Nottingham City Joint Strategic Needs Assessment:

Emotional and Mental Health of Children and Young People

Topic information	
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Table of Contents

Foreword 2
Executive Summary 3
Full JSNA report 7
1. Who is at risk and why? 7
Mental Health and Wellbeing 7
2. Size of the issue locally 16
3. Targets and performance 30
4. Current activity, service provision and assets 32
5. Evidence of what works 44
6. What is on the horizon? 55
7. Local Views 57
What does this tell us? 59
8. Unmet needs and service gaps 59
9. Knowledge gaps 61
What should we do next? 62
10. Recommendations for consideration by commissioners 62

Foreword

This JSNA was started in June 2019 setting out to gather data for 2018/2019 and be published in March 2020. In March 2020 work on this report was halted so that public health staff could focus on the COVID-19 pandemic.

In the intervening period, the pandemic has affected the wellbeing of children and young people in obvious ways, such as not being able to attend school in person or socialise with friends.

We now present this report as a reflection of 'what was' then, recognising that much has changed. The Local Authority is preparing a separate JSNA on impacts from the pandemic and this will have a section on mental health and wellbeing of children and young people.

We didn't want this work to go to waste and we believe this set of information will provide a useful yardstick for the future, with which we can draw comparisons, monitoring impacts of the pandemic on children and young people's mental health and wellbeing, to ensure we promote the conditions in which children and young people can thrive, and that children and young people get the support they need when they need it.

Executive Summary

Good mental and emotional health is essential to enable children and young people to fulfil their potential and achieve positive health, social and educational outcomes. Mental wellbeing can be influenced by a range of individual, familial, social and environmental factors that can impact on children and young people throughout their development. Whilst good emotional and social wellbeing is associated with good physical health, academic engagement and economic independence, poor mental health can have significant long lasting and far reaching impacts on children and young people. The government's *Future in Mind* strategy, published in 2015, states:

"Mental health problems cause distress to individuals and all those who care for them. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment… and are strongly associated with behaviours that pose a risk to their health" (DHSC 2015).

Half of all long-term adult mental health disorders are established by age 14 and three quarters by the age of 24 (Kessler, 2005). The impacts of poor mental health can be seen on social relationships, educational attainment, physical health, crime, homelessness and employment prospects (Department of Health, 2009).

Children are at a higher risk of developing mental illness if they experience adverse events in childhood, are looked after by their local authority, if they have a long-term illness or disability, if they are a young carer or if they have a parent with a substance misuse problem. On the other hand, children with stable home lives, who attend school regularly and who have positive relationships with their peers and adults have a reduced risk for mental illness.

Nationally, there has been a gradual rise in the number of CYP with a mental health disorder over the last decade so that in 2017 one in eight 5 to 19-year-olds had at least one mental health disorder compared to one in ten in 2014.

Currently, it is estimated that 8718 children in Nottingham City have a diagnosable mental health disorder at any one time. In 2018/19 there were 1763 children and young people referred to CAMHS Single Point of Access (SPA), 1014 referrals to Specialist CAMHS, 308 referrals to CAMHS Crisis Resolution and Home Treatment service (CRHT) and 141 referrals to CAMHS for Children in Care. Many more children and young people will seek support through informal networks and charity/voluntary services, and as is the case across the UK, it is likely that others will not seek help and will not be identified as needing help

Nottingham has developed strong, evidence-based strategies to support children and young people, particularly through improving access to mental health services, including the recent introduction of a policy to allow self-referrals. Additionally, through supporting development of robust pathways in perinatal mental health and tailored

Child and Adolescent Mental Health Services (CAMHS) for targeted groups such as the Mental Health Support Teams in Schools and Colleges.

There has also been significant investment in the workforce; not only in the NHS, but across a wide range of public sector roles, in addition to this, schools have made a concerted effort to build resilience. There is good evidence to show that school-based interventions can be a cost-effective investment.

However, despite good progress there are still significant unmet needs and gaps. National policy (Long Term Plan, 2019) recognises the need to improve the experience young people have with their mental health and that changes need to be made to improve transitions and support for young children and young adults. These ambitions are described in more detail in the targets and performance section.

Unmet needs and gaps

Many services in the public sector are still commissioned in isolation. With mental health in particular, this is untenable due to the complexity of interactions between different risk factors and behaviours. For example, parental substance misuse may cause poverty and familial stress, which may result in a mental disorder, which then becomes a risk factor for other behaviours such as crime or risk-taking. There needs to be a whole-systems approach to mental health commissioning.

Reductions in funding to early intervention services have resulted in a reduction of universal provision and of parenting support, particularly around the skills they need to help support the positive mental and emotional development of their children.

Transition to adult care is still cited by young people as needing improvement, and although work has been undertaken recently to improve the process, there could still be more done to improve the quality of the experience. Many patients do not currently return their post-transition surveys, however, and alternative methods of assessing the quality of transition may need to be undertaken.

More action is needed to reduce inequalities in mental health and wellbeing particularly for looked after children, young carers, children with a special educational needs and disabilities and Lesbian Gay Bisexual Transgender, queer (or questioning) and others (LGBTQ+) young people.

Social media is both a risk and an opportunity. There is much in the media about online bullying and negative consequences of interactions, such as the promotion of unrealistic expectations, cyber-bullying and developing a fear of missing out. However, apps and web support offer new ways for children and young people to access services and to connect with peer support networks in what is often their preferred medium. The landscape changes fast, and there is undue focus on misuse of particular platforms in media reports, rather than on promotion of positive safety messages.

There is a gap in formal psychology input where children have adverse childhood experiences, or are below CAMHS threshold for emotional health

difficulties e.g. anxiety which can impact on a behavioural/developmental presentation, and lack of formal cognitive assessments to determine whether behavioural/developmental needs are related to an underlying learning disability.

There is a gap in mental health support for Children in Care from other local authorities and for Nottingham children in care placed in other local authorities Other Local Authority Children in Care do not have access to the Children in Care CAMHS service in Nottingham. Young people who are the responsibility of Nottingham City but are placed elsewhere have variable levels of mental health support depending on the placement location. The choice of placement is often very limited, particularly for children with complex needs.

There is a lack of high intensity long-term mental health support for children and young people with the highest level of mental health need alongside unsafe or challenging home environments. This results in frequent acute hospital presentations, delayed discharges and repeat psychiatric inpatient admissions. The crisis team, social care and CAMHS are currently unable to provide the high intensity long-term mental health support required for this cohort.

Training for professionals to support for young people with Autism Spectrum Disorder (ASD) is not yet in place. There is growing evidence that young people with ASD are at increased risk of suicide and co-morbid mental health conditions. There is currently a lack of effective training for mental health professionals to understand how young people with ASD may present differently when experiencing a mental health crisis and how best to then support them.

Table 1. Recommendations for consideration

	Recommendation	Lead(s)
1	**Review inequalities in access to services, experience, and health outcomes of Black, Asian and Minority Ethnic groups (BAME).** Ensure systemic barriers are mitigated or removed using the Advancing Mental Health Equality Framework. Undertake an equity audit, ensure services routinely collect data on protected characteristics and ensure that the workforce have appropriate training/skills. This work will be overseen by a mental health equalities group should consider development of specific pathways.	CCG, Nottinghamshire Healthcare Trust (NHT), Third Sector providers
2	**Commissioning should be planned as integrated multi-agency services**, ensuring that services meet the needs of the 0-25 age group	Integrated Care System's (ICS), Public Health, CCG
3	**Undertake further work to develop a comprehensive 0-25 years service**. As part of this, consider flexible transition points for children and young people with mental health difficulties, closer working with adult mental health services, and opportunities to pool resources. This should have a particular focus on early years (0-5) and 19-25.	Integrated Care System's (ICS), Public Health, CCG

4	**Ensure that mental health and wellbeing are considered in all policies in schools** relating to both staff, service users and pupils, e.g. by using Five Ways to Wellbeing	LA, ICS, Schools/ Colleges/Academies
5	**Ensure equitable access to prevention and early intervention mental health support in schools** focusing strategically on areas where there is likely to be greatest benefit and where risk factors are most prevalent i.e. areas of high deprivation.	PH, LA, CCG
6	**Ensure an equitable offer for all Children in Care**, including out of area and other local authority children.	LA, CCG, NHT
7	**Review delivery models for children in urgent and crisis care** to ensure they are consistent with regional and national models of best practice, to ensure the right support is available.	PH, LA, CCG, NHT
8	**Consider how to meet the high intensity, long-term support needs of young people with mental health and social care needs.** Explore options for a combined CAMHS and Social Care offer.	PH, LA, CCG, NHT
9	**Consider how to develop workforce capacity within CAMHS and the wider workforce** to meet increased demand, including additional roles and further training opportunities.	LA, CCG, NHT
10	**Explore how we further develop our online offer.** This may include evaluating the effectiveness of digital interventions locally to ensure any benefits from the switch to digital models of care are sustained beyond COVID-19, in line with regional guidance from NHS England.	PH, CCG
11	**Expand universal and selective parent education and training programmes** to support preventative work on mental health & well being	Local Authority (LA), PH, CCGs
12	**Ensure appropriate support for parents when issues are emerging, and after diagnosis** e.g. drawing on the New Forest model.	LA, CCG
13	**Embed trauma-informed and ACES-informed practice** in all relevant services in Nottingham.	PH, LA, CCG, NHT
14	**Mobilise community assets** to generate multigenerational networks of interpersonal support, capitalising on initiatives such as lifestyle interventions, volunteering and social prescribing	Third sector, PH, Primary Care Networks (PCNs)
15	**Undertake further work to understand the impact of COVID 19** on children and young people's mental health and identify appropriate steps to address these	PH, LA, CCG

What do we know?

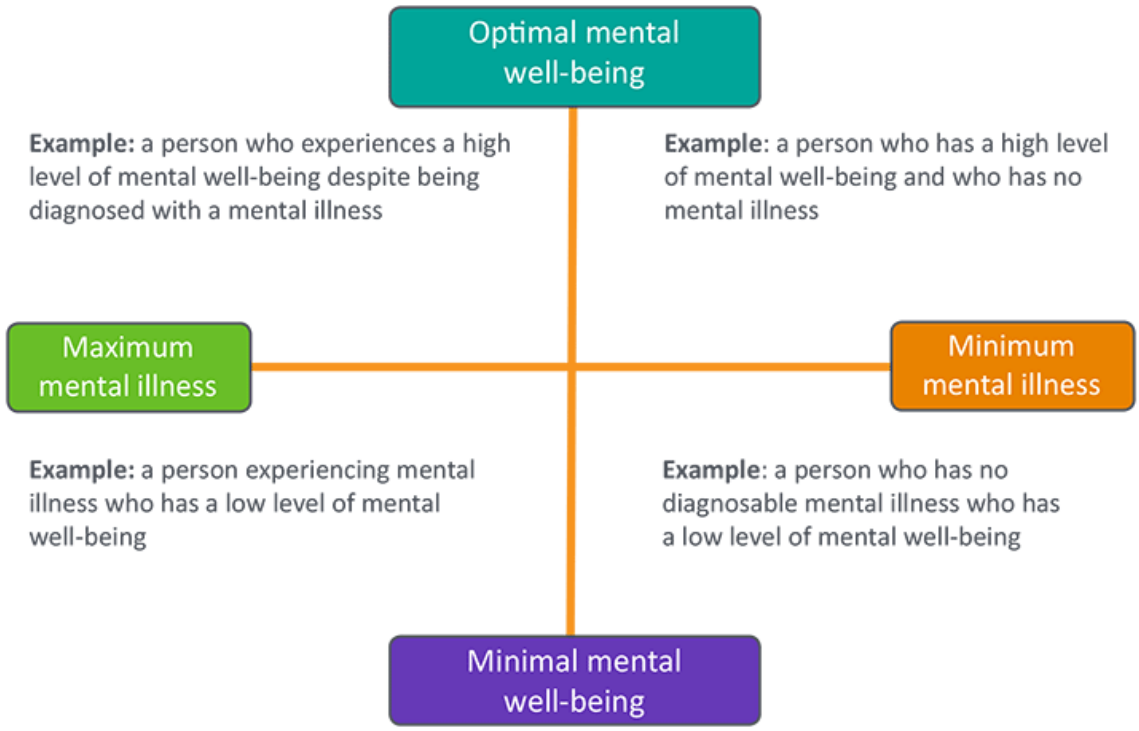
1. Who is at risk and why?

Mental Health and Wellbeing

Good mental health is defined by WHO (2018) as not simply the absence of mental disorder but "a state of wellbeing in which an individual realises his or her own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community."

Mental health and emotional well-being can be described as being on a continuum, where people can move between states and languish or flourish, depending on a range of personal, social or contextual factors. The concept is centred on the ideas that mental health is not simply the absence of mental illness, and that interventions and behaviours can help individuals to move into more positive areas of the continuum (see figure 1).

Figure 1. The relationship between mental health and wellbeing.



Source: Public Health Agency of Canada / AMI Quebec (2016)

It is estimated that one in four people have a mental disorder at any one time, and this costs the English economy around £105b every year. Mental disorder is also responsible for the largest burden of disease in England (23% of total burden, compared to 16% for cancer and 16% for heart disease; JCPMH, 2016). Poor mental health starts at an early age and can have consequences throughout life, impacting on

physical health, relationships, education, crime and employment. Research shows that half of all lifetime mental health disorders start by age 14 years and three quarters by age 24 years (Kessler, 2005).

Mental health problems range from day-to-day worries to serious long-term conditions. In children, four broad groups of disorder can be defined in national reporting (NHSD, 2018):

- Emotional disorders, which includes conditions such as anxiety, depressive disorders, and mania and bipolar affective disorder, along with phobias and panic disorders.
- Behavioural (or conduct) disorders, which includes repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or rules, are violated.
- Hyperactivity disorders, which includes disorders characterised by inattention, impulsivity and hyperactivity, including Attention Deficit Hyperactivity Disorder (ADHD).
- Less common disorders, which includes autistic spectrum disorder, eating disorders, tic disorders and a number of very low incidence conditions.

National prevalence of mental health problems in children and young people

In 2017 ONS carried out the third Mental Health of Children and Young People in England survey (MHCYP survey) of 9,117 children and young people aged 2-19 years old living in England and registered with a GP. The survey combines reports from children, their parents and teachers to identify if the child or young person met the International Classification of Disease (ICD-10) diagnostic criteria (WHO, 2016) for a range of different types of disorder. This survey provides the most robust and comprehensive data on the prevalence of mental disorders among children in the UK.

The national survey shows that one in eight Children and Young People (CYP) living in England are at risk of poor mental health at any one time. Rates of mental disorder increase with age, with around 6% of pre-school age children experiencing a mental disorder, but 17% of 17 to 19-year-olds reporting the same. Nationally, this trend has been increasing gradually over the course of the 21st Century.

Trends in the MHCYP survey show a gradual rise in mental disorders overall, largely accounted for by a proportionally large increase in emotional disorders since 2004 (see figure 2, below). However, for reasons of comparability, this chart does not include ages over 16, where prevalence is much higher for emotional disorders.

2021 survey details

The 2021 survey looked at the mental health of 9,117 children and young people aged 6 to 23 years old in England in February and March 2021, including the experiences of these children during the coronavirus (COVID-19) pandemic. It also looks at changes in levels of mental disorders in children since 2017, comparing children over a four-year period using the Strengths and Difficulties Questionnaire (SDQ).

Children and young people were asked a series of questions about their mental health and wellbeing, known as the Strengths and Difficulties Questionnaire (SDQ). This provides an indication of whether a child had a probable mental disorder at time of interview. Analysis in this report looks at the characteristics of children with “probable mental disorders” compared with children who were either “unlikely to have a mental disorder” or had a “possible mental disorder”.

The survey shows that:

Rates of probable mental disorders have increased since 2017; in 6 to 16 year olds from one in nine (11.6%) to one in six (17.4%), and in 17 to 19 year olds from one in ten (10.1%) to one in six (17.4%). Rates in both age groups remained similar between 2020 and 2021.

39.2% of 6 to 16 year olds had experienced deterioration in mental health since 2017, and 21.8% experienced improvement. Among 17 to 23 year olds, 52.5% experienced deterioration, and 15.2% experienced improvement.

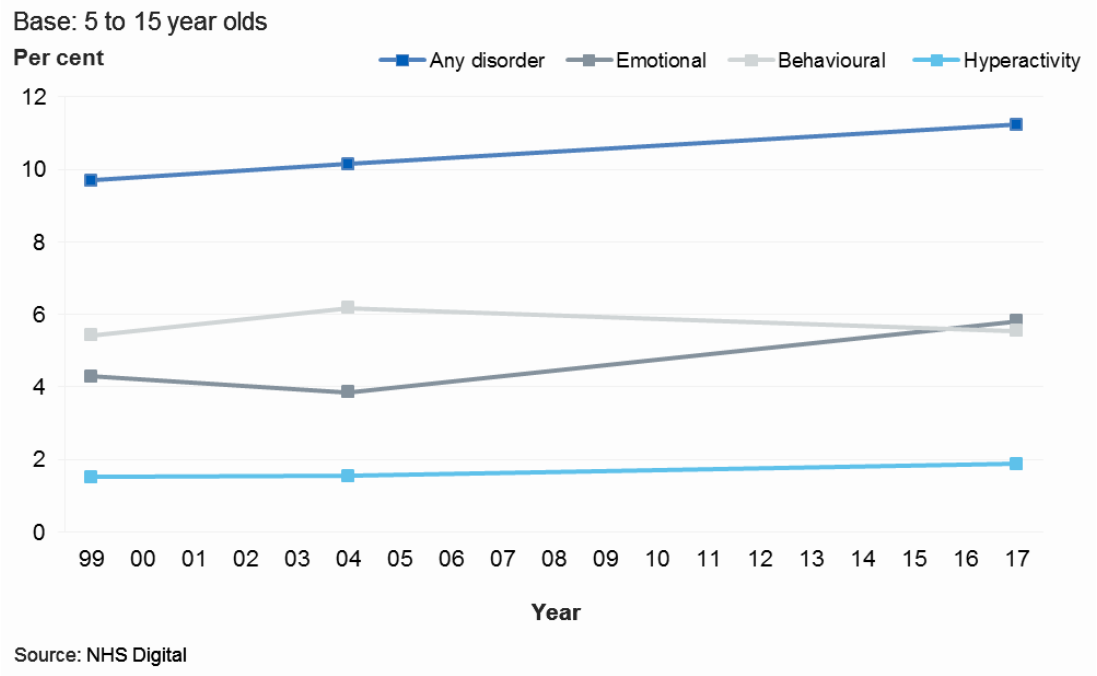
The proportion of children and young people with possible eating problems increased since 2017; from 6.7% to 13.0% in 11 to 16 year olds, and from 44.6% to 58.2% in 17 to 19 year olds.

