Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Children's Mental and Emotional Health' JSNA Chapter Summary Update '2014-15'

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Kent Children's Mental and Emotional Health JSNA Chapter Update 2014

Introduction

All children have an emotional and mental health – but not all children will need to access specialist Child and Adolescent Mental Health Services (CAMHS).

CAMHS are understood in the **broadest** sense – that is, *'any service provision whose aim is to meet the mental health and emotional wellbeing of children and young people'* – as opposed to a **narrow** interpretation focused on *'specialist' CAMHS*.

As children develop, they are dependent on their environment being stable and loving enough to ensure they grow the resilience and coping skills to deal with life as an adult. Adolescence is a particularly fraught time for a person developing their resilience and wellbeing. This is because so many changes occur simultaneously, which coupled with societal expectations – can be overwhelming at times – even for the most resilient of teenagers.

A young person's mental health is a product of their family and home environment, their friends and peers, the quality of their education, their relationships with trusted adults and the ease and accessibility of supportive early help services – as well as a high quality and responsive specialist CAMHS service.

This is why all services that are provided universally for all young people should identify their role in enabling health and resilience. Waiting until a young person is so distressed, or has developed behaviours that are causing harm and distress before referring to a specialist service, will easily overwhelm that specialist service.

There has been, nationally, a rise in diagnosis of development and behavioural disorders such as autistic spectrum and attention deficit disorder. Nationally there has also been a rise in young people self-harming and attempting suicide. This has also come at a time of focus on child sex exploitation, maltreatment and abuse. Newer issues of cyber-bullying and social media exploitation are also contributors to the context of a young person's distress.

The local response has been to come together and form the "The Way Ahead: Kent's Emotional Wellbeing Strategy for Children and Young People".

This chapter is a summary of the updated Kent Children and Adolescent Needs Assessment 2015.

This chapter also links to a number of needs assessments that contribute to young people's mental health:

- Child Sex Abuse, Looked after Children, Substance Misuse, Youth Offending, Children with Disabilities. Child Health, Suicide and Self Harm, Maternal Mental Health.

Key Issues and Gaps

Clarity: It is important for all commissioners of children's services (both specialist and universal) to communicate clearly to providing organisations, what the expectations and visions are in delivering safe, timely and resilience building services for children and young people. Therefore agreed definitions, thresholds and understanding of the way services link together is important for commissioners.

Expectations and capacity: There is a great deal of subjectivity on the thresholds of severity in emotional health. Currently this is best assessed in specialist services – who have highly trained staff to understand the clinical thresholds. However by expecting clinical specialist services to assess every child in distress will turn the service into an assessment service and lead to long waiting times. This is a picture that is recognisable nationally and has led to many CAMHS reviews.

Resilience: A response is to equip all services with ways in which to cope and build resilience in the distressed child. There are many services across Kent that are commissioned to help a child's emotional development and distress and it is important that these services are commissioned in strategic alignment and with clear outcome measures – so services themselves can operate most efficiently.

Involvement and engagement: One strength in the formation of the Kent Emotional Wellbeing Strategy has been in the continued involvement of young people. Young people have been clear in wanting services where there is one trusted adult, where there is time to build up trust and where they are safe and able to build up resilience.

Self-harm: There has been a national increase in young people self-harming and this is also seen in Kent. The reasons for these increases are not fully understood. There is a big difference between self-harm as 'attempted suicide' and self-harm as an 'expression of emotional distress'. Key antidotes must be to listen to young people and enable them to have safer outlets to express distress eg drama, creativity, trusting relationships with adults and peers. It is also vital that provider services know what to do when a young person has self-harmed and that that person is helped to recovery in a safe and timely way.

Vulnerable groups: It is well known that some young people are more vulnerable to mental health problems than others. These are often young people who are in local authority care or known to a wide array of services. The data from the needs assessment shows that there is still a 50% treatment gap for children in local authority care in accessing specialist CAMHS services. This means that those children and young people from the harder to reach and more vulnerable groups are not getting the same degree of access to treatment or support.

Data: The services that provide CAMHS services are currently disjointed. It is hoped that the new strategic framework will improve this. There are a range of services commissioned and supplied by Kent County Council. The NHS services are commissioned via CCGs. These services collect data differently and via a range of differing geographies and thresholds. This makes data collection and linkage almost

impossible. For future needs assessments to be more accurate this is an important issue to address.

Who's at Risk and Why?

There are 362,028 children and adolescents aged 0 to 19 in Kent, making up 24% of the county's total population. Of these children and adolescents, 51.3% are male and 48.7% are female. There are also variations at CCG level. Ashford CCG has the highest proportion of children and adolescents aged 0 to 19 (at 26%), though West Kent CCG has the highest number of people in this age group (n = 115,135).

Mental disorder is more likely to develop or become apparent in adolescence. The adverse experiences, conditions or environments that affect the mental health and wellbeing of younger children also apply to adolescents. However, there are other significant risks that have particular pertinence to this life stage such as tobacco, alcohol or drug use, which often starts in adolescence.

Table 1: Children at Greater Risk of Mental Health Disorders

• Children excluded from school • Children experiencing personal abuse or neglect or witnessing domestic violence • Children who are socio-economically disadvantaged • Children living with a long-term physical illness or disability • Children with parents who have mental health or substance misuse problems	• Looked after children • Not in education, employment or training • Refugee or asylum seeker • Teen parents • Young black and minority ethnic (BME) people • Young lesbian, gay, bisexual, transgender and questioning (LGBTQ) people • Young offenders

Sources: JCPMH commissioning guide; Bhui and O'Hara (2014)[1]

The rates for mental health disorders in children looked after by local authorities are higher than those seen in the CAMHS survey of children in private households. [2]

[1] Bhui K and O'Hara J. (2014) Ethnic inequalities, complexity and social exclusion in mental health. Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence, p. 279.
[2]Meltzer H, Corbin T, Gatward R, Goodman R, Ford T. (2003) The mental health of young people looked after by local authorities in England. A summary version of that research is available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060689.pdf Accessed 7 December 2014.

Table 2: Prevalence Rates of Mental Health Disorders in Looked After Children

	Looked After Children (Ages 5 to 17)	National CAMHS Survey – Private Households (Ages 5 to 16)	PHE Kent estimated rates[3] (Ages 5 to 16)
Any mental health disorder	45%	9.6%	9%
Conduct disorders	37%	5.8%	5.4%
Emotional disorders	12%	3.7%	3.5%
Hyperkinetic disorders	7%	1.5%	1.4%

Source: Meltzer et al (2003)

Please note that there are several other needs assessments and reports which provide further details on children in care, children with learning and physical disabilities, trafficked children, those with substance abuse problems, those with eating disorders, adults with mental health problems and IAPT equity. These can be accessed at the KMPHO website: http://www.kpho.org.uk

Risk factors: The relationship between risk factors and outcomes for young people's mental health is complex, with the two influencing each other. The likelihood of a child experiencing mental health problems increases dramatically as the number of risk factors increases. A combination of risk factors tends to increase their adverse effects, though this is not always the case for all children. Not all children experiencing the same risk factors will develop mental health problems as some are more resilient, due to the protective factors in their lives.[4, 5]

a Child characteristics – age, sex, ethnicity, physical illness, Special Educational Needs (SEN), smoking, drinking and cannabis use.
b Family characteristics – one- or two-parent family, reconstituted family (containing step-children), mother's educational qualifications.
c Household characteristics – employment status, socio-economic status, tenure and household gross income; poverty.
d Social factors – psychological distress of mother and number of stressful life events.
E Children with a parent who has a mental illness or substance use disorder are at a high risk of experiencing family discord and mental health problems. The higher risk of mental health disorders across generations is in part explained as a result of interactions between genetic, biological, psychological and social risk factors occurring as early as pregnancy and infancy.[6, 7, 8]

[3]PHE. (2014) Children's and Young People's Mental Health and Wellbeing Profile for Kent.
[4] Department for Children, Schools and Families, and Department of Health. (2008) Children and young people in mind: the final report of the National CAMHS Review.
[5] Newman. (2002) Promoting Resilience: A review of effective strategies for child care services. Exeter: Centre for Evidence-Based Social Services, University of Exeter.
[6] World Health Organisation. (2004)

[7] Hetherington R, Baistow K, Katz I, Trowell J. (2001) *The welfare of children with mentally ill parents: Learning from inter-country comparisons*. Chichester: Wiley and Sons.

[8]Matteblat F, Remschmidt H. (2008) The children of mentally ill parents. *Deutsches Arzteblatt International*, 105: 413-418. Quoted in CMO annual report on mental health.

f Children experiencing and witnessing domestic violence.
g Having a disability.

Table 3: Risk Factors and Higher Prevalence of Mental Health Disorders in Children

Lone parent	Lone-parent (16%) compared with two-parent families (8%)
Blended family	Reconstituted families (14%) compared with families containing no stepchildren (9%)
Education of parent	Interviewed parent had no educational qualifications (17%) compared with those who had a degree-level qualification (4%)
Parental work situation	Families with neither parent working (20%) compared with those in which both parents worked (8%)
Weekly income	Families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 or more (5%)
Occupational group	Families where the household reference person was in a routine occupational group (15%) compared with those with a reference person in the higher professional group (4%)
Residential area	Living in areas classed as 'hard pressed' (15%) compared with areas classed as 'wealthy achievers' or 'urban prosperity' (6% and 7% respectively).

