | 13.1 | 2,902 |
| | All 11 – 16 | 43,594 | 11.7 | 5,100 |
| **5 - 16 years** | **All** | **88,308** | **9.6** | **8,477** |

Source: Census population estimates for 2011. Green, H. et al (2004).

The study also breaks types of mental health disorders down further into 'emotional disorders' (anxiety and depression); 'conduct disorders' (significant emotional/behavioural issues, for example, oppositional defiance disorder), and 'hyperkinetic disorders' (including conditions such as ADHD).

Modelling data from the former Child and Maternal Health Observatory, now the National Child and Maternal Health Intelligence Network (www.chimat.org.uk) uses the above study to predict the numbers of children and young people with specific diagnoses in Bradford.

Note that the figures may not add up to those in Table 2 above, as it is common for young people to have more than one disorder (eg conduct disorder may be diagnosed together with ADHD).

**Table 3: Estimated number of young people with emotional disorders in Bradford**

| | Boys aged 5-10 years | Girls aged 5-10 years | All children aged 5-10 years | Boys aged 11-16 years | Girls aged 11 – 16 years | All children aged 11-16 years |
|---|---|---|---|---|---|---|
| **Bradford** | 510 | 565 | 1,095 | 885 | 1,320 | 2,185 |

Source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004). Adapted from www.chimat.org.uk

**Table 4: Estimated number of children and young people with conduct disorder in Bradford**

| | Boys aged 5-10 years | Girls aged 5-10 years | All children aged 5-10 years | Boys aged 11-16 years | Girls aged 11 – 16 years | All children aged 11-16 years |
|---|---|---|---|---|---|---|
| **Bradford** | 1,590 | 630 | 2,230 | 1,790 | 1,100 | 2,880 |

Source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004). Adapted from www.chimat.org.uk

**Table 5: Estimated number of children and young people with hyperkinetic disorder (eg ADHD) in Bradford**

| | Boys aged 5-10 years | Girls aged 5-10 years | All children aged 5-10 years | Boys aged 11-16 years | Girls aged 11 – 16 years | All children aged 11-16 years |
|---|---|---|---|---|---|---|
| **Bradford** | 625 | 90 | 730 | 530 | 90 | 615 |

Source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004). Adapted from www.chimat.org.uk

With our present population of children and young people, we should expect there to be around 8,477 children between 5 and 16 in Bradford with some form of significant mental health difficulty.

This equates to 9.6% of Bradford children, or almost one in ten. Unsurprisingly, the prevalence of mental health difficulty rises with age, and is highest in boys of secondary school age. In this group, 13% of children are expected to have some form of mental health difficulty.

The lowest prevalence is among primary school aged girls, where the prevalence is just 5%.

To put this in a local context, we should expect that:

- between two and three children in every primary school classroom is likely to have a clinically diagnosable mental health difficulty
- between three and four children in every secondary school class is likely to have a clinically diagnosable mental health difficulty

**6.2 Children with less severe emotional difficulties**

Beyond these predicted numbers of children with 'named' and diagnosable mental health difficulties, there will be many more who have low-level or transient emotional or mental health difficulties. Children may, for example, be struggling to cope with the effects of family breakdown, illness or bereavement. Others may be experiencing bullying. While these children may not go on to be diagnosed with mental health problems, their emotional well being, functioning at home and at school, and ultimately adult mental health, is likely to be significantly impaired if they are not offered timely intervention and support.

There is no readily available data which predicts the numbers of children with these types of needs. However, as the previous section discussed, Bradford has one of the largest populations of children in the country, living in circumstances which contain risk factors for poor well being, especially in relation to poverty. We would expect to see high numbers of children with lower level difficulties, or transient needs related to their life circumstances.

Some large cohort studies have attempted to assess the numbers of children in a population with emotional or psychological difficulties. The birth cohort study, *Growing Up In Ireland,* collected initial data on 11,000 children born in 2007/8 (the infant cohort), and 8,000 children who were aged 9 in the same year (the child cohort). They followed up the infant cohort at 3 and 5 years, and the child cohort at 9 and 13.

The emotional well being of 9 year olds was assessed using the 'Strengths and Difficulties' Questionnaire, reported by both parents and teachers. 15-20% of 9 year olds were reported to have either 'borderline' or 'problematic' levels of emotional difficulty (Nixon, 2012). Similarly, 19% of mothers in the cohort of 5 year olds reported their children as having some level of socio-emotional difficulties, ranging from minor to severe (Nixon, 2013).

These figures should be treated with a high level of caution. Nevertheless, they support a rough estimate that, in addition to the 10% of children with diagnosable mental disorders, a further 5-10% would be likely to have less severe emotional or mental health difficulties at any one time.

This would equate to a further 8,500 children between 5 and 15 with less severe difficulties.

### 6.3 Combined estimate of mental health disorders and less severe emotional difficulties

This can be regarded only as a very tentative estimate, at the level of 'ball park figures' which may help commissioners to gain understanding of the likely numbers of children in need.

The two above figures would produce an estimate of **17,000 children** with some level of emotional or mental health difficulty in Bradford currently.

A rise in proportion with the increasing population in the relevant age bands would see this broad estimate rise to **23,600 children with some level of emotional or mental health difficulty by** 2025.

### 6.4 Numbers of children with behavioural, emotional and social special educational needs

A process to produce a single list of children identified as having special educational needs and/or disabilities took place in Bradford Metropolitan District Council in 2014. This combined data held from teams within the council, and compared all the lists to allow double-counting to be removed.

Children registered as having 'behavioural, emotional or social' special educational needs will have a relationship with the figures above, but not a straightforward one. Many children in this category may have difficulties which either are, or could be, diagnosed as one of the 'mental health disorders' described in the 2004 survey. A child with challenging behaviour who is diagnosed with ADHD or conduct disorder would be one such example.

Other children are likely to have lower-level or more transient difficulties, and would probably fall outside the national survey.

A very small number of children are registered as having a specific 'mental health' need.

Table 6 shows the figures. In February 2014, 4,058 children were recorded as having behavioural, emotional and social difficulties, or mental health needs.

This is a much smaller number than that predicted by national modelling, which in part reflects the very different methods used to arrive at the two estimates.

It seems likely that not all children with emotional or mental health difficulties are as yet having their needs appropriately identified and met in school.

Nevertheless, this figure of 4,058 represents 4.6% of the school age population in Bradford whose behavioural, emotional or social functioning is sufficiently problematic to be recorded as a special educational need.

The definition of a special educational need is that a child has a learning difficulty or disability that calls for special educational provision to be made for them (Special Educational Needs Code of Practice, 2014).

This means that, even on these figures, we should expect there to be between one and two children in every school classroom whose behavioural, social or emotional difficulties require additional provision.

**Table 6: Numbers of children and young people recorded as having special educational needs and/or disabilities in Bradford, February 2014, by type of SEND**

| **Split by SEND Type** | | | |
|---|---|---|---|
| | Number | % of all | % of those where data available |
| Autistic Spectrum | 745 | 3.9% | 5.3% |
| Communication | 3794 | 19.7% | 27.0% |
| Either Autistic Spectrum or Communication* | 204 | 1.1% | 1.4% |
| Behaviour / Emotional / Social | 3991 | 20.8% | 28.4% |
| Learning | 9940 | 51.7% | 70.6% |
| Physical | 1177 | 6.1% | 8.4% |
| Sensory | 974 | 5.1% | 6.9% |
| Long Term Illness | 97 | 0.5% | 0.7% |
| Mental Health | 67 | 0.3% | 0.5% |
| Other | 1406 | 7.3% | 10.0% |
| No Details Recorded | 5142 | 26.8% | |

* (Data from DCIS which does not distinguish between the two, and no info available from other sources)

### 6.5 Children with behaviour difficulties

A recurrent theme in discussions with professionals concerned the availability of appropriate support for children who present with very challenging behaviour. Sometimes these children will be seen within the CAMHS service, where there is a newly established 'conduct disorder' clinic. They may also receive support from the BESD team.

