Children and Young People's Emotional Health and Well-being in Sandwell

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Executive Summary

Background

Previous reviews (SMBC and SWB CCG, 2014) and the recent child and adolescent mental health services (CAMHS) transformation plans for Sandwell 2015/16 acknowledge that there have been challenges in meeting the emotional health and well-being needs of children and young people. Despite concerted efforts over several years, a number of issues remain unresolved.

Purpose

This health needs assessment seeks to describe the emotional health and well-being needs of children and young people in Sandwell to inform service commissioning and planning.

This health needs assessment provides a number of conclusions and recommendations, some of which are in line with the intentions of the Child and Adolescent Mental health Services (CAMHs) Transformation Plans 2015/16 for Sandwell and others that will need consideration by key stakeholders at a strategic and operational level to inform future commissioning intentions.

Local context

The needs assessment provides an analysis of the demographics of the population and forecasts for future trends. The population forecasts for Sandwell up to 2021 show an increasing number of children and young people in the age range 0 – 14 years, a decrease and then an increase in the number of young people aged 15-19 years and a decrease in the number aged 20-24 years. Sandwell has a higher proportion of 0-24 year olds from black and minority ethnic communities.

The evidence is clear that the social determinants of health such as housing, education, employment and environment, are major influences on peoples emotional health and wellbeing. Analysis of risk and protective factors for Sandwell shows that the people of Sandwell face a number of challenges related to the high levels of disadvantage when compared to the rest of England. Balancing these challenges are strong communities and a vibrant voluntary sector.

Evidence for need

When looking at the evidence for levels of emotional health and wellbeing in Sandwell, and the need for treatment and support, the strength of the evidence is variable. There is a lack of solid data and evidence for the levels of wellbeing in Sandwell. This lack of information about wellbeing is a national as well as a local problem that needs addressing.

There is better evidence for levels of poor mental health requiring care and treatment. However, much of this evidence comes from the levels of demand for services, this risks confusing demand with need. This lack of robust data is an area that will need development.

Emotional health and wellbeing in vulnerable groups is another area where more information is required. This includes women with perinatal mental health problems, people

with a learning disability, looked after children, children whose parents have mental health problems and children whose parents have a history of alcohol or substance misuse.

Anecdotally, there are reports of increasing levels of self-harm. Schools in particular are reporting increasing levels. This is important because self-harm may be an indicator for developing mental health problems and an opportunity for early intervention. However, the data on levels of self-harm, especially for lower level harm, is poor. There is potential for gathering information through better identification and data collection across partners and development of this should be a priority.

Current services

The needs assessment includes a description of services in Sandwell. However, this service mapping exercise was completed in late 2015 and therefore provides a snapshot of services at that time. Through the CAMHS transformation plan, many of these services are currently under review, re-design and re-commissioning.

The commissioning and partnership context is complex. There are a number of different statutory organisations involved in the commissioning and delivery of services, alongside voluntary sector and community based services and support. Delivery of the CAMHS transformation plan is through a partnership group, the CAMHS transformation board. This board includes representation from the commissioning organisations and other partners such as education.

The mapping of services for the needs assessment, and the review as part of the development of the CAMHS transformation plan, identified the problems that exist with current services. Although there is an agreement to move services to a Thrive model, the commissioning of current services is through a tiered model and the needs assessment reflects this approach.

- A lack of investment in services at all levels and a need to move investment from acute to prevention based services to ensure long-term sustainability
- A lack of robust data and information on levels of need
- A lack of robust data on the performance and delivery of outcomes from commissioned services
- A lack of data and information for vulnerable groups and from the services for these groups
- A lack of clear pathways into services and between services, fragmented services that are difficult to navigate
- Difficulties in transition between services for children and young people and services for adults
- Long waiting times for assessment and treatment, especially for tier 3 and tier 4 services
- Limited availability of services for people needing lower levels of support. This has meant children and young people being referred into more intensive services when they could have been supported at a lower level.
- Significant gaps in services for pre-school children and their families. This misses an opportunity for early intervention to prevent later problems.
- Potential duplication of services resulting in poor use of the available resources

- A shortage of tier 4 in-patient beds for children and young people needing the highest levels of support

Child and Adolescent Mental Health Services (CAMHS)

The needs assessment contains a service mapping and overview of CAMHS services in Sandwell. However, since the services were mapped in late 2015 there have been substantial changes through implementation of the CAMHS transformation plan. Under the previous service model, there were challenges in obtaining performance and outcomes data. Through delivery of the CAMHS transformation plan there is now robust performance monitoring and measuring of outcomes. However, due to the relatively short time the services have been in place it is too early to report outcomes and assess the effectiveness of these services.

Evidence, policy and guidance

The needs assessment summarises the evidence for improving the emotional health and wellbeing of children and young people. This includes guidance from NICE and a range of other relevant evidence.

It also describes the current policy context. The main national policy document is 'Future in Mind'. This states that local areas should move towards a single commissioner model for emotional health and wellbeing services for children and young people. This should include the local development of pooled budgets. The policy document also advocates that commissioning moves away from traditional tiered models of service to an approach that addresses the needs of the individual and their family, for example, the thrive model.

Future model for services

This needs assessment has shown that the current picture of services and support is complex. The links between, and pathways through, services are not clear. Transitions between services, especially between children's and adult services, are an area of major challenge.

Currently, there is a disproportionate investment in treatment services. While the provision of treatment for people experiencing mental illness is essential, it is as important to ensure that there is investment in preventative services to keep people healthy. For services to be sustainable in the long-term, it is essential that there is a reduction in the demand for services. This will need comprehensive preventative and emotional wellbeing approaches, including providing support for children and young people and building life skills and resilience. Young people who are resilient are better able to respond to stress and are less likely to develop anxiety and depression.

Emotional health and wellbeing is complex with a wide range of determinants and influences. A person's social context is central to promoting mental health and wellbeing or providing support for mental illness. As well as helping young people deal with better with stress, it is essential that the causes of stress and inequality are also tackled. This will include tackling the social determinants of mental health.

The mental wellbeing of parents affects the wellbeing of children and this can have a generational influence. Improving mental wellbeing or treating mental illness therefore requires an approach that considers the needs of the whole family through a joined up, family based approach to mental health promotion and mental illness prevention and treatment

Much importance is placed on the transition between adults and children's services to ensure that children in a vulnerable state are not moving onto adult services at a time in their life when they are also adjusting to other major changes e.g. in education, employment or housing. The proposed joined up approach would enable a young person to access the best service to suit their needs. Such an approach would provide a better service for the young person and alleviate potential pressures on adult services by preventing young adults from deteriorating and requiring support that is more intensive.

Adults suffering from mental health disorders have children who are at higher risk of developing mental health and well-being problems. Joined up mental health services involving children and adults would make it easier to identify 'vulnerable' children of those with a mental health disorder which would enable the delivery of targeted preventative support and services for those children affected e.g. to build resilience and coping skills.

Similarly, children accessing mental health and well-being services as a result of behaviour difficulties at school, may well have parents who have mental health and well-being problems. These parents may not be known to adult mental health services and could then be provided with support and specialist help as appropriate.

Mental health and wellbeing is also an important influence on physical health and wellbeing. National policy including No Health without Mental Health, the NHS Five Year Forward View and publications on Parity of Esteem identify this as a priority. Improving mental health and wellbeing will contribute to improving the physical health of the population. This will reduce the overall demand on health and social care services.

There is agreement that Sandwell will move towards a model that provides services for the age range 0 – 25 years. There is also agreement that this is a first step towards developing a fully integrated, all age approach, based on the Thrive model, which covers all services and provides flexible support as needed by children, young people and their families.

The adoption of this life course based commissioning model across all age bands, based on the Thrive model, will enable joined up family based approaches. This will tackle mental health problems in both adults and children and reduce demand across health, social care and wider services.

Recommendations

Principles

- Children, young people and their families must be fully involved throughout the review, re-design, commissioning and evaluation of services. All partners to work towards a co-design / co-production approach.
- All commissioning and services must be evidence based and effective. Where the evidence base is weak, we must ensure that robust evaluation is in place to build the evidence base.
- Focus on the reduction of inequalities; make sure that everyone has equal access to information and to services. Assess all services, as part of the commissioning process, to make sure they provide equal access to all sections of the population and will reduce inequalities in health and health outcomes.
- Early identification of people at risk of, or experiencing, mental health problems must be a priority across all partners.
- People must have rapid access to the support and treatment they need as soon as they need it. All partners need to reduce substantially the waiting times for access to assessment and treatment.

1. **Vision and strategy**
   a. Identify capacity and resources to develop a clear partnership vision and joint commissioning strategy for promoting emotional wellbeing and supporting people with mental health problems. This must describe how all partners will align commissioning and services to move to 0-25 years model and then to all age, all services commissioning based on the thrive model.
   b. The partnership strategy must address the current fragmentation of services and ensure that there are clear pathways through services and across the whole life course.

2. **Commissioning**
   a. Agree a collaborative commissioning approach across all partners. Within 2 years move to a pooled budget, lead commissioner model to commission a single, all age service covering the full range of services from prevention to intensive support.
   b. Analysis of service use by ethnicity, age and geographical area must be a priority in the future development of services and must inform future commissioning decisions.
   c. Review all current investment across partners with a comprehensive review of the outcomes delivered by all services. Identify how investment in mental health and wellbeing services will increase in line with parity of esteem with physical health services.

d. Identify how the balance of investment will change to reduce investment in intensive services and increase investment in prevention and early intervention.

e. Agree outcome measures across partners and with providers to enable robust evaluation of effectiveness and value for money for all services.

f. Audits of services for compliance with NICE guidance should be an integral part of the review of current services and the commissioning of new services.

3. **Data and information**

a. Ensure data collection is included in the development of a partnership strategy and joint commissioning plan. Develop data sharing agreements and systems between partners to support the pooled budget, lead commissioner model and development of an all age, all services model.

b. Agree a single measure for monitoring wellbeing that all partners will include in all relevant commissioning. This will allow measurement of a baseline and monitoring of change over time. The whole school approach is using the Stirling Measure, this may be applicable across a wider range of services.

c. Improve data collection from current services to allow evaluation of effectiveness and delivery of outcomes. This will support monitoring of waiting times for access to services and treatment, flows through, and transitions between services.

d. Develop data collection for specific priority areas. This must include self-harm, including low level self-harm that does not result in hospital admission. It must also include monitoring of wellbeing and emotional health for pre-school children and their families.

e. Undertake a population level survey to establish a baseline measurement of population emotional wellbeing and mental health. The survey design should include a specific, age stratified, sample for children and young people. A sample of 15 year olds would allow comparison with the national young person's wellbeing survey.

4. **Training**

a. Map all current training across universal, targeted and specialist services to identify gaps and duplications. This must cover purpose, audience, scope and a review of any existing evaluations of the training.

b. Based on the outcomes from the CAMHS transformation plan, and on the partnership commissioning strategy as it develops, develop standard competencies for staff operating at the different levels of service.

c. Develop a partnership training strategy to ensure staff have the necessary competencies to deliver the partnership outcomes.

d. Align commissioning of training, with a move towards co-commissioning of training across all partners.

5. **Pre-school**
    a. Review current support for women in the perinatal period and develop an evidence based service offer based on the NICE guidelines. Delivery of this offer will need to be included within the commissioning and delivery of maternity services and health visiting services.
    b. The needs assessment has identified a lack of services for pre-school children and their families. Undertake a comprehensive review of the needs of this population, including a review of current services.
    c. Consider expansion of parenting programmes to meet needs of specific groups of parents e.g. parents of those with learning disabilities. Commissioners and providers need to ensure availability of evidence based parenting interventions for those with mental health disorders e.g. conduct disorder.

6. **Specific service developments**
    a. Ensure robust evaluation of current service developments that will influence the development of a partnership commissioning strategy
        i. Whole school approach: evaluate and consider expansion into secondary schools.
        ii. Primary mental health workers
        iii. Re-commissioning of tier1 / 2 provision by SMBC Children's Directorate
        iv. Development of CAMHS services including home treatment and place of safety
    b. Work with schools to ensure that the wellbeing and mental health services they commission are evidence based and evaluated for effectiveness. Where possible standardise the service offer between schools.

7. **Areas for further investigation**

The needs assessment has identified areas where further in-depth investigation is required;
    a. Learning disability, autism and ADHD
    b. Self-harm, establish local approaches to gather data about the level of self-harm, especially in schools. Work with young people to gain insight into the motivations and influences around self-harm. Develop evidence based interventions to reduce self-harm and to support those who are harming.

Needs Assessment – Children and Young People's Emotional Health and Well-being in Sandwell

1. Introduction

Purpose

The purpose of this Health Needs Assessment (HNA) is to describe the emotional health and well-being needs of children and young people in Sandwell to inform service commissioning. In particular:

- Commissioning interventions that will improve emotional health and well-being and support early intervention
- Commissioning services for those with common and complex mental health problems

HNA Objectives

- Identify levels of need
- Describe how we are addressing this need in Sandwell and identification of gaps in provision
- An overview of the relevant evidence and guidance
- Consideration of how we might meet the needs of this group more effectively.

Definitions of emotional health and well-being

For the purposes of this needs assessment the definitions used come from the Joint Commissioning Panel for Mental Health (2013)[1] and from NICE:

Social and emotional wellbeing - Happiness, confidence and not feeling depressed (emotional wellbeing) a feeling of autonomy and control over one's life, problem-solving skills, resilience, attentiveness and a sense of involvement with others (psychological wellbeing) the ability to have good relationships with others and to avoid disruptive behaviour, delinquency, violence or bullying (social wellbeing). (NICE, 2009a)

Resilience – the capacity to bounce back from adversity. Protective factors increase resilience, whereas risk factors increase vulnerability. Resilient individuals, families and communities are more able to deal with difficulties and adversities that those with less resilience. (UCL Institute of Health Equity 2014)

Mental health and wellbeing – this refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships.

Mental illness – this refers to depression and anxiety (which can also referred to as 'common mental health disorder') as well as schizophrenia and bipolar disorder (which can also referred to as 'severe and enduring mental illness')

Mental disorder – this includes mental illnesses as well as personality disorder and alcohol and drug dependency

Framework for mental health and wellbeing services

Mental health services have been organised through a framework based on tiered levels of response to need. This framework usually includes four tiers as shown below.

Tier 1: universal provision, working with all children
Tier 2: early intervention/targeted provision
Tier 3: specialist provision for those with complex needs
Tier 4: highly specialist provision
(The Child and Adolescent Service (CAMHS) categorisation of Tiers 1- 4)[2].

An additional tier, tier 0, can also be included to cover primary prevention and the promotion of population wellbeing.

Recently criticisms of the tiered model have argued that it has led to a system of care defined in terms of the services provided. There has been a move towards models based more on the needs of individuals and communities 'Future in Mind', the Department of Health vision for mental health services for children and young people, advocates for local areas to adopt this approach[3].

In line with this aspiration, the Sandwell CAMHS Transformation Plan 2014/15 includes the adoption of the Thrive model. The Thrive defines four areas of support based on people's needs rather than on the services provided.

- Coping
- Getting help
- Getting more help
- Getting risk support

2. The determinants of mental health and wellbeing

This section will provide a brief overview of the determinants of mental health and wellbeing. Within the narrative, there are references that provide more detailed information and discussion.

The social, economic and physical environments in which people live have a strong influence on their mental health and wellbeing; these are the social determinants of health. The World Health Organisation report "Social Determinants of Mental Health" provides a detailed examination of this topic[4].

The independent Foresight Mental Capital and Wellbeing Project Final Report states that;

An individual's mental capital and mental wellbeing crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion, and our prosperity.[5]

At all stages of life, the risk factors for common mental health disorders are strongly associated with poverty and disadvantage. The relationship with mental wellbeing is less clear, wellbeing is more strongly associated with education and the quality of social relationships. Poor mental health and wellbeing in childhood is negatively associated with many adult health outcomes, including poor adult mental health, higher rates of alcohol and substance misuse and an increased risk of suicide[6].

- 27.6% of Children (under 16) in Sandwell live in low-income households (compared to 18.6% nationally and 21.5% regionally).

Antenatally, important determinants are maternal stress, diet and smoking status. Similar concerns exist in relation to mothers using illegal substances and abusing alcohol.

For children, their experiences in their first two years of life can have a life-long effect on their mental health and wellbeing. Research into the impact of adverse childhood experiences has highlighted how important this influence can be. There is a growing body of evidence that experiences during this time affect brain development and can affect how resilient children and adults are in response to stress.

Being in care when young is also a determinant of adult mental health, such as levels of antisocial behaviour, emotional instability and psychosis.

- 69.5 out of every 10,000 children in Sandwell are in local authority care, lower than the national average of 60.0/10,000, and lower than the West Midlands average of 74.5/10,000.

Bullying in childhood is an important influence on mental health and wellbeing as an adult[7]. Children and young people in Sandwell have identified this as an important factor in their mental health and wellbeing. Existing and developing services recognise this and it is a component of the 'Whole School Approach' initiative. This programme is working with schools to support them in gaining a Wellbeing Charter Mark. Schools have to demonstrate that they are taking a school wide approach to supporting wellbeing and building resilience in children and young people, including tackling bullying.

Teenage pregnancy is a risk factor for poor mental health outcomes. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers.
- In children aged 13-15, the annual rate of conception is 8.2 per 1000 females, higher than the national rate of 4.4 and the regional rate of 5.2.

- In children aged 15-17, the annual rate of conception is 38.3 per 1000 females, higher than the national rate of 22.8 and the regional rate of 26.5.

Parental mental illness is a risk factor for childhood mental illness, with children of mothers with mental ill health being five times more likely to have a mental disorder[8].
- There are 108.3 parents attending treatment for substance misuse for every 100,000 children in Sandwell. This is on par with the national rate of 110.4.
- There are 63.2 parents attending treatment for alcohol misuse for every 100,000 children in Sandwell. This is significantly lower than the national rate of 147.2.

The quality of parenting is a key determinant. A priority must be to enable families to provide the best possible family, social and physical environments for their children. This includes good quality housing, poor housing is a key factor associated with children's mental health and wellbeing. This also includes provision of parenting support for families, supporting parents with gaining and maintaining employment and supporting families facing debt.

Family conflict and breakdown is a risk factor for poor mental health and wellbeing. In Sandwell, the proportion of people who are separated or divorced, at 11.2%, is comparable with similar areas (12% in statistical neighbour areas). Single parent households make up 9.0% of Sandwell households, compared to 7.1% nationally and 7.5% regionally.

For children and young people, vulnerable groups that need consideration in commissioning, and who may require additional support include;
- Children with learning disabilities
- Looked after children
- Children whose parents have mental health problems
- Children whose parents have a history of alcohol or substance misuse

For adults there is a gender difference in the prevalence of common mental health disorders, women tend to have higher levels than men do across the social gradient. Other risk factors for poor mental health are household income, low educational attainment, unemployment, and material disadvantage, such as poor housing.

Poor physical health is also a risk factor for poor mental health, though this is a two-way relationship. People with poor mental health are more likely to experience poverty and disadvantage and to have unhealthy lifestyles that are themselves major risk factors for poor physical health. For older people these same risk factors apply, along with additional factors associated with older age such as increased social isolation and increased levels of poor physical health and disability.

For people in areas already experiencing high levels of disadvantage, such as Sandwell, the impact of national economic challenges, recent changes to welfare support and reductions in funding for local authorities have exacerbated existing problems. This significantly increases the risks of poor mental health and wellbeing for the population.

Early identification and access to services

A common theme that emerges from the literature is the importance of early identification of people at risk of, or who are starting to experience, mental health problems. Early intervention and prevention, improves quality of life, life expectancy, educational achievement, productivity and economic outcomes. It reduces violence, antisocial behaviour and crime[9]

As well as early identification, it is essential that people have rapid access to the right support and services. In both No Health Without Mental Health and Future in Mind, the message is clear that delays in access to services can exacerbate mental health problems and make them more difficult to manage or treat[10,3]. Long waiting times into services can allow mental health problems to become more established. Treatment can be more difficult and may not be as effective. This can harm the long-term mental health of the individual and their family.

Early identification and rapid access to the relevant services must therefore be a priority in all commissioning and in the delivery of all services.

3. Policy and Guidance

National Policy

The following summaries of policy and guidance are restricted to specific policies that will have a direct impact on the commissioning of health and social care services. It is recognised that all government and wider policy can potentially have an impact on mental health and wellbeing.

No health without mental health: delivering better mental health outcomes for people of all ages.
Department of Health (2011)

This policy document outlines the governments overall approach to improving mental health outcomes. It describes the government's key pledges. It also explains how public sector reform will transform public mental health and mental health services. It has six main objectives and, along with an implementation plan, describes the roles of health, social care, wider local government (including housing and education) and wider stakeholders in delivery of these objectives.

i. More people will have good mental health
ii. More people with mental health problems will recover
iii. More people with mental health problems will have good physical health
iv. More people will have a positive experience of care and support
v. Fewer people will experience stigma and discrimination

The report also includes a commitment to develop intelligence about mental health and wellbeing and the measurement of outcomes including the development of a national mental health dashboard.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf

Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing.
NHS England (2015)

The Children and Young People's Mental Health and Wellbeing Taskforce was established in 2014 to look at how to make it easier for children, young people, parents and carers to access the support and care they need and improve the commissioning of services. The report is structured around five main themes based on the findings of the taskforce.

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

The taskforce found that current services are fragmented with a lack of coordination. The report calls for local areas to agree a coordinated approach and recommends a lead commissioner approach with a single pooled budget and much closer multi-agency working.

The report also includes a commitment to improve intelligence about mental health and wellbeing and the development of a CAMHS minimum dataset.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Closing the Gap: priorities for essential change in mental health.

Department of Health (2014)

Closing the Gap sets out the challenge that, although progress is being made, much more needs to happen to achieve the objectives set in No Health Without Mental Health. It identifies twenty-five areas of mental health care and support where there need to be tangible changes within the next two years. These areas are grouped into four themes.
- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems

Commitments within the report include improving information and intelligence around mental health, involving people in their own care, improved management of mental health crisis and increased integrated working. The report also covers the role of wider stakeholders including criminal justice and schools and supporting people with mental health problems to gain and maintain employment.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

The five year forward view for mental health

Independent Mental Health Taskforce report to NHS England (2016)

This report sets out the start of a ten-year transformation to the approach to preventing and treating mental health problems. It makes recommendations about what the NHS needs to do to achieve parity of esteem between mental and physical health for the whole population.
- A 7 day NHS
- An integrated mental and physical mental health approach
- Promoting good mental health and preventing poor mental health

The report then makes recommendations about where wider action is needed in relation to housing, jobs and social networks. Mental health problems disproportionately affect people living in poverty, people who are unemployed and who already face discrimination. The report has a particular focus on tackling these inequalities.

Mental health crisis care concordat: improving outcomes for people experiencing mental health crisis.

HM Government (2014)

The Mental Health Crisis Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work

together better to make sure that people get the help they need when they are having a mental health crisis. The concordat is arranged around;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crisis

Local areas are required to develop a local crisis care concordat agreed by relevant local organisations. In Sandwell the concordat has been co-produced with the Sandwell Mental Health Parliament and is overseen by the health and wellbeing board.
http://www.crisiscareconcordat.org.uk/

Local transformation plans for children and young people's mental health and wellbeing: guidance and support for local areas.

NHS England (2015)
This document provides guidance for local areas - CCGs, working closely with their Health and Wellbeing Boards and partners from across the NHS (including NHS England Specialised Commissioning), Public Health, Local Authority, Youth Justice and Education sectors - on the development of Local Transformation Plans to support improvements in children and young people's mental health and wellbeing.
http://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf

New Horizons – confident communities, brighter futures: a framework for developing well-being.

HM Government (2010)
This document describes the government's vision for improving the mental health and wellbeing of the population as a whole.

- Use a life course approach to ensure a positive start in life and healthy adult and older years.
- Build strength, safety and resilience: address inequalities and ensure safety and security at individual, relationship, community and environmental levels.
- Develop sustainable, connected communities: create socially inclusive communities that promote social networks and environmental engagement.
- Integrate physical and mental health: develop a holistic view of well-being that encompasses both physical and mental health, reduce health-risk behaviour and promote physical activity.
- Promote purpose and participation to enhance positive well-being through a balance of physical and mental activity, relaxation, generating a positive outlook, creativity and purposeful community activity

Local Policy

The Sandwell Early Help Strategy

This strategy sets a direction for the protection of children in Sandwell. The main aspects of the strategy are; the need to work together within one system, working with our communities and transferring skills and capacities to our communities

The strategy defines the term 'Early Help' as;

- As a single term without distinction between 'Early Help', 'Early Intervention' and 'Prevention' and 'integrating services', used by all staff across all partners;
- To define this as services for, and an approach to working with, children and families who are below the threshold of social care intervention, but require a multi-agency approach that stops problems emerging and supports families to improve their situation;
- To define the clear link between social care services and our Early Help provision so as to ensure that access to specialist advice and support is simple and clear, enabling all staff to manage risk appropriately.
- To include all of the partners involved in this strategy.

The overall aim for the strategy is to enable families to successfully help themselves without the need for support from the council or other external support. The children and families of Sandwell are at the centre of the strategy.

- Ensuring that our universal services, which all families can use to help build resilience and develop skills they require to meet the needs of their children;
- Ensuring our Early Help offer maintains strong links with more targeted services;
- Encouraging and enabling families to help themselves through the provision of effective information, and developing the capability of communities to support families without the need for intervention;
- Maintaining high quality systems and skilled and supported workforces capable of identifying families that need support as early as possible; with effective signposting and referral pathways to targeted services that can help them;
- Understanding needs at a community level in order to commission and provide the right services and interventions to achieve key target outcomes;
- A multi-agency approach which unites provision around families and ensures professionals understand thresholds and have an awareness of the families in the system;
- A clear and accessible link is in place between our social care services and Early Help offer, so that practitioners can access social care advice and guidance to ensure we effectively manage risk and protection for children;
- Wherever possible, our services will work in smaller neighbourhood localities to build networks of support and what support is available;
- Engaging with children and families, using their views to shape the service offer and the way we work with them;
- A rigorous focus on the quality and impact of our services which are continuously monitored;
- Using public money in the best way and, where necessary, re-investing in Early Help.

