Child & Adolescent Mental Health (CAMHS) Joint Strategic Needs Assessment

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JSNA
Joint Strategic Needs Assessment

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SUMMARY

Having good mental health means being able to:

- Make the most of our potential
- Cope with life
- Play a full part in our family, workplace, community and among friends.

A person's mental health can alter as circumstances change and as they move through different stages of life, from infancy through to old age. Many people with mental health problems experience stigma and for some the term (psychological and) emotional well being may be preferable to something containing the word mental. In this review the terms mental health and emotional well being are used interchangeably unless specifically stated otherwise.

This document contains and analyses data that is relevant to the strategic commissioning of Child & Adolescent Mental Health Services (CAMHS). It also contains the evidence of effective interventions along with outlining the costs of mental illness.

Main findings

It is estimated that the prevalence of mental health disorders across the tri-borough are as follows:

	Boys		Girls		Estimated total number across the tri-borough
	5-10	11-15	5-10	11-15	
Conduct Disorder	3.75%	4.8%	1.75%	2.1%	**Between 1281-1764**
Hyperkinetic Disorder	1.0%	0.4%	0.1%	0.1%	Between 175-229
Emotional Disorder	2.2%	3.5%	2.8%	5.2%	Between 1336-1736
Co-Morbid Disorder	2.1%	2.9%	0.6%	1.3%	Between 714-963
Neurotic Disorders (16-19 year olds)					2688
Autistic Spectrum Disorder					406

Based on population projections the number of children presenting with mental health conditions will increase as a total number and as a percentage of the population for the next 15 years.

Children and Young People who are particularly vulnerable to mental health conditions are:

- BAME children
- Looked After Children
- Care Leavers
- Young Offenders
- Children with learning Disabilities
- Unaccompanied Asylum Seekers
- Homeless young people
- Those who self harm and are at risk of Suicide

The number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been estimated using national research.

The following table shows the estimates for the population aged 17 and under across the tri-borough area:-

	Tier 1	Tier 2	Tier 3	Tier 4
Hammersmith & Fulham	4926	2299	608	25
Kensington & Chelsea	4080	1904	503	20
Westminster	5550	2590	685	28

Main issues

- The service data collected from across the tri-borough is not consistent across all the services and there is a wide variation in the data and information that they can provide. This means that it is difficult to know if the services that provide the different tiers of service are doing so effectively.
- Currently prevalence of mental health conditions in children and young people is an estimation based on national research. It is not possible to get local prevalence data currently as the data is not consistently collected across the services.

DEMOGRAPHICS

Resident Child Population

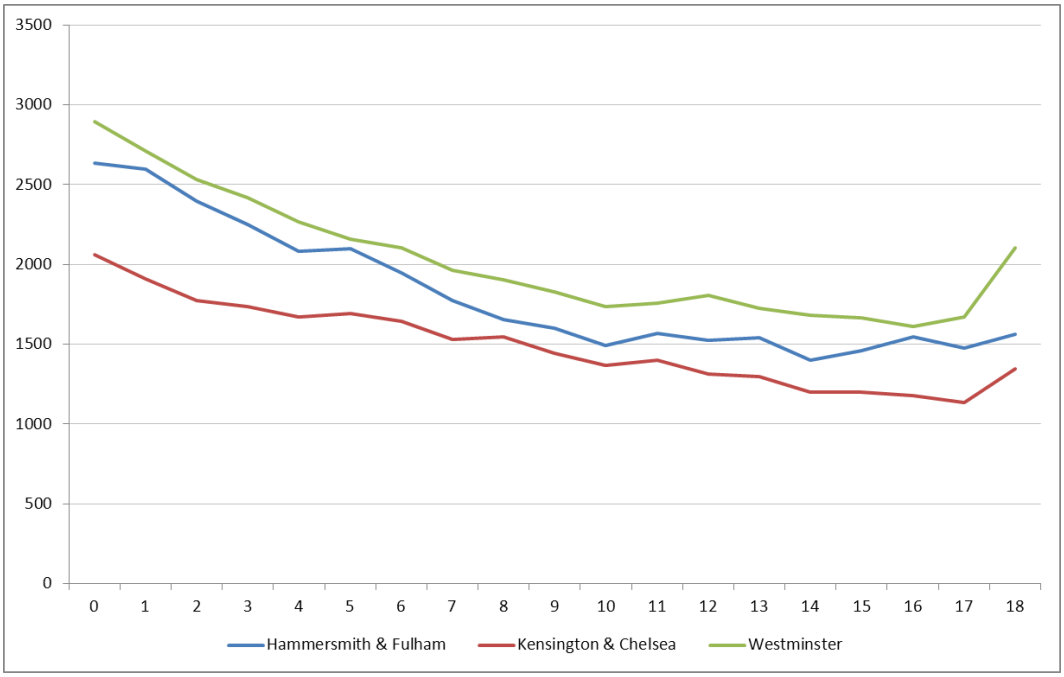
There are currently 101,555 children (up to and including age 18 years) resident within the tri-borough region. This is comprised of 34,596 children in Hammersmith & Fulham, 28,423 in Kensington & Chelsea, and 38,526 in the City of Westminster (GLA DMaG, 2012).

Children make up approx. 18% of the total population across tri-borough. This proportion of children is in line with other inner London boroughs but is smaller when compared to the rest of England.

Across the whole of tri-borough, the age structure of those aged 0-18 currently resident is skewed towards younger children, with over a third aged 0-4. This is a pattern seen across many inner-city areas where new families spend the very early years of their child's life living in urban boroughs before a significant outward migration occurs prior to primary school age (age 5).

There is a spike of 18 year olds in both Westminster and Kensington & Chelsea each September due to the intake of students living in residences of the boroughs Universities.

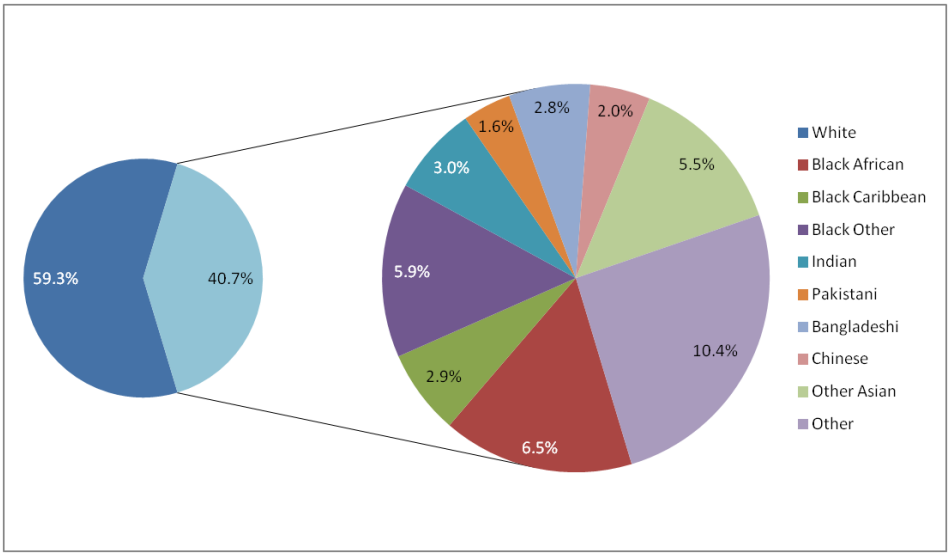
Figure 1: Graph to show the number of resident children by single year of age across tri-borough, by borough (GLA DMaG, 2012)



In terms of gender, 49,776 (49.0%) of the 0-18 year olds across the tri-borough area are Female, while 51,779 (51.0%) are Male.

The latest borough level data on ethnicity by single year of age shows that across tri-borough 40.7% of those aged 0-18 are from a Black and Minority Ethnic (BAME) group. Figure 2 shows that of the total population 15.3% of children are from a 'Black African', 'Black Caribbean' or 'Black Other' background; 7.4% are from an 'Indian', 'Pakistani' or 'Bangladeshi' background; 2.0% are from a 'Chinese' background; 5.5% are from an 'Other Asian' background (mainly those from Arab states); and 10.4% are 'Other' (GLA DMaG Projections, 2010).

Figure 2: Table to show the ethnicity of children in the tri-borough area (2012 projection)



Census 2011 data related to ethnicity by single year of age is yet to be released. However, if the pattern for children follows that seen at the whole borough level, it is expected that there will be a significant increase in the number of children from BAME groups.

A Changing Resident Child Population...?

Over the next 20 years it is expected that there will be some significant change to the numbers and age structure of children in the tri-borough area. Figure 3 below shows the numbers of children expected to be resident in each borough in 5, 10, 15 and 20 years time by age group (GLA DMaG Population Projections, 2012).

Figure 3: Table to show change in the number and proportion of children resident in the tri-borough area 2012-2033 (GLA DMaG, 2012)

		2012	2018	2023	2028	2033
0-4	Hammersmith & Fulham	11,956	12,400	12,400	12,400	12,400
	Kensington & Chelsea	9,153	9,200	9,100	8,900	8,700
	Westminster	12,817	13,100	12,800	12,600	12,600
5-9	Hammersmith & Fulham	9,077	10,400	10,700	10,700	10,600
	Kensington & Chelsea	7,857	7,900	8,100	7,800	7,600
	Westminster	9,955	10,700	10,900	10,600	10,400
10-14	Hammersmith & Fulham	7,521	8,400	9,400	9,700	9,600
	Kensington & Chelsea	6,569	7,200	7,400	7,400	7,100
	Westminster	8,706	9,300	9,800	9,900	9,700
15-18	Hammersmith & Fulham	6,042	6,000	6,800	7,400	7,600
	Kensington & Chelsea	4,854	5,400	5,800	5,900	5,900
	Westminster	7,048	7,500	7,900	8,300	8,400
TOTAL (0-18)	Hammersmith & Fulham	34,596	37,200	39,300	40,200	40,200
	Kensington & Chelsea	28,433	29,700	30,400	30,000	29,300
	Westminster	38,526	40,600	41,400	41,400	41,100
Tri-Borough TOTAL		**101,555**	**107,500**	**111,100**	**111,600**	**110,600**
% Change on 2012		-	**+5.8%**	**+9.4%**	**+9.9%**	**+8.9%**
% of population which are children		**18.0%**	**18.2%**	**18.1%**	**17.8%**	**17.3%**

It is expected that the number of children living in tri-borough will increase significantly in the short term with a rise of 5.8% on the 2012 figures expected by 2018. By 2023 there is expected to be a 9.4% increase on the 2012 figures.

However, while the actual number of children is increasing, the proportion of the whole population that they make up is relatively steady at approx. 18%.

During this period it is understood that the greatest rise in the number of children will be seen in Hammersmith & Fulham, and while the number of younger children stays relatively steady, the number of older children and adolescents is expected to grow.

By 2028, however, the significant increase in the number of children in expected to slow, with only a small rise in numbers expected between 2023 and 2028. This is in contrast to what is expected in the wider population across this time period as the proportion of residents that are children starts to fall.

Between 2028 and 2033 the actual number of children is expected to start falling and the proportion will continue to fall.

Resident Population Mobility

Across all of the tri-borough area, outward migration is higher than inward migration from birth until the age of 18. This pattern is similar to other inner city areas, but is highly pronounced across tri-borough, particularly in the pre-school years. In some wards, 40% of GP registered one year olds have left the borough by the age of five.

- Hammersmith and Fulham had the fifth highest population mobility rate in England and Wales in 2001, with one in five residents moving address in the previous year.

- Kensington and Chelsea had the sixth highest population mobility rate in England and Wales in 2001, with one in five residents moving address in the previous year.

- Westminster had the highest population mobility rate in England and Wales in 2001, with more than one in five residents moving address in the previous year.

Registered Child Population

There are currently 107,358 children (up to and including age 18 years) resident within the Inner North-West London CCG region. This is comprised of 37,535 children in Hammersmith & Fulham CCG, 40,888 in West London CCG, and 28,935 in Central London CCG (NHS North West London, 2013). See Figure 4.

Children make up approx. 17.5% of the total registered population across Inner North-West London, with a smaller proportion of children in Central London CCG compared to Hammersmith & Fulham and West London CCGs. The proportion of children in Inner North-West London is in line with other inner London boroughs but is smaller when compared to Outer London and the rest of England.

Across the whole of Inner North-West London, the age structure of those aged 0-18 currently registered is skewed towards younger children, with over a third aged 0-4. The registered population largely mirrors that of the resident population.

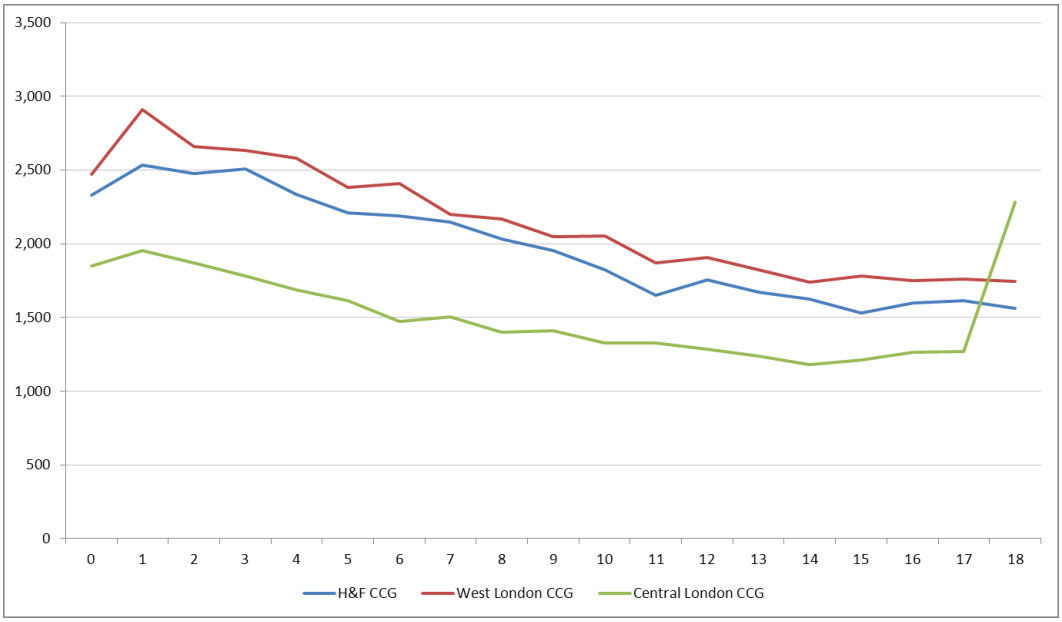
There is a spike of 18 year olds in registered in Central London CCG as it incorporates students registered at Kings College Health Centre.

In terms of gender, 53,055 (49.4%) of the 0-18 year olds across the tri-borough area are Female, while 51,544 (50.6%) are Male.

Data on ethnicity by single year of age at CCG level is currently not available.

It is expected that future changes to GP registration in the health system may impact the registered child population. However, this potential change currently cannot be quantified. The most reliable projections for future the registered child population is in line with that of resident children.

Figure 4: Graph to show the number of registered children by single year of age across Inner North-West London, by CCG (NHS NWL, 2013)



School Population

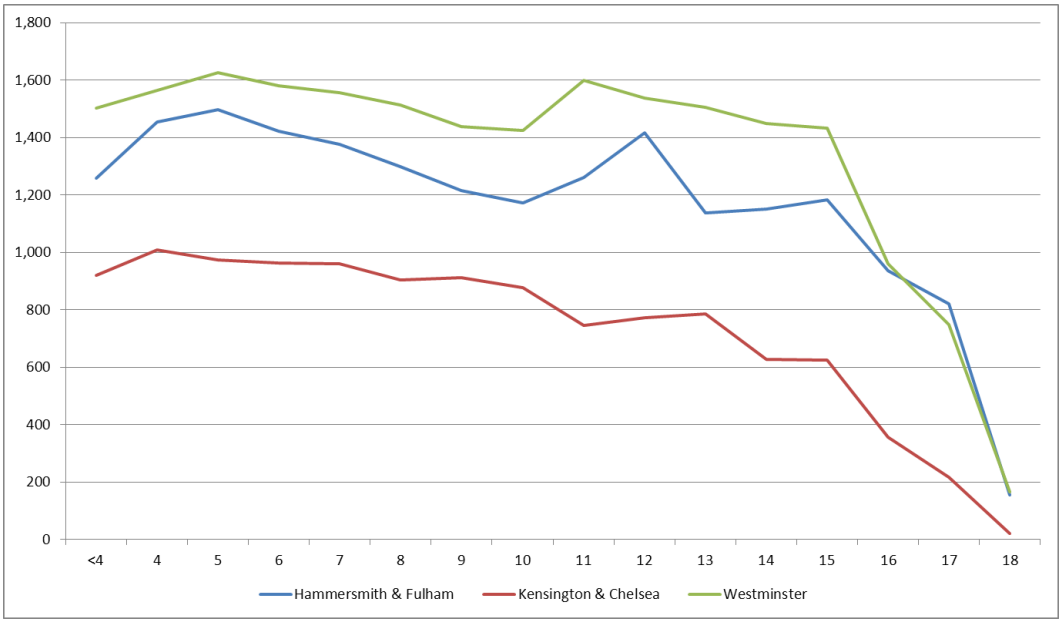
There are currently 52,022 children (up to and including age 18 years) attending a state maintained school within the tri-borough area. This is comprised of 18,733 children in Hammersmith & Fulham, 11,668 in Kensington & Chelsea, and 21,601 in the City of Westminster (Tri-Borough Children's Services, 2013). See Figure 5.