However, children whose main presenting difficulty is behavioural may fall 'through the cracks' if they are not seen as having an emotional difficulty, mental health disorder, or neurodevelopmental condition (eg ASC, ADHD). Yet in terms of the extent to which their own functioning and life chances are impaired, and the effect they can have on others, these children arouse a high degree of concern in professionals and supporting them in the right way can be a very significant challenge. For example, one professional described how some children had ended up being educated in isolation because their behaviours posed such a risk to others.

Although precise referral numbers could not be obtained for this needs assessment, the BESD team described a growing pressure on referrals:

'We need to be twice the size we are'

'Pupil referral units' (PRU) in Bradford cater for pupils who have been excluded from mainstream schools. Both the BESD team and the local authority Head of Special Educational Needs described a situation in which while PRUs should be a short term option while more suitable provision is decided upon, many children were becoming 'stuck' in PRUs. This led to PRUs taking on a role more akin to a special school, and supporting children with complex needs which they were not necessarily best suited to manage. Meanwhile, limited places are available for children with less severe behavioural difficulties who may need the short term provision the PRU provides.

The pressure to better support these children may increase following the revised Special Educational Needs Code of Practice (2014). In this, challenging behaviour *per se* is no longer classified as a special educational need, and the category of 'behavioural, social and emotional difficulties' has been renamed 'social, emotional and mental health difficulties'. Alongside new guidance to schools concerning mental health and behaviour (DfE, 2014), schools are encouraged to identify unmet mental health, emotional or developmental problems which may underlie the behaviour.

CCG commissioners and the Special Educational Needs service are currently working to develop a model which will identify and respond to children with difficult behaviour as early as possible. Professionals in children's social care are also working to design more appropriate support for children with behavioural difficulties.

The links between this work and the Healthy Minds strategic group must be maintained, and appropriate support for these children considered as an integral part of the overall system for children's emotional well being and mental health.

## 6.6 Children and Young People's Lifestyle Survey

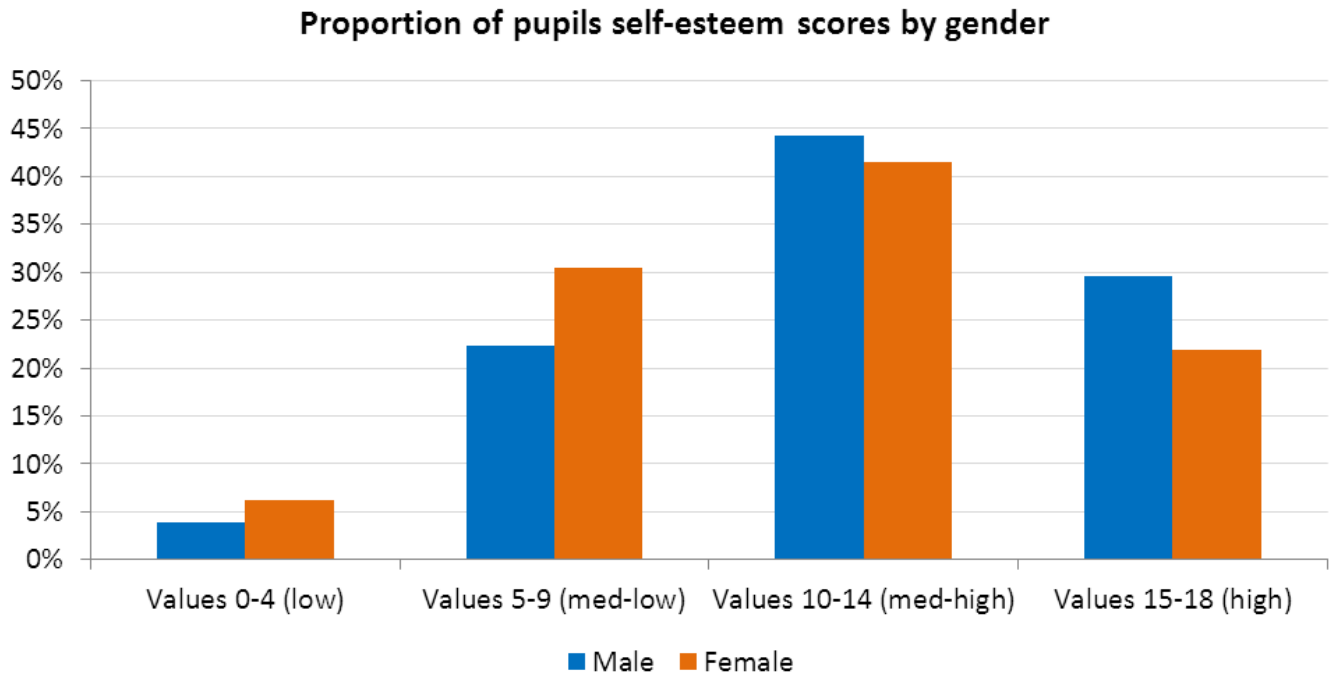
The Health and Lifestyle Survey carried out in Bradford district schools in 2010, and repeated in 2013, has enabled us to build a much richer picture of the wider concerns of children and young people in Bradford district. 9,372 children from 119 primary and 22 secondary schools in Years 4, 7 and 10 were asked a number of questions about their health, lifestyle and emotional well being. We asked Year 4 pupils about their self esteem, and all pupils were asked about the things they worried about.

The findings of the Lifestyle Survey in relation to bullying have already been discussed in more detail in Section 4 above.

### Self-esteem - Year 4 pupils

Pupils in year 4 had their self-esteem measured by using a series of statements, in which they were asked to indicate their agreement. Each response had a score against them, the result was out of a possible 18, and those which scored between 15 and 18 had the highest level of self-esteem. Figure 4 shows the results.

**Figure 4: proportion of year 4 children returning different levels of self-esteem scores**




Most year 4 pupils scored in the medium-high range for self-esteem. There was some variation by gender with more girls than boys having low or

medium-low self-esteem and and more boys with medium-high or high self-esteem.

### *Ethnicity and self esteem*

Ethnicity made little difference to self-esteem scores, with the two largest communities in Bradford district, White and South Asian children, showing very similar scores.

### *Deprivation and self esteem*

In the most deprived 20% of children, low self esteem scores were slightly more common, and only 24% of these children recorded a high self esteem score, in comparison to 41% of the least deprived group of children.

This reflects the national research described above, and supports the view that children living in more disadvantaged circumstances in Bradford are more likely to have low self esteem and are at greater risk of mental ill health and emotional difficulties.

### *Special educational needs*

Pupils with special educational needs (SEN) were also more likely to record low self esteem scores, indicating the importance of addressing the emotional needs of this group of children alongside their educational progress.