Problems with sleep on three or more nights of the previous seven affected over a quarter (28.7%) of 6 to 10 year olds, over a third (38.4%) of 11 to 16 year olds, and over half (57.1%) of 17 to 23 year olds. Across all age groups figures were much higher in those with a probable mental disorder (59.5%, 74.2%, 86.7% respectively).

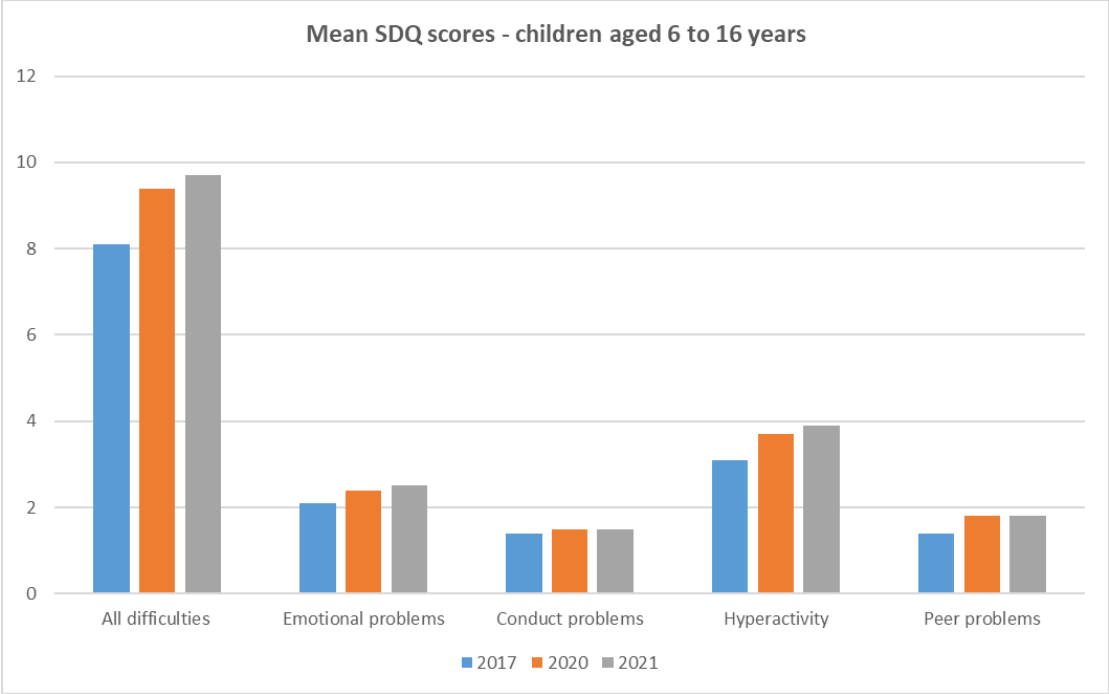
10.6% of 6 to 16 year olds missed more than 15 days of school during the 2020 Autumn term. Children with a probable mental disorder were twice as likely to have missed this much school (18.2%) as those unlikely to have a mental disorder (8.8%).

The proportion of 6 to 16 year olds with a laptop or tablet they could work on at home increased from 89.0% in 2020 to 94.4% in 2021. The proportion receiving regular support from school or college also increased, from 73.7% in 2020 to 79.9% in 2021.

Figure 2. Recent trends in estimated number of school-age children (5 to 15) experiencing mental ill health 1999-2017



Source: NHS Digital



Source: MHCYP survey 2021

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural and emotional screening questionnaire, which asks about 25 attributes, some positive and others negative. These 25 items are divided between five scales each with 5 items (emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour).

Similar trends are evident in the annual Good Childhood Report (2020), which looks at children's wellbeing and happiness and is based on an annual survey of about 2,400 households and a longitudinal study involving 40,000 households.

The Good Childhood Index measures children's happiness with 10 aspects of life that are crucial to their wellbeing. Compared to the first survey in 2009-10, there has been a significant decrease in happiness with life as a whole from mean happiness score (0-10) of 8.17 in 2009-10 to 7.2 in 2020-21. In particular, there were significant decreases in happiness with friends and school among both boys and girls, and a significant decrease in happiness with appearance for boys.

In addition, the survey found that 33% of children are very or quite worried about having enough money in the future and 29% are worried about finding a job. In terms of broader issues, 41% of children are very or quite worried about crime and 41% are worried about the environment.

1.1 Risk factors

While all children and young people can experience mental health problems, there are a number of factors that increase or decrease the risk of mental ill-health. Conceptually, these factors can be divided into three broad groups (WHO 2012):

- *Individual attributes and behaviours*, such as self-esteem, learned emotional intelligence, genetic and biological factors
- *Social and economic circumstances*, such as having the opportunity to have positive relationships with family and friends, gain an education and work
- *Environmental factors*, living environment, including access to basic commodities and services. Exposure to predominating cultural beliefs, attitudes or practices, social and economic policies formed at national level. Discrimination, social or gender inequality and conflict are examples of adverse structural determinant of mental well-being.

These different categories interact with each other in a dynamic way and can be either a positive of negative influence on an individual's mental health.

Figure 3. Contributing factors to mental health and wellbeing



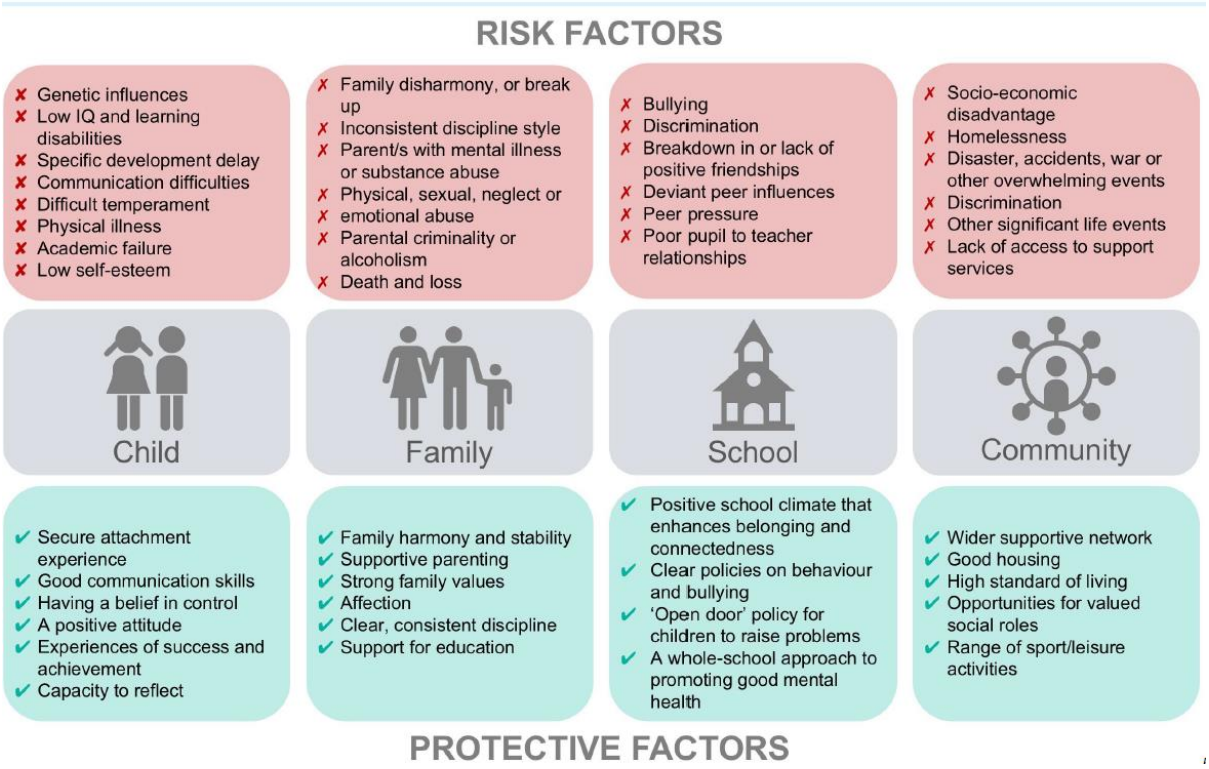
Source: World Health Organisation, Risks to Mental Health: An Overview of vulnerabilities and risk factors (2012) available at: https://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf

Overall, there is a strong association between inequality and mental health. Children and young people who experience poverty and social disadvantage have an increased risk of poor mental health (King's Fund 2017).

Some groups of children and young people are at greater risk. These include young carers, refugees and asylum seekers, LGBTQ+, looked after children, disabled children and youth offenders.

In addition, children and young people that have experienced one or more adverse childhood experiences (ACEs) - such as neglect, abuse, conflict, bereavement and parental substance use, imprisonment or mental illness - are at increased risk of mental ill-health during childhood and later in life. This links to inequality, as children from socially disadvantaged families are at greater risk of experiencing ACEs.

Table 2. Risk and protective factors in the development of mental health and emotional wellbeing



Source: PHE The mental health of children and young people in England (2016)

Table 2 illustrates some of the risk and protective factors in the development of mental health and emotional wellbeing in children and young people.

The National CYP Mental Health survey also identified a range of modifiable risk factors and behaviours among children and young people who have been identified as having a disorder compared with those who do not (NHS Digital, 2017). Interestingly it found that children and young people with mental disorders:

- Were more likely to have spent longer on social media on a typical day
- Were more likely to link their mental wellbeing to feedback received on social media platforms
- Were more likely to have experienced cyberbullying, either as victim or as perpetrator
- Were more likely to have experienced bullying, either as victim or as perpetrator
- Were less likely to be a member of a club. The largest positive impacts of club membership were evident in:
    - Sports clubs
    - After school clubs
    - Dramatic arts clubs associated with school
- Were less likely to report a strong score on the social support scale
- Were more likely to have experienced a stressful life event, such as family breakdown, financial crisis, family court appearances, family illness, injury or death or the breakdown of a close personal friendship or romantic relationship
- Were more likely to have tried smoking or vaping
- Were more likely to have tried alcohol

- Were more likely to have tried illicit drugs
- Were less likely to identify as heterosexual (14-19 year-olds)

These patterns were generally evident across all 11+ age groups and across male and female respondents.

Protective Factors

There are also several protective factors which can help to build good mental health and wellbeing. The Joint Commissioning Panel for Mental Health has identified a number of such factors which need to be considered in whole-systems strategies to promote good mental health and in the development of services. They include:

- Good living environment
- Good general health
- Educational attainment
- Good start in life
- Social engagement and strong networks
- Good attachment to caregivers
- Reciprocal altruism
- Positive self esteem
- Life skills (e.g. communication, problem-solving, resilience)
- Development of coherent personal values.

Impact of social media

The impact of social media on children and young people's mental health is not yet clear due to limited evidence available but as such it has become a big topic of debate and a focus for future research.

A report from the Office for National Statistics in 2015 found that children spending more than three hours on "social websites" on a normal school night were more than "twice as likely to show symptoms of mental ill health". However, the relationship of the two is unclear, whether social media usage is a cause or a consequence of the symptoms of mental ill health.

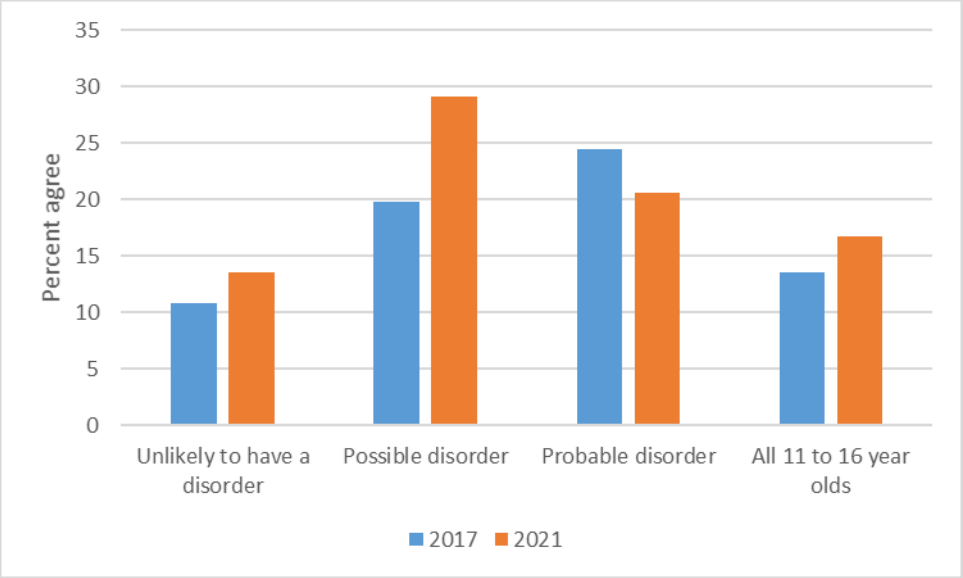
The mental health of children and young people (MHCYP) in England survey, published by NHS digital in 2017, found that 11 to 19-year-olds with a mental disorder were more likely to use social media daily (87.2%) compared to those without a disorder (77.8%). Also, that those with a disorder who were on social media daily tended to be on for longer, with 29.4% of daily users with a disorder being on social media for four hours on a typical school day. Again, these statistics indicate an association but do not provide the direction of the relationship between social media and mental health.

Relating specifically to the health impacts of screen time, the Royal College of Paediatrics and Child Health reported that there was a "moderately-strong evidence for an association of screen time and depressive symptoms" but that there was weak evidence for an association of screen time with "behaviour problems, anxiety, hyperactivity and inattention, poor self-esteem and poor wellbeing".

Conversely, it has been highlighted that some of the most robust research to date indicates that moderate engagement in digital activities has little detrimental effect on, and even some positive correlates with, wellbeing (Przybylski, 2017).

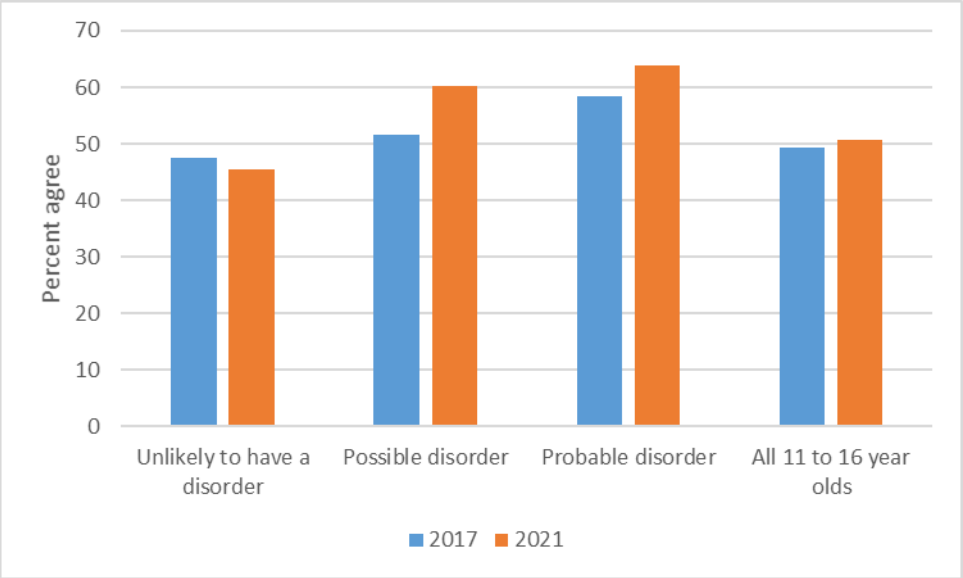
The 2021 follow up to the Mental Health of Children and Young People in England survey looked at the following aspects of social media use –

The number of likes, comments or shares I get on social media has an impact on my mood (percent agree)



	2017	2021	% change
Unlikely to have a disorder	10.8	13.5	24.5
Possible disorder	19.8	29.1	47.1
Probable disorder	24.5	20.6	-15.8
All 11 to 16 year olds	13.6	16.7	22.7

In general, I spend more time on social media than I mean to (percent agree)



	2017	2021	% change
Unlikely to have a disorder	47.4	45.5	-4.0
Possible disorder	51.6	60.3	16.9
Probable disorder	58.4	63.8	9.2
All 11 to 16 year olds	49.2	50.7	3.0

The data shows children with a probable or possible disorder are more likely to agree with both statements than the average for all 11 to 16-year olds

1.2 Impacts

Lower levels of emotional and psychological wellbeing has been linked to bullying, disruptive behaviour at school, disengagement, poor nutrition choices, lower levels of activity and poor long-term mental health (Royal College of Paediatrics & Child Health, 2017). Other outcomes include poor educational attainment; antisocial behaviour and criminal activity; teenage pregnancy and drug and alcohol abuse, and sometimes self-harm and suicide [See Suicide JSNA here]

More than half of children who show signs of mental health problems continue to experience them into adulthood, with an estimated three-quarters of all mental health problems diagnosed having emerged in those affected before the age of 25. Research by Scott et al (2001) suggests that public service usage by individuals with unmet psychological needs were on average ten times higher than those for individuals without mental health disorders, and the World Health Organization predicted annual additional costs of up to £59,000 per person with mental illness (WHO, 2008).