Table 4: Risk Factors: Household Characteristics Indices

Indices	Period	Kent Value	England Value
Children under 20 in poverty: % of all dependent children under 20	2011	17.50	20.10
Children under 16 in poverty: % of dependent children under 16	2011	18.30	20.60
Family homelessness: rate per 1,000 households	2012/13	1.21	1.73
Lone-parent households: % of households that have lone parents with dependent children	2011	6.78	7.13
Families out of work: % of households with dependent children where no adult is in employment	2011	3.82	4.18
Families with health problems: % of households with dependent children where at least one person has a long term health problem or disability	2011	4.58	4.62

Source: PHE (2014) CYP Mental Health and Wellbeing Profile for Kent

Cyber-bullying

'Cyber-bullying', or bullying through digital media, is increasingly recognised as the most common type of bullying.[9, 10, 11, 12] According to publications from 2008 to 2011, between 8% and 34% of young people in the UK have been cyber-bullied, with girls twice as likely to be victims of persistent cyber-bullying.[13]

While evidence is limited and contradictory on the potential negative effects of the emergent digital culture on children and young people, such effects may include increased physiological arousal, decreased attention, hyperactivity, aggression, antisocial or fearful behaviour, social isolation and excessive use or 'technological addiction':[14,15, 16, 17, 18]

[9]Williams KR and Guerra NG. (2007) Prevalence and predictors of internet bullying. *Journal of Adolescent Health*, 41(6, Supplement 1): S14-21.

[10]Landstedt E and Persson S. (2014) Bullying, cyberbullying, and mental health in young people. *Scandinavian Journal of Public Health*, 7.

[11]Kozlowska K and Durheim E. (2014) Is bullying in children and adolescents a modifiable risk factor for mental illness? *Australian and New Zealand Journal of Psychiatry*, 48(3): 288-289.
[12]Slonje R and Smith PK. (2008) Cyberbullying: another main type of bullying? *Scandinavian Journal of Psychology*, 49(2): 147-154.
[13] Munro E. (2011) The protection of children online: a brief scoping review to identify vulnerable groups. London: Department for Education.
[14]Anderson CA. (2004) An update on the effects of playing violent video games. *Journal of Adolescence*, 27(1): 113-122.

[15]Department for Children, Schools and Families; Department for Culture Media and Sport. (2008) Byron Review. Children and New Technology. Safer Children in a Digital World: Full Report.

[16]Kappos AD. (2007) The impact of electronic media on mental and somatic children's health. *International Journal of Hygiene and Environmental Health*, 210(5): 555-562.

a A small increase in behavioural problems at age seven is associated with watching television for more than three hours per day by age five. However, this activity did not have an impact on emotional symptoms, hyperactivity/ inattention or peer relationship problems. Playing electronic games also had no effect.[19]
b Websites that normalise unhealthy behaviours such as anorexia and self-harm as lifestyle choices may give rise to more direct harm.[20]

Evidence that exposure to media violence prompts increased aggression is conflicting.[21]

Maltreatment: abuse and neglect
Information for this section is from a recent British Medical Association Board of Science Report on Child Maltreatment, which advocates a public health perspective on this issue.

Child maltreatment are any acts of commission or omission by a parent of caregiver that results in harm, potential harm, threat of harm – even if the intent is not to harm the child. All of these are strong indicators of poor mental health for the child suffering maltreatment, both in childhood and through into adulthood. There are five main forms of maltreatment:

- physical abuse
- sexual abuse
- emotional abuse
- neglect
- witnessing intimate partner violence.

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[17]Mathers M, Canterford L, Olds T, Hesketh K, Ridley K, Wake M. (2009) Electronic media use and adolescent health and well-being: cross-sectional community study. *Academic Pediatrics*, 9(5): 307-314.

[18]Zimmerman FJ, Christakis DA. (2007) Associations between content types of early media exposure and subsequent attentional problems. *Pediatrics*, 120(5): 986-992.

[19]Parkes A, Sweeting H, Wight D, Henderson M. (2013) Do television and electronic games predict children's psychosocial adjustment? Longitudinal research using the UK Millennium Cohort Study. Archives of Disease in Childhood.

[20]Andrist LC. (2003) Media images, body dissatisfaction, and disordered eating in adolescent women. *MCN: The American Journal of Maternal/Child Nursing*, 28(2): 119-123.

Luxton DD, June JD, Fairall JM. (2012) Social media and suicide: a public health perspective. *American Journal of Public Health*, 102 (Supplement 2): S195-200.; Whitlock JL, Powers JL, Eckenrode J. (2006) The virtual cutting edge: the internet and adolescent self-injury. *Developmental Psychology*, 42(3): 407-417.

[21]Munro E. (2011)

Anderson CA, Bushman BJ. (2001) Effects of violent video games on aggressive behavior, aggressive cognition, aggressive affect, physiological arousal, and prosocial behavior: a meta-analytic review of the scientific literature. *Psychological Science*, 12(5): 353-359.

More than 80% of child maltreatment is perpetrated by parent or parent substitutes, apart from sexual abuse, which is most frequently perpetrated by acquaintances or other relatives (BMA.org.uk).

Recent national survey data shows that child maltreatment is common. They show that **1 in 25 to 1 in 10** children are exposed each year in the UK. This is a far higher number than are placed in child protection at any one time.

The average national rate for being a classified child in need to receive social services is 3% of all children, mainly for emotional abuse. This makes data from child protection agencies gross underestimates of the prevalence of maltreatment in the Kent population.

Child maltreatment affects mainly adolescents. It is also known, and clearly highlighted in the BMA report, that the issue of maltreatment is a chronic situation that develops over time (involving risks to mental health, obesity and alcohol abuse as well as risks of criminality). Please see the BMA report 2003 “Adolescent Health”.

The risk factors for maltreatment are well known: poverty, unemployment, poor housing and lack of social support. Parent risk factors are mental health problems, substance misuse and intimate partner violence as well as lack of parenting experience. Many of these factors coexist adding stresses and demands on parenting. Support for parents must be a priority in any strategy tackling wellbeing for families and children.

Protective factors: There are also protective factors. Several protective factors are associated with mental health and wellbeing, including genetic and early environmental factors; higher income and socio-economic status; living environment; good general health; education; and activities such as socialising, working towards goals and exercising. Additional protective factors include spirituality; strong personal, emotional and social literacy life skills; and social competencies and attributes such as communication skills, cognitive capacity, problem-solving, relationship and coping skills Furthermore, a sense of control and resilience – the capacity to cope with, or even be strengthened by, adversity – is also associated with helping to safeguard mental wellbeing, particularly in adverse circumstances.[22, 23]

At a population level across Kent there is a mixed picture of risk factors associated with a higher prevalence of mental health disorders in childhood, though the upward trend for domestic abuse may be of concern. More up-to-date figures on child poverty and several other risk factor indicators are required for an enhanced

[22]Joint Commissioning Panel for Mental Health. (2013) Guidance for commissioning public mental health services, p. 26.

[23]Rutter, M. (1990) Psychosocial resilience and protective mechanisms, 9: 181-214. In Rolf J, Masten A, Cicchetti D and Nuchterlein K. (1993) Risk and protective factors in the development of psychopathology. Cambridge University Press; and Masten A and Yates T M. (2004) In Newman T (ed). What works in building resilience. Barkingside: Barnardo's. Quoted in Young Minds:

http://www.youngminds.org.uk/training_services/young_minds_in_schools/wellbeing/risk_and_resilience Accessed 13 November 2014.

understanding of the current profile of risk factors for mental health at a population level in Kent.

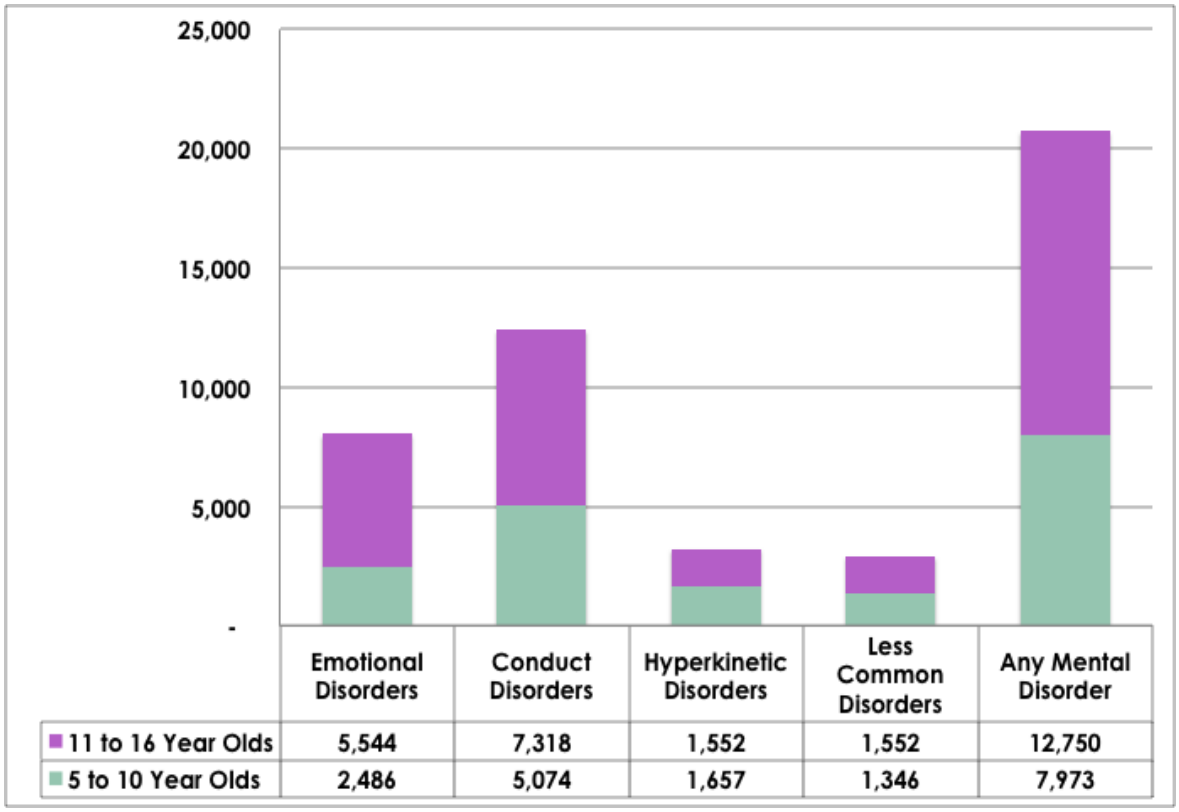
The Level of Need in the Population

Pre-school children: It is estimated that there could be 14,254 children aged two to five years inclusive, living in Kent who have a mental health disorder.