***Children's worries***

We asked children to tell us if they worried about anything, and if so, what. When asked what, if anything, they worried about "quite a lot" or "a lot", young people answered as shown in Figure 5:

**Figure 5: Subjects children in Bradford worry about**

| 2012-13 | Year 4 | Year 7 | Year 10 |
|---|---|---|---|
| School-work problems | 16% | 15% | 32% |
| Exams and tests | 24% | 32% | 60% |
| Money problems | 21% | 10% | 17% |
| Bullying | 23% | 17% | 12% |
| Health | 21% | 25% | 31% |
| Problems with friends | 16% | 17% | 21% |
| Family problems | 19% | 20% | 26% |
| The way you look | 13% | 18% | 28% |
| Relationships | | 9% | 19% |
| Sexually transmitted infections | | 3% | 7% |
| Drugs | | 6% | 6% |
| The environment | 16% | 12% | 10% |
| War and terrorists | 28% | 14% | 15% |
| Crime | 27% | 15% | 16% |
| Gambling | | 6% | 6% |
| Other | | 1% | 1% |
| None of the above (or missing data) | 32% | 40% | 22% |

[Boxes around the figures indicate significantly higher than the average for Bradford]

*SOURCE: Every Child Matters in Bradford District: A report of the Health and Lifestyle Survey for Children and Young People 2012-2013*

Year 10 children were most likely to say that they worried 'a lot' or 'quite a lot' about particular issues. For Bradford young people, the most significant sources of worry appeared to be around exams and schoolwork, probably reflecting the importance of public exams for this age group.

Problems with friends and family were the second most significant group of worries. It is also of note that a higher proportion of Year 4 children reported worrying about bullying, while more Year 10 children reported worrying about

‘problems with friends’. This may suggest that while worries about friendship groups and social exclusion are a constant for our young people, these anxieties are perhaps redefined by older pupils as ‘worries about friends’.

Again, the importance of supporting children in developing strong social networks, and good social skills is underlined. Support for family functioning is also of key importance in promoting the well being of our young people.

### 6.7 Referrals and activity in specialist CAMHS

Referrals to CAMHS show a substantial increase over the past three years and a rising trend. The active caseload has also risen substantially in the past 18 months.

Referrals to specialist CAMHS increased by 16% between 2012/13 and 2013/14.

The active caseload for specialist CAMHS shows a 20% increase over the 18 month period between March 2013 and October 2014.

This is likely to reflect the current and predicted increase in Bradford’s child population, as discussed in Section 4.1, and corresponding increases in demand.

It is not yet possible to analyse this data further in order to understand whether any individual categories of referral are accounting for this increase.

Regional benchmarking data (discussed further in Section 7) suggests that rates of referral to specialist CAMHS are even now, very low when compared with national figures and other local authorities in the region. It is unlikely that this increase represents low-level or inappropriate referrals.

This view is supported by qualitative comments from interviews with other providers, survey responses from schools and CAMHS practitioners. Comments have included:

‘Its difficult to get the help our pupils need’ (survey response from secondary school)

‘Services are only just about adequate but waiting times are too long … school nursing service appears more stretched than ever’ (survey response, secondary school)

‘Waiting lists are shorter but a lot of young people still aren’t getting a service … in that intermediate stage between school and reaching CAMHS’ (VCS worker)

‘Referrals are spiking … we need to be twice the size we are’ (BESD team in local authority)

Workers from both Relate and Sharing Voices, key VCS organisations working with children and young people, have commented that they are seeing cases of increasing complexity, which would previously have been handled by CAMHS. The Shared Voices schools worker perceived her role to be moving from mentoring to formal counselling, and was preparing to undertake the necessary qualifications.

Thus these figures, taken in the context of qualitative evidence, suggest a combination of rising demand in proportion with the rising child population, and perhaps a greater presentation of previously unmet demand.

**Figure 6: Referrals to specialist CAMHS between 2012/13 and 2014/15.**

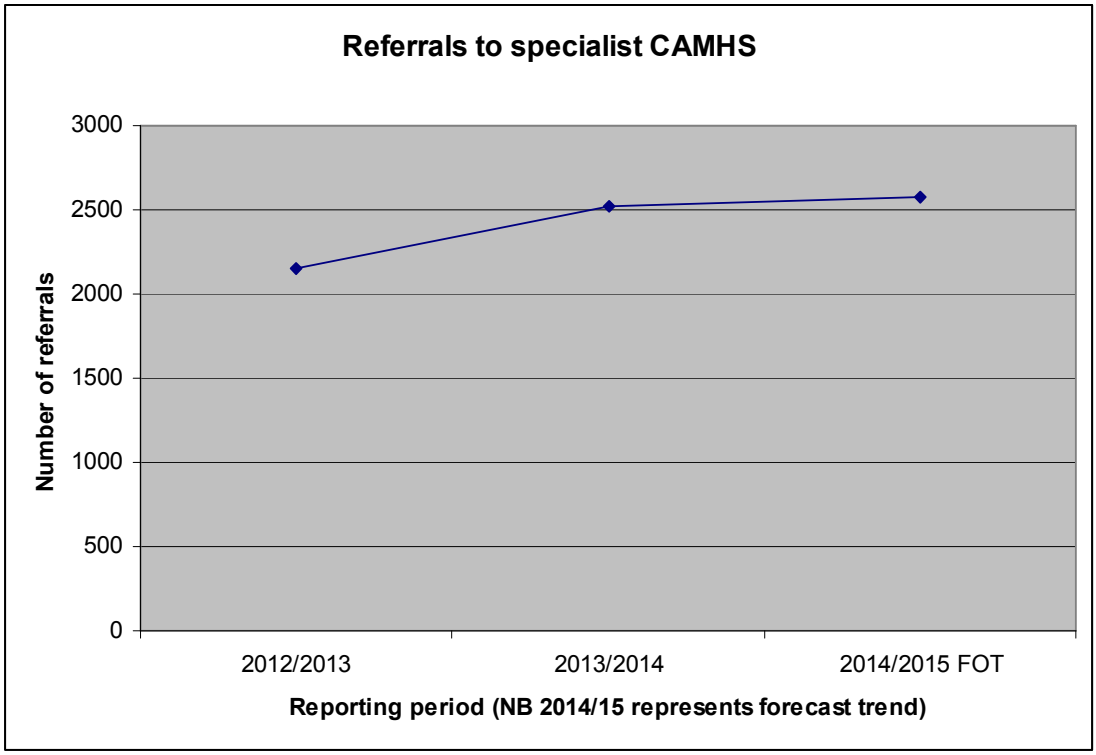
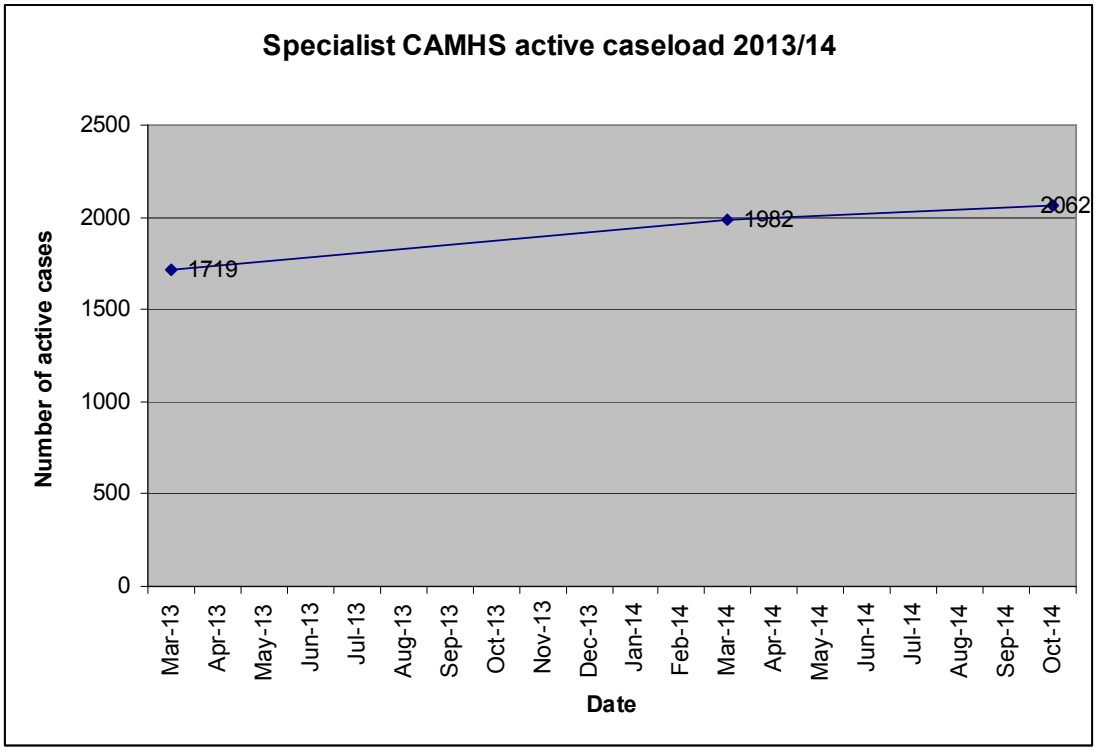