2. Size of the issue locally

Prevalence and incidence of mental disorders are difficult to determine locally for a number of reasons. Some conditions may fall below diagnostic thresholds for specialist support (and therefore not be recorded in a meaningful way), whilst some children and young people may not seek help, due to factors which may include lack of awareness of support available or stigma, for example.

There is no local survey which collects information and data on the emotional health and wellbeing of children and young people who live in Nottingham, however the national Mental Health of Children and Young People survey allows age and sex-based weighting of prevalence data by local area, which provides a 'synthetic estimate'. The estimated number of children and young people aged 5 to 19 years old with any mental disorder in Nottingham is shown in Table 3.

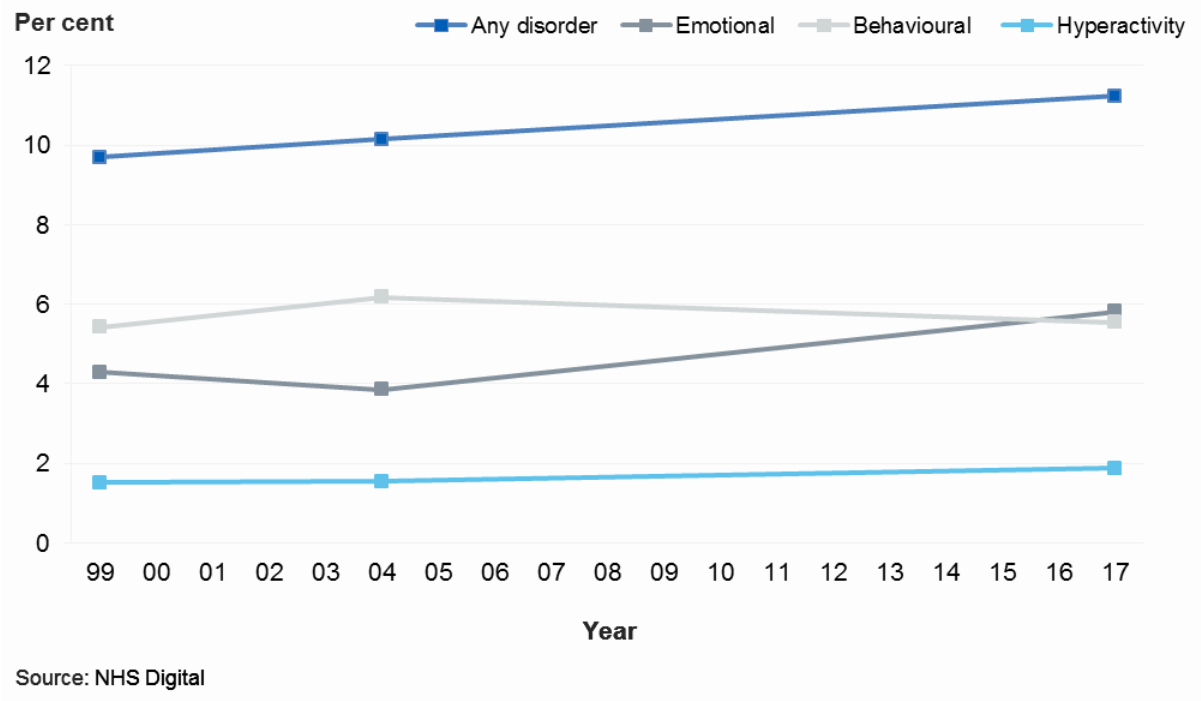
Table 3. Estimated numbers of children and young people with mental disorders in Nottingham (ages 5-19) (2018 mid-year population estimates)

	5 to 10 year olds			11 to 16 year olds			17 to 19 year olds			All 5 to 19 year olds		
Condition	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Any disorder	1536	780	2318	1614	1520	3134	1133	2616	3709	4398	4319	8718
Emotional disorders	576	427	1004	797	1149	1953	865	2449	3270	2147	3352	5499
Anxiety disorders	550	405	955	699	1022	1727	687	2220	2864	1892	3035	4927
Separation anxiety disorder	124	130	253	85	40	125				245	203	448
Generalised anxiety disorder	154	25	179	117	230	349	208	502	701	448	606	1053
Obsessive compulsive disorder	15	16	31	82	60	142	78	72	150	161	135	296
Specific phobia	81	112	193	87	105	193	48	94	140	227	316	543
Social phobia	20	22	41	87	138	226	107	290	392	190	365	556
Agoraphobia	6		6	26	79	105	68	308	370	79	278	358
Panic disorder	6		6	71	173	246	157	610	755	187	572	760
Post-traumatic stress disorder	24	25	49	38	89	128	37	260	291	97	291	388
Body dysmorphic disorder (BDD)	13	6	19	18	195	216	89	612	687	91	607	699
Other anxiety disorder	186	107	293	137	229	367	130	372	496	460	626	1086
Depressive disorders	45	28	73	184	406	593	352	715	1056	486	948	1434
Major depressive episode	31	16	47	116	293	412	265	513	771	336	678	1014
Other depressive episode	14	12	27	68	112	181	86	202	285	150	270	420
Bipolar affective disorder				6		6		29	28	7	17	24
Behavioural disorders	836	381	1218	836	528	1360	113	59	173	2032	1125	3157
Oppositional defiant disorder	587	300	888	439	315	752	76		78	1252	737	1989
Conduct disorder confined to family	22	16	38		19	20				26	42	68
Unsocialised conduct disorder	46	27	73	78	55	133				145	98	243
Socialised conduct disorder	70	6	77	214	105	318	37	9	47	355	140	495
Other conduct disorder	112	32	144	105	34	138		50	48	254	108	363
Hyperactivity disorders	327	91	419	361	78	435	169		174	912	203	1115
Hyperkinesis	303	85	389	293	71	360	92		94	756	186	943
Other hyperactivity disorder	24	6	30	68	7	75	78		80	156	16	172
Other less common disorders	422	113	536	270	209	478	150	244	391	906	532	1438
(PDD)/Autism Spectrum Disorder (ASD)	313	46	359	199	69	266	104	0	107	667	137	805
Eating disorders	7	6	13	26	101	129	0	175	171	38	234	272
Tics/other less common disorders	202	75	278	93	44	137	45	92	136	376	198	574

Source: Based on MHCYP survey estimates from 2017 applied to 2020 mid-year Nottingham population estimates

The above data must be interpreted with caution. These are 'synthetic estimates' based on findings from a national survey being applied to the age and sex structure of our local population in Nottingham. In addition, these are estimates of point prevalence (or the number of individuals who may have a disorder at any one point in time). The period prevalence of these disorders will normally be higher, and many of these conditions will continue to impact individuals into adulthood.

Figure 4. Prevalence of any disorder, emotional disorder, behavioural disorder, hyperactivity disorder 1999, 2004, 2017 (5-15 year olds)

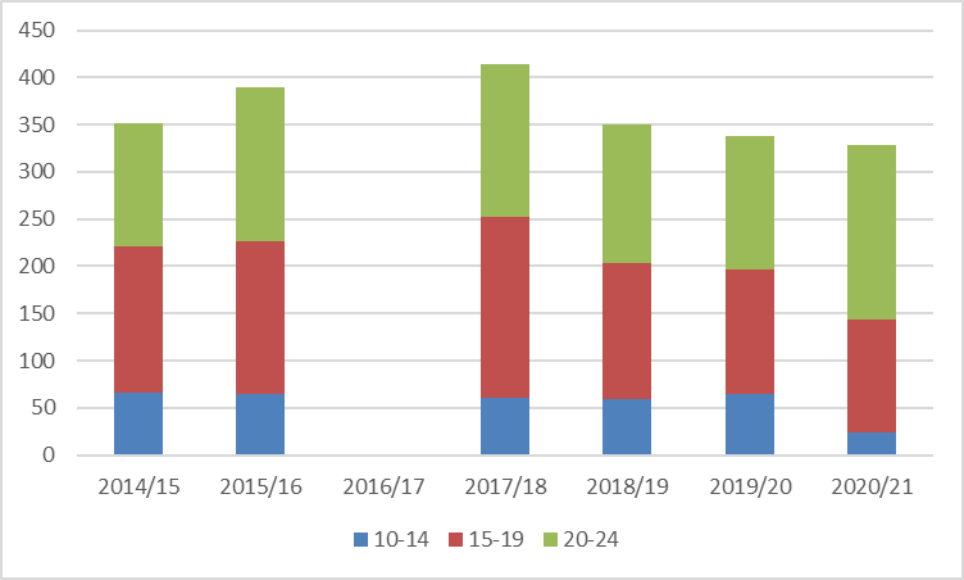


Source: NHS Digital

Nationally, trends in the MHCYP survey show a gradual increase in prevalence of mental disorders overall, from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017. This is largely accounted for by a proportionally large increase in emotional disorders since 2004 (see figure 4 above).

Nationally, the MHCYP survey found that one in four (25.5%) 11 to 16 year olds with a disorder reported that they had self-harmed or attempted suicide at some point, and one in eight (13.0%) had done so in the past four weeks. In 17 to 19 year olds with a disorder, nearly half (46.8%) had self-harmed or made a suicide attempt, and the rate was higher in young women (52.7%) compared to young men.

Figure 5. Hospital admissions for intentional self-harm in Nottingham by financial year and age band



Source: Hospital Episode Statistics 2014/15–20/21. Data: Nottingham City residents aged 10-24 years. Admissions to Nottingham University Hospitals. ICD10 codes X60-X84. Data for 2016-17 not presented due to data quality issues.

Table 4 shows the prevalence of a number of factors that increase or decrease the risk of mental ill-health in children and young people. These factors can threaten or protect an individual's mental health at different times. In Nottingham, we have significantly higher rates of children and young people living in low-income families, experiencing family homelessness and being taken into care. School readiness and educational attainment is lower than the national average. We also have higher rates of young people entering the youth justice system, and higher rates of violent crime in our neighbourhoods.

This suggests that children and young people in Nottingham are more likely to experience adversity in their social and economic circumstances and living environment and this will increase their risk of poor mental health.

Figure 5 shows in 2020/21, 329 children and young people aged 10 to 24 year olds from Nottingham City were admitted to hospital as a result of intentional self-harm. This is one admission less than 2019/20 but within this small change the data shows admissions for 10-14-year olds fell by 63% and 15/19 year olds by 9.8% whilst admissions for 20-24 year olds increased by 31.9%.

Table 4. Factors that influence children and young people's mental health in Nottingham City (Public Health Outcomes Framework)

Indicator	Year	Nottingham	England

Children in low income families (under 16s) (%)	2019/20	22.5	17.0
Family homelessness (%)	2017/18	3.2	1.7
Breastfeeding prevalence at 6-8 weeks after birth (%)	2017/18	47.3	42.7
School readiness: percentage of children achieving a good level of development at the end of reception (%)	2018/19	66.9	70.3
Educational attainment (5 or more GCSEs) (%)	2015/16	45.0	57.8
Average Attainment 8 score	2019/20	45.3	49.0
School pupils with social, emotional and mental health needs (all school age) (%)	2020	3.30	2.58
Pupil absence (%)	2018/19	4.82	4.61
Children in care (rate per 10,000 population aged under 18 years)	2020	95	67
Unaccompanied asylum seeker children (count)	2018	31	4480
Children leaving care (per 10,000 children aged under 18)	2017/18	31.9	25.2
First time entrants to the youth justice system (rate per 100,000 population 10-17-year olds)	2019	455.9	208.0
Young people providing unpaid care (16-24 year olds) (%)	2011	4.9	4.8
16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%)	2019	5.8	5.5
Percentage with a long-term illness, disability or medical condition diagnosed aged 15 (%)	2014/15	13.1	14.1
Domestic abuse-related incidences and crimes (per 1,000 population) (includes Nottinghamshire)	2019/20	21.9	25.4
Violent crime (including sexual violence) (per 1,000 population)	2019/20	39.8	29.5
Parents in drug treatment (per 100,000 children aged 0-15)	2011/12	237.0	110.4
Hospital admissions as a result of self-harm (10-24 yrs) (per 100,000 population)	2019/20	365.0	439.2
Hospital admissions for mental health conditions (0-17 yrs) (rate per 100,000 population)	2019/20	115.8	89.5

2.1 Inequalities

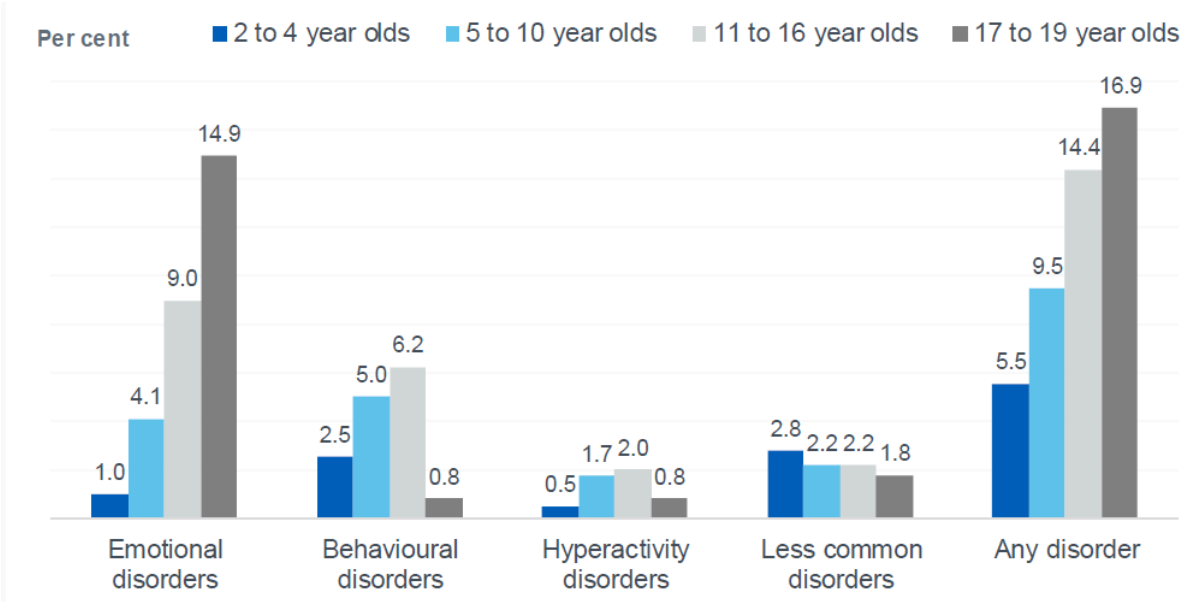
There is a social gradient in relation to mental health and wellbeing. Social inequalities are associated with increased risk of many common mental disorders (WHO 2014). This means that children and young people from some population groups are more likely to have poor mental health than others. Sometimes, this may be because of individual attributes such as low self-esteem or because of the environment in which they live for example, poverty, poor housing, parental substance use, family or neighbourhood violence (King's Fund 2017).

Age

The MHCYP survey found that rates of mental disorder increased with age, from one in eighteen (5.5%) preschool children aged 2-4 years, to one in ten (9.5%) primary school children aged 5-10 years, to one in seven (14.4%) secondary school children

aged 11-16 years, to one in six (16.9%) 17-19 year olds (see Figure 6). Behavioural disorders were more common in younger age groups, with emotional disorders becoming more common from secondary school age.

Figure 6. Rates of different types of disorder in 5 to 19-year olds by age (MHCYP national survey)



Gender

According to the MHCYP survey, nationally nearly one in four girls aged 17-19 years (23.9%) have a mental health disorder compared to one in ten boys (10.3%). Half (52.7%) of girls with a disorder reported having self-harmed or making a suicide attempt.

Highlights from the 2021 follow up to the 2017 MHCYP survey

Subgroup variation in mental health

• Age and sex: Boys aged 6 to 10 years were more likely to have a probable mental disorder (21.9%) than girls (12.0%). In 17 to 23 year olds, this pattern was reversed, with rates higher in young women (23.5%) than young men (10.7%).

• Ethnic group: Rates of probable mental disorder were higher among 6 to 23 year olds in the White British (18.9%) and the mixed or other (22.5%) groups, than in the Asian/Asian British (8.4%) and Black/Black British (8.3%) groups.

• Special educational need or disability: More than half of children with a special educational need or disability (SEND) had a probable mental disorder (56.7%), compared with 12.5% of those without SEND; this was an increase from 43.9% and 8.2% in 2017 for these respective groups.

• Long-term physical health conditions: In 2021, 6 to 16 year olds with a long-term physical health condition were twice as likely to have a probable mental disorder (29.6%) as those without a long-term physical health condition (14.9%).

Eating problems, sleep problems, loneliness and substance use

• Eating problems: The proportion of children and young people with possible eating problems increased between 2017 and 2021. In 11 to 16-year olds, this rose from 6.7% to 13.0%, and in 17 to 19-year olds from 44.6% to 58.2%.

• Sleep problems: In 2021, problems getting to sleep, waking in the night or waking early on three or more nights of the previous seven affected over a quarter (28.7%) of 6 to 10 year olds, over a third (38.4%) of 11 to 16 year olds, and over half (57.1%) of 17 to 23 year olds. Rates of sleep problems were higher in those with a probable mental disorder, compared with those unlikely to have one.

• Loneliness: In 2021, 4.9% of 11 to 16 year olds and 12.8% of 17 to 22 year olds reported feeling lonely often or always. Rates were higher in girls and young women (than in boys and young men), and in those with a probable mental disorder (compared with those unlikely to have one).

• Substance use: In 2021, most 11 to 16 year olds reported that they had not used alcohol (94.4%), cigarettes (98.4%), or cannabis or other drugs (99.2%) in the previous seven days.

• While rates of cigarette and drug use remained similar in 2020 and 2021, the proportion of 17 to 22-year olds who had had an alcoholic drink in the previous seven days fell from 55.5% in 2020 to 43.3% in 2021.