Young people 5-16: (Figure 1)

a Children aged 11 to 16 years old are more likely (11.5%) than five- to 10-year-olds (7.7%) to experience mental health problems. Boys are more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%).
b It is estimated that 20,585 children and young people aged five to 16 in Kent have a mental health disorder.
c It is estimated that 12,400 children and young people aged five to 16 in Kent have a conduct disorder and nearly 8,000 have an emotional disorder.
d Conduct disorders, hyperkinetic disorder and autism spectrum disorders were more common in boys, and emotional disorders were more common in girls. This is true for both younger children (five to 10 years old) and older children (11 to 16 years old).
e For the 5 to 10 age group, Maidstone LA has the highest estimated number of children with mental health disorders (n = 839), followed by Swale LA (n = 760). Shepway LA has the lowest estimated numbers of children aged 5 to 10 with any mental health disorder (n = 522).
f The estimated numbers of mental health disorders increase for the 11 to 16 age group. Maidstone (n = 1320) and Swale (n = 1,234) are again the districts where these numbers are largest. Within this age group, the lowest estimated number for any mental health disorder is in Dartford (n = 833).
g At the CCG level, in the five to 10 age group, the highest number for any mental health disorder is in NHS West Kent CCG, with over 2,600 children with treatable conditions. The lowest number is found in NHS Swale CCG (n = 607). (Table 5)
h At the CCG level, in the 11 to 16 age group, the numbers for any mental health disorder are highest in West Kent CCG (n = 4,121) and lowest in NHS Swale CCG (n = 987). (Table 6)
i National studies have shown that 13% of Girls (aged 15-16) had self-harmed over a period of one year (Hawton et al 2006).

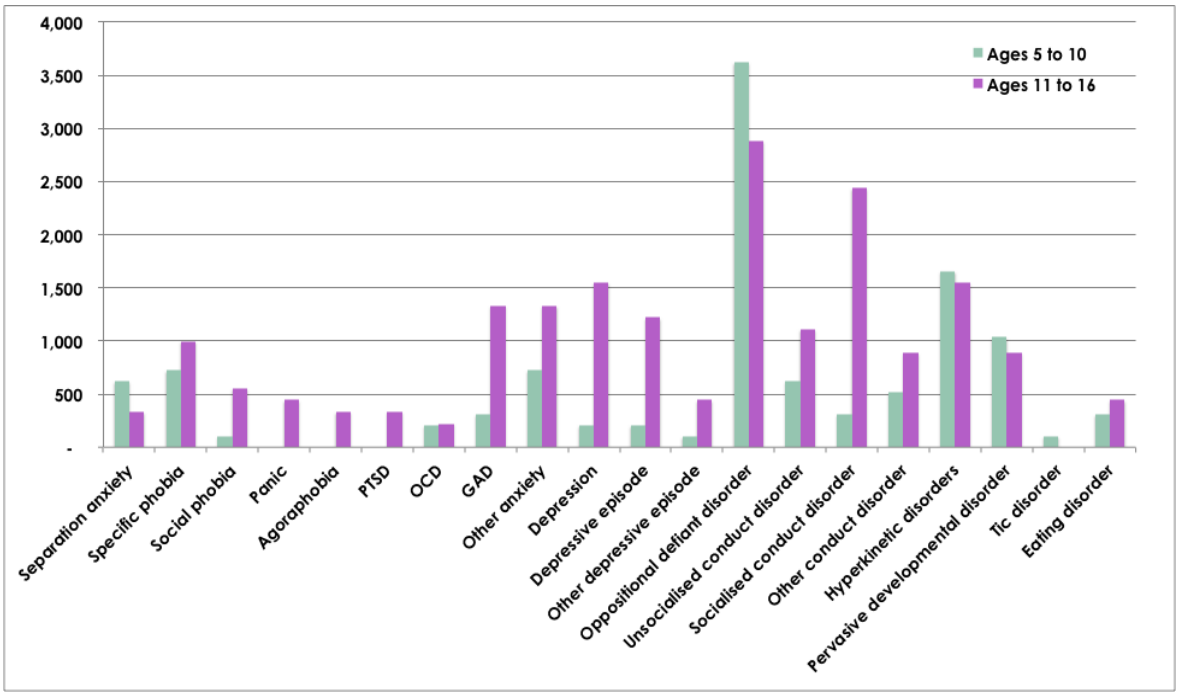
Figure 1: Estimated Numbers of Children and Young People Aged 5 To 16 in Kent with a Mental Health Disorder by Age and Broad Diagnosis, 2012



	Emotional Disorders	Conduct Disorders	Hyperkinetic Disorders	Less Common Disorders	Any Mental Disorder
11 to 16 Year Olds	5,544	7,318	1,552	1,552	12,750
5 to 10 Year Olds	2,486	5,074	1,657	1,346	7,973

Sources: Green et al (2005); ONS Mid-Year Population Estimates, 2012

Figure 2: Estimated Numbers of Children and Young People Aged 5 To 16 in Kent with a Mental Health Disorder by Age and Detailed Diagnosis, 2012



Sources: Green et al (2005); ONS Mid-Year Population Estimates, 2012

Kent & Medway Public Health Observatory

Kent County Council kent.gov.uk

Table 5: Estimated Numbers of Mental Health Disorders in Five- To 10-Year-Olds in Kent by CCG, 2012

Clinical Commissioning Group	Emotional Disorders	Conduct Disorders	Hyperkinetic Disorders	Less Common Disorders	Any Mental Disorder
	Ages 5 to 10	Ages 5 to 10	Ages 5 to 10	Ages 5 to 10	Ages 5 to 10
NHS Ashford	220	448	146	119	704
NHS Canterbury and Coastal	297	606	198	161	953
NHS Dartford, Gravesham and Swanley	429	876	286	232	1,376
NHS South Kent Coast	308	629	205	167	988
NHS Swale	189	386	126	102	607
NHS Thanet	217	444	145	118	697
NHS West Kent	826	1,685	550	447	2,648
Kent County Total	**2,486**	**5,074**	**1,657**	**1,346**	**7,973**

Sources: Green H et al (2005); ONS Mid-Year Population Estimates, 2012

Table 6: Estimated Numbers of Mental Health Disorders in 11- To 16-Year-Olds in Kent by CCG, 2012

Clinical Commissioning Group	Emotional Disorders	Conduct Disorders	Hyperkinetic Disorders	Less Common Disorders	Any Mental Disorder
	Ages 11 to 16	Ages 11 to 16	Ages 11 to 16	Ages 11 to 16	Ages 11 to 16
NHS Ashford	472	623	132	132	1,086
NHS Canterbury and Coastal	688	907	192	192	1,581
NHS Dartford, Gravesham and Swanley	924	1,219	259	259	2,124
NHS South Kent Coast	724	956	203	203	1,665
NHS Swale	429	566	120	120	987
NHS Thanet	516	681	144	144	1,186
NHS West Kent	1,792	2,365	502	502	4,121
Kent County Total	**5,544**	**7,318**	**1,552**	**1,552**	**12,750**

Sources: Green, H et al (2005); ONS Mid-Year Population Estimates, 2012

For children and young people aged 11 to 16, the numbers for any mental health disorder are highest in West Kent CCG (n = 4,121) and lowest in Swale CCG (n = 987). These numbers are in line with the relative size of population of children aged five to 10.

Deprivation
Adjusting for deprivation increases the rates and numbers for the conditions in areas such as Shepway, Swale and Thanet. For instance, the rate for conduct disorder in Thanet is 8.1% – that is, about one in 12 children and adolescents aged five to 16. This is nearly double that of the adjusted rate for Tonbridge and Malling of 4.1%. The associated estimated number of those affected by conduct disorder in Thanet goes up from 1,124 to 1,568.

Less common disorders (autism, tics, eating disorders and selective mutism) do not show associations with deprivation, and as such no further adjustments were made for these.

Autistic Spectrum Disorder (ASD):
This is a disorder with a large functional spectrum ie there are milder forms of the condition where people can lead almost normal lives and severe forms where those with the condition will need help and support in every element of their daily lives. The condition is technically a neurologically based learning disability; however there are great co-morbidities with mental health because people with ASD may suffer many forms of social distress. There are also many differing views on the prevalence of this condition. Please see the full needs assessment for further explanation. The prevalence estimate quoted here are the most recent from ChiMat.