**Figure 7: Specialist CAMHS active caseload between March 2014 and October 2014.**




## 6.8 Referrals and activity outside specialist CAMHS

In terms of children's mental health, referrals to specialist CAMHS very much represent the 'tip of the iceberg' and we would expect significant numbers of children with difficulties to present and receive intervention in the community, at what is known as 'Tier 2' services.

The services for which referral data is available are:

Primary Mental Health Worker service – employed by and based within CAMHS, working at Tier 2 level to liaise with schools, provide low level intervention and triage referrals.

Relate Bradford – VCS family and relationship counselling service for children, families and young people

School nursing Family Consultation Service – a clinic run jointly with the Primary Mental Health Worker team to provide early advice and intervention

### 6.8.i Primary Mental Health Worker service

Figure 8 shows the number of referrals and discharges to Primary Mental Health Workers in the 2013/14 year, while Figure 9 shows the number of face to face contacts with young people.

**Figure 8: Referrals and discharges to PMHWs 2013/14 and year to date 14/15**

| Referrals & Discharges | 13/14 | 14/15 (01/04/2014-09/09/2014) |
|---|---|---|
| No of Referrals | 875 | 358 |
| No of Discharges | 710 | 266 |

**Figure 9: Face to face contacts with young people in 2013/14 and year to date 2014/15**

| Attendances | 13/14 | 14/15 (01/04/2014-09/09/2014) |
|---|---|---|
| Total | 1,923 | 874 |

875 young people were referred to the service during 2013/14.

### 6.8.ii School nursing services / Family Consultation Model

School nursing is one of the chief 'gatekeeping' points for CAMHS services in that for the majority of referrals, it is expected that school nurses will have been working with the child or young person, potentially in partnership with the Primary Mental Health Worker.

School nurses offer what is known as the Family Consultation Model, where they will meet with the young person and/or the family for a few sessions, followed by a consultation meeting with the Primary Mental Health Worker for the school, which will determine whether the young person requires referral to specialist CAMHS or whether another service can meet their needs.

Figure 10 shows a snapshot of referrals to the Family Consultation Clinic, and outcomes of those referrals, over a single quarter of 2013/14.

| Referrals | Discharged to CAMHS | Discharged other agencies | Discharged - DNA | Discharged due to improvement |
|---|---|---|---|---|
| 126 | 27 | 16 | 31 | 36 |

Figure 10: Referrals and outcomes for school nurse Family Consultation Service

Assuming that the quarter considered is representative, around 600 children and young people a year are seen through the school nursing Family Consultation Service.

From qualitative interviews with practitioners, it appears that informal advice, intervention and signposting is made available to many more children through the day to day role of the school nurse.

### 6.8.iii Bradford Relate and other VCS services

Bradford has a number of third sector organisations who play a significant part in providing counselling and emotional or mental health interventions to children and young people. These are commissioned through a variety of routes, of which the most significant are either Clinical Commissioning Groups or local authority funding.

The most significant organisations, and the numbers of children and young people seen in 2013/14, are:

**Bradford Relate**

In 2013/14 Bradford Relate delivered a total of 966 sessions to 183 children and young people and 174 parents and carers.

They had a total of 109 young people on the waiting list for counselling over that year with an average wait of 19 days.

For the first quarter of 2014/15, they reported 47 young people on the waiting list.

**Relate Pennine, Keighley and Craven**

Numbers of young people seen are not available, but in 2013/14 Relate PKC delivered a total of 1,208 hours of counselling which probably reflects similar numbers to the 183 children and young people seen by Relate Bradford.

Funding was jointly provided by Bradford CCG, by North Yorkshire County Council and by individual schools.

'**Off the Record'**

Off the Record is a young people's counselling service which was supported in 2013/14 through CCG grant funding.

In 2013/14 they delivered 1,000 hours of counselling to young people. The number of young people is not recorded.

There is also a degree of direct commissioning of services from schools, the extent of which is not clear.

**YMCA**

YMCA received a small local authority grant in 2013/14 to deliver 144 sessions of counselling to young people.

**Sharing Voices**

Sharing Voices is a community development mental health organisation which promotes self help and mutual support to adults and young people with mental health difficulties.

As well as self-help, the organisation offers befriending and mentoring support to young people experiencing emotional distress, especially from BME communities.

The organisation receives grant funding from the Bradford Clinical Commissioning Groups (check whether just City)

**Barnardos**

Barnardos is commissioned by the local authority to provide participation work for children and young people using mental health services.

They are also piloting WRAP (Wellness Recovery Action Programme) groups which help children and young people develop coping strategies for managing emotional or mental health difficulties. 3 such groups are currently being operated.

**6.9 Bradford compared with other local authorities in the region**

In 2014, the Strategic Clinical Network instigated a regional benchmarking exercise. CAMHS services, Clinical Commissioning Groups and local authorities were asked to provide information about referrals, activity and staffing levels.

The benchmarking exercise raises significant concerns about the level of unmet need and of investment in services, when Bradford is compared to regional peers.