Child and Adolescent Mental Health Services Transformation Plan

In August 2015 NHS England advised clinical commissioning groups to develop local CAMHS transformation plans, to be agreed and endorsed by the local health and wellbeing board. The Sandwell health and wellbeing board agreed the plan in November 2015.

This plan collates intelligence on local need and information on current investment and service provision. This includes an analysis of how services are delivering and where there are challenges and gaps in service.

The plan describes the partnership ambition to move away from a traditional tiered approach to CAMHS provision, using the 'Thrive Model' as a key driver for the transformation of services. The ambition is to move towards a 0-25 service as part of a longer-term move towards an all age, all service level approach. The components of the model are;
- Preventing
- Coping
- Getting help
- Getting more help

Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Local areas are required to develop a local crisis care concordat. Sandwell and West Birmingham CCG are leading on the development of the Sandwell crisis care concordat on behalf of the health and wellbeing board. A partnership planning group is in place and the work is informed by a co-produced plan developed with the third sector through the Sandwell Mental Health Parliament.

Joint Health and Wellbeing Strategy

The Sandwell Health and Wellbeing Board agreed, in consultation with local people and stakeholders, five new priorities for the next five years. These have been included within a new Joint Health and Wellbeing Strategy (JHWS), which the health and wellbeing board endorsed in March 2016. The main priority for the board is to increase healthy life expectancy in Sandwell. This recognises that the main influences on healthy life expectancy are people's lifestyle choices, and that these choices are heavily influenced, and constrained, by people's emotional health and wellbeing and the social determinants of health.

The refreshed Joint Health and Wellbeing Strategy will provide a clear partnership strategy for how all partners will work together to improve the emotional health and wellbeing of people of all ages in Sandwell. It will provide a framework for improving wider health and wellbeing and reducing the gap in healthy life expectancy.

Comprehensive Review of Emotional Health and Wellbeing for Children and Young People (2014)

This aim of this report is to review all services in Sandwell, aimed at: promoting emotional wellbeing and resilience amongst children and young people; offering support to those at risk of mental ill health and the treatment of children and young people who experience mental ill health. This review considered the service available across all tiers, for early years,

20

school aged children and young adults and those with specific needs. The document draws on two previous reviews, carried out in 2007 and 2012.

An assessment of the recommendations from the review has identified progress since 2014 and areas where more action is required.

A number of the recommendations related to the development of a partnership vision and strategy for improving CAMHS services. This included agreeing a partnership vision, strategy and improvement plan, including reviewing current investment. The recommendations also included establishing appropriate governance arrangements with the health and wellbeing board overseeing delivery. The production of a CAMHS transformation plan and the establishment of a partnership CAMHS transformation board are addressing these recommendations. The CAMHS transformation board reports to the health and wellbeing board.

The CAMHS transformation plan includes integration of services across partner organisations. The commissioning of primary mental health workers by SMBC aims to align services across health, social care, the multi-agency safeguarding hub and community operating groups.

In line with the recommendations in the report, there is now agreement to a move to a CAMHS service that meets the needs of clients up to the age of 25 years.

- The report included recommendations regarding improvement in Black Country Partnership Foundation Trust (BCPFT) services. These service improvements are included within the work of the CAMHS transformation board and through provider development.

Further work is needed to fully deliver these service improvements.

- The report made recommendations regarding increasing the investment in emotional wellbeing and mental health services. A review of the level of Investment is part of the work of the CAMHS transformation board. Additional money from national funding sources is supporting development of CAMHS services. There has been investment in the Whole School Approach to support young people's resilience.

Further work is needed to understand how the balance of investment between prevention and acute services can be changed to support more prevention services.

- The report recommended investment in antenatal programmes, there is work underway to develop pilot programmes and wider antenatal provision. Health visitors are providing antenatal visits to families.

- The report recommends improved engagement with service users and parents in the development of services. This is part of the CAMHS transformation plan and is being built into service development.

- The report recommends an assessment of the emotional health and wellbeing needs of new migrants. A joint strategic needs assessment of migrant health is planned for 2016/17.

Under development

Joint Strategic Needs Assessment Chapters
- Emotional Health and Wellbeing Health Needs Assessment for Children and Young People (April 2016)
- 0-4 year olds Health Needs Assessment (Publication in January 2016)
- Adult mental health needs assessment (Working draft in September 2016)

Wider Policy

There are wider policy documents that do not specifically relate to mental health but which will have a significant influence on the future commissioning of services.

Five year forward view

NHS England (2014). http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The Care Act 2014

The Stationary Office.
http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

4. Local context- descriptive epidemiology

Scope

- 0-25 years (where data is available)
- Sandwell children and adolescents and their families
- Emotional health and well-being including learning disability
- Tier 1-4 emotional health and well-being and mental health services (or universal, targeted or specialist)

0-25 Years Population

The proportion of people in Sandwell aged 0-25 years is 34.9% of the population. This is higher than the average for England (31.8%)

In Sandwell in 2014 the population estimates were;
- 73,592 people aged 0-16,
- 81,744 aged 0-18,
- 110,403 aged 0-25.

Source: Office for National Statistics 2014- Mid-year population estimates.

Chart 1 shows the predictions for population change up to 2021. The number of young people aged 0-24 in 2014 was 105,992 (51,474 males, 54,518 females). By 2021, the predicted population of 0-24 year olds increases to 111,000 (57,000 males, 55,000 females).

The forecast is that the population in all the five-year age bands up to aged 19 will increase. For the 19-24 age band the prediction is for a reduction in population by 1,147 people. This increase in the numbers of young people will influence the planning for future demand for Child and Adolescent Mental Health Services (CAMHS) over the next five years.

Chart 1: Young Person Population Estimates 2011-21

Estimated Number of People By Five Year Band-Sandwell 2011-21
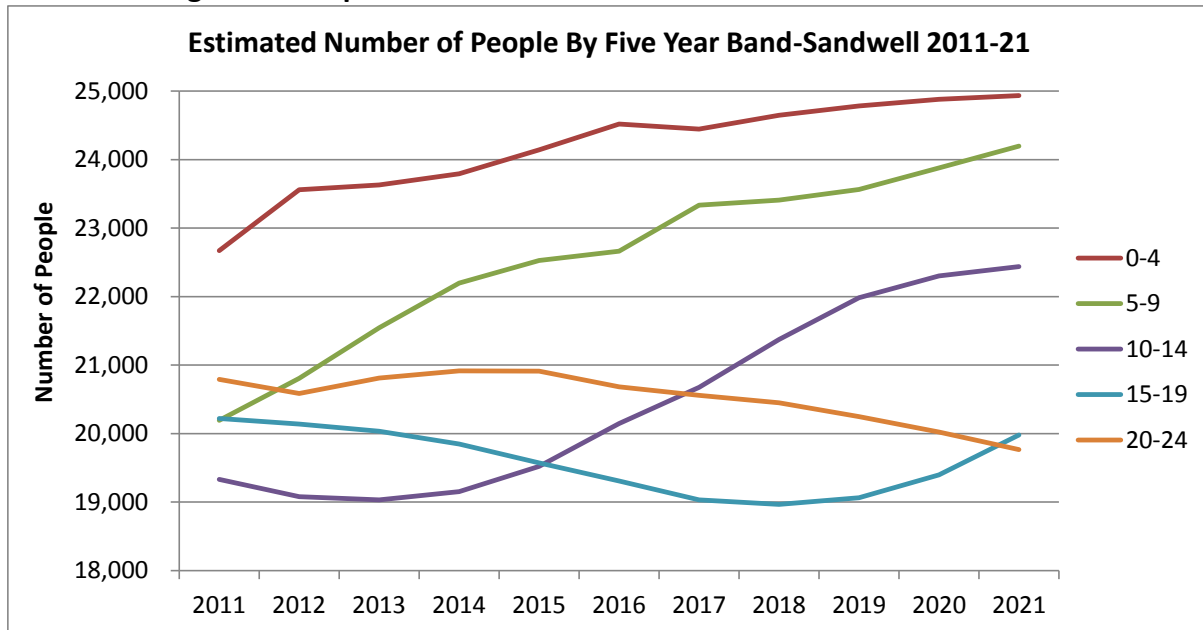
Source: Office for National Statistics (ONS) Census 2011 Table QS103EW and ONS Subnational Population Projections, 2012-based projections

Ethnicity of young people in Sandwell

Chart 2 Ethnicity of young people in Sandwell

Proportion of Sandwell 0-24 Year Old Population By Ethnicity
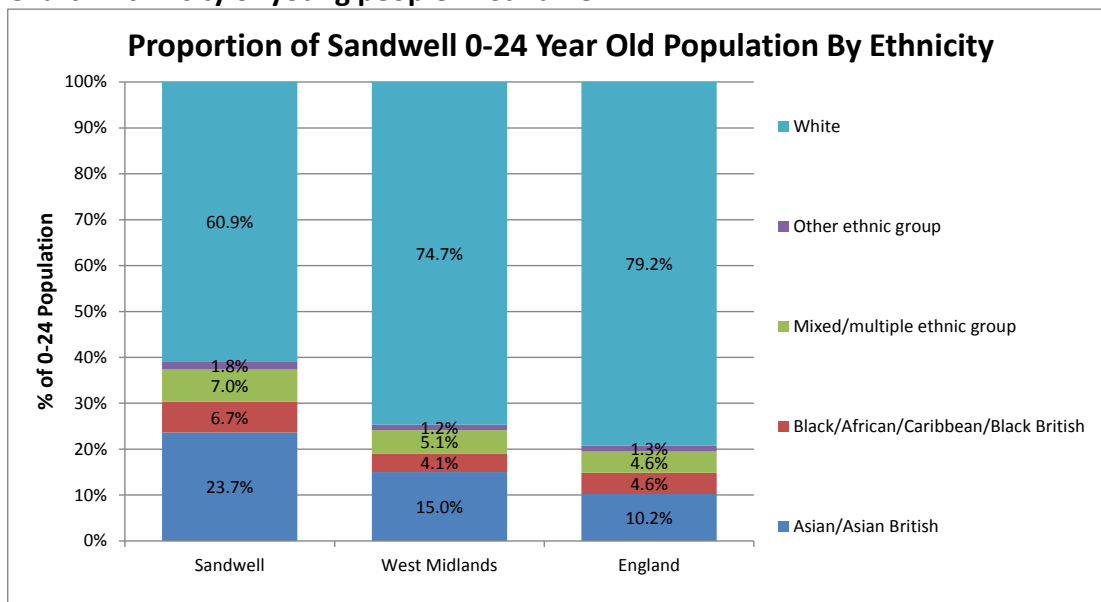
Source: derived from ONS 2011 Census

As shown in chart 2, Sandwell has a higher proportion of 0-24 year olds from the black and minority ethnic (BME) community (39.1%) than both the West Midlands region (25.3%) and England (20.8%). In the 0-24 age group in the 2011 census in Sandwell there were:-

- 24,417- Asian/Asian British
- 6,898- Black/African/Caribbean/Black British

- 7,233- Mixed/multiple ethnic group
- 1,843- Other ethnic group

There is considerable variation by area within Sandwell, as shown in the chart below. This shows a breakdown of ethnicity by Community Operating Groups (COGs). The COGs operate at a town level within Sandwell. The figure shows that Smethwick has the highest proportion of young people from BME backgrounds; collectively they make up the majority of the population in this town and nearly half of the population in West Bromwich Central.

Chart 3: Age 0-24 Ethnicity by Community Operating Groups

Community Operating Groups - Ethnicity (Ages 0-24)
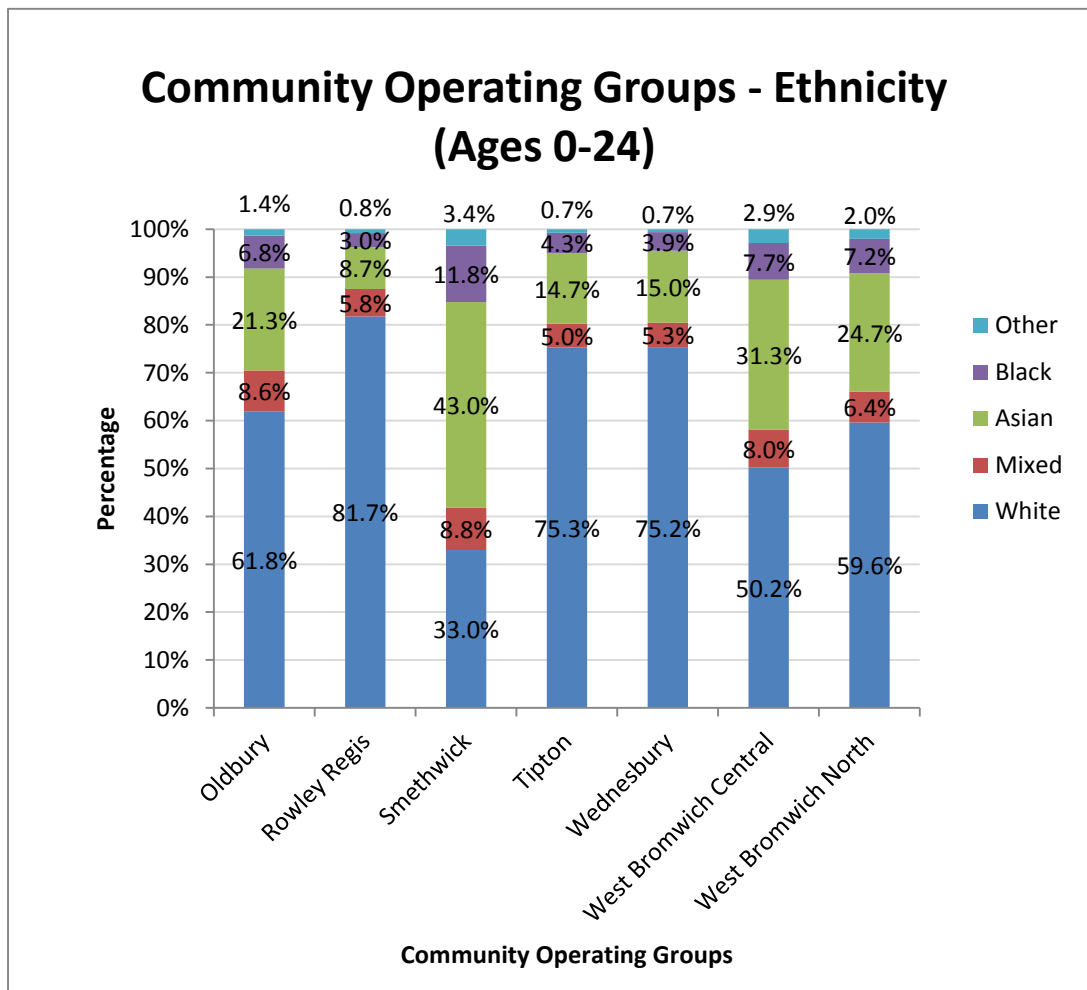
Source: Office for National Statistics (ONS) Census 2011 data

Equity of access to services by ethnicity

Nationally, there is robust evidence that there is under and over representation of different ethnicities in services. The Joint Commissioning Panel for Mental Health has published guidance for commissioners on addressing these inequities[11]

This guidance demonstrates that people from BME communities face multiple challenges in accessing mental health and wellbeing services. They experience adverse experiences and

negative outcomes within mental health care compared to the majority population in relation to;

- Inequalities
- Access
- Experience of care
- Within BME group differences
- Between BME group differences[11]

Data on the ethnicity of people in services in Sandwell is limited. For emotional wellbeing services (SHIELD), there is some data on ethnicity. However, this is limited and has a high proportion of 'not known'. It is not possible to draw clear conclusions, but the available data would suggest that people from Asian and Black African backgrounds are under-represented in the services.

Data on the ethnicity of people in CAMHS services is not currently available due to limitations in data collection from the previous services. Implementation of the CAMHS transformation plan includes substantial improvements in data collection and monitoring. This will allow for analysis of the ethnicity of people in services in the future.

Commissioners have a legal duty to ensure equitable access to services across the whole population[11]. With the current available data, this cannot be assured. Analysis of service use by ethnicity, age and geographical area must be a priority in the future development of services and must inform future commissioning decisions.

Local Levels of risk and protective factors for well-being

There are a number of risk and protective factors for well-being. Risk factors linked with poor well-being include genetic and early environmental factors as well as deprivation, health risk behaviour (e.g. alcohol, smoking) as well as being a member of a group at greater risk of poor well-being[1].

Protective factors for well-being include living environment, education and emotional and social skills as well as resilience, which can help safeguard mental well-being at times of adversity.

The English Indices of Deprivation provides a deprivation score (the result of the weighted calculations of the indicators) which can be ranked. The latest indices were released in September 2015 and Sandwell was ranked the 13th most deprived Local Authority out of 326 (from being ranked 12th in the 2010 indices) and so deprivation remains a major concern in Sandwell.

Table 1: *Proportion of Sandwell LSOAs in worst deciles nationally*

	2007	**2010**	**2015**
Worst 10%	29.4%	30.5%	22.6%
Worst 10-20%	29.9%	28.3%	32.3%
Worst 20-30%	16.6%	16.0%	17.7%
Worst 30-40%	5.9%	7.0%	5.9%
Worst 40%	81.8%	81.8%	78.5%

Source: Derived from the English Indices of Deprivation 2007, 2010 and 2015

Deprivation varies across Sandwell, there are186 Lower Super Output Areas (LSOA). Deprivation remains high across much of Sandwell but it is positive that there has been some relative improvement in deprivation levels with the proportion of LSOA in the worst 40% in England falling from 81.8% in 2007 and 2010 to 78.5% in 2015. Deprivation is likely to have an adverse impact on families and children and lead to an increased prevalence of emotional and behavioural problems in children.

Poor levels of educational attainment in Sandwell are a cause for concern.
For example in 2014, 50.7% of Pupils in Sandwell achieved 5+ A*-C GCSEs (or equivalent) including English and maths compared to 53.4% for England **Source:** Department for Education.

Local Levels of risk factors for mental disorder and poor well-being

Risk factors for mental disorder and poor wellbeing include children living in poverty, parental factors such as children in lone parent families, children of parents with a mental health disorder and maternal smoking.[1]

It is estimated that in 2012 there were 21,830 children and young people (all dependent children under 20) in poverty in Sandwell, a rate of 27.6% compared to 21.1% for the West Midlands Government Office Region and 18.6% for England **Source:** HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics).

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Table 2: Prevalence of risk factors for mental disorders amongst children.

Great Britain-Prevalence of Child Mental Health Disorders		The picture in Sandwell
High Prevalence	**Low Prevalence**	**The picture in Sandwell**
Lone parent families 15% e.g. 15% of children in Lone parent families have mental health disorders	Two parent family 8% e.g. 8% of children in Lone parent families have mental health disorders	In Sandwell 32.8% of families with Dependent Children were Lone Parents and 67.2% Couples compared to 28.7% and 71.3% for England rate respectively **Source:** ONS 2011 Census Table DC1114EW
No parental educational qualifications 17.0%	Parents with a degree 4.4%	19.2% of the Sandwell working age (16-64) population have no formal qualifications compared to 8.6% in England. 21.6% of the Sandwell working age (16-64) population have NVQ4+ (which includes degrees) compared to 35.7% in England. **Source:** ONS Annual Population Survey (APS) 2014
Neither parent working 20%	Both parents work 8%	In 2012 27.6% of all dependent children under 20 live in poverty in Sandwell- England 18.6% **Source:** HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)
Gross household income less than £100 per week 16%	More than £600 per week 5%	Median Weekly Gross Full time worker earnings in Sandwell was £430.60 a week compared to £523.60 in England. **Source:** ONS Annual Survey of Hours and Earnings - Resident Analysis-2014
Someone in house receives disability benefit 24%	No one receives disability benefit 8%	Sandwell 8.3% of working aged adults (16-64) claim Employment and Support Allowance or Incapacity Benefit - England 6.1% (Feb 2015) **Source**: DWP Benefits data available via ONS

| Household reference person in routine occupation 15% | Household reference person is in higher professional group 4% | Sandwell 20.2% work in routine occupations – England 12.7%

Source: ONS 2011 Census Table LC6115EW |
|---|---|---|
| Living in social housing or private rented 17% and 14% | Home owner 7% | Sandwell 27.5% of households are social rented (England rate17.7%). Sandwell 12.9% of households are private rented-England 16.8%. Source: ONS 2011 Census Table KS402UK |
| Living in 'hard pressed' area 15% | Living in wealthy achievers or urban prosperity area

6% and 7% | 2015 Sandwell was the 13th most deprived out of 326 English boroughs. Deprivation varies across Sandwell.

Source: English Indices of Deprivation 2015 |

Numbers of people in particular groups at higher risk of mental disorder and low well-being

There are particular groups of people at higher risk of mental disorder and poor well-being. It is useful to understand the numbers of individuals in such groups to inform appropriate targeting of prevention and promotion interventions. Higher risk groups include: looked after children, children with special educational needs or a learning disability; children with parents in prison, 16-18 year old not in employment, education or training and (NEETS) young offenders[1].

The table below captures the proportions of children and Sandwell who fall into these high-risk groups (where the data is available) in comparison with other parts of the region and the national average.

Sandwell appears to have relatively high rates in some of these groups, such as looked after children. Research has shown that 45% of children aged 5-17 years in the care of the local authority have a mental health disorder[12]. The presence of these higher rates may contribute to a higher level of emotional and mental health need in the CYP population in Sandwell.

Table 3 Numbers of people in particular groups at higher risk of mental disorder and low well-being

Measure	Sandwell Number	Sandwell Level	West Midlands Government Office Region Level	England Level	Notes	Source
Looked After Children (at 31st March 2014)	575	75	73	60	Rates are per 10,000 children aged under 18 years	LAC 903 Return, Department for Education.
Pupils With Statements Of Special Educational Needs (SEN), Where Pupil Attends School -2014	1,165	2.2%	3%	2.8%	% rates	Department for Education, 2014 Special Educational Needs Statistics
Children with learning disabilities known to schools per 1,000 pupils- 2012/3	N/A	30.1	33.1	21.7	rate per 1,000 pupils known to schools	Public Health England Learning Disability Profiles sourced from Department for Education, Special Educational Needs in England
16 - 18 year olds NEET - summary (End of 2014)	430	3.7%	5.4%	N/A	% rates NEET only, No directly comparable data for England	Department for Education, 2014 local authority NEET figures
Young Offenders	228	N/A	3,897	41,569	All figures are numbers not rates- comparable England figures not available but Sandwell's Rate Per 100,000 was 729 compared to Birmingham (895), Walsall (946) and Wolverhampton (873)	Youth Justice Board / Ministry of Justice, Youth Justice Statistics 2013/14 and ONS Mid-2014 Population Estimates

Parental Alcohol and Drug Misuse

Exposure of children to parental substance misuse has significant implications as it can affect the parent's ability to provide care. This can lead to neglect, educational problems, emotional difficulties and abuse[13].

Estimates for the number of children impacted by alcohol and drug misuse are difficult to achieve because figures are only available for those accessing structured treatment.

The Cabinet Office (2004) estimated that 10% of all children are affected by parental alcohol misuse. This would mean that 7,359 Sandwell children (aged 0-16 years) are affected by parental alcohol misuse.

The Advisory Council on the Misuse of Drugs estimated that 2-3% of all children under 16 years are affected by parental drug misuse in England and Wales – this would mean that between 1,391 and 2,087 Sandwell children are estimated to be affected by parental drug misuse[14].

5. Levels of mental disorder and numbers affected

Levels of mental well-being

Well-being surveys provide one way of measuring population wellbeing. Whilst an adult well-being survey has taken place in Sandwell, this has not been addressed yet for children and adolescents and therefore data is not readily available.

A national survey to measure a range of health indicators for 15-year-old young people (What About Youth survey) published its first results in 2015. The survey includes a section

on feelings and satisfaction with life including the Warwick- Edinburgh Well-being Scale (WEMWBS). The results of the survey are available at local authority level. This survey found that the WEMWBS scores for Sandwell were the same as the national average for both boys and girls. www.hsic.gov.uk/article/3742/What-About-Youth-Study

Boys 50   (national average 50)
Girls 45   (national average 45)

However, the survey showed limited variation between areas across the country, for boys the national range for scores was between 47 and 52 and for girls the range was 42 to 47. This may limit the statistical significance of differences between areas. When this national survey is repeated, it will provide useful trend data to monitor changes in wellbeing. As part of the proposed lifestyle survey for Sandwell consideration is needed about including a sample of 15 year old young people to develop a local baseline measure.

Levels of need for mental health services

During pregnancy and in the first two years of life a baby's brain develops rapidly and neurological pathways are set for life. This is the most important period for brain development and is a key determinant of intellectual, social and emotional health and wellbeing. Early interactions directly affect how the brain is wired, signifying the importance of the mothers and fathers role and need to be supported.

Perinatal Mental Health

Maternal depression increases the risk of mental illness in children to the extent that they are five times more likely to have a mental health problem, more than three times more likely to have an emotional problem that persists for at least three years and almost seven times more likely to have conduct problems that persist for at least three years. (DFE, 2013).

In the most up to date birth data available there were 4,680 live births in Sandwell (**source**: ONS Live Births by Area of Usual Residence, 2014) which leads to the estimated prevalences in table 4 below.

NSPCC estimate that during pregnancy and after birth, at least 10% of women are affected by a range of mental health problems including anxiety disorders, depression and postnatal psychotic disorders thus increasing the risk of mental illness in children[15]. In Sandwell, this would equate to around 468 women. Therefore it is important that consideration of services to meet this need are included as part of a preventative approach in Sandwell.