In terms of age and type of school attended, the proportion of children is broken down as follows:-

Nursery age (<4)	-	7.07%
Primary age (4-10)	-	51.36%
Secondary age (11-16)	-	37.43%
Post-16 (16+)	-	4.14%

In terms of gender, 49.6% of the 0-18 year olds across the tri-borough area are Female, while 50.4% are Male.

Figure 5: Graph to show the number of children attending school by single year of age across tri-borough, by borough (Tri-borough Children's Services, 2011/12)



There is a significantly smaller figure of children in Kensington & Chelsea because of a smaller capacity of state-maintained schools, and it is also noticeable that there is a significant drop-off of students attending higher education institutions (A-Level, KS6) that are state maintained across the whole tri-borough area.

Several tri-borough schools have intakes from across the capital and the beyond, and there is significant migration of children both out and into the boroughs to attend school. Figure 6 shows the percentage of children who attend school in each borough who are resident and non-resident.

Figure 6: Table to show the number of children attending school who are resident / not resident, by borough

	Resident	Not-Resident
Hammersmith & Fulham	71.7%	28.3%
Kensington & Chelsea	63.1%	36.9%
Westminster	70.3%	29.7%

The School Census data (2012) provides data on ethnicity within schools as shown in the table below.

Figure 7: Table to show the ethnicity of children attending schools in the tri-borough area, by borough (School Census, 2012)

	Hammersmith & Fulham	Kensington & Chelsea	Westminster
White British	22.8%	24.1%	13.9%
White Irish	0.8%	1.8%	0.6%
White Other	12.7%	15.0%	14.0%
Asian Indian	0.8%	0.6%	0.8%
Asian Pakistani	1.6%	0.9%	1.2%
Asian Bangladeshi	1.9%	1.5%	9.4%
Asian Other	3.4%	0.7%	2.9%
Black Caribbean	7.2%	5.2%	4.0%
Black African	19.9%	11.5%	13.0%
Black Other	2.4%	1.1%	2.4%
White/Black Caribbean	3.9%	3.2%	1.5%
White/Black African	1.5%	2.0%	1.5%
White/Asian	1.5%	2.1%	1.1%
Any other Mixed Background	4.6%	11.0%	5.4%
Any Other Ethnic Group	14.0%	19.0%	26.6%
Not Obtained	1.0%	1.0%	1.9%

However, there are limitations that must be highlighted in using the School Census data for ethnicity. Firstly, the School Census only collects data for pupils attending Local Authority maintained nursery, primary, secondary and special schools, non-maintained special schools, city technology colleges and academies. It does not cover independent schools, Pupil Referral Units (PRUs), General Hospital Schools and Alternative Provision although some aggregate data is available.

Secondly, the reliability of the data is poor due to it being self-referential. The self-identification with a certain ethnic group may be clear and well defined in some cases, such as for indigenous groups that have existed for many generations. However, in other cases the person may feel that he/she does not fit into one particular group or he/she might identify with more than one ethnic group, all of which may lead to confusion.

DEPRIVATION

The Department of Health report, Confident Communities, Brighter Futures: A Framework for Developing Wellbeing (HM Gov, 2010) reported that 15% of children and young people at the lowest income levels were found to experience mental health problems compared to 5% from families at the highest income levels.

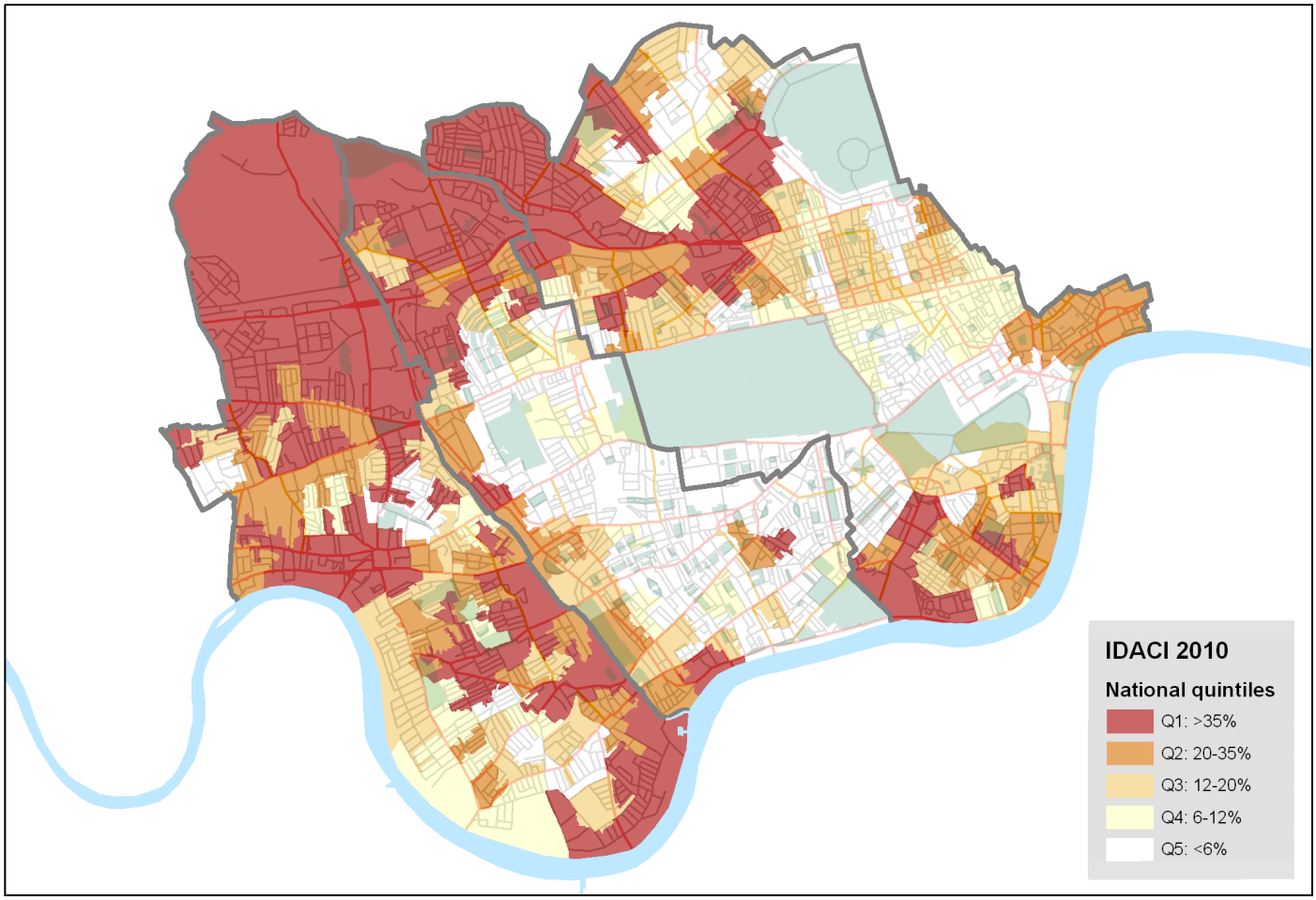
There are two nationally recognised measures for identifying deprivation amongst children - the Child Wellbeing Index (CWI) and the Income Deprivation Affecting Children Index (IDACI).

The Child Wellbeing Index (CWI) is a composite index of deprivation based on seven domains: material well-being; health; education; crime; housing; environment; and children in need. Based on these,

- Hammersmith & Fulham is ranked 24th lowest out of 354 in England for wellbeing.
- Kensington & Chelsea is ranked 127th lowest out of 354 in England for wellbeing.
- The City of Westminster is ranked 21st lowest out of 354 in England for wellbeing.

Figures from the Income Deprivation Affecting Children Index 2010 suggest that 36% of Hammersmith & Fulham's children live in income-deprived households. This figure is 21% for Kensington & Chelsea, 37% for the City of Westminster. The map below shows the location of the highest concentration of deprivation in the borough according to IDACI.

Figure 8: Map to show the concentration of deprivation (by national quintile) according to IDACI 2010



However, generally children growing up in adverse circumstances do not present with mental health problems. The factors of increased vulnerability through economic disadvantage should therefore be interpreted as associations rather than direct causes of mental health disorders.

PREVALENCE

The majority of mental health disorders fall into the following categories - emotional, conduct and hyperkinetic disorder.

According to a study carried out for the Office for National Statistics in 2004 (Green et al, 2005):

- 1 in 10 children aged five to fifteen has a clinically significant mental health problem (for boys the rate is 11% and for girls, 8%)
- 5.8% have clinically significant conduct disorders
- 3.7% have clinically significant emotional disorders
- 1.5% have clinically significant hyperkinetic disorders

Some children experience more than one mental health problem (co-morbidity) and this can make assessment, diagnosis and treatment more complex. The 2004 ONS survey found that one in five of the children with a mental disorder were diagnosed with more than one of the main categories of mental disorder. This figure represented 1.9% of all children. (The Royal College of Psychiatrists 2010 handbook, edited by Richardson and colleagues, cites Audit Commission findings that 95% of children attending CAMHS have more than one diagnosis).

The prevalence of these disorders amongst children and adolescents was estimated by the Kings Fund report 'Paying the Price' (McCrone et al, 2008). These estimates are shown in Figure 9 below.

It is these estimates that have been used throughout this section to estimate the number of children and adolescents within tri-borough who have mental health disorders.

Data is presented where possible for the three relevant population cohorts across tri-borough – the resident child population, the registered child population and the population attending school within the borough.

Figure 9: Table to show estimated prevalence of Mental Health disorders amongst children and adolescents in England and Wales (Kings Fund, 2008)

	Boys		Girls	
	5-10	11-15	5-10	11-15
Conduct Disorder	3.75%	4.8%	1.75%	2.1%
Hyperkinetic Disorder	1.0%	0.4%	0.1%	0.1%
Emotional Disorder	2.2%	3.5%	2.8%	5.2%
Co-Morbid Disorder	2.1%	2.9%	0.6%	1.3%

Following on from the prevalence for these disorders above, prevalence is also shown for Neurotic disorders, Autism Spectrum Disorder and the estimated need for CAMHS at each tier across the tri-borough area.

In addition to all the prevalence data that follows, it should be noted that a greater number of children will have mental health problems that are less severe and more likely to be short-lived, but may nonetheless affect their psychological well-being.

It must be noted as a caveat to the data presented, for all age groups except the youngest children, there is expected to be a higher proportion of mental health needs in inner London than the rest of England, and therefore the data presented may be a low estimate.

Conduct Disorders

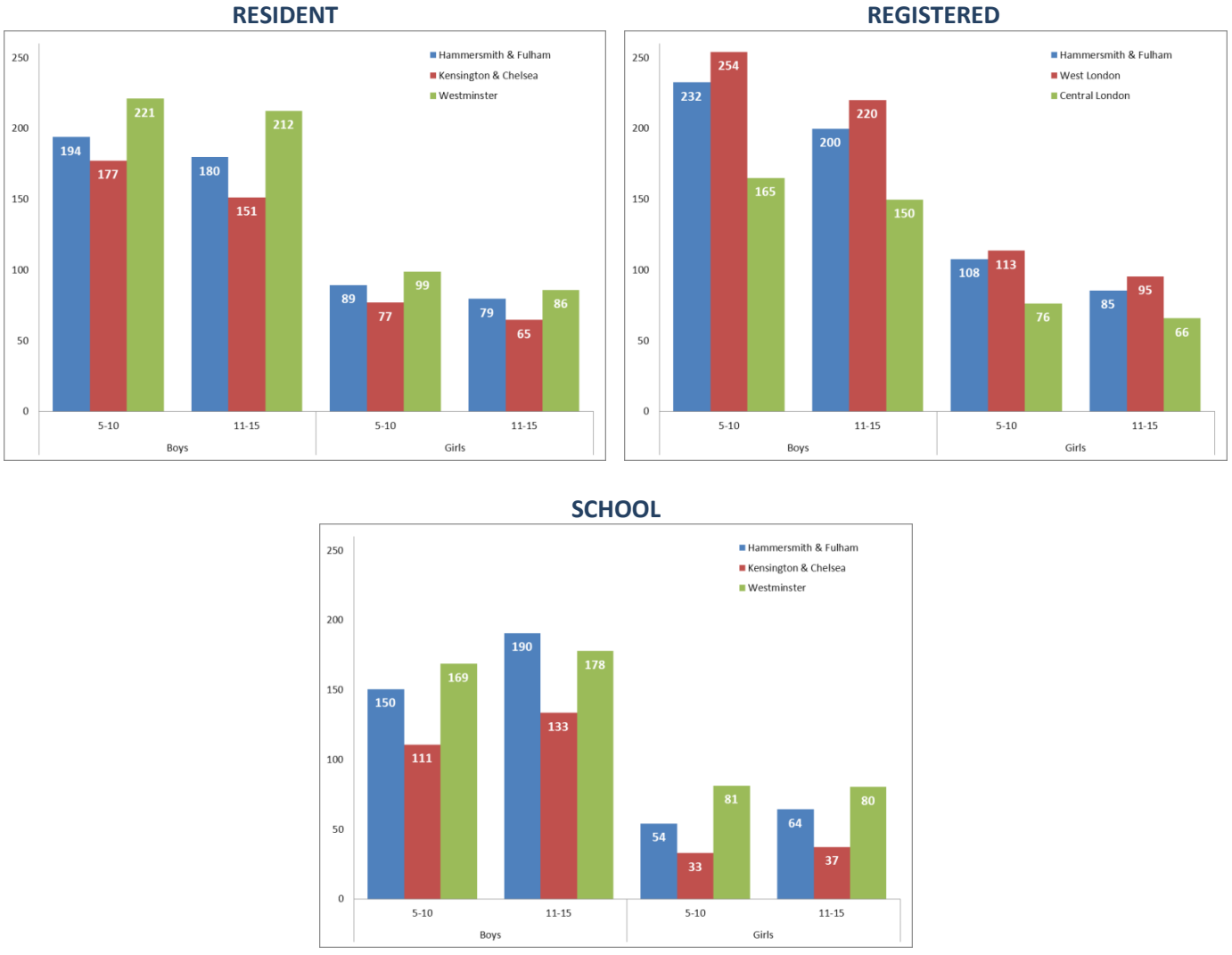
The prevalence of Conduct Disorders is estimated to be at 3.75% in boys aged 5-10, 4.8% in boys aged 11-15; and 1.75% in girls aged 5-10, and 2.1 in girls aged 11-15 (McCrone et al, 2008). Studies have shown that these children are more likely to be living with cohabiting, single or previously married lone parents and also to live in households with a large number of children (Green et al, 2004).

This Kings Fund prevalence modelled on local cohorts of children shows that locally there is estimated to be:-

- 1,629 children aged between 5 and 15 **RESIDENT** across tri-borough with a Conduct Disorder, with the greatest burden amongst boys in the younger age group (5-10) in the City of Westminster.
- 1,764 children aged between 5 and 15 **REGISTERED** across Inner North-West London CCGs with a conduct disorder, with the greatest burden amongst boys in the younger age group (5-10) in West London CCG.
- 1,281 children aged between 5 and 15 attending **SCHOOL** across tri-borough with a Conduct Disorder, with the greatest burden amongst boys in the older age group (11-15) in Hammersmith & Fulham.

Figure 10 shows these numbers broken down by cohort, age group, gender and borough.