Here ChiMat has applied the prevalence rates from Baird et al (2006) and Baron-Cohen et al (2009) to give the numbers of children with autistic spectrum disorders (ASD) in Kent.

Table 7: Estimated Numbers of Children with Autism and ASD in Kent

Autism In children aged 9 to 10 years	130
Other ASD in children aged 9 to 10 years	260
Total of all ASDs in children aged 9 to 10 years	390
Autistic-spectrum conditions disorders in children aged 5 to 9 years	1,365

Source: ONS Mid-Year Population Estimates, 2012; Baird G et al (2006); Baron-Cohen S et al (2009). Taken from ChiMat.

Eating disorder
For more detailed information on eating disorder needs in Kent, please see the Kent Eating Disorder Needs Assessment.[24] The eating disorder needs assessment is largely an aggregate of Kent and Medway data. Nevertheless, the recent study by Micali et al (2013) found the incidence of any eating disorder for those aged 15-19 to be 164.5 per 100,000, and 63.5 per 100,000 in females aged 10-14. In males aged 10-14, the incidence of any eating disorder was 17.5 per 100,000; and for those aged 15-19, the incidence was 17.4 per 100,000.[25]

The eating disorder incidence rate is highest in females aged 15 to 19.

[24] Mookherjee J. (2014) Assessment of Need for Those Affected by Eating Disorders in Kent and Medway http://www.kmpho.nhs.uk/disease-groups/mental-health/?assetdet973403=392278 Accessed 30 October 2014.
[25] Micali N et al. (2013) The incidence of eating disorders in the UK from 2000-2009: findings from the General Practice Research Database. *BMJ Open*, 3:e002646. http://bmjopen.bmj.com/content/3/5/e002646.abstract Accessed 4 November 2014.

Table 8: Incidence Rates and Estimated Numbers for Eating Disorders in Kent

	Incidence rates of any eating disorder, per 100,000	Estimated Incidence of eating disorder numbers for Kent
Females aged 10-14	63.5	28
Females aged 15-19	164.5	76
Males aged 10-14	17.5	8
Males aged 15-19	17.4	8

Source: Micali et al (2013); ONS Mid-Year Population Estimates, 2012

Please note that the information in table 8 above relates to incidence (that is, all patients with a first-time diagnosis of anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified in primary care). These are typically the most severe presentation of eating disorders.

The study concluded that age-standardised incidence of eating disorders increased in primary care between 2000 and 2009. New diagnoses of eating disorder not otherwise specified (EDNOS) increased; this was the most common eating disorder in primary care.

Prevalence of mental health problems in older adolescents (over 16s)

The widening gap between physical maturity (that is, at the end of puberty) and attaining adult social and financial independence has been postulated to explain growing mental health problems and behavioural and substance use issues among adolescents and young adults.[26] Poorly planned transition may be associated with increased risk of non-adherence to treatment and lack of follow-up, and may affect outcomes such that there is a growing call to provide young adult services together with adolescent services for long-term conditions (such as now seen with cancer services).[27]

Prevalence rates for young people aged 16 and over are from the ONS survey of adult psychiatric morbidity survey (APMS) of 2007.[28] As this survey uses different assessment methods and categories to the surveys of under-16s, direct comparisons are problematic (Table 9 & 10).

Obsessive-compulsive disorder, post-traumatic stress disorder, ADHD and eating disorders have the highest occurrence in those aged 16 to 24 compared with other adult age groups. This age group also has the highest percentage of co-morbidity (experiencing two or more mental health disorders).

[26] Patton GC and Viner R. (2007) Pubertal transitions in health. *Lancet*, 369(9567): 1130–9. Quoted in Viner R. (2013) Life Stage: Adolescence, in CMO annual report, Chapter 8.
[27] Viner R. (2013) Life Stage: Adolescence, in CMO annual report, Chapter 8.
[28] McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R. (2009) Adult Psychiatric Morbidity in England, 2007: Results of a household survey. London: The Health and Social Care Information Centre. http://www.hscic.gov.uk/pubs/psychiatricmorbidity07 Accessed 28 November 2014.

The estimates indicate that about **29,000** young people aged 16 to 24 have a common mental health disorder, and that about 3,600 young people in this age group in Kent are experiencing a depressive episode.

The APMS also indicates that 13.8% of those aged 16 to 24 screened positive for ADHD in the last six months and 13.1% screened positive for eating disorder in the past year. Applying the APMS rates, Public Health England estimates that as at 2013, potentially 21,872 young people and adults aged 16 to 24 in Kent have an eating disorder and 23,057 are estimated to have ADHD.[29]

In the 20 to 24 age group, Canterbury has the highest number with any common mental health disorder, with over 3,200. The lowest number, which is less than a third of the highest number, is in Tunbridge Wells (n = 927). This is in line with the relative population size in the districts.

In the overall 16 to 24 age group, Canterbury has the highest number of young people with a mental health disorder, at 5,077. This is nearly two times the second highest number of 2,791 in Maidstone.

Table 9: Prevalence of Various Conditions by Age Group, %

Condition	Age group					
	16 - 24	**25 - 34**	**35 - 44**	**45 - 54**	**55 - 64**	**Notes**
Any Common Mental Disorder	17.5	18.8	17.3	19.9	14.1	
Mixed Anxiety / Depressive Disorder	*10.2*	*10.8*	*8.5*	*11.2*	*8.0*	
Generalised Anxiety Disorder	*3.6*	*4.2*	*5.3*	*6.1*	*4.1*	
Depressive episode	*2.2*	*2.2*	*2.9*	*3.7*	*1.9*	
All phobias	*1.5*	*1.9*	*2.1*	*1.5*	*1.4*	
Obsessive-Compulsive Disorder	*2.3*	*1.5*	*1.1*	*1.1*	*0.5*	*Highest in 16 to 24*
Panic Disorder	*1.1*	*1.6*	*1.3*	*0.9*	*1.0*	
Post-traumatic Stress Disorder	4.7	3.7	3.2	3.9	1.9	Highest in 16 to 24
Psychotic Disorder	0.2	0.4	0.9	0.5	0.3	
Attention Deficit Hyperactivity Disorder (ADHD)	1.1	0.6	0.9	0.6	0.2	Highest in 16 to 24
Eating Disorder	3.5	2.1	1.4	1.9	0.5	Highest in 16 to 24
Co-morbidity (2+)	12.4	10.1	8.1	7.8	4.1	Highest in 16 to 24

Source: Adult Psychiatric Morbidity in England Survey (APMS) 2007

[29]Public Health England. (2014) Children and Young People's Mental Health and Wellbeing Profile for Kent. Relevant Indicators: Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds; and Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds.

Table 10: Prevalence of Probable Psychosis and Personality Disorders by Age Group, %

Condition	Ages 16 to 34	Ages 35 - 44	Ages 45 - 54	Ages 55 - 64	Notes
Probable Psychosis	0.4	0.8	0.2	0.4	
	Ages 16 - 34	**Ages 35 - 54**	**Age 55 - 74**		
Borderline Personality Disorder	0.8	0.4	0.2		Highest in 16 to 34
Antisocial Personality Disorder	1.0	0.1	-		Highest in 16 to 34

Source: Adult Psychiatric Morbidity in England Survey (APMS) 2007

In the overall 16 to 24 age group, there are over **7,800** young people with a common mental health disorder in West Kent CCG and just over **2,000** in Swale CCG. The other CCGs fall in between these figures. (Please see full needs assessment for detailed Tables as assessments have been produced for each CCG).

Self-harm

Self-harm and suicide among young people are extremely important issues. Many psychiatric problems, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders, are associated with self-harm. Self-harm increases the likelihood of a person eventually dying by suicide by between 50 and 100 times that of the rest of the population in a 12-month period.[30, 31, 32]

The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Being an older teenage male, using violent methods of self-harming, multiple previous episodes of self-harming, apathy, hopelessness, insomnia, substance abuse, and previous admission to a psychiatric hospital are factors indicative of greater risk of suicide after deliberate self-harm.[33]

In addition to discussing self-harm and suicide in children and adolescents, this section also examines the estimates of need for those young people over 19 years of age.

National studies show that more girls than boys self-harm at the ages 15-19 years (Figure 5). However, hospital attendances show that young men aged 20-24 are at risk of serious self-harm. (Figure 6)

[30]Taken from NICE guideline CCG 133. (2011) Self-harm: longer-term management. https://www.nice.org.uk/guidance/cg133/resources/guidance-selfharm-longerterm-management-pdf Accessed 23 November 2014.

[31] Hawton K, Harriss L, Hall S et al. (2003a) Deliberate self-harm in Oxford, 1990–2000: a time of change in patient characteristics. *Psychological Medicine*, 33: 987–995. IN http://www.nice.org.uk/guidance/cg133/resources/cg133-selfharm-longer-term-management-full-guideline3 Accessed 06 January 2014.

[32] Owens D, Horrocks J and House A. (2002) Fatal and non-fatal repetition of self- harm: systematic review. *British Journal of Psychiatry*, 181: 193–199.

[33] Hawton K and James A. (2005) Suicide and deliberate self harm in young people. *BMJ*, 330(7496): 891-894.

In Kent the majority of attendances at A&E for deliberate self-harm appear to be in people under the age of 24 (Figure 6). The largest group affected are females aged 15-19 (Figure 6). However there are also a significant number of young men aged 20-24 who are also self-harming in Kent (see section below on Trends for further data on A&E attendances in Kent) (Figure 6). There is also indication that self-harm behaviour that ends up in A&E is also more severe in young people ((Figure 7).