The coronavirus context

• COVID-19 infection: About one in twenty 6 to 16 year olds (4.7%) and one in eight 17 to 23 year olds (12.5%) had tested positive or been diagnosed with COVID-19. Of these, 69.7% of 6 to 16 year olds (as reported by parents) and 83.3% of 17 to 23 year olds (self-report) experienced symptoms. According to parents, 1.2% of 6 to 16 year olds with symptoms experienced them for four or more weeks. In young people aged 17 to 23 years with symptoms, 3.9% reported symptoms lasting from four to eleven weeks, and a further 7.8% for 12 weeks or more.

• Family connectedness: Children and young people aged 11 to 23 years with a probable mental disorder had lower levels of family connectedness than those unlikely to have a mental disorder.

• Family functioning: In 2021, 15.6% of 6 to 16 year olds were living in a family with reported problems with functioning. Rates were similar in boys and girls and in younger (6 to 10 years) and older (11 to 16 years) children.

• Special Educational Needs and Disabilities support: In 2021, the parents of 46.2% of 6 to 16 year olds with SEND reported a reduction in the support their child received for special educational needs, due to the coronavirus pandemic.

• School absence: Overall, 10.6% of 6 to 16 year olds missed more than 15 days of school during the 2020 Autumn term. Children with a probable mental disorder were twice as likely to have missed this much school (18.2%) as those unlikely to have a mental disorder (8.8%).

• Learning resources: The proportion of 6 to 16 year olds with a laptop or tablet they could work on at home, increased from 89.0% in 2020 to 94.4% in 2021. The proportion receiving regular support from school or college also increased, from 73.7% in 2020 to 79.9% in 2021.

• Household circumstances: In 2021, 12.8% of 6 to 16 year olds with a probable mental disorder lived in households that had fallen behind with bills, rent or mortgage during the pandemic, and 9.1% had become more likely to be unable to afford to buy food, or had used a food bank. This compares with 6.7% and 2.8% respectively of those unlikely to have a mental disorder.

• Ethnic group variation: Black/Black British 6 to 16 year olds were about three times more likely to live in a household that Mental health of children and young people in England, 2021: Wave 2 follow up to the 2017 survey Copyright © 2021 NHS Digital 13 had recently fallen behind with bills, rent or mortgage (18.6%) than children in the White British group (6.5%).

• Perceived impact of restrictions: In 2021, 13.5% of 11 to 16 year olds and 23.9% of 17 to 23 year olds felt their lives had been made 'much worse' by coronavirus restrictions. In contrast, 4.4% of 11 to 16 year olds and 2.3% of 17 to 23 year olds felt these had made their lives 'much better'. Children and young people with a probable mental disorder were about twice as likely to report that restrictions made their lives much worse, compared with those unlikely to have a mental disorder.

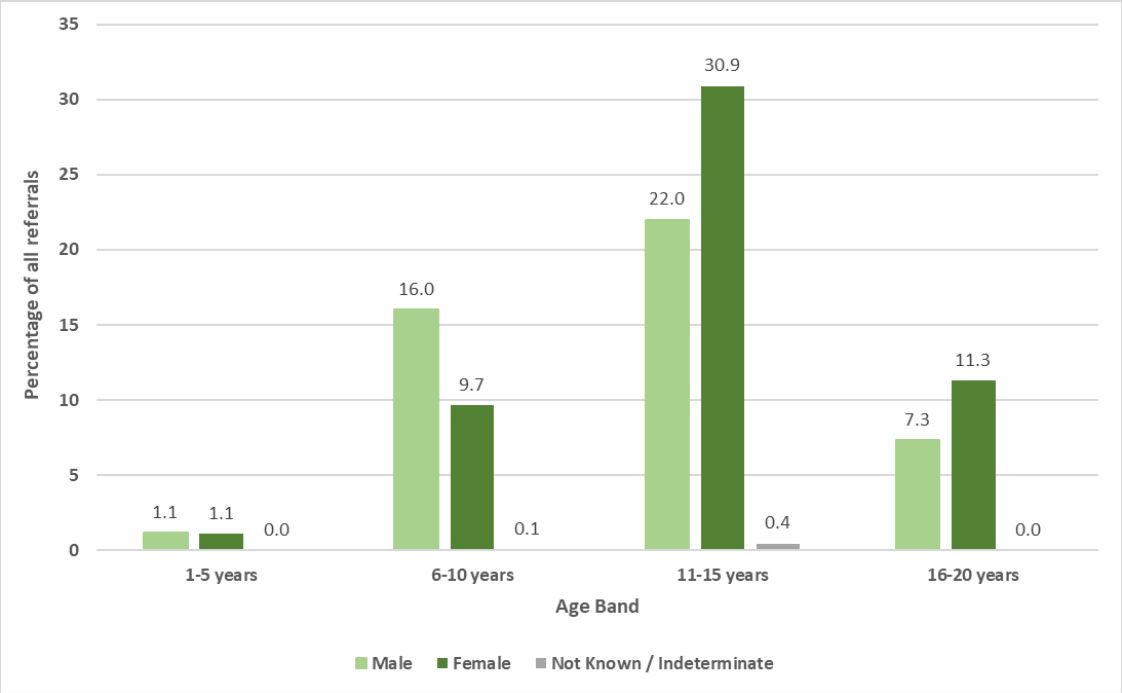
• Help-seeking: For about a quarter (26.2%) of 6 to 16 year olds with a probable mental disorder, whose parents were concerned about their child's mental health, the parent had not sought help or advice between Summer 2020 and Spring 2021. In 17 to 23 year olds with a probable mental disorder, two-fifths (41.5%) of young people with mental health concerns had not sought help during this time.

• Sources of help: Help sought by parents for 6 to 16 year olds with a probable mental disorder was most likely to be from education services (68.3%), while help sought by 17 to 23 year olds with a probable mental disorder was most likely to be from friends and family (59.7%) or online or telephone support (44.1%).

In Nottingham, referrals to the CAMHS SPA are equally divided between girls and boys (49.9% compared to 50.1%), as shown in Figure 7. However, there is a higher proportion of referrals for boys in earlier age groups (11.6% boys compared to 6.5% girls at age 6-10 years) and this may be more related to referrals for behavioural

disorders. This pattern reverses in teenage years where there are more CAMHS SPA referrals for girls (20.2% girls compared to 16.1% boys at age 16-20 years).

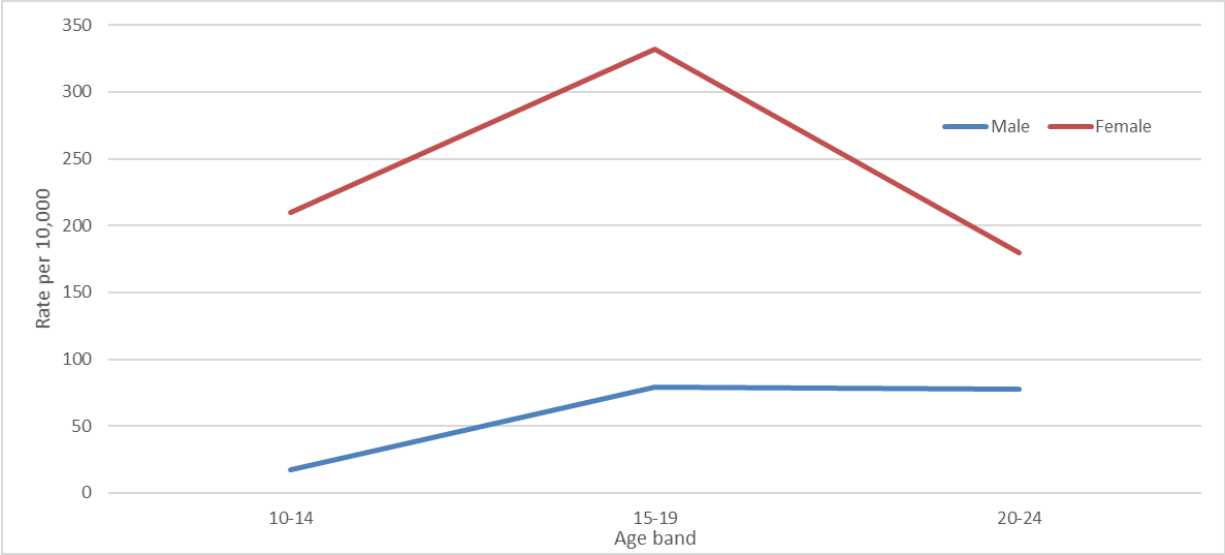
Figure 7. CAMHS Referrals in Nottingham by age group and gender (2018/19 - 2020/21)



Source: CAMHS Referrals 2018/19-2020/21 (3 financial years pooled) ages 0-20.

Girls are significantly more likely to be admitted to hospital as a result of intentional self-harm than boys (76.0% v 24.0%), and this was consistent across all age groups. The highest rate of hospital admissions for intentional self-harm is in females aged 15-19 years, at 402 per 10,000 population, as shown in Figure 8.

Figure 8. Hospital admissions in 10-24 year olds as a result of intentional self-harm by age band and gender in Nottingham City

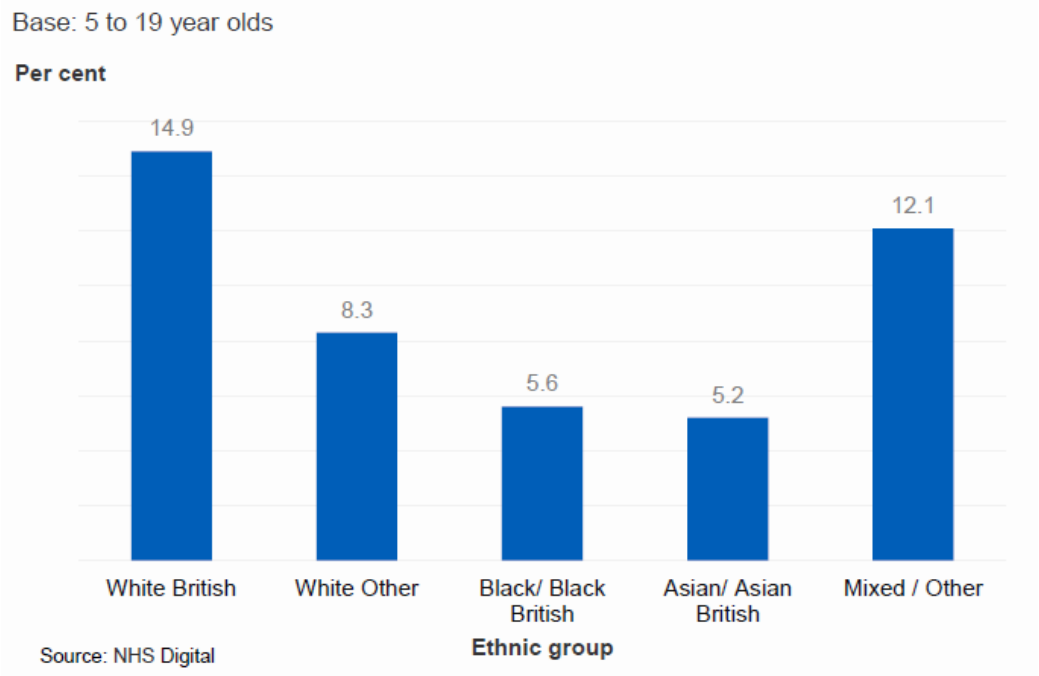


Source: Hospital Episode Statistics. Nottingham City residents aged 10-24 years. Admissions to NUHT with ICD10 codes X60-X84 (intentional self-harm). Pooled 4 years admissions 2017/18 – 2020/21.

Ethnicity

In the MHCYP survey, rates of mental disorder in 5 to 19 year olds varied between ethnic groups and tended to be higher in White British children than those who were Black/Black British or Asian/Asian British. Given the survey was somewhat based on self-report, these differences may reflect varying levels of health literacy, health-seeking behavior and stigma between different communities.

Figure 9: Any disorder by ethnic group in England

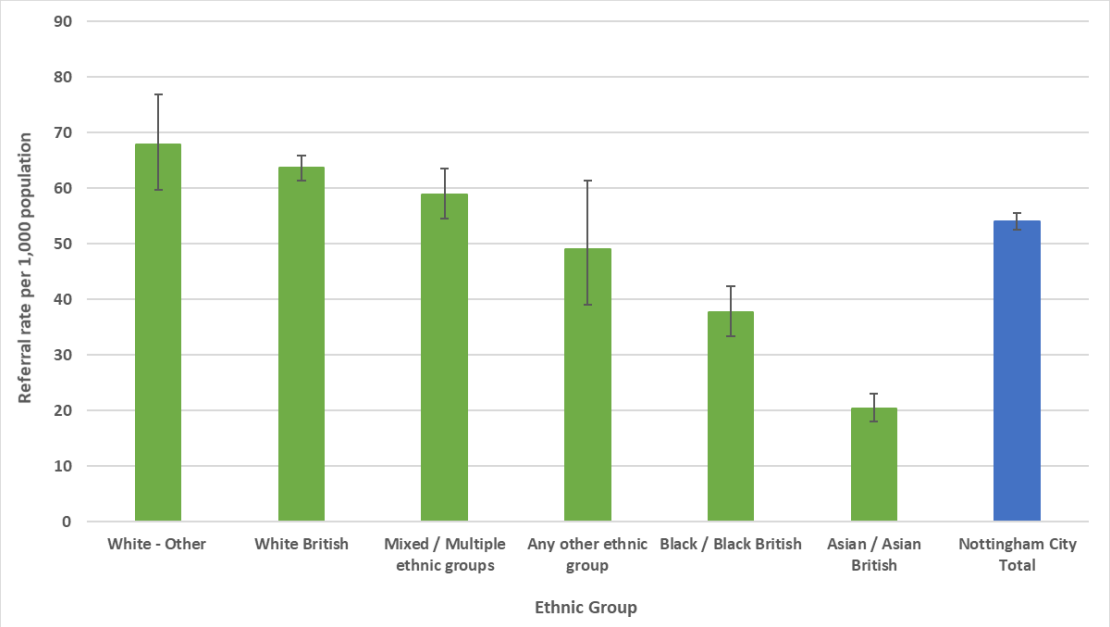


In Nottingham, the rate of referrals to CAMHS is significantly higher in White non-British children (67.9 per 1000, 95% CI 59.8 to 76.9) and White British children (63.7

per 1000, 95% CI 61.4 to 66.0) compared to the average for Nottingham City (54.0 per 1000, 95% CI 52.5 to 55.6). By contrast, Black/Black British and Asian/Asian British have significantly lower rates of referrals than the Nottingham City average (37.6 and 20.4 per 1000 respectively) (See Figure 10).

For the same reason above, these data should be interpreted with caution. It may be that there are systematic differences in the way in which different ethnic groups respond to mental health issues, with perhaps greater stigma in groups for which we see lower referral numbers.

Figure 10. CAMHS Referrals in Nottingham by ethnicity (2018/19-2020/21)

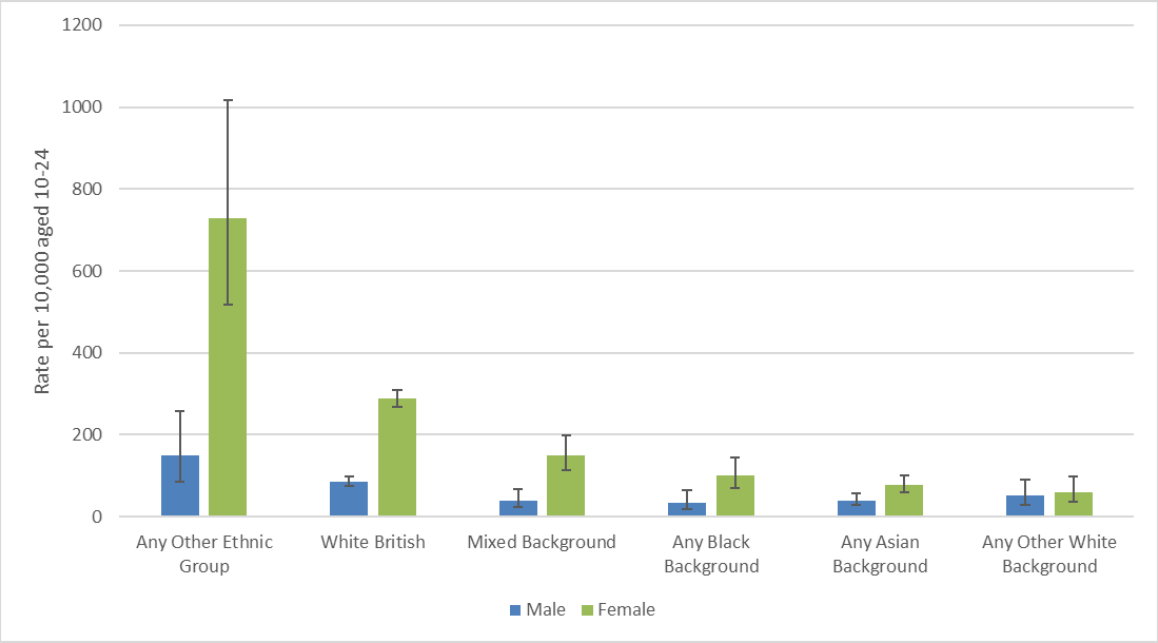


Source: CAMHS Referrals 2018/19-2020/21 (3 financial years pooled) ages 0-20. Ethnicity: ONS Census 2011.

Local data shows that around 75% of children and young people admitted to hospital as a result of self-harm were of White British ethnicity. Other ethnicities had significantly lower rates of hospital admissions for self-harm, with the exception of Any Other Ethnicity, which had significantly higher rates in girls but not boys. As previously mentioned, this may be due to small numbers (31 girls) and changes in population size, however it could also represent a high level of need. This would require further analysis to understand.

Again, these data should be interpreted with caution given the potential for different levels of stigma between ethnic groups.