Table 4 Estimated numbers of women affected by perinatal mental illness in Sandwell

Condition	% of live births	No. of women affected in Sandwell
Mild to moderate depressive illness and anxiety states	10-15%	468-702
Severe depressive illness	3%	140
Post traumatic stress disorder (PTSD)	3%	140
Chronic serious mental illness	0.20%	9
Postpartum psychosis	0.20%	9
Adjustment disorders and distress	15-30%	702-1,404

* There may be some women who experience more than one of these conditions.
Source: Applying prevalence from the NSPCC Prevention in Mind Report 2013 to ONS Live Births by Area of Usual Residence, 2014 data

Prevalence in the Pre-School Years

There is little prevalence data for mental health conditions in children in the pre-school years. However, a literature review found that the average prevalence rate of any mental disorder was 19.6% in the 2-5 year inclusive population[16]. In Sandwell this would indicate that there are an estimated 3,720 children aged 2-5 with a mental health disorder. There is anecdotal evidence from pediatricians that there is an increasing level of need in this population.

Prevalence in the school years

Recent prevalence data estimated that a total of 4,767 Sandwell children had mental health disorders (NB this is approximate since some children will have more than one disorder), of these 2,880 children would have had a conduct disorder. Table 5 below provides further data.

The Prevalence estimates for mental health disorders in children aged 5 to 16 years have been produced by Green *et al (*2005). Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders. Prevalence varies by age and sex, with boys more likely (11.4%) to be diagnosed with a mental health problem than girls (7.8%). Children aged 11 to 16 years old are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the table below shows the estimated prevalence of mental health disorder by age group and sex in Sandwell. Some children and young people (2 percent) have more than one condition and so the number with any disorder is not the total of the individual disorders.

Table 5: Estimated Prevalence of Mental Health Conditions in Children Aged 5-16 in Sandwell (Great Britain Prevalence Applied to Sandwell)

	Age 5 to 10			Age 11 to 16			Age 5 to 16		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Emotional disorders (anxiety or depression)	323	298	636	678	482	1,159	1,034	794	1,837
Conduct disorders	362	935	1,298	567	977	1,529	937	1,921	2,880
Hyperkinetic disorders	52	366	424	44	289	324	96	666	745
Less common disorders (including autism and eating disorders)	52	298	344	122	193	324	192	487	645
Any disorder	659	1,383	2,039	1,144	1,520	2,665	1,875	2,920	4,767

Source: Applying the prevalence from Green *et al* (2005) to ONS 2014 mid-year population estimates.

Please note: Age 5 to 16 totals may not be the same as adding up age 5-10 and age 11-16 totals because of rounding of the prevalence estimates. In addition, Sandwell may have a different gender and age mix to Great Britain, which will which influence the Sandwell figures.

Estimated number who may experience mental health problems appropriate to a response from CAMHS

Child and adolescent services have tended to be organised in service tiers in recent years from tiers 0-4. Whilst services may be organised in different ways in future it is useful to consider the service needs that the different tiers represent.

The Mental Health Foundation provided estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4[17]. Applying these figures to the Sandwell population gives the following estimates for the number of children in Sandwell needing support at each level.

Table 6: Estimated number of children/young people requiring CAMHS by Tier.

	Tier 1	Tier 2	Tier 3	Tier 4
Kurtz estimated proportion	15%	7%	1.85%	0.08%
Sandwell 5-16	7,448	3,476	919	37
Sandwell 0-25	16,560	7,728	2,042	83

Source: Applying proportions suggested in Kurtz (1996) to ONS 2014 mid-year population estimates

A review of the actual referrals for April to Oct 2015 shows that 1156 referrals had been made into specialist CAMHS. Of these a total of 791 (68.43%) had attended and engaged with the service. (NB this is based on the number of initial appointments over the number of referrals received during the period)

The service and referral data available from the CAMHS service is limited. It is not possible to draw clear conclusions from this data; however, it would suggest that the number of referrals is broadly in line with the estimated levels of need. The implementation of the CAMHS transformation plan will include improved data collection that will allow detailed analysis of referrals against estimated need. It will also allow analysis of possible under and over representation of different population groups in referrals and services. For example, representation in services by age group and ethnicity.

Waiting times for this period of activity were 11.2 weeks (8.5 days). It is important to note that both referral rates and waiting times fluctuate throughout the year.

Learning Disabilities and Mental Health Issues

As discussed in the section on the determinants of mental health and wellbeing, children and adults with learning difficulties are at higher risk of experiencing mental health problems.

This area needs detailed investigation and analysis to understand the challenges and opportunities for this population in Sandwell. This detailed analysis is beyond the scope of this needs assessment. There is a separate joint strategic needs assessment for learning disability and autistic spectrum disorders.

There are a number of different definitions and datasets related to learning disability. For school age children the council records the numbers of children registered with learning disability. Chart 4 shows the numbers for Sandwell in 2015.

Chart 4: Numbers of children in Sandwell registered with special educational needs and education, health and care (EHC) plans. 2015
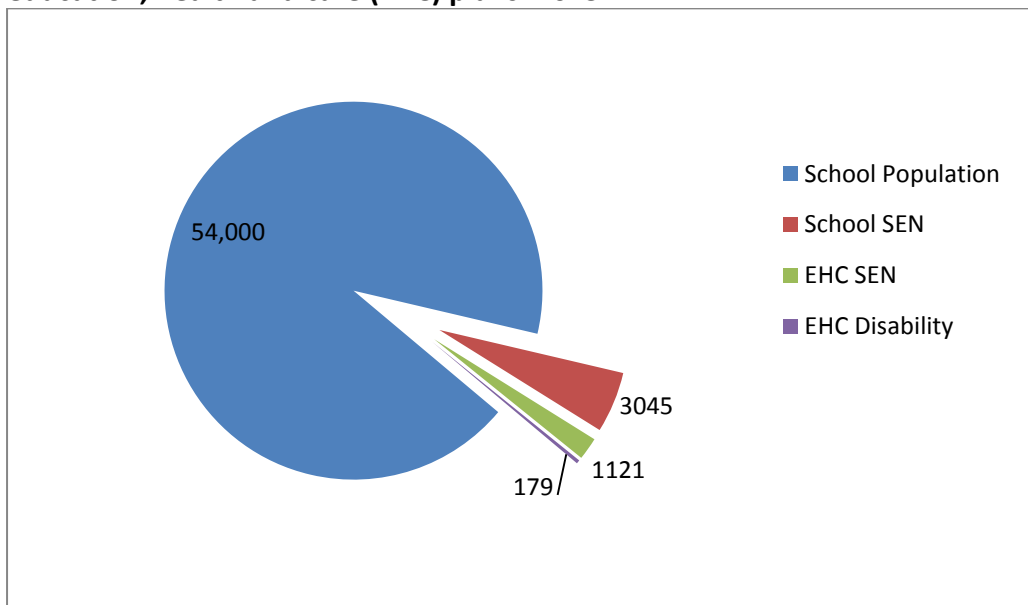
Public Health England (PHE) data may not correlate fully with the locally held data but it does allow comparison between areas. Chart 5 shows the PHE data.

Chart 5: Comparison of rates of learning disability in school aged children between Sandwell, West Midlands and England. Rates per 1000 pupils for 2014.
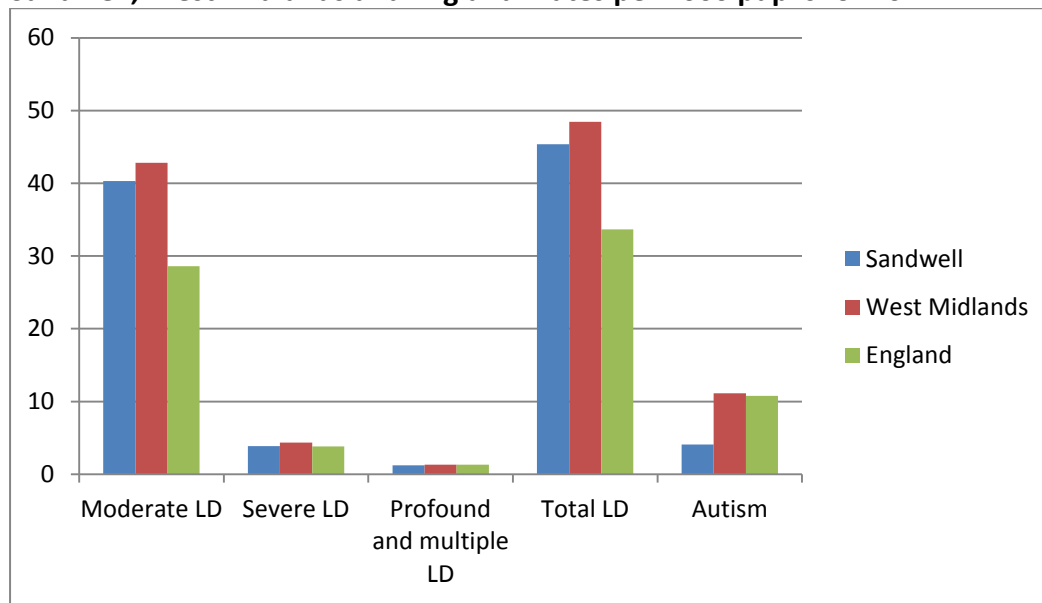
This comparison shows that, for autism, the prevalence in Sandwell is lower than both the West Midlands and England averages. There is considerable variation in levels of diagnosed autism between areas; this does not correlate with deprivation or urban / rural areas. Anecdotally the variation is liable to be due to local pathways and thresholds for diagnosis. Chart 6 shows the variation in diagnosis rates across the West Midlands

Chart 6: Children with autism known to schools: West Midlands

Area ▲▼	Value ▲▼		Lower CI	Upper CI
England	10.8		10.7	10.8
West Midlands region	11.1		10.9	11.3
Birmingham	14.7		14.2	15.3
Coventry	19.1		18.0	20.3
Dudley	8.7		7.9	9.6
Herefordshire	6.6		5.7	7.7
Sandwell	4.1		3.6	4.7
Shropshire	7.7		6.9	8.5
Solihull	18.2		16.9	19.6
Staffordshire	12.2		11.6	12.8
Stoke-on-Trent	6.7		5.9	7.6
Telford and Wrekin	8.7		7.7	9.8
Walsall	7.1		6.4	7.9
Warwickshire	11.5		10.8	12.2
Wolverhampton	4.6		4.0	5.3
Worcestershire	9.5		8.8	10.1

Source: Department for Education, Special Educational Needs in England; Statistics: special educational needs; Local authority tables spreadsheet, sum of Autistic Spectrum Disorder

A report published in 2012, Improving the health and wellbeing of people with learning disabilities[18], summarised the evidence for mental health problems for people with learning disabilities. They found that the prevalence of common mental health disorders was similar to the general population, between 20% and 41%. For severe and enduring disorders, the rate of schizophrenia was three times higher than the general population at 3%.

Self-Harm

For suicide, based on national rates of suicide in 15-24 year olds (Intentional self-harm or undetermined intent in England and Wales, ONS, 2014) the rate calculated for suicides is 6.6 deaths per 100,000 people. If Sandwell has the same rate, it would equate to 2 suicides per year in Sandwell. Accurate data on the number of suicides by age group at local authority level is not currently available.

Anecdotally, schools are reporting increases in the number of incidents of self-harm amongst school-aged children. The nationally collected data records hospital admissions for self-harm. However, this is likely to be a small proportion of overall self-harm and may not reflect increases in self-harm that do not require hospital admission.

Data collection for admissions due to self-harm changed in 2012/13. Prior to this date, the data is for three-year rolling averages, after this date reporting is for individual years. Although both methods are collecting data on the same indicator, it is not possible to make direct comparisons between the datasets. Public Health England also warns that there may be inconsistencies in the data due to collection methodology. It is not possible to combine these datasets to allow comparison or time trends. Therefore, the datasets are shown separately in charts 7 and 8. Due to the level of variation between years, it is not possible to draw conclusions about trends over time. This would need a longer-term trend for which the data is not available.

Chart 7: Young people hospital admissions for self-harm: rate per 100,000 aged 10 – 24- 2007/8 -2012/3
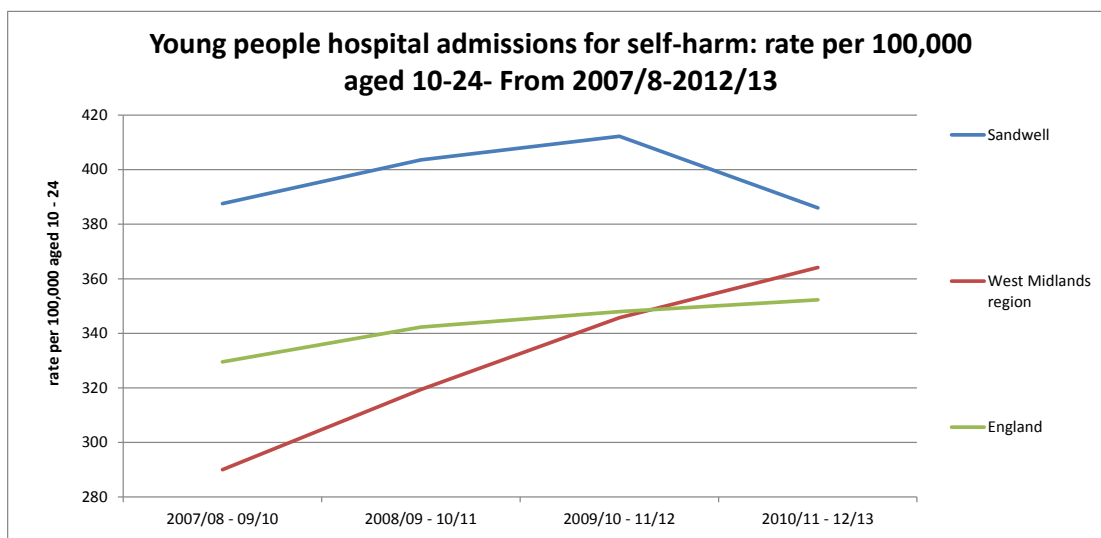
Source: Public Health Profiles

Chart 8: Young people, hospital admissions for self-harm: rate per 100,000 aged 10-24 – 2012/13 – 2014/15
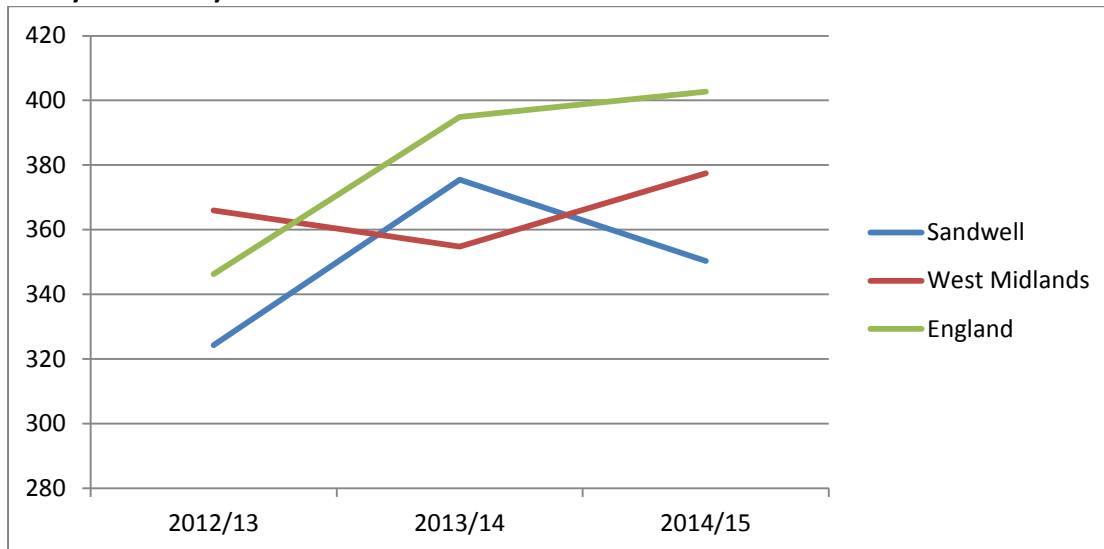
Undetermined Deaths

Chart 9: Undetermined Deaths – Sandwell- Age 0-24- 2006/8 to 2010/12
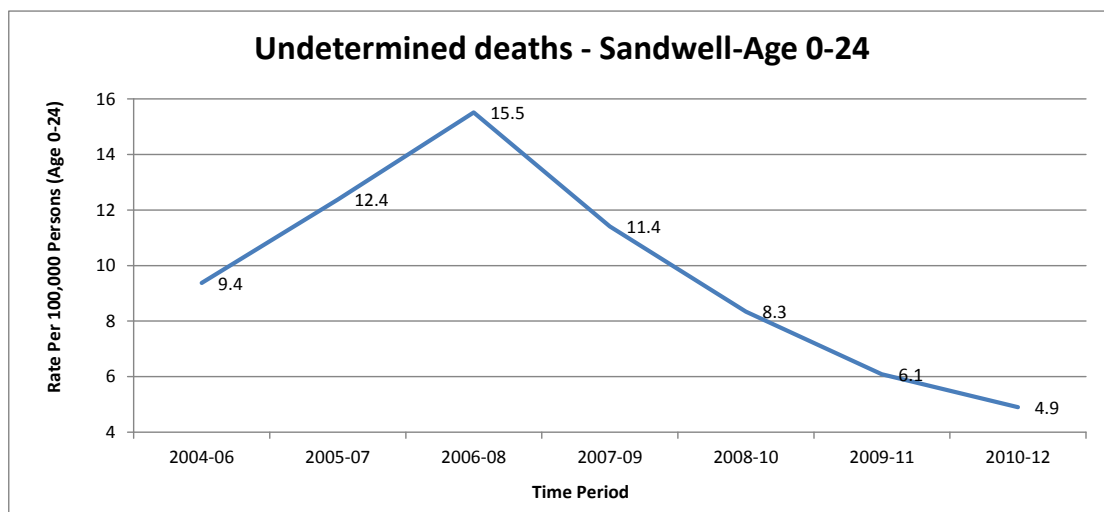
Source: Hospital Episodes Statistics (HES)

Since 2006-8 the rate of undetermined deaths in Sandwell in the 0-24 age group has been falling.

Hawton and James (2005) found that Young South Asian women living in the UK appear to have an increased risk of self-harming, which may be a relevant consideration in Sandwell[19]. As shown in the table below, Sandwell has a higher proportion of its Females aged 0-24 with a South Asian ethnicity than both the West Midlands Region and England both within the three South Asian ethnicities and at a total level. In the last census there were 10,395 South Asian Females aged 0-24 in Sandwell.

Table 7: South Asian Females Aged 0-24

South Asia Females Aged 0-24		% of 0-24 Females		
Ethnicity	Sandwell Population	Sandwell	West Midlands Region	England
Asian/Asian British: Indian	5,073	10.0%	4.1%	2.7%
Asian/Asian British: Pakistani	3,616	7.2%	6.5%	3.3%
Asian/Asian British: Bangladeshi	1,706	3.4%	1.6%	1.4%
Total South Asian Ethnicity	**10,395**	**20.6%**	**12.3%**	**7.3%**

Source: Office for National Statistics (ONS) Census 2011 Table LC2101EW - Ethnic group by sex by age

6. Evidence review

Six priority areas for promoting wellbeing in children

Expanding on the idea of risk and resilience factors, the Children's Society 'Good Childhood Report' identified six priority areas for promoting wellbeing in children[20];

1. **The conditions to learn and develop,** such as access to early years play, high quality education, good physical development e.g. diet/obesity, school activities, levels of happiness at school, health and disability.

2. **A positive view of themselves and an identity that is respected,** such as self-esteem, being listened to and not being bullied.

3. **Have enough of what matters,** indicated by family circumstances, household income, parental employment, child poverty, access to green space, etc.

4. **Positive relationships with family and friends**, where stable and caring relationships are important (e.g.in the case of looked after children, they are more likely to experience changes in caring relationships).

5. **A safe and suitable home environment and local area,** such as feeling safe, privacy, good local facilities, stable home life (e.g. overcrowded housing or moving house a lot is a risk factor to wellbeing – but positive caring relationships over-ride this). (*Children and young people's emotional health and wellbeing needs assessment Liverpool Public Health Observatory*)

6. *Opportunity to take part in positive activities to thrive*, involving a healthy balance of time – with friends, family, time to self, doing homework, helping at home, being active e.g. access to garden or local outdoor space.
   (Children's Society, 2012a & Children's Society June 2012)

These priority areas come from research carried out by the Children's Society into the wellbeing of children aged 8 to 15 across the UK (Children's Society, 2012a).

National Institute for Health and Clinical Excellence

NICE have published a number of guidelines on emotional health and well-being and the management of mental health disorders among children and young people as follows:

Published Guidance

CG 28: Depression in children and young people: identification and management in primary, community and secondary care

This provides detailed guidance for the treatment and care of children and young people through assessment and coordination of care, detection and risk profiling, mild depression and moderate to severe depression.

The main themes within the guidance are;
- Ensuring that all professionals have appropriate training in working with children and young people with mental health problems.
- A whole family approach which considers the needs of the parents and family as well as the individual child or young person.
- Cross agency and cross professional working to ensure consistency and joined up care.
- Raising the awareness of mental health problems and developing the skills of relevant professionals in schools and community settings.
- Identifying and addressing all of the child or young person's needs, recognising co-morbidities including developmental, social and emotional problems.
- The guidance also covers the use of anti-depressants in children and young people, avoiding use in mild depression and only using in conjunction with psychological therapies for moderate to severe depression.

CG 40: Social and emotional wellbeing: early years

This document provides detailed guidance related to the social and emotional wellbeing of vulnerable children under 5 years old. This guidance is broken down into;
1. Strategy, commissioning and review
2. Identifying vulnerable children and assessing their needs
3. Antenatal and postnatal home visiting
4. Early education and childcare
5. Delivering services

The cross cutting themes within the guidance are;
- Joined up working across all agencies and professional groups across health, local government, education, police, housing and the voluntary sector.
- Integrated commissioning of comprehensive universal and targeted services that support social and emotional wellbeing of children and their families.
- A life course perspective that recognises the lifelong impact of adverse experiences in childhood.
- Working with families, parents and carers as part of any interventions with families. Identifying the families strengths and assets as well as the problems they experience.

CG 12: Social and emotional wellbeing in primary education

This provides detailed guidance related to the social and emotional wellbeing of children in primary education (aged 4-11 years). It states that social and emotional health is important both in itself and because of the impact on physical health and on achievement in education.

The main themes within the guidance are;
- Ensure that all primary schools adopt a comprehensive 'whole school approach' that creates an ethos and environment that supports positive behaviours.
- Provide training and development in social and emotional wellbeing for teachers and practitioners.
- Support all children and, where appropriate, their parents and carers.
- Close working between schools and child and adolescent mental health and other relevant services.
- Develop a curriculum that integrates social and emotional skills within all subject areas.
- Provide targeted support for children showing early signs of anxiety or emotional distress, including their parents and carers.

CG 20: Social and emotional wellbeing in secondary education

This provides detailed guidance related to the social and emotional wellbeing of young people aged 11-19 years in all education establishments.

The main themes within the guidance are;
- Enable all secondary education establishments to adopt an organisation-wide approach to promoting the social and emotional wellbeing of young people. This should encompass organisational and management issues as well as the curriculum and extra-curricular activity.
- Ensure secondary education establishments have access to the specialist skills, advice and support they require.
- Foster an ethos that promotes social and emotional wellbeing including mutual respect, successful relationships, inclusiveness and which reduces the threat of bullying and violence and promotes positive behaviours.
- Work in partnership with parents, carers and other family members.
- Ensure young people and families living in disadvantaged circumstances are provided with the support they require to participate fully in activities to promote social and emotional wellbeing.
- Develop partnerships between young people and staff and involve young people in decision making and in the creation, delivery and evaluation of training.

CG 9: Eating disorders

This provides guidance on the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. The priorities for implementation within the guidance are;

Anorexia nervosa
- Most people should be managed on an outpatient basis from a service with the relevant specialist knowledge and experience.
- Where in-patient treatment is needed this should be in a specialist unit.
- Family interventions that directly address the eating disorder should be offered to children and adolescents.

Bulimia Nervosa
- A possible first step is an evidence based self-help programme.
- Adults may be offered a trial of an antidepressant drug and a specifically adapted form of CBT (CBT-EN).
- Adolescents may be treated with CBT-EN adapted to their age and including the family as appropriate.

Atypical eating disorders
- It is recommended that treatment follows the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.

CG 192: Antenatal and postnatal mental health: clinical management and service guidance

This provides detailed guidance on;

General guidance
- Guidance on areas for discussion and advice for women who have a new, existing or past mental health problem.
- Guidance on recognising mental health problems in pregnancy and the postnatal period and appropriate referral. This includes the use of the 2 item generalized anxiety disorder scale (GAD-2)
- The development of clinical networks for perinatal mental health services managed by a coordinating board of healthcare professionals, commissioners, managers and service users and carers.

During pregnancy and the postnatal period
- Develop an integrated care plan which includes care of the mental health problem and which identifies the responsibilities of the professionals involved.
- Advice that should be provided by mental health professionals to the woman and other professionals.
- Advice on starting, using and stopping treatment for mental health problems during pregnancy and the postnatal period, including specific advice on different types of medication
- Care for women who have experienced a traumatic birth, stillbirth or miscarriage.

CG 158: Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management

This guideline offers best practice advice on the care of children and young people with a diagnosed or suspected conduct disorder, including looked-after children and those in contact with the criminal justice system.

Health and social care professionals working with children and young people who present with behaviour suggestive of a conduct disorder, or who have a conduct disorder, should be trained and competent to work with children and young people of all levels of learning ability, cognitive capacity, emotional maturity and development.

The key priorities within the guidance are;
Health and social care professionals
- Should be appropriately trained and experienced
- Able to assess capacity and competence including 'Gillick competence'.

Guidance is provided on improving access to services and development of local services and care pathways. These should ensure that care is consistent and coherent.

Assessment
- Guidance on the initial assessment and comprehensive assessment of children and young people with a suspected conduct disorder. This includes assessment of the quality of parenting they are experiencing.

Training programmes
- Guidance on training programmes for parents and foster care / guardians.
- Group training programmes for parents and carers of young people between 3 and 11 years old.
- Child-focused programmes including social and cognitive problem solving for children and young people aged between 9 and 14 years old.

Guidance is provided on multimodal and pharmacological interventions for children and young people according to their age.