Using data pooled over two - three years, it appears that Canterbury CCG, South Kent Coast and Thanet CCGs have higher then Kent average rates of admissions to hospital for self-harm compared to other Kent CCGs (Figure 8).

An excellent report has been published on Self Harm in the UK by the Mental Health Foundation: called **"The truth about self-harm"**. It highlights the groups more at risk of self-harming:

- young people in residential settings (prisons, care, hostels, boarding schools)
- lesbian, gay, bisexual and transgender young people
- young Asian women
- young people with learning disabilities

The report summarises what is known about the reasons people self-harm. These reasons are a long list of issues that cause emotional distress to young people ranging from sexuality, fear of pregnancy, family break-up, feeling isolated, abuse, cultural problems and feeling rejected.

There are three key problems that commissioners need to be concerned with when designing services to prevent self-harm:

a It is addictive (young people come to rely on this as a coping mechanism).
b It is a response to distress and a sign they are not being given any other outlet for expressing their emotions.
c The antidote is (from the young person perspective in the report) having enough time from a trusted person to really listen to their issues and other distraction activities.

Suicide

Suicide is a significant cause of death in young people. The 2007 adult psychiatric morbidity survey found that over 17% of 16- to 24-year-olds had had suicidal thoughts and that 6.2% of 16- to 24-year-olds had attempted suicide. The comparative rate reported for suicidal thoughts in all adults (over 16) was 13.7% and that for suicide attempts 4.8%. However self-harm is more common in young people and there is little evidence to show a direct link between self-harming and suicidal intent in younger people under 18. However as seen in Figures 3 and 4 there are still deaths occurring in people under 25 in Kent.

Data on suicides in the UK between 1997 and 2003 indicate that only 14% of young people aged 10 to 19 who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults; and 20% of

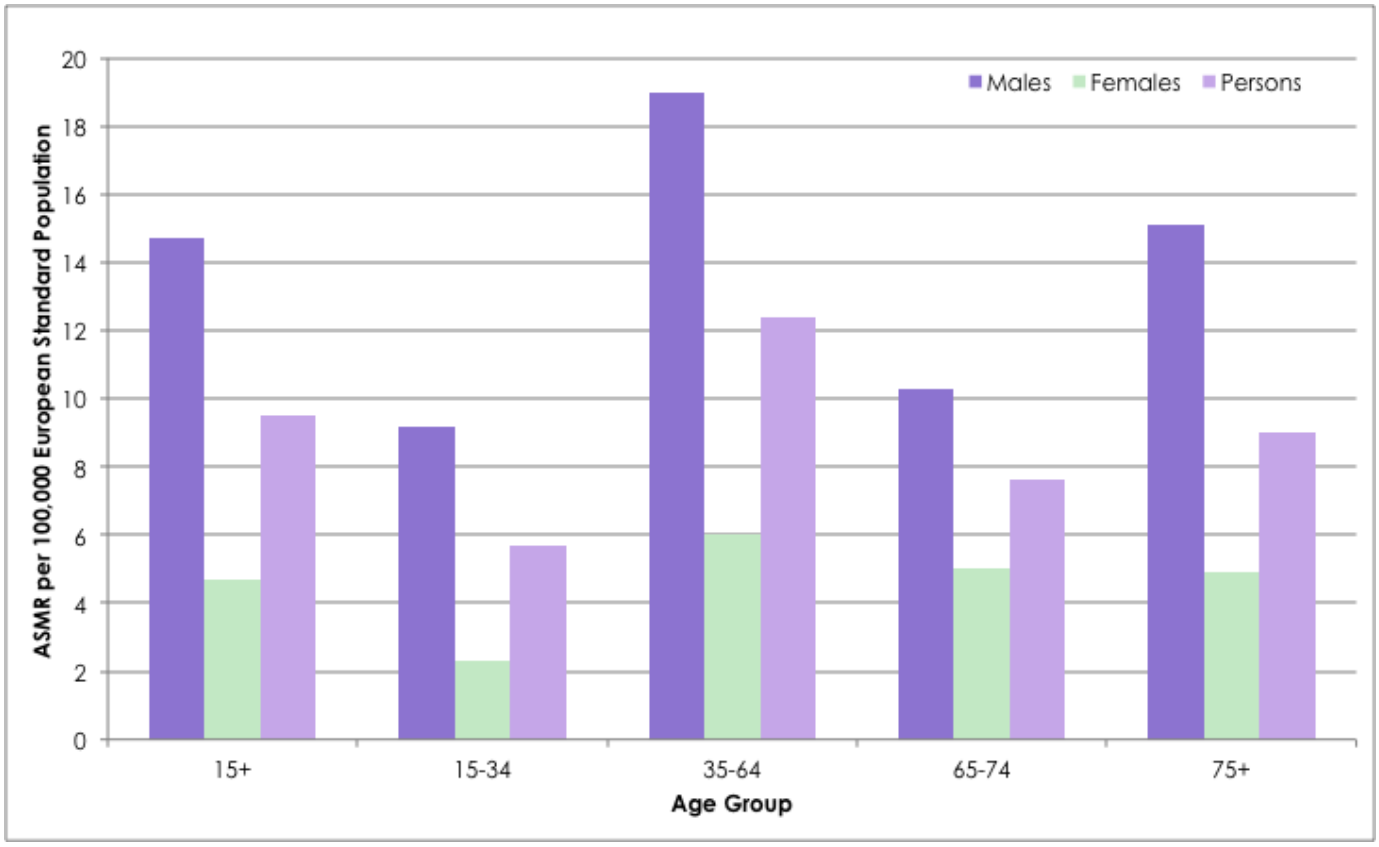
young women were in contact with mental health services compared to only 12% of young men.[34, 35]

Please see the Adult Mental Health Needs Assessments and the JSNA Chapter for more detail on suicide.

There is also NICE Guidance on the safe transition of young people from CAMHS to AMHS in event of suicide attempts due to the high risks for young people falling through gaps in services.

There is a Kent and Medway Suicide Strategy which takes many of these issues forward.

Figure 3: Age-Standardised Mortality Rates per 100,000 for Suicide and Undetermined Injury, 2010/12, Kent County Residents Aged 15+; Pooled Data by Age Group and Gender



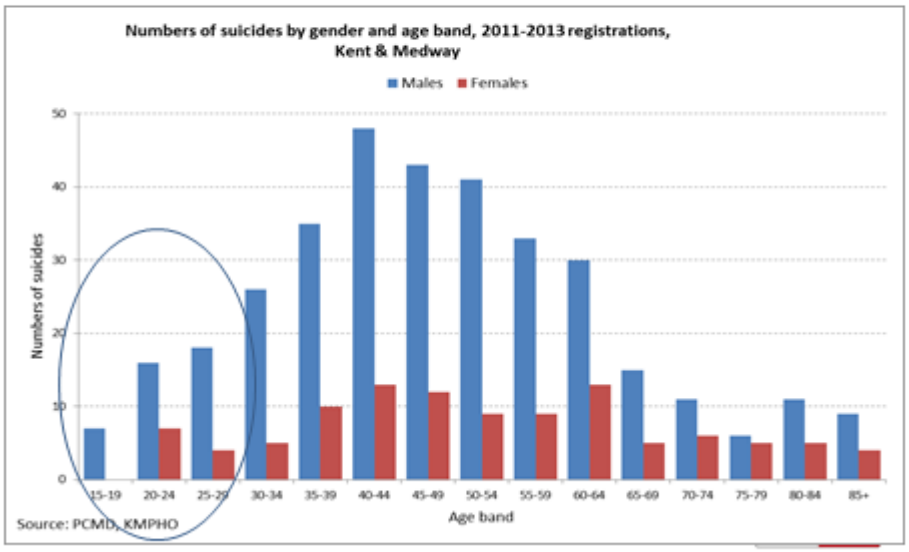
Source: NHS Information Centre Indicator Portal

[34]Windfuhr K, While D, Hunt I, Turnbull P, Lowe R, Burns J, Swinson N, Shaw J, Appleby L, Kapur N and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2008) Suicide in juveniles and adolescents in the United Kingdom. *Journal of Child Psychology and Psychiatry*, 49 (11): 1157–67. From ChiMat Kent Profile. http://www.ncbi.nlm.nih.gov/pubmed/19017029 Accessed 27 December 2014.
[35]Hawton K and James A. (2005) Suicide and deliberate self harm in young people. *BMJ*, 330(7496): 891-894.

Figure 4:

Kent & Medway Public Health Observatory

Numbers of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender, 2011-2013 registrations



From 2006 to 2013, NHS West Kent has consistently had the highest number of suicides and death by undetermined intent for people aged 15 and above. While West Kent has the highest numbers of suicides, South Kent Coast has the highest rate of suicide per 100,000 (2011-13 pooled data). In 2013, all CCG areas – with the exception of NHS South Kent Coast – had the highest numbers of suicides and death by undetermined intent for that age group within the 2006-13 period (where numbers have not been suppressed) (Table 11).

The A&E data for September 2013 to August 2014 shows 2,381 attendances by Kent residents at A&E departments in Kent and Medway. Children and young people aged 24 and under account for nearly 41% of A&E attendances for self-harm in Kent and Medway. Young people aged 18 to 24 are the largest single age category for A&E self-harm attendances.