Figure 10: Graphs to show estimated numbers of children across tri-borough with a conduct disorder using resident, registered and school populations (McCrone et al, 2008)



Assuming current levels of conduct disorder remain the same within age bands, the continued growth of the 0-18 population and the changing age structure is likely to result in a rise in the number of children expected with conduct disorders in the future 10-15 years.

By 2028 the number of children across tri-borough with a conduct disorder is expected to be approx. 1,804 children aged between 5 and 15 **RESIDENT** across tri-borough with a Conduct Disorder, with the most significant growth being amongst boys aged 11-15. This growth is expected to be higher than seen elsewhere across the country, as England on the whole is less influenced by inward migration and will probably henceforth grow more slowly in the next decade.

It is not currently possible to accurately project the numbers of children registered who will have a Conduct Disorder in future years. School populations are generally static so it is not expected that a significant change in the numbers projected will be seen.

It is worth noting that there is a marked difference in the projected numbers of children affected by Conduct disorders and where the burden falls between organisations using the three different cohorts - resident, registered and school attendees. This is likely to be the case in all projected numbers seen in this document for the following reasons:-

The difference between the registered and resident population projections

The number of children registered across Inner-North West London is higher than the number resident. It is therefore expected that the projected burden will also be higher amongst the registered population.

As of the 1st April 2013, changes to the boundaries of healthcare provision will change from the current situation where healthcare is provided along borough boundaries to the new boundaries of CCGs. The boundaries of Hammersmith & Fulham will remain the same, but West London CCG will cover the borough of Kensington & Chelsea and the Queens Park area of the City of Westminster, while Central London CCG will cover the remainder of the City of Westminster. This will result in an increased population for West London CCG which is also reflected in the higher number of people projected with Mental Health problems.

The difference between the school population and registered and resident population projections

The number of children attending school is the borough is significantly lower than the registered or resident population. This is likely to be because of two reasons:-

- the significant migration of children going to school outside of the borough because of lower state-maintained school capacity across tri-borough, and,
- the large proportion of non-state maintained schools across tri-borough (data provided is for state maintained schools only, there is likely to be a significant prevalence of Mental Health problems in these schools that is not quantified here)

Hyperkinetic Disorders

The prevalence of Hyperkinetic disorders is much lower than that for Conduct or Emotional Disorders. The prevalence of Hyperkinetic Disorders is estimated to be at 1.0% in boys aged 5-10, 0.4% in boys aged 11-15; and 0.1% in girls aged 5-10, and 0.1% in girls aged 11-15 (McCrone et al, 2008).

Children with a hyperkinetic disorder are far more likely to be boys than girls (88% boys / 12% girls) and the highest prevalence is amongst the younger age group (5-10). In total approx. 69% of those believed to have a hyperkinetic disorder in the tri-borough area were male, aged 5-10.

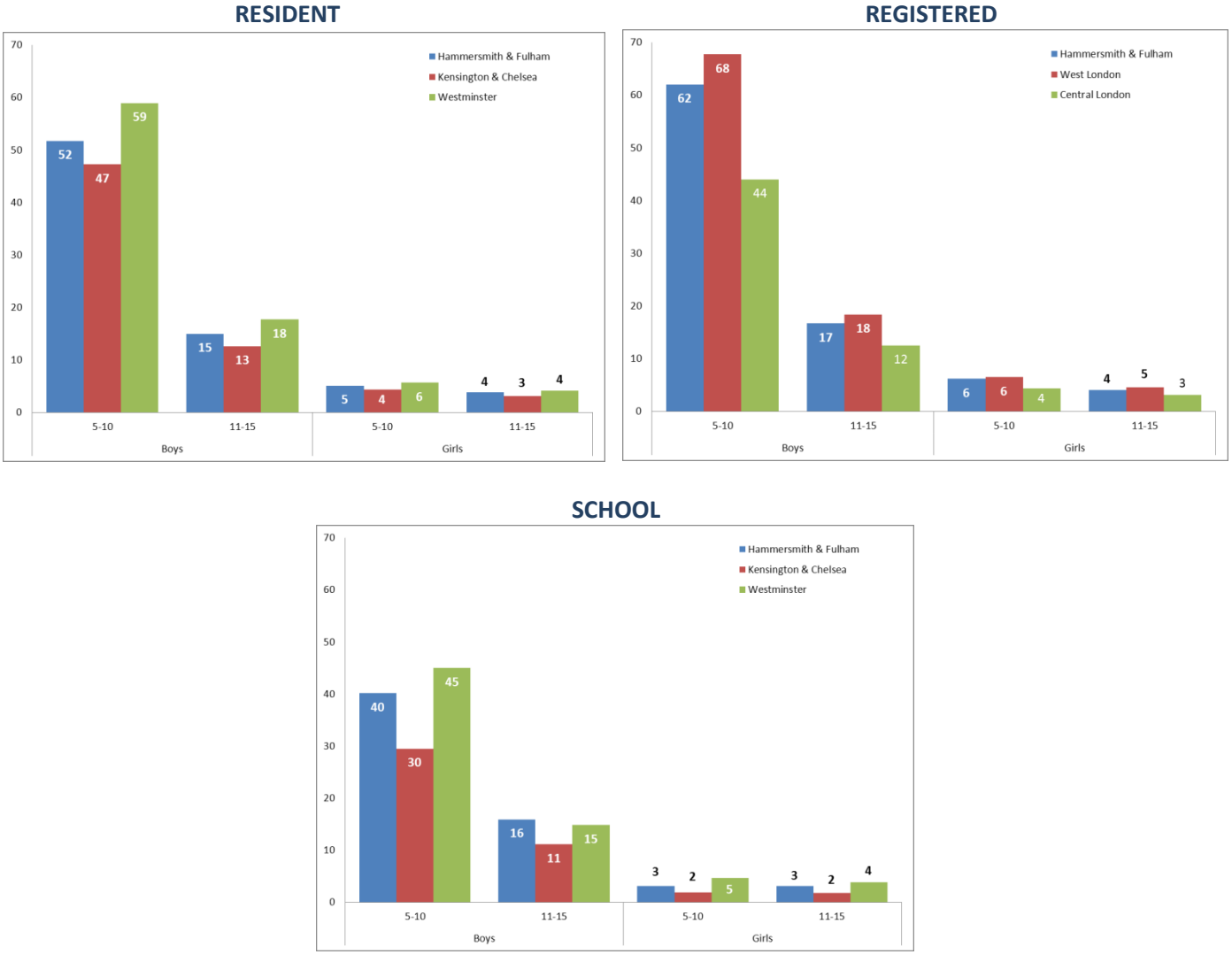
A study by the Office for National Statistics (Green et al, 2004) showed that two thirds of children with a hyperkinetic disorder were rated as being behind in their overall scholastic ability and nearly a fifth were three or more years behind.

This Kings Fund prevalence modelled on local cohorts of children shows that locally there is estimated to be:-

- 229 children aged between 5 and 15 **RESIDENT** across tri-borough with a Hyperkinetic Disorder, with the greatest burden amongst boys in the younger age group (5-10) in the City of Westminster.
- 250 children aged between 5 and 15 **REGISTERED** across Inner North-West London CCGs with a conduct disorder, with the greatest burden amongst boys in the younger age group (5-10) in West London CCG.
- 175 children aged between 5 and 15 attending **SCHOOL** across tri-borough with a Conduct Disorder, with the greatest burden amongst boys in the older age group (11-15) in the City of Westminster.

Figure 11 shows these numbers broken down by cohort, age group, gender and borough.

Figure 11: Graph to show estimated numbers of children across tri-borough with a hyperkinetic disorder using resident, registered and school populations (McCrone et al, 2008)



Assuming current levels of conduct disorder remain the same within age bands, the continued growth of the 0-18 population and the changing age structure is likely to result in the numbers of children with a hyperkinetic disorder staying relatively stable in the future 10-15 years. By 2028 the number of children **RESIDENT** across tri-borough with a hyperkinetic disorder is expected to be approx. 233, with there being very little change in the demographic makeup of those with the disorder.

It is not currently possible to accurately project the numbers of children registered who will have a hyperkinetic Disorder in future years. School populations are generally static so it is not expected that a significant change in the numbers projected will be seen.

Emotional Disorders

Conversely to Conduct and Hyperkinetic disorders, children with an emotional disorder were more likely to be girls and to be in the older age group (11-15), who account for approx. a third of all cases estimated across tri-borough. However, the Kings Fund study suggests that prevalence amongst older boys is increasing.

The prevalence of Emotional Disorders is estimated to be at 2.2% in boys aged 5-10, 3.5% in boys aged 11-15; and 2.8% in girls aged 5-10, and 5.2% in girls aged 11-15 (McCrone et al, 2008).

Previous studies (Green et al, 2004) show that children with an emotional disorder were also twice as likely to live with a widowed, separated or divorced lone parent as children with no disorder, and there was a fairly consistent pattern for children with separation anxiety to live in the poorest economic circumstances.

This Kings Fund prevalence modelled on local cohorts of children shows that locally there is estimated to be:-

- 1,736 children aged between 5 and 15 **RESIDENT** across tri-borough with an emotional disorder, with the greatest burden amongst girls in the older age group (11-15) in the City of Westminster.
- 1,883 children aged between 5 and 15 **REGISTERED** across Inner North-West London CCGs with an emotional disorder, with the greatest burden amongst girls in the older age group (11-15) in West London CCG.
- 1,336 children aged between 5 and 15 attending **SCHOOL** across tri-borough with an emotional disorder, with the greatest burden amongst girls in the older age group (11-15) in the City of Westminster.

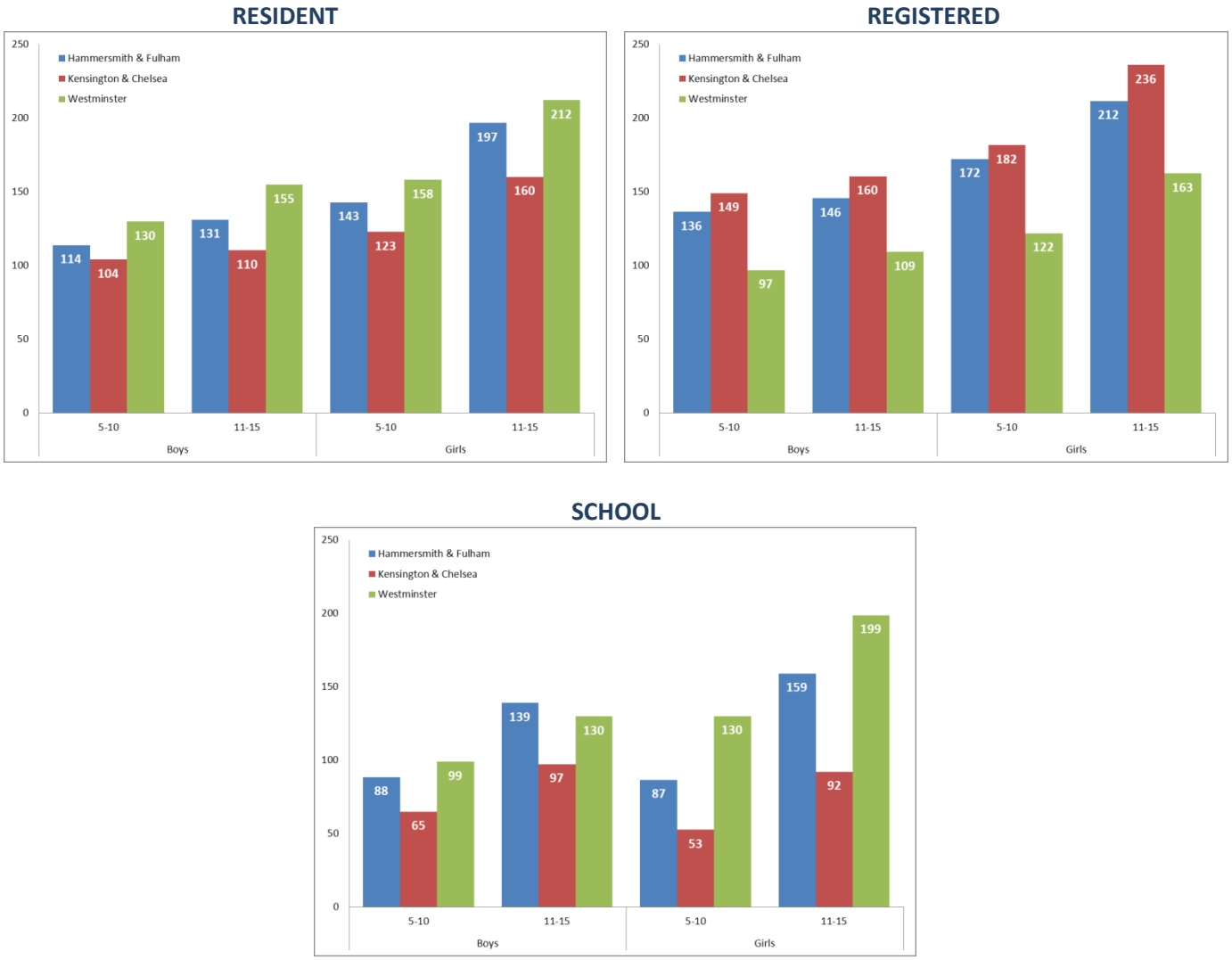
Figure 12 overleaf shows these numbers broken down by cohort, age group, gender and borough.

Assuming the current levels of emotional disorder remain the same within age bands, the continued growth of the 0-18 population and the changing age structure is likely to result in a rise in the number of children **RESIDENT** expected with emotional disorders in the future 10-15 years. By 2028 the number of children across tri-borough with an emotional disorder is expected to be approx. 1,993, with significant growth in both boys (up 115) and girls aged 11-15 (up 188).

This growth is expected to be higher than seen elsewhere across the country, as England on the whole is less influenced by inward migration and will probably henceforth grow more slowly in the next decade.

It is not currently possible to accurately project the numbers of children registered who will have a hyperkinetic Disorder in future years. School populations are generally static so it is not expected that a significant change in the numbers projected will be seen.

Figure 12: Graph to show estimated numbers of children across tri-borough with an emotional disorder using resident, registered and school populations (McCrone et al, 2008)



Co-morbid Disorders

The prevalence of Co-morbid Disorders is estimated to be at 2.1% in boys aged 5-10, 2.9% in boys aged 11-15; and 0.6% in girls aged 5-10, and 1.3% in girls aged 11-15 (McCrone et al, 2008).

Approx. 75% of those with co-morbid disorders are boys, meaning that boys are three times more likely to suffer from multiple mental health conditions than girls.