Figure 11. Hospital admissions for intentional self-harm in Nottingham by ethnicity & gender



Source: Hospital Episode Statistics. Nottingham City residents 10-24 years. Admissions to Nottingham University Hospitals Trust. ICD10 codes X60-X84. 4 yrs admissions 2017/18 to 2020/21. Ethnicity was 'not stated' for 189 individuals (6.6%). Ethnicity populations from ONS Census 2011

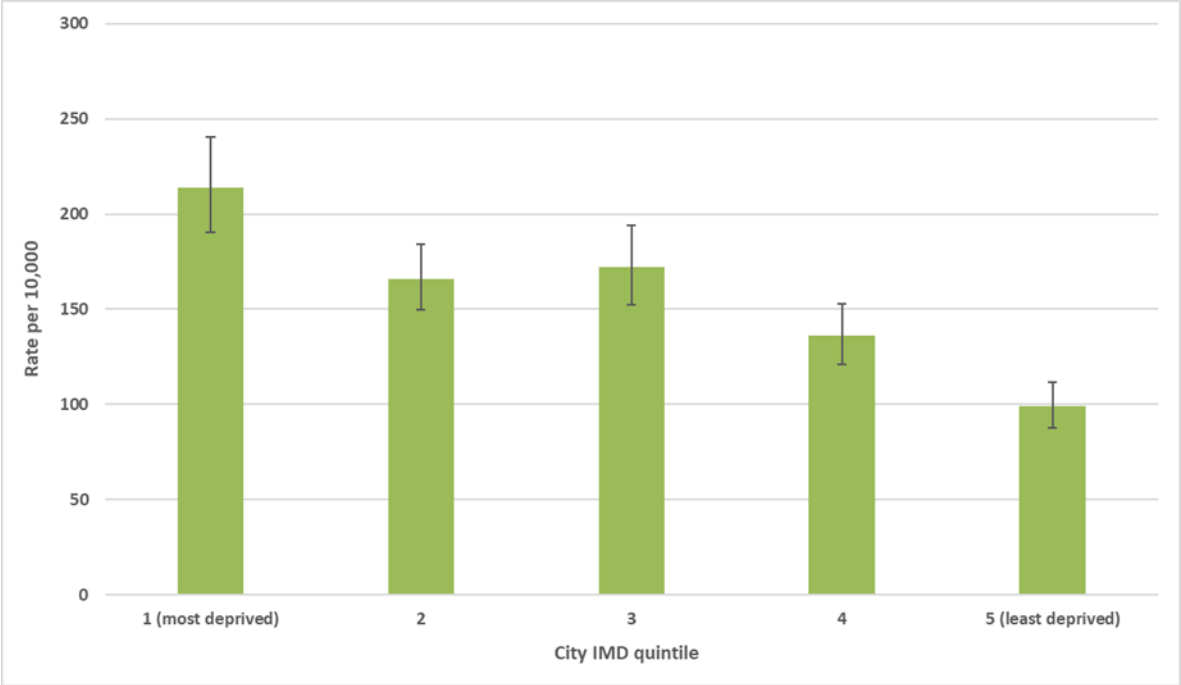
Socio-economic deprivation

According to the MHCYP survey, rates of mental disorders tended to be higher in children living in lower income households for emotional, behavioural and autism spectrum disorders, but not for hyperactivity or eating disorders. Emotional disorders affected 4.1% of 5 to 19 years from households with the highest income, compared to 9.0% from households with the lowest income.

Children and young people living in households receiving parental benefits were more likely to have mental disorders than those who were not. Nearly a third (32%) of all children and young people living in households receiving parental disability benefits had a mental disorder, and this effect was stronger in boys (36% than girls (27%), compared with only 10% of those living in households receiving no benefits.

In Nottingham, children and young people aged 10 to 24 years old from the most deprived areas were more than twice as likely to be admitted to hospital as a result of intentional self-harm (213.9 per 10,000, 95% confidence interval 190.3 to 240.4) than those from the least deprived areas (98.6 per 10,000, 95% confidence interval 87.6 to 111.6).

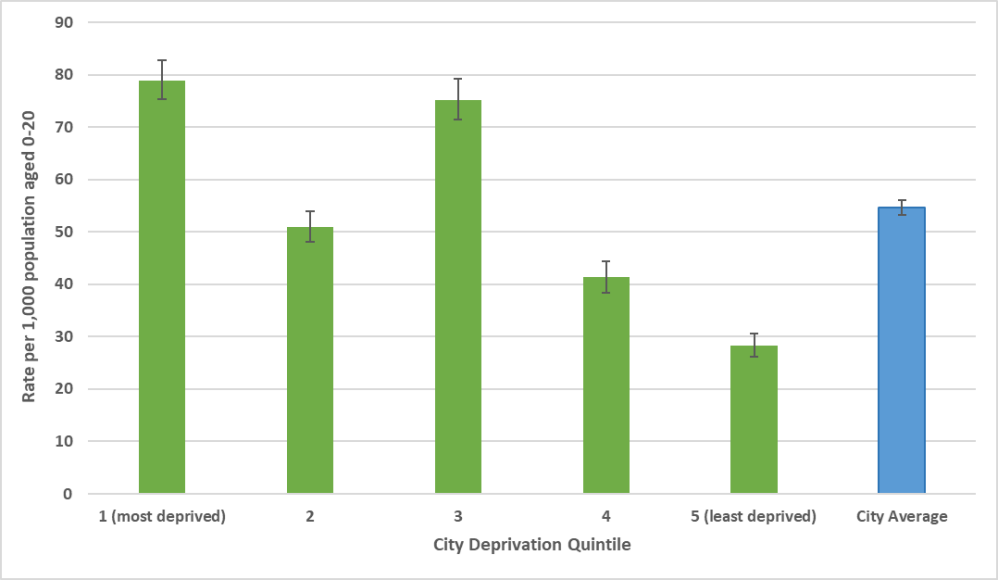
Figure 12. Hospital admissions for intentional self-harm in Nottingham by deprivation quintile



Source: Hospital Episode Statistics. Nottingham City residents 10-24 years. Admissions to Nottingham University Hospitals. ICD10 codes X60-X84. 4 years adm's 2017/18 to 2020/21.IMD quintiles from ONS Deprivation 2019.

Referrals for CAMHS assessment through the SPA are significantly higher for children and young people from the most deprived areas

Figure 13. CAMHS Referrals in Nottingham by deprivation quintile (2018/19-2020/21)



LGBTQ+

In the MHCYP survey, non-heterosexual identity in 14-19-year olds were associated with an increased risk of mental disorder (34.9% compared to 13.2% in those identifying as heterosexual).

Locally, we were unable to identify sexual orientation in the data from the CAMHS SPA or HES.

Children in care

Children in care are more likely to have had experience of social and environmental risk factors and a number of adverse childhood events (ACEs) than other children. Nationally, 45% of children in care were found to have a diagnosable mental health disorder, with mental health problems thought to be even more prevalent in this group (Meltzer et al, 2002; McAuley & Davis, 2009).

A local service, *You Know Your Mind*, provides mental health support services to children in care in Nottingham and Nottinghamshire. Of the 239 children in care who have accessed this service, over half report a mood disorder, two fifths feel socially isolated and around a quarter engage in self-harming behaviour (See Table 5). In terms of behavioural outcomes, over a fifth are known to the police, one in ten is at risk of sexual exploitation and one in five misuse drugs or alcohol.

Table 5. Mental Health needs of Children in care and Care Leavers

Percentage of cohort identified with a mental health need (multiple needs may be reported)	
Anxiety, depression, stress or other mood disorder	55%
Social isolation	40%
Self-harming behaviour	26%
Bereavement	13%
Developmental disorders	13%
ADHD / hyperkinesis	12%
ASD	11%
PTSD	8%
Suicidal thoughts / behaviour	8%
Conduct disorder	4%
Eating disorder	3%
OCD	1%

Of 239 service users (LAC and care leavers) in Nottinghamshire accessing services via You Know Your Mind project.

Disabled children

Mental health, and physical health/impairment are closely linked. According to the national MHCYP survey, children with mental health condition are more likely to have poor general health, a limiting long-term illness, a physical or developmental problem, or a special educational need. Nearly three quarters of children with a mental health condition (71.7%) had a physical health condition or developmental problem. A quarter (25.9%) had a limiting long-term illness, compared to 4.2% of children without a mental health condition. A third (35.6%) had a recognised special educational need.

Locally, between 2018/19 and 2020/21 the number of children and young people referred to CAMHS SPA who were recorded as having a disability was 728, which represents 12.7% of all referrals.

Table 6. Number of children and young people referred to CAMHS Single Point of Access with a recorded disability in Nottingham City (2018/19 & 2020/21)

Disability	Count
Behaviour and Emotional	153
Mobility	58
Hearing	24
Sight	23
Speech	19
Personal, Self-Care and Continence	6
Manual Dexterity	2
Other	443
Total with a disability	**728**

Asylum seekers & refugees

In data for CAMHS SPA referrals, immigration status was completed for only 5 records. These were all Unaccompanied Asylum Seeking Children. To understand service access for this group, we need to improve data quality or conduct a specific audit. One issue is likely to be that UASC referrals don't always go through the SPA, as they are children in care.

Other factors

In the MHCYP survey, other factors identified as increasing the risk of mental disorder in children were poor parental mental health; experiencing adverse life events; low levels of social support; and, problems with family functioning.

3. Targets and performance

National Policy

The national strategy, *Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing* (2015), set out the government's ambition to transform children and young people's mental health services by 2021.

Ambitions include:

a. Promoting resilience, prevention and early intervention: acting early to prevent harm, investing in early years and building resilience through to adulthood.
b. Improving access to effective support – a system without tiers: changing the way services are delivered to be built around the needs of children, young people and families.
c. Care for the most vulnerable: developing a flexible, integrated system without barriers.
d. Accountability and transparency: developing clear commissioning arrangements across partners with identified leads.
e. Developing the workforce: ensuring everyone who works with children, young people and their families is excellent in their practice and delivering evidence-based care.

The Government Green paper Transforming Children and Young People's Mental Health Provision (December 2017) places schools at the centre for early intervention around mental health support and aims to establish the following:

- A mental health lead in every school and college by 2025 to support pupils and staff, offer advice and to refer children and young people to specialist services
- Establishment of mental health support teams to provide more specialised services and link to wider networks
- Reduce waiting times for treatment with piloting a four-week waiting time in some 'trailblazer' areas.
- Bolster transitional care from CYP to adult services through the development of a national partnership approach
- Invest in research in to supporting families and prevention of mental health problems

In addition to this, the NHS 2019 Long Term Plan also includes the following key commitments around children and young people's mental health.

- Transform mental health care so more people can access treatment by increasing funding at a faster rate than the overall NHS budget – and by at least £2.3bn a year by 2023/24
- Make it easier and quicker for people of all ages to receive mental health crisis care, around the clock, 365 days a year, including through NHS 111
- Expand specialist mental health care for mothers during and following pregnancy, with mental health assessments offered to partners so they can be signposted to services for support if they need it
- Embed mental health support for children and young people in schools and colleges, allowing extra capacity for early intervention and ongoing help.

- Ensure that all children and young people aged 0-25 can get support when they need it, in ways that work better for them, through a comprehensive offer that reaches across mental health services for children, young people and adults.
- Boost investment in children and young people's eating disorder services over the next 5 years.
- A new approach to young adult health services for people aged 18-25 will support the transition to adulthood.
- Continue to develop services in the community and hospitals, including talking therapies and mental health liaison teams, to provide the right level of care for hundreds of thousands more people with common or severe mental illnesses.

Local Policy

CCGs have been required to produce a plan which describes our local response to Future in Mind. The plan was updated annually and. Nottinghamshire and Nottingham City have a joint plan which can be viewed here Children and Young People's local transformation plans (LTP).The aim of the plan was to **improve the emotional and mental health of our population of children and young people** through implementing the recommendations of *Future in Mind*.

All partners remain committed to delivering the following *Future in Mind* priorities:

- more young people to have good mental health, including those in vulnerable groups such as children looked after, children subject to child protection plans, children with disabilities and young offenders
- more children and young people with mental health problems to recover
- more children and young people to have a positive experience of care and support
- fewer children and young people to suffer avoidable harm
- fewer children and young people to experience stigma and discrimination

Other relevant indicators to monitor include those on the Children and Young People's Mental Health and Wellbeing Profiling Tool, which provides a wide range of national, regional and local data on the need, protective factors, risk factors and services that support children and young people's mental health.

Please see the Annex 1 for links to relevant local and national strategies

Other relevant indicators to monitor include those on the Children and Young People's Mental Health and Wellbeing Profiling Tool, which provides a wide range of national, regional and local data on the need, protective factors, risk factors and services that support children and young people's mental health.

4. Current activity, service provision and assets

4.1 Prevention

Perinatal

The perinatal mental health pathway for the Nottingham and Nottinghamshire STP area has been redeveloped, along with enhanced capacity in the Perinatal Psychiatry Service. This is focused on early identification of mental health needs, with a particular focus on mild to moderate and emerging mental health needs, including women who:

- Enter pregnancy with existing mental health conditions
- Would benefit from talking therapies (IAPT)
- Develop a serious mental health problem during pregnancy or after birth.

Best Start Children's Public Health Service & Early Help Service

The Best Start Children's Public Health Service supports 0-19 year olds, with a focus on emotional health and wellbeing. This service works closely with the Early Help Team on delivering an integrated service for the 0-5 year old age group.

Developing resilience in schools

The Green Paper *Transforming Children and Young People's Mental Health* (December 2017) and the *NHS 10 Year Plan* have both had a focus on schools playing a key role in early intervention, building resilience and prevention around children and young people's mental health. In Nottingham, engagement and collaboration with schools and colleges has increased, and we have a number of initiatives in place.

- **The Emotional Health and Resilience Charter** – a way for schools to demonstrate their commitment to supporting the mental health and emotional wellbeing and resilience of their pupils. Once the school has signed the charter, they complete an audit to record their strengths and areas for development. An action plan is created and support can be requested from the Emotional Health and Wellbeing Consultants and partner services. Once the actions have been completed, the schools submit a case study to be disseminate across the city as an example of good practice. Network sessions are held for schools each term to share their practice. So far:
    - 24 schools in Nottingham have signed up to the Charter
    - 2 case studies have been published.

- **Youth Mental Health First Aid (MHFA)** – a training programme to develop the skills to recognise young people showing early signs of emotional distress as well as more complex mental health need, and to ensure appropriate support. Training to become a Youth Mental Health First Aider (2 day training) and/or a Youth MHFA Champion (1 day training) is available to schools and the wider children's workforce. So far:

Schools

- 61 staff from 39 schools have completed the 2 day training (since September 2018) to become Youth Mental Health First Aiders
- 46 staff from 27 schools have completed the 1 day training (since January 2019) to become Youth MHFA Champions
- In addition, 8 staff from 8 schools have accessed the Adult MHFA course in association with the University of Nottingham to support colleagues.

Wider children's workforce

- 250 members of the children's workforce have become Youth Mental Health First Aiders.

- **Targeted CAMHS training and support**
  - CAMHS training and support for staff in schools and universal services so that they can support children and young people with mental health needs.
  - Time4Me - an initiative where young people can access direct monthly support in their secondary school from a CAMHS professional.
  - Amazing Me – a pilot project for primary schools for early intervention to promote emotional wellbeing.
  - Self-Harm Awareness and Resource Project (SHARP) – raises awareness, builds confidence and skills to front-line staff to intervene and manage young people who present with self-harm and suicidal behaviours. Monthly self-harm clinics are delivered in 18 City secondary schools, one in Nottingham College and one for the CAMHS Children Looked After service. Of these, approximately 80% of YP seen over a 2.5 year period have received support from Universal Services and not required input from Targeted/Specialist mental health services.

- **Character Curriculum Programme** – training has been provided to x schools and resources provided to x schools. This is delivered by Nottingham City Council Personal, Social and Health Education team.
- **Zippy and Apple's Friends** – academic resilience programme was piloted in 8 primary schools. The University of Belfast is currently undertaking the evaluation.
- **Applied Suicide Intervention Skills Training (ASIST)** - Training has been provided to x individuals across x schools/services.
- **Mental Health Support Teams** - Mental Health Support Teams (MHSTs) in Nottingham City offer support across 46 schools, as part of a national project that is NHS England funded. These teams provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing. The teams act as a link with local children and young people's mental health services and be supervised by NHS staff.

Voluntary and charity sector

Kooth – a universal service for children aged 11 years and over, that offers open access online counselling, online emotional health support tools and moderated forums with access to a community of peers. During 2017/18 376 young people accessed the Kooth face to face service offered within Nottingham City with 2038 appointments delivered, whilst 892 young people from Nottingham City registered for Kooth online services with 589 online counselling sessions offered. Service users rated the service very positively, with 87% of them returning more than once and 96% of them reporting that they would recommend it to a friend.

Base 51 – offers face-to-face counselling to young people aged over 11, along with confidential advice and learning support. In 2017/18 223 young people from Nottingham City were referred to Base 51 with 1071 appointments offered.

Action for Children – are funded to provide support for up to 4000 parents across Nottingham and Nottinghamshire to support parenting during early years via online support sessions with family support workers, along with further targeted local sessions around bullying, parental separation, bereavement and substance abuse.

CYGNET – is a support service for parents of children and young people with autism spectrum disorder.

IMARA - an independent specialist service that supports children, young people and their safe family members following a disclosure or discovery of child sexual abuse.

NSPCC - provide therapeutic services to help children move on from abuse, as well as supporting parents and families in caring for their children. NSPCC also provide Life Story Work to help children in care begin to understand and accept what's happened to them.

Childline - a counselling service for children and young people up to their 19th birthday provided by the NSPCC, accessed by phone, email or online.

Harmless – provides support to young people to address and overcome issues related to self-harm and suicide.