Table 11: Number of Suicides / Deaths by Undetermined Intent of People Aged 15+ by CCG, 2006 to 2013

Resident CCG	2006	2007	2008	2009	2010	2011	2012	2013
NHS Ashford	-	-	-	-	-	-	-	-
NHS Canterbury and Coastal	16	17	-	20	-	-	15	21
NHS Dartford, Gravesham and Swanley	17	22	-	21	15	23	23	28
NHS South Kent Coast	-	20	-	18	18	25	22	18
NHS Swale	-	-	-	-	-	-	-	-
NHS Thanet	-	17	-	-	-	17	-	-
NHS West Kent	36	36	34	42	30	30	37	48
Kent County	**112**	**125**	**87**	**131**	**100**	**115**	**120**	**148**

Source: Public Health Mortality Database
[Numbers <15 have been suppressed]

Figure 5:

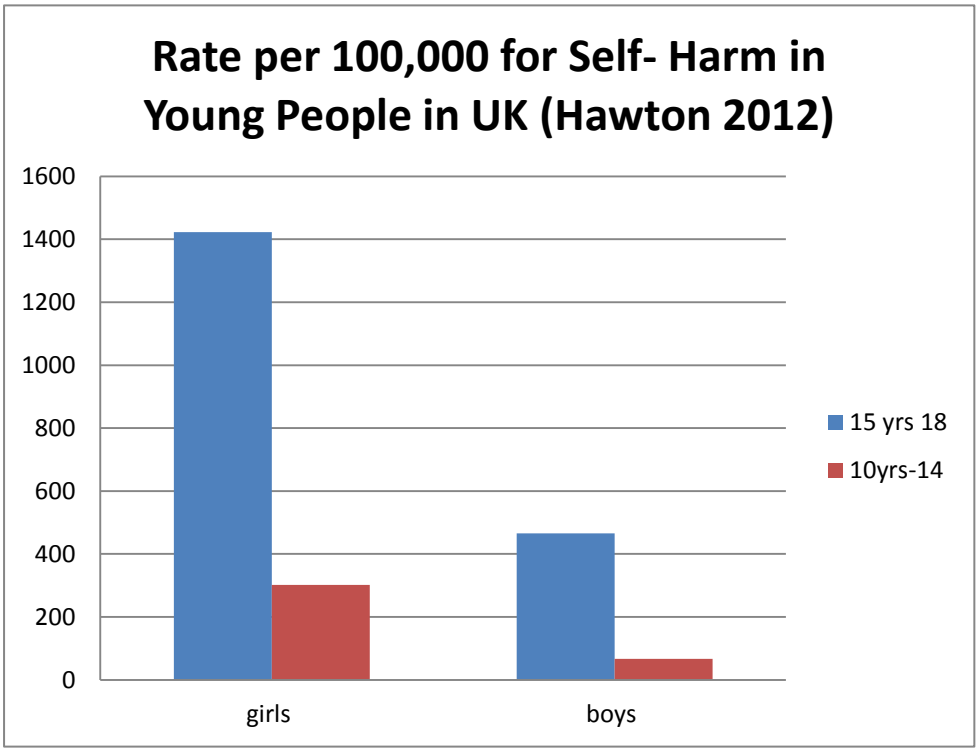


Figure 6:

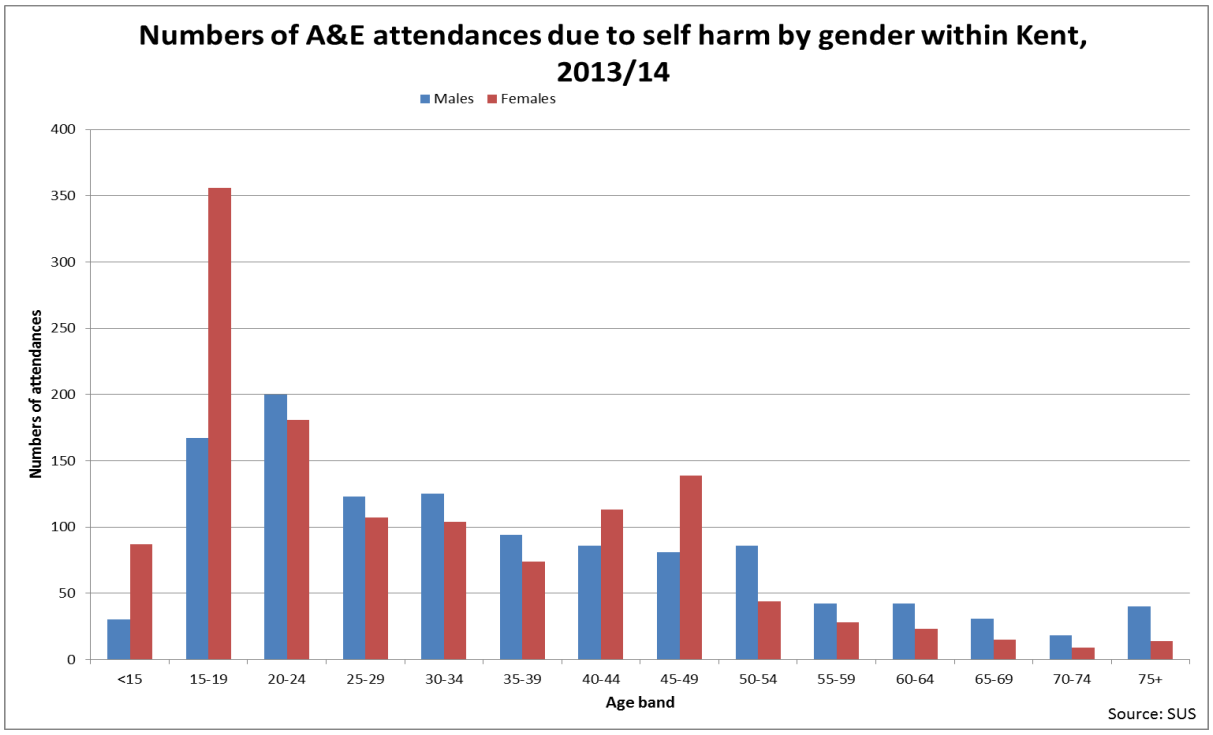
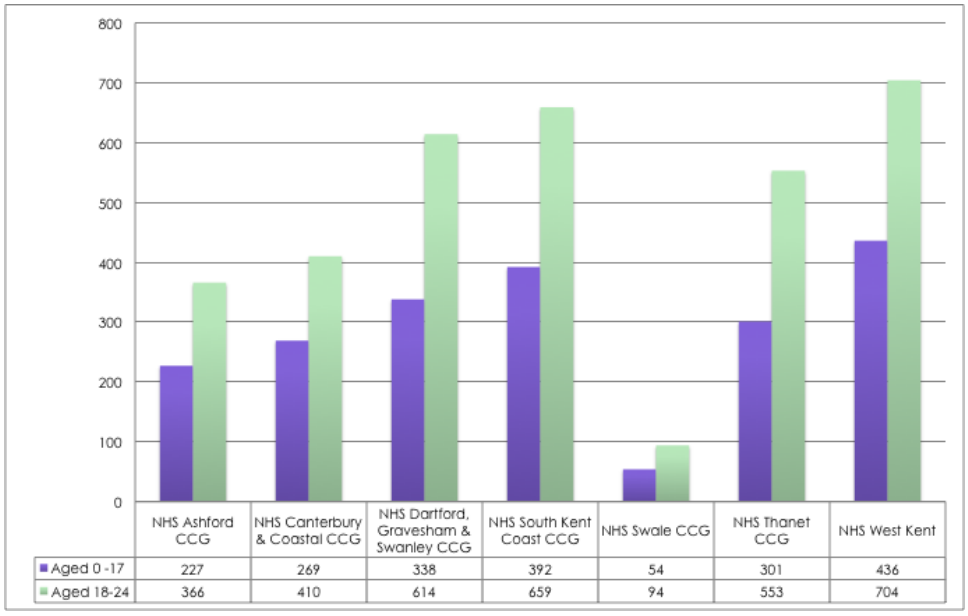


Figure 7: Attendances by Kent Residents at A&E Departments of Kent and Medway for Self-Harm by CCG, 2009-10 – 2013-14