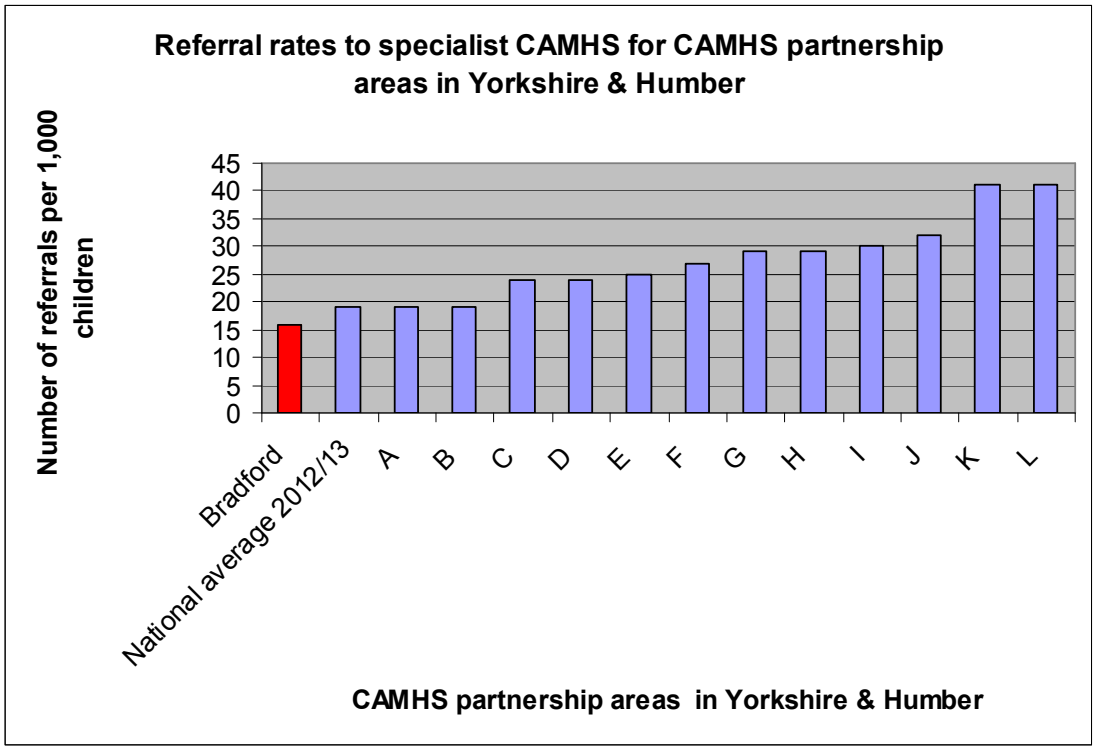
Figure ( ) shows the rate of referral to Tier 3 ('specialist') CAMHS per 1,000 children in the population in 2013/14.

As it demonstrates, Bradford has the lowest rate of referrals to specialist CAMHS in the region, lower than the average obtained from a similar benchmarking exercise conducted nationally.

This also takes account of the significant increase in referrals between 2012/13 and 2013/14, without which the disparity between Bradford and peers would have been even lower.

A low referral rate may not, *per se*, be of concern if it reflects excellent community provision or a low prevalence of difficulties. However, it seems more likely that in this context it reflects unmet need and barriers to reaching services in some communities (discussed further below)

**Figure 11: Referral rates to specialist CAMHS, per 1,000 children, 2013/14**




Commissioners across the region were also asked to report on the total spend on specialist CAMHS by their CCG. Again, Bradford has the second lowest spend on specialist CAMHS per head in the region. This is of significant concern and has fewer explanations other than low investment in services.

From discussions with providers and commissioners as part of this needs assessment, Bradford Districts and City CCGs do not make substantial recurrent investments in mental health services other than specialist CAMHS. They support 'Off the Record' and 'Sharing Voices' through grant funding arrangements.

Since March 2013 they have also supported the Primary Mental Health Worker service through short-term, non-recurrent funding, but this was previously funded through the local authority.

There is no evidence of the level of substantial, planned investment in community and Tier 2 services that would justify so low a level of investment in specialist CAMHS by the CCG.

The benchmarked results are shown below in Figure 12.

**Figure 12: Spend by CCG commissioners, per child, in CAMHS partnership areas in Yorkshire and Humber, 2013/14**

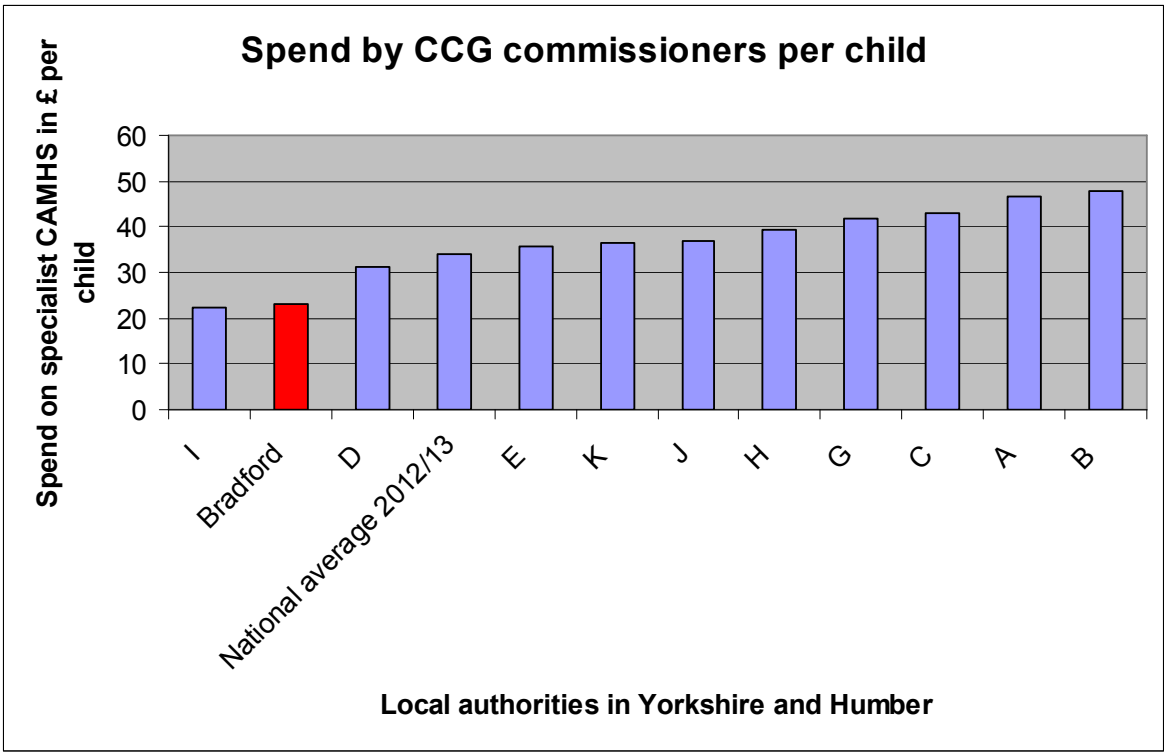
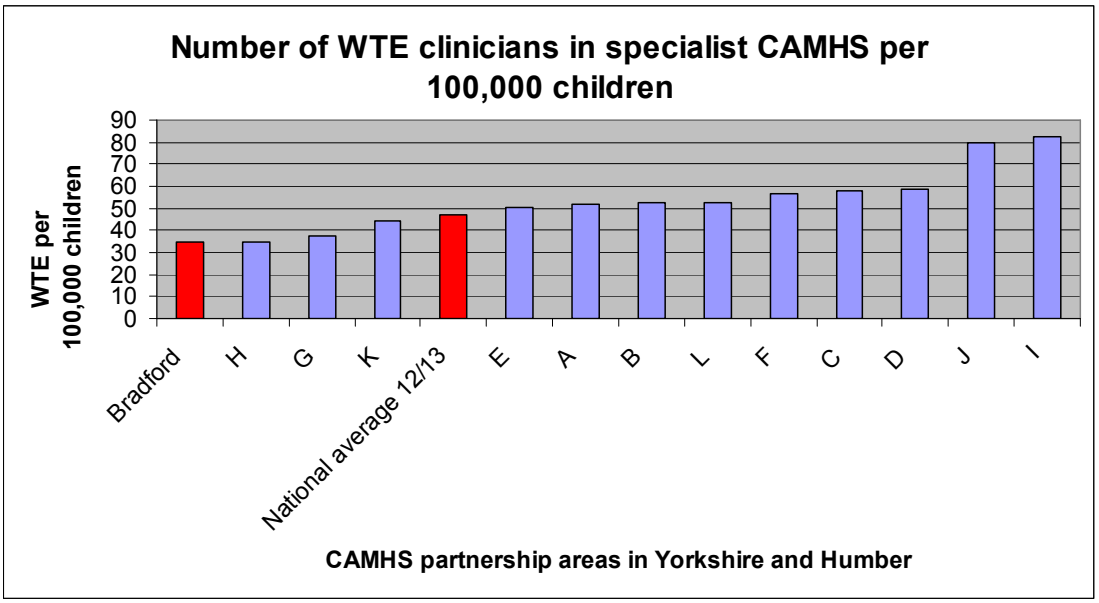



Figure 13 goes on to present the number of clinicians in specialist CAMHS as a WTE per 100,000 children in the population. Again, Bradford appears to have a very low complement compared to peers in the region, which correlates with low levels of CCG investment and low referral rates.