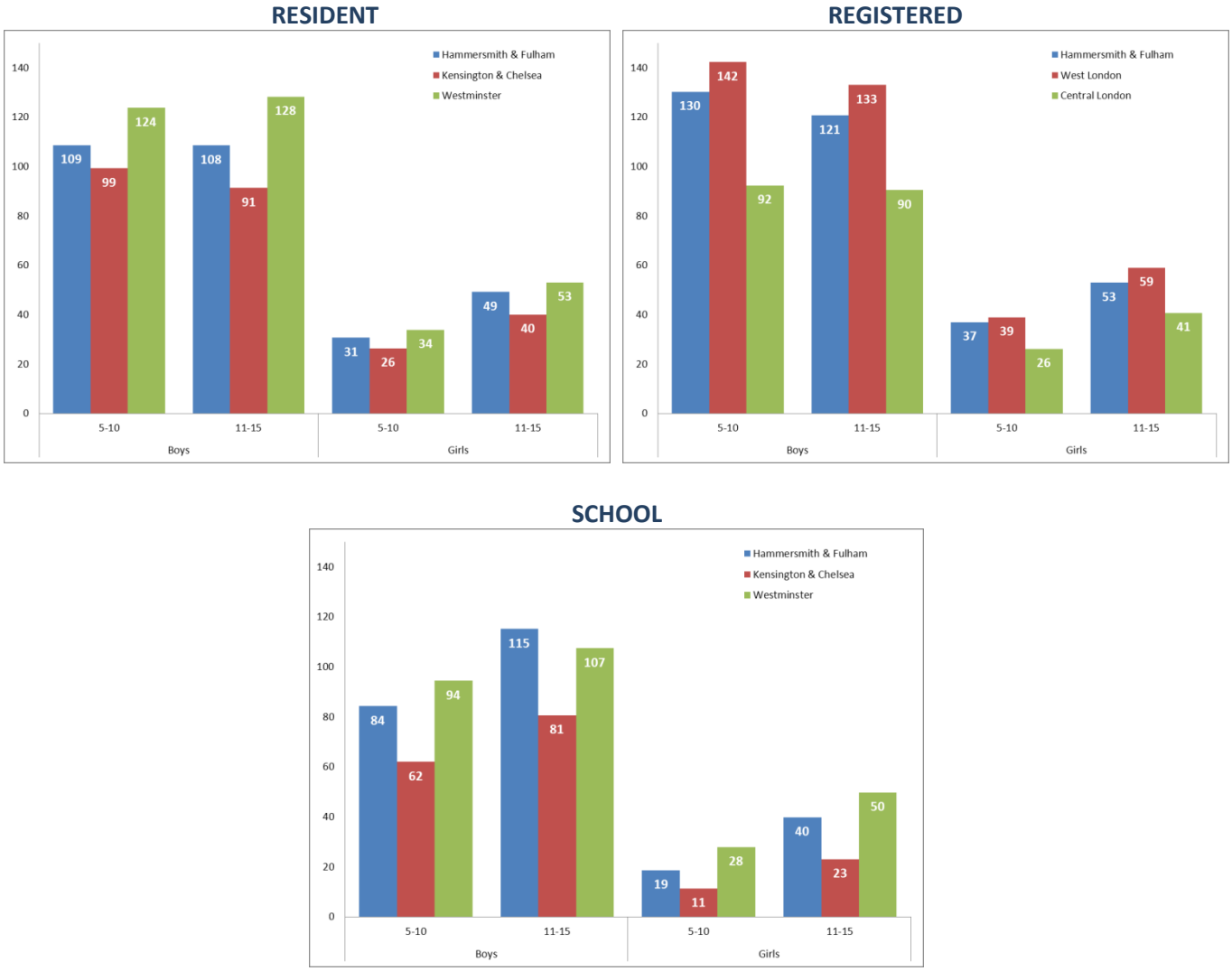
The ONS survey (Green et al, 2004) found that one in five children diagnosed with a disorder had more than one disorder, the most common combinations being conduct and emotional disorder, and conduct and hyperkinetic disorder. The majority (72%) of children with multiple disorders were male, reflecting the high proportion of children with conduct disorder in this group. Children suffering from more than one disorder were at greater risk of suffering more serious problems. 63 per cent of those with multiple disorders were behind in their intellectual development, compared to 49 percent of those with a single disorder. Children with multiple disorders accounted for approximately one third of those using specialist mental health services.

This Kings Fund prevalence modelled on local cohorts of children shows that locally there is estimated to be:-

- 893 children aged between 5 and 15 **RESIDENT** across tri-borough with co-morbid disorders, with the greatest burden amongst boys in the older age group (11-15) in the City of Westminster.
- 963 children aged between 5 and 15 **REGISTERED** across Inner North-West London CCGs with an emotional disorder, with the greatest burden amongst boys in the younger age group (5-10) in West London CCG.
- 714 children aged between 5 and 15 attending **SCHOOL** across tri-borough with an emotional disorder, with the greatest burden amongst boys in the younger age group (5-10) in Hammersmith & Fulham.

Figure 13 shows these numbers broken down by cohort, age group, gender and borough.

Figure 13: Graph to show estimated numbers of children across tri-borough with co-morbid disorders using resident, registered and school populations (McCrone et al, 2008)



Assuming current levels of co-morbid disorders remain the same within age bands, the continued growth of the 0-18 population and the changing age structure is likely to result in a rise in the number of children **RESIDENT** expected with co-morbid disorders in the future 10-15 years. By 2028 the number of children across tri-borough with co-morbid disorders is expected to be approx. 1,004, with the most significant growth in boys aged 11-15.

Interestingly, co-morbid disorders are expected to fall in boys aged 5-10.

It is not currently possible to accurately project the numbers of children registered who will have a hyperkinetic Disorder in future years. School populations are generally static so it is not expected that a significant change in the numbers projected will be seen.

Neurotic Disorders

A study conducted by Singleton et al (2001) has estimated prevalence rates for neurotic disorders in young people aged 16 to 19 (inclusive) living in private households.

The tables below show how many 16 to 19 year olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population across tri-borough.

Figure 14: Estimated number of Males aged 16-19 with neurotic disorders across tri-borough (Singleton et al, 2001)

	Mixed Anxiety and Depressive Disorder	Generalised Anxiety Disorder	Depressive Episode	All Phobias	Obsessive Compulsive Disorder	Panic Disorder	Any Neurotic Disorder
Hammersmith & Fulham	163	51	29	19	29	16	275
Kensington & Chelsea	135	42	24	16	24	13	227
Westminster	212	67	37	25	37	21	358

Figure 15: Estimated number of Females aged 16-19 with neurotic disorders across tri-borough (Singleton et al, 2001)

	Mixed Anxiety and Depressive Disorder	Generalised Anxiety Disorder	Depressive Episode	All Phobias	Obsessive Compulsive Disorder	Panic Disorder	Any Neurotic Disorder
Hammersmith & Fulham	387	34	84	66	28	19	599
Kensington & Chelsea	317	28	69	54	23	15	492
Westminster	476	42	104	81	35	23	737

Autism Spectrum Disorder

A study of 56,946 children in South East London by Baird et al (2006) estimated the prevalence of autism in children aged 9 to 10 years at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000, making the total prevalence of all ASDs 116.1 per 10,000.

A survey by Baron-Cohen et al (2009) of autism-spectrum conditions using the Special Educational Needs (SEN) register alongside a survey of children in schools aged 5 to 9 years produced prevalence estimates of autism-spectrum conditions of 94 per 10,000 and 99 per 10,000 respectively. The ratio of known to unknown cases is about 3:2. Taken together, a prevalence of 157 per 10,000 has been estimated, including previously undiagnosed cases.

The European Commission (2005) highlights the problems associated with establishing prevalence rates for Autistic Spectrum Disorders. These include the absence of long-term studies of psychiatric case registers and inconsistencies of definition over time and between locations.

Nonetheless the Commission estimates that according to the existing information, the age-specific prevalence rates for 'classical autism' in the European Union could be estimated as varying from 3.3 to 16.0 per 10,000. These rates could however increase to a range estimated between 30 and 63 per 10,000 when all forms of autism spectrum disorders are included. Debate remains about the validity and usefulness of a broad definition of autism. The EU definition of rare diseases still focuses on those diseases lower than 5 per 10 000. The Commission notes that ASD "... could be considered as a rare disease using the most restrictive diagnosis criteria but it seems more appropriate to not refer more to ASD as a rare disease."

Figure 16 shows the numbers of children with autistic spectrum disorders if the prevalence rates found by Baird et al (2006) and by Baron-Cohen et al (2009) were applied to the population across tri-borough.

Figure 16: Estimated number of children with autistic spectrum disorders (ChiMat, 2012)

	Autism (age 9-10)	Other ASDs (age 9-10)	Total of all ASDs (age 9-10)	Autism-spectrum conditions disorders (age 5-9)
Hammersmith & Fulham	13	25	38	135
Kensington & Chelsea	11	22	33	119
Westminster	14	28	43	152

Estimated need for CAMHS at each tier

Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been provided by Kurtz (1996). The following table shows these estimates for the population aged 17 and under across tri-borough:-

Figure 17: Estimated number of children and adolescents who may experience mental health problems appropriate to a response from CAMHS (Kurtz, 1996)

	Tier 1	Tier 2	Tier 3	Tier 4
Hammersmith & Fulham	4926	2299	608	25
Kensington & Chelsea	4080	1904	503	20
Westminster	5550	2590	685	28

Persistence

Mental health disorders in childhood can have high levels of persistence:

- 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder still had the problem three years later.
- Persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively).
- Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood.

They can also have long-term adverse consequences lasting into adulthood. For example, according to Meltzer and colleagues (Meltzer et al, 2003), children and young people with diagnosed mental health problems are 17 times more likely to have been excluded from school. Also, only 55% of children and young people with a mental health problem remain in school full-time past the age of 15.

VULNERABLE GROUPS

Any child can experience mental health problems, but some children and young people are more vulnerable than others. Those life events and circumstances that make some children and young people more vulnerable than others have been known for some time, but there is now a growing evidence base for the relative risks of different factors and their proportionality. The table below illustrates this (HM Gov, 2010).

Table 1: The degree of risk of developing mental health problems

Risk group	Degree of risk	Prevalence of risk
Children with learning disability	6.5 fold increased risk of mental health problem	2.6% of pupils have learning disabilities
Children with physical illness	2 fold increased risk of emotional/conduct disorders over a 3 year period	5-6% of children (600,000) report/are reported by parents as being in "fair or poor" health)
Homeless young people	8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation	Between 36,000 to 52,000 homeless young people in England
Young LGBT	7 fold increased risk of suicide attempts in young lesbians 18 fold increased risk of suicide attempts in young gay men	Estimated 6% of population are LGBT
Young offenders	18 fold increased risk of suicide for men in custody age 15 – 17 40 fold increased risk of suicide in women in custody age < 25 4 fold increased risk of anxiety/ depression 3 fold increased risk of mental disorders	Over 6,000 children aged under 18 entering custody during a year – the vast majority are boys. 10% of 10– 25 year olds report committing a serious offence in previous year
Looked after children	5 fold increased risk of any childhood mental disorder 6 – 7 fold increased risk of conduct disorder 4 – 5 fold increased risk of suicide attempt as an adult	64,400 children (0.5% of under 18 year olds) are "looked after" in England
Children of prisoners	3 fold increased risk of antisocial-delinquent outcomes	160,000 children and young people per year have a parent in prison

BAME children

Evidence reveals that the rates of mental health problems tend to be higher among people from BME groups, as they are more likely to experience risk factors associated with poor mental health, such as deprivation, discrimination and poor educational and employment opportunities. Breakdowns from the 2004 ONS cohort (Green et al, 2005) and explored by Coleman and colleagues in the report Key Data on Adolescence 2011 (Coleman et al 2011), indicate variations on the basis of ethnicity where rates of mental illness are higher among black young people (just over 14%) and lower among young Indian people (just under 3%).

These young people face a variety of specific barriers to accessing services, including:

- Cultural barriers. There is often a lack of understanding of different cultural and religious needs among professionals, and there is a shortage of mental health professionals from BME backgrounds. Staff need to be trained in race equality and cultural competences; such training must be standard, and across the board.

- People from different cultures may have different understandings of what mental health is. For example, the survey found that the stigma of mental health problems is particularly strong among people from certain backgrounds. Such attitudes can impact on how children seek and access treatment.

- Language barriers. English may not be the first language for these children, especially asylum seeking and refugee children, and translation services are not always available.

The table below shows the ethnic makeup of children in need known to local authorities:-

Figure 18: Table to show the ethnicity of children in need across tri-borough (Tri-borough Children's Services, 2011/12)

	Hammersmith & Fulham	Kensington & Chelsea	Westminster
White	29%	27%	21%
Asian	4%	5%	10%
Black	27%	24%	18%
Mixed	18%	16%	15%
Other	10%	12%	25%
Missing	12%	16%	11%

The ethnic makeup of children in need is different to the ethnicity of the general population of children in across tri-borough. Specifically, it is noticeable that in all the three boroughs a higher percentage of Black and Mixed children are known to services. In Westminster a significantly higher percentage of children from 'Other' backgrounds are known to services.

Looked After Children

Looked-after children are more likely to experience mental health problems (Ford, T. et al, 2007). It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic (Meltzer, H. et al, 2003).

About two-thirds of children living in residential care (68%) were assessed as having a mental disorder and about four in ten of those placed with foster carers (39%) or with their birth parents (42 per cent).

As of the 31st March 2012, across the tri-borough area there were a total of 571 looked after children. This comprised of 224 in Hammersmith & Fulham, 139 children in Kensington & Chelsea, and 208 children in the City of Westminster.

This would equate to an approximate total of 280 currently looked after children who could be experiencing some type of mental disorder. This would break down across the three boroughs as follows:-

- Hammersmith & Fulham - 110
- Kensington & Chelsea - 68
- Westminster - 102

Care Leavers

While there is little research currently done on the prevalence of Mental Health problems amongst young care leavers, it is expected that this group may also be vulnerable to high levels of mental disorders.

As of the 31st March 2012, across the tri-borough area there were a total of 455 care leavers. This comprised of 162 in Hammersmith & Fulham, 135 children in Kensington & Chelsea, and 158 children in the City of Westminster.

Young Offenders

There are a number of studies which provide insight to the mental health of young people who have had contact with the criminal justice system. Young offenders are at high risk of suffering mental health problems; 40 per cent have a diagnosable disorder (Green et al, 2003).

Although not a precursor to criminal behaviour in later years, there is a positive correlation between time lost from education and crime, with half of all male prisoners having been excluded from school. Many of these children suffer from conduct disorders and there is evidence that they may also exhibit problems with social understanding, and disorders on the autistic spectrum. However, these disorders often remain undetected: one research programme found that a significant minority of children with disruptive behaviour have significant, previously unidentified, social communication difficulties. These children are therefore not receiving the necessary treatment, which could perhaps in turn help to prevent behaviour that would lead to exclusion.

As of the 31st March 2012, across the tri-borough area there were a total of 327 young offenders known to social services. This comprised of 130 in Hammersmith & Fulham, 68 children in Kensington & Chelsea, and 129 children in the City of Westminster.

Children with Learning Disabilities

People with learning disabilities are more likely to experience mental health problems (Emerson, E. et al, 2008). However, estimation of the population prevalence of learning disability is problematic and should be treated with caution.

These rates for different age groups reflect the fact that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities (2002) estimates an upper limit of 40% prevalence for mental health problems associated with learning disability, with higher rates for those with severe learning disabilities.

As of the 31st March 2012, across the tri-borough area there were a total of 708 children with a learning disability (as defined by each local authority). This comprised of 233 in Hammersmith & Fulham, 202 children in Kensington & Chelsea, and 273 children in the City of Westminster.

Using the above estimates the Figure 19 overleaf shows the expected number of children with learning difficulties who have mental health problems.

Figure 19: Table to show the estimated numbers of children across tri-borough with a Learning Disability and Mental Health problems (Foundation for People with Learning Disabilities, 2002)

	5-9	10-14	15-19	TOTAL
Hammersmith & Fulham	33	69	84	186
Kensington & Chelsea	29	59	69	157
Westminster	37	79	107	223

Unaccompanied Asylum Seekers

Unaccompanied asylum seeker children are at high risk of mental health problems. They have often suffered traumatic experiences prior to reaching the UK, and can face discrimination once here. They are likely to have come from countries with poor human rights records, may have witnessed acts of violence, and will need to cope with new social and cultural experiences in the UK. Practical problems of living in the UK are particularly difficult for refugee and asylum seeking families, and they are more likely to be living in deprivation and poor conditions. Their lack of understanding of the UK health and welfare services may hamper access to treatment, as can poor knowledge of other British systems.

The legal status of asylum seekers can be uncertain, and this in itself can present an obstacle to receiving help. There are language and cultural barriers, and such children may be reticent about discussing their situation following previous experiences where either they or their parents may have been persecuted for their views. CAMHS staff may also find the experiences these children have been through difficult to cope with, and may need support and training in working with them.

As of the 31st March 2012, across the tri-borough area there were a total of 52 unaccompanied asylum seekers who were children. This comprised of 21 in Hammersmith & Fulham, 22 children in Kensington & Chelsea, and 9 children in the City of Westminster.

Homelessness and sleeping rough

Vonstanis, P. (2002) states that homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including acquired immune deficiency syndrome (AIDS). Two major studies of this group in London (Craig, T. et al, 1996) and Edinburgh (Wrate, R. et al, 1999) found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were associated with sexually risky behaviours, substance misuse and co-morbid psychiatric disorders, particularly depression.

In a study by Quilgars et al (2011), the estimated number of young people aged 16 to 24 sleeping rough in England in 2008/9 was 3200, giving a rate of 51.3 per 100,000. In a study of 16 to 25 year olds who were sleeping rough in London, Vasiliou (2006) found that 67% had mental health problems. Applying these rates to the population in Hammersmith and Fulham LB provides an estimate of 8 young people with mental health problems who are sleeping rough.

Those at-risk of Suicide & Self-Harm

Suicide is a complex issue and one which requires further research to understand better the specific risk factors associated with it. Looking at suicides in the UK between 1997 and 2003, one study has made the following observations (Windfuhr, K., 2008):

Three times as many young men as young women aged between 15 and 19 committed suicide
Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults.

Looking at the difference between genders, 20% of young women were in contact with mental health services compared to only 12% of young men.