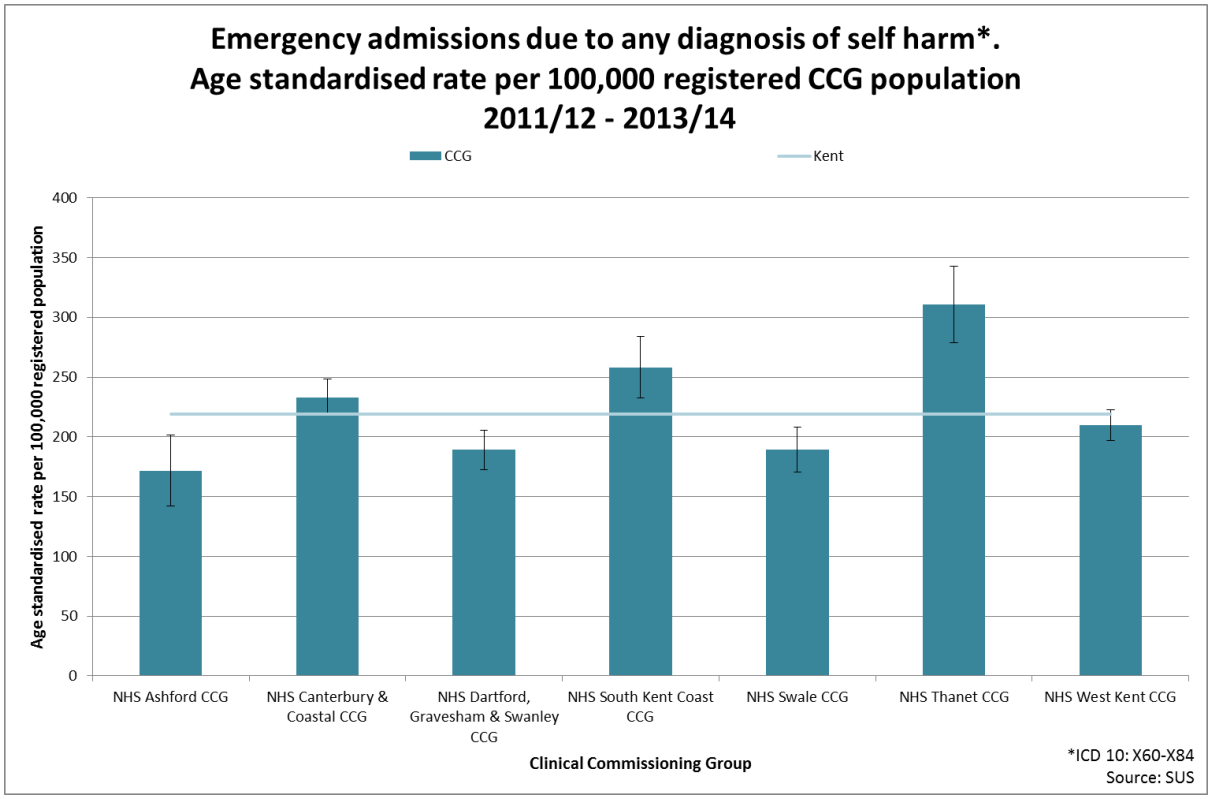
	NHS Ashford CCG	NHS Canterbury & Coastal CCG	NHS Dartford, Gravesham & Swanley CCG	NHS South Kent Coast CCG	NHS Swale CCG	NHS Thanet CCG	NHS West Kent
Aged 0-17	227	269	338	392	54	301	436
Aged 18-24	366	410	614	659	94	553	704

*Sources: A&E Dataset, Secondary Users' Service**

*Extraction criteria = Arrival Date between 1st April 2009 and 31st March 2014, A&E patient group = 30

At CCG level, NHS West Kent had the highest number of attendances at A&E departments of Kent and Medway in those aged 0 to 17 and 18 to 24.

Figure 8:



Current Services in Relation to Need

Trends

a It is uncertain if the rates of mental health problems in children and young people have increased and whether the profile of these problems has changed, given the paucity of up-to-date epidemiological data. This assessment therefore examined trend data for hospital admissions and self-harm. An increase in self-harm may point to an increase in mental health problems amongst young people.

b Nationally there has been an increase in the rate of admission for self-harm in those aged 10 to 24. Although the rate in Kent shows a drop between 2009-10 to 2011-12 and 2010-11 to 2012-13, it remains higher than the national rate.

c There has been an upward trend in the numbers of under-18s (0 to 17 years old) attending A&E for self-harm in Kent from 2009-10 to 2013-14.

d The crude rates of admission for any mention of intentional self-harm have also increased for those aged 0 to 19 and 0 to 24. Within these age groups, the highest rates are found in the 16 to 19 and 20 to 24 age groups. An increase is also noted for those aged 19 and under, as well as for 0 to 15s and 16 to 19s.

e Additionally, there has been an increase in the incidence of eating disorders.

Severity and Service Design

Table 12: National Model of CAMHS Tiers and Severity of Need

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

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

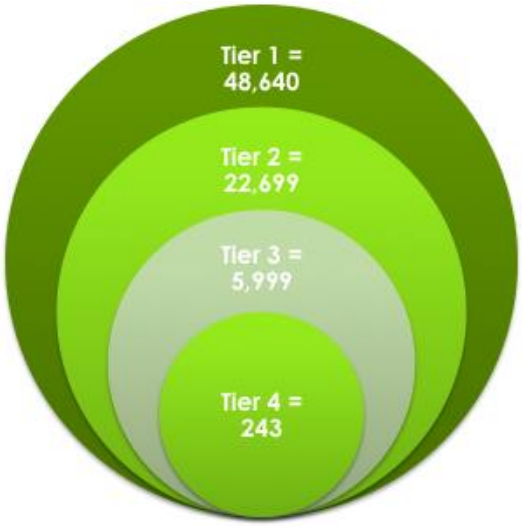
The current design of the CAMHS pathway is that there are many services commissioned for 'universal' access eg youth services, counselling services, school programmes and these are often called Tier 1 services and many are commissioned by KCC. Tier 2 services are usually for those with increasing need and people who can benefit from a more structured service by a trained professional. The main service that is commissioned for this purpose is Young Healthy Minds.

The NHS commissioned service (or specialist CAMHS) is provided by Sussex Partnership Trust and covers both T2 and T3. The highly specialised services are provided by SLAM.

As there is no clear definition of thresholds between each service / Tier, predicting need for each level of service is not an exact science. Taking the best estimates available (Kurtz and Campion & Fitch) – the current needs assessment estimates:

- there may be between **32,000 and 48,000** children in Kent in need of Tier 1 services
- the figure for Tier 2 services is in the region of **22,000**
- the estimate for Tier 3 services ranges from just under **6,000 to nearly 10,000**
- the estimate for Tier 4 services ranges from **243 to 1,524**.

Figure 9: Estimated Numbers for CAMHS Tiers in Kent for Under-17s (Kurtz Estimate)



Sources: Kurtz (1996);ONS Mid-Year Population Estimates, 2012

Meeting Expected Needs
NHS West Kent CCG has the largest share of activity from Sussex Partnership Foundation Trust for the period examined.

The existing service landscape appears to be somewhat disjointed and this may be in part a consequence of Kent's large geography and complex commissioning environment.

Some services appear to provide a combination of Tier 2 and 3 services. However, a move towards a pathway model of commissioning (which combines the provision of Tier 2 and Tier 3 services with preventive Tier 1 services) must be considered in order to give providers more incentive and greater flexibility to reach out into schools and families, to improve diagnosis and identification rates, and to focus on early intervention.

This should be supported by a greater emphasis on commissioning for outcomes and specific objectives. This will improve integration of care and support across all children' services; including education and housing.

Caseload and waiting lists of all services analysed in the needs assessment suggest that many services are largely working at maximum capacity and demand is at a greater level than what services can provide.

Data on waiting lists suggests that over half of services have waiting lists, and that the sizes of lists and waiting times vary. Several providers reported that they currently have more young people in services than they are funded to provide for.

The profile of referrals by condition is different from that which would be expected from prevalence estimates.

Self-harm and OCD are the top two reasons for referrals in data returns. Performance reports highlight witnessing domestic abuse as a top reason for referrals. Reporting of domestic abuse and violence are increasing in Kent and at a national level, and these are factors associated with psychiatric morbidity. The Increasing and higher then national expected rates of self-harm in Kent is an indication that services are not currently tackling emotional wellbeing. It is a recognised sign that services are currently not preventative enough.

Incomplete data: The data suggests low representation amongst the more common presenting disorders such as anxiety, depression and autism, although this may reflect the incomplete data provided by services for this analysis.

Capacity across the tiers is at a far lower than expected level to meet quantified need for services. Estimated capacity suggests that Tier 2 is 46% of what would be expected, Tier 3 at 53% and Tier 4 at 9% under capacity.

Equity

Age: 66% of children and young people within services are aged between 11 and 16. The higher proportions of children aged 11 to 16 compared with those aged five to 10 is in line with expectations from the 2004 national prevalence study, which found children aged 11 to 16 more likely (11.5%) than those aged five to 10 (7.7%) to experience mental health problems. Nevertheless, there may be a lower proportion of those in the younger age group within services than would be expected.

Young people aged 18 and under account for 96% of cases in services and those aged 19 and above accounted for 4%. This is in line with service descriptions with many noting offerings up to age 18, though it raises questions of how these young adults are cared for if they have not successfully transitioned to adult services.

Gender: There are likely to be proportionally fewer males than would be expected in the five-to-16 age group in services.

Ethnicity*:* The majority of service users are white and the data suggests that there are higher proportions of white young people receiving services than would be expected based on relative population proportions. The proportions of Asian/Asian British and Black / Black British service users is lower than expected, though this is partly explained by prevalence studies that indicate a lower prevalence of mental disorders compared to the white population in the five to 16 age group.

Geographical location: There are lower proportions of children and young people from Maidstone, Canterbury, Swale, Ashford and Sevenoaks districts than would be expected within the services examined based on relative population sizes, though not adjusted for deprivation.

At CCG level, there are lower proportions of children and young people from **NHS Swale and West Kent** than would be expected in services for which a breakdown of activity by CCG was available.

Evidence of What Works

Much of the evidence base and recommended interventions for managing mental health disorders in children and adolescents and prevention are obtained from National Institute for Health and Care Excellence (NICE) guidelines.