Bradford also falls below the national average obtained in 2012/13, of 47 per 100,000.

**Figure 13: Number of WTE clinicians in specialist CAMHS, per 100,000 children**




## 6.10 Why are referrals to CAMHS so low compared to regional peers?

The low rate of referrals to CAMHS per 1,000 children, and the low level of investment from CCG commissioners, are of significant concern. Potential explanations are explored below.

### 6.10.i Bradford's child population has proportionately more very young children

Although Bradford has a very large child population, the largest proportion is currently in the 0-4 age band. Referrals to specialist CAMHS services in this age group would be expected to be extremely low. Hence this may 'dilute' the number of CAMHS referrals made in older age groups.

If this is the sole reason for the apparently low referral rate, we must expect to see numbers of referrals and referral rates rise, as the 10-14 age group becomes the largest proportion of the child population over the next five years.

### 6.10.ii Potential contribution of effective 'gatekeeping'

A low referral rate might be the result of extensive and effective community services, providing early intervention and ensuring that only the children and

young people most in need of specialist input were referred on to specialist CAMHS.

The referral figures reported to the regional benchmarking exercise do not include the Primary Mental Health Worker team, the school nursing-based Family Consultation Service, or the third sector counselling organisations described above. In numerical terms, all of these services combined saw between 1,000 and 2,000 young people in 2013/14.

Without a good understanding of referral thresholds and the configuration of Tier 2 services in other areas, it is impossible to assess the contribution of this factor accurately.

However, qualitative data from interviews suggests increasing pressure on the system, rising waiting times and difficulty in obtaining CAMHS intervention for children who need it. Anecdotally, VCS organisations report that they are increasingly receiving referrals for more complex cases because of a lack of capacity to see children in specialist CAMHS. CAMHS clinicians also report increasing pressure on the service. This does not suggest a planned shift of care from specialist services into Tier 2.

Although for the reasons described above, an accurate numerical estimate would be very difficult to obtain, if the rate of *any* referral to specialist or Tier 2 services is assessed against the size of the child population, it is still below that of the rates of referral to specialist CAMHS for many partnership areas in the region. In other words, it seems likely that less children in Bradford may be referred, proportionately, for *any* mental or emotional health intervention, than are referred to specialist CAMHS alone in some areas.

The low level of CCG investment also suggests that substantial and effective community services are not the right explanation for this low referral rate. There is no evidence of substantial and planned investment by CCG or local authority commissioners in the types of Tier 2 services that would be likely to produce a significant reduction in specialist referrals.

### 6.10.iii Barriers in access to services

Qualitative data from interviews suggests that a third explanation for low rates of referral may be barriers to accessing services, particularly among children and young people from BME communities.

Professionals interviewed stressed how difficult it could sometimes be for children and young people, and those working with them, to identify the appropriate service and negotiate referral. A VCS professional pointed out that ‘lots of people don’t know about CAMHS, and a young person can only get to a service if the worker knows about it and chooses to tell them’. Sometimes young people can be reluctant to go to a venue where it is

obvious they are going to see CAMHS, or to make use of a drop in if they perceive that it's where 'all the naughty kids go'.

In complex family situations, professionals described how intervention from CAMHS could be viewed alongside social services and educational intervention, and families only persuaded to accept help after a lengthy process of building trust.

Waiting lists can be a significant challenge for young people, which is of concern in a context where waiting times are rising. Some VCS professionals also expressed that for some young people, the need for a GP referral may present problems. Many young people may not see their GP, may not be registered, or may be reluctant to engage with them. Some young people may be concerned about the GP's links to family, friends or their local community. A number of professionals expressed a wish for a more flexible referral system.

Barriers to access for children from black and minority ethnic (BME) backgrounds may also be an issue. There is some evidence to suggest (Hackett et al, 2006) that rates of referral to specialist CAMHS may be lower for children from BME backgrounds, and that these children and families may experience greater barriers of language or culture in making use of CAMHS services. In Bradford, lower rates of referral could be related to lower access to services for children from BME communities. Unfortunately, it is not yet possible to break the data on CAMHS referrals down in the detail that would be required to substantiate this suggestion locally.

Sharing Voices, a community development organisation which works in central Bradford primarily with BME communities, felt that many children and young people, or their families, were reluctant to admit to difficulties or to accept help. She described it as very important to offer help in school, where children are, and where they can easily access an informal drop in.

As an example, she described considerable levels of self harm among young girls in certain schools, but was very clear that most of these girls would not willingly seek help, or present to their GP or to A&E.

Clinicians working in CAMHS also pointed out that the presentation of some mental health difficulties can vary between communities. The lead psychiatrist for the eating disorders team pointed out that young girls from the South Asian community tended not to meet the 'classic' definition of an eating disorder, which had led to fewer girls being diagnosed despite having significant problems. A revision of the service's guidelines had redressed this issue.

Other community professionals suggested that there could also be issues with access of Eastern European children and young people to services. The presence of significant numbers of children and young people from refugee and asylum seeker families was also mentioned: these children and young

people may well have experienced very significant trauma, but may also find it very hard to understand or gain access to services.

CAMHS professionals also described the impact of the growing Central and Eastern European community, who present with different issues and require a different set of cultural competencies.

Thus the anecdotal evidence suggests that children and young people from Bradford's BME communities may be reluctant to approach services, may be under-diagnosed due to cultural differences in the presentation of emotional distress or mental health disorders, and may experience greater barriers in access to specialist services. CAMHS professionals describe this as an 'ongoing dynamic' of which they are well aware.

All of this could contribute to apparently low rates of referral to specialist services for children from these communities.

Further exploration of potential barriers to accessing emotional and mental health services for these children and families would be of benefit, as would the ability to interrogate CAMHS referral data to determine by how much, and in what areas, children from BME communities are under represented.

### 6.10.iv Conclusion

All of the above three factors may contribute to an explanation for Bradford's low referral rates to specialist CAMHS.

However, commissioners should remain concerned that access to specialist CAMHS, as measured by referral rates, appears to be below the national average and lower than any other local authority in the region. In a population with the significant risk factors identified in Section 4, a higher rate of referral than other local authorities would be anticipated if referral was a genuine reflection of need.

It appears likely that there is a high level of unmet need for specialist intervention around emotional and mental health in Bradford, which is of particular concern when we expect increasing numbers of children in the age band most likely to develop significant emotional and mental health difficulties. The level of unmet need is only likely to grow over the next few years.