G16: Self-harm: short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

This guideline makes recommendations for the physical, psychological and social assessment and treatment of people in primary and secondary care in the first 48 hours after having self-harmed.

This guidance includes statements about the experience of service-users who have self-harmed and the challenging nature of this work.
- The experience of care for people who self-harm is often unacceptable. All healthcare practitioners involved in the assessment and treatment of people who self-harm should ensure that the care they offer addresses this as a priority.

- Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of skills. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood.

The key priorities for implementation are;
- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.
- Ensuring all staff that may meet someone who has self-harmed should have appropriate training.
- Activated charcoal should be immediately available in all settings where care is needed for people who have self-harmed by poisoning.
- Guidance on triage of people who have self-harmed including use of the Australian Mental Health Triage Scale and providing an appropriate safe and supportive environment.
- Guidance on treatment, including addressing the physical consequences of the self-harm and assessment of physical, emotional and social needs.
- Risk assessment for the individual.
- Psychological, psychosocial and pharmacological interventions where appropriate.

CG 133: Self-harm: longer-term management
This guideline is concerned with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm, and does not include recommendations for the physical treatment of self-harm or for psychosocial management in emergency departments. The guideline is relevant to all people aged 8 years and older who self-harm, and it addresses all health and social care professionals who come into contact with them. Where it refers to children and young people, this applies to all people who are between 8 and 17 years inclusive.

- Guidance for professionals on the principles that should be applied when working with people who self-harm.
- Use of integrated and comprehensive psychosocial assessment of needs.
- Detailed guidance for the risk assessment of people who self-harm or are at risk of suicide. The guideline states that risk assessment tools and scales to predict future suicide or self-harm should not be used.
- The use of care plans and the aims of longer term treatment which have been discussed and agreed with the individual.
- The use of risk management plans which should be a clearly identifiable part of the overall care plan.
- Offering 3 to 12 sessions of psychological interventions that are specifically structured for people who self-harm.
- The treatment of associated mental health conditions including psychological, pharmacological and psychosocial interventions.

CG 31: Obsessive compulsive disorder

This guideline provided detailed guidance on services for people, adults and children, with obsessive compulsive disorder and body dysmorphic disorder. This summary covers the guidance relevant to children and young people.

General guidance
- All organisations that provide mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care.
- OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list.

Children and young people with OCD or BDD
- The guideline recommends a stepped approach based on the severity of the condition and the level of functional impairment experienced. This is based on the use of CBT as a first intervention and the use of pharmacological interventions (SSRI) where this is not effective. This treatment should involve the family or carers and be suited to the developmental age of the child or young person.

Wider guidance

There are other NICE guidelines which, while not focusing on mental health and wellbeing, are relevant to the mental health and wellbeing of children and young people.
- CG 28: Looked after children and young people
- CG 128: Autism diagnosis in children and young people
- CG 170: Autism: the management and support of children and young people on the autism spectrum

Quality Standards

QS48: Depression in children & young people
QS37: Postnatal care
QS 31: The health and wellbeing of looked-after children and young people
QS 59: Antisocial behaviour and conduct disorders in children and young people
QS34: Self-harm
QS39: Attention deficit hyperactivity disorder
QS53: Anxiety disorders

Guidance in Development (expected date for publication)
- Challenging behaviour and learning disabilities (Oct 15)
- Mental health problems in people with learning disabilities (Sept 16)
- Mental health community settings (tbc)
- Suicide prevention (April 18)
- Antenatal and postnatal mental health (tbc)
- Social and emotional wellbeing in primary & secondary education (update)

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7. Current service provision/ service mapping

Current service Provision/service mapping

Following the publication of Future in Mind[21], each local authority area was required to develop a CAMHS transformation plan. Sandwell and West Birmingham CCG are the lead partner for this work In Sandwell. In November 2015, the Sandwell CAMHS transformation plan was agreed[22].
http://sandwellandwestbhamccg.nhs.uk/images/documents/Sandwell_CAMHS_Transformation_Plans_final.pdf

The service mapping which follows is from late 2015. Since this mapping was completed, there has been considerable activity to review, redesign and re-commission services. Governance of this activity is through a partnership CAMHS transformation board, the purpose of which is to oversee delivery of the CAMHS transformation plan, reporting to the Sandwell health and wellbeing board.

The service mapping which follows is therefore a view of services at a point in time. It is recognised that these services are currently changing in line with the CAMHS transformation plan.

Overview - Service Provision

There are currently a number of organisations involved in commissioning CAMHS services in Sandwell. These include the CCG which commissions tier 3 services, NHS England which commissions tier 4 services and Children's services and Public Health departments of Sandwell Council who commission tiers 2 and 1 respectively.

Commissioned services
Services in Sandwell are currently organised and commissioned in tiers

Tier 1: Universal Services Mental health promotion and mental disorder prevention interventions
In addition to the following commissioned areas of work, there are likely to be a range of interventions delivered by other organisations that contribute to emotional health and wellbeing which are primarily concerned with prevention and early identification.

Health Visiting Service

Description of Service
Since October 2015, local authorities have been responsible for the commissioning of health visiting services as part of their public health responsibility. Health visitors play a crucial role in ensuring children have the best possible start in life, and lead delivery of the 0-5 elements of the Healthy Child Programme in partnership with other health and social care colleagues. Investing in the health visiting service has a profound impact on supporting the lifelong

health and wellbeing of young children and their families as evidenced through numerous studies such as the Marmot Review.

Service Capacity
There are currently 85 Health Visitors working within the service across Sandwell.

Age/gender/ethnicity
All families with children under the age of 5 years can access the service.

Interventions Delivered
Health Visitors are responsible for five mandatory checks including:
- antenatal health visit,
- the new baby review
- 6-8 week assessments
- the one year assessment and the
- 2 to 2 ½ year review.

Health Visitors can promote targeted parents programmes and signpost to a wide range of information and services e.g. parents support, benefits, housing advice alongside other resources and advice on wider health and wellbeing issues including screening, immunisation and promoting positive behaviour change.

Other interventions delivered: -
- Antenatal contacts to identify, early on, any history of depression or social problems requiring Early Help/Intervention and referring to the appropriate agencies for that support e.g. early help, Wellbeing Hub.
- Receives 'Cause for Concern' maternity liaison notifications from the Midwife where it has been identified that maternal mental health, social problems requiring Early help/Intervention, assess and action as appropriate.
- Assess for postnatal depression and liaise with the GP or refer to Sandwell Wellbeing Hub and offer 'listening visits' if appropriate to support women until other services are on board.
- Work collaboratively with other agencies such as Children's centres that are able to offer support to enable women and their children to integrate into various groups to reduce isolation and build networks.
- Work collaboratively with Breastfeeding Network that supports breastfeeding women in Sandwell.
- Where families do not wish to engage with any of the above, Health Visiting teams are able to offer Universal Plus services tailored to the family's individual needs with the Health Visitor effectively taking on the role of 'Lead professional', assessing, planning, implementing and evaluating specific plans of care.
- Health Visitors promote 'Early Learning for Two's', encouraging children into nursery to help them to develop social skills which will impact on their emotional wellbeing.

Outcomes

The Health Visiting Service will lead on the delivery of the full Healthy Child Programme (0-5 years), outcomes include: -

- Improving life expectancy and healthy life expectancy;
- Reducing infant mortality;
- Reducing low birth weight of term babies;
- Reducing smoking at delivery;
- Improving breastfeeding initiation;
- Increasing breastfeeding prevalence at 6-8 weeks;
- Improving child development at 2-2.5 years;
- Reducing the number of children in poverty;
- Improving school readiness;
- Reducing under 18 conceptions;
- Reducing excess weight in 4-5 and 10-11 year olds;
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14;
- Improving population vaccination coverage;
- Disease prevention through screening and immunisation programmes;
- Reducing tooth decay in children aged 5.

School Health Nursing Service

Description of Service

The School Health Nursing Service has been commissioned by Public Health (Sandwell Council) since 1st April 2014 and is provided by Birmingham Community NHS Trust.
The service has a focus on public health and aims to improve the life chances of children and young people aged 5-19 through effective preventative services and 'Early Help'. They provide health education, assessment, individual advice and support to children and parents, targeted interventions, referral to specialist services and safeguarding.

Interventions Delivered

The School Health Nursing Service aims to protect and promote the health and wellbeing of children 5-19 by delivering the Healthy Child Programme. This contributes to improving a wide range of public health outcomes by taking a holistic approach.
In relation to improving emotional wellbeing this will include:

- Holistic health needs assessments
- Pupil drop-in advice, information and support sessions in secondary schools.
- Supporting classroom delivery of PSHE looking at topics such as exam stress, bullying etc.
- The School Nurse Ambassador Programme, which enables pupils to have a voice and role in promoting health messages in schools
- Early identification of risk factors and early offers of support/brief intervention especially in relation to children at increased risk e.g. looked after children, bereaved.
- Advice and support for parents

Sandwell School Nurses work in partnership with CAMHS and MyShield services to improve the emotional health and well-being of Sandwell young people.

CAMHS provide supervision to nursing staff on cases relating to mental health on a fortnightly basis. This may take the format of liaison to discuss mental health conditions for further information or consultations on specific cases and discussion as to how to work with that young person and when the need for a referral to CAMHS is required.

Service Capacity- This is a universal service, available to all young people attending mainstream Sandwell Schools. A vulnerable children's team works in Pupil Referral Units, the youth offending team and with other groups in need of a more targeted service.

Numbers - In addition to universal services, in the academic year 2014/15 there were 5374 referrals for assessment and active intervention by the service across the whole range of health issues, including emotional health and wellbeing

Access to service
Via schools and other youth settings, pupil and parent drop-ins, referrals from schools, families and other professions.

Average Waiting Time – On referral, cases are triaged according to need. The waiting list is updated on a weekly basis and current waiting times are at a maximum of 12 weeks with a total of 42 sitting within the waiting list.

Description of severity of cases seen – All referrals are assessed, and onwards referrals made to CAMHS where specialist interventions are required. The team will continue to support children in school while they are receiving specialist services.

Interventions delivered – Holistic health assessment, health education, brief advice, drop-in support, individual health plans for pupils with medical needs, prevention of cases escalating to specialist services, support for the Primary Schools to deliver on their emotional health and wellbeing plans.

Outcomes – Contributes to a wide range of health outcomes, including the emotional wellbeing of children.

General Comments – This is an area of development for the service. Some nurses have undertaken foundation training in emotional and mental health and further training needs have been identified on specific mental health issues covering self-harm and suicide, voices, ASD, eating disorders, anxiety and depression. School Nurses are currently developing pathways for working with young people who attend drop-ins for support relating to emotional health and well-being and referring on to CAMHS or MyShield

Parenting Support
The vision for effective parenting support in Sandwell is that there would be no stigma attached to parents seeking help to strengthen their parenting skills. There is therefore a strong emphasis on universal provision.

Practitioners from a broad range of agencies are trained to deliver parenting courses and interventions which can then be delivered in universal and targeted settings.

Intervention

CHANGES 2014 is Sandwell's 'home grown' successful Parenting Programme. It provides an appropriate, flexible and imaginative framework to support parents to cope with the challenges of raising their children. Changes can be delivered as both a universal and targeted offer for parents of age ranges 0–3, 4–10 and 11-19. It includes a variety of two hour core and optional modules to ensure the contents are responsive to parent's needs. Changes provides a holistic package of support for the whole family as it has embedded

Outcomes

Outcomes Family Star Plus into every module to enable tracking of improved outcomes for parents/families. An external evaluation is currently being conducted.

Primary Outcomes:
- Improved child behaviour;
- Improved parenting as resulted of better coping skills, better knowledge,
- and increased self-confidence;
- Increased parent/child attachment.

Secondary Outcomes:
- Increased capacity to self-care and less reliance on care services
- Increased school readiness
- Increased school achievement
- Improved parent and child emotional health
- Reduction in risky behaviours
- Reduction in anti-social behaviour and crime

Service Capacity: -

122 practitioners trained to deliver the Changes programme (47 include trained practitioners from schools).

Access to service

This is a universal service and targeted offer.

Interventions delivered

35 programmes have been delivered during Spring and Summer 15
Another 31 programmes planned to run from September 15 – March 16.

General Comments

From the post questionnaires the programme has found: -
- 95% of parents feel that their parenting skills have improved
- 93% of parents feel that they have better coping skills
- 78% of parents feel that their child's behaviour has improved (99% of parents said some improvement)
- 90% of parents feel that they have a better bond with their child.

Primary Whole-School Approach to Emotional Wellbeing

A whole school approach around emotional health and wellbeing is concerned with having a culture and ethos in a school that supports the development of emotional health and wellbeing as well as the teaching of social and emotional skills as part of the taught curriculum to build resilience and coping strategies.

This is an evidence-based programme that supports a whole school approach in Sandwell Primary Schools. It includes three elements: an emotional health and wellbeing audit for schools; the development of an action plan to address 'gaps' identified in each school; and the implementation of a social and emotional learning programme incorporated into the taught curriculum.

Social and Emotional Learning programmes are concerned with building self-awareness, self-management, social awareness, relationship skills and responsible decision-making.

Reach
This programme will be available to all primary schools in Sandwell over three years. Delivery started in autumn 2015. This has the potential to reach 20,555 pupils over 2 years; and 33,065 pupils over 3 years.

Outcomes
Monitoring of outcomes will be through a variety of school-level indicators (e.g. absenteeism) and a validated scale for measuring improvements in children's emotional health and wellbeing.

Children's Centres

Description of Service
Children's Centres are a universal service for families primarily with children under 5 years of age.
The service includes elements of early years education; health promotion; and steps to employment for parents; and family support work.
The service works in close partnership with other statutory and voluntary sector agencies.

Service Capacity
There are 21 Children Centres (including a virtual young parent's centre) in Sandwell.

Access to Service
The service is available to all families within the borough with children under 5 years of age.

Average Waiting Time
N/A

Age/Gender/Ethnicity?
All families can access the service

Interventions

A range of services linked to the overarching objectives noted above.

Centres provide a range of universal group-based services eg stay and play sessions for parents and young children which offer the opportunity for offering help and advice as well as giving parents the chance to meet with other parents for mutual support. Sessions are held within centres and other community venues.

Centres offer support to families on an individual basis on a range of issues eg parenting, child care, benefits, housing, early education etc. Family support is provided both in the centre and in homes as necessary.

Description of Severity of cases seen?

Can play a part in all families with children under 5 years.

Outcomes

Children's Centres aim to deliver better outcomes for young children and families. They are based on a commitment to improve the coordination, quantity and quality of services for young children. This stems from the belief that the joining up of services and disciplines such as education, care, family support and health is a key factor in determining good outcomes for children.

Outcomes are measured on a cluster and individual family basis

General Comments

Services are arranged on a cluster basis so different services will be provided at different centres. Contact the main core centre in each cluster area for more details

<u>Connexions</u>

Description of the Service

Connexions encourage young people to be active and to engage socially thereby improving their emotional health and wellbeing. The service primarily supports young people aged 16 - 18 years old to participate in learning and signpost them to relevant opportunities.

There are two aspects of work
- Prevention work in Year 11 to ensure young people participate many of whom are known to the Early Help Service or are from troubled families.
- Work to re-engage 16 - 18 year old NEET young people. Mental health and emotional wellbeing issues such as lack of confidence, low self esteem, drug misuse are some of the reasons for non participation.

Services commissioned take into account that young people should be participating in learning and that participation will support improvement of health and wellbeing. The services are available to learning providers, schools and colleges as required.

Out To Play

Brief Service description

'Out to Play' is a Sandwell Council service aimed at broadening and extending the range of quality free play opportunities across the Borough. Playing is an excellent way to engage with emotions, with other people and the environment developing resilience, emotional wellbeing and strategies which are key protective factors for the future. The service aims to

- Support organisations in delivering a sustainable play offer
- Offer bespoke alternative services to individual organisations to encourage inclusion and breaking down barriers to learning.
- Offer a range of equipment and resources to support organisations to offer a wider, more challenging range of play experiences, which encourage exploration and creativity.
- Provide direct delivery across the year which is free for children and young people to access

Sandwell Play Service also manages the Sandwell Forest School Initiative, formed in 2011 with the opening of a designated Forest School site located in Sandwell Valley Country Park and partnership working between Warley Woods Community Trust and Haden Hill Park to provide forest play activities during the holidays from 3yrs to 14yrs

Service Capacity

The service is supported by two full time and four 4 part time staff as well as the use of casual bank staff.
(2014/2015)
Direct play hours delivered   1141
Children reached   10136
Practitioners trained   254
CPD hours delivered   97
Vulnerable children reached   average 97 per quarter
Disabled children reached   average 38 per qtr

Age
6 – 19 years
Average wait time
There is no wait time generally however there is a 3 month wait for specialist disability provision

Severity of cases
Disability – profound and complex needs catered for
Vulnerable children – up to tier 5 but predominantly tiers 2/3

Interventions
- Free community play provision across Sandwell all year round
- "Big Welcome" programme – six-session intervention programme supporting new arrivals into the primary school environment, focusing on identity and emotional well-being including embedded literacy and numeracy.

- "Scrap Pack" playtime – a two week loan of scrap resources and playground equipment to support creativity, cooperation and behaviour and increased physical activity during free play opportunities and includes eight hours play ranger support.
- Bespoke packages which can include training, play audits and policy development and intervention support.
- Bespoke packages for Secondary educators and intervention packages
- Loan Equipment Scheme
- Specialist provision for children with complex and profound disabilities
- Referral provision to support vulnerable families in times of crisis
- Forest School training and direct delivery
- Training and CPD packages for schools, voluntary organisations, foster carers on a range of subjects.

Outcomes
- Extending the choice and control children have over their play, the freedom they enjoy and the satisfaction they take from it.
- Maximising the range of play opportunities for indoors and outdoors and maximise the amount of time for play.
- Fostering independence and self-esteem.
- Increasing children's respect for others and offer opportunities for social interactions.
- Improving children's wellbeing, healthy growth and development and capacity to learn.
- Recognising that children need to test boundaries and responding positively.
- Managing the balance between children's need to play and the need to prevent exposure to unacceptable risk.

Sandwell Residential Education Service

Description of service
Sandwell Residential Education Service is an in-house Council provision. The services comprises of four centres providing residential and day programmes.
All the centres are open at weekends and during school holiday periods. Programmes of activities are bespoke to the requirements of the group. As well as curriculum-focused learning and practical skills, planned outcomes include promoting and improving physical health and fitness, emotional well-being, healthy lifestyles, taking responsibility, and social, moral, spiritual and cultural development. All centres are income generating and therefore charge for service provision.

Centres are booked during term time by schools up to 18 months in advance. Weekends, day visits, and cottage / camping bookings are sometimes available at shorter notice.

Approximately 7,000 Sandwell children and young people used the facilities annually; about 5,300 residentially and 1,700 on day visits. All programmes support resilience and emotional well-being, with some courses specifying these as priority aims. Most Sandwell schools (and

academy schools) make use of the centres. Youth, community and family groups visit at weekends and in school holidays,

The services at the centres are available to all children from reception through to post 16 years. Equal numbers of males and females use the centres. Ethnicity is currently not recorded and there is some limitation around specialist skills and equipment for severely disabled children. However, all centres have accommodation accessible to wheelchair users, and courses are as inclusive as possible.

The centres have been invited to work with Sandwell Educational Psychology team to achieve the well-being charter, and to work with schools to provide well-being experiences.

Library Services

Description of services

The Library and Information Service provides free universal provision through 19 libraries and 5 express libraries for all age groups. The service provides
- **Information** on health and services available in Sandwell, some services provide surgeries and health events in libraries
- **Resources** such as Books on Prescription (BoP), large fiction book stock, health related books for young people free internet and Wi-Fi access at all libraries.
- **Activities, events and volunteering opportunities** - providing things for people to do and places for people to meet e.g. Youth council meeting in libraries, young people's reading groups, drama groups, work experience placements, volunteer opportunities, homework help sessions, gaming clubs, baby groups, rhythm and rhyme sessions, holiday activities.
- **Partnership working** the library service works closely with partners to support service provision for children e.g. children's centres, schools, colleges, DECCA, Summit House, fostering services, health visitors, Out to Play.

Numbers seen over the last 12 months
- In 2014/15 1.86 million visits were recorded in Sandwell libraries
- 30% of library users report having some kind of disability / condition with the most common problems reported as mobility and getting around (12%), mental health problems (8%), hearing (7%), dexterity (4%), eyesight (3%) and learning disability (3%)
- 30% of library customers report that the library has helped them with health and wellbeing (up from 20% in 2009)
- In a detailed analysis of enquiries 10% of non-book / library related enquiries were identified as being about health and wellbeing, 27% welfare benefits and 23% personal finance

Age, gender, ethnicity
Usage figures show that there is a broad range of correlation between the population of Sandwell and libraries visited by age and ethnicity.

Interventions delivered

58

- Young Peoples Reading Well / BoP scheme launching March 2016.
- Things for young people to do and safe places to meet - 94% of children said that libraries are a safe place.
- Reading for pleasure is shown to increase mental wellbeing – large fiction book stock available along with regular class visits / story times, plus Bookstart scheme delivered in partnership with local health visitors. Free access to books both in print and electronically.

Tier 2: Targeted Services

Primary Care Mental Health link workers
There is currently a small team of primary care mental health workers (PCMHWs). This team have limited capacity for the identified levels of potential need for their service. Funding has been made available to commission an additional 7 PCMHWs to work across the Community Operating Groups (COGs) and to place a further 2 specific PCMHWs with the Multi Agency Safeguarding Hub, Looked After Children (LAC) and Youth Offending Services. A key purpose of these new primary mental health worker posts is to address the lack of integration that exists in relation to CAMHs both internally and externally.

The Family Nurse Partnership (FNP)
The FNP is a voluntary home visiting programme for first time young mothers, aged 19 or under (and fathers) the programme is evidence-based and is a prevention and early intervention programme. A specially trained family nurse visits the young mother regularly from early pregnancy until the child is two years old.

A recent evaluation of the FNP approach[23] stated that;
"Adding FNP to the usually provided health and social care provided no additional short-term benefit to our primary outcomes. Programme continuation is not justified on the basis of available evidence, but could be reconsidered should supportive longer-term evidence emerge."

However, another review of the approach in the Netherlands found that the programme was associated with reduced levels of child maltreatment.[24]

This service is currently under review.

Sandwell Shield

This service is currently under review.

Brief Description of the Service
Sandwell Council Children's Service commissioned Murray Hall Community Trust in 2012 to deliver Targeted emotional wellbeing service called 'Shield' for Children & Young people aged 5 - 19 years old (and 25 years old for care leavers) who live in Sandwell. The service aims to reduce the number of young people experiencing emotional wellbeing difficulties and requiring Specialist provision.
Main features of the service include:
1. A joint working approach with CAMHS and the establishment of the Sandwell POA
2. Screening all the referrals and ensure that CYP get the most appropriate intervention based on presenting issues. Offering one to one counselling and Creative Therapy intervention (occasionally group if suitable) to Children and young people 5-18 living in Sandwell.
3. To develop links with Adult Mental Health Services to ensure that Young people 16+ who do not meet CAMHS threshold or need more support and long term intervention can be referred to most appropriate services.

4. To fully implement the Outcome Star within all client assessment and across all Shield Sub-contract providers.
5. To Sub-contract to Krunch to deliver focused intervention for the target group Year 5 – Year 11 who are experiencing issues that include anger, behaviour, school issue, peer relationships etc. needs model and detail of assessment process
6. To develop the Shield Webpage to be the main support site for all Children, Young people, families and professional to get information on services available in Sandwell, how to access the POA, self-help fact sheets etc.
7. The development of a volunteering arm (MENT 4 U) and Young Person Workers role to provide one to one practical support to Children and young people with low level need who require hand holding support and direction including access to other Sandwell provision i.e. youth provision, support groups etc.
8. To work in partnership with MHCT other therapeutic funded project 'Looking Forward' to refer clients who meet the criteria i.e. Self-harm, Abuse and Domestic violence. This will include the on-line counselling, counselling and creative therapy.
9. Deliver group therapeutic intervention for young people with similar issues such as Anger, Anxiety and Self-esteem.
10. To develop and implement CYP IAPT service through existing trained CYP IAPT workers who will be trained in CBT to deliver one to one work with young people will low level needs.

Access and Referral

The service provides interventions and feedback to support the integrated working model in Sandwell. The referral criteria ensures that resources are targeted for young people experiencing poor emotional wellbeing and mental health, who may be engaging in harmful risk-taking behaviours and / or living in families experiencing difficulties and/or known to other services.

All referrals for emotional and mental well-being are required to complete a POA referral that is done through the Early Help System which is forwarded to the Point of Access Team.

The purpose of the POA is to enable a seamless pathway to appropriate mental health and Emotional wellbeing services in collaboration with other Sandwell services to ensure children
and young people receive the most appropriate support at the earliest opportunity by the right professional in the right place.

Assessment

An Initial assessment is carried out by Shield Workers/Therapist/Counsellors/Mentors on the information received for the Child or young persons from the Early Help and multi-agency process. The assessment is based on My Outcome Star – which includes exploring each of the outcome star area i.e. education & learning, physical health, where they live, being safe, relationships, feeling & behaviour, friends, confidence & self-esteem. Pre-intervention Outcome scores are recorded on early help system as well as mid-point and at end of intervention which enables tracking of child and young person journey through Shield intervention.

The service aims to complete and write the initial assessment within 10 days of the initial appointment been offered with the child or young person (and their parents / carers where appropriate). As part of the assessment the worker will negotiate and agree an Outcome Star Action Plan. The plan outlines specific goals that the children or young person wants to achieve by the end of Shield involvement – this is based on the Outcome star assessment.