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

Self-harm is a related issue:

- Levels of self-harm are higher among young women than young men. The rates of self-harm in young women averaged 302 per 100,000 in 10 to 14 year olds and 1,423 per 100,000 in 15 to 18 year olds. Whereas for young men the rates of self-harm averaged 67 per 100,000 in 10-14 year olds and 466 per 100,000 in 15 to 18 year olds (Hawton, K., 2012). Self-poisoning was the most common method, involving Paracetamol in 58.2 % of episodes (Hawton, K., 2012)

- Presentations, especially those involving alcohol, peaked at night. Repetition of self-harm was frequent (53.3 % had a history of prior self-harm and 17.7 % repeated within a year) (Hawton, K., 2012). Common characteristics of adolescents who self-harm are similar to the characteristics of those who commit suicide (Hawton, K., 2005)

- Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors (Hawton, K., 2005)

- As many as 30% of adolescents who self-harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self-harm during the following year, with repeats being especially likely in the first two or three months (Hawton, K., 2005)

- The risk of suicide after deliberate self-harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage boy; violent method of self-harm; multiple previous episodes of self-harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital (Hawton, K., 2005)

COSTS OF MENTAL HEALTH SERVICES

The King's Fund (McCrone, 2008) provide a range of figures concerning current and projected spending on mental health services in England. Based on prevalence data on specific conditions that are targeted by mainstream services and for which there is a reasonable evidence base as to the effectiveness of interventions, combined with population projections for England, McCrone et al gave the following spend on CAMHS, excluding services for the 0-4 age group:

- In 2007, a spend of £0.14 billion (out of an overall total of £22.5 billion)
- In 2026, based on real pay and price effects, a projected spend of £0.24 billion (out of a total projected spend of £47.48 billion).

Clearly these sums are significant, even if they are but a tiny part of overall expenditure on mental health and thus considering costs and cost effectiveness is an increasingly important part of the CAMHS commissioning landscape. In addition, even where interventions can be shown to be effective, they must also be capable of demonstrating a return on investment. Some interventions require significant resource investment and it is important to understand what later gains and savings are likely to accrue as a result of that investment.
Only recently in the UK have we been able to quantify the cumulative costs of mental health problems and disorders; the table below is reproduced from supporting material for the recent policy *No Health Without Mental Health* (Department of Health, 2011).

Table 2: Costs of different mental disorders across the life course

Mental illness during childhood and adolescence	UK costs of £11,030 to £59,130 annually per child
Conduct disorder	Lifetime costs of a one year cohort of children with conduct disorder (6% of the child population) has been estimated at £5.2 billion. Cost of crime attributable to adults who had conduct problems in childhood is estimated at £60 billion a year in England and Wales, of which £22.5 billion a year is attributable to conduct disorder and £37.5 billion a year to sub-threshold conduct disorder.
Depression	Total annual costs of depression in England in 2007 were £7.5 billion, of which health service costs comprised £1.7 billion and lost earnings £5.8 billion. This does not include informal care or other public service costs. It has been estimated that lower productivity accounts for a further £1.7 – £2.8 billion and human costs for another £9.9 – £12.4 billion, bringing the total annual cost of depression to £20.2 – 23.8 billion a year.
Anxiety	Health service costs of anxiety disorders in 2007 were £1.2 billion. The addition of lost employment brings the total costs to £8.9 billion.
Medically Unexplained Symptoms (MUS)	Annual NHS cost of MUS in England amount to £3.1 billion (2008/9) with a further £5.2 billion in lost productivity and £9.3 billion reduced quality of life.
Schizophrenia	Total costs of schizophrenia were approximately £6.7 billion per year in England in 2004–05. Cost of treatment and care was £2 billion, annual costs of welfare benefits were £570 million and the cost to families of informal care and private expenditure amounted to £615 million. Costs of lost productivity due to unemployment, absence from work and premature mortality were £3.4 billion.

SERVICE USE

Local provision of CAMHS in Inner North West London is provided by Central North West London Mental Health Trust (for the boroughs of Kensington & Chelsea and Westminster) and West London Mental Health Trust (for the borough of Hammersmith & Fulham).

The following section includes service data provided by the relevant trusts for each borough.

HAMMERSMITH & FULHAM

SUMMARY OF LOCALISED NEED

CHILD POPULATION

Resident	-	34,596
Registered	-	37,535
School	-	18,733

ESTIMATED NUMBER OF CHILDREN WITH MENTAL HEALTH CONDITIONS

Below are expected number of children with Mental Health conditions at any one time, calculated using prevalence estimates from 'Paying the Price' (Kings Fund, 2008). Data is presented for three relevant child population cohorts where possible - resident, registered, and children attending borough schools.

Conduct Disorder	-	542 resident, 625 registered, 459 school attendees
Hyperkinetic Disorder	-	76 resident, 89 registered, 62 school attendees
Emotional Disorder	-	584 resident, 666 registered, 473 school attendees
Co-morbid Disorders	-	297 resident, 341 registered, 258 school attendees
Neurotic Disorder	-	874 residents (aged 16-19)

ESTIMATED NEED FOR CAMHS

There is estimated to be a total of 7,858 children resident in Hammersmith & Fulham who may experience mental health problems appropriate to a response from CAMHS - 4,926 at Tier 1; 2,299 at Tier 2; 608 at Tier 3; and 25 at Tier 4.

VULNERABLE GROUPS

BAME Children	-	59% of children in need are from a BAME background.
Looked After Children	-	There are currently 224 Looked After Children, of which 110 could be experiencing some type of mental disorder.
Care Leavers	-	There are currently 162 Care Leavers.
Young Offenders	-	There are currently 130 Young Offenders known to social services, of which 65 are expected to have a diagnosable Mental Health disorder.
Learning Disabilities	-	There are currently 233 people with Learning Disabilities, of which 186 could be experiencing some type of mental disorder.

Service Activity and User Demographics (2011/12)

The following data has been provided by West London Mental Health Trust (WLMHT) and shows a full year of data from April 2011 to March 2012, unless specified. Data is first presented for all CAMHS activity and is then broken down by the separate teams that comprise the service, where possible. Some of the data contains inconsistencies and should therefore be used a general guide to CAMHS activity.

All CAMHS Teams - Referrals

There were 870 new referrals between April 2011 to March 2012.

Figure 20 below shows the average number of monthly referrals to all CAMHS teams for October 2011 to September 2012. Approx. 88% of referrals are accepted, while 12% are deemed as inappropriate.

Figure 20: Average number of monthly referrals to WLMHT CAMHS, October 2011 to September 2012 (WLMHT, 2013)

Average monthly referrals received	64
Average monthly inappropriate referrals	8
Average monthly accepted referrals	56

Most new referrals came from General Practitioners (41%) followed by Local Authority Education Services (19%) and Local Authority Social Services (17%). 8% of new referrals are internal referrals, and 6% are coded as 'Other'.

Figure 21 below shows a more detailed breakdown of all referral sources.

Figure 21: Source of new referrals for all CAMHS teams, April 2011 to March 2012 (WLMHT, 2013)

Referral Source	No.	%
GP - General Practitioner	358	41%
ESL - Education Service - LEA	167	19%
LA - Local Authority Social Services	146	17%
IR - Internal referral	67	8%
OT - Other	55	6%
CH - Community Health Services	19	2%
AE - Accident And Emergency Department	14	2%
OS - Other clinical specialty	12	1%
ADCC - CONSULTANT, other than in an A&E Department	7	1%
YOT - Youth Offending Team	6	1%
LO - Local Authority - other departments	5	1%
ES - Education Service - Non LEA	4	0%
SE - Self	2	0%
V71CLINIC - General hospital (Clinic)	2	0%
V71WARD - General hospital (Ward)	2	0%
AHP - Allied Health Professional	1	0%
DSS - Drug service statutory	1	0%
FF - Family / Friend / Neighbour	1	0%
LAES - Local Authority Education Service	1	0%
TOTAL	**870**	**100%**

Data on where the most inappropriate referrals come from is currently not available for this time period. In the last CAMHS JSNA in 2009, the following reasons were identified as the key when considering inappropriate referrals:

- Incomplete referral information
- Children not meeting the Tier 3 referral threshold so therefore diverted to Tier 2 services or other agencies
- Children's services not completed their assessments on children referred to CAMHS

All CAMHS Teams - Open Cases

Based on a snapshot of open cases on the 20th December 2012, there were 531 children on the caseload for all CAMHS teams in Hammersmith & Fulham.

282 were male (53%) and 249 were female (47%).

Figure 22 below shows the age breakdown, by single year of age, of those on the caseload for the relevant time period. The majority of cases were children aged 4-17 with a peak in the 12-15 age group, and then again at 17. This mirrors the times of life that include the transition from primary to secondary school, and the leaving secondary school.

Figure 22: Age of patients on all CAMHS teams caseload, December 2012 (WLMHT, 2012)

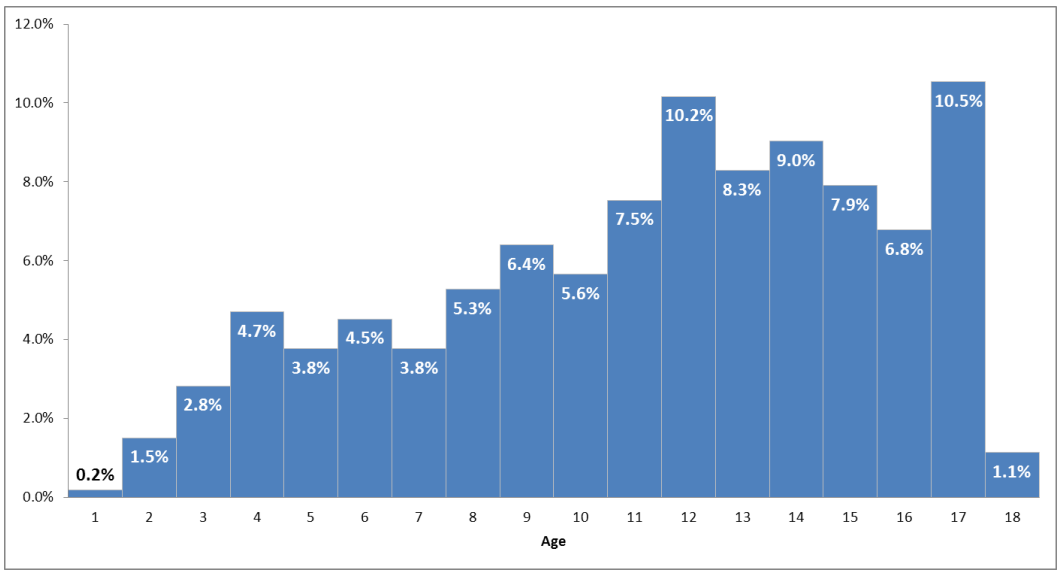
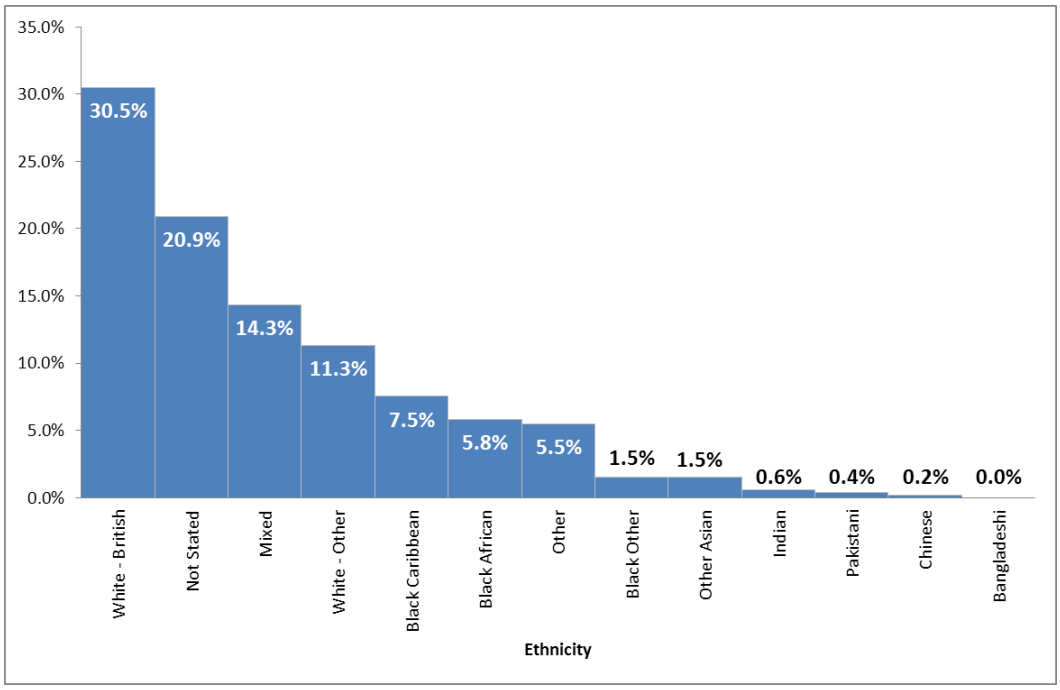


Figure 23 overleaf shows that 30.5% of CAMHS cases were of 'White - British' ethnicity, the second largest ethnic group was Black (14.9% when combining all Black ethnic categories), followed by Mixed (14.3%).

The Asian caseload of approx. 1% suggests an under representation of Asian children and young people which is common across CAMHS nationally.

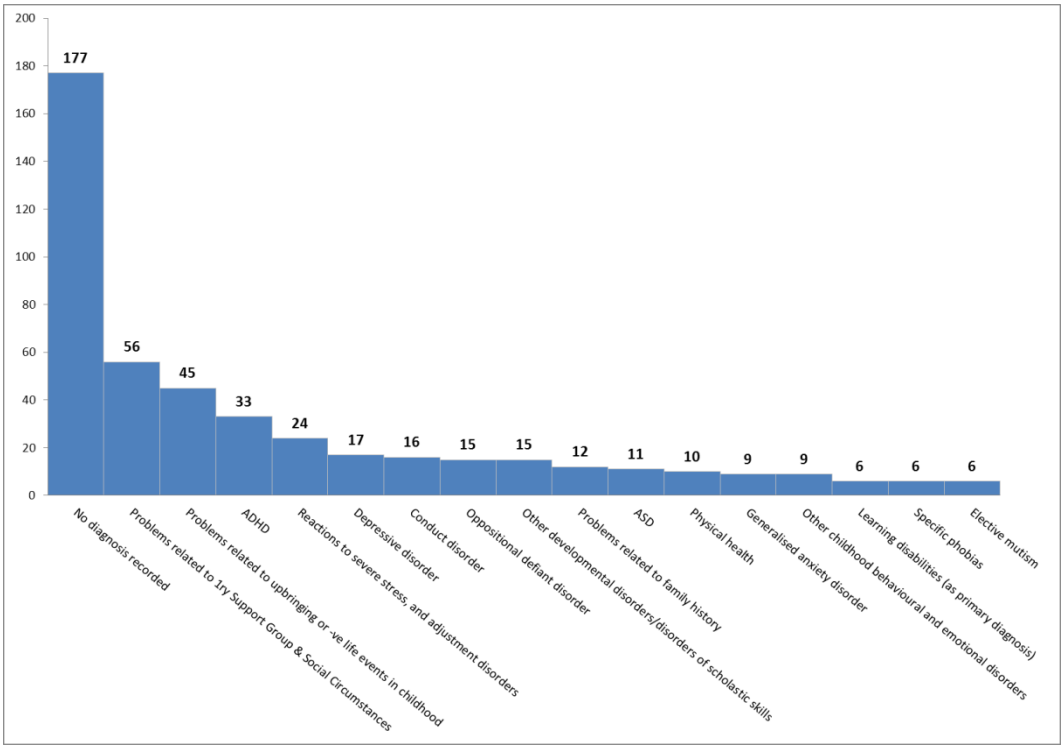
However, a significant proportion of cases had no ethnicity recorded (20.9%). It would helpful to reduce this poor recording rate to give a better picture of the ethnic makeup of CAMHS in Hammersmith & Fulham.

Figure 23: Ethnicity of patients on all CAMHS teams caseload, December 2012 (WLMHT, 2012)



A diagnostic audit of those currently on the caseload for CAMHS in Hammersmith & Fulham was conducted in November 2012. 177 patients had no diagnosis recorded, while 319 had a clinical diagnosis. Figure 24 shows the results of the audit for conditions which more than 5 patients had.