Maintenance of present levels of service and investment, as a minimum, needs to be given a high priority, and despite the present financial climate, serious consideration from all partners needs to be given to increased investment in services around children and young people's mental health.

Partners need to recognise that successfully meeting this unmet need is likely to be reflected in higher referral rates either to specialist CAMHS or to Tier 2 community services. Reduction in referrals to specialist CAMHS may not be a realistic aim, and is unlikely to reflect the delivery of effective services.

The perceived barriers to access for many of our young people, particularly from BME communities, also underlines the importance of commissioning a 'mixed economy' of mental health services. Children who would find referral specialist CAMHS difficult may need interventions in school, at a voluntary sector service, or in a drop in group. It remains extremely important to 'upskill' the workers with whom children and young people from BME communities will be in day to day contact.

The solution to barriers experienced by children and young people from BME communities is not always simple or straightforward. Some young people in participation work described how a worker from their own cultural or religious background could actually make it harder for them to discuss cultural pressures that might be contributing to their difficulties. For other young people, as Shared Voices described, the opportunity to obtain support from someone who understood their cultural or religious perspective was very important to them.

Organisations such as Shared Voices with a specific remit to support the BME community, may offer more culturally sensitive options, as well as providing advice and guidance in ensuring that all services are 'culturally competent'. Shared Voices and Barnardos are currently in discussions about providing a

WRAP (Wellness Recovery Action Programme) group specifically aimed at children from BME communities.

Basing early intervention services 'where children are' (mainly in and around school) minimises the physical and emotional barriers around seeking support, and is likely to be key in increasing children's access to early intervention.

### 6.11 Rates of admission to hospital for self harm

The number of young people admitted to hospital because of self-harm is an indicator against which local authorities must report in the Public Health Outcomes Framework.

Local analysis shows that for all young people aged between 0 and 19, there have been an average of 240 admissions relating to self harm each year.

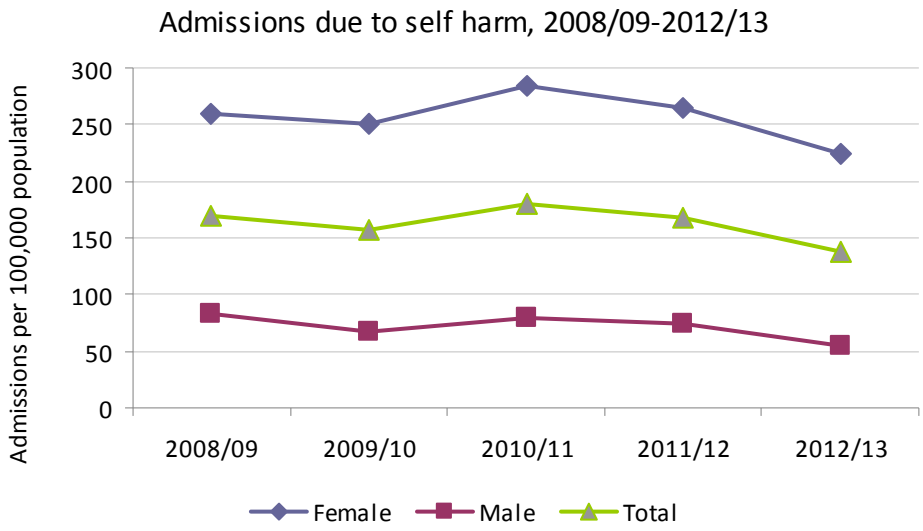
Figure 14 below shows the changes in admission rates for self harm over time. Rates have been relatively stable, rising in 2010/11 but have now fallen to below the rate of 170/ 100,000 seen in 2008-9.

ChiMat have provided benchmarked data, analysed slightly differently from the locally produced information, for rates of admission of young people between 10 and 24. This data has been 'standardised' or adjusted, to take account of the fact that different local authorities have different proportions of children and young people in their population.

Bradford's rate of admission for self-harm among young people aged 10 to 24 is 373.7/ 100,000, which falls into the middle quintile of local authorities. Rates of admission nationally range from 82.4 to 1,152.4/100,000.

Young women are more likely to be admitted because of self harm than young men, which reflects the national pattern.

**Figure 14: changes in admission rates for self harm in Bradford**




Despite the reassuring nature of the published data, discussions with various local professionals have revealed significant concerns about rising levels of self harm among young people in Bradford, much of which will not register in these figures. In general, professionals agree that young people represented in hospital admission rates are likely to be those who have taken an overdose.

Rising numbers of young people locally appear to be engaging in forms of self harm such as cutting, which are unlikely to lead to hospital admission but nevertheless demonstrate significant emotional distress. In particular, school staff often feel poorly equipped to cope with incidents of self harm.

Particular issues are said to have arisen in local all-girls' schools, where teenage girls have tended to be influenced by peers who are self harming, with a rapid spread of incidents. At one girls' school a pilot project has been set up through the Mental Health Matters Strategy, to provide group interventions for young girls who are self harming and provide alternative coping strategies.

A protocol has also been developed by a CAMHS psychiatrist to support schools in working with young people who self harm, and through the MHM strategy group, schools are being encouraged to record incidents of self harm. This work may, in time, provide a more accurate picture of the levels of self harm in young people which are presently 'under the radar'.

## 7. What do young people tell us they want?

The Barnardos service in Bradford has been commissioned since at least 2007 to undertake participation work with young people who use CAMHS services. They currently run two regular groups, for different age ranges. These have both a consultative and therapeutic element, as attending the groups often provides a source of regular support for young people who have experienced mental health difficulties.

Rather than attempting to conduct a fresh consultation, this needs assessment draws on the skilled work of an established service. It benefits from being undertaken by a worker with skills and experience specific to the task, who has regular contact with many of the children involved.

The Healthy Minds Participation Worker conducted an extensive consultation with 122 children and young people in 2007. The group was diverse, with 40% of children from BME backgrounds, and including some children from hard to reach groups such as Looked After Children and young people who were NEET (not in employment, education or training). 15% of children in the consultation had experience of using a counselling service, including CAMHS.

The children and young people were asked to design their ideal service for meeting emotional and mental health needs. Their work was subsequently incorporated into the 2008-2011 Healthy Minds Strategy.

This needs assessment also draws on the findings of a consultation with participation groups in August 2013, and with a presentation to Bradford City CCG in March 2013. In 2010, children and young people prepared a set of ‘top tips’ for commissioners about how to provide the best emotional and mental health support across Bradford. These thoughts give a concise and still very relevant summary of young people’s views, and are reproduced overleaf.

The main themes coming out of the two consultations are further discussed below:

*Accessibility of service*

Young people found waiting lists very hard to deal with. They felt that their ideal service would be responsive, providing help when they needed it.

Current referral systems were difficult for some young people. Not all young people were comfortable engaging with their school nurse, or GP. Children

and young people would like a range of professionals to be able to refer into CAMHS on their behalf, and to be able to self-refer.

For some young people, engaging with CAMHS was seen as a difficult process. They felt that there should be support for a process of building up trust and in particular, a 'safety net' for children and young people who fail to attend appointments. Children mooted the idea of a community based service which would work with young people who failed to attend specialist CAMHS.

Children and young people expressed strong support for the idea of drop-in services. They wanted a range of drop in services in places where they were – school, youth services, in their local area. They saw drop in services as accessible, quick and responsive, although at the same time it was important to them to see the same worker at each drop in.