The Initial Assessment is completed with the child and young person through face to face contact, which include:

1. <u>Statement of understanding</u> (this will include why the young person is working with Shield, Understanding what is meant by confidentiality, and when confidentiality is broken)
2. <u>Clinical Assessment Form –</u> that covers a number of areas which will be explored further to identify some key areas of work.
3. <u>Family Tree / Genogram</u> (This will help the assessor to explore family members, sibling etc. this is optional and will depend on the CYP if there is relationship concerns)
4. <u>Emotions Grid</u> (This is optional and again depend on the CYP particularly those who find it difficult to express how they feel etc.)
5. <u>My Star</u> (Pre-intervention)
6. <u>MY Star Action Plan</u> (Which highlights the areas that the Child or Young Person wishes to work on i.e. goal, how it will be achieve, who it will be completed by and when it will be completed by). A copy will be added onto Early Help System and a copy retained by the client.

Interventions

Service delivery

Shield works in partnership with local statutory and voluntary agencies Krunch and Base 25, Looking Forward and KOOTH.com (online counselling service), Therapists, Counsellors and volunteers to deliver a range of behavioural change interventions which encourage young people to reflect on their current emotional and mental well-being behaviours, recognise their self-efficacy, and support / reinforce positive change to enable sustainable behavioural change.

Interventions are aimed to improve self-esteem, confidence, positive self-image, resilience, aspirations, negotiating skills and motivation with specific applications to healthy behaviour in the areas of emotional wellbeing, resilience, offending, substance misuse, sexual health and poor/abusive/coercive relationships. Interventions are measured and monitored through the early help and Outcome Star from start to finish. The different levels of interventions are detailed below followed by the service model diagram.

Level 1: Universal plus

Some of the presenting issues may include self-esteem, relationship issues, low mood, stress, behavioural issues, substance misuse, sexual health, self-image issues etc.

MHCT Shield offers Volunteering Programme **'Ment 4 U'**, who will offer one to one practical support and guidance to children and young people who have been referred for low level need or early emotional well-being difficulties i.e. self-esteem , confidence; transition, vulnerability, low mood, exam stress etc. As part of this offer a team of Young Peoples Workers will also provide practical solution focused intervention to young people who just need someone to talk to and provide them with direction and solutions to overcome their emotional well-being difficulty.

The Universal Plus offer also provides Protective Behaviours which empowers and equip children and young people with the skills and strategies they need to recognise when they are in unsafe situations and to know what to do about it. It uses universally-experienced physical 'early warning signs' to help young people to listen to their own instincts about when they are feeling unsafe.

Level 2 – Target Provision (moderate needs)

Referral presenting issues include bullying, isolation, anger issues, family/peer relationships, low mood, attachment, self-esteem, anxiety, historical self-harm etc.

Shield offers a range of intervention for CYP through MHCT 'Looking Forward' online counselling 'Kooth', placement counsellors/therapist and Krunch (Sub-contractor). Interventions are delivered through one to one work as well as group based intervention around anger, anxiety and low self-esteem. Krunch delivers a range of evidence-based individual work around the key outcomes of staying healthy and being resilient.

Level 3 – Targeted provision (complex needs)

Children & young people with significant presenting issues such as Self-Harm, Suicidal thoughts, bereavement, sexual abuse, physical abuse, domestic abuse , self-imagine etc. receive one to one Counselling of Creative Therapy (Drama/Art/Music or complimentary Therapy) through qualified BACP counsellors or HPC registered therapist. This is delivered over a 7 session model with possibility of extension for further sessions depending on client needs.

MHCT shield draw upon a bank of experienced children and young people's counsellors/therapist to provide a client centred approach but also have counsellors/therapist who also uses various other approaches such as Humanistic, behavioural and psychodynamic approach to work face to face with the CYP.

Figure 1 Shield Process from PoA referral to closure

```
┌─────────────────┐          ┌────────────────────────────────────────┐          ┌─────────────────┐
│  Sandwell       │          │  Referral allocated from Sandwell POA  │          │  Sandwell       │
│  POA            │          └────────────────────────────────────────┘          │  POA            │
└─────────────────┘                            │                                  └─────────────────┘
        ▲                                       ▼
        │                  ┌────────────────────────────────────────┐
        │                  │  Allocated to appropriate intervention  │
        │                  │  Counsellor/therapist/Krunch/MENT4U      │
        │                  └────────────────────────────────────────┘
        │                                       │
        │                                       ▼
        │                  ┌────────────────────────────────────────┐
        │                  │  Client Assessment book (DNA* 2 & up to  │
        │                  │  2 cancellations)                        │
        │                  └────────────────────────────────────────┘
```

Referral allocated from Sandwell POA

Allocated to appropriate intervention Counsellor/therapist/Krunch/MENT4U

Client Assessment book (DNA* 2 & up to 2 cancellations)

If suitable to continue with follow-up counselling or therapy sessions on either one to one of possible a group

Not suitable – issues more complex need to be discussed at POA . Or the intervention allocated not suitable for client needs. The young person would be sent to Shield office and re-allocated.

Intervention sessions booked (7 Session model)

Mid-point Review (Session 3+) completed with Child or young person.

Intervention completed and relevant paperwork completed

Further worked in other areas – referral to other appropriate intervention or externally

No further work required

File Closed, referral source notified through feedback pro-forma and ECaf

Access to Services

During 2014 /2015, Shield received 1,371 referrals to the service, an increase from 900 referrals in the previous year. The number of referrals has increased as more agencies and professional are becoming aware of the shield model.

The figure below shows the increase in referrals received each quarter over the last 12 months.

Chart 10: Shield referrals per quarter

2014 - 2015 Shield Referrals per Quarter

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
■ Series1	483	289	286	313
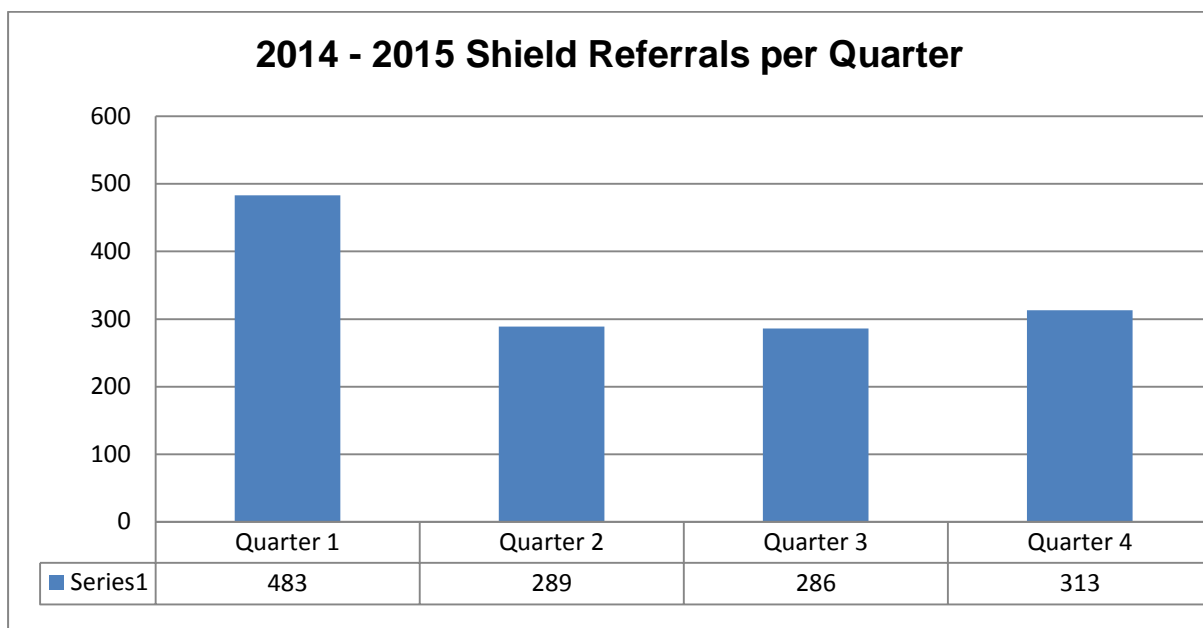
Of the total number of referrals, 690 were female and 681 were male.

Chart 11: Shield Female/ Male referrals

2014 - 2015 Shield Female/ Male referrals
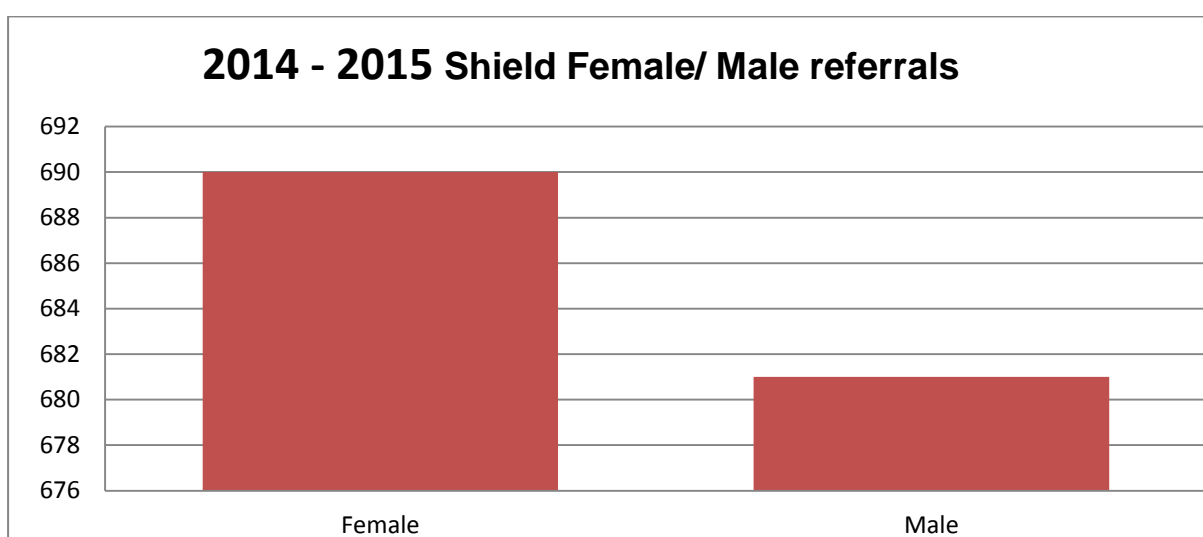
An analysis of the data by age is indicated in the below illustrates that the highest number of referrals received to the service were for young people aged 11 years old, closely followed

65

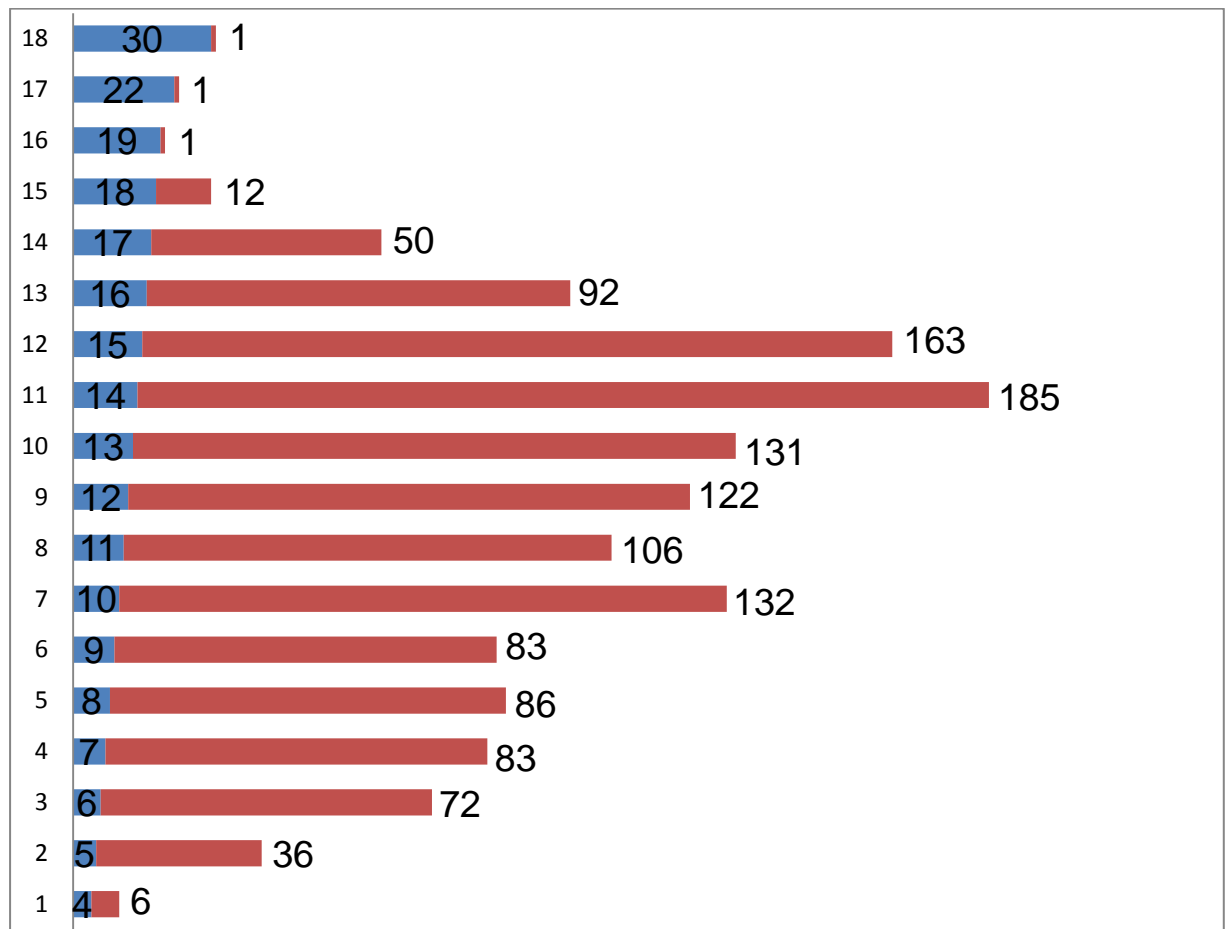by referrals for 12 year olds. This analysis also highlights the gender differences in referrals. Up to 15 years of age, the referrals are much higher for females than for males. For young people over 15 the number of referrals for females reduces significantly. The number of referrals for males increases slightly and they make up the largest proportion of referrals.

Chart 12: Referrals to Shield by age

Age	Blue	Red
18	30	1
17	22	1
16	19	1
15	18	12
14	17	50
13	16	92
12	15	163
11	14	185
10	13	131
9	12	122
8	11	106
7	10	132
6	9	83
5	8	86
4	7	83
3	6	72
2	5	36
1	4	6

The Ethnic mix of clients continued throughout 2014-2015, the illustrates on following page highlights the breakdown of referrals received per ethnic groups continues to be dominated with 52% of referrals to the service from of the White British ethnic group, which equates to 684 of the referrals received in 2014- 2015 from this ethnic group.

Represented in Fig. 4b as White other, 16 referrals to the service have been received from European ethnic groups including Polish, etc. and we continue to address the language barrier problems by utilising the English speaking skills of the young people to provide translating services as it is very rare when we encounter referrals with English as a second language.

Children & Young People EH&W in Sandwell   *26 July 2016*
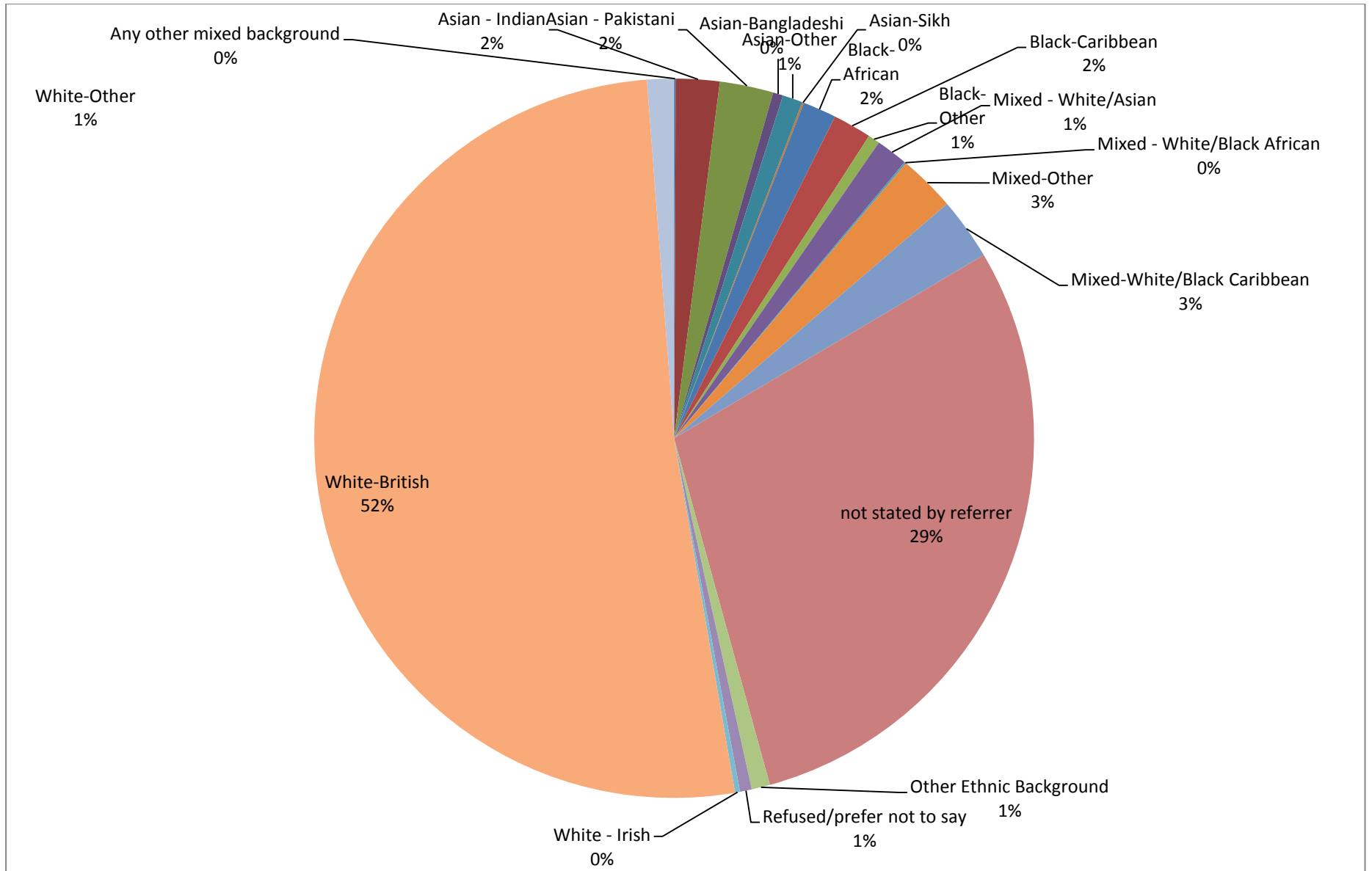
Referrals to the service come from across and beyond the Sandwell area. Referrals from children and young people living outside of Sandwell are due to Sandwell bordering Dudley, Birmingham and Walsall areas as in the diagram shown below.

It is also due to children and young people travelling from outside the borough to Sandwell schools. The qualifying criteria previously was for Shield to accept referrals for young people that attend a Sandwell educational facility but live outside of Sandwell or those who live in Sandwell but attend a school outside Sandwell. However, this criterion has now changed and Shield will now only accept referrals for children and young people who live under a Sandwell postcode.

Chart 13: Shield referrals by residence

Draft C&YP EH&WB Service Mapping 24 11 15
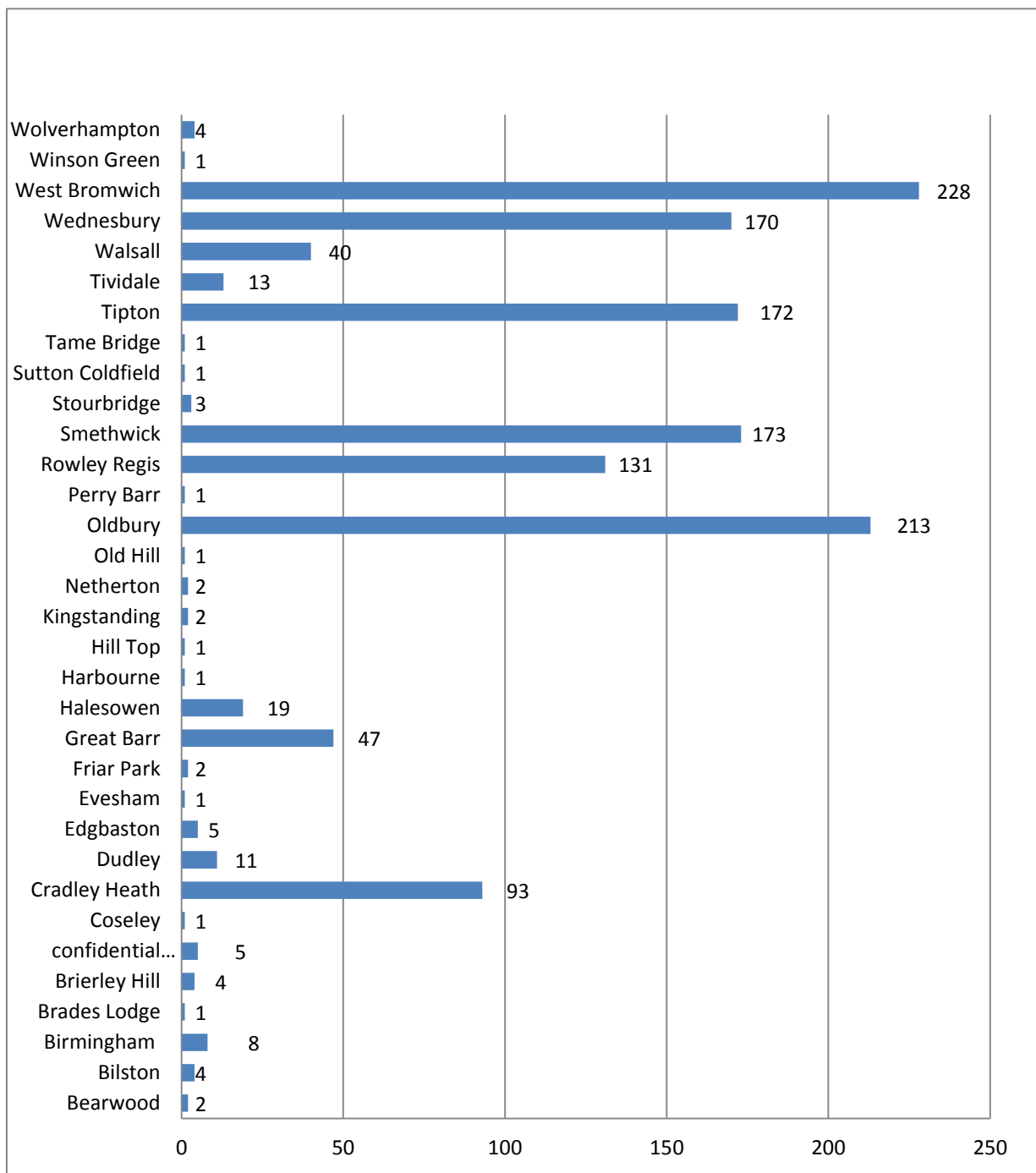
The average waiting time for intervention is between 6-12 weeks. This is dependent on the type of intervention that the CYP has chosen. From 2015/16 the POA team will decide on the intervention that is most appropriate for the client based on the referral form and additional information gathered on early help system, schools and from parents/carers etc. half away through 2014/15 Shield will stop using the Core Net system and will move to using the Outcome Star tools.

Shield is one of a range of therapeutic interventions that Murray Hall Community Trust offers, over the last year money has been secured for further development of therapeutic intervention for CYP, including:

- Looking Forward – offering one to one counselling and creative therapy including online counselling and Family therapy.
- School Buy in - number of primary and secondary school buy in counselling or creative therapy, based at the school one day a week for an academic year. This offer includes one to one work; drop in sessions at lunch time and low level group intervention.
- Delivery of training including Youth Mental Health First Aid & Mental Health First Aid for Schools and Colleges.
- Children In Need – Counselling and Creative Therapy for Young people with Self-Harming behaviour.

Inclusion Support Service

Description of service

Sandwell's Inclusion Support Service delivers services for children's emotional wellbeing and mental health at a number of levels including: strategic; whole organisations; training; consultations for staff, parents and young people; direct assessment and interventions at a case work level. The service is funded by Sandwell Council from the schools budget with total funding of just under £2 million.

Inclusion Support Services for children's emotional wellbeing and mental health range from 2 years to 25 years and are both statutory and non-statutory services. The services delivered correspond with universal, targeted and specialist services (Tier 1, Tier 2 and Tier 2+) working jointly with Health and Social Care regarding children identified as requiring Tier 3 provision.

The service provides direct support to special schools and children with behavioural and mental health difficulties found within these specialist environments.

The services providing direct support for children's emotional wellbeing and mental health are: Educational & Child Psychology; Behaviour & Emotional Support Team; Preventing Primary Exclusions Team; and Complex Communication & Autism Team. The teams deliver evidence based approaches and follow standards set by the British Psychology Society, Health Care Professions Council and NICE guidance such as ADHD, autism, conduct disorders and SEN Code of Practice for children with communication, learning, physical and 'social emotional and mental health difficulties'.

Service Capacity
There are 10.6 FTE Educational and Child Psychologists who undertake a range of statutory and non-statutory duties with children and young people aged 0-25 years of age across universal, targeted and specialist services.

The Behaviour & Emotional Support Team comprises 7 Behaviour & Emotional Support Teachers.

The Preventing Primary Exclusions Team comprises 6 LSPs who work intensively with approximately 56 children per year.
Staff undertake casework and deliver training to school staff. In 2012/2013 over 5,000 school staff were trained. The service also provides a consultation service for school staff, parents and other professionals.

Access to service
There is no waiting list for access to Inclusion Support Services and 124 referral points are operated across Sandwell. Over a 1,000 new cases are dealt with each year and overall the service holds some 5,000 cases that are open. Not all of these cases are identified as having emotional wellbeing or mental health difficulties,

Draft C&YP EH&WB Service Mapping 24 11 15

however, a significant number of children and young people experience problems with self-esteem and self-concept in relation to their learning and / or behavioural-emotional difficulties.