The provision of services for self-harm and anorexia, (important reasons for admission to hospital) have the potential to reduce the need for hospital admission as well as improving outcomes

It is expected that a good Child and Adolescent Mental Health Service should be able to provide care that is:

- **timely** – delivered without long (internal or external) waits for interventions appropriate to the age and needs of the child or young person;
- **effective** – sufficient numbers of staff with the right skills to be able to offer evidence-based interventions that meet the needs and goals/wishes of children, young people and families; and
- **efficient** – with a delivery model that best focuses the capacity of the service to the demands of the population.[36]

A range of sources indicate that comprehensive mental health services for children and young people should:

- cover all ages (pre-birth to 18);
- address all emotional, behavioural and mental health disorders;
- provide for children and young people with intellectual disabilities;
- work across all interfaces – education, social care, youth justice, paediatrics and child health (including acute care, community child health, primary care, substance misuse, and adult mental health);
- address all levels of severity from prevention and early intervention through to intervention for children and young people with severe and complex problems;
- support other agencies/professionals working with children and young people;
- be prepared to focus on the relationships and systems surrounding the child or young person (rather than simply taking an individual-based approach); and
- work through networks, collaboration and pathways with other agencies.[37, 38]

These mental health services will thus range from universal to highly specialist provision, and will offer a range of evidence-based treatments for the most common child and adolescent mental health problems. Services should also have arrangements in place to ensure provision of specialist interventions/services for less common problems where there may not be a sufficient critical mass of patients presenting to an individual team.[39]

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[36] JCPMH. (2013) Extract from Guidance for Commissioners of Child and Adolescent Mental Health Services.
[37] National CAMHS Support Service (2011) Better Mental Health Outcomes for Children and Young People – a directory for Commissioners.
[38] JCPMH. (2013) Extract from Guidance for Commissioners of Child and Adolescent Mental Health Services.
[39] Murphy M and Fonagy P. (2013) in CMO report https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252660/33571_2901304_CMO_Chapter_10.pdf Accessed 8 December 2014.

Mental health issues pervade many aspects of the lives of children and young people, such that dealing with these issues cannot be the sole responsibility of CAMHS workers. All professionals working with children and young people have a responsibility to help them be emotionally and mentally healthy. Sample scenarios often quoted include:

- a teacher in a primary school helping a child who is being bullied
- a youth counsellor helping a young man who is depressed and unemployed
- a GP considering if a young woman is experiencing early signs of psychosis
- a paediatrician caring for a child with diabetes whose treatment adherence is poor; or a social worker working with a child who has just been received into care.[40]

Good transition services

There is no consensus on the preferred model for an optimal transitions team, as configuration depends on local circumstances, including need, geography and the configuration of other related services. The commonly found configurations include:

- a designated stand-alone transition service
- a designated transition team within an existing adult or children and adolescent service
- designated staff trained in working with young people seconded to adult mental health service teams.

Please also see the recently published model specification for transitions from child and adolescent mental health services and related standard contract.[41][42]

[40] JCPMH. (2013) Guidance for commissioners of child and adolescent mental health services.

[41] NHS England (2015) Model Specification for Transitions from Child and Adolescent Mental Health Services http://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf. Accessed 02 February 2015.
[42] NHS England (2015) 2014/15 NHS standard contract: Model Transfer of and Discharge from Care Protocol for young people with mental health problems in transition from child and adolescent mental health services http://www.england.nhs.uk/wp-content/uploads/2015/01/mod-camhs-transt-prot.pdf Accessed 02 February 2015.

Table 13: Common and Less Common Interventions

Common interventions	Less common interventions
• treatment for ADHD including medication and psychosocial treatments • interventions for suicidality and self-harm • cognitive behavioural therapy and other evidence-based treatments for anxiety (including obsessive-compulsive disorder and social phobia) by clinicians trained to at least CYP IAPT practitioner criteria • parent training groups for oppositional and conduct disorders • family therapy including evidence-based approaches for conduct problems • cognitive behavioural therapy and interpersonal therapy for depression and medication where appropriate.	• psychodynamic psychotherapy • specialist eating disorder teams who are able to offer a range of interventions including eating disorder-focused family therapy for anorexia nervosa • dialectical behaviour therapy or other evidence-based treatment for young people who repeatedly self-harm • treatments for young people with psychoses.

Source: Murphy and Fonagy (2013)

Summary of good practice

NICE has produced a number of detailed clinical guidelines to guide intervention in mental health problems occurring in children and young people. Although there is a growing evidence-base for interventions with children and young people, there are still areas where the evidence base is scant. Where they exist the NICE Guidance is published in the full needs assessment.

Early intervention can equip children socially and emotionally to reach their full potential, and many early intervention programmes can significantly improve mental and physical health, educational attainment and employment opportunities.

NICE guidelines summarise evidence-based treatments for conduct disorders and a range of other mental health conditions in childhood. Psychosocial therapies are regarded as the mainstay of treatment for conduct disorder, considered to be both clinically and cost-effective.

Although providers in Kent offer a range of evidence-based interventions to address the mental health of children and young people, information on the exact capacity of services for each of these interventions in relation to need is not always known.
As mental health issues pervade many aspects of the lives of children and young people, all professionals working with these groups have a responsibility to help them be emotionally and mentally healthy.

Recommendations for Commissioning

Strategic planning

a Whilst developing the strategy and related delivery plans, continued priority should be given to a strategic approach that makes explicit goals for early help/intervention, prevention approaches, mental health promotion, treatment, implementation of evidenced cost effective interventions, and widening of whole family approaches and interventions.

b Ensure the voice of children and young people in Kent is heard, involved and engaged in the commissioning process.

c The different environmental context of a large county such as Kent must be taken into consideration when designing services across a whole CAMHS pathway. Tailoring services to local needs and geographies is important for joined up commissioning: particularly in strengthening NHS services.

d There will be, in most parts of Kent, future increases in people aged 0-19 and service designs need to take account of this.

e Building workforce capacity and strengthening and expanding the provision of universal services to reflect the increasing volumes and complexity of lower grade emotional, behavioural and mental health needs in the general population of children and young people is essential - particularly for tackling growing rates of self-harming behaviour.

Data and information

a This needs assessment should be updated regularly with more up to date and accurate information. This should form part of natural commissioning cycle and be planned accordingly.

b Commissioners must be clear which services are delivering outcomes to their commissioning objectives and be able to plan a path of performance indicators and outcomes that can be assessed both for performance and for assessing need. Joint agreement of these with public health analysis will vastly improve the validity of needs assessments in the future.

c To streamline future needs assessments and ensure that data is collected properly, it would be useful to have a consistent format for performance reports incorporating information fields that would aid in public health tracking of services and provision.

d New national information and guidance occurs regularly and should form part of on-going needs assessment.

Early help, vulnerable groups and equity

a The specific nature of what 'early help' services are, needs to be made explicit and commonly understood. Providers and many others who work with children and young people have a role in early intervention, mental health prevention and promotion. Providers have an important role in the early recognition of emotional and mental health issues in children and young people. The term 'early help' may mean different things to different people – ranging from universal prevention to preventing crisis. Therefore terminology must be communicated effectively.

b The incident rate for domestic abuse in Kent and nationally is increasing. This is an area that must be given greater emphasis.

c Prioritise interventions that increase resilience in children and whole families and improve parenting skills.

d Understanding the risk-taking behaviour of adolescents and linking it with wider public health services eg substance misuse and sexual health etc is important for practitioners.

e There are pockets of excellent work in Kent - however to achieve population impact many of these examples of good practice need to be commissioned at scale.

Capacity

a Consideration must be given to how capacity can be expanded in services, though this may be challenging given ongoing austerity measures. This is not a question of commissioning more of the same, but rather is an opportunity to ensure that evidence-based cost effective interventions with clear consistent outcomes monitoring are in place. It is also an opportunity to explore technological innovations in mental health care that may drive efficiencies, increase user involvement, widen access and encourage self-management by young people

b Although it can be beneficial to monitor waiting lists and waiting time targets, there needs to be a shift towards improving outcomes for specific conditions in children's and adolescents' mental health.

c Commissioners are urged to take steps to create a more seamless CAMH services. Services must be considered in order to give providers more incentive and greater flexibility to reach out into schools and families, to improve diagnosis and identification rates, and to focus on early intervention. This should be supported by a greater emphasis on commissioning for outcomes, and on specific objectives to improve the integration of care and support across health, children's services, education and housing.

d Providers need to address workforce issues and ways in which to create a comprehensive service that reaches out to the community.

e Create a commonly understood model of transition from children and adolescent services to adult mental health services which includes pathways and thresholds for referrals and eligibility criteria for adult services.

f It is imperative that preventive and management strategies, pathways and adequate resources are in place to support acute hospitals and A&E departments (including out-of-hours crisis services, paediatric liaison teams within acute hospitals, and Tier 3.5 assertive outreach teams)

Recommendations for Future Needs Assessment Work

More local information is required on the mental health needs of specific at-risk groups including BAME, homeless, lesbian, gay, bi-sexual, transgender, questioning and traveller communities. With regards to children in care, this report has focused on children in the care of Kent County; however, as it is known that many children are placed in Kent by other local authorities, this may be an area for further investigation given reports of their impact on services. Additionally, the consistently high average 'strength and difficulties scores' of Kent's looked after children require further investigation.

Further work needs to be done to understand what interventions, if any, schools are directly commissioning as well as to understand the scope and capacity of Tier 1 services and service user experiences. Greater alignment with school-based provision can be beneficial in responding to established and emergent risk factors such as bullying, cyber-bullying and harms arising from websites or online forums that normalise anorexia and self-harm.

The matter of self-harm requires further exploration. It is important that any underlying disorders or difficulties (if present) are managed, given that at least 10% repeat self-harm during the following year, with repeats being most likely in the first two or three months.[43] A local policy/protocol and implementation of relevant NICE guidelines, as well as scheduled audits of adherence to these, should be considered.

A needs assessment for maternal mental health is planned for autumn 2015.

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[43]Hawton, K. and James, A. (2005) Suicide and deliberate self harm in young people. *BMJ*, 330 (7496): 891-894.