Although children and young people recognised that some people might prefer the anonymity and accessiblility of helplines or online support, in general this was not a preferred option at the time of the consultations. They felt that online services lacked personal contact, would fail to provide a trusting relationship. Young people were worried about not knowing who they were talking to online.

*Trusted relationships*

Young people found it very important to be able to speak to somebody they trusted, which might be any one of a range of people from parents to teachers to workers in other services with whom they already had a trusting relationship.

In the 2007 consultation 77% of those consulted would seek help through talking to somebody already known to them, who they trusted and were comfortable with.

This underlines the importance of 'skilling up' workers in a range of universal services. It is not necessarily simple to predict who a young person will form a trusting relationship with. The people with whom they have day to day contact need to have the skills to identify and respond to difficulties.

Those young people who were seen by specialist services such as CAMHS felt that it was very important to them to see and for that worker to take time to build a relationship with them.

*Knowledge about services*

'There is no point telling, if there is no help out there'

Children and young people did not feel that they always knew enough about what services were available. They tended to have knowledge of the services they had accessed, but not a broad knowledge of what help might be out there.

Professionals working with them did not always know enough about available services, and many young people felt that they wanted the information readily available to them, and to be able to self refer if they needed the help.

Young people asked for information to be available through word of mouth, signposting and advertising at places they go to, such as youth clubs, schools and GPs.

*Stigma*

Children and young people still felt a sense of stigma and 'being different' because of using CAMHS services. They asked for work to raise awareness of mental health issues in schools and in the community.

Young people did not find it easy to speak up and ask for help. They wanted support to teach coping skills, and help in understanding where to go if they needed support.

*Understanding and support in school*

Many young people felt that school could be a very difficult place for them, and that they were easily written off as 'trouble makers' if their emotional or mental health issues led to difficult behaviour.

They wanted schools to understand their needs and some of the reasons they might behave as they did. It was important to them that teachers and other school staff had an understanding of emotional and mental health issues.

## 7.1 'Top Tips' from children and young people

**'Top Tips' for commissioners of emotional and mental health services**

**(Young people from Healthy Minds Participation Groups, 2010)**

**Waiting List**

No waiting lists – we should get help when we need it. Not months down the line when we have to rake it all up again.

**Skills and Training**

All workers (especially GPs and teachers) in contact with children and young people and families should have a better understanding and knowledge about emotional and mental health needs. Emotional and mental health training should be mandatory for all staff to be able to do their job and meet our needs

**Emotional and mental health should be everyone's responsibility**

All staff should be confident in their ability to spot and support emotional and mental health issues. Workers we have day to day contact with and who we trust need to have these skills to help us. It is not good enough to just have individual specialist workers who cover a wide area. These workers have no chance of providing all the support needed for all the children and young people across Bradford.

**The same worker**

We need a continuity of service. We should not get different workers all the time. We should have the same worker that we get to know, trust and can talk to. It is hard to continually build relationships and re tell our stories to lots of different workers just to get the help that we need. What is the point of telling our story loads of times if we are not listened to?

**Positive Activities**

To help our emotional and mental health we should have the chance to be involved in lots of positive activities where we can achieve, build self esteem, have fun and get time out from our family and/or the situation we are in.

**Drop Ins**

Drop ins are great for us. No waiting lists, a place that we feel we belong, have reguilar groups at the same time so that we can meet other children and young people and make new friends. At the drop in there should be a worker there that we can go talk to, when we want to, on our terms, if we need to … and it be the same worker each time.

**Raising Awareness**

We need to make it easier for us and others in society to be open about experiencing emotional and mental health difficulties and needing support. We should raise awareness and understanding of mental health to workers, to the public and to our peers.

## Top tips from young people (continued)

**Transition**

Help should not stop for us just because we turn 18. Our problems may not stop so why does the help? Make sure we get the help we need at whatever age we are. We need help to find out about adult services, help building relationships with them and moving on. Most importantly the services need to be there!

**Understand us**

Services should not write us off as trouble causers. Look a little deeper at our situation, understand our lives and think about why we are acting as we do. We might have autism, might be getting bullied, it may be bad at home. Respect us and take time to understand us.

**School support**

Schools and teachers should have techniques to deal with our issues in lessons without triggering our bad behaviour. If we are struggling in class let us have some time out, let us get away from the bullies, listen to us. Work out a way of communicating with us what our needs are … do not always put the education before our needs. How can we learn when we are upset, angry, struggling?

**Information**

We have a right to receive information about support services out there and it be explained in a way that we all (including parents) understand. We should not have to rely on a worker such as a GP to pass on the information. What if they do not tell us and we do not get the help that we need? We have to be able to self refer to services if we feel that we need the help.

## Emotional and mental health should be everyone's responsibility

## 8. Conclusions

This needs assessment takes place in the context of an extremely challenging financial climate, both for the local authority and for the NHS locally. The recommendations made at the beginning of this document must reflect this, and necessary as they may seem, calls for major investment of new resources in services are unlikely to be realistic.

Nevertheless, the clear picture presented from local data is one of high levels of unmet need, which are likely to worsen significantly as Bradford's child population grows and the 10-14 age group, a key group for the onset of mental health difficulties, becomes the largest proportional group in the child population. Bradford's significant risk factors, particularly in relation to poverty, will also increase the levels of demand and unmet need.

All services report increasing pressure, growing waiting times, and in the case of VCS services, an increasing burden of complexity. Cases that would previously have been referred to CAMHS are now being seen by VCS organisations.

The regional benchmarking exercise shows Bradford to have both low levels of referrals to specialist CAMHS, and the second lowest level of investment from CCG commissioners, per child. While lower levels of referral may have a variety of explanations, the low level of investment is of major concern, particularly alongside the financial vulnerability of those parts of the service historically funded by the local authority.

So far as possible in the current climate, children's mental health services should be protected from further disinvestment and if financial circumstances allow, additional investment should be considered in the future.

In order to meet the predicted rising demand, and protect the limited specialist CAMHS capacity, priority will need to be given to the design of effective community based services. The promotion of mental well being, resilience and coping skills will also be critical. Schools are key potential players in the provision of early intervention, and need to be brought into the partnership around children's mental health via the Mental Health Matters strategy. We should continue to support workforce development to 'skill up' all the workers who have day to day contact with children, to ensure they have the skills to identify and respond to emotional or mental health difficulties.

This fits with what children and young people tell us they want and need from services: open, accessible and non-stigmatising services that are as far as possible, delivered where they are – in schools, in youth services, in residential units, in their community. They want the people they trust and see every day to have the skills to help them.

Professionals report that children and young people can experience barriers to accessing CAMHS, and one reason for the lower referral rate may be barriers experienced by young people from BME backgrounds. Waiting times and the need for GP referrals may also play a part. Further work needs to be done to ascertain whether young people from BME backgrounds are under

represented. It is also important to commission a ‘mixed economy’ of services, so that children can be helped in a range of different ways.

However, there is also an important need for strong strategic oversight of the system. The more diverse the system becomes, and the more organisations and individuals there are delivering support, the greater the need for strong lines of communication to ensure that all the support and services being delivered is effective and evidence-based. In commissioning terms, the likelihood is that services will become increasingly complex, and it will be important to have an overview of the whole system to understand how changes in one element will affect capacity and demand everywhere else.

This needs assessment provides a starting point and a summary of what we know ‘so far’ about children’s emotional and mental health services locally. As CYP-IAPT and the minimum dataset are implemented, more information is likely to emerge. There are many fruitful areas for further work: equally, there are some very clear recommendations which need little further explanation, and these are presented at the front of this document.

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