Educational and Child Psychologists and Behaviour Support staff time is allocated to each school based on need through a Service Level Agreement. Activities provided schools are negotiated and include whole school training, staff training, consultations with staff and parents, individual work with children and young people.

The Inclusion Support Service caters for children and young people aged 0-19 and up to 25 for those with a disability. The majority 68% (3,605) of the service users are primary school students, 26% (1,401) secondary school students and 8% (285) pre-school children.

The ratio of boys to girls using the service is higher in boys in all the services
- Behaviour & Emotional Support Team - 6:1 boys to girls
- Complex Communication & Autism Team - 6:1 boys to girls
- Educational & Child Psychologist - 3:1 boys to girls
- Preventing Primary Exclusions Team - 9:1 boys to girls

Recent service data indicated that the majority 62% (3,617) of children accessing the service were from a white ethnic origin, 15% (885) Asian, 7% (433) Black, 7% (408) of mixed parentage, 0.2% (10) Chinese and the ethnic origin was not known for 8% (477).

Interventions delivered

Inclusion Support offers wide range of interventions to combat poor emotional wellbeing and mental health problems in children including CBT to personal construct psychology, solution focussed therapy, motivational interviewing, behavioural approaches, therapeutic and counselling skills from a humanistic perspective. Cognitive approaches support children and young people's wellbeing and learning. In addition, various strategies to support and promote children's self-esteem, self-concept and self-identity are used.

In primary schools Behaviour Learning Improvement and Support Strategy (BLISS) is used. This provides a range of interventions at whole school, group and individual level for children and school staff.

Courses such as Inclusion Support's 'Therapeutic Mentoring' course aims at building provision in schools to promote and restore positive mental health for children and young people via the training of school support staff. Other courses related to ADHD, self-harm, autism and behavioural difficulties are also provided and fully evaluated, including a three month time lapse impact measure.

Outcomes

Add reference to audit as part of whole school approach to well-being.

Drugs, Education, Counselling and Confidential Advice (DECCA)

Description of service

The DECCA (Drug Education, Counselling and confidential Advice) Team provide the young peoples, aged 18 and under, universal education, targeted outreach, early intervention and specialist treatment alcohol, drug and tobacco services in Sandwell.

Service Capacity

Currently we have 9 full time members of staff and 2 part time. The team focuses on drugs, alcohol and tobacco fitting across all areas of provision for young people's services. It is located within Targeted Youth Support (TYS) / Early Help. DECCA is also commissioned for bespoke pieces of work generating income to meet the service target.

A full time treatment worker holds a maximum caseload of 15 in line with national best practice guidance. This is however dependant on the complexity of the cases e.g. the more complex the cases a worker holds the lower the overall caseload numbers.

Numbers

During the period 2014/15 the team worked face to face with:
- 16,828 young people in universal educational settings
- 1,076 young people in targeted outreach settings such as PRU, alternative education providers and VCS
- 182 young people received specialist treatment

Average waiting time
The service offers all young people an appointment within 15 days of their referral. If the young person is not able to attend in this time frame DECCA will liaise with them and those working and/or living with them to identify an appropriate time to meet. DECCA will work with a young person at a location mutually agreed which will mean the young person will most often be seen in the community.

Description of the severity of cases seen
Decca works with services already engaged with the clients or makes appropriate referrals to other agencies. Clients present with issues such as mental and emotional health, sexual health, troubled families and a range of issues 'wider than their drug use' which directly affects them and their using behaviour. DECCA's caseload is more complex than it has ever been and due to this partnership working has become ever more important to ensuring the safeguarding og the young people it works with.

Interventions delivered
DECCA delivers a range of psychosocial interventions in accordance with the National Drug Treatment Monitoring System (NDTMS), National Treatment Agency (NTA) and the National Institute for Clinical Excellence (NICE) guidance. The service has developed the Sandwell Treatment Effectiveness Model (STEM) in conjunction with the University of Birmingham. Client interventions are tailored to their individual needs ensuring that they achieve the best outcomes leaving the service in a planned way and drug free.

Outcomes
All clients are assessed before and after the intervention to ensure that knowledge has been improved. DECCA performs higher than the NTA national averages and is very proud of this fact considering the deprivation levels of the borough.

General comments
The service continues to have an excellent relationship and reputation with its key partners and further partnership working developments are underway.

Chin Up
Description of service
Chin Up is a group based emotional health intervention commissioned by Sandwell and West Birmingham Clinical Commissioning Group (CCG). While the aim of every programme is to improve the emotional wellbeing and resilience of participants, the group determine their own objectives to reach that aim. This ensures the programme is truly person centered, there are no pre-determined sessions, each group creates its own pathway and their process is facilitated rather than directed. The Chin Up practitioner embeds evidenced based Positive Psychology techniques into the creative activities that are chosen by the young people, creating a programme unique to each group's needs.

Service Capacity

Chin Up has only ever been delivered by a lone practitioner, therefore capacity is limited. At most a single practitioner can deliver up to 8 school-based Chin Up groups of 8 young people per week, or 48 groups per academic year, leading to engaging a total of 384 young people per academic year in school based programmes. Additionally the practitioner can deliver up to 5 community based programmes in the school holidays, with 10 young people per programme, equating to a further 50 children per year.

During 2014, the practitioner did not reach these maximum figures as they delivered 1:1 Play and Creative Arts Therapy one day per week.

Numbers

During the financial year of 2014, the practitioner single-handedly worked with 247 young people on the Chin Up programme. This equates to 1782 Chin Up client contacts.

Age/ gender/ethnicity

Gender

During 2014, 109 young females and 138 young males benefited from the Chin Up programme.

Age

Children aged 7-16 accessed support from the Chin Up programme.

Ethnicity

The distribution of ethnicities entering the Chin Up service is in line with the general population of Sandwell. In 2014 64% of Chin Up participants were White British, while 36% came from BME communities. Similarly the most recent census data claims that 65.8% of Sandwell residents are White British, and 34.2% come from BME communities.

Average waiting time

The current waiting time for the service is 2 months with 10 schools on the waiting list.

Description of the severity of cases seen

Community Based Chin Up

Chin Up referrals come via the Wellbeing Hub. In 2014 Chin Up received referrals from GP practices, School Health, Maternal Emotional Wellbeing Service, Education, COGs, Barnardos, Esteem Team, parents/carers, Sandwell Lifestyle Choices, Children's Services, Sandwell Advocacy, Sandwell Women's Aid, Intensive Family Support Service and CAMHS, with CAMHS being the main referrer.

The main reasons for referral in 2014 included low mood, anxiety, self-harm, body confidence issues, bullying, confidence and self-esteem issues, anger, bereavement, sexual exploitation, issues with transition and social isolation.

School Based Chin Up
Schools contact the practitioner directly to go on the waiting list for a school based closed Chin Up programme. There has been no advertising for this service; its popularity has grown purely by word of mouth.

The main reasons for referral included not meeting the threshold for higher tier services (mainly CAMHS and Shield), not engaging with talking therapies, bullying, low confidence and self-esteem, issues with transition, anxiety (predominantly around exams), self-harm, anger and difficulties interacting with peers.

Interventions delivered
School and community based Chin Up programmes.

Outcomes
Quantitative
The average young person's WEMWBS score increased from 29.8 pre intervention to 60.9 post Chin Up during the 2014 financial year.

A paired samples t-test revealed that this increase is statistically significant ($p < 0.0001$), with all participant's scores improving.

ANOVAs were performed on the age and ethnicity Chin Up data collected. The statistical tests revealed that there was no significant difference in scores across age ($p > .05$), nor ethnicity ($p > .05$). Therefore in 2014 Chin Up was found to be equally effective across ethnicities and ages (7-16).

Qualitative
Each young person is asked to complete a qualitative evaluation at the end of their Chin Up programme. Key outcome themes identified in the 2014 evaluations included:
-   Increased confidence
-   Improved emotion awareness/ emotion regulation
-   Increased positive emotion
-   Reduction in self-harming behaviours
-   Raised self-esteem/ self-worth

General comments
The demand for Chin Up cannot be met by a single practitioner.

Tier 3: Specialist CAMHS Services

Brief Description of Service

Sandwell Child and Adolescent Mental Health Service (CAMHS) are commissioned by Sandwell and West Birmingham CCG from the Black Country Partnership Mental Health Trust. It sits as one of the mental health services provided by their Children Young People and Families and Learning Disability Group that also delivers services for Early Intervention in Psychosis (14 to 35 year olds) and Eating Disorders for Adults. The CAMHS provide mental health support across Sandwell for children and young people (5 to 18 year olds) who are experiencing mental health difficulties that are severe, enduring and complex. The service provides assessment and direct interventions and consultation to other professional working with children and young people.

Sandwell CAMHS is made up of a range of professionals including doctors, psychologists, nurses, psychotherapists, family therapists, occupational therapists, social workers and mental health practitioners, as well as assistant practitioners and administration staff. We accept trainees and students from many of the professional disciplines within our service.

The service is provided through four teams who all work together to provide a comprehensive service:
- Prevention and community engagement team provides training based on referral trends and needs, support, consultation and advise to professionals within universal services and short term brief interventions. This provision is led by our Primary Mental Health practitioners.
- Point of access team is a collaborative venture with the local authority and Murray Hall Trust tier 2 services to jointly screen and manage referrals into the appropriate service and ensure   timely access
- Specialist mental health team provides initial assessment and a range of evidence based interventions inclusive of; individual therapy, cognitive behavioural therapy, family therapy, child psychotherapy, psychiatric assessment and review. Embedded within our specialist mental health provisions are dedicated services for looked after children and children and young people with severe learning disabilities.
- CAMHS Crisis assessment and intervention team (CAIT) provide a fast response to children and young people who present at the acute hospitals. They also respond to crisis situations that may otherwise have resulted in tier 4 inpatient admissions.

Source of referral

Referrals originate from a range of people including
- GPs
- Health Professionals including; Paediatric services, School nurses, Health Visitors and SALT's
- Schools via education staff
- Social Services via social workers in children's services

- Targeted Youth Support
- Youth Offending Service
- Third sector organisations

Referral Criteria

The core business of specialist CAMHS is the assessment and treatment of complex mental health difficulties and associated risks in young people under the age of 18 years. We see children and young people with serious mental health difficulties regardless of their level of learning disability, co-morbid health issues, neurodevelopmental difficulties, looked after status.

CAMHS offer services to children and young people who meet the following criteria and present with symptoms at the point of referral which suggest major mental illness and other psychiatric disorders such as:
- Mood disorders
- Anxiety disorders that cause major dysfunction to the child/young person
- Obsessive Compulsive presentations or Post Traumatic Stress Disorder
- Psychosis – under 16 years. Above 16 years are referred to the Early Intervention Team
- Attention Deficit Hyperactivity Disorder/Autistic Spectrum Disorders/Tic Disorders with co-morbid mental health difficulties
- Eating Disorders
- Self-Harming Behaviours

Referrals are managed at the joint Point of Access.

Skills and Interventions Delivered through the Care Pathways in CAMHS

The Sandwell CAMHS Care Pathways provide a framework and evidence based guide to inform the care and intervention offered to children, young people and families within Sandwell CAMH services from referral through to discharge.

The development of the care pathways provides a resource for referrers, young people, families and CAMHS to allow an understanding and awareness of what should be expected at any point during the journey of care and provide a further opportunity for collaborative practice. In clinical practice and by service design, many young people and their families will receive sufficient support from only very brief clinical interventions or a single consultation where treatment /advice is given at the choice appointment which may not proceed beyond the assessment and formulation stage.

The care pathways within Sandwell CAMHS ensure that:
- assessment, care planning and care delivery are centered on the child or young person and positive outcome focused
- care and treatment is in line with the available evidence base
- effective case partnerships are developed and sustained between services, agencies, children, young people and their parents / carers
- relevant and useful information is shared appropriately and in a timely manner with children, young people., parents / carers, professionals, services and agencies

- variation to planned care is captured, analysed with supporting narrative and acted upon where appropriate

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Table 8: Care pathways offered with Sandwell CAMHS

Mood Disorder Care Pathway
Challenging Behaviour Care Pathway
Anxiety Disorder Care Pathway
Attention Deficit Hyperactivity Disorder
Eating Disorder Care Pathway
Post-Traumatic Stress Disorder Care Pathway
Emerging Personality Disorder Care Pathway
Obsessive Compulsive Disorder Care Pathway
Parenting Care Pathway
Sleep Care Pathway
Feeding Care Pathway
Attachment Disorder Care Pathway
Psychosis Care Pathway
Self-Harm Care Pathway
Continence Care Pathway
Autistic Spectrum Disorder Care Pathway

Although the care pathways for specific problems or interventions provide detailed information and guidance regarding the care and management of young people and families accessing CAMH services, clinical judgement remains paramount. The experience and knowledge of the CAMH practitioner will always have a bearing on any decisions made with the young person and family regarding the most appropriate treatment or intervention option. Care pathways aim to retain clinical judgement while enhancing clinical outcomes.

The care pathways will normally be built on clinical effectiveness evidence, particularly NICE guidelines. However, many children and young people accessing CAMH services will not have a definitive diagnosis; it is in the emerging nature of young people's difficulties that such a definitive diagnosis may not be readily available or appropriate. Intervention and the identification of an appropriate care pathway is therefore guided by a case formulation, (that is, a conceptualisation or account of the presenting difficulties based on an assessment and, drawing together information about the cause and nature of those difficulties). Consequently, interventions may focus on the young person's context – their family or environment. Therefore modular care pathways, rather than the standard linear pathways, are utilised to allow increased flexibility in addressing the needs of individuals referred to CAMHS. A case formulation can draw together such a care

pathways on the basis of a child or young person's often complex situation, changing emotional and mental health needs but also their strengths, personality and learning styles.

Location and Time of services

The service operates out of a building dedicated to CAMHS, which is located at Lodge Road, Sandwell. Clinical interventions and multi-agency meetings can be provided from this location, however, the service provides outreach work and works with clients in the community and in their own home, where appropriate. The CAIT hours of work are 8am to 8pm seven days a week; other services currently operate from 9am to 5pm Monday to Friday. There is a 24 hour call psychiatry service that provides telephone support.

Referral Rates

For the period of April to Oct 2015
1156 referrals had been made into specialist CAMHS and a total of 791 (68.43%) had attended and engaged with the service. (NB this is based on the number of initial appointments over the number of referrals received during the period)
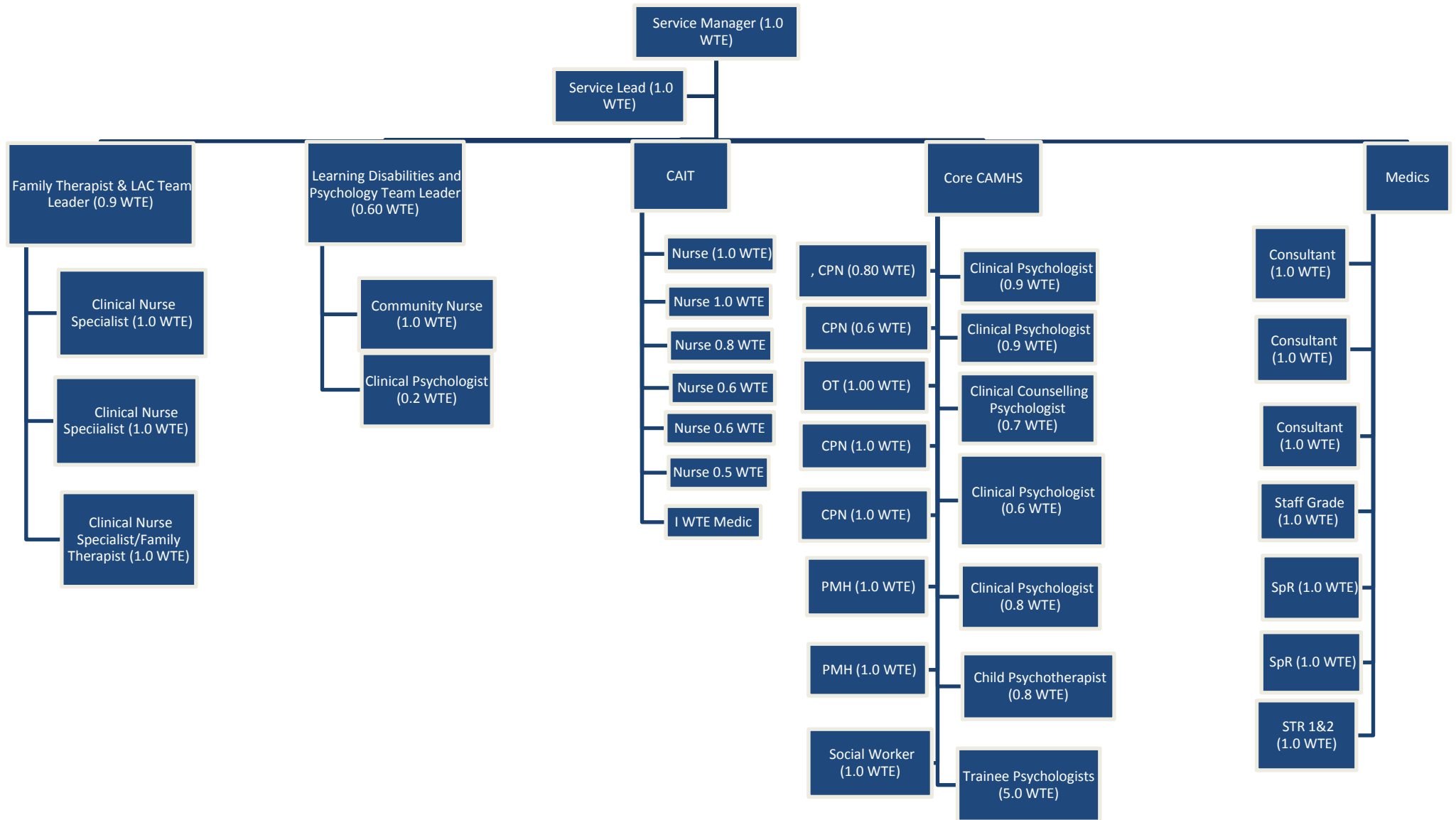Waiting times for this period of activity were 11.2 weeks (8.5 days)
It is important to note that both referral rates and waiting times fluctuate throughout the year.

Management and Leadership

The Division is led by the new Director for Children Young People and Families and Learning Disabilities Group, and a new Divisional Manager and Head of Nursing. Clinical leadership for Sandwell CAMHS is led by the Associate Clinical Director, who is a Psychiatric Consultant within the service. The Service Manager provides day to day leadership, operational direction and contributes to the strategic direction with the leadership team.
 The CAMHS leadership team recognises that individual clinicians have both implicit and explicit leadership roles within their field of operation as they extend their support of emotional and mental health in universal children's services through to highly specialised interventions provided by their core specialist teams.

Sandwell CAMHS Staffing Structure

Service Manager (1.0 WTE)

Service Lead (1.0 WTE)

Family Therapist & LAC Team Leader (0.9 WTE)
- Clinical Nurse Specialist (1.0 WTE)
- Clinical Nurse Speciialist (1.0 WTE)
- Clinical Nurse Specialist/Family Therapist (1.0 WTE)

Learning Disabilities and Psychology Team Leader (0.60 WTE)
- Community Nurse (1.0 WTE)
- Clinical Psychologist (0.2 WTE)

CAIT
- Nurse (1.0 WTE)
- Nurse 1.0 WTE
- Nurse 0.8 WTE
- Nurse 0.6 WTE
- Nurse 0.6 WTE
- Nurse 0.5 WTE
- I WTE Medic

Core CAMHS
- , CPN (0.80 WTE)
- CPN (0.6 WTE)
- OT (1.00 WTE)
- CPN (1.0 WTE)
- CPN (1.0 WTE)
- PMH (1.0 WTE)
- PMH (1.0 WTE)
- Social Worker (1.0 WTE)
- Clinical Psychologist (0.9 WTE)
- Clinical Psychologist (0.9 WTE)
- Clinical Counselling Psychologist (0.7 WTE)
- Clinical Psychologist (0.6 WTE)
- Clinical Psychologist (0.8 WTE)
- Child Psychotherapist (0.8 WTE)
- Trainee Psychologists (5.0 WTE)

Medics
- Consultant (1.0 WTE)
- Consultant (1.0 WTE)
- Consultant (1.0 WTE)
- Staff Grade (1.0 WTE)
- SpR (1.0 WTE)
- SpR (1.0 WTE)
- STR 1&2 (1.0 WTE)

Sandwell CAMHS Staffing Structure

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Crossover with adult wellbeing and mental health services

From age 16, young people in Sandwell are eligible to use the comprehensive array of adult wellbeing services that operate across the six towns and provide services at all levels up to low risk Tier 3 adult services.

Service Capacity

Numbers /Age/gender/ethnicity

CAMHS cannot provide this information

Tier 4 – Highly Specialised CAMHS

Brief Description of Service

Tier 4 inpatient services are commissioning on a national basis by NHS England. There are currently two national service specifications for the service; one that covers Children's inpatient provision for under 12 year olds and one that covers 13-18 year olds inpatient provision.

The under 12s service provides for an estimated 140-150 patients a year across England. There are currently eight dedicated Tier 4 CAMHS Children's Units in England these are located in Manchester, Liverpool, Sheffield, Birmingham, Cambridge and London.

For 13-18 year olds there are approximately 35 NHS and 11 independent units across England and all accept NHS funded patients, although services are not evenly distributed across the country (Source Quality Network In-patient CAMHS Database 2012).

There are also a small number of CAMHS Tier 4 Learning Disability Units catering for varying ages and degrees of disability, although these services tend to focus on young people with moderate to severe learning disabilities.

Access, Thresholds and Waiting Times

There is no recent data on estimated levels of need for the different elements of CAMHS including Tier 4 services. This is dependant not only both on prevalence but also other factors including the range of alternative services. The only available data is that detailing actual admissions by Government Office region.

Chart 13: Inpatient admissions for mental health disorders

Inpatient admissions for mental health disorders per 100,000 population aged 0-17 years – England 2011-12
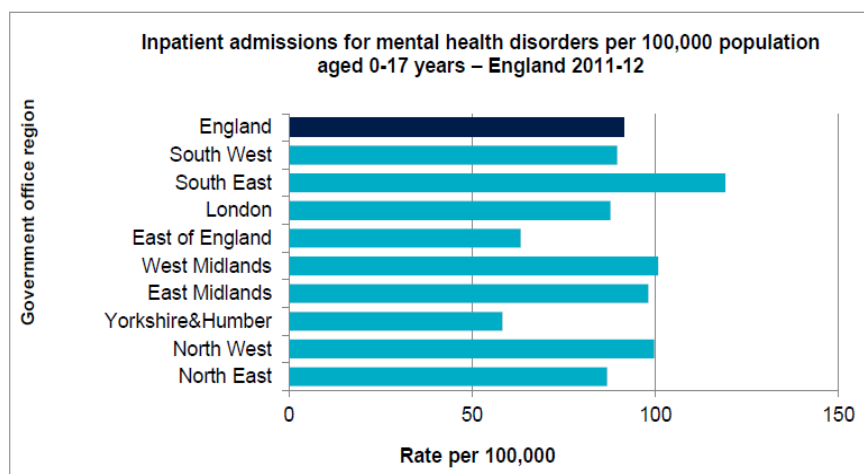
Referral to Inpatient CAMHS from Sandwell

Over the last 3 years from 2012 to August 2014 a total of 41 children were referred by Tier 3 to Tier 4 services.

This included 13 admissions in 2012, 21 in 2013 and 7 in 2014 which suggests a much lower demand for Tier 4 services in each of the years compared to the 56 estimated by Kurtz. (Kurtz 2007)

Subsequently 31 children were discharged back to Tier 3 including 11 (85%) in 2012, 18 (86%) in 2013 and 2 (29%) in 2014. The BCPFT figures could not be validated due to lack of availability of data from NHS England.

In the past staff from Shield were trained in CYP –IAPT however they have not been able to continue to deliver this with fidelity (?). However, some IAPT principles are embedded within the Shield sessions offered. Currently some workers within Voluntary and community services in Sandwell are delivering on CYP IAPT.

CAMHS includes looked after team – there is a small CAMHs/LAC team which includes 2 CPNs dedicated to LAC. The provision is managed by a Family Psychotherapist. The service works with the wider CAMHs team to access additional interventions or skills as and when required.

Crisis and Assessment Team (18 plus) – Getting Risk Support

Sandwell has a liaison service that is available for 18 plus years. During the last year the CCG commissioners have worked with BCPFT to develop a crisis and assessment service that supports children and young people who attend A&E to identify whether inpatient admission is required for mental health. The crisis service is delivered from 8am to 8pm, has 2 hour response rates and 12 hours to complete an assessment. An on –call service is available 24/7. The team also provide wrap around home

treatment to patients until the crisis has been de-escalated and where it is felt that tier 3 CAMHs services can continue to support. The purpose of this service is to avert unnecessary admissions to tier 4 services. Data in recent years would suggest that whilst there has been an apparent increase in CYP attending A & E for mental health related concerns, there has been a sharp decrease in admissions when compared with years prior to the service being in place.
/Sandwell place of safety or a Black Country wide place of safety.
The total cost for this service is £453,000 and is staffed by 5 band 7s and I medic. With some additional admin support.

There is no place of safety for under 18s , however, discussions are underway to understand the need as well as options to develop either a Wolverhampton/Sandwell place of safety or Black Country wide place of safety.

CAMHS have bespoke services for LAC and LD patients.

There is no Home treatment service (think this is tier 3/Getting more help ?) to reduce the demand on specialist services and to keep young people closer to home.

Crisis Care Concordat
Sandwell is committed to delivering against the crisis care concordat and Children's mental health is a feature of the plan.

Multi-Systemic Family Therapy (getting more help)
Sandwell has developed a new multi-systemic therapy service (MST) in partnership with Dudley Council that supports children and young people aged 10-17 years. The board, which oversees delivery of the programme, includes representation from Local authority, police and CCG. Intensive interventions are offered to those families who require additional support.

Sexual Exploitation – CAMHs work with children who present with mental health difficulties and have CSE issues as part of the main services they provide. Sandwell has a multi-agency child sexual exploitation team (no health input) which refers into the service.