Figure 24: Diagnosis of patients on all CAMHS teams caseload (where available), December 2012 (WLMHT, 2012)



Other disorders that were recognised and diagnosed by the services but had 5 or fewer people living with the condition included - Tic disorder, Bipolar disorder, Anorexia nervosa, Separation anxiety disorder of childhood

OCD, Panic disorder (including traumas), Psychotic disorders, Attachment disorder, Nonorganic enuresis, Sleep problems, Intentional self-harm (as primary diagnosis) and Substance misuse (as primary diagnosis).

There is currently no available data on the resident location of the children who are seen by CAMHS in Hammersmith & Fulham. This information would be useful to collect as it would enable an evaluation to the links between social deprivation and access.

In addition, data on family composition and the prevalence of children seen who require a carer has not been provided.

All CAMHS Appointments

During the period April 2011 and March 2012, the 870 reported referrals accepted onto the CAMHS caseload resulted in 7,816 appointments offered.

Of the appointments offered, 1,371 appointments were not attended resulting in a DNA rate of 17.5%.

Data shows the ratio of First to Follow-Up appointments across this period to be on average 1:5.

Tier 2

Tier 2 services are those that are provided by specialist working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery. For the purposes of this assessment Tier 2 services also include those commissioned directly by schools for example, counselling and psychotherapy services.

The phrase Tier 2 is often used interchangeably with 'Targeted Services' and there are similarities. A useful definition of targeted provision are those partnership and services delivered through children's trust arrangements to improve mental health outcomes for especially vulnerable groups in particular: looked after children; children in need; children about whom there are child protection concerns; children from refugee and asylum seeking families; children with learning difficulties and disabilities; children from black and minority ethnic groups; young offenders; children with additional needs requiring integrated support.

In Hammersmith & Fulham, Tier 2 services consist of Primary Mental Health Workers, Psychotherapists in schools, in the Primary Care Centre at Richford Gate, Looked After Children services, and services for Young Offenders. Data for those services is provided below.

The Tier 2 teams provide services in a number of community locations including schools, local authority sites, GP practice (Richford Gate), and home visits.

Primary Mental Health Workers

The Primary Mental Health Worker team provides support and guidance to promote children's emotional wellbeing in schools and other community settings, through consultation and training of professionals, and direct work with young people and families.

As of December 2012, the Primary Mental Health Worker caseload was 49 patients.

27 of the patients were Male (55%) and 22 were Female (45%).

The age range of patients seen was quite wide (ages 1-17). The ages which had the highest number of patients on the caseload were ages 4, 6, 11 and 12, each having 6 patients of that age.

There was no discernible difference in the ethnicity of this cohort of patients compared to that presented above for all CAMHS teams.
In terms of referral source, 68% of referrals came from the Local authority Education service, 17% were Internally referred, and 5% were from a General Practitioner. Only 11 other referrals came from outside of these sources.

Between April 2011 and March 2012, 1,224 appointments were offered, of which 82% were attended. Over this period DNA rates for this service averaged at approx. 16%.

Psychotherapy in Schools

The Psychotherapy in Schools programme in Hammersmith & Fulham is a Child Psychotherapy outreach service for children with emotional and behavioural difficulties which is provided at a community Early Years Centre.

As of December 2012, the Psychotherapy in Schools caseload was 28 patients.

13 of the patients were Male (46%) and 15 were Female (54%).

The age range of patients seen was quite young (ages 2-12). The majority of patients were aged between 2 and 5 (89%) - only 3 patients were older than this age range.

Due to the small numbers of patients it is difficult to draw distinct comparison to the local population in terms of ethnicity, as you would expect the data to fluctuate. However, as of December 2012, we can say that children of ethnic Black groups were over-represented in this cohort compared to the local population.

In terms of referral source, all except two referrals were from Local Authority Education Services.

Between April 2011 and March 2012, 542 appointments were offered, of which 94% were attended. Over this period DNA rates for this service averaged at approx. 6%.

Primary Care (Richford Gate)

The Richford Gate Primary Care Centre offers a Clinical Psychology service for children and young people with emotional and behavioural difficulties, providing time-limited interventions in a primary care setting.

As of December 2012, the Richford Gate caseload was 19 patients.

8 of the patients were Male (42%) and 11 were Female (58%).

The age range of patients seen was wide, between 2 and 17, and evenly spread between this age range. Due to the small numbers it is difficult to draw any inference into this.

For this service, data on ethnicity was poorly coded. With just over 50% of the patients having no ethnicity stated.

In terms of referral source, 66% of referrals came from a local GP, a further 14% were Internally referred, and 6% were referred from Community Services. Only 8 other referrals came from outside of these sources.

Between April 2011 and March 2012, 425 appointments were offered, of which 85% were attended. Over this period DNA rates for this service averaged at approx. 15%.

Looked After Children

The Looked After Children service in Hammersmith & Fulham is a collaborative service that invites specialist mental health input into to a multi-agency service for Looked After Children and those leaving care.

The LAC team remit is to provide a service to looked after children via direct work and through consultancy, teaching, training and therapeutic support to foster carers and social workers about understanding and responding to the mental health needs and experiences of children in care.

Distinctive direct models of intervention are used depending on what is perceived to be the most useful and appropriate for the child, carer or parent. The integrative approach enables the team to be adaptive to the needs of family placement services in order to continuously reassess and evaluate how support can be provided.
The overarching ethos of the service is to support the child, carer, family and professional systems to work together in bringing about positive outcomes for the looked after child.

The team are currently based with LAC services at Cobbs Hall. The team will see children and their families on site or in the home; this is dependent on what works best for the child and/or carer.

As of December 2012, the Looked After Children's team caseload was 52 patients.

An even split of Male and Females were recorded, 26 of each.

The age range of patients seen was wide, between 4 and 18, and evenly spread between this age range. Due to the small numbers it is difficult to draw any inference into this.

Due to the small numbers of patients it is difficult to draw distinct comparison to the local population in terms of ethnicity, as you would expect the data to fluctuate. However, as of December 2012, we can say that children of ethnic Black and Mixed groups were over-represented in this cohort compared to the local population.

In terms of referral source, 88% of referrals came from a Local Authority Social Services, a further 4% from a General Practitioner. Only 3 other referrals came from outside of these sources.

Between April 2011 and March 2012, 265 appointments were offered, of which 76% were attended. Over this period DNA rates for this service averaged at approx. 24%.

Dominant themes within the referrals were reported as being:-

- Preventing placement breakdown.
- (Directly or indirectly via the carer) supporting looked after children manage transitions (i.e. from birth family into care; moving foster placement; moving from foster care into permanency).
- Support to the carer in understanding and managing behaviours of looked after children.
- Emotional and behavioural difficulties of the child that can include severe temper tantrums.
- Self-esteem work with newly adopted young person.
- Preparatory work with family before referral to (out of borough) tier 3 CAMHS.
- Direct work with birth parent of looked after child.
- Support to the carer of a pregnant LAC (Unaccompanied minor).
- Eating problems for the looked after child.
- Child enuresis, and,
- Minor deliberate self-harm.

In addition to the data above, the Clinical Nurse Specialist of this team undertakes appropriately 30 consultations each month with social workers from the LAC & Leaving Care Service. From these, 10 approximate referrals are made to local or external tier 3 CAMHS, per month.

The Clinical Nurse Specialist currently has between 15-20 on-going liaisons with external agencies related to looked after children placed outside of Hammersmith & Fulham.

Youth Offending Service

The Youth Offending service in Hammersmith & Fulham is a collaborative service that invites Specialist mental health input into the multi-agency Youth Offending Service for children and young people known to the police and courts and at risk of re-offending.

At December 2012, there were only 7 patients on the caseload - 6 of which were Male. Half of the cohort were from a 'White - British' ethnic background and half were from a BAME background.

All referrals were made by either Local Authority Social Services or the Youth Offending Team.

Between April 2011 and March 2012, 107 appointments were offered, of which 70% were attended. Over this period DNA rates for this service averaged at approx. 30%.

Tier 3

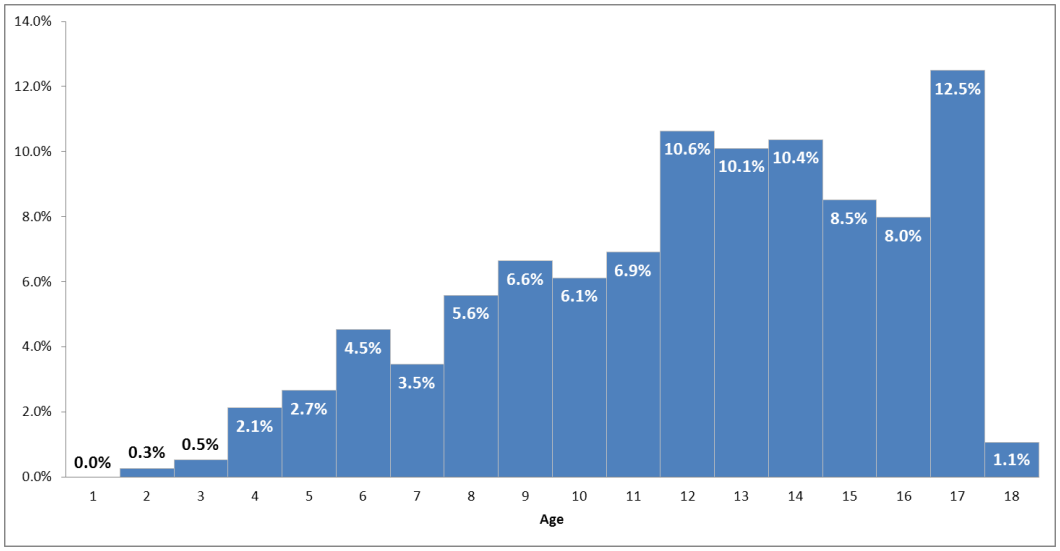
Tier 3 services are specialised services for more severe, complex or persistent disorders.

In Hammersmith & Fulham there is a large multi-disciplinary team which provided specialist assessment and treatment for children and young people with complex mental health problems. Tier 3 services offer appointments primarily in the clinic, but with some home visits and network meetings at other locations such as school or local authority.

As of December 2012, the Tier 3 caseload was 376 patients. 202 of the patients were Male (54%) and 174 were Female (46%).

Figure 25 below shows the age breakdown, by single year of age, of those on the caseload for the relevant time period. The majority of cases were children aged 4-17 with a peak in the 12-15 age group, and then again at 17. This mirrors the times of life that include the transition from primary to secondary school, and the leaving secondary school.

Figure 25: Age of patients on CAMHS Tier 3 caseload, December 2012 (WLMHT, 2012)



There was no discernible difference in the ethnicity of this cohort of patients compared to that presented above for all CAMHS teams.

Most new referrals came from General Practitioners (51%) followed by Local Authority Social Services (16%) and Local Authority Education Services (9%). 8% of new referrals are coded as 'Other', and 6% were Internal referrals.

Figure 26 below shows a more detailed breakdown of all referral sources.

Figure 26: Source of new referrals for CAMHS Tier 3 caseload, April 2011 to March 2012 (WLMHT, 2013)

Referral Source	No.	%
GP - General Practitioner	308	51%
LA - Local Authority Social Services	98	16%
ESL - Education Service - LEA	57	9%
OT - Other	48	8%
IR - Internal referral	37	6%
AE - Accident And Emergency Department	14	2%
CH - Community Health Services	13	2%
OS - Other clinical specialty	10	2%
ADCC - CONSULTANT, other than in an A&E Department	7	1%
ES - Education Service - Non LEA	3	0%
V71CLINIC - General hospital (clinic)	2	0%
V71WARD - General hospital (ward)	2	0%
AHP - Allied Health Professional	1	0%
DSS - Drug service statutory	1	0%
LO - Local Authority - other departments	1	0%
YOT - Youth Offending Team	1	0%
FF - Family / Friend / Neighbour	0	0%
LAES - Local Authority Education Service	0	0%
SE - Self	0	0%
TOTAL	**603**	**100%**

Between April 2011 and March 2012, 5,253 appointments were offered, of which 82% were attended. Over this period DNA rates for this service averaged at approx. 18%.

Tier 3 CAMHS is the only service in Hammersmith & Fulham with a waiting list - with the average over the last year is 4 weeks from referral to assessment.

KENSINGTON & CHELSEA

SUMMARY OF LOCALISED NEED

CHILD POPULATION

Resident	-	28,423
Registered	-	40,888 (West London CCG)
School	-	11,668

ESTIMATED NUMBER OF CHILDREN WITH MENTAL HEALTH CONDITIONS

Below are expected number of children with Mental Health conditions at any one time, calculated using prevalence estimates from 'Paying the Price' (Kings Fund, 2008). Data is presented for three relevant child population cohorts where possible - resident, registered, and children attending borough schools.

Conduct Disorder	-	470 resident, 683 registered, 314 school attendees
Hyperkinetic Disorder	-	67 resident, 97 registered, 44 school attendees
Emotional Disorder	-	497 resident, 727 registered, 307 school attendees
Co-morbid Disorders	-	257 resident, 373 registered, 177 school attendees
Neurotic Disorder	-	719 residents (aged 16-19)

ESTIMATED NEED FOR CAMHS

There is estimated to be a total of 7,858 children resident in Kensington & Chelsea who may experience mental health problems appropriate to a response from CAMHS - 4,080 at Tier 1; 1,904 at Tier 2; 503 at Tier 3; and 20 at Tier 4.

VULNERABLE GROUPS

BAME Children	-	57% of children in need are from a BAME background.
Looked After Children	-	There are currently 139 Looked After Children, of which 68 could be experiencing some type of mental disorder.
Care Leavers	-	There are currently 135 Care Leavers.
Young Offenders	-	There are currently 68 Young Offenders known to social services, of which 27 are expected to have a diagnosable Mental Health disorder.
Learning Disabilities	-	There are currently 202 people with Learning Disabilities, of which 157 could be experiencing some type of mental disorder.

Service Activity and User Demographics (2011/12)

The following data has been provided by Central North West London Mental Health Trust (CNWL) and shows a full year of data from April 2011 to March 2012, unless specified. Data is first presented for all CAMHS activity and is then broken down by the separate teams that comprise the service, where possible. Some of the data contains inconsistencies and should therefore be used a general guide to CAMHS activity.

All CAMHS Teams - Referrals

There were 1,072 new referrals between April 2011 to March 2012.

Figure 27 below shows the average number of monthly referrals to all CAMHS teams for April 2011 to March 2012. Approx. 89% of referrals are accepted, while 11% are deemed as inappropriate.

Figure 27: Average number of monthly referrals to WLMHT CAMHS, April 2011 to March 2012 (CNWL, 2013)

Average monthly referrals received	89
Average monthly inappropriate referrals	9
Average monthly accepted referrals	80

Most new referrals to the Kensington & Chelsea CAMHS were coded as 'Other' (27%). With a very clear list of referral sources it is interesting to find this, and would be useful if this category could be more clearly explained.

Of the referrals from sources that could be identified, the greatest number came from General Practitioners (23%) followed by Self-referral (17%) and from another Clinical specialty (13%). Local authority services comprised 16% of new referrals, with 11% coming from the Education services and 5% coming from Social services.

Figure 28 below shows a more detailed breakdown of all referral sources.

Figure 28: Source of new referrals for all CAMHS teams, April 2011 to March 2012 (CNWL, 2013)

Referral Source	%
Other	27%
GP	23%
Self	17%
Other Clinical Speciality	13%
Education Service	11%
Social Services	5%
Community MHU (Adult)	3%
A&E	0%
Employer	0%
Police	0%
Carer	0%
Courts	0%
Probation Service	0%
Medium Security	0%
High Security	0%
Temporary Transfer from MHU	0%
Permanent Transfer from MHU	0%
Transition from CAMHS	0%
Eating Disorder Service	0%
Prison	0%
TOTAL	**100%**

Data on where the most inappropriate referrals come from is currently not available for this time period.

All CAMHS Teams - Open Cases

Based on a snapshot of open cases on the 31st March 2012, there were 533 children on the caseload for all CAMHS teams.

Figure 29 below shows the age breakdown, by single year of age, of those on the caseload for the relevant time period. The majority of cases were children aged 4-17 with a peak in the 12-15 age group, and then again at 17. This mirrors the times of life that include the transition from primary to secondary school, and the leaving secondary school.