4.2 Treatment

Behavioural support

The Behavioural and Emotional Health (BEH) Team is a CCG commissioned service that aims to bridge the gap between universal and targeted CAMHS provision for children/young people who are registered with a City GP. The service is primarily receiving referrals for children/young people who have behaviour issues and/or where there are concerns that the child/young person may have autism or ADHD. The CCG has recently commissioned an educational psychologist and a clinical psychologist to ensure the diagnostic service meets NICE guidance. In 2017/2018, the BEH team received 2323 referrals. This high number of referrals evidences the level of need within the City, and the increasing number of referrals to the paediatric service in relation to Autism and/or ADHD. The CCG is currently reviewing the service, as it is due to be recommissioned in 2020. This will take into consideration the recent BEMH

service evaluation, SPA audit and recommendations from the multi-agency working group, to decide a model of future delivery.

CAMHS (Child and Adolescent Mental Health Services)

CAMHS provision is now 'tierless' in Nottingham, and self-referral to all CAMHS services is possible through accessing the Single Point of Access (SPA). The main CAMHS services are:

- **Targeted Children and Adolescent Mental Health Services (CAMHS)** – offers an early intervention service to prevent emotional and behavioural difficulties emerging into more complex ones. It is provided by Nottingham City Council and is jointly commissioned by Nottingham City Council and NHS Nottingham City CCG.

  The model uses a Single Point of Access (SPA) for all referrals into a range of services, which is unique nationally, and sits alongside the Nottingham City Multi-Agency Safeguarding Hub (MASH). This model offers many benefits, for example by ensuring children and young people whose emotional needs do not meet the threshold for CAMHS services get access to support from other more suitable services, and that young people with mental health and safeguarding concerns are jointly assessed.

  In 2018/19 there were 1763 referrals into the CAMHS SPA with the most common reasons for referral being anxiety, depression and conduct disorders. 1000 CAMHS assessments were offered to children & young people and their families, including 124 joint assessments with Community CAMHS. An additional 102 consultations were offered to professionals.

  The average CHI service satisfaction outcomes were 22/24 for children and young people and 23/24 for parents and carers. Over 70% of CYP self-reported improvements in anxiety and depression, and over 70% showed an improvement in SDQ score (strengths and difficulties).

  Over the last 4 years 95% of cases remain at a Targeted CAMHS or universal level. In 2018/19, of the SPA referrals that require CAMHS input, 92.5% remained within Targeted CAMHS who were able to support them within their local community (traditionally known as Tier 2 services), with only 7.5% needing to be sent onto more specialist services.

- **Specialist Community CAMHS** provides specialist multi-disciplinary services for severe and complex child and adolescent mental health problems. It is provided by Nottinghamshire Healthcare NHS Foundation Trust and is commissioned by Nottingham City CCG.

  In 2018/19, there were 1014 new referrals to Specialist CAMHS for children and young people, of which 562 referrals were for females and 441 for males. Of these, 308 referrals were to the Crisis and Home Treatment Team, 233 referrals to CAMHS South, 139 referrals to Head 2 Head and 117 referrals to CAMHS Liaison at NUH.

- **CAMHS Eating Disorder Service** In 2018/19, there were 29 new referrals to CAMHS Eating Disorder Service for children and young people, of which 24 referrals were for females and 4 referrals were for males.

- **CAMHS Crisis Resolution and Home Treatment Service (CRHT)** funded by Nottingham City and Nottinghamshire County Councils to respond to young people experience mental health crisis, offering crisis assessments in the community and in acute hospital settings, in-reach support to acute hospitals and inpatient mental health settings, and intensive home treatment to those young people deteriorating into crisis.

- **CAMHS for Children in Care** is a jointly funded multi-disciplinary service which aims to improve responses to the mental health and emotional wellbeing of Nottingham City children in care. The service offers specialist assessment and intervention when needed, with a particular focus on promoting placement stability. The team includes a psychiatrist, psychotherapist, art therapist, community psychiatric nurses and social work staff, and the team sits within the Children in Care team. The team also provide specialist training and psychoeducation to schools, social workers, homes staff and carers. The service does not support other local authority children placed in Nottingham City.

  In 2018/19 there were 141 new referrals to CAMHS for Children in Care, with the following characteristics
  - Gender: Females 44%, Males 56%
  - Ethnicity: White British 55%, Dual heritage 21%, Polish 5%, Afghan 2%, Kurdish 2%, Black African 2% and others 11%
  - Age at referral: 0-5 years 15%, 6-10 years 24%, 11-15 years 44%, 16-18 years 24%. There was an increase in referrals of 11-15 year olds, possibly due to a number of children with complex presentations moving back into the City from other local authority placements. There was also a slightly decrease in the number of referrals made in other age bands.
  - Primary reason for referral: Attachment 39%, Trauma response 35%, Relationship issues 6%, Sexualised behaviour 4%, Suicidal thoughts 4%, Self-harm 4%, Low self-esteem 4% and others 4%.

  In terms of the service provided, the average waiting time between referral and initial choice consultation in 2018/19 was 4.48 weeks, however this varied considerable month-to-month from 2.1 weeks in October 2018 to 7.75 weeks in March 2019.

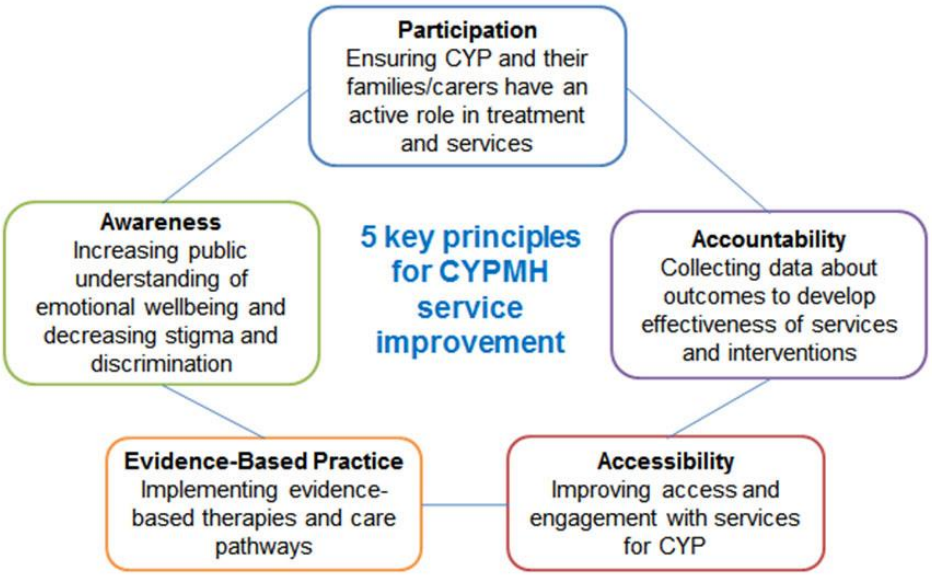
  CAMHS Inpatient provision - Highly specialised inpatient CAMHS and intensive community treatment service is provided at Hopewood inpatient unit by Nottinghamshire Healthcare NHS Foundation Trust and is commissioned by NHS England Specialised Commissioning. In Nottingham, Hopewood enables children and young people to remain close to home during their inpatient stay, where bed availability allows. If a young person is placed outside of

Nottingham the system works together to repatriate the young person at the earliest opportunity. The Hopewood site includes inpatient provision for dedicated specialist eating disorders and psychiatric intensive care unit along with inpatient perinatal services.

- **CYP-IAPT (Improving Access to Psychological Therapies)**
  The Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT) aims to improve outcomes and experience of care for children, young people and their families by increasing access to effective services and evidence-based therapies through system-wide service improvements.

  The programme works with existing services that deliver mental health care for children and young people across the system (provided by NHS, Local Authority, Voluntary Sector, Youth Justice) and aims to create, within teams, a culture of full collaboration between child, young person and/or their parents or carers by embedding the following principles (See Figure 14)

Figure 14: Five key principles for CYPMH service improvement



Services for 18-25 year-olds

Transition from CAMHS to Adult Mental Health services

Transition between adolescent and adult services is a difficult time for service users (see section 7). During 2018/19, there was a national CQUIN in place to focus on and improve the quality of care received by those in transition. This process has involved the creation of 'transition champions' and also a new transition protocol which involves a joint panel of adult and children's staff to facilitate the process.

You know your mind

Since April 2018, the You Know Your Mind Project has been operating across Nottingham City and Nottinghamshire County, supporting looked after children aged 0-17 and care leavers aged 18-25 who are experiencing poor or deteriorating mental health.

Through a 'Different Conversation', the child or young person is empowered to determine what they think will genuinely improve their mental health outcomes and make every day a 'good day'. By offering children and young people the choice and control over their mental health support, personalised and non-clinical support arrangements have been commissioned for over 300 children and young people, including community-based activities

Feedback from an evaluation tells us:

- 94% of young people reported feeling better or a lot better about **their quality of life**
- 85% of young people reported feeling better or a lot better about **their health and wellbeing**
- 78% of young people reported feeling **that their support arrangement has improved their confidence and self-esteem**
- 86% of young people reported feeling **their support arrangement has given them something to look forward to**
- 64% of young people reported feeling **that their support arrangement has helped them to make friends**

Targeted provision for vulnerable groups

Specific services are commissioned across Nottingham and Nottinghamshire ICS which are evidence-based:

- Domestic abuse CAMHS practitioner
- Asylum seeker CAMHS practitioner
- CBT specialists
- Forensic CAMHS team
- Animal assisted therapy services
- Bespoke services for victims of sexual abuse or exploitation

4.3 Workforce development

Trauma informed practice

A workforce development programme is in place to ensure that Nottingham City Children's Integrated Services become **trauma informed**. This follows a growing body of evidence about the impact of childhood adversity and trauma on children, families and workforces.

The approach taken in Nottingham aims to identifying adverse childhood experiences (ACES), as well as the current impact and existing protective factors, to identify how to meaningfully intervene to reduce further negative impact on the whole family.

The current offer is a 2 day training course followed by a trauma focussed reflective practice session and manager's briefing. So far, training has been provided to teams including the Youth Justice Service, Exploitation and Violence Reduction Hub, Parenting team, Children and Families Direct and Social Work teams.

Briefings have been given at a range of partner events including the teaching partnership D2N2 and Notts Healthcare Foundation Trust.

4.4. Current demand

The number of referrals to CAMHS SPA for 0-20 year olds has remained consistently high in 2018/19 (1829 referrals), 2019/20 (2048 referrals) and 2020/21 1861 referrals).

The majority of referrals to CAMHS SPA are from GPs (40.5%) followed by education professionals (13.7%) and parents / carers (9.0%).

Table 7. Source of referrals to CAMHS SPA in Nottingham 2018/19 - 2020/21

Referral source	Count	%
GP	2171	37.8
Education	1231	21.5
Parent/Carer	840	14.6
Paediatrician	398	6.9
Social Care	308	5.4
Other Dept in local authority	179	3.1
Other Health	167	2.9
Specialist CAMHS	122	2.1
Self	91	1.6
External Organisations	90	1.6
BEHT	70	1.2
School Nurse	40	0.7
Any Other professional	12	0.2
Any other person	8	0.1
A key agency for the child/young person	5	0.1

A person on this system	3	0.1
KOOTH	2	0.0
Not known	1	0.0
Total	**5738**	

Reasons for referral to CAMHS SPA can be multiple and complex. However, the most common reasons noted on referrals to CAMHS SPA were: anxiety; depression; conduct disorders; self-harm behaviours; post-traumatic stress disorder; and, relationship difficulties.

Table 8. Presenting reason for referrals to CAMHS SPA in Nottingham by gender 2018/19 - 2020/21

Presenting reason	Male	Female	Indeterminate /Not known	Total
Low Mood	422	720	16	1158
Anxiety	484	626	17	1127
Anger Management	520	216	7	743
Suicidal Thoughts	192	282	11	487
Trauma Response	224	239	2	465
Self-Harm	150	226	7	383
Low Self-Esteem	62	84	3	149
Bereavement	78	62	0	140
Oppositional Behaviour	84	49	1	134
Eating or Food	32	91	2	125
Obsessional Behaviour	52	69	1	122
Depression	42	70	2	114
NULL	50	43	1	94
Bullying	28	36	0	64
Relationship issues – Family	26	37	0	64
School attendance	34	28	1	63
Attachment	26	23	0	49
Emerging Psychosis	18	18	2	38
Gender Dysphoria	11	20	5	36
Safeguarding	19	16	0	35
Sexualised Behaviour	26	7	1	34
Learning Disability	17	11	0	28
Attentiveness	13	5	1	19
Relationship issues – Peers	6	9	1	16
Gender Identity	6	7	0	13
Hyperactivity	5	4	0	9
Domestic Violence	4	3	0	7
Sexuality	4	2	0	6
Sexual Abuse	2	3	0	5
Soiling – Enuresis	2	2	0	4

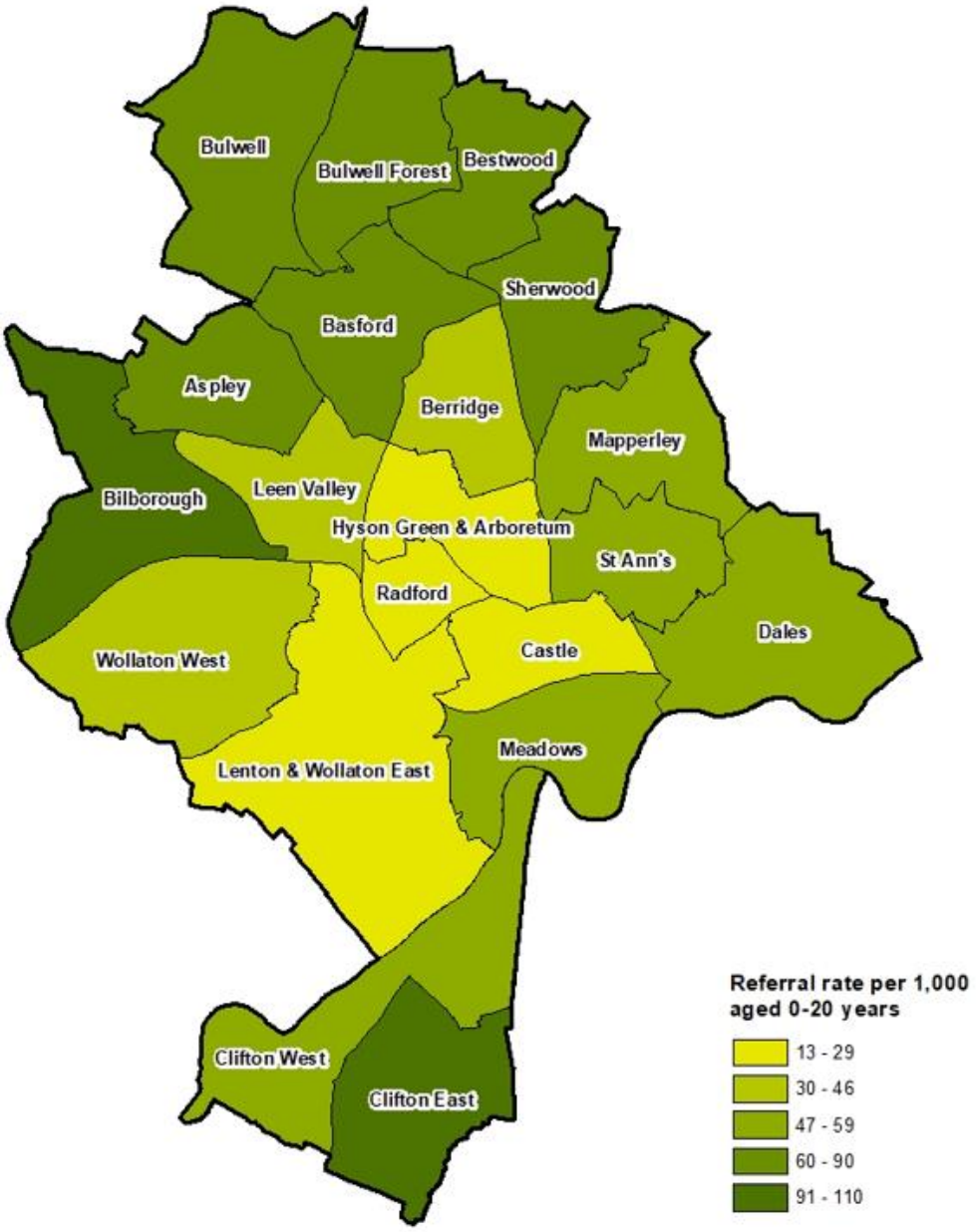
Body Dysmorphia	0	2	0	2
Offending - ASB	2	0	0	2
Sexual Exploitation	0	2	0	2
Trilogy of Risk	1	0	0	1
Total	**2642**	**3012**	**81**	**5738**

Table 9. Outcome of CAMHS SPA referrals in Nottingham 2017/18-2018/19

Outcome	Count	%
Episode/SST	3877	67.6
Signpost /Other	1846	32.2
Not known	15	0.2
Total	**3529**	**100.0**

The rate of referrals was highest in Clifton East (109,5 per 1,000 0-20 year olds and Bilborough (101.8). It was lowest in Castle (12.6) and Lenton & Wollaton East (20.1)

Figure 15. Referrals to CAMHS Single Point of Access 2018/19 and 2020/21 in Nottingham by ward for children and young people aged 0-20 years.



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5. Evidence of what works

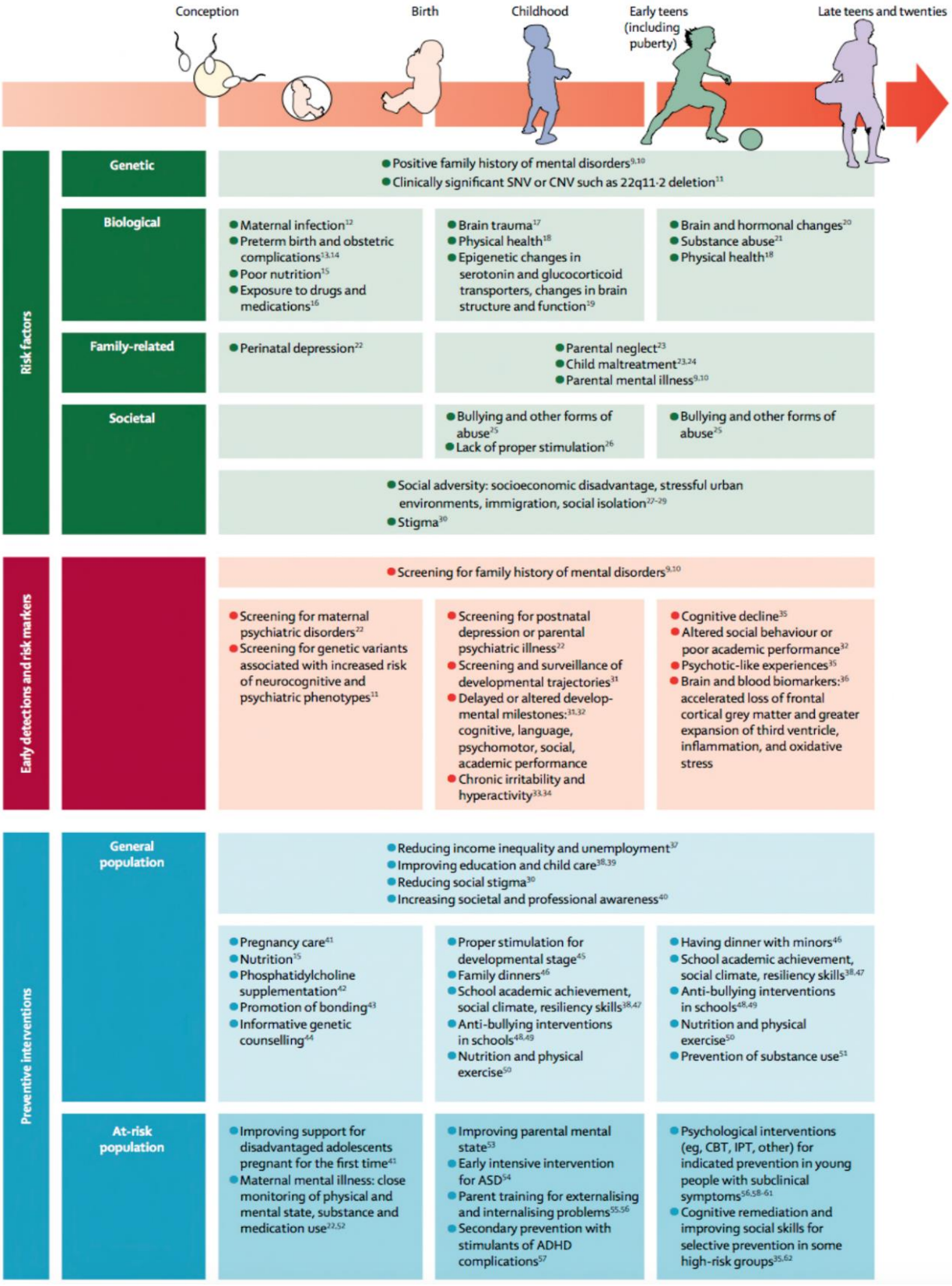
5.1 Preventive approaches

Arango et al's (2018) review lists several effective courses of preventive action across populations and age bands. They cite as key features of any preventative approach a strong focus on the wider determinants of good mental health (for example, addressing income inequality) and the development of selective preventative interventions throughout the life course, such as parental training courses for parents of children with specific needs. The review also points out the strong case for investing in processes and systems to improve early identification, such as the routine enquiry about adverse childhood experiences (ReACH) (See Figure 16 below).

The key prevention messages from a life-course perspective are:

- Translate scientific evidence for prevention into locally relevant, cost effective public health initiatives, clinical practice and service delivery frameworks
- Invest in mental health prevention and promotion exercises
- Move clinical practice toward risk-oriented detection and intervention, particularly around development of new tools for early detection and quality training for professionals in helping those at risk to understand options, benefits and risks
- Tailor interventions for developmental stage
- Promote multi-disciplinary approaches and improve collaborative infrastructure
- Promote healthy lifestyles
- Encourage school-based interventions

Figure 16. Risks, identifiers and preventative interventions to tackle mental health disorders in children and young people



Adult IAPT Services

IAPT services offer a range of NICE recommended therapies for a wide range of common mental health issues including depression, anxiety, obsessive compulsive disorder and post-traumatic stress disorder in line with a stepped care model. Low intensity interventions are offered to those with mild to moderate anxiety and depression. These include guided self-help, computerise Cognitive Behavioural Therapy (CBT) and group-based programmes. For those who do not benefit from a lower intensity intervention, higher intensity interventions such as CBT, psychotherapy and counselling can be accessed.

Parenting Programmes

It is known that parenting behaviour and the quality of the parent-child relationship are strongly associated with children's outcomes.

The Healthy Child Programme (HCP) 0 - 5 brings together the evidence on delivering good health, wellbeing and resilience for every child. This is achieved through a schedule of services covering care of 28 weeks of pregnancy though to age 5 and is delivered as a universal service. The programme includes health promotion, child health surveillance and screening, proving a range of services to families.

The HCP covers parent-infant interaction and sensitive and attuned parenting as well as screening for poor maternal mental health which helps minimise risk factors and reinforces protective factors for a child's mental health.

Beyond this period, it is known that parents continue to play a vital role in supporting the mental health of young people. The Association for Young People's health conducted a survey looking at the role of parents in supporting young people with mental health problems. The survey was completed by 316 parents of the charity Young Minds parents' network; made up of parents with children with mental health problems who discuss issues and share information online.

It found that parents of adolescents are the most unsupported of all groups of parents, and those who have teenagers with mental health problems seem to be particularly isolated.

The findings identified some common and reoccurring themes that could help improve support for young people at home (AYPH, 2016). These included:

- Development of parent support groups
- Provision of more practical advice for parents – to successfully navigate crises, avoid escalating the situation and generally manage the young person at home.
- Provision of mentors, advocates or liaison staff for parents – to support and assist in knowing where to go for help, ensuring parents views were considered.
- More consistency in how schools operate as intermediaries and supporters.
- Easier access in relation to early intervention
- Provision of more consistent, widely available, reliable crisis support.

Parents can access www.helpforparents.org.uk, a website managed by AYPH, which aims to support, advice and provide information to parents about children and adolescents mental health addressing the areas set out above.

Embedding Whole School Approaches

Schools play a hugely important role to in supporting the mental health and wellbeing of their pupils, through developing approaches tailored to the needs of their pupils. All schools are under a statutory duty to promote the welfare of their pupils, including: preventing impairment of children's health or development, and acting to enable all children to have the best outcomes (Department of Education, 2016).

Identifying issues promptly and providing early intervention and effective support is crucial. The school role in supporting and promoting mental health and wellbeing can be summarised as:

- **Prevention:** creating a safe and calm environment where mental health problems are less likely, improving the mental health and wellbeing of the whole school population, and equipping pupils to be resilient so that they can manage the normal stress of life effectively. This includes teaching pupils about mental wellbeing through the curriculum and reinforcing this teaching through school activities and ethos.
- **Identification**: recognising emerging issues as early and accurately as possible.
- **Early support**: helping pupils to access evidence based early support and interventions; and
- **Access to specialist support**: working effectively with external agencies to provide swift access or referrals to specialist support and treatment.

Coherent frameworks for early intervention and prevention exist for developing schools resilience. In response to guidance from PHE and the Children and Young People's Mental Health Coalition (2015), Nottinghamshire have developed a mental health and wellbeing pathway based around the eight key principles to achieving whole school approach to mental health (see figure 18)

Figure 17. Eight principles to promote mental and emotional health and wellbeing in schools and colleges.



Source: PHE (2015)

There is some health economics evidence to suggest that several school-based interventions can be cost effective (Public Health England, 2017) (See Table 10).

Table 10: Health economics evidence relating to school-based mental health interventions

Intervention	Benefit-cost ratio	Study population	Summary of evidence
Investing in social and emotional learning			
School based resilience	£5.08: £1	Pupils in Year 7, Key Stage 3 (Age 11-12)	Costs avoided by NHS and families, and some small impacts on schools. In addition (not quantified in ROI tool), benefits to school and children related to short term improvements in academic performance
School-based social and emotional learning programmes to prevent conduct	£83.73: £1	10-year-old children	School-based Social and Emotional Learning (SEL) programmes help children and young people to recognise and manage emotions, set and achieve positive goals, appreciate the perspectives of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively. International evidence shows

problems in childhood			that SEL participants demonstrate significantly improved social and emotional skills, attitudes, behaviour, and academic performance.
Investing in school-based interventions			
School anti-bullying programme	£1.58: £1	Children aged between 7 - 11	Outcome evidence on likelihood of avoiding bullying drawn from RCT in Finland. Outcomes per pupil over 4-year period and costs to school of delivery. Benefits to families, schools and health sector.
School-based interventions to reduce bullying	£14.35: £1	Children aged between 7 - 11	Anti-bullying programmes in schools show mixed results, depending on the design of the intervention and its implementation. That said, there is a consensus in the literature that whole-school programmes with a range of components operating at different levels within the school are more effective in reducing the prevalence of bullying than curriculum-based programmes. One high-quality evaluation of a school-based anti-bullying intervention found a 21–22% reduction in the proportion of children victimised. Benefits include improvements in the emotional, physical and social health of victims, school attendance and educational attainment, all of which are associated with better long-term employment and earnings outcomes.

Source: PHE, Mental health Services: cost-effective commissioning (2017)

More research is acknowledging the important role played by groups and communities in promoting wellbeing (Glasgow Centre for Population Health, 2013). The protective factors which demonstrated the strongest association with mental health and positive behaviours in this systematic review of 55 papers were:

- Positive parent-child relations (e.g. family mealtimes)
- Social support networks including peers and non-familial adults
- High quality neighbourhoods (knowing neighbours, fewer hazards)
- Attendance at religious events (e.g. church services)

Digital interventions

Nationally there is a drive to increase digital interventions for tackling mental health issues in children and young people due to the increasing prevalence of mental health issues alongside a low general understanding.

Digital health interventions, including computer-assisted therapy, smartphone apps and wearable technologies, have been seen to have enormous potential to improve uptake and accessibility, efficiency, clinical effectiveness and personalisation of mental health interventions. However, current evidence regarding its efficacy is still unclear and one systematic review found that more research was needed before definitive conclusions could be drawn (Hollis, 2017).

Another systematic review looking at 63 studies of e-mediated or computer-based therapies found that computer-based CBT showed promise in reducing depression and reducing anxiety in young people. However, again it acknowledged the evidence was predominantly of low quality, with limited data, inadequacies in study design and unreliable outcome measures (National Collaborating Centre for Mental Health, 2014).

All recent research acknowledges that the digital climate is a fast evolving one and does yield potential opportunity, but that more research is needed into its efficacy and best delivery. Locally there has been positive feedback for Kooth, an online counselling service for children aged 11 and over, which also provides access to a community of peers**.**

The onset of COVID-19 has necessitated a rapid switch from face -to-face to digital interventions. Early evidence from providers and from young people indicates that some children and young people do not wish to access support digitally. However, the number of young people accessing KOOTH on-line support has been steadily increasing since 17/18. Further work is being undertaken across the region by NHS England to understand children and young people's use of digital support and to develop regional guidelines on implementing digital services

NICE have published a number of guidelines on to support positive development and to build emotional capacity and resilience among children and young people.

Universal provision

Social and emotional wellbeing of children and young people. NICE has developed guidance to support schools and local government to promote emotional health and wellbeing for teachers and school governors, and for staff in local authority children's services, primary care and CAMHS by specific school setting (either primary or secondary school) (See Table 11).

Table 11. NICE guidance relating to emotional health and wellbeing

NICE guidelines	Key guidance
PH40 Social and emotional wellbeing: early years (2012)	Defines how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. The aim is to ensure universal, as well as more targeted services, to offset the risk of disadvantage.
QS128 Early years: promoting health and wellbeing in under 5s (2016)	It includes the following statement: • Statement 1. Parents and carers of children under 5 have a discussion during each of the 5 key contacts about factors that may pose a risk to their child's social and emotional wellbeing.
PH12 Social and emotional wellbeing	• Comprehensive approach: ensure all primary schools adopt a comprehensive, 'whole school' approach to

in primary education (2008)	children's social and emotional wellbeing. Schools to work closely with local authority children's services, CAMHS and other services. • Universal approach: Provide a comprehensive programme to help develop children's social and emotional skills and wellbeing including curriculum, training, support to parents/carers and integrated activities. • Targeted approaches: targeting children showing early signs of anxiety or emotional distress or at risk of developing disruptive behavioural problems; and, parents or carers of children showing difficulties.
PH20 Social and emotional wellbeing in secondary education (2009)	It includes the following (extract). • Adopt organisation-wide approaches to promoting the social and emotional wellbeing of young people including curriculum and extra-curriculum provision. • Provide a safe environment which nurtures and encourages young people's sense of self-worth and self-efficacy. • Provide a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying. • Work in partnership with parents, carers and other family members. • Develop partnership between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing.
PHE Promoting children and young people's emotional health and wellbeing: A whole school and college approach (2015)	Outlines 8 key principles for headteachers and college principals to promote emotional health and wellbeing: 1. Leadership and management that supports and champions efforts to promote emotional health and wellbeing; 2. An ethos and environment that promotes respect and values diversity; 3. Curriculum, teaching and learning to promote resilience and support social and emotional learning; 4. Enabling student voice to influence decisions; 5. Staff development to support their own wellbeing and that of students; 6. Identifying need and monitoring impact of interventions; 7. Working with parents/carers; 8. Targeted support and appropriate referral.

6.2 Treatment approaches

A comprehensive set of NICE guidelines exist for treatment approaches for specific disorders and for building responses to conditions (See Tables 12, 13 and 14).

Table 12. NICE guidelines relating to treatment of mental health disorders

Mental Health Disorder	NICE guidelines and summary
Depression	NG134 Depression in children and young people: identification and management (2019) QS48 Depression in children and young people includes the following quality statements: ○ Statement 3 Children and young people with suspected severe depression and at high risk of suicide are assessed by CAMHS within a maximum of 24 hours of referral. ○ Statement 4 Children and young people with suspected severe depression but not at high risk of suicide are assessed by CAMHS within a maximum of 2 weeks of referral.
Anxiety	QS53 Anxiety disorders (2014) – covers generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder. CG159 Social anxiety disorder: recognition, assessment and treatment (2013) NG116 Post-traumatic stress disorder (2018) CG31 Obsessive Compulsive Disorder and Body Dysmorphic Disorder (2005)
Bipolar disorder, psychosis and schizophrenia	CG185 Bipolar disorder: assessment and management (2014) CG155 Psychosis and schizophrenia in children and young people: recognition and management (2013) QS102 Bipolar disorder, psychosis and schizophrenia in children and young people (2015) includes the following quality statement: ○ Statement 1. Children and young people who are referred to a specialist mental health service with a first episode of psychosis start assessment within 2 weeks.
Personality disorders	CG77 Antisocial personality disorder: prevention and management (2009)

	CG78 Borderline personality disorder: recognition and management (2009)
Self-harm	CG16 Self-harm in over 8s: short-term management and prevention of recurrence (2004) CG133 Self harm in over 8s: long-term management (2011)
Suicide prevention	NG105 Preventing suicide in community and custodial settings (2018)
Behavioural (or conduct) disorders	CG158 Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) QS59 Antisocial behaviour and conduct disorders in children and young people (2014)
Hyperactivity disorders	NG87 Attention deficit hyperactivity disorder: diagnosis and management (2018) QS39 Attention deficit hyperactivity disorder (2018)
Autism	CG128 Autism spectrum disorder in under 19s: recognition, referral and diagnosis (2011) CG170 Autism spectrum disorder in under 19s: support and management (2013) QS51 Autism (2014) • Statement 1. People with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral.
Eating disorders	NG69 Eating disorders: recognition and treatment (2017) QS175 Eating disorders (2018) includes the following quality statement: ○ Statement 1 People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults.