Sexual Exploitation – CAMHs work with children who present with mental health difficulties and have CSE issues as part of the main services they provide. Sandwell has a multi-agency child sexual exploitation team (no health input) which refers into the service.

8. Effectiveness of current services

Strategy and Vision: Fragmentation

'Future in Mind' calls for pooled budgets and a lead commissioner in order to address fragmentation of services at a local level and to support a more co-ordinated approach[21].

Previous local reviews (SMBC and SWBCCG, 2014) have concluded that: There is a lack of an integrated vision and strategy in Sandwell to inform service commissioning around emotional health and well-being.

Much has been done in Sandwell to work to address challenges identified in previous reviews and the recent CAMHs Transformation Plan for Sandwell also seeks to improve CAMHs provision in future years building on the work already underway.

However, feedback from a partnership stakeholder event around Children and Young People and Emotional Health and Well-being (16th November, 2015) included: a perception of fragmentation of services at commissioning and strategic levels leading to dis-jointed services at a provider level. It was made clear that: 'there are some good services' but a need was expressed for an overarching, joined up strategy.

Fragmentation with respect to the commissioning of emotional health and well-being services in Sandwell across universal, targeted and specialist services appears to be leading to fragmentation in the way in which services are delivered.

The CCG and Sandwell Council have agreed to appoint a joint commissioning post which will help to develop a partnership strategy for improving mental health and wellbeing. This post will operate across both children's and adults mental health and wellbeing services to support the move to a 0-25 yrs service and the future move towards an all age, all services integrated model for the commissioning of mental health and wellbeing services in Sandwell.

Promoting wellbeing and prevention of mental illness

Promotion and Prevention – Universal Provision

Closing the Gap (2014) identifies areas for action in the next two years which include the need to start early to promote mental well-being and prevent mental health problems[25].

There are a range of opportunities already in place in Sandwell to promote mental well-being and to prevent mental health problems as indicated in the service mapping section e.g. the BLISS strategy for primary schools delivered by the Inclusion Support Service and the 'Out to Play' Council Service.

Further plans are in place to implement interventions such as an evidence based whole school approach to emotional health and well-being in Primary schools; an ante-natal parenting programme and; a programme is being developed to put in place a 'risky behaviours' training programme for teachers which is concerned with addressing risks around issues such as alcohol misuse which can impact negatively on well-being.

Overall, it is difficult to determine the effectiveness of the existing interventions and the availability of these programmes for all young people. Funding needs to be at least maintained, at a universal level to ensure that evidence based promotion and prevention interventions can be routinely in place for children and young people across schools, communities and other settings.

This will be particularly important for Sandwell bearing in mind the high numbers of young people who will require help and support around emotional well-being at a universal level. Robust universal provision is vital to help prevent some emotional health issues in children and young people and to reduce pressures on more specialist services. It will also be important to find ways to maximise the use of the existing resources/services that are already operating in statutory and non-statutory sectors.

Effective emotional health and well-being training for universal workers is a key aspect of enabling promotion and prevention of emotional health and well-being, as well as early identification of individuals with mental health issues.

The mapping of services and a subsequent stakeholder event (PH,16th November 2015) identified that there are a range of existing Sandwell organisations who provide or commission training around emotional health and well-being for universal workers. This includes training provided by the Inclusion Support Team, Public Health, Shield, DECCA, Voluntary and Community sector providers and CAMHS specialist services. Whilst this is indicative of the potential resource available to support universal provision in Sandwell it is unclear how effective these different approaches to training might be, and if there is consistency in messages, and referral pathways advised. It is also unclear what proportions of universal workers from key organisations have accessed this training.

Maternal Health and Early Years – Shortfalls

NICE guidelines (CG 40) identify the importance of the transition to parenthood and early years, including attachment, as well as provision around post-natal depression. Whilst there are some services in place to address these areas in Sandwell (e.g. Children's centres, health visitors, and Changes Parenting programme) there are still some gaps in provision.

The transformation plans (2015/16) for Sandwell, state that Peri-natal mental health services are not currently in line with published guidance and identify the need to

resource shortfalls in services to address outcomes related to: earlier diagnosis of emotional perinatal mental health; improved intervention and support; and improved access to services. At a Public Health Stakeholder event (PH, 16th November 2015) attendees voiced concerns about a lack of clarity around perinatal care pathways.

There are a number of existing providers who could play an integral part of more robust perinatal pathways and there is a need to ensure that a shared awareness and understanding of these pathways is in place, so that women who have emotional health issues, are identified at an early stage and can promptly be referred for appropriate support and treatment.

The evidence based Family Nurse Partnership programme is in place but currently only 20% of the eligible population receives the intervention. There is a high level of need for this resource intensive service in Sandwell hence the shortfall in uptake.

Whilst parenting programmes are already in place in Sandwell, gaps in provision include the need to ensure that commissioned parenting programmes are effective and accessible to those who most need them. The need for specialist parenting programmes e.g. for parents with children who have a learning disability, was raised at a Public Health stakeholder event (PH, 16th November 2015). It is also important that commissioners and providers ensure, that evidence based parenting programmes are in place, as an intervention for children and young people with mental health disorders, such as conduct disorder. The Sandwell Transformation Plan 2015/16 identifies additional parenting programmes as part of its implementation plan. There is also a current gap around ante-natal parenting classes, though Public Health are currently exploring ante-natal parenting provision to address this.

Access to Targeted Services

The mapping of services in Sandwell, undertaken as part of this HNA, has identified issues around waiting times and access to emotional health and well-being services in Sandwell for Children and Young people at a targeted and specialist level. Indeed, one of the issues fed-back from a recent children and young peoples consultation (Changing Our Lives, 2015) on emotional health and well-being services in Sandwell was the need for timely access to services.

Chin-up, a service, commissioned by the CCG, sees young people aged 7-16 years and often receives referrals for young people who fail to meet service access thresholds for other services e.g. Shield and CAMHS. There is limited capacity within the service as it is delivered via one worker. Last year, Chin-up did not reach the target for sessions with young people, and there was a waiting time of 2 months for the service.

However, the service has demonstrated success in improving on young people's Well-being scores (Warwick Edinburgh Mental Well-being Scale) when compared pre

and post intervention. Chin-up is an example of an emotional health and well-being service in Sandwell that is defined as a targeted service, which delivers good outcomes but is unable to meet current demand. This suggests a need to review the service provided by Chin-up to consider if it could and should be expanded upon in the context of other targeted services such as Shield.

Shield delivered by Murray Hall Community Trust, and commissioned by Sandwell Council, provides a range of services at a targeted level in Sandwell. However, the service is also accessed by a number of children and young people who have CAMHS specialist (Tier 3) level needs. Again performance data indicates issues around waiting times and access to services.

A review (update) was undertaken by West Midlands Quality Review Services (WMQRS) in July 2014 and September 2015, they noted a number of concerns in relation to Sandwell Shield related to: activity; the referral process and assessment of referrals; the balance of therapeutic interventions offered; data collection; adherence to appropriate guidelines and the need to prioritise its offer to children and young people.

Shield services include delivery of the 'point of access' assessment process, though this currently includes referral into a limited range of emotional health and well-being services.

Children and Young Peoples IAPT (increasing access to psychological therapies) was previously delivered within Shield but the service was discontinued due to issues around fidelity. The Sandwell CAMHs Transformation Plan 2015/16 includes increasing the use of CYP IAPT principles across a range of partners and increasing numbers of staff able to use CYP IAPT.

The Inclusion Support Service also contributes a targeted service for those school age children and young people who meet their service criteria. The inclusion support service do not have waiting lists to access these services.

Those with a mental disorder who receive prompt treatment and unmet need.

Pre-School Years

There is little prevalence data for mental health conditions in children in the pre-school years. However, based on available literature[26] it is estimated that there are an estimated 3,720 children aged 2-5 years in Sandwell with a mental health disorder.

There are no specific emotional health and well-being services in Sandwell for children under 5 years old at tiers 2, 3 and 4 (though some support is offered to

parents through children's centres and children may be seen by paediatricians). This lack in provision has been identified in previous reviews (West Midlands Quality Review,2015) and was raised as an issue at the Emotional Health and Well-being Stakeholder Workshop (16th November 2015). The Sandwell Transformation Plans 2015/16 include the development of services for 0-5 year olds including additional parenting programmes.

School Years – Specialist Services

The recent estimated prevalence of total mental health conditions in Sandwell (ONS 2014 mid-year population estimates) in children aged 5-16 was 4,767, including conduct disorders affecting approximately 2,880 children

In 2014/15 the CAMHs Specialist team saw 1393 patients. Patients were on average, assessed within 11.4 weeks and were able to access treatment within 18.6 weeks.

An eating disorders Service for 14-35 year olds is also delivered by Tier 3 CAMHs. Eating disorder services need to be in place which are in line with current guidance to ensure that individuals are able to access help at an appropriate stage preventing deterioration and the need for additional support /treatment - the current provision falls short of the guidance. However, the Transformation plan for Sandwell 2015/16 sets out plans to invest in existing provider, Black Country Partnership Foundation Trust to develop an eating disorder service for Sandwell Children and young people which is compliant with current guidance.

There is a growing demand in complexity and volume of referrals (CAMHS specialist), with increased self-harm and eating disorders. This can sometimes impact on the level of resources. As with other emotional health and well-being services in Sandwell, the service is struggling to meet the current demand within a reasonable timeframe. Indeed, based on the Royal College of Psychiatrists guidance (2006) on workforce configuration, the current CAMHs specialist workforce is below the recommended capacity.

Evidence Based Interventions

Evidence (Centre for Mental Health,2015) suggests the most effective/cost effective interventions to deliver the most common mental health disorders affecting CYP are as follows (see table below):

Table 9: Evidence based interventions

Condition	Name of intervention
Conduct disorder in Early Years	Family nurse partnership (<2yrs), Group parenting Programmes(3-12yrs); Individual parenting programmes(2-14yrs) school based interventions(6-8yrs) Whole school anti-bullying intervention
Conduct Disorder in Adolescence	Aggression Replacement Therapy (12-18 yrs) Functional Family Therapy (11-18 yrs) Multi-systemic Therapy (12-17 yrs) Multi-dimensional treatment fostering (12-18 yrs)
Anxiety Disorders	Group CBT for children (5-18yrs) Group CBT via parents (5-18yrs).
Depression	Group CBT (12-18yrs) individual CBT (12-18yrs)
ADHD	Group parent training (2-12 years); Multi-modal therapy- treatment, combining medication management and behavioural interventions (school age).

Whilst a number of these interventions appear to be in place in Sandwell, current provision needs to be reviewed further, to identify if these specific interventions are currently routinely being made available to children and young people when diagnosed with these conditions. Consideration needs to be given to making sure these interventions are routinely available for children and young people with these specific mental health disorders.

As indicated previously there are capacity issues and waiting lists which prevent young people accessing services in a timely way even where evidence based interventions are available. Therefore the work underway to address issues around access to services already underway in Sandwell needs to continue.

Commissioning

Overall services appear under commissioned at tiers 1, 2 and 3 when the estimated numbers of children age 5-16 years, requiring help and support, at each tier is considered (7,448, 3,476 and 919 respectively). However, it is acknowledged that schools independently commission a number of services and the voluntary and community sector provides some emotional health and well-being services. Therefore, it is important to find ways to maximise the use of existing resources currently provided across statutory and non-statutory sectors.

It will be important to continue to monitor and review capacity at tier 3 (specialist services), as necessary to improve access here, since more effective provision at tiers 1 and 2 should alleviate pressure at tier 3. It will need to be borne in mind that the CAMHS specialist workforce capacity is below recommended levels and Shield is also providing some tier 3 provision.

The interface between community based Tier 2 services and CAMHS specialist services (Tier 3) is ill-defined, which leads to an increase of inappropriate referrals to either service which are then referred back. This can protract the clients experience within the service and delay treatment.

A point of access (POA) has been developed to enable joint working between Murray Hall and the Black Country Foundation Trust (BCPFT), and to help alleviate some of the issues around appropriate referrals and timely access to services. Referrals are triaged by Shield workers into current tier two and three services.   At the time of writing, the POA had only been established for a short time and therefore it would not be possible to understand its impact. However, an evaluation of the POA will be undertaken in due course and it will be important to consider the outcomes and recommendations. The perceptions of attendees at a stakeholder event (Public Health,16th November 2015) were that the POA was referring service users to a limited number of commissioned providers only i.e. Shield or CAMHs specialist services and that an expansion of this to include a broader range of service providers across different tiers would be beneficial.

The stakeholder event (PH, 16th November 2015) also identified concerns around a lack of awareness of the range of emotional health and well-being services operating in Sandwell 'who does what?' and of referral pathways. There was also a strong feeling of fragmentation of services at a provider level and lack of integrated working.

The existing small team of primary care mental health workers (PCMHWs) have insufficient capacity. Funding has been made available to commission an additional 7 PCMHWs to work across the Community Operating Groups (COGs) and to place a further 2 specific PCMHWs with MASH, Looked After Children (LAC) and Youth Offending Services. A key purpose of the new primary mental health worker posts is

to address the lack of integration that exists in relation to CAMHs both internally and externally.

Therefore it will be important to ensure that these new posts add value and do not duplicate existing provision. In particular, they will need to work closely in partnership with the main emotional health and well-being service providers across universal, targeted and specialist services.

Performance Management

A Lack of consistency in the outcomes measures used to performance manage emotional health and well-being services in Sandwell has been identified as an issue in previous reviews (SMBC and SWBCCG, 2014) e.g. the use of Shield CORE- net scores and the use of CHIN-UP WEMWBS. This was also raised as an issue at the HNA Stakeholder event (16th November 2015) since it makes assessment of effectiveness and cost-effectiveness between differing services more difficult to achieve.

A high proportion of children in Sandwell are in black and minority ethnic groups, and they are expected to grow as a proportion of the population. A previous review (SMBC and SWB CCG, 2014) identified that uptake of emotional health and well-being services is lower than expected from Asian Children and young people but higher than expected in those of mixed ethnicity suggesting there is a need to understand this under and overuse.

Crisis Management

The Mental Health Crisis Care Concordat (HM Government, 2014) highlights the importance of ensuring that individuals, of all ages, who require crisis mental health service support are able to access it 24 hours a day, 7 days a week[27].

There is no funded CAMHS home treatment service (Tier 3.5) for children and young people in Sandwell. The lack of this service, increases the likelihood of potential service users being admitted to Tier 4 bedded services, many of which are located away from the West Midlands. This impacts on the length of stay in hospital as there is limited intensive outreach support to facilitate discharge and families struggle to visit. The transformational plan for Sandwell 2015/16 acknowledges this service gap in Sandwell and services will be re-designed to include provision for home treatment as part of the plan.

However, Sandwell has recently invested in a Crisis and Assessment Team for children and young people. The team provides crisis support and intensive interventions to those patients who attend A&E (and through other routes), as appropriate. The intention is to reduce the numbers of these individuals being admitted as inpatients.

Sandwell has higher levels of self-harm admissions (ref) than the national average in 10-24 year olds. It will be important to ensure that current (and future) provision which is included as part of the Crisis and Assessment Team response, is in line with current guidance and that this is addressed as a priority.

Tier 4 - There are a lack of Tier 4 beds locally and regionally which remains a concern. The Area Team considers there is adequate provision of Tier 4 beds locally for local demand but services are taken up by referrals from other areas making them less available to local children.

Transition Children to Adults Services 16-25 years

The transition stage between children and adults services has long been recognised as an important time to ensure vulnerable young people are not adversely affected when many other aspects of the young person's life may also be subject to significant change e.g. in education and employment. The partners have agreed that children and young people's emotional health and well-being services in Sandwell should be extended from 0-18 years to 0-25 years. Where available, data has been provided around the 0-25 year age group in order to inform any future plans to include this broader age range.

Feedback from the Public Health Stakeholder event (November 2015) and a previous review (SMBC and SWBCCG,2014), proposed that there is a need to fully engage with the client group, to fully understand the best approach to make regarding future provision. Suggestions included utilising the Sandwell Youth Parliament.

9. **Consultation with stakeholders including parents and service users**

Summary Stakeholder and User engagement (Emotional Health and Wellbeing of children and Young People Needs assessment Dec 2014)

There has been a range of engagement with users of (young people, parers/carer's) and professionals working in (commissioners, managers and providers) in Sandwell's children and young people's emotional, mental health and wellbeing services in recent years (2012 – onwards) as well as the Schools Tellus 4 Survey carried out in 2009. This is a summary of the broad findings from service user engagement.

Service user engagement has been with very small numbers and therefore results may be seen as giving un-representative views e.g.

- **Centre for Public Innovation needs assessment 2012** (4 service users and one carer interviewed – all female some 1st contact with CAMHS, other repeat users-

Issues centred on lack of pre CAMHS universal provision e.g. PHSE across Sandwell schools

- **Service user consultation in Aug 2014** with 12 young people (10-17) and 6 parents who had accessed a number of services: All of the young people and parents had accessed Chin-up, five young people and three parents had also used SHIELD, six young people and four parents had also accessed CAMHS. Mixed responses about the services:.

  Overall Chin-Up was positively rated by all of the young people and parents and was reported as being the most helpful service by those who had also used SHIELD and CAMHS.

  Only one young person reported positive experience with SHIELD whilst all the others including parents talked of negative experience of the service.

  Similarly no positive feedback was received from anyone who had used the Sandwell CAMHS service.

The following key recommendations were drawn from the above user feedback:-

Chin-Up
- should be expanded to offer 'top-up' groups for those who have been on the programme, which would support young people in maintaining the positive changes and strengthen their ability to continue to cope on their own in times of difficulty
- should be widely promoted and easily accessible by parents, schools, as well as directly by the young people themselves

SHIELD
- improve involvement of and communication with parents and young people, and ensure young people and parents are contacted when this is communicated would happen
- ensure quality interventions are offered and that staff are appropriately skilled and trained to work with young people who may be experiencing emotional and psychological distress; specific skills relating to suicide prevention would be recommended
- assess staffing levels in relation to case number ratios to reduce waiting times
- offer a flexible service that is responsive to the needs of each individual child
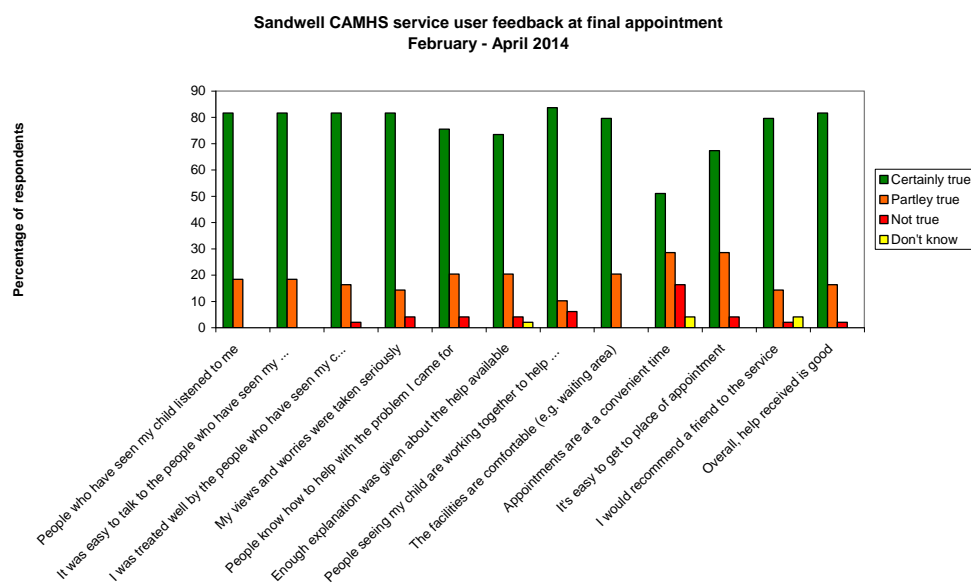
CAMHS
- improve reputation with key stakeholders and offer clarity on referral / access criteria

- offer signposting and referrals into other services for cases that are not suitable for a CAMHS service
- Reduce waiting times from referral to first appointment
- Ensure quality and effectiveness of treatment / interventions offered
- Improve communication with children and young people explaining the CAMHS journey and giving reasons for discharge when that happens
- Improve the aesthetic condition of the CAMHS premises
- Ensure continuity of care for the young person with the assigned therapist / support worker

Black Country Partnership Foundation Trust CAMHS service user evaluation

BCPFT compiled a service user evaluation report, based on 49 returned CHI-ESQ (Commission for Health Improvement Patient Experience Questionnaire) during February and April 2014. These responses are summarised in the figure below. Whilst the majority of responses were positive, the most negative responses related to the convenience of appointment times and the ease of getting to the appointment.

Chart 14: Sandwell CAMHS user feedback

From other sources, including reviews of the CAMHS services, waiting times have been identified as a problem for the CAMHS service. It is noticeable that the survey did not gather families' views regarding waiting times for treatment.

As part of the West Midlands Quality Review Service (WMQRS) the Trust was required to obtain service user views on the CAMHS provision. A questionnaire comprising of six questions was produced by the WMQRS and disseminated to service users by the receptionist over a one-week period in June. Overall, 21 service users completed and returned the questionnaire the response of which are shown in figure below.

Chart 15: WMQRS quality review user survey results

Results of West Midlands Quality Review Service CAMHS Service User Survey
Sandwell BCPFT June 2014
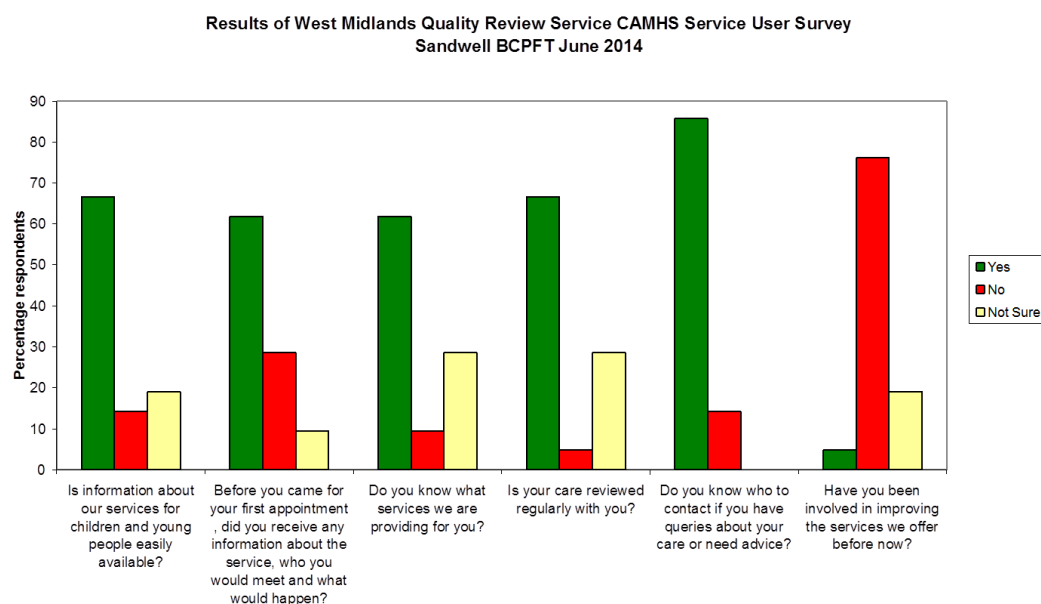
The stand out overwhelming response is that 76% of service users stated that they had not been involved in improving any services compared to only 5% who said they had been involved and 19% were unsure.

## The views of children and young people

SHAPE Programme

The SHAPE programme is part of Sandwell Council's commitment to work with local people and partners to improve services through engagement with young people. The programme ensures that the voices of children and young people are heard in the development and commissioning of services that affect them.

During November 2014 a survey was carried out across schools in Sandwell to ask young people what they felt was important for Sandwell. This was across five themes;

- Staying safe
- Being healthy
- Enjoying and achieving
- Making a positive contribution
- Economic wellbeing.

In December 2014, there was a conference involving children and young people, council members and officers and a range of other partners and stakeholders. Across all the five themes the children and young people explored what was important to them and for Sandwell. Within the 'being healthy' theme, the children and young people were asked "what health concerns do you have?" The chart below shows the results from children from year 9 and above.

96

Chart 16: Health concerns of young people (year 9 and above)

What health concerns do you have?
Year 9 & above
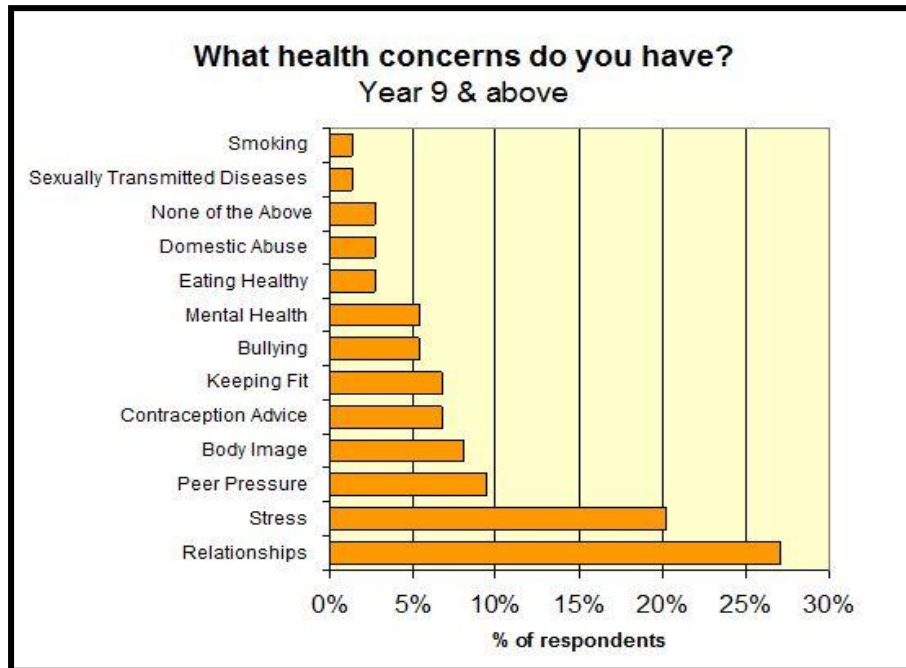
These findings show that the most significant concerns for children in year 9 and above were related to emotional health and wellbeing, with a particular focus on relationships and stress.