Figure 29: Age of patients on all CAMHS teams caseload, March 2012 (CNWL, 2012)

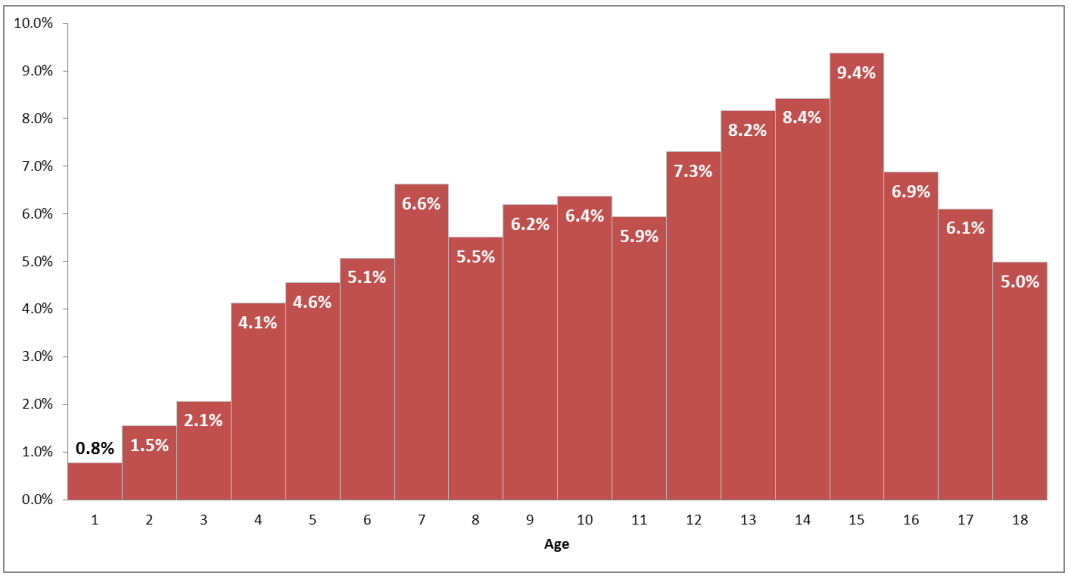


Figure 30 overleaf shows that 23.2% of CAMHS cases were of 'White - British' ethnicity, the second largest ethnic group was 'White - Other' where 20.1% were listed. 18.7% reported to be from a Black ethnic background (once combining all Black ethnic categories), and 14.3% were categorised as Mixed.

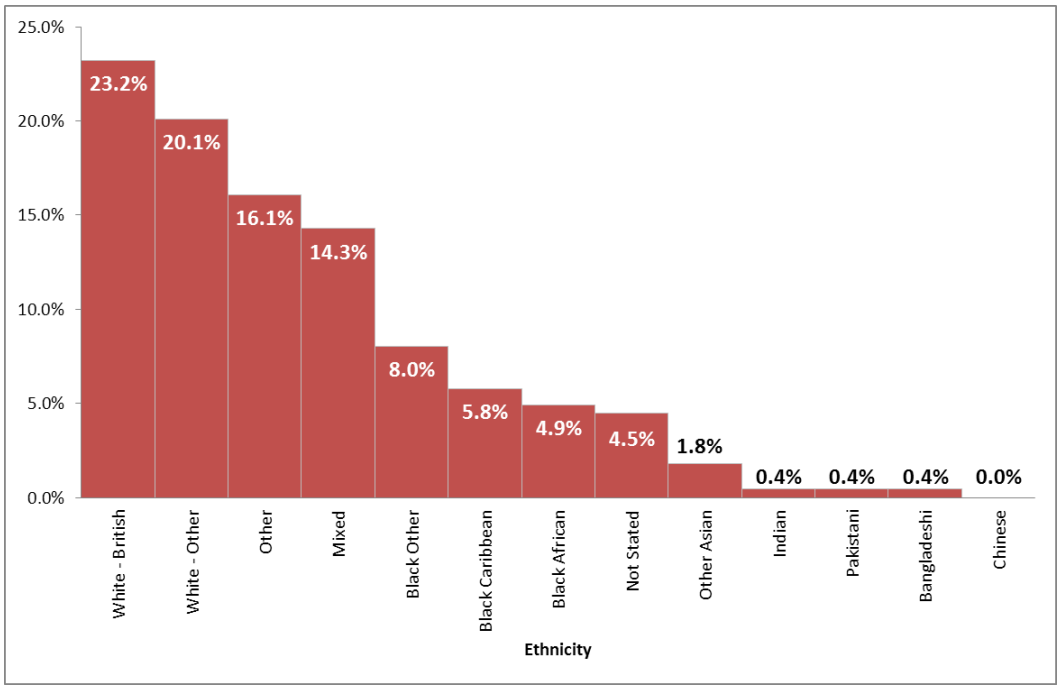
The Asian caseload of approx. 3% suggests a slight under representation of Asian children and young people in Kensington & Chelsea which is common across CAMHS nationally.

However, a significant proportion of cases had no ethnicity recorded (16.1%). It would helpful to reduce this poor recording rate to give a better picture of the ethnic makeup of CAMHS in Kensington & Chelsea.

There is currently no available data on the resident location of the children who are seen by CAMHS in Kensington & Chelsea. This information would be useful to collect as it would enable an evaluation to the links between social deprivation and access.

In addition, data on family composition and the prevalence of children seen who require a carer has not been provided.

Figure 30: Ethnicity of patients on all CAMHS teams caseload, March 2012 (CNWL, 2012)



A diagnostic audit of those currently on the caseload for CAMHS in Kensington & Chelsea was conducted in March 2012. 48 patients on the caseload at the time had a clinical diagnosis.

15 patients were diagnosed with Mood Disorders, 11 with Childhood Disorders, 8 with Neurotic, stress-related and somatoform disorders, and 6 with Psychological development disorders.

Other disorders that were recognised and diagnosed by the services but had 5 or fewer people living with the condition included - Physical & Psychological Syndromes, Personality Disorder and Psychosis.

All CAMHS Appointments

During the period April 2011 and March 2012, the 1,072 reported referrals accepted onto the CAMHS caseload resulted in 6,396 appointments offered.

Of these appointments 1,342 were First appointments, and 5,054 were follow-up appointments. This results in a First to Follow-Up ratio across this period of 1:3.76.

Of the appointments offered, 869 appointments were not attended resulting in a DNA rate of 13.6%. Of the appointments that were not attended, 9% were First appointments and 91% were Follow-up appointments.

Tier 2

Tier 2 services are those that are provided by specialist working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery. For the purposes of this assessment Tier 2 services also include those commissioned directly by schools for example, counselling and psychotherapy services.

The phrase Tier 2 is often used interchangeably with 'Targeted Services' and there are similarities. A useful definition of targeted provision are those partnership and services delivered through children's trust arrangements to improve mental health outcomes for especially vulnerable groups in particular: looked after children; children in

need; children about whom there are child protection concerns; children from refugee and asylum seeking families; children with learning difficulties and disabilities; children from black and minority ethnic groups; young offenders; children with additional needs requiring integrated support.

In Kensington & Chelsea, Tier 2 services consist of Early Intervention Primary Mental Health Workers who work in schools, Looked After Children services, services for Young Offenders, and services for those with Learning Disabilities. Data for those services is provided below.

Within the K&C CAMHS provision there is also an Arabic Families Service which is based in Parkside but does mostly outreach in to the communities working for example with community groups delivering parenting work, consulting to YOT and other statutory agencies on an ad hoc basis and delivering interventions to children and families.

Early Intervention & Primary Mental Health Workers

The Early Intervention team in Kensington & Chelsea is a multi-disciplinary team that delivers interventions in schools across the borough primarily in Primary Schools. The team also support the PRU's through Latimer Education Centre. There are currently 5 Early Intervention Workers.

In addition to the Early Intervention team there are three Primary Mental Health workers who carry out related work in Kensington & Chelsea schools.

As of September 2012, the Early Intervention Team caseload was 162 patients. The Primary Mental Health Workers caseload was 148 patients.

Between October 2011 and September 2012, 828 appointments were offered by the Early Intervention Team. Another 567 were made by the Primary Mental Health Workers.

Further demographic and referral data from these services have not been made obtainable.

Looked After Children

The Looked After Children service in Kensington & Chelsea is a collaborative service that invites specialist mental health input into to a multi-agency service for Looked After Children and those leaving care.

There is one clinician who does direct Looked after Children work in Kensington & Chelsea. Much of the work carried out is on an advisory and consultation basis with other professionals and foster parents and is not captured in data by CNWL.

As of September 2012, the Looked After Children team caseload was 38 patients.

Between October 2011 and September 2012, 273 appointments were offered.

Youth Offending Service

The Youth Offending service in Kensington & Chelsea is a collaborative service that invites Specialist mental health input into the multi-agency Youth Offending Service for children and young people known to the police and courts and at risk of re-offending.

Data for the Youth Offending Service is recorded by another organisation separate to CNWL and has not been made obtainable.

Learning Disabilities

In Kensington & Chelsea the Behaviour & Family Support Team (BFST) work intensively with children with Learning Disabilities and challenging behaviour**.**

The team provides, support, practical advice and behavioural management advice and strategies to support families who have a disabled child with:

- challenging behaviours (such as aggression, self-harm, tantrums, non-compliance)
- emotional problems (such as anxiety, depression, phobias and anger)
- language and communication issues that cause behaviour problems or affect emotional wellbeing
- sensory processing needs
- difficulties with sleep, toilet and eating issues
- issues relating to adolescence

The team also provide training and consultation to staff, carers and professionals in relation to the above issues.

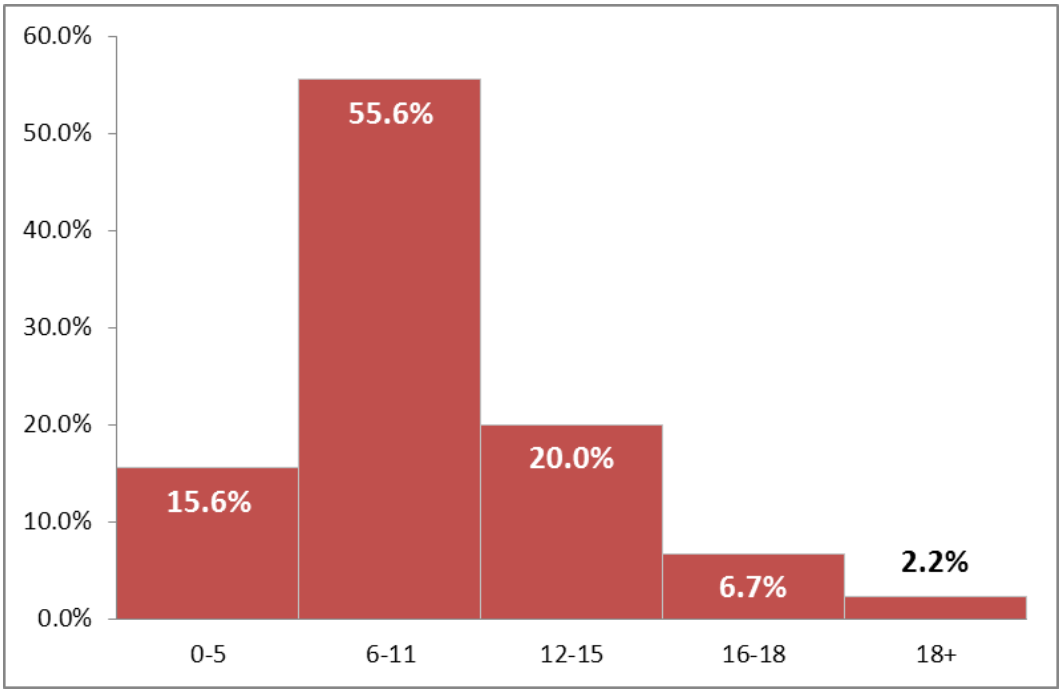
The community-based team provide assessments, intervention work, consultation, support and practical advice regarding children with learning disabilities who have emotional, behavioural or mental health problems and their families. These services are also offered to their families and carers. The team will see children who are resident in the borough up to their 18th birthday.

As of September 2012, the Learning Disabilities team caseload was 77 patients.

Of these patients 75% were Male while 25% were Female.

The age range of patients seen was wide, from Under 5's through to 18. The modal group were those aged 6-12. Figure 31 below shows the age range of patients to this service. However, due to the small numbers it is difficult to draw any inference into this.

Figure 31: Age of patients on CAMHS Learning Disability caseload, March 2012 (CNWL, 2012)



Due to the small numbers of patients it is difficult to draw distinct comparison to the local population in terms of ethnicity, as you would expect the data to fluctuate. However, as of December 2012, we can say that children of ethnic Black groups were over-represented in this cohort compared to the local population.

In terms of referral source, 33% of referrals came from Local Authority Social Services, a further 20% were referred from each the Local Authority Social Services and Other Service or Agency. A further 27% of referrals came from sources such as Carer, Community Services, General Practitioners and Other Clinical Specialties.

Between October 2011 and September 2012, 962 appointments were offered, off which approx. 93% were attended. Over this period DNA rates for this service averaged at approx. 7%.

Tier 3

Tier 3 services are specialised services for more severe, complex or persistent disorders.

Tier 3 services are mostly provided in clinic in Kensington & Chelsea.

Tier 3 data has not been specifically broken out for this assessment by CNWL.

JSNA
Joint Strategic Needs Assessment

CITY OF WESTMINSTER

SUMMARY OF LOCALISED NEED

CHILD POPULATION

Resident	-	38,526
Registered	-	28,935 (Central London CCG)
School	-	21,601

ESTIMATED NUMBER OF CHILDREN WITH MENTAL HEALTH CONDITIONS

Below are expected number of children with Mental Health conditions at any one time, calculated using prevalence estimates from 'Paying the Price' (Kings Fund, 2008). Data is presented for three relevant child population cohorts where possible - resident, registered, and children attending borough schools.

Conduct Disorder	-	618 resident, 456 registered, 508 school attendees
Hyperkinetic Disorder	-	86 resident, 64 registered, 68 school attendees
Emotional Disorder	-	655 resident, 490 registered, 557 school attendees
Co-morbid Disorders	-	339 resident, 249 registered, 279 school attendees
Neurotic Disorder	-	1,095 residents (aged 16-19)

ESTIMATED NEED FOR CAMHS

There is estimated to be a total of 8,853 children resident in the City of Westminster who may experience mental health problems appropriate to a response from CAMHS - 5,550 at Tier 1; 2,590 at Tier 2; 685 at Tier 3; and 28 at Tier 4.

VULNERABLE GROUPS

BAME Children	-	68% of children in need are from a BAME background.
Looked After Children	-	There are currently 208 Looked After Children, of which 102 could be experiencing some type of mental disorder.
Care Leavers	-	There are currently 158 Care Leavers.
Young Offenders	-	There are currently 129 Young Offenders known to social services, of which 52 are expected to have a diagnosable Mental Health disorder.
Learning Disabilities	-	There are currently 273 people with Learning Disabilities known to social services, of which 223 could be experiencing some type of mental disorder.

Service Activity and User Demographics (2011/12)

The following data has been provided by Central North West London Mental Health Trust (CNWL) and shows a full year of data from April 2011 to March 2012, unless specified. Data is first presented for all CAMHS activity and is then broken down by the separate teams that comprise the service, where possible. Some of the data contains inconsistencies and should therefore be used a general guide to CAMHS activity.

All CAMHS Teams - Referrals

There were 1,110 new referrals between April 2011 to March 2012.

Figure 32 below shows the average number of monthly referrals to all CAMHS teams for April 2011 to March 2012. Approx. 90% of referrals are accepted, while 10% are deemed as inappropriate.

Figure 32: Average number of monthly referrals to WLMHT CAMHS, April 2011 to March 2012 (CNWL, 2013)

Average monthly referrals received	93
Average monthly inappropriate referrals	9
Average monthly accepted referrals	84

Most new referrals came from General Practitioners (28%) followed by Local Authority Education Services (27%) and Local Authority Social Services (13%). 11% of new referrals are referrals from another clinical specialty, and 10% are coded as 'Other'.

Only 6% were recorded as self-referral, a significantly smaller amount than the service in Kensington & Chelsea which are run by the same providers.

Figure 33 below shows a more detailed breakdown of all referral sources.

Figure 33: Source of new referrals for all CAMHS teams, April 2011 to March 2012 (CNWL, 2013)

Referral Source	%
GP	28%
Education Service	27%
Social Services	13%
Other Clinical Speciality	11%
Other	10%
Self	6%
A&E	3%
Community MHU (Adult)	3%
Employer	0%
Police	0%
Carer	0%
Courts	0%
Probation Service	0%
Medium Security	0%
High Security	0%
Temporary Transfer from MHU	0%
Permanent Transfer from MHU	0%
Transition from CAMHS	0%
Eating Disorder Service	0%
Prison	0%
Unknown	0%
TOTAL	**100%**

Data on where the most inappropriate referrals come from is currently not available for this time period.

All CAMHS Teams - Open Cases

Based on a snapshot of open cases on the 31st March 2012, there were 533 children on the caseload for all CAMHS teams.

Figure 34 below shows the age breakdown, by single year of age, of those on the caseload for the relevant time period. The majority of cases were children aged 4-17 with a peak in the 12-15 age group, and then again at 17. This mirrors the times of life that include the transition from primary to secondary school, and the leaving secondary school.

Figure 34: Age of patients on all CAMHS teams caseload, March 2012 (CNWL, 2012)

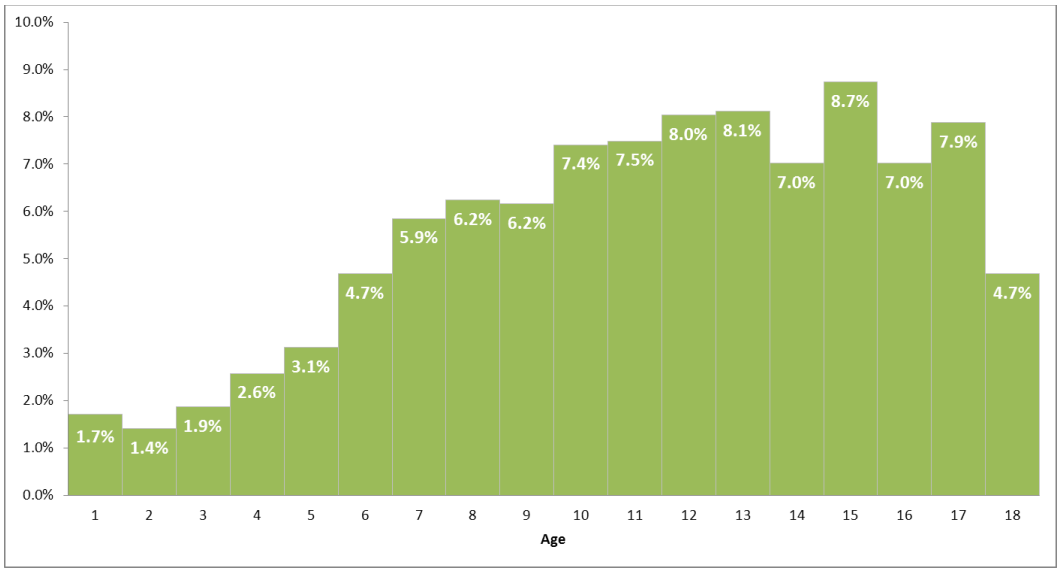


Figure 35 overleaf shows that 20.3% of CAMHS cases were of 'White - British' ethnicity, the second largest ethnic group was 'Other' where 16.1% were listed. It is expected that the 'Other' category would be high in Westminster because of the large proportion of Middle-Eastern and Arab residents, but it would be helpful to have the 'other' category further explained to see if this corroborates.

10.6% reported to be from a Black ethnic background (once combining all Black ethnic categories), and 6.2% were categorised as Mixed.

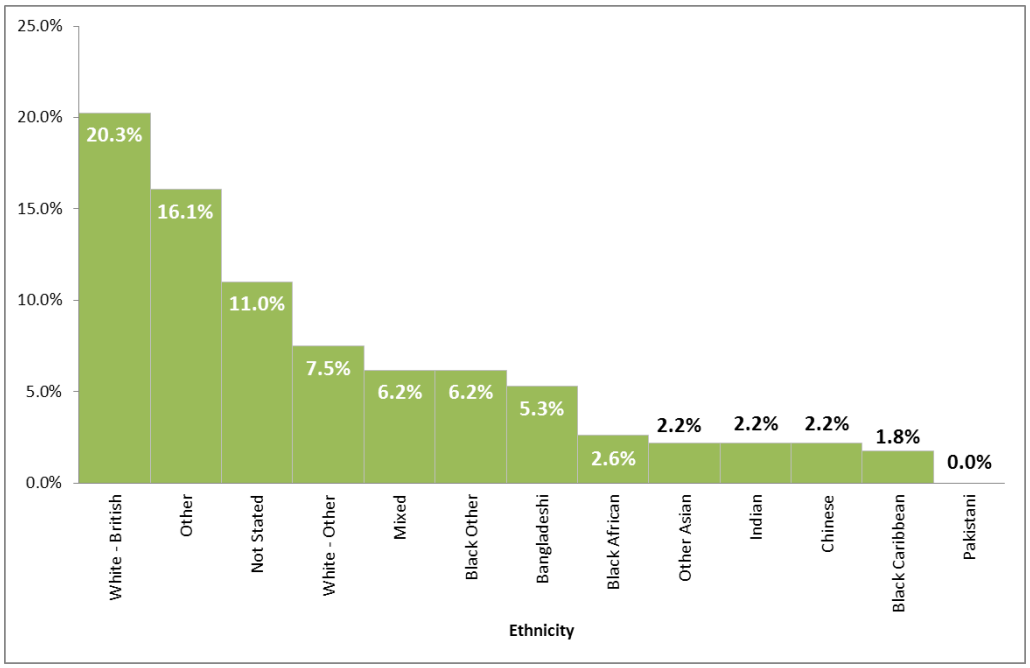
The Asian caseload of approx. 10% suggests is reflective of the large Bangladeshi community in Westminster and potentially signifies positive targeted services as it is common to see Asian children under-represented across CAMHS nationally.

However, a significant proportion of cases had no ethnicity recorded (11%). It would helpful to reduce this poor recording rate to give a better picture of the ethnic makeup of CAMHS in Hammersmith & Fulham.

There is currently no available data on the resident location of the children who are seen by CAMHS in the City of Westminster. This information would be useful to collect as it would enable an evaluation to the links between social deprivation and access.

In addition, data on family composition and the prevalence of children seen who require a carer has not been provided.

Figure 35: Ethnicity of patients on all CAMHS teams caseload, March 2012 (CNWL, 2012)



A diagnostic audit of those currently on the caseload for CAMHS in Westminster was conducted in March 2012. 141 patients on the caseload at the time had a clinical diagnosis.

58 patients were diagnosed with Childhood Disorders, 32 with Neurotic, stress-related and somatoform disorders, 25 with Mood Disorders, and 8 with Psychological development disorders.

Other disorders that were recognised and diagnosed by the services but had 5 or fewer people living with the condition included - Physical & Psychological Syndromes, Personality Disorder, Psychosis, disorders due to substance misuse, Mental retardation, and Organic Disorders.

All CAMHS Appointments

During the period April 2011 and March 2012, the 1,110 reported referrals accepted onto the CAMHS caseload resulted in 10,470 appointments offered.

Of these appointments 1,549 were First appointments, and 8,921 were follow-up appointments. This results in a First to Follow-Up ratio across this period of 1:5.76.

Of the appointments offered, 1,429 appointments were not attended resulting in a DNA rate of 13.6%. Of the appointments that were not attended, 8% were First appointments and 92% were Follow-up appointments.

Tier 2

Tier 2 services are those that are provided by specialist working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery. For the purposes of this assessment Tier 2 services also include those commissioned directly by schools for example, counselling and psychotherapy services.

The phrase Tier 2 is often used interchangeably with 'Targeted Services' and there are similarities. A useful definition of targeted provision are those partnership and services delivered through children's trust arrangements to improve

mental health outcomes for especially vulnerable groups in particular: looked after children; children in need; children about whom there are child protection concerns; children from refugee and asylum seeking families; children with learning difficulties and disabilities; children from black and minority ethnic groups; young offenders; children with additional needs requiring integrated support.

In Westminster, Tier 2 services consist of Early Intervention services, Looked After Children services, services for Young Offenders, and services for those with Learning Disabilities. Data for those services is provided below.

Within Westminster the Marlborough Cultural Therapy Team provide language specific outreach interventions to the Chinese Mandarin and Cantonese speaking communities, and consultation to statutory services.

Early Intervention

Early intervention services in Westminster include:-

- Primary mental health workers who link in with GPs and Health Visitors
- Therapists based within Children's centres
- Dedicated therapy time for liaison with schools for children who are refugees, and,
- Outreach workers from the Marlborough Education Service working in school settings.

The Marlborough Family Education Centre (MFES) provides intense interventions on a term time basis to children at Westminster schools.

Westminster City Council commissions the service to deliver work in all primary schools in Westminster. Outreach work from MFES is commissioned by individual Westminster secondary schools to deliver work on their premises.

The outreach workers includes staff from all clinical backgrounds who work agreed hours in each school and follow the Marlborough multi-families model.

Currently there is no CAMHS provision to the Westminster PRU which is an identified gap.

As of September 2012, the Early Intervention caseload for was 297 patients.

Between October 2011 and September 2012, 3,475 appointments were offered, off which approx. 90% were attended. Over this period DNA rates for this service averaged at approx. 10%.

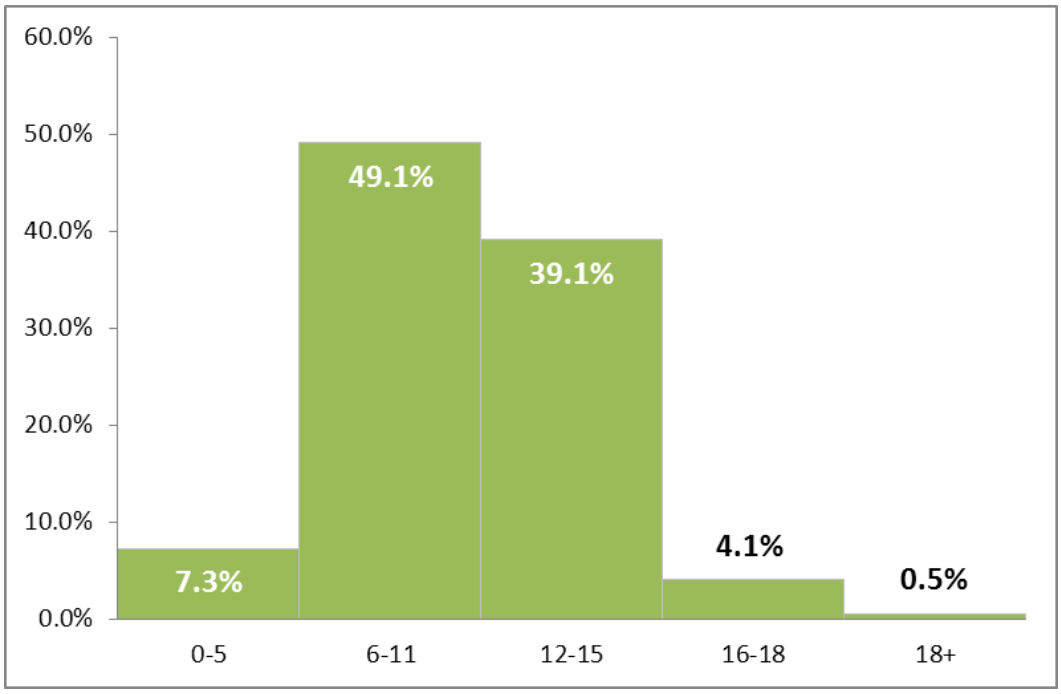
Of the 220 patients seen at the Marlborough Family Education Centre, 156 of the patients were Male (71%) and 64 were Female (29%).

The age range of patients seen was wide, from Under 5's through to 18. The modal group were those aged 6-12. Figure 36 overleaf shows the age range of patients to this service. However, due to the small numbers it is difficult to draw any inference into this.

Due to the small numbers of patients it is difficult to draw distinct comparison to the local population in terms of ethnicity, as you would expect the data to fluctuate. However, as of September 2012, we can say that children of ethnic 'Arab' and 'Other' groups were over-represented in this cohort compared to the local population.

In terms of referral source, 95% were received from the Local Authority Education Services.

Figure 36: Age of patients on CAMHS Early Intervention caseload, March 2012 (CNWL, 2012)



Looked After Children

Looked after children who live within the borough of Westminster are able to access the core CAMHS teams but there is also a dedicated CAMHS Team for LAC which is based in Social Services enabling access to services for children who either do not live in Westminster or who do not meet the threshold for core CAMHS despite having significant needs, or are difficult to engage in clinic based services.

This team is a multi-disciplinary team including Psychiatry, Systemic Family Therapy, Child Psychology and Child Psychotherapy.

Much of the clinical intervention also involves significant contact with foster carers, birth parents and the attending of professional and network meetings. Many of the cases in which the LAC team have involvement are in a 'consultation' period where there is no formal allocation to a named clinician (open as a referral to the team) with no face to face activity with the identified patient.

As of September 2012, the Looked After Children's team caseload was 51 patients.

An even split of Male and Females were recorded.

The age range of patients seen was wide and evenly spread between this age range 0-18. Due to the small numbers it is difficult to draw any inference into this.

Due to the small numbers of patients it is difficult to draw distinct comparison to the local population in terms of ethnicity, as you would expect the data to fluctuate. However, as of September 2012, we can say that children of ethnic 'Arab' and 'Other' groups were over-represented in this cohort compared to the local population.

In terms of referral source, 95% of referrals came from a Local Authority Social Services. Only 3 other referrals were recorded, all coded as from an 'Other service or agency'.

Between October 2011 and September 2012, 392 appointments were offered, of which 80% were attended. Over this period DNA rates for this service averaged at approx. 20%.

Youth Offending Service

St Mary's CAMHs has developed targeted provision to meet the specific needs of children known to the Youth Offending services, which includes high levels of mental health needs and social disadvantage.

Conduct disorders occur with frequent psychiatric co-morbidity including depression, self-harm, anxiety, PTSD, substance misuse, psychosis and neurodevelopmental difficulty such as ADHD and reading delay. Risk to self and others is increased and families characterized by high levels of conflict and breakdown.

The Youth Offending team serves approximately 100 open cases at a time (175-200/year).

St Mary's CAMHS receives approximately 12-15 referrals per year of young people in YOT (some are referred via GP/school/social services) plus approximately 10 further cases already known to St Mary's CAMHS become known to YOT within a year.

A substantial proportion of cases that are engaged with St Mary's CAMHS while under YOT will remain open to CAMHS beyond their YOT involvement for on-going intervention (such as ADHD medication, cognitive and family therapy).

Features that characterise this targeted provision include:

- Provision occurs within multiagency framework
- Provision is stepped with increased resource focused on those with more complex needs
- Seamless boundary between YOT and St Mary's CAMHS
- High flexibility to enhance engagement (e.g. timing, venue, preparation for referral)
- Multimodal interventions with shifting focus over time
- Longitudinal involvement required for young people and families with high levels of chronic needs.

Learning Disabilities

Current specialist Learning Disabilities (LD) provision in Westminster is provided by St Mary's CAMHS neuropsychiatry / LD team.

The specialist neuropsychiatric / Learning Disabilities team provides consultation to and liaison with the Children with Disabilities (CWD) Team in Westminster Social Services and the Specialist School provisions in the borough (College Park and QE2) enabling easy access for referrals as well as on-going consultation about these children's management.

A behavioural nurse runs a parenting group for children with learning disabilities jointly with one of the Social Workers from the CWD team (Triple P Stepping Stones).

Although children with learning disabilities and different types of mental health problems are seen in all clinics in Westminster CAMHS, the team at St Mary's CAMHS provides a specialist diagnostic and management service for children up to the age of 18 years with Learning disabilities and complex mental health difficulties - including autistic spectrum and attention deficit hyperactivity disorders which are particularly high in this group of children - and who live within the borough of Westminster.

Often these families are receiving a service from the CWD team due to their high level of need. There is close joint working - and cross referrals as appropriate - with the Community Paediatric team and we hold regular joint assessments of children with co-morbid difficulties including possible Autistic Spectrum disorders (ASD).

Currently there are approximately 60 cases with a diagnosis of learning disability (LD) and/or ASD open to the team (ASD and LD:26; ASD without global LD:18; LD without ASD:15).

Diagnosis and management of mental health problems in children with learning disability can be more elaborate, time consuming and require more intensity and duration of input than similar problems in children of normal intelligence level, hence the importance of providing specialist provision. In generic CAMHS the presence of learning disability has been associated with less positive mental health outcomes.

Tier 3

Tier 3 services are specialised services for more severe, complex or persistent disorders.

Tier 3 services are mostly provided in clinic in Kensington & Chelsea.

Tier 3 data has not been specifically broken out for this assessment by CNWL.

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