Table 13. NICE recommended psychological interventions

	Condition	Psychological therapies	Source
Step 2: Low-intensity interventions (delivered by PWPs)	Depression	Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme	NICE guidelines: CG90, CG91, CG123
	Generalised anxiety disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Panic disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Obsessive-compulsive disorder	Guided self-help based on CBT	NICE guidelines: CG31, CG123
Step 3: High-intensity interventions	Depression For individuals with mild to moderate severity who have not responded to initial low-intensity interventions	CBT (individual or group) or IPT Behavioural activation Couple therapy[d] Counselling for depression Brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication.	NICE guidelines: CG90, CG91, CG123
	Depression Moderate to severe	CBT (individual) or IPT, each with medication	
	Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy[e]	

Table 14. NICE system-wide guidance relating to CYP mental health

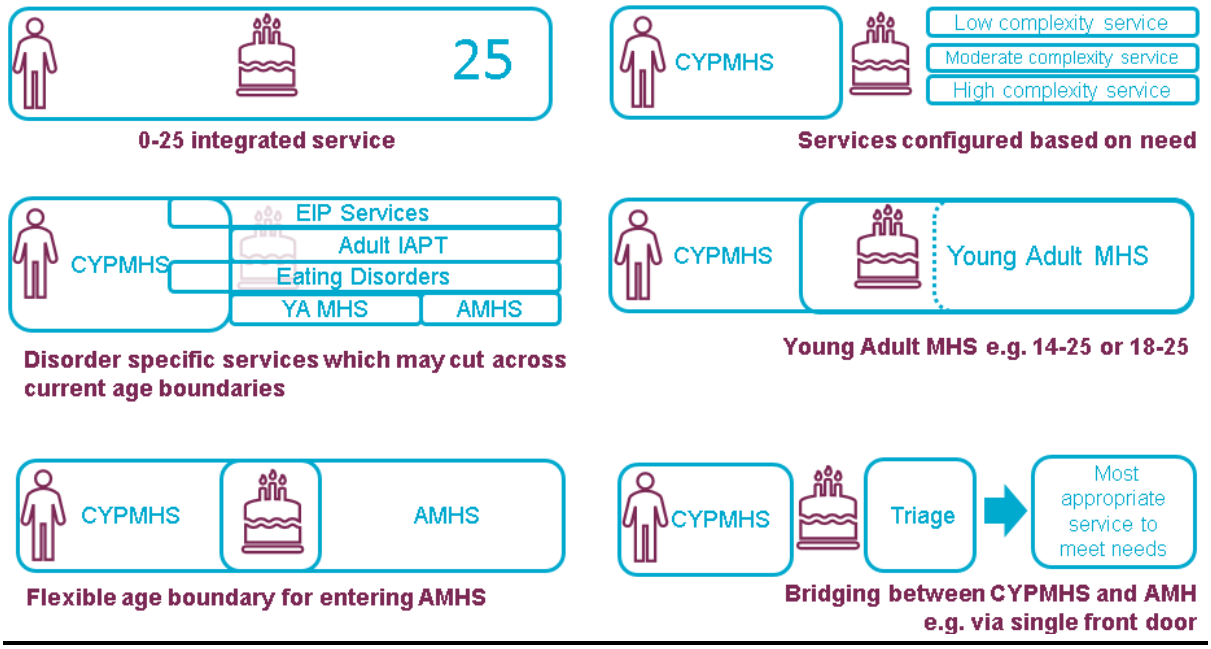
Child abuse and neglect	NG76 Child abuse and neglect (2017) – guideline covers recognising and responding to abuse and neglect in children and young people aged under 18. CG89 Child maltreatment: when to suspect maltreatment in under 18s (2009)
Transition to adult services	Transitioning from CAMHS to adult mental health services (AMHS) can be daunting for children and their families, especially if the young person will not receive the same level of support from adult services. In some cases, young people will not be eligible for any support from AMHS. NG43 Transition from children's to adults' services for young people using health or social care services (2016) QS140 Transition from children's to adult's services (2016)

Re-shaping services for 18-25 year-olds

Evidence shows when proposing pathway redesign models of care for 18-25, they must be person-centred, holistic, delivered closer to home and are age appropriate, with transition to adult services based on need not age.

Figure 18 below details service models that have been developed across the country to meet the needs of the 18-25 cohort

Figure 18. Service models for 0-25 year olds



6. What is on the horizon?

The onset of the COVID -19 pandemic is likely to increase the number of children and young people developing mental health problems. There may also be an increase in children and young people presenting with mental health issues for the first time. Emerging evidence indicates that children and young people with neurodevelopmental issues are likely to be significantly impacted in terms of mental health and wellbeing. Overall, the impact of COVID has fallen more heavily on communities already facing multiple disadvantage.

Over a 10-year period, the Long-Term Plan explains what the NHS aims to do to improve mental health and wellbeing for ages 0-25. It seeks to expand mental health services for children and young people, including a robust and accessible mental health crisis team. It also sets out how to reduce unnecessary delays and deliver care in ways that young people, their families and carers have highlighted as working better for them.

The requirement to develop a comprehensive 0-25 service will require much closer working between adult and children's services, both at provider and commissioner level and across the wider system.

Additionally, the Long-Term Plan recognises the need for embedding a whole school approach, including introducing mental health support teams and focusing resources on early intervention on those who those most likely to face mental health problems. In addition to this, the OFSTED Inspection Framework now includes mental health provision, which may also drive a greater focus on developing whole school approaches.

However, the NHS Long Term Plan does not describe change in the same whole system way as Future in Mind did.

The Long Term Plan has a continued focus on increasing the workforce. Table 13 shows expected workforce increase for Nottingham and Nottinghamshire up to 2023/2024, split by Community CAMHS, Crisis and 18-25 pathway. A Workforce Development Steering Group is in place and will have oversight of plans to increase the workforce and identify areas of need.

Table 15: Workforce Increase to 2023/24

		NHS Five Year Forward View		NHS Long Term Plan		
		Year 4	Year 5			
		Year 1 2019/20	Year 2 2020/21	Year 3 2021/22	Year 4 2022/23	Year 5 2023/24
Workforce additional required to deliver LTP (cumulative)	<u>Community services for CYP aged under 18</u>					
	Psychiatrist- consultant	-	-	0.5	1.4	2.2
	Nursing/midwifery	-	-	1.7	4.3	7.0
	Psychologist	-	-	1.4	3.4	5.6
	Psychotherapists and psychological professionals	-	-	0.8	2.1	3.3
	Support to clinical staff/ other therapists	-	-	1.0	2.6	4.2
	Social worker	-	-	0.3	0.9	1.4
	Admin	-	-	1.0	2.6	4.2
				6.8	**17.2**	**27.9**
	<u>Crisis services for CYP</u>					
	Psychiatrist- consultant	-	-	0.1	0.2	0.3
	Psychiatrist- non consultant	-	-	0.1	0.2	0.3
	Nursing/midwifery	-	-	4.3	8.6	12.9
	Psychologist	-	-	0.4	0.8	1.2
	Occupational Therapists	-	-	0.4	0.8	1.2
	Support to clinical staff/ other therapists	-	-	2.7	5.5	8.2
	Social Worker	-	-	0.4	0.8	1.2
	Admin	-	-	1.2	2.3	3.5

			9.5	**19.1**	**28.7**
	Community services for CYP aged 18-25				
	Psychiatrist- consultant -	0.3	0.5	0.8	1.0
	Nursing/midwifery -	0.9	1.7	2.4	3.2
	Psychologist -	0.7	1.3	2.0	2.5
	Psychotherapists and psychological professionals -	0.4	0.8	1.2	1.5
	Support to clinical staff/ other therapists -	0.5	1.0	1.5	1.9
	Social Worker -	0.2	0.3	0.5	0.6
	Admin -	0.5	1.0	1.5	1.9
			6.7	**9.8**	**12.7**

A proportion of the workforce are at retirement age which will have an impact on capacity and capability over the coming years. Further work is required to understand what this means locally and that there are recruitment plans in place to mitigate any gaps in provision.

Following the recommendation in the Nottinghamshire Director of Public Health report in 2017 that all agencies should work together to prevent ACEs in order to reduce health and social inequalities, work has continued on developing training and support for professionals across the system. A number of training programmes and learning packages have been rolled out at all levels of the system; trauma-informed approach is included in commissioning intentions and service specifications; and consideration of ACEs is a fundamental part of the All Ages Mental Health Strategy.
It is unclear as to whether there will be additional funding for Local Authorities and wider services over the coming years, however, it is likely that there will be further funding cuts, resulting in further re-shaping of services and further reductions in universal services. This will impact on the reach and effectiveness of the whole systems approaches to Children and Young People's Mental Health.

The onset of the COVID-19 pandemic has increased the drive towards providing more digitalized support in order to widen access and reduce waiting times**.**

7. Local Views

Children and Young People

In 2017-18, the MH:2K project was rolled out in Nottingham and Nottinghamshire. It provides a powerful model for engaging young people in conversations about mental health and wellbeing.

The MH:2K Local Advisory Panel drives work to improve children's emotional and mental health outcomes and links closely to the local Future in Mind transformation plan.

The project has recruited over 30 young people as Citizen Researchers and has delivered a series of workshops and roadshows that have engaged over 670 local young people. Based on this engagement, five priorities for children and young

people's mental health in Nottingham and Nottinghamshire have been identified along with a set of recommendations for action. These are:

1. **Stigma and public awareness**

Key issues include: lack of education and awareness of mental health; use of negative language; fear of judgement; lack of visibility of support services; and, stigma being affected by different cultural and religious viewpoints, as well as notions of masculinity.

Recommendations

i. Mental health education should be provided to children and young people from an early age, with a focus on promoting mental health as a positive concept
ii. Harness social media as a positive tool to challenge stigma and raise awareness of common mental health problems among young people.
iii. Provide information in discreet ways, to direct young people to the support available, without fear of exposure in public.
iv. Target information specifically for religious and cultural groups.
v. Use peer-to-peer approaches to combat stigma among young people.

2. **Treatment and therapies**

Key issues include: long waiting times and insufficient duration of treatment; poor communication with professions and not feeling understood; opening hours that didn't work well for young people; treatment not meeting individual need; and, transitions from child to adult services not being smooth.

Recommendations

i. Young people should be able to access support on a 24/7 basis
ii. Increase the coverage of staff across mental health services, so that young people are able to access help when they need it.
iii. Provide treatment based on a continuous assessment of the individual's needs and stop limiting treatment to a specified number of weeks.
iv. Provide training for professionals to equip them to communicate more effectively with young people.
v. Provide treatment in spaces where children and young people feel comfortable.

3. **Education and prevention**

Key issues include: barriers to seeking help in schools including not being aware of help available; not having enough privacy when seeking help in schools; teachers not equipped to spot the signs or support young people with mental health issues; and, academic pressure.

Recommendations

i. Increase the privacy and confidentiality of support
ii. Provide training for all members of staff on mental health
iii. Make sure all students are aware of the support available, inside and outside school

iv. Offer informal peer support for mental health and well being
v. Schools should do more to alleviate stress and help students cope with exam pressure

4. Cultures, genders and minorities

Key issues include: lack of mental health education reaching religious and ethnic minority groups; barriers to access services for underrepresented groups; LGBTQ+ facing homophobia and transphobia, including bullying, within education and on social media; pressures facing young males, including ideas of masculinity and being told to 'man up'; and, addition to drugs, alcohol, gambling, social media, gaming and pornography.

Recommendations

i. Services need to work more closely with the voluntary sector to reach minority groups with knowledge and awareness around mental health.
ii. Where possible, young people should be given a choice of professionals to speak to, with consideration of their gender, age, or cultural preferences.
iii. Campaigns and programmes should prioritize young men to tackle 'toxic masculinity'.
iv. Schools and teachers must take firmer action on homophobia and transphobia, to create an environment where LGBTQ+ students feel safe.
v. Deliver PSHE or Citizenship lessons to ensure that all students have a good understanding of mental health.

5. Family, friends and carers

Key issues include: feelings of isolation; fear of being different; parents having lack of knowledge about mental health; and, finding it hard to communicate with friends and family about mental health.

Recommendations

i. Run PHSE lessons in school to talk to friendship groups about self-esteem and positive mental health
ii. Ensure that students can seek support without their friends and peers finding out
iii. Invite parents to compulsory talks about mental health & stress throughout the school years
iv. Consider innovative ways to target & engage parents in conversations about mental health

What does this tell us?

8. Unmet needs and service gaps

Many services in the public sector are still commissioned in isolation. With mental health in particular, this is untenable due to the complexity of interactions between different risk factors and behaviours. For example, parental substance

misuse may cause poverty and familial stress, which may result in a mental disorder, which then becomes a risk factor for other behaviours such as crime or risk-taking. There needs to be a whole-systems approach to mental health commissioning.

Reductions in funding to early intervention services have resulted in a reduction of universal provision and of parenting support, particularly around the skills they need to help support the positive mental and emotional development of their children.

Transition to adult care is still cited by young people as needing improvement, and although work has been undertaken recently to improve the process, there could still be more done to improve the quality of the experience. Many patients do not currently return their post-transition surveys, however, and alternative methods of assessing the quality of transition may need to be undertaken.

More action is needed to reduce inequalities in mental health and wellbeing particularly for looked after children, young carers, children with a special educational needs and disabilities and Lesbian Gay Bisexual Transgender, queer (or questioning) and others (LGBTQ+) young people.

Social media is both a risk and an opportunity. There is much in the media about online bullying and negative consequences of interactions, such as the promotion of unrealistic expectations, cyber-bullying and developing a fear of missing out. However, apps and web support offer new ways for children and young people to access services and to connect with peer support networks in what is often their preferred medium. The landscape changes fast, and there is undue focus on misuse of particular platforms in media reports, rather than on promotion of positive safety messages.

There is a gap in formal psychology input where children have adverse childhood experiences, or are below CAMHS threshold for emotional health difficulties e.g. anxiety which can impact on a behavioural/developmental presentation, and lack of formal cognitive assessments to determine whether behavioural/developmental needs are related to an underlying learning disability.

There is a gap in mental health support for Children in Care from other local authorities and for Nottingham children in care placed in other local authorities

Other Local Authority Children in Care do not have access to the Children in Care CAMHS service in Nottingham. Young people who are the responsibility of Nottingham City but are placed elsewhere have variable levels of mental health support depending on the placement location. The choice of placement is often very limited, particularly for children with complex needs.

There is a lack of high intensity long-term mental health support for children and young people with the highest level of mental health need alongside unsafe or challenging home environments. This results in frequent acute hospital presentations, delayed discharges and repeat psychiatric inpatient admissions. The crisis team, social care and CAMHS are currently unable to provide the high intensity long-term mental health support required for this cohort.

Training for professionals to support for young people with autism spectrum disorder (ASD) is not yet in place. There is growing evidence that young people with ASD are at increased risk of suicide and co-morbid mental health conditions. There is currently a lack of effective training for mental health professionals to understand how young people with ASD may present differently when experiencing a mental health crisis and how best to then support them.

9. Knowledge gaps

The prevalence of mental health conditions in children and young people in Nottingham City is still unknown. Data on the prevalence has been extrapolated based on NHS Digital estimates. Since April 2018 all NHS commissioned providers have been developing their systems to be able to provide service level data to the Mental Health Services Data Set (MHSDS). Therefore, we are now in a better position to understand local need and further develop services to meet this need. Further work is also required to understand the impact of inequalities within Nottingham.

There is currently a gap in knowledge around access to services, particularly for the wide range of online support contact. We know that some children and young people with mental health support needs are not accessing CAMHS services, but we do not know how many.

Furthermore, there are interventions being undertaken in the community which are not monitored or evaluated. An audit of these should be undertaken and a co-ordinated evaluation.

Parenting confidence and capability remains a largely unknown factor. Many parents may express doubts about their skills but may not access parenting courses on offer due to time availability or perceived stigma in attending such a course. We need to engage with parents to understand what their support needs are.

There is a lack of information about the needs or even the composition of some groups, especially those with protected characteristics. In particular, we do not have robust data on young carers, a group that is likely to have significant mental health and wellbeing needs. There are also groups who we know exist, but for whom we do not fully understand needs, for example children under the age of five. Locally , there are significant gaps around data collection around inequalities, despite national evidence that highlights poor outcomes for a number of groups including children and young people who are disabled, LGBTQ+ and from minority ethnic groups. We do not routinely collect data on the number of LGBTQ+ young people who access our services.

The changing technological landscape also offers challenges. Developments such as the “internet of toys”, where the objects that young children may be using on a daily basis connect to other objects and users may lead to emergent issues which are difficult to predict. This said, the opportunities offered by new technology to assist in supporting our young people through difficult circumstances must also be recognised

What should we do next?

10. Recommendations for consideration by commissioners

	Recommendation	Lead(s)
1	**Review inequalities in access to services, experience and health outcomes of Black, Asian and Minority ethnic groups (BAME).** Ensure systemic barriers are mitigated or removed using the Advancing Mental Health Equality Framework. Undertake an equity audit, ensure services routinely collect data on protected characteristics and ensure that the workforce have appropriate training/skills. This work will be overseen by a mental health equalities group should consider development of specific pathways.	CCG, Notts Healthcare Trust (NHT), Third Sector providers
2	**Commissioning should be planned as integrated multi-agency services**, ensuring that services meet the needs of the 0-25 age group	Integrated Care System's (ICS), Public Health, CCG
3	**Undertake further work to develop a comprehensive 0-25 years service**. As part of this, consider flexible transition points for children and young people with mental health difficulties, closer working with adult mental health services, and opportunities to pool resources. This should have a particular focus on early years (0-5) and 19-25.	Integrated Care System's (ICS), Public Health, CCG
4	**Ensure that mental health and wellbeing are considered in all policies in schools** relating to both staff, service users and pupils, e.g. by using Five Ways to Wellbeing	LA, ICS, Schools/ Colleges/ Academies
5	**Ensure equitable access to prevention and early intervention mental health support in schools** focusing strategically on areas where there is likely to be greatest benefit and where risk factors are most prevalent i.e. areas of high deprivation.	PH, LA, CCG
6	**Ensure an equitable offer for all Children in Care**, including out of area and other local authority children.	LA, CCG, NHT
7	**Review delivery models for children in urgent and crisis care** to ensure they are consistent with regional and national models of best practice, to ensure the right support is available.	PH, LA, CCG, NHT
8	**Consider how to meet the high intensity, long-term support needs of young people with mental health and social care needs.** Explore options for a combined CAMHS and Social Care offer.	PH, LA, CCG, NHT
9	**Consider how to develop workforce capacity within CAMHS and the wider workforce** to meet increased demand, including additional roles and further training opportunities.	LA, CCG, NHT

10	**Explore how we further develop our online offer.** This may include evaluating the effectiveness of digital interventions locally to ensure any benefits from the switch to digital models of care are sustained beyond COVID-19, in line with regional guidance from NHS England.	PH, CCG
11	**Expand universal and selective parent education and training programmes** to support preventative work on mental health & well being	LA, PH, CCGs
12	**Ensure appropriate support for parents when issues are emerging, and after diagnosis** e.g. drawing on the New Forest model.	LA, CCG
13	**Embed trauma-informed and ACES-informed practice** in all relevant services in Nottingham.	PH, LA, CCG, NHT
14	**Mobilise community assets** to generate multigenerational networks of interpersonal support, capitalising on initiatives such as lifestyle interventions, volunteering and social prescribing	Third sector, PH, Primary Care Networks (PCNs)

Key contacts

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References

Annex 1 – National and local strategies regarding children and young people's mental health and wellbeing

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