Following this, there is an ongoing programme of work with children and young people to ensure their voice is heard and that they can influence services and are involved in the development of new services relevant to them.

'Tell us' Survey

'Tell us' was a national survey to seek views of children and young people about their school and area. The survey was completed in 2009 by 253,755 children and young people schools years 6, 8 and 10 in 3,699 primary, secondary, special schools pupil referrals units (PRU) across 151 local authorities in the country. In Sandwell 8,823 children and young people in school years 6 (n=2,246), 8 (n=3,534) and 10 (n=3,043) took part in the survey.

The survey asked some questions to establish children and young people's emotional health. One of these was about the quality of relationships that they have with their parents or carers, other adults and their friends. Figure 1 shows that for year 6 all most all children had one or more good friends. In addition 70% stated that they feel happy about life, 58% said that they could talk to a friend and 42% to another adult when they were worried about something. However 70% of children stated that it was neither true or not true that they could talk to their parents.

Chart 17: Emotional health of year 6 school children

Emotional Health of year 6 school children
Sandwell Tellus 4 Survey 2009
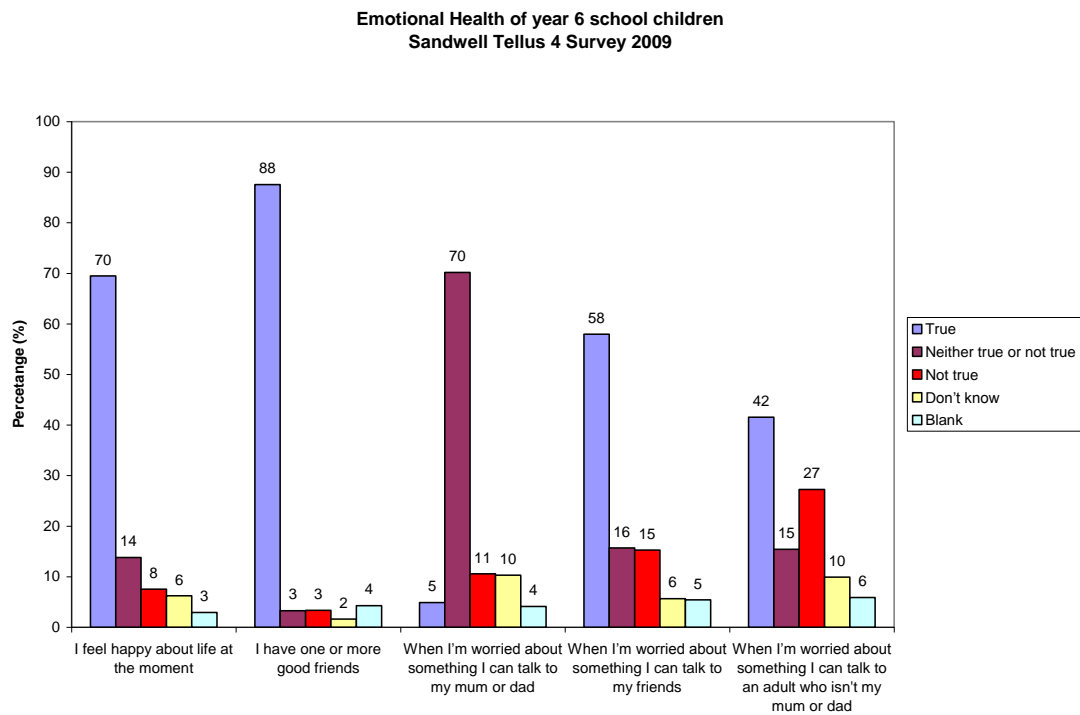
In comparison a higher percentage (92%) of years 8 and 10 schoolchildren stated that they had one or more good friends. In addition 67% felt happy about life, 56% could talk to their parents 67% could talk to friends or 36% to another adult when they were worried about something (Figure 2).

Chart 18: Emotional health of years 8 and 10 school children

Emotional Health of years 8 and 10 school children
Sandwell Tellus 4 Survey 2009

98
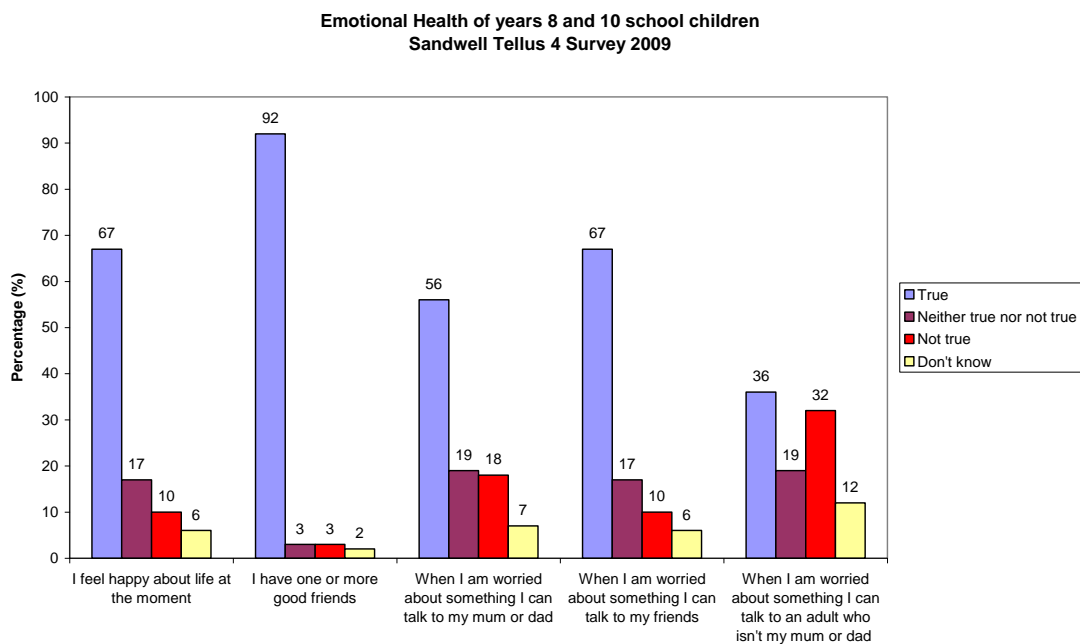
Notwithstanding that year 6 schoolchildren who said that they could not talk to their parents when they were worried about something, overall the results suggest that children and young people have relationships in their lives which support them. However, a separate question was asked in the survey to explore the nature of issues about which children and young people worried. Figures 3 and 4 below show that most children and young people had some aspects of their lives about which they worried about.

For year 6 the top five reasons children say they worried about were school work/exams (46%), bullying (31%), friendships (30%), parents/family (28%) and looks (22%). For years 8 and 10 the top five reasons children and young people say they worried about were school work/exams (56%), what to do after year 11 (43%), looks (35%), friendships (31%) and parents/family (31%). Most of the reasons were common between the young and older children except the percentage being worried about bullying was higher in year 6 compared to years 8 & 10.

An area for consideration is the level of support available to young people when they are preparing for, sitting exams or waiting for their results. This could include mapping current support and undertaking insight studies to understand what support would be acceptable and beneficial.

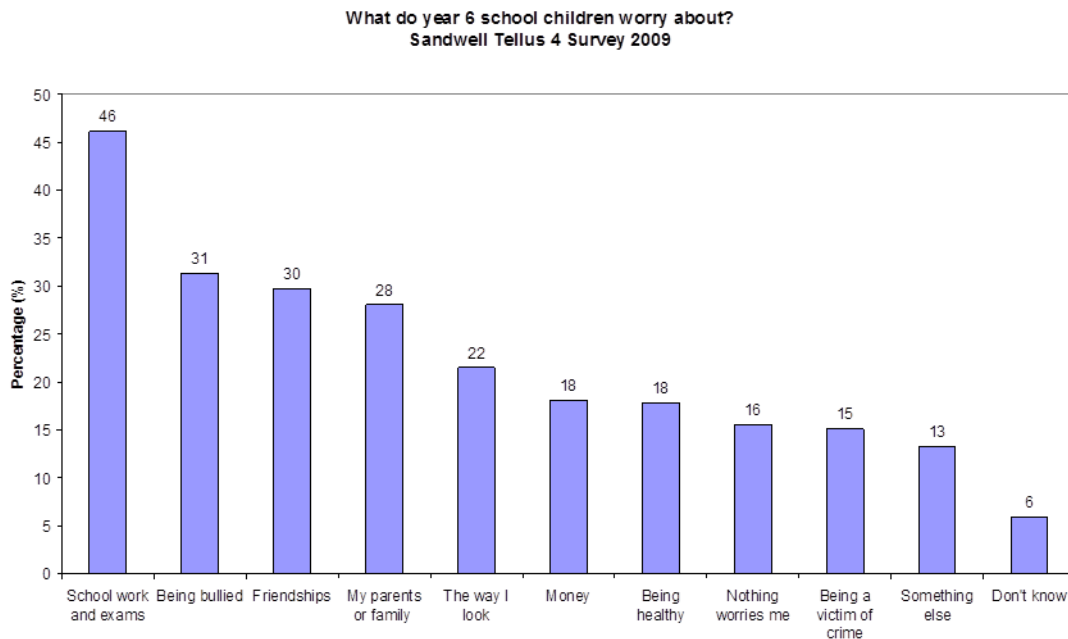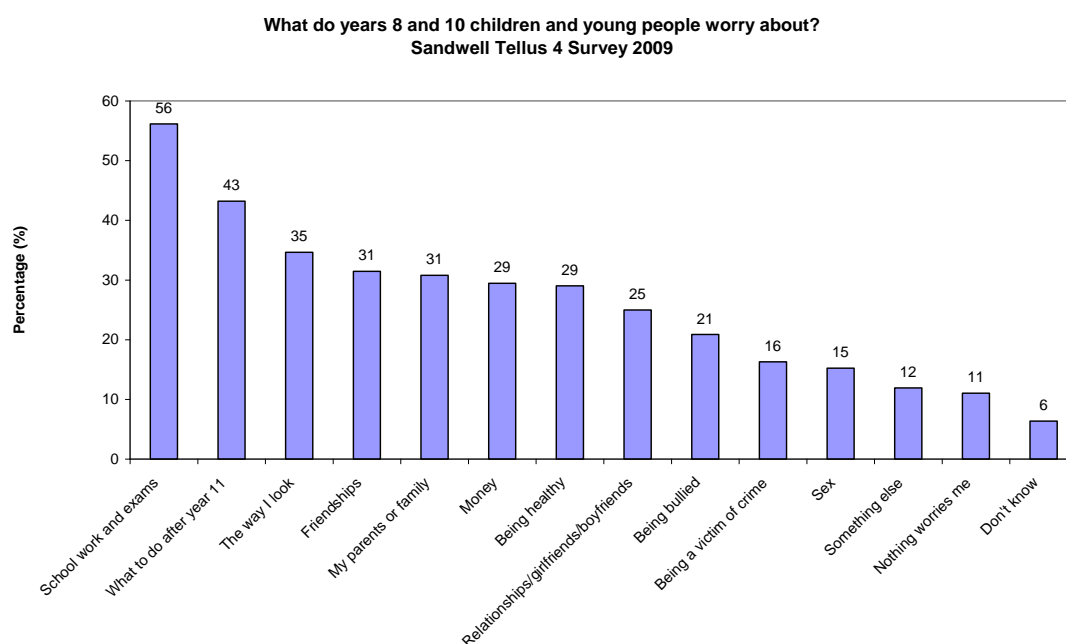**Chart 19: What do year 6 school children worry about**

What do year 6 school children worry about?
Sandwell Tellus 4 Survey 2009

Chart 20: What do years 8 and 10 school children worry about

What do years 8 and 10 children and young people worry about?
Sandwell Tellus 4 Survey 2009

Mytime CiC consultation

In 2012 Sandwell Council commissioned My Time CIC to undertake consultation with children and their parents to inform an emotional, wellbeing and mental health strategy, needs assessment, future commissioning intentions and the development of an outcomes framework.

My Time CIC utilised community based participatory action research to engage children (5-14), young people (15-25) and their parents in focus groups and workshops on emotional wellbeing and mental health services in the Borough. The research looked to address whether

- young people were aware of the services
- these services were accessible
- the services responded to the needs of young people
- the parents/carers were of their children's emotional wellbeing

The consultation was led by young people aged 20-25 recruited from Sandwell. They engaged 115 children and young people as well as 13 young parents aged 19-25 and discussed wide ranging topics including

- Friends
- Relationships
- Bullying
- Teachers
- Body Image
- Education and Careers
- Alcohol and Drugs
- Services

Communication

- Ensure greater level of awareness of young people's emotional wellbeing and mental health
- Raise awareness of availability and accessibility of services for children and young people through the use of social media such as facebook, twitter
- Ensure that the Council website is 'young people friendly' and that information is easily accessible

Workshops and support groups

- Deliver regular workshops around confidence building, self esteem, bullying, CV writing and job clubs etc

Counselling services

- Deliver 'floating' counselling services in different settings including young persons home, schools and youth centres
- Implement GCSE Counselling in secondary schools

Specific services

- Deliver specific services for young people where they can meet in a safe environment others with similar issues
- Deliver specific services for young people aged 17-24 transitioning from child to adulthood
- Services for educating parents about the importance of emotional wellbeing and mental health and enhance wellbeing of their families

Workforce development and training

- Ensure that staff from youth services, schools, and therapeutic, mental health and CYP support services are trained and aware of children and young peoples emotional well-being

Seminars, workshops and discussion groups

- Deliver workshops led by young people (emotional well-being champions) for young people, professionals and parents on emotional well-being so that the outcomes can influence change in service provision

These results presented in this summary could usefully be compared with results from the current engagement being conducted with young people through Changing our Lives to provide confirming information and strengthen recommendations.

10.Conclusions

Demographic Factors:

Sandwell has high levels of a number of risk factors for mental disorder and poor well-being. These include children living in poverty, children in lone parent families, and those in families where parents have no educational qualifications. This suggests that there is likely to be a higher prevalence of mental disorder and poor well-being in Sandwell CYP than the national average. This is likely to contribute to increased needs for emotional health and well-being services when compared with other areas with less affected by these risk factors.

Deprivation remains high across much of Sandwell, with Sandwell-being ranked the 13th most deprived Local authority out of 326 in terms of its deprivation score (English Indices of deprivation, 2015). Deprivation is a risk factor for well-being and, as such, is likely to adversely impact on the emotional well-being of many children and young people in Sandwell. It will be important to ensure that robust prevention interventions are in place (e.g. to build resilience and coping skills) to help to support children and young people, particularly those living in the most deprived areas.

A high proportion of children in Sandwell are in black and minority ethnic groups, and they are expected to grow as a proportion of the population. A previous review (SMBC and SWB CCG, 2014) identified that uptake of emotional health and well-being services is lower than expected from Asian Children and young people but higher than expected in those of mixed ethnicity suggesting there is a need to understand this under and overuse. It will be important to make sure that services are accessible to BME groups and to consider the specific emotional health and well-being needs of new migrants.

There are particular groups of children and young people (CYP) who are at greater risk of mental disorder and poor well-being. Sandwell appears to have relatively high proportions of its CYP in some of these groups for example, Looked after children. This suggests the need to consider targeting preventative interventions and services towards some of these more vulnerable groups, particularly where they appear over represented in Sandwell in comparison with other areas.

There are already pressures (e.g. issues around access and waiting times) on some Children and Young Peoples (CYP) emotional health and well-being services, it will be important for commissioners to bear in mind that the population of children and young people in Sandwell aged 0-25years is expected to increase further by 2021.

Sandwell has higher levels of self-harm admissions (ref) than the national average in age 10-24 year olds. It will be important to ensure that current (and future) provision which is included as part of the Crisis and Assessment Team response, is in line with the guidance and that this is addressed as a priority.

The recent estimated prevalence of total mental health conditions in Sandwell (ONS 2014 mid-year population estimates) in children aged 5-16 was 4,767, including conduct disorders affecting approximately 2,880 children (ref). It is estimated at a universal level (Tier 1) there are 16,560 children and young people who require emotional health and well-being help and support in Sandwell (ref). Overarching commissioning strategy will need to take account of the considerable level of need at universal, targeted levels and specialist levels to comprehensively meet the needs of children and young people.

Strategy and Vision

Future in Mind calls for pooled budgets and a lead commissioner in order to address fragmentation of services at a local level and to support a more co-ordinated approach[3]. The CAMHS transformation board provides the forum for this joined up approach. The appointment of a joint commissioning post between the CCG and Sandwell Council will support this approach. However, at the current time there is still a degree of fragmentation with respect to the commissioning of emotional health and well-being services in Sandwell.

A key role for the joint commissioning post will be to develop and overarching strategy for all children and young people's mental and emotional health services. A pooled budget for Children and young people's emotional health and well-being services would contribute significantly to the integration of services.

Promotion and Prevention

Closing the Gap identifies areas for action in the next two years that include the need to start early to promote mental well-being and prevent mental health problems[25]. Whilst there are some examples of good prevention and promotion work taking place, more is needed to enhance this in Sandwell so that effective programmes are available to all children and young people. This would provide a robust evidence based approach to promotion and prevention that would also require sufficient investment. In addition, it will be important to make the best use of the existing range of voluntary and community sector providers who already deliver a range of emotional health and well-being services in this area.

There is a need for a partnership approach to be adopted across Sandwell to ensure that the current training delivered to a range of universal workers around emotional health and well-being (EHWB) is evidence based, accurate, up to date and consistent. There also needs to be a mechanism in place to monitor the uptake of EHWB training among workers of key universal organisations, in the statutory and non-statutory sector, who work with children and young people.

Maternal health and early years

Maternal anxiety and depression is an important risk factor in increasing the likelihood of emotional and mental health issues in children and young people (ref). However, within Sandwell there are areas of concern as follows:

- Sandwell peri-natal mental health services currently fall short of current guidelines;
- There is a lack of understanding of key referral pathways to access emotional health and well-being services among important stakeholders;
- The Family Nurse Partnership intervention is in place but currently only 20% of the eligible population receives the intervention.

Whilst parenting programmes are already in place in Sandwell, gaps in provision include the need to ensure that commissioned parenting programmes are effective and accessible to those who most need them. The need for specialist parenting programmes e.g. for parents with children who have a learning disability, should be considered. It is also important that commissioners and providers ensure that evidence based parenting programmes are available as an intervention for children and young people with mental health disorders such as conduct disorder.

Pre-school services

There are no specific emotional health and well-being services in Sandwell for children under 5 years old at tiers 2, 3 and 4 (though some support is offered to parents through children's centres and children may be seen by paediatricians). This lack in provision has been identified in previous reviews (West Midlands Quality Review,2015) and was raised as an issue at the Emotional Health and Well-being Stakeholder Workshop (16th November 2015). The Sandwell Transformation Plans 2015/16 include the development of services for 0-5 year olds including additional parenting programmes.

The mapping of services in Sandwell, undertaken as part of this HNA, has identified issues around waiting times and access to emotional health and well-being services in Sandwell for Children and Young people at a targeted and specialist level.

Overall services appear under commissioned at tiers 1, 2 and 3 when the estimated numbers of children age 5-16 years requiring help and support at each tier is considered (7,448, 3,476 and 919 respectively). However, it is acknowledged that schools independently commission a number of services and the voluntary and community sector also provides some emotional health and well-being services.

It will be important to continue to continue to monitor and review capacity at tier 3 (specialist services), as necessary to improve access here, since more effective provision at tiers 1 and 2 should alleviate pressure at tier 3. However, it will need to be borne in mind that the CAMHS specialist workforce capacity is below

recommended levels (Royal College of Psychiatrist Guidance, 2006), and Shield is also providing some tier 3 provision.

Eating disorder services need to be in place which are in line with current guidance to ensure that individuals are able to access help at an appropriate stage preventing deterioration and the need for additional support/treatment. The Sandwell service currently falls short of this guidance. The Transformation plan for Sandwell 2015/16 sets out plans to invest in existing provider, Black Country Partnership Foundation Trust to develop an eating disorder service for Sandwell CYP which is compliant with current guidance.

Evidence from the Centre for Mental Health suggests the most effective/cost effective interventions to deliver the most common mental health disorders affecting CYP[28]. Whilst a number of these interventions appear to be in place in Sandwell, current provision needs to be reviewed further to identify if these specific interventions are currently routinely being made available to children and young people when diagnosed with these conditions. Consideration needs to be given to making sure these interventions are routinely available for children and young people with these specific mental health disorders.

The interface between community based Tier 2 services and CAMHS specialist services (Tier 3) is ill defined, which leads to an increase of inappropriate referrals to either service which are then referred back. This can protract the clients experience within the service and delay treatment.

 A point of access (POA) has been developed to enable joint working between Murray Hall and the Black Country Foundation Trust (BCPFT), and to help alleviate some of the issues around appropriate referrals and timely access to services. The perceptions of attendees at a stakeholder event (Public Health,16th November 2015) were that the POA was referring service users to a limited number of commissioned providers only i.e. Shield or CAMHs specialist services and that an expansion of this to include a broader range of service providers across different tiers would be beneficial.

A Stakeholder event (Public Health, November 2015) identified concerns around a lack of awareness of the range of emotional health and well-being services operating in Sandwell and of referral pathways. There was also a strong feeling of fragmentation of services at a provider level and lack of integrated working.

The existing small team of primary care mental health workers (PCMHWs) have insufficient capacity. Funding has been made available to commission an additional 7 PCMHWs to work across the Community Operating Groups (COGs) and to place a further 2 specific PCMHWs with MASH, Looked After Children (LAC) and Youth Offending Services. A key purpose of the new primary mental worker posts is to address the lack of integration which exists in relation to CAMHs both internally and externally.

A Lack of consistency in the outcomes measures used to performance manage emotional health and well-being services in Sandwell has been identified as an issue in previous reviews (SMBC and SWBCCG, 2014) and at the Stakeholder event (16th November 2015) since it makes assessments of effectiveness and cost effectiveness more difficult to achieve when comparing services.

Crisis Management

The Mental Health Crisis Care Concordat highlights the importance of ensuring that individuals, of all ages, who require crisis mental health service support are able to access it 24 hours a day, seven days a week[27]. There is no funded home treatment service (Tier 3.5) for CAMHS for working with children and young people. The transformational plan for Sandwell 2015/16 acknowledges this service gap in Sandwell and services are being re-designed to include provision for home treatment as part of the plan.

Sandwell has higher levels of self-harm admissions (ref) than the national average in 10-24 year olds. It will be important to ensure that provision for self-harm (which is currently included as part of the Crisis and Assessment Team provision) will be accommodated within the re-designed proposed services as part of the Transformation Plan (2015/2016). This will need to be in line with current guidance and addressed as a priority.

Tier 4 - There is a lack of Tier 4 beds locally and regionally which remains a concern. The Area Team considers there is adequate provision of Tier 4 beds locally for local demand but services are taken up by referrals from other areas making them less available to local children.

Transition from Children's to Adult Services

The transition stage, between children and adults services, is recognised as an important time for vulnerable young people. It is particularly important that young people are involved in any potential changes to service arrangements around this transition period including helping to inform decisions around whether to extend the current CAMHS service from 0-18 years to 0-25 years.

11. Integration of commissioning and services

This needs assessment has shown that the current picture of services and support is complex. The links between, and pathways through, services are not clear. Transitions between services, especially between children's and adult services, are an area of major challenge.

Currently, there is a disproportionate investment in treatment services. While the provision of treatment for people experiencing mental illness is essential, it is as important to ensure that there is investment in preventative services to keep people healthy. A long-term reduction in demand for services will need comprehensive preventative and emotional wellbeing approaches. This will include providing support for children and young people and building life skills and resilience. Young people who are resilient are better able to respond to stress and are less likely to develop anxiety and depression.

Emotional health and wellbeing is complex with a wide range of determinants and influences. A person's social context is central to promoting mental health and wellbeing or providing support for mental illness. As well as helping young people deal with better with stress, it is essential that the causes of stress and inequality are also tackled. This will include tackling the social determinants of mental health.

The mental wellbeing of parents affects the wellbeing of children and this can have a generational influence. Improving mental wellbeing or treating mental illness therefore requires an approach that considers the needs of the whole family through a joined up, family based approach to mental health promotion and mental illness prevention and treatment

Much importance is placed on the transition between adults and children's services to ensure that children in a vulnerable state are not moving onto adult services at a time in their life when they are also adjusting to other major changes e.g. in education, employment or housing. The proposed joined up approach would enable a young person to access the best service to suit their needs. Such an approach would provide a better service for the young person and alleviate potential pressures on adult services by preventing young adults from deteriorating and requiring support that is more intensive.

Adults suffering from mental health disorders have children who are at higher risk of developing mental health and well-being problems. Joined up mental health services involving children and adults would make it easier to identify 'vulnerable' children of those with a mental health disorder which would enable the delivery of targeted preventative support and services for those children affected e.g. to build resilience and coping skills.

Similarly, children accessing mental health and well-being services as a result of behaviour difficulties at school, may well have parents who have mental health and

well-being problems. These parents may not be known to adult mental health services and could then be provided with support and specialist help as appropriate.

Mental health and wellbeing is also an important influence on physical health and wellbeing. National policy including No Health without Mental Health, the NHS Five Year Forward View and publications on Parity of Esteem identify this as a priority. Improving mental health and wellbeing will contribute to improving the physical health of the population. This will reduce the overall demand on health and social care services.

There is agreement that Sandwell will move towards a model that provides services for the age range 0 – 25 years. There is also agreement that this is a first step towards developing a fully integrated, all age approach, based on the Thrive model, which covers all services and provides flexible support as needed by children, young people and their families.

The adoption of this life course based commissioning model across all age bands, based on the Thrive model, will enable joined up family based approaches. This will tackle mental health problems in both adults and children and reduce demand across health, social care and wider